Testimony of Francis J. Braceland, M. D., Sc. D.

representing the

American Psychiatric Association

and

The National Association for Mental Health

in support of appropriations for the

NATIONAL INSTITUTE OF MENTAL HEALTH

before the

HOUSE APPROPRIATIONS SUB-COMMITTEE ON

LABOR, HEALTH, EDUCATION AND WELFARE

Representative John E. Fogarty, Chairman

April 2, 1963

Mr. Chairman; Members of the Committee:

There is no need for me to recount for you the number of years I have been coming before this Committee in behalf of the mentally ill; sometimes I think it has been so regularly and frequently that I may have worn out my welcome. This year, however, in addition to representing the American Psychiatric Association--the oldest of our national medical societies--I am also professional representative of that great group of citizens who comprise the National Association for Mental Health. These responsibilities are great. One group is made up of the nation's more than 13,000 psychiatrists who have been accustomed to speak for legions of distressed patients down through the ages when no one else seemed to care. The other consists of a valiant group of citizens banded together, with a history of more than 50 years of wonderful work toward alleviating the plight of people who were sick and more often than not neglected. Fortunately, in representing the citizens' group I have the honor of being associated with one of the NAMH's distinguished officers, Mr. Frazer Cheston.

My first pleasant duty is to respectfully salute you and your Committee, Mr. Chairman, for it is this Committee and its counterpart in the Senate which have steadfastly stood by the efforts of those groups which have sought to raise the level of psychiatric practice and to bring the humane care of the mentally ill to its present high level. We have recently acquired a lot of new friends, Mr. Chairman, and we are extremely grateful for them, but you gentlemen are old friends; you have been so down through the years. In fact, you fought for stipends to educate mental health personnel, for research funds to help find the causes of mental illness, and for community funds to try new approaches to the problem. These efforts are now coming to fruition; the Committee worked hard, often against great odds. You

gentlemen need no encomiums from me but I have repeatedly said in public and in private what I would like to repeat here--without the help of this Committee and Mr. Hill's Committee in the Senate, our situation in mental hospitals and in our overall fight against mental disease might well be in chaos.

In an appearance before you about four years ago we mentioned that we were probably wrong in looking for a dramatic breakthrough against mental disorder, for, as we were doing so, the specialty of psychiatry was advancing slowly and steadily, though undramatically. Today it is almost incredible to see the interest, the advances and the results of concentrated efforts to control this scourge. My colleague, Mike Gorman, and I asked you at that time to bear with us for another decade, for certainly great things were in the offing and, while we knew well that you had no intention of deserting, neither you nor we expected things to happen as quickly as they did. I don't think any of us expected to hear a President of the United States say in our time what our present distinguished President said as he announced a veritable crusade:

> "This situation has been tolerated far too long. It has troubled our national conscience but only as a problem unpleasant to mention, easy to postpone and despairing of solution."

The objectives the President mentioned, as you know, were: First, seeking the causes of the illnesses--this means research. Second, strengthening the skilled manpower pool necessary to sustain the attack--this means the training stipends and the funds for teachers and courses and the preparation of those who are dedicated to preparing personnel for a concerted attack on the mental disease problem. Third, strengthening and improving programs and facilities serving the mentally ill and the retarded; this includes many of the projects which you have endorsed--the clinical centers, the new concepts

under Title V, and various other projects for which you earlier prepared the groundwork.

As to the present situation, as I see it from my vantage point, so much has happened that it is hard to get it all in proper perspective. General and private mental hospitals now are reporting a much shorter stay--some as low as 3 or 4 weeks--for psychiatric patients. Think of what this means to families, to friends, to the economy, to industry, to the nation, to the patients themselves. A whole new philosophy seems to be springing up; people are now expected to get well, and they seem to meet this expectation.

The attitudes in the better mental hospitals have changed immeasurably. People are confidently expected to recover and return to their homes and their jobs as quickly as possible. One phenomenon has appeared which I would like to comment upon. In general medicine, when a patient is affected with diabetes, the doctor tries to adjust his blood sugar while keeping him at home or, better yet, on the job. Failing in this the individual is admitted to the hospital for a short period and attempts at adjustment of his blood chemistry are made. But the patient does not have to stay in the hospital for an interminable period. This is in contrast to the way things used to be handled in emotional disorder. Let the person have one upset, which distressed his family, friends or society in general, and away he would go to a mental hospital--and the period of his absence was usually an extended one. This routine is changing now, fortunately. Attempts are being made to treat the mental patient early and intensively and, if at all possible, to keep him out of hospitals altogether. A sizeable number of these patients will have recurrences and will come back--but that is all right; so does the diabetic come back. In the meantime, however, they will

have been home and perhaps will have been at work, and this is a great step in the right direction.

Perhaps you will hear the complaint, made by the ultra-conservatives in our field: Yes, the patients went home, but they still have the illnesses. Well, the diabetic still has his illness, also, but he is functioning, and he is not in a chronic disease hospital, and he is not a public charge.

I am sure that you gentlemen know, as we do, two important corollaries of this situation: (1) No matter what we do, there will always be a number of sick people whose illness will drag on over a long period and some of them will not get well at all. These folks will have to be placed in institutions intended for the chronically ill. (2) There are some illnesses which, because of the inherent danger involved in them, will require attention in the security of state hospitals. In other words, gentlemen, no matter how intensive our treatment efforts, there will always be a type of state hospital required. I believe firmly, however, that with the fruition of present plans we definitely can prevent chronicity in a large number of cases and we can cut the state hospital population in half within the next decade. I believe also something that is said more frequently now, namely that within several decades the old type of state hospital as we know it can be made to disappear.

May I introject at this point one explanatory statement. In making the above remarks I in no way intend to cast aspersions upon those fine people who work in state hospitals and who have through the years dedicated themselves to a most difficult task, usually against great odds. These hospitals contain many fine professional people who have stayed on their jobs and taken abuse because they knew they were needed and because they were

held there by their social consciences. The abuses in state hospitals may fairly be placed at the door of the citizens--all of us--we got what we paid for and we allowed things to deteriorate because we did not insist that state legislators correct them.

Well, at present citizens are aroused, communities are enthused, psychiatry is moving closer to medicine, and things are better in general. The family doctor is interested and, fortunately, is playing a larger role in the alleviation of emotional illnesses; he is the first line of defense against it.

There is still some feeling about people with mental disorder, but much of it is covert and it is only infrequently expressed openly. This feeling, this mild fear and antipathy is a remnant of the past; it is a carry-over. It is as if there were some moral connotations connected with mental illness. It is a feeling often unexpressed that, "if he had been a better man, he would not be sick." In other words: "If he were like me, he would not have gotten this illness." This is Phariseeism of the worst sort; it is the Pharisee standing afar off and thanking God he is not as one of these. As a matter of fact, it usually is not the "bad guy" who becomes ill; his conscience is made of gutta percha. It is more often the good and dedicated person who becomes sick because he has suffered in some fashion at the hands of others.

Gentlemen, I hope you will forgive me these preliminary remarks; they are the musings of a clinician. You have heard by now from many people--some of them experts, all of them in earnest--and I shall take but little more of your time. I desire only to accentuate a few of the things you already have heard and perhaps to add one additional professional slant to

them. There is little need to recall that there are still more than a half million people in our state hospitals. Forty per cent of them have been hospitalized for more than 10 years and more than one third of them are over 65 years of age. There are now 17 million people in the nation over 65 years of age and it is estimated that there will be 20 million in that age group in the next decade. In other words, while we are thinking of the contemplated wonderful new institutions of the future, we cannot forget that we have these large numbers still in state hospitals and we must keep at them and never give up in our efforts to help them. We cannot let them down.

I am sure that you have heard that every day a small number of people (between 5 and 10 of them), who have been hospitalized for more than 20 years, are leaving the hospitals and taking their places in the community. True enough, the number is small, but it has an important lesson for you and for me. The fact that they do get well after such a long time means that all the while they must have had that potentiality for recovery. It is up to us, each in our way, to enable all others who have similar potentialities to realize them.

Just one more statement, if you please, gentlemen, about some of the legislation comtemplated for the future and before I get down to the several points I would like to make regarding the present budget. You are thoroughly familiar with the concept of the comprehensive mental health center and what it entails in the future. Among its manifold tasks will be the prevention of the return of people to state hospitals. You know how many of them now leave these hospitals under medication and then fail to continue to receive it or take the medication while they are out. Also you know that families are not always overjoyed to see these patients come back

and employers are not always in a hurry to hire them. Hence their gravitation back to state hospitals, and hence the excellent reasons for trying to keep them out of these hospitals in the first place. They need treatment quickly, thoroughly and close to home so they do not lose contact with jobs or with loved ones.

This situation had its counterpart in the military service. In World War II a great many men were lost to the service by reason of invaliding those with emotional upset from the area of combat into hospitals remote from their units. Once in hospitals and with no responsibility, many lost their motivation for returning to difficult combat situations and could not be returned to duty. Later Colonel Glass made particular note of this fact and, as a consequence, in the Korean conflict those who broke emotionally were treated quickly and within the combat area with remarkably better results. The same will surely hold true in civilizn life. Treatment in the area and in the community thus is medically and psychiatrically sound and it has been proven to be so. Hospitalization is no longer the single and inevitable method or locus of treatment; it is only one of several possibilities and it is not neccessarily the best.

In regard to the budget for this present fiscal year, we would like to address ourselves to you regarding the personnel situation. In spite of the advent of new drugs and of changed environment in hospitals and in view of all of the contemplated advances, there looms before us a severe personnel shortage. Even now there is still insufficient personnel to utilize and apply all of the techniques which are known to us. The authorities in one foreign country reasoned that with new drugs and techniques available they could cut down on the numbers of personnel involved,

but this was a miserable failure and the opposite proved to be the case. There is still an urgent need for trained individuals to eliminate some of the obvious deficiencies in the care of psychiatric patients. The rise in population and the intensification of treatment efforts spell the need for an urgent increase in the recruitment and training of workers of different skills to carry out the various required procedures.

Several years ago the Joint Commission report presented a rather grim picture of mental health manpower trends. Things have improved very little since then. At present there are approximately 13,000 psychiatrists in the United States and it is conservatively estimated that we need twice that number. The shortages of trained clinical psychologists and psychiatric social workers are also distressingly obvious. The shortage of nurses is common knowledge in all fields, but it is particularly obvious in psychiatry. Albee's report was published nearly four years ago and at that time he concluded that, unless we are industrious in continuing our recruitment and training of individuals in all of these so-called core psychiatric fields, we will slowly lose ground in the next several decades.

You can well imagine what the situation would now be if you had not turned your attention to the problem over the past decade. Due largely to the help of NIMH stipends and training grants, the numbers of individuals in the four disciplines which make up the core mental health professions have increased two and a half times in 11 years. This speaks volumes for the effectiveness of the training grant programs and accentuates the need for continual interest in that direction. We need to begin right now to train more people for the contemplated work to be done in the years to come. Comprehensive mental health centers will be of little use without

trained personnel to run them.

It is my experience that there are many more individuals applying for training in psychiatry than there are stipends to cover them. This is true also of the situation with general practitioner grants. This year we had three times as many bona fide applicants for these grants as we could accommodate. This is a source of never ending wonderment to me. I once thought that,after the first flurry,interest in this general practitioners' program would die out, but instead it has increased. The reason for interest in it is obvious; the practitioner sees such need for understanding of emotional problems. He encounters them frequently, masquerading as physical diseases.

I need say nothing to you about research training or training in fields other than psychiatry; you have heard about those problems from men who are experts in them. I would only respectfully suggest that this year the training grants for general practitioners be raised to 11 million dollars. There is an urgent need for this.

Certainly, one of the neglected areas in the care of patients is that of recruiting and improving the quality of sub-professional and technical manpower personnel. These are the people often closest to the mentally ill patients--they stay with them for the longest periods of time--and yet most of them have had no training or, at best, their training is skimpy. Thus far there has been little incentive for these individuals to undertake work in mental hospitals. Most of their jobs lead up a dead end street. For many of them to be an attendant or an aide today means that they will be aides next year and 10 years from now with little hope of advancement.

In the light of things to come in the mental health field and keeping in mind present unemployment figures and the likely effects of automation on future employment, I would suggest much more attention be paid to training and retraining in these groups--perhaps particularly in the training of aides and in attempting to increase their levels of competence. Toward this effort I would suggest raising also the in-service appropriation for training from 3 million, three hundred four thousand to six million, three hundred four thousand; it is well justified and it might help solve several problems. The Department of Labor might be interested in this particular facet of the problem.

I would like particularly to endorse the President's request for 12 million dollars for hospital improvement grants. A lot will come from this effort, I am sure. In fact, I know of one state which has already experimented with an improvement grant to a few hospitals for several wards in order to move the patients out more quickly. This "sneak preview" was an unqualified success; not only were patients moved out twice as fast, but the excitement the effort created in the hospital was electric. It raised the tone of the other wards which set out to compete with the segments of the hospital which they thought had been favored over their own.

One thing I see in the offing which needs your especial attention, if you please, gentlemen, is the over-all picture of the state control programs. The funds which you have allocated to the states in the past have acted as "seed money" and many of the states have responded to your prompting by allocating funds for clinics for adults and children. This area is extremely important if we are to prevent chronic illness or to prevent hospitalization at all. Here is one of the early warning systems, an early

defense line against chronicity. I have personal knowledge of community areas which are having a hard time and which are in need of clinics and grants-in-aid, and I have no hesitation in requesting that you think of raising the present projected budget from $6,750,000 to $10,750,000. It will repay the funds and efforts expended ten-fold in a reasonable period of time.

I fear that I am taking too long and I know that there will be others who will follow me who are quite knowledgeable in other aspects of this field. I know, too, that you have already heard a large number of witnesses. In general, we in the profession are happy with the President's budget and there are only two other areas in which we would suggest increases. I shall simply mention them and hope that they have been, or will be, more completely covered by other witnesses. I would increase the funds for Clinical Research Centers by $1,250,000 over the President's budget. The need for these centers and their potentialities for good are obvious; it is out of these centers that new and vital information certainly must come and I commend them to you highly.

Also, the Title V project grants hold possibilities for advance in knowledge in the field. It is unnecessary for me to spell out these projects; they have played a large part in the trying out of new concepts. I have personal knowledge of several of these and I am highly impressed by things accomplished by these projects. One that is fresh in my mind enabled several autistic children to enter regular nursery school, whereas beforehand they had been condemned almost surely to lifetime custodial care. These projects could well use an additional six million dollars over the $15,190,000 already requested in the 1964 budget.

There are many other aspects of the program I would like to discourse upon--research, professional training, collaborative studies, pharmacology, etc.--but it is not fair to take your time. I have seen some wonderful results in all aspects of the present-day approaches to the mental health problem. I would have liked to discourse at length upon the various aspects of the program concerned with mental retardation but I have not been commissioned to do so. I am, however, in complete admiration of the efforts in this field; great things will be sure to come from the dedicated efforts of those who espouse this cause, professional and lay. I might add that I think I recall that this Committee also thought of the problem of mental retardation some years back and you must be encouraged and gratified at the interest which is being shown today.

If I seem a bit enthusiastic or intense in my statements or efforts, I would ask your indulgence. Please remember that I have watched this situation for over 30 years and I have seen people neglected, humiliated and otherwise badly treated, and now with the present new enthusiasm I may be injudicious in asking for a great deal for them. I live in dread that the bubble will burst and, to mix metaphors, in dread that the clock will strike 12 and the royal coach will turn into a pumpkin. I know that this Committee will not allow that to happen.

In back of the various jokes about psychiatrists, mental hospitals and sick people and beneath the cartoons in which couches and men with beards are prominent, there is still a certain amount of dread about these illnesses. Maybe in the partnership of the professions, the government and aroused citizens we can remove most of that. I certainly hope so.

Thank you, gentlemen, for allowing me to come before you.

Suggested Increases in Proposed 1964 Budget

	President's Budget	Suggested Budget
Training		
General Practitioners	$ 9,000,000	$ 11,000,000
In-service Training	3,304,000	6,304,000
State Control Program		
Grants to states - clinics, etc.	6,750,000	10,750,000
Research		
Title V	15,190,000	21,190,000
Clinical Research Centers	1,750,000	3,000,000
Total Request, Fiscal 1964	190,096,000	206,346,000

STATEMENT BY

FRANCIS J. BRACELAND, M. D.

BEFORE THE

SUBCOMMITTEE OF THE SENATE APPROPRIATIONS COMMITTEE

IN SUPPORT OF THE PRESIDENT'S BUDGET

FOR THE NATIONAL INSTITUTE OF MENTAL HEALTH,

NATIONAL INSTITUTES OF HEALTH,

PUBLIC HEALTH SERVICE.

May 16, 1963

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Presented on behalf of

The American Psychiatric Association

and the

National Association for Mental Health

I am Francis J. Braceland and I have been a psychiatrist for over 30 years. I graduated from Jefferson Medical College in 1930 and was an intern and Chief Resident at Jefferson Hospital until November, 1932, when I began my psychiatric fellowship training at the old Pennsylvania Hospital in Philadelphia. I was then a Rockefeller Fellow in Psychiatry in Zurich, Switzerland, and at the National Hospital, Queens Square in London. I returned to be Clinical Director at the Pennsylvania Hospital until 1941 when I was appointed Professor of Psychiatry and Dean of the School of Medicine, Loyola University.

I have since occupied the following positions:

1942-46 - Special Assistant to the Surgeon General, U. S. Navy and war-time Chief of the Psychiatric Section. I am a Rear Admiral, Medical Corps, USNR-Retired.

1946-51 - Head of the Section of Psychiatry, Mayo Clinic, and Professor of Psychiatry, Graduate School, University of Minnesota

1951 until Present - Psychiatrist-in-Chief, the Institute of Living, Hartford, Connecticut, and Clinical Professor of Psychiatry, Yale University. Since 1959 Lecturer on Psychiatry, Harvard Medical School.

I have been in the past: President, American Board of Psychiatry and Neurology, 1953; President, American Psychiatric Association, 1956-57; President, Association for Research in Nervous and Mental Disease, 1957; Chairman, American Medical Association Section on Nervous and Mental Disease, 1956; Chairman, National Health Forum, 1958; President, Board of Examiners for Certification of Mental Hospital Superintendents, 1955; Vice-President, World Psychiatric Association, 1961. I have served as a member of the Advisory Council to the National Institute of Mental Health.

Mr. Chairman, members of the Committee, I am happy to appear before you once more to represent the American Psychiatric Association and the professional

aspects of the National Association for Mental Health in behalf of the President's budget for the National Institute of Mental Health.

As you know, the professional organization I represent has a membership of 13,000 psychiatrists -- most of the physicians in the country practicing psychiatry in institutional settings of all kinds, in community mental health programs of all kinds, and in private practice; the voluntary organizations I represent, with a membership of tens of thousands of persons, has, over more than fifty years of its existence, relied heavily upon its professional members to efforts to improve the plight of the mentally ill, and to improve the mental health of our citizens.

My first pleasant duty is to transmit to you, Mr. Chairman, and to the members of your committee, the greetings of my colleagues in both organizations. I wish, too, to communicate to you their heartfelt thanks, for it is this committee and its counterpart in the House which have steadfastly stood by the efforts of the APA and the NAMH to raise the level of psychiatric practice, and to ensure that the mentally ill and the mentally retarded receive the best care that modern psychiatric medicine can provide.

We think of you gentlemen as our friends, for so you have proved yourself to be down through the years as you staunchly supported for goals for which we stand: for the promotion of the mental health of the citizens of this wonderful country of ours; for the prevention of the psychiatric disorders whenever possible; for the prompt and effective treatment of the psychiatric disorders when they do occur; for the rehabilitation and the reintegration into society of those who have suffered from these disorders; for the compassionate and hopeful care of those unfortunates whose illnesses lead to lifelong, and several disabilities.

We are grateful to you, as psychiatrists, for your concern for our patients. But we are, perhaps, more grateful to you as citizens who are committed

to improving the lots of millions of our fellow citizens who are today -- or perhaps tomorrow -- undergoing the anguish that accompanies the mental illnesses.

You have fought valiantly for years, and often against great odds, for research funds to help find the causes of the mental illnesses, and how they may be prevented and cured; for training funds to ensure that there be a sufficient number of adequately trained personnel to care for the mentally ill, and that the helping persons within our communities -- our teachers, our clergymen, those working in social agencies and others -- understand how to promote the mental health of our citizens; for grant-in-aid funds to stimulate the growth of community mental health programs in our various states; for project funds designed to test and evaluate new methods of caring for the mentally ill.

Though you gentlemen need no encominums from me, I would like to repeat here what I have repeatedly said in public and in private -- without the help of this committee and Mr. Fogarty's committee in the House, our situation in mental hospitals and in our overall fight against mental disease might well be in chaos.

The efforts of the past are coming to fruition -- and the fruit is good, though the tree which bears it is yet too small to provide for all our needs.

Four years ago, when we appeared before you, we mentioned that we were probably wrong in looking for a dramatic breakthrough against mental disorder, for the specialty of psychiatry was advancing slowly and steadily, though undramatically. Gentlemen, we were wrong in our expectations, for in the past two years, since the Joint Commission on Mental Illness and Health, which was authorized by Congress, submitted its Final Report to you, we have witnessed a breakthrough of major proportions. We have broken through the walls of general indifference towards the fate of the mentally ill which sometimes made it appear that those concerned with controlling this scourge were few in number, and isolated from their fellows.

The nature of this breakthrough was presented to us in unmistakably dramatic terms on February the fifth of this year, when the President of the United States, for the first time in the history of our country, proposed to the Congress that a wholly new national approach to the twin problems of mental illness and mental retardation be adopted.

As he said then:

> "I am convinced that, if we apply our medical knowledge and social insights fully, all but a small portion of the mentally ill can eventually achieve a wholesome and constructive social adjustment ... It is clear that a concerted national attack on mental disorders is now both possible and practical . . . ."
>
> "If we launch a broad new mental health program now, it will be possible within a decade or two to reduce the number of patients now under custodial care by 50 percent or more."

Gentlemen, the American Psychiatric Association and the NAMH which I represent today wholeheartedly support all the specific proposals contained in this Presidential message. We consider the adoption by Congress of each specific proposal to be essential to the successful development of each and of all of the other specific proposals, and to the effectiveness of the total program as an integrated attack upon the problems of mental illness and mental retardation. The program is designed to meet the needs of many different types of patients -- the mildly and severely mentally ill, the acutely and the chronically ill.

The President in his message proposed essentially a five-point program. Provisions for implementing the first four points of this program were as you know made in the budget which you are now considering. The five essential points in his message are:

1. The provision of Federal assistance through planning grants for the development of comprehensive mental health programs by the States.

2. The expansion and extension of efforts to increase the supply of and improve the utilization of trained manpower.

3. The support of expanded research in order to "push back the frontiers of knowledge in basic and applied research into the mental processes, in therapy, and in other phases of research with a bearing upon mental illness."

4. The provision of special grants for demonstration projects to assist State mental hospitals to improve the quality of care, and to provide in-service training for personnel manning these institutions. This will permit the hospitals to perform a valuable transitional role, through the strengthening of their therapeutic services, and by becoming open institutions serving their local communities.

5. The establishment of comprehensive community mental health centers through the provision of Federal support on a sharing basis for construction and early year operation.

Gentlemen, last week it was my great pleasure to attend the one hundred and nineteenth Annual Meeting of the American Psychiatric Association. Approximately three thousand of the nation's psychiatrists -- and many professional persons who work closely with psychiatrists -- gathered in St. Louis, Missouri, to report scientific developments, and to discuss matters of mutual concern. You may be sure that much of the talk centered around the President's proposals. Many of the psychiatrists present there have devoted their entire professional lives to the care and treatment of the mentally ill and mentally retarded in public institutions. They care for the destinies of over 700,000 persons.

With their viewpoints fresh in my mind, I would like to discuss with you, first, the role of the public institutions, and its bearing upon the budget you are now considering.

First, the atmosphere in the better mental hospitals has changed immeasurably. People are confidently expected to recover and return to their homes

and their jobs as quickly as possible. One phenomenon has appeared which I would like to comment upon. In general medicine, when a patient is affected with diabetes, the doctor tries to adjust his blood sugar while keeping him at home or, better yet, on the job. Failing in this the individual is admitted to the hospital for a short period and attempts at adjustment of his blood chemistry are made. But the patient does not have to stay in the hospital for an indeterminable period. This is in contrast to the way things used to be handled in emotional disorders. Let the person have one upset, which distressed his family, friends, or society in general, and away he would go to a mental hospital -- and the period of his absence was usually an extended one. This routine is changing now, fortunately. Attempts are being made to treat the mental patient early and intensively and, if at all possible, to keep him out of hospitals altogether. A sizable number of these patients will have recurrences and will come back -- but that is all right; so does the diabetic come back. In the meantime, however, they will have been home and perhaps will have been at work, and this is a great step in the right direction.

I am sure that you gentlemen know, as we do, two important corollaries of this situation: (1) No matter what we do, there will always be a number of sick people whose illness will drag on over a long period of time and some of them will not get well at all. The appropriate treatment for these folks has been, and continues to be, available in our public institutions. (2) A very small minority of the mentally ill have illnesses which make them a ~~treat~~ threat to society over rather extended periods of time -- these require the security offered by the State hospitals.

In other words, gentlemen, however successful intensive treatment in the community may be, for the foreseeable future we must realistically anticipate that some patients will continue to need longer term treatment in public mental

hospitals. We have every evidence to expect the patient load in these hospitals to be dramatically reduced but not eliminated in its entirety. The important factor is, of course, that so-called longer term treatment shall be genuine treatment and not simple custody.

Thus I have been distressed in recent months to learn that, in some instances, the President's plea to launch a concerted drive to reduce the number of patients now under custodial care by 50 percent or more within the next decade or two has been interpreted to mean that the proposed new program has no place within it for the public mental institution.

Moreover, I have been somewhat fearful that, in my previous testimony on the budget before the House Subcommittee on Appropriations and in the testimony I presented on March 6 in support of Senate Bills 755 and 756, I may have slighted a number of important points and in so doing lent credence to this interpretation of the President's program.

Let me therefore take this occasion to state forthrightly the concerns of the two associations I represent today vis-a-vis this aspect of the proposed program. First, we are well aware of the burdens under which the public mental institutions of this country have struggled for many decades. From their own personal reminiscences my colleagues could supply ten thousand pages of testimony to this committee -- testimony detailing the inadequacies inherent in our present system of caring for the mentally ill in state hospitals with inadequate budgets, outmoded buildings, and sparse personnel.

This is an old story, and a heartrending one to them. Their lives have been spent in making medical and moral decisions which no physician, and no person dedicated to serving the spirit of mankind should be called upon to make. They have had to decide on which ward to place one physician, when ten physicians are needed. They have had to decide which patients are to receive active

treatment, when all patients could benefit from more intensive therapeutic efforts.

Among my colleagues, gentlemen, there is no quarrel with the President's statement that the number of patients under custodial care should be sharply reduced. For them, a patient lost to the state institution is a patient saved for a life in the community.

Second, my colleagues and I, while aware of present inadequacies in state institutions, are also aware that for many patients, treatment in a state institution is the treatment of choice -- if the state institution is equipped to do its job, is properly staffed with trained personnel, and is imbued with the spirit of hopefulness that is the proper reflection of our current state of knowledge.

Let me tell you the story of one state hospital, which became imbued with this spirit of hopefulness some few years ago, and which was given proper equipment with which to work.

In the space of a few years, the resident patient population of Worcester State Hospital, Massachusetts, has decreased from 2,600 to 1,600, a decrease of 38%. Worcester State Hospital is the oldest state hospital in Massachusetts, having been established in 1833. Until a few years ago, the original building was still in use as an administration building. This was replaced by the 560-bed Bryan building, named after a well-known administrator-psychiatrist, which combined, under one roof, an admission center, a surgical-medical unit, and an intensive treatment unit.

For a time, the major push within the hospital was to utilize the new building to the fullest extent possible. When this was accomplished, a major effort was made to meet the needs of the chronic patients who had remained in the back wards.

To accomplish this, the Superintendent and Assistant Superintendent took over the management of some of the chronic wards themselves, and functioned as ward physicians. It didn't take them very long to discover that some of the patients could be released -- and this was done.

Since then, the discharge of patients to the community -- to their own homes, foster homes, nursing homes, etc. -- has accelerated.

While the happenings at Worcester are particularly dramatic, many different state hospitals throughout the country report considerable success in reducing the number of patients under custodial care by the use of modern treatment methods.

And now, gentlemen, we come to the major point of my plea before you today. The President's budget for 1964 contains a request for $12 million to provide for the first phase of a three-phase program to upgrade the quality of care in State institutions for the mentally ill and for the mentally retarded.

This would make possible the awarding of grants up to one-third of the State institutions for the mentally ill and the mentally retarded, at amounts of up to $100,000. It is my understanding that in 1965 and 1966, funds will be requested to permit funding of projects in the other two-thirds of the institutions. These projects, as required by law for all mental health project grants, must be reviewed by the National Advisory Mental Health Council and recommended favorably as a basis for support.

Until the marvelous new community mental health services of the future are more widely developed, the mental health project grant (under authority of title V) offers an ideal mechanism for stimulating and encouraging the State hospitals to strengthen their therapeutic programs through the undertaking of demonstration projects. Active treatment-oriented programs, particularly those interwoven with an active prevention and treatment-oriented program in the

community are especially desirable and provide an excellent transitional device to bridge the gap between the present State hospital and the emerging community mental health programs in which the State hospital of the future will have a new role.

I can hardly express to you my dismay when I learned that no provision for this portion of the President's budget request was included in the budget for the NIMH as reported by the House,~~committee~~.

In the name of the more than 700,000 persons who reside in our public institutions for the mentally ill and the mentally retarded, and of the tens of thousands of persons who care for these unfortunates, I urge that this cut in the President's budget be restored to the full amount requested.

Now I would like to address you regarding the personnel situation. In spite of the advent of new drugs and of changed environment in hospitals, there looms before us a severe personnel shortage. The rise in population and the intensification of treatment efforts spell the need for an urgent increase in the recruitment and training of workers of different skills to carry out the various required procedures. We have 13,000 psychiatrists in the United States, and it is conservatively estimated that we need twice that number. The shortages of trained clinical psychologists and psychiatric social workers are also distressingly obvious. The shortage of nurses is common knowledge in all fields, but it is certainly obvious in psychiatry, and was commented on by Mr. Gorman.

You can imagine what the situation would now be if you had not turned your attention to the problem of personnel over the past decade. Due largely to the help of NIMH stipends and training grants, the numbers of individuals in the four disciplines which make up the core mental health professions have increased $2\frac{1}{2}$ times in 11 years. This speaks volumes for the effectiveness of the training grant programs and accentuates the need for continual interest in that direction.

It is my experience that there are many more individuals applying for training in psychiatry than there are stipends to cover them. This is true also of the situation with general practitioner grants. This year we had three times as many bona fide applicants for these grants as we could accommodate. I would therefore respectfully suggest that this year the training grants for general practitioners be raised to $11 million. There is an urgent need for this.

Certainly one of the neglected areas in the care of patients is that of recruiting and improving the quality of subprofessional and technical manpower personnel. These are the people often closest to the mentally ill patients -- they stay with them for the longest periods of time -- and yet most of them have had no training, or at best their training is skimpy. Therefore I would suggest that much more attention be paid to training and retraining these groups -- perhaps particularly in the training of aides and in attempting to increase their levels of competence. Toward this effort I would suggest raising also the in-service appropriation for training from $3,304,000 to $6,304,000: it is well justified and it might help solve several problems. The Department of Labor might be interested in this particular facet of the problem.

One thing I see in the offing which needs your special attention, if you please, gentlemen, is the overall picture of the State control programs. The funds which you have allocated to the States in the past have acted as "seed money" and many of the States have responded to your prompting by allocating funds for community programs. This area is extremely important if we are to prevent chronic illness or to prevent hospitalization at all; I therefore have no hesitation in requesting that you think of raising the present projected budget from $6,750,000 to $10,750,000.

I fear that I am taking too long and since, in general, we in the profession are happy with the President's budget, there are only two other areas in

which we would suggest increases. I would increase the funds for Clinical Research Centers by $1,250,000 over the President's budget. The need for these centers and their potentialities for good are obvious; it is out of these centers that new and vital information certainly must come and I commend them to you highly.

Also, the title V project grants hold possibilities for advance in knowledge in the field. It is unnecessary for me to spell out these projects. I have personal knowledge of several of these and I am highly impressed by what they can accomplish. One that is fresh in my mind enabled several autistic children to enter regular nursery school, whereas beforehand they had been condemned almost surely to lifetime custodial care. These projects could well use an additional $6 million over the $15,190,000 already requested in the 1964 budget.

I would like to discuss at length many aspects of the budget and the proposed National Mental Health Program but it is not fair to take your time. If I have seemed a little intense in my statement, I would ask your indulgence. Please remember that I have watched this situation for over 30 years and I know, by heart, the inadequacies of our present system of caring for the mentally ill.

And when it seems that now is the time, in our field, that "There is a tide in the affairs of men, which, taken at the flood, leads on to fortune," it would be injudicious for me to ask for less than a great deal for the mentally ill of this country. For this flood of interest in their plight, which is already washing away the outmoded aspects of our present system of psychiatric care, must not be allowed to recede until -- to mix a metaphor -- the foundations of the new system of care are firmly laid. I know that this committee will not allow that to happen.

Thank you, gentlemen, for allowing me to come before you.

* * *

SUGGESTED INCREASE IN PROPOSED 1964 BUDGET

TRAINING	President's Budget	Suggested Budget
General Practitioner Program	9,000,000	11,000,000
Inservice Training	3,304,000	6,304,000
STATE CONTROL PROGRAM		
Grants to States for Clinics, etc.	6,750,000	10,750,000
RESEARCH		
Title V	15,190,000	21,190,000
Clinical Research Centers	1,750,000	3,000,000
TOTAL REQUESTS FOR FISCAL 1964	190,096,000	206,346,000

* * *

Testimony of Francis J. Braceland, M.D., Sc.D.

representing the

American Psychiatric Association

and

The National Association for Mental Health

in support of appropriations for the

NATIONAL INSTITUTE OF MENTAL HEALTH

before the

HOUSE APPROPRIATIONS SUB-COMMITTEE ON

LABOR, HEALTH, EDUCATION AND WELFARE

Representative John E. Fogarty, Chairman

March 11, 1964

I am Francis J. Braceland and I have been a psychiatrist for over 30 years. I graduated from Jefferson Medical College in 1930 and was an intern and Chief Resident at Jefferson Hospital until November, 1932, when I began my psychiatric fellowship training at the old Pennsylvania Hospital in Philadelphia. I was then a Rockefeller Fellow in Psychiatry in Zurich, Switzerland, and at the National Hospital, Queen Square in London. I returned to be Clinical Director at the Pennsylvania Hospital until 1941 when I was appointed Professor of Psychiatry and Dean of the School of Medicine, Loyola University.

I have since occupied the following positions:

1942-46 - Special Assistant to the Surgeon General, U. S. Navy and wartime Chief of the Psychiatric Section. I am a Rear Admiral, Medical Corps, USNR-Retired.

1946-51 - Head of the Section of Psychiatry, Mayo Clinic, and Professor of Psychiatry, Graduate School, University of Minnesota.

1951 until present - Psychiatrist-in-Chief, The Institute of Living, Hartford, Connecticut, and Clinical Professor of Psychiatry, Yale University; since 1951 Lecturer on Psychiatry, Harvard Medical School.

I have been in the past:

President, American Board of Psychiatry and Neurology, 1953.

President, American Psychiatric Association, 1956-57.

President, Association for Research in Nervous and Mental Disease, 1957.

Chairman, American Medical Association, Section on Nervous and Mental Disease, 1956.

Chairman, National Health Forum, 1958.

President, Board of Examiners for Certification of Mental Hospital Superintendents, 1955.

Vice-President, World Psychiatric Association, 1961-

I have served as a member of the Advisory Council to the National Institute of Mental Health.

Mr. Chairman and Members of the Committee:

I am appreciative of the privilege of appearing before you and with my colleagues discussing the citizens' budget as presented by Mr. Mike Gorman and of giving professional testimony to substantiate the need for the requests which he makes of you. On previous occasions here I have represented several dedicated groups of citizens; today, along with Dr. Ewalt, I represent the American Psychiatric Association, which is made up of 14,000 psychiatrists who are occupied in the various segments of psychiatric practice. I respectfully ask permission to enter a statement for the record and time to comment briefly upon the present mental illness and mental health situation here.

It is written that Pericles remained persona grata with the Athenian people because they only heard him occasionally. I can only hope that my regular appearance here does not jeopardize my most pleasant relationship with you. As a representative of a band of dedicated colleagues, I appear here as a hardy perennial, but always encouraged by the knowledge that you know our cause is a serious and worthy one. You have been patient and farsighted and, while understandably protective of the taxpayers' funds, you have at the same time and with the help of your colleagues in the Senate, kept the situation of the mentally ill in this country from becoming chaotic. Had you not seen over the past decade and even beyond that that this problem goes to the very root of the nation's fibre, we would not have nearly advanced to the point that we have reached today. It is true, there is a frightening amount of work still to be done, but we have the framework now and Mr. Gorman has told you of the lowered census in our hospitals. What he did not emphasize enough, although he helped mightily to bring it about, was the widespread hope that people now have that we will make inroads upon mental illness and learn to institute preventive measures

in our communities. He has told you of the great strides forward which have been taken and none of us has any hesitation in prophesying that in the future, with your continued help and assistance, even greater advances will be brought about to the advantage of patient, family, community and nation.

I have no intention of taking up your time with our past, none too happy or humane history, but I must observe that in my 33 years as a psychiatrist I have never been quite so hopeful or so edified at the signs of progress which I see now. When I began in this, then unpopular, field we had, as I recall it, about one drug we could count on and that was a sedative; there were no physical treatments except hydrotherapy and its related and admittedly somewhat anemic approaches. The outlook was anything but bright. Hospitals were locked tightly; it was difficult to get in or get out; and the public knew nothing of the distressed people they housed--and they seemed to care less. We were completely alien and isolated from the profession and the community. Fortunately, all of this has changed and you have helped to change it and it is about these changes that I would like to talk first.

The most remarkable change of all is to be found in the marked and steadily increasing interest that the community is displaying in the cause of mental health and mental illness. The public now, by an almost incredible turn-about, is becoming patently anxious and willing to help--willing to take direction and impatient to get on with the job. Understandably, that particular attitude was given a healthy transfusion by the unprecedented Mental Health Message sent by the late President to congress in February, 1963, but even so there is more of a ground swell than we ever were justified in expecting. Fortunately, you had laid the groundwork for this reaction by the programs you encouraged and supported over the past decade, so we have not been taken

entirely unawares. The psychiatrist who is invited to address community groups now is more frequently than not asked to come prepared to advise what steps the community can take to help with the plight of its sick fellow citizens and what it can do by way of prevention. This reaction is extremely gratifying because it is in the last analysis the community which will decide upon the status of the institutions and the workers in the field and it is they who will determine through their representative legislators the calibre and the support which our hospitals and clinics will receive.

Actually, this community interest is fitting, proper and well justified, for there is a bond between the community and the families which go to make it up. It is becoming more and more apparent that the community, the larger family to which we belong, often can be a potent source of help and correction by giving professional support, advice and assistance in times of need. The family, sharing in and contributing to the activities and general needs of the community, should in turn look to the community to provide support when a catastrophe, such as mental illness, strains its financial and emotional resources. To allow the mental health of an entire family to be undermined by the illness of one sick member is too high a price for either the family or the community to pay. Just as the family tries to protect its individual members, so does the community have the responsibility of preserving the health of the individual family and its members, for they are the segments which go to make it up.

It is the community, therefore, through its many resources and agencies that should provide help and guidance for the mentally ill patient and his family. Heretofore, however, the reactions of all of

us have been to quickly get the patient out of the way--to warehouse him, as it were--for earlier the custom has been to reject those people who were sick mentally and whose social behavior was unpredictable. Yet, the mind of man, sick or well, has such limitless possibilities for growth and creativeness, or trouble and destructiveness, that neglect of it is a serious matter. Daniel Webster put it this way:

> If we work upon marble, it will perish. If we work upon brass, time will efface it. If we rear temples, they will crumble to dust. But, if we work upon men's immortal minds, if we imbue them with high principles, with the just fear of God, with love of their fellow men, we engrave on those tablets something which no time can efface and which will brighten and brighten to all eternity.

It is apparent from this and numerous other comparable observations, that effort put into the maintenance of mental health and the prevention of mental illness has lasting values for the community and for mankind far beyond what we can contemplate here.

The community has taken avidly to the concept of the Comprehensive Community Mental Health Centers, as outlined in the Presidential Mental Health Message. They are not quite clear on what is entailed as yet, but they are aware of the fact that there is a desperate effort needed to decentralize psychiatric treatment and regard the hospital, not as the pivotal point in the program, but rather as only one of the several possibilities for help and a late resort for the more serious and longer lasting problems. They know that treatment could be furnished closer to home and to loved ones and jobs and that hospitals are not made better by being isolated or overcrowded. I have no critical remarks to make about these institutions here. They are what we, as citizens, have made them and any fault we have to find about them is fault found with ourselves, for citizens get what they are interested in financing and in encouraging.

The President's message emphasized that the centers should "focus community resources and provide better community facilities for all aspects of mental care." Finally, and of extreme importance, the centers should aim at prevention. "Prevention will require both selected, specific programs directed especially at known causes, and the general strengthening of our fundamental community social welfare and educational programs." Thus, it is clear that these centers are proposed as single elements, i.e. coordinating elements or focal points of a network of mental health services and, important though it may be, it will be only one of the components of the comprehensive mental health program for a geographical region, through which two results are sought:

(1) Quicker and, if possible, better diagnosis, treatment, rehabilitation and consultation.

(2) Creation of a positive mental health action with preventive value.

As we visualize it presently, a conceptual model of comprehensive mental health services may be presented as a single entity with three dimensions:

(1) The mental hospital dimension (intra-mural services) where the problem essentially would be that of upgrading services.

(2) The extra-mural dimension, or outpatient services, broadly defined, where the most urgent problem is a very considerable expansion of services for very large numbers who need help and have none now available to them.

(3) A new dimension, described as "Comprehensive," which develops out of the effort to focus all community resources and better coordinate all efforts in order to improve treatment results

and to create a positive mental health program with preventive aspects.

I spend this time on Comprehensive Community Mental Health Centers and Comprehensive Community Mental Health Programs here, Mr. Chairman and gentlemen, for several important reasons, the most important of which is staffing and the urgent need for more and more personnel. Whether many communities will believe themselves able to staff either the centers or the programs remains to be seen; if they do believe they can, the problem then arises: Can they get the personnel?

The cutting out of funds for staffing from the bill for Comprehensive Centers was a sad blow. An editorial in The Hartford Courant had this to say about it:

> And what good are buildings without staff? All of this was done in the misguided notion that local centers would encourage socialized medicine. But the Mental Health Committee of the American Medical Association backed the plan, even if the House of Delegates did not. The net result was, of course, exactly the opposite of what was intended. There is nothing more socialized than the medicine practiced in a State Institution. . . In locally operated centers all the forces of private enterprise would be served, including medical insurance and the use of private physicians."

That same editorial was highly complimentary to the Chairman and members of this Committee. It then hoped that someone would introduce a bill in this Congress, because "Congress could find no more fitting way to memorialize the first President to display an adequate appreciation of the greatest social problem of our time--mental health--and who himself was a victim of its absence." I shall say no more here about that unbelievable, senseless savagery of November 22. There has been a death of a beloved member of the family, and I shall remain respectfully silent about it.

There is indeed an urgent need for additional psychiatric manpower, not only to staff these contemplated new centers, but also to carry out the duties which are already facing us. The President has asked for 73 million, 213 thousand dollars for this aspect of the over-all program; I would urgently ask you to increase this amount to the 83 million dollars which President Kennedy foresaw would be needed for fiscal 1965.

It takes a long time to prepare individuals for the demanding work required of them in the mental illness, mental health disciplines. Their availability will determine how fast we can expand our programs and carry out the urgently needed functions which all of us know need to be done. No matter what advances we make, no matter what new drugs are found, we can do nothing without the manpower which will administer the treatment and supervise the over-all care of sick people. Unless we implement the programs which have been projected by preparing men for the 150 new mental health centers which are to be built with federal matching funds, we will get nowhere. Our mental hospitals in some of the states are still in the same precarious condition they have been in for many years. They are constantly plagued with personnel shortages. Were it not for the large numbers of foreign physicians assisting in most state hospitals, we would be in serious trouble. This cannot go on forever; we do need a cadre of physicians who will work part or full time in these institutions. The need--the urgent need--the sick people in thousands are realities which must be faced and your assistance here will pay dividends in the future.

I confessed to you earlier that I was one of the ones who was not too convinced about the general practitioner training programs. I

have recanted on that score a number of times. These, I have found, are capable men, tempered in the fire of general family practice, and they do an excellent job. Year after year we are short of funds to train the increasing numbers who are applying for this training and, though the President asks for 10 million dollars to carry out this segment of the program, I would respectfully ask you to appropriate 12 million dollars for it--it will come nearer to meeting the demands, I assure you.

Those courses which are being given to practitioners at night are filled regularly and in my area several additional courses must be organized to fill the demand. Let me quote to you, if I may, two editorials taken from The New York Times on the same day, mind you--on Saturday, March 7--a few days ago. They set forth the problem of personnel shortages in general much more eloquently than can I. I shall simply abstract from them, if you please.

> Recent incidents of violence against teachers by pupils in the city's schools are a shocking reminder of the explosiveness of the problems facing this vast system. The harvest of slums, social tensions, broken homes and individual rebellion is bitter indeed.
>
> It would be naive to suggest that there are simple answers or, in fact, any total solution, short of a general abolition of poverty and maladjustment. The frustrations and violence of society cannot be prevented from spilling over into the schools. Stationing police in classrooms and corridors, even if the manpower were available, would destroy the educational atmosphere and teachers can hardly be expected to carry arms. Police protection can play a useful part mainly in keeping intruders out of the schools.
>
> At the heart of the issue--as documented in every report and survey of the system--is the desperate shortage of qualified and psychiatric personnel. Since teachers know that only the most flagrant behavior problems are given serious attention, they often are understandably reluctant to refer problem cases for observation and treatment.

> Earlier this year the High School Principals Association charged that the number of pupils returned to classrooms from correctional institutions "before they are ready and with no supportive or rehabilitary program" has greatly increased in recent months. The report warned of their adverse influence on their classmates.
>
> When courts deal leniently with juvenile offenders and then return them to schools, without proper safeguards in the form of follow-up counseling, they turn lawbreakers into heroes, emulated by the teen-age crowd.
>
> Superintendent Gross's order for the removal from schools of persistent troublemakers is a necessary assertion of discipline. Yet the glaring truth is that only massive educational, social and psychological measures, supported by effective law-enforcement and corrective action, can defuse the social dynamite in today's urban schools.

Note the reference to the desperate shortage of psychiatric personnel; and listen, if you please, to another editorial in the same paper on the same day. I quote only the first paragraph of it.

> Emotionally disturbed children, families on the verge of break-up and other New Yorkers in urgent need of professional help are the chief victims of the strike that has disrupted service at six child-care and family agencies since Feb. 19. The efforts of state and city mediators to end the walkout have thus far proved unavailing; the prospect is for an economic siege, in which the maximum pressure will be on the city's most fragile citizens--children and adults who find even the day-to-day problems of existence too demanding.

I think anything added to these two factual statements regarding present-day needs and conditions would be post-climactic.

Research

As to research, the need for it continues to be pressing. The old expectations and attitudes and the old systems of care are deeply imprinted on the tapestry of our time. These old concepts are not only in our institutions and on our statute books, they are still in the brains of men and it is only research and the wide dissemination of

our results which will enable us to change them. The time approaches when we may be able to "cash in" on some of the work already done and the preparations which have already been made. The times definitely are changing. There are changes in the illnesses we see in our mental hospitals. There are many, too many, young people getting fouled up and dropping by the wayside. They act out their impulses and get into serious difficulty and then either want to hurt or dispose of themselves. Solving these problems is a frustrating experience. I am not critical of them as a group, but rather I have an affection for them; I am simply anxious to see that those who need it get help.

Schizophrenia is still a serious problem in our hospitals and clinics; rather we should say the schizophrenic reactions are still our most serious problems, for they are not simply one single entity; they still comprise 25 per cent of all first admissions to public hospitals and 50 per cent of all resident patients. Although research regarding it is going on in the biological, psychological and social sciences, as well as in clinical and social fields, the etiologies of these ills still elude our grasp. Research work will have to continue, for the eventual understanding of a complex disorder such as schizophrenia will depend not only on exhaustive studies of the process itself, but also will depend on an accumulation of knowledge regarding the fundamental mechanisms involved in the brain and behavior. The causes of these disorders must involve complex inter-relationships with the nervous system, as well as interactions among nervous system and other bodily organs, and the interpersonal relations of the individual. Basic information from a variety of sciences is therefore of prime importance. Before we can understand

and explain abnormal thinking, we must acquire more exact knowledge of normal thought processes. Fundamental knowledge of normal metabolism and biochemistry of the brain is essential to comprehension of the ways in which these processes may be defective in a schizophrenic disorder.

Research leads and results being achieved today in the basic sciences warrant optimism. We are acquiring and accumulating knowledge on how the biological processes, psychological and social experiences determine an individual's level of adaptation. Research is a gamble, like the Bank at Monte Carlo; one cannot guarantee a hit and one must pay heavily for wrong guesses. But schizophrenic illnesses have challenged the best of scientific minds for centuries and, therefore, is a worthy foeman, and every avenue of approach to its causation must be followed closely.

I shall not take your time discussing the problems attendant upon the increase of older persons in our society. I have been surprised to learn that a much higher number of patients in the near 65 age group is suffering from acute brain syndromes than I had expected. There is a need, therefore, for more adequate facilities to deal with the phsyical illnesses which produce behavioral symptoms. In one report of 600 persons living in a community a research study indicated that one-seventh of them were psychologically impaired.

Careful consideration of all of the research programs concerning young and old and those in-between presents a rather definite indication that an additional 10 million dollars will be required, over the 73 millions dollars which the President has requested in his budget. It will require 83 million to continue the programs

now in force and to add to them those which are urgently required in the light of present happenings.

I would like to comment on one particular phase of research which is singularly pressing at the moment in order to demonstrate a problem which is of great concern to a large number of people. I refer to research in psychopharmacology for which 11 million dollars was requested by the President and for which, I believe, 13 million dollars is required.

You already know of the remarkable effect of drugs in aiding that phenomenal drop in inpatient census in our hospitals, despite increased admissions. A drop of 9.7 per cent since 1956, in the face of a rising population, is not to be passed off lightly. Net discharges have almost doubled between 1955 and 1963 from 126,498 to 247,228. Well, in addition to all of this, a number of patients have been maintained outside of hospitals on medications--both tranquilizers and anti-depressants--and it is about the latter that I would like to comment.

There is a great deal of depression in the middle and older age groups today and it is being recognized much more often than heretofore. Earlier it was covered by physical complaints of various sorts and more often than not its real import was missed; but now depressions are being recognized more readily and the physician needs drugs which will act reasonably quickly and effectively to lift patients over the depressive period. In the meantime the search for causative and dynamic factors goes on. This is ticklish business. Many of these patients are suicidal. The drug given them must be potent and should be reasonably rapid acting.

Some of the anti-depressants in use today apparently do work and men and women are being sustained and kept in the community with their help. I mentioned the need for a drug which would act quickly--and we had one--and we had numerous patients taking it and a large number of people were taking it in various parts of the country and were being sustained at home. About ten days ago the F.D.A. ordered the drug withdrawn from the market. Some deaths had been reported from its use.

Now we knew that this drug had to be carefully controlled; but over the years it has been available and in use we had little or no trouble with it, for we stayed within the dose range advised by the manufacturer, kept careful watch on the patients, and were ready to move at the first sign of trouble. Had the drug not been valuable, we would not have gone to all this bother. Well, as a result of this sudden stoppage and our inability to begin another anti-depressant for one week, lest there be serious trouble, a number of patients have had difficulties and some of them had to be hospitalized. The drug is called Parnate.

Now, why do I go into all of this with you here? Simply to impress you with the great need to continue to support research in psychopharmacology. The President has asked for 11 million; we need at the very least 13 million to continue our work with these drugs. Out in clinical practice we rather play for keeps. The anti-depressants help people to keep going and keep some of them from suicide. The phenothiazines help us get and keep people out of mental hospitals. These are adjuncts to the overall treatment, mind you, but they are important adjuncts. They helped to reduce the

hospital patient load that we have already commented upon.

Iproniazid (Marsalid) was another drug--the first of the so-called M.A.O. (mono amine oxidase) inhibitors; it had to be removed from distribution in this country because of its toxicity. But used carefully, it is a good drug; and it is still being prescribed carefully in England with good results.

All of this simply points up the fact that we must support research in this field to its fullest extent; it will pay off in results far beyond the amounts we expend to make potent drugs safe for our use.

As to the various other research items in the budget--the clinical research centers, the hospital improvement projects, the mental health projects--I agree with my colleagues, they are in urgent need of your support. The Title 5 projects grants have supported new and bold methods of approach to the problems posed by mental disease. In fact, it is probable that they have been the greatest influence in the march which is now culminating in the concept of Community Mental Health Programs. They have been the advance agents which have called forth matching funds from states and municipalities. There will be more calls for these projects now, as we determine to cut down the size of our big hospital populations. Numerous new methods will have to be tried to satisfactorily take the pressure off these institutions, so that they too may better their treatment approaches. I agree heartily with my colleagues that there is an urgent need for a six million dollar increase over the President's budget for this item.

Mr. Chairman, I need take no more of your time in explaining things you already know all too well. Newspapers in every part of the country daily present concrete evidence of the need of distressed people for trained professional help. Every aspect of the mental health problem needs continuing attention. It was neglected for generations and we are reaping the fruit of that neglect. I know that you will not allow it to slide backward for lack of necessary funds now that we have come this far.

NIMH FISCAL 1965 BUDGET INCREASES PROPOSED BY CITIZENS

Mental Health Activities	1965 President's Budget	1965 Citizens Budget
Grants:		
Research:		
Regular	$26,112,000	$26,112,000
Psychopharmacology	11,000,000	13,000,000
M. H. projects	17,000,000	23,000,000
Indirect costs	3,250,000	3,250,000
General research support	5,222,000	5,222,000
Clinical research centers	1,750,000	3,750,000
Hospital improvement projects	12,000,000	12,000,000
Sci. evaluation	161,000	161,000
Total research	$76,495,000	$86,495,000
Research Fellowships:	$ 8,057,000	$10,057,000
Training:		
Regular	$49,163,000	$55,163,000
Research	8,000,000	8,000,000
General Practitioner	10,000,000	12,000,000
Inservice	6,000,000	7,000,000
Sci. evaluation	50,000	50,000
Total training	$73,213,000	$82,213,000
State control	$ 6,750,000	$ 6,750,000
Direct operations	$24,402,000	$24,402,000
Total Request	$188,917,000	$209,917,000

Total Increase Requested - Citizens Budget $21,000,000

STATEMENT

by

FRANCIS J. BRACELAND, M. D.

before the

HOUSE APPROPRIATIONS SUBCOMMITTEE ON

LABOR, HEALTH, EDUCATION AND WELFARE

Representative John E. Fogarty, Chairman

In support of appropriations for the

NATIONAL INSTITUTE OF MENTAL HEALTH

March 15, 1965

Presented on behalf of

The American Psychiatric Association

and

I am Francis J. Braceland and I have been a psychiatrist for over 30 years. I graduated from Jefferson Medical College in 1930 and was an intern and Chief Resident at Jefferson Hospital until November 1932, when I began my psychiatric fellowship training at the old Pennsylvania Hospital in Philadelphia. I was then a Rockefeller Fellow in Psychiatry in Zurich, Switzerland, and at the National Hospital, Queen Square, London. I returned to be Clinical Director at the Pennsylvania Hospital until 1941, when I was appointed Professor of Psychiatry and Dean of the School of Medicine, Loyola University.

I have since occupied the following positions:

1942-46 - Special Assistant to the Surgeon General, U. S. Navy, and war-time Chief of the Psychiatric Section. I am a Rear Admiral, Medical Corps, USNR, Retired.

1946-51 - Head of the Section of Psychiatry, Mayo Clinic, and Professor of Psychiatry, Graduate School, University of Minnesota.

1951 until present - Psychiatrist-in-Chief, The Institute of Living, Hartford, Connecticut, and Clinical Professor of Psychiatry, Yale University; since 1960 Lecturer on Psychiatry, Harvard Medical School.

I have been in the past:

President, American Board of Psychiatry and Neurology, 1953.

President, American Psychiatric Association, 1956-57.

President, Association for Research in Nervous and Mental Disease, 1957.

Chairman, American Medical Association, Section on Nervous and Mental Disease, 1956.

Chairman, National Health Forum, 1958.

President, Board of Examiners for Certification of Mental Hospital Superintendents, 1955.

Vice-President, World Psychiatric Association, 1961-

I have served as a member of the Advisory Council to the National Institute of Mental Health.

Mr. Chairman and members of the Committee, I appreciate this opportunity to appear before you on behalf of the American Psychiatric Association and to express our support of the citizens' budget for the National Institute of Mental Health as proposed by the capable Executive Director of the National Committee Against Mental Illness, Mr. Mike Gorman.

I appear here as a hardy perennial but, as always, I am encouraged by the recognition that you consider our cause a worthy one. In fact, your interest in and support of the cause of the mentally ill of this nation has brought us to the point we have now reached. Never in my 33 years as a psychiatrist have I been quite so hopeful or so encouraged by the signs of progress I see everywhere as I am today. The community mental health center concept, of course, is the most striking sign of progress. But coincidental with the emergence of this concept are changing patterns of hospital care for the mentally ill, changing methods of treatment, changing goals which now include more emphasis on prevention and adjustment without absolute "cure," and changing public attitudes and beliefs which have helped remove stereotyped misconceptions and stigmas in regard to mental illness.

My colleagues and I are discerning in enlightened communities throughout the land a quickening of interest in mental health problems. By an

almost incredible turn-about there can now be sensed in some quarters a willingness to help, a willingness to accept direction, an impatience to get on with the job. The mental health professional invited to speak to community groups now is not faced with the necessity of convincing people of the importance of his mission; he is expected to give advice as to how the community can help with the plight of its sick adults and children and how preventive measures may be established.

Just a few statistics will indicate the extent to which patterns of care are changing, thus giving rise to the new optimism about community-based programs we see everywhere.

In 1964 the average daily resident population in state and county mental hospitals dropped to below 500,000 for the first time in 15 years. Net live releases from the hospitals have moee than doubled in the last 10 years.

The number of outpatient psychiatric clinics increased from about 1,200 in 1954 to about 1,800 in 1963. The number of patients under care in these clinics increased in that same period from 379,000 to 862,000.

Twenty years ago only 48 general hospitals were known to admit mental patients. In 1964 there were 1,005 general hospitals admitting an estimated 413,000 psychiatric patients.

Facilities for partial hospitalization have increased rapidly. In March 1964 there were 142 day-night units in the United States in which a psychiatrist assumed medical responsibility for all patients. This was an increase of 28 units compared with the previous year; prior to 1960 there were only 37 day or night units in the United States.

Yes, as Mr. Gorman has pointed out, the state hospital, once the major resource of psychiatric treatment for most Americans, now no longer fills that role. Furthermore, the 24-hour bed has lost its primacy and today two out of every three mental patients receive treatment on a partial hospitalization or outpatiant basis.

So, I feel we have good reason for our optimism.

The great need for a relocation and a revitalization of this nation's mental health services became manifest in 1961 and 1962, partly as a result of the work of the Joint Commission on Mental Illness and Health, established by Congress to evaluate and analyze the needs of the mentally ill in the United States and the resources for their care. In 1963 President Kennedy delivered his historic Special Message on Mental Illness and Mental Retardation, in which he called for "a new type of health facility, one which will return mental health care to the mainstream of American medicine and at the same time upgrade mental health services." That same year the Congress responded by passing the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. In 1964 the components and the mechanics of a community mental health centers program were established.

Thus, the need which crystallized in 1961 and 1962 has become the challenge which must be met in 1965 and beyond. In meeting it all of us have a share--the Congress, the Administration, professional associations such as the one I represent here today, and citizens' groups.

As I reflect on this challenge, it is obvious that two problems are uppermost--manpower and money. The National Institute of Mental Health, charged by the Congress with administering the programmatic aspects of the community mental health centers program, as well as a myriad of other responsibilities in the areas of research and training, needs a great deal of money to do its job. I am mindful that you must be protective of the taxpayers' funds, but at the same time I am mindful that the task facing us is a large, difficult, and expensive one. I believe that the citizens' budget as outlined to you by Mr. Gorman comes closer to meeting the need than does the official one which was earlier presented to you.

I would like to turn my attention first to the area of manpower and training. All of us are acutely aware of both the manpower shortages in all the mental health professions and the unequal distribution of this manpower throughout the country. When I ponder the manpower problem, I am reminded of a quotation from Abraham Lincoln. Lincoln said: "The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty and we must rise with the occasion. As our case is new, so we must think anew, and act anew."

While training programs in the core mental health disciplines are increasing in number and capacity, their total output continues to fall short of demand, even for the limited mental health facilities now in operation. You have heard, gentlemen, that by 1970 we will require at least 87,000 workers in the core professions of psychiatry, clinical psychology,

psychiatric social work, and psychiatric nursing. About 22,000 of them will be needed to staff the community mental health centers we hope to see built by then. It is obvious that we will not be able to provide the mental health personnel we will need in the next decade--or even in the next two decades--unless we can greatly increase existing training programs for which NIMH is the major source of support. A lack of yearly increases in training appropriations for NIMH can seriously hamper the efforts to reach the projected manpower goal. While the Congress increased the training funds for the Institute by eight million dollars for fiscal 1965, the increase was ten million dollars less than the amount anticipated for this year in the 10-year NIMH projections.

Translated into actual manpower, the loss of that ten million dollars means the loss of one year's training for about 1,425 people and produces a shortage almost impossible to make up. It also can have a profound effect upon the quality and stability of training centers, which are forced to reconsider their goals if funds are not forthcoming at the national level.

The impact on persons needing treatment is greatest of all. According to recent calculations, a shortage of 1,000 professionals makes it impossible to provide direct clinical services to about 100,000 patients. A loss of 1,000 trainees for one year would mean that about 39 community mental health centers could not be staffed and that services would not be available to nearly four million people in areas the centers are designed to serve.

Another crucial factor affecting manpower is the level of stipend support for training. Increases in mental health stipends are long overdue,

since the last general increase occurred in 1960. Both the National Science Foundation and the National Institutes of Health have increased levels for predoctoral stipends, leaving a great gap between the level of NIH fellowships and NIMH trainee stipends--a gap that increases the difficulty of attracting the highest quality personnel into the mental health professions.

I understand that last year, due to a shortage of funds, the National Advisory Mental Health Council had to reject applications for training stipends which would have amounted to ten million dollars; and it is expected that in 1965 the Council could recommend award of more than twelve million dollars than is available. I hope that the Congress will find it appropriate to correct this situation as it considers the 1966 budget for NIMH. The official budget presented to you earlier asked for a total of 83.2 million dollars to carry out the NIMH training program for fiscal year 1966; I would respectfully ask you to appropriate 95.2 million dollars for this purpose, which will come closer to meeting the demands.

There are one or two special aspects of the training program to which I would like to pay particular attention. The first is the general practitioner program, which I did not enthuse about as much as I might have originally, but of which I have since become a strong supporter. Like many of my psychiatric colleagues, I was afraid that this program would not attract the highest quality applicants. I have recanted a number of times, for we have found that the applicants have been capable men who are turning their psychiatric training to very good use indeed. As you know, there are three

types of training available under this program: a three-year residency program for non-psychiatric physicians, so that they may become fully qualified psychiatrists; short-term training, usually in the evening, designed to improve the psychiatric skills of the non-psychiatric physician while he continues in his regular practice; and full-time psychiatric training for 6 to 12 months for non-psychiatric physicians who want more intensive training than can be offered in a part-time or short refresher course but who intend to remain in non-psychiatric practice.

The kind of general practitioner training that I know the most about is the short-term courses given in the evening. In the Hartford area, where I live, not only are the courses regularly filled, but additional courses have had to be organized to meet the demand. And the results are already apparent in the increasing interest with which physicians in our area are regarding the emotional problems which patients present.

I feel that for the three general practitioner programs the sum of 12 million dollars mentioned in the citizens' budget comes closer to meeting the need than the 10.5 million dollars in the official budget.

Another kind of training that I think is very important is training in community psychiatry for psychiatric residents and other mental health personnel. NIMH is now supporting--among others--training in community psychiatry at Columbia, Yale, and Johns Hopkins Universities, and at the State Department of Mental Hygiene in California.

Last year our Association, in cooperation with the National Association for Mental Health, made a survey of existing community mental health

centers across the country. The Psychiatry Department of Columbia University and the American Medical Association participated in this project. In addition to identifying 234 mental health facilities which had some of the elements of a community mental health center, it was decided to do a more intensive study of 11 programs which came close to meeting the goal of comprehensive community-based facilities.

Some interesting findings came out of this intensive study, which I think have implications for the kind of research and training programs, supported by NIMH funds, that we are talking about today.

The 11 centers chosen for intensive study were not necessarily the best community mental health centers in the country but there is no question but what they were representative of some of the best work going on in this new and exciting field.

And yet, as Dr. Walter Barton, Medical Director of the American Psychiatric Association, pointed out in his introduction to the book describing the centers, most of the centers are lacking in adequate facilities for special groups, such as children, the aged, the mentally retarded, and alcoholics. I am afraid that, despite our best efforts, psychiatry has found it difficult to treat these groups successfully. This, of course, points to the need for more research and I am happy to see that the NIMH has supported a number of research efforts which may point to new and promising approaches to these difficult problems.

I could mention just briefly the Cooperative Commission on Alcoholism, which for four years has been carrying on a large-scale study with NIMH

support and is expected to issue a report by the end of 1965. In addition, 16 other alcoholism projects are being supported by NIMH funds in the current fiscal year.

The problem of mentally disturbed children and adolescents is also an extremely serious one, as indicated by the fact that the hospitalization rate for children and adolescents continues to climb alarmingly, even though rates for other age groups have leveled off or even decreased. In fiscal year 1964 NIMH spent a total of 20 million dollars for research in child and adolescent mental health, including juvenile delinquency and mental retardation. About half of this was for basic research and about half for research under the Mental Health Projects Grants program, which supports pilot projects, demonstrations, and operational and evaluative studies. One of the long-term studies under a Mental Health Project Grant that I have watched with interest is "Project Re-Ed," which is training so-called "teacher counselors" at the George Peabody College for Teachers in Nashville, Tennessee, to work with emotionally disturbed children. The project, under the direction of Dr Nicholas Hobbs, also operates two schools for such children, one in Nashville and the other in Durham, North Carolina. This research project still has four years to run but early experience suggests that the teacher-counselors, who are teachers with a year of special graduate training, can, with the consultation of mental health professionals such as psychiatrists and psychologists, deal effectively with children with serious emotional disturbance. This kind of program is considerably less expensive to operate than the more conventional residential treatment for

disturbed youngsters and the children have been staying at the Re-Ed schools about six months instead of the usual stay of about two years in the residential treatment centers.

This kind of research, I suggest, gentlemen, will eventually result in our being better able to come to grips with some of our most serious problems.

Another NIMH activity that I think is bringing encouraging progress is the Hospital Improvement Program, authorized by Congress in 1963 to provide for the immediate improvement of treatment of patients now residant in state mental hospitals and institutions for the retarded. By providing funds Congress is making it possible for the state hospitals to raise the level of patient care through demonstration projects. The funds are being used in a variety of ways but I was very pleased to learn of the projects that are developing specialized treatment programs for the specific groups I have just been talking about, such as the aged, mentally ill children, and the retarded. Many of the Hospital Improvement Project grants are directed at the older chronic patients who have been on the back wards of state hospitals for years without any special attention being paid to them. By means of therapy and activity programs many of these patients improve to a point where they can be discharged,if a suitable home can be found for them,and outpatient services are made available after the patient's discharge.

I am also impressed with the work being done for the mentally retarded by means of the Hospital Improvement Program; 46 such projects

are now underway in 31 states. To show the kind of thing that is being done I could cite a self-care training program at a hospital in Texas for totally dependent crib cases. Six months after the project began all these very severely retarded children were ambulatory and dressing themselves and most were feeding themselves and were toilet trained.

I feel that the Hospital Improvement Program is not only extremely valuable in itself, but is going to give us some clues on how to handle some of our special problem groups in community mental health centers, as well as in hospital or institutional settings. The 18 million dollars recommended in the President's budget and in the citizens' budget for this purpose will be money well spent.

An aspect of research that I feel especially strongly about has to do with discovering techniques of psychiatric intervention that will be effective with groups at all levels of society. Again I would like to quote Dr. Walter Barton from his introduction to the book, THE COMMUNITY MENTAL HEALTH CENTER, AN ANALYSIS OF EXISTING MODELS. Dr. Barton, like most of his other psychiatric colleagues, recognizes the essentiality of psychotherapy in the treatment of emotional problems but also sees the impossibility of effecting it in many of the problems which the community mental health centers will encounter. He writes: "The psychiatric disorders of the blue collar worker and of the medically indigent are the hard-core problem. The community mental health program was designed to assume much of the responsibility for treatment, particularly of acute illnesses, heretofore delegated to the public mental hospital. To effect such a drastic change

requires an eclectic approach, with great emphasis on group and milieu therapy, as well as chemotherapy."

Since this is a subject that is also dear to my heart, I was pleased to read last year that NIMH had awarded a Mental Health Project Grant to the Sidney Hillman Health Center in New York City which, among other things, will identify new case-finding techniques among union members and experiment with new methods of providing mental health services for blue collar workers and their families.

There are many other kinds of mental health research that I wish I had time to mention--the clinical research centers, the psychopharmacology program, research into schizophrenia, and many others. I feel that we must support research efforts to the fullest possible extent and that the results will be worth many times the dollar expenditure. Therefore, my colleagues and I agree that there is an urgent need for the 11 million dollar increase asked for in the citizens' budget over the amount requested in the official budget for the total NIMH research effort.

Before I finish there are two other budget items I would like to speak about briefly; both are included under the amount requested for Direct Operations. Included in the President's budget are funds for 25 more positions in the Institute's regional offices and community services programs. I have already mentioned the important work being done through the mechanism of the Hospital Improvement Program, the Mental Health Projects Grant program, as well as the new program for the construction of community mental health centers. Their success depends in part on the

quality of the applications submitted and in the preparation and review of the applications, regional office staff play a key role. I have found in my own experience as administrator of psychiatric programs in and out of government that economizing on staff is usually false economy. A program is only as good as the quality of the staff that directs it and I respectfully suggest that the important programs being administered by NIMH require high-quality staff in sufficient numbers to do the job.

The other item pertains to the National Clearinghouse for Mental Health Information. When I was beginning my practice of psychiatry 33 years ago, it was not very difficult to keep up with the literature in the field. We all know about the information explosion since that time; a physician cannot hope to be fully informed with regard to research and other developments, even if he spends two or three hours a day reading his professional journals. There is need now for highly refined--and expensive--computer techniques to acquire, process, store, and make available information of use to mental health professionals and program people. One of the items in the Direct Operations budget has to do with increased funds for a new stage in the development of the Clearinghouse, calling for the use and refinement of computer techniques unique to the needs of the Clearinghouse. I feel this expense is justified.

Earlier in my statement I remarked that the mental health need which crystallized in 1961 and 1962 has become the challenge which must be faced in 1965 and beyond. I noted that the challenge must be shared by the Congress, the Administration, citizens' groups, and professional

associations such as the one I represent here today. As I close I would like to tell you very briefly how my profession of psychiatry is preparing to play its role in meeting the new challenge.

Last September our Council had a special three-day meeting to consider the question: Is the American Psychiatric Association organized to play its appropriate role in dealing with existing problems and pressures which confront the profession of psychiatry as a whole and, if not, what changes are indicated?

We were unanimous in recognizing that changes were needed. Among other things we agreed that psychiatric services must be available to all citizens and that we will bend every effort to recruit, train, and make better use of all mental health personnel; that we will support adequate budgets for all existing psychiatric facilities and the new ones that are needed; that we will search for broader roles for other disciplines and helpers in all mental health services; that we will urge our members to redirect their skills to more active consulting and service roles in the new community facilities.

I think you will agree that fresh winds are blowing on the mental health front. It is therefore of prime importance to give adequate support to training, research and other programs that will bring us closer to our goal of having good mental health services available to all citizens.

TESTIMONY BEFORE

HOUSE APPROPRIATIONS SUB-COMMITTEE

on

Labor, Health, Education and Welfare

Representative John E. Fogarty, Chairman

on

FISCAL 1967 BUDGET
for the
NATIONAL INSTITUTE OF MENTAL HEALTH

by

Francis J. Braceland, M.D.

Presented on behalf of
The American Psychiatric Association

March 21, 1966

I am Francis J. Braceland and I have been a psychiatrist for nearly 35 years. I graduated from Jefferson Medical College in 1930 and was an intern and Chief Resident at Jefferson Hospital. I began my psychiatric fellowship training at the old Pennsylvania Hospital in Philadelphia in 1932. I was then a Rockefeller Fellow in Psychiatry in Zurich, Switzerland, and at the National Hospital, Queen Square, London. I returned to be Clinical Director at the Pennsylvania Hospital until 1941, when I was appointed Professor of Psychiatry and Dean of the School of Medicine, Loyola University.

I have since occupied the following positions:

1942-46 - Special Assistant to the Surgeon General, U.S. Navy, and war-time Chief of the Psychiatric Section. I am a Rear Admiral, Medical Corps, USNR,Retired.

1946-51 - Head of the Section of Psychiatry, Mayo Clinic, and Professor of Psychiatry, Graduate School, University of Minnesota.

1951-65 - Psychiatrist-in-Chief, The Institute of Living, Hartford, Connecticut; since 1965 Senior Consultant in that institution and Clinical Professor of Psychiatry, Yale University; since 1960, Lecturer on Psychiatry, Harvard Medical School.

I have been in the past:

President, American Board of Psychiatry and Neurology, 1953

President, American Psychiatric Association, 1956-57

President, Association for Research in Nervous & Mental Disease, 1957

President, Board of Examiners for Certification of Mental Hospital Superintendents, 1955

Chairman, American Medical Association, Section on Nervous & Mental Disease, 1956

Chairman, National Health Forum, 1958

Vice-President, World Psychiatric Association, 1961 -

I am now Editor of The American Journal of Psychiatry, the official organ of American Psychiatry and am a psychiatric consultant to the Surgeons General of the Army, Navy, and Public Health.

Mr. Chairman and Members of the Committee.

I appreciate this opportunity to appear before you on behalf of the American Psychiatric Association, an organization which numbers approximately 17,000 psychiatrists on its rolls, and to express the support of that official organization for the citizens' budget for the National Institute of Mental Health as just elaborated by my colleague and friend, Mr. Mike Gorman.

I began to appear before this Committee 20 years ago and with few exceptions I have had the privilege of appearing before you every year since then, so you can see that I am a hardy perennial. However, Mr. Chairman, we are appearing today in a different psychiatric world than the one in which we began our testimony 20 or even 10 years ago and I hasten to add that much of the progress which we have made over that period was aided, abetted, encouraged, and financed by the assistance given us by you gentlemen and your counterpart in the Senate. Apropos of this fact, the March issue of The American Journal of Psychiatry, which I have the honor to edit, has a special section of 10 papers on community psychiatry and an editorial by Dr. Robert H. Felix, which is entitled "Community Mental Health, A Great and Significant Movement." I quote two short statements taken from Dr. Felix's commentary, for I know that you know he played an important part in our mental health advances. He said:

(1) It is not a dream but a reality. More progress has been made in psychiatry in the last 30 years than in all the span of recorded medical history before that time.

(2) Now mental illnesses and their prevention have become in fact the community concern we have said for so long they should be. Mere words cannot express the great debt the American people and, in fact, people everywhere owe to the late President Kennedy and the Congress of the United States for translating the findings and recommendations of the Joint Commission on Mental Illness and Health into law, thus making possible action at the community level.

Here today I need not add that this Committee played an important part in the formulation and financing of the Joint Commission; incidentally, this is the fifth anniversary of the publication of its report, Action for Mental Health.

I said recently in a review of 1965 psychiatric advances in the Medical World News that psychiatry has been influenced more by happenings outside of its field than those events which took place in it. In that you are acutely aware of and have been the obstetricians of many of those external happenings, I would ask your permission to examine for you the professional aspects and background of those urgent requests which Mr. Gorman made of you here today.

The figures which he gave you are dramatic in their impact: "The unprecedented reduction in state mental hospital populations has saved the states an estimated two billion dollars in patient care costs and four billion dollars in construction costs over the ten year period." He then called your attention to the fact that, even with these savings, the goals of the martyred President have not been met. The average annual reduction in the state hospitalized patients has been only 1.5 percent and the President had hoped the census of these institutions would be reduced by 50 percent in one or at most two decades. He expressed the opinion that we are failing because budgetary allocations to accomplish this had not been forthcoming.

I have lived in mental hospitals for over 30 years, gentlemen, and I am acutely conscious of the number of sick people they house. Despite our advances,

those institutions still house 475,000 souls and some of them are hardly proper places in which to expect people to get well. Even if we attain our goals and gradually reduce their populations, these institutions will be with us for a long time to come. In the past we have investigated them, exposed them, condemned them, excoriated them, and abolished them numerous times but they are still with us. Actually, the talk of abolishing them is far-fetched -- sheer demands of economics of space and long-term illness require them. Besides, we do not want to abolish them, we only want to abolish the old image they cast. We must improve them, however, and make them habitable, decent, and functional.

Most of these hospitals were built in the last century. They are large structures and some of them are grim. Earlier they simply warehoused human beings. Most of them are much better now but they need to be kept up and in good repair, for proper surroundings are an aid to convalescence, and the road back to home and loved ones is a hard one, which needs all the help and encouragement which can be given.

Therefore, the Hospital Improvement Program is an exceedingly important one. It has to do with the surroundings and the dignity of sick people. It cannot be short-changed, for these people have few understanding friends. It is our opinion professionally that the sum of twenty-four million dollars is needed to do this job properly. Admittedly, this is six million dollars more than is asked for in the President's budget but this is necessary if the 70 institutions which have asked for help will not be turned down.

In that problems do not arise singly, the mention of hospitals brings up another serious situation, namely, manpower. Without proper staffing at all levels, hospitals simply become shelters. My colleague, Dr. Daniel Blain, who is well known to you, has recently been chairman of a Commission on Manpower of the American Psychiatric Association. He was charged with thoroughly investigating this

important problem and his group made a thorough examination of the situation and has recently completed a report on the subject. Fortunately, he is here today and prepared, in case you would care to ask him questions on the subject. To avoid repetition and conserve time, I forbear to anticipate what he will say. However, there are six important new elements which will drain precious manpower of all types away from hospitals, clinics, schools, and communities which at present are only sparsely covered. Please note that most of these are due to conditions outside the discipline of psychiatry and some are due to government regulations, some to changing times.

The first new element is the government regulations which concern patients 65 and over. These will profoundly influence this age group and necessarily greatly increase the number of older people utilizing psychiatric facilities. This trend will require additional personnel.

The second is the already mentioned community centers. These will require sufficient personnel to make their existence justifiable. From whence are they to come? Essential as these new centers will be in the new plans to make sick people, heretofore isolated and in some instances lost, return to home and loved ones, they will need capable personnel in all of the four core disciplines to help them on their road to recovery.

Thirdly, we might keep in mind the physician draft. Essential as it is to provide physicians for the care of our fighting men, this promises to wreak havoc with the production of new psychiatrists, junior medical and psychiatric staffs, as well as nurses and male aides. Just as the rain falls on the just and the unjust alike, physicians will have to hesitate, as they did in the Korean war, before taking residencies in psychiatry or jobs after they have completed them, lest their draft

numbers come up. In like manner, employers will be hesitant about hiring them.

Fourth, and extremely important as far as personnel is concerned, will be the carrying out of the resolve made by Surgeon General Stewart of HEW and enunciated at the White House Conference, that the best of health services must be made available to all who need them. This will require a number of psychiatrists, for it is known that many people express their anxieties and depressive reactions by means of physical symptoms and large numbers of psychiatrists will be needed to help in the nation's clinics.

Fifth, it should be noted that there are ten new medical schools in the making and they will be ready in a few years. Where are they to get staff personnel? Undoubtedly they will require full-time clinicians and teachers of psychiatry, among other personnel. Unless we can train more individuals to replace those who aspire to academic life, we are in trouble. Thus far all that is left to deans of the new schools is the ancient and not so honorable art of pirating the help they need, but that is often an exhibition of the law of diminishing returns; they can't all steal staff from one another for long.

Sixth, and not to be neglected, is the increasing trend to the opening of new psychiatric wards in general hospitals and new Day Hospitals and the search for men to man them. This trend will surely increase as hospital staffs throughout the country learn that human beings have a psyche which is completely intertwined with their bodies and one cannot get out of order without affecting the other. Heretofore some of these folks looked upon the psyche as only an unfortunate appendage which got in the way of their making physical diagnoses. Fortunately, that is rapidly changing.

Gentlemen, we can only meet these situations by the training of more personnel. I had the honor of writing the mental health section of the Second Hoover Commission Report some years ago and I said then and repeat it now: Had not the Congress empowered the NIMH to train men for our discipline, things would be in utter chaos and we would be back to warehousing a large number of sick human beings. A survey in 1963 indicated that almost 30 percent of the psychiatrists and 16 percent of the psychologists are providing services in more than one institution, moonlighting if you will, and the proportion of psychiatrists working in outpatient departments who have multiple jobs is 46.1 percent for psychiatry, and for psychology 23.8 percent, nursing 22.4 percent, and social work 13.5 percent. Unless additional personnel is provided for, therefore, the psychiatric aspects of Medicare, community centers, psychiatric wards in general hosptials, even psychiatrists to serve the armed forces, will be in a sorry state. It is none too satisfactory even now.

I have publicly done penance a number of times in the past for not backing General Practitioners' Training more enthusiastically when the idea was first introduced. But I make amends for that now. I thought at first we would not attract the men, but we have done so, and, gentlemen, those whom I have helped train are in general good doctors in every sense of the word. They have done excellent work, many of them returning to the communities in which they formerly practiced, and, armed with their new skills, they are eagerly awaited by the colleagues who knew them. I note in my own hospital this year that, while we have additional applicants for this program, that poignant little note which says: "Your program is approved but there are not sufficient funds to pay for it.", has again appeared.

For a number of years now we as a hospital and our local Branch Society as a unit have conducted classes for non-psychiatric physicians. These are remarkable exhibitions of the willingness of these men to learn new skills. They arrive at 8:00 P.M. and at some phase of their program bring psychiatric problems from their own practices with them. It is hard to get them to go home at 11:00 P.M. This all redounds to improved care of people and is a remarkably good program. Professionally we have no hesitation at all in requesting an increase of two million dollars over the limit set by the administration, so that this plan can be spread and that the physicians outside of the psychiatric discipline be helped to care for the emotional problems of their patients, problems which present themselves in many disguises.

For the overall Graduate Training Programs, which encompass psychologists, nurses, social workers, and other mental health personnel, in addition to psychiatrists, we recommend the addition of twelve million dollars to the Administration Budget. The case for In-service Training for those who are closest to the patients and with them constantly, the aides, practical nurses, house mothers, etc., has been eloquently presented by Mr. Gorman and we endorse his stand and his suggested budget, as we do his suggestions for staffing Mental Health Centers. Without a satisfactory budget they will simply be additional tax-free buildings on the landscape.

Research

As to the present state of psychiatric research, a number of exciting things are happening -- nothing particularly melodramatic, but certainly a slow steady advance in our understanding of the distressing conditions which we encounter. Each year we have hoped to come before you with some dramatic break-through but

this we know now may not be fated to happen, though we may continue to hope. We can work and strive for some breath-taking discovery but, actually, what happens is usually a slow making of inroads upon the illnesses which we treat.

As to the basic sciences, research in them is slowly contributing its leaven. The study of brain metabolism is proceeding in a much more sophisticated manner than ever before. All of the reports of advances need careful checking and replication before we can get excitied about their potentialities for treatment. For instance, work was reported last year which postulated the possible transfer of learned information from one animal to another and from one species to another in the form of RNA extracted from the brains of animals trained in particular tests. Next month, however, an investigator from my own hospital will report his inability to replicate this work in The American Journal of Psychiatry. Others will probably confirm this negative report. Thus the need for many investigators to examine the same leads.

The psychophysiologists have continued their interest in so-called Biologic Clocks and their preliminary data indicate that there is a correlate between disturbed behavior in experimental animals and the deterioration of the ability of these clocks to keep accurate time. They tend to go slower or lose time as behavior becomes increasingly disturbed. However, the administration of some of the newer psychoactive drugs reduces the disturbed behavior and with it comes an improvement in the time kept by the monkey's inner clock. Has all of this any possible value as far as humans are concerned? Well, one cannot say for sure as yet; the cause and effect relationship in this association of disturbed behavior, drugs, and biologic clocks as physiologic correlates is not conclusive. However, it is not improbable that further investigation will indicate that there is an

optimum time for the administration of drugs of various classes for various types of illness. This would be an advance, indeed, for it would make the action of drugs much more effective.

Before getting into a consideration of the psychoses, I would like to comment briefly on the unfortunate increase in the number of young patients who are emotionally disturbed. From 1950 to 1960 the first admission rates in state and county mental hospitals for children under 15 rose from 10.4 per 100,000 population to 21.5. The rates for youths between 15 and 24 rose from 58.8 per 100,000 to 79.3. Private psychiatric hospitals have a plethora of these patients; they constitute from one-third to one-half of their population and more often than not they present difficult problems. One sad by-product of all of this is that there is an interference with the education of these patients, some of whom are exceptionally bright and have fine potentialities. It has always distressed me that we as a nation are so intent upon and will spend so much money upon the education of young people and yet, if they falter and come down with emotional problems, we are prone to abandon them and fail to provide educational facilities for them.

The greatest impact upon this problem will come from work already under way through grants from NIMH, already in action or programmed. And it will be the availability of treatment services and preventive efforts of the new mental health centers that will aid in keeping these young folks out of mental hospitals and close to their homes and their schools. Research efforts with these groups must continue and increase and the reduction in present funds or failure to grant additional funds to finance these efforts would be tragic.

You have already heard of the need for special help in dealing with the estimated 60,000 narcotic addicts who are to be found most frequently in the major

metropolitan areas. Not only are they in a fair way to be lost but their efforts to get funds for the illegal purchase of drugs by criminal action or, saddest of all, by involving younger people are extremely serious accompaniments of their illnesses.

Coupled with narcotic addiction, there is an abuse of sedatives, barbiturates, and addicting drugs of various classes. Occasionally now young patients appear who have been experimenting with drugs of the type of LSD and find their way into mental hospitals. This problem may increase.

As to alcoholism, there is no need to tell you of its ravages. There are over five million chronic alcoholics and probably five million more trying hard to earn that title. No particular class or group is involved; it goes through the population from those economically deprived to those economically privileged. Again, the seeds of this are being sown too freely in the young and strangely -- perhaps not so strangely -- in men in middle life, many of them in prominent positions. The causes in these variant groups are different but the results are the same -- heartache and suffering for the more than 25 million people they encounter or are related to in some fashion.

To handle drug and alcohol and other addicting problems it is essential (1) to foster a wide range of research efforts; (2) to coordinate and stimulate epidemiologic studies; (3) to learn to use the knowledge we already have; (4) to provide leadership in the development of inservice training and a continuation of postgraduate training for use of new knowledge. Fortunately, a center is contemplated within the NIMH to coordinate all program activities in drug and alcohol areas. It is probable that the idea of this center was stimulated by this Committee.

As to suicide, one is surprised to learn that it is the tenth leading cause of death in the United States -- it outranks stroke. It even outranks the toll of traffic accidents in Los Angeles. What interests me most is the suicide rate in students -- it ranks third in the cause of death in this group and, if the truth were known, it is probably second. An unknown number of accidents which occur are really carefully planned and then too, for many diverse reasons, some suicides are deliberately not reported as such. While the total given nationally is 20,000, the true number is much higher and the number of suicide attempts is ten times the number of successes. Fortunately, a number of cities now are developing suicide prevention services and the Los Angeles center, which has been operating more than six years and which is outstanding, has developed the basic knowledge, methods and techniques for a nationwide prevention program -- but increased funds will be required to continue research and to distribute widely the information which has been acquired.

The suicides of college students bother me very much. Although I am convinced, after 35 years experience, that one cannot with any certainty prevent a person from destroying himself when he is intent and bound to do so, we must make sure that we do all we can to detect early signs of that intent and take steps to protect the individual who is inclined to self-destruction. One way to do this is through the health services of the institutions of learning, for psychiatrists in these services can detect the early signs of depression which, left untreated, might well result in serious consequences. Farnsworth, who probably is more knowledgeable in the field of emotional problems in college students than anyone else, notes that a number of these individuals can be recognized in college health

centers. Some institutions have psychiatrists in their health departments; others do not for various reasons -- some financial, some because of lack of psychiatric assistance in the area; others seem to feel that this is not the concern of educators and I often wonder what these officials say to parents whose sons have had an emotional break. It must be difficult; maybe one has to have physical symptoms to attain respectability. Maybe, too, I am unfair in these statements.

As to the psychoses, of course the greatest interest is probably exhibited in that congeries of symptoms known under the catch-all title of schizophrenia, a group of symptoms which has defied the efforts of some of the world's most brilliant men to arrive at its solution. It is probable that, when a solution of the problem is arrived at, it will encompass many other basic research ideas over and above the schizophrenic problem itself.

Major investigators are of the opinion that the most promising evidence for a biochemical abnormality lies in the area of transmethylation. One recent study compatible with this idea was the demonstration of an abnormal catecholamine metabolite in the urine of some schizophrenics. The evidence is still preliminary that this substance is produced within the body and is not a component of the diet. There is no direct evidence that this material produces schizophrenic symptoms. Interest in a protein constituent of the blood of schizophrenics continued strong; it also is apparently in the blood of some schizophrenics and it is capable of producing certain behavioral metabolic or cellular changes in experimental animals.

There are a number of such studies and, fortunately, no wild claims are being made regarding the. That has been our trouble in the past and has led to quizzical attitudes toward them. We seem to be playing around the edges research-wise and as

yet cannot get things together. There is apparently a fatty acid compound found exclusively in the sweat of schizophrenics; what its significance is we do not know. Brain studies made by means of new instruments measure the electrical activity of the brain of schizophrenic patients through the intact scalp. This may lead to a demonstration of significant differences in the brain function between the mentally ill and the normals. No door can be left unopened and every lead must be followed.

The social, psychological, and cultural factors of the illness are being investigated. One does not know how these factors and basic research findings can be gotten together to produce their devastating effects, but in some way they do. It is simply further evidence, however, that schizophrenia is not an isolated disease, but rather a combination of mental and emotional malfunctionings.

It is easier for the economically better situated and the more highly educated psychotic patients to stay out of hospitals and, if hospitalized, to get out of them. It is not clear as yet whether the improved prognosis for the first group is due to greater clinical improvement or to the greater supportiveness of the environment available to them outside. Though they seem to be free of major psychiatric symptoms one year later, their community adjustment leaves something to be desired.

As to treatment, phenothiazine drugs seem to be the treatment of choice. Symptoms can be controlled by this means. Studies show that a number of patients who earlier would have had to be hospitalized now can be maintained at home by drugs and a cooperative family. There is some evidence that those who improve on different drugs have different pretreatment symptoms and background histories. If these results hold up, they would provide a basis for assigning patients to

that drug on which they are most likely to improve.

As to depression, research on its causes may be becoming more fruitful. Studies underline the involvement of norepinephrine in the mechanism of action of both major classes of anti-depressant drugs and it is evident now that two quite different drugs used to treat hypertension occasionally produce defressive illnesses; both groups cause a dramatic drop in the brain levels of norepinephrine. This evidence needs careful study and exhaustive research.

From Europe, and to a lesser extent from American studies, comes evidence now of electrolyte abnormalities in depression, and of the response to mania and possibly recurrent depression to treatment with an electrolyte, lithium ion. All of this, however, is in its earliest stages and we would do well to contain our enthusiasm about it.

I could go on and on, Mr. Chairman, but your time is valuable. At the end of the innumerable examples of research leads I would give, I would speak of the things we would urgently hope for, things which might be brought to pass if we continue our efforts. I would not imply that we could buy advances but I would suggest that now that so many fine research men are interested in our field we have higher hopes of accomplishment than ever before. All of this would add up to one thing, however, and that is crystal clear -- a cut in the research budget of $2,374,000., as proposed by the administration, is unthinkable. Actually, the budget should be increased and we recommend the modest increase of $626,000 over the 1966 budget, or a total of $40,756,000.

We have already considered the Demonstration Projects (Title V) and we agree heartily with Mr. Gorman that the important projects under this heading merit greater support or they will die of inanition. We recommend an additional two

million dollars be appropriated to aid the alcohol, drug, and suicide projects for the reasons I gave above. This would mean a total of $20,357,000. rather than the $18,357,000. in the official budget.

I think I need not comment on other aspects of the budget; that has been done very well by my colleague. I am aware of your dedicated interest, as you are of ours. I am aware, too, of the numerous calls upon the Congress for funds. I can only hope that now that we have finally started to get our patients out from behind forbidding large stone walls that we will not be slowed down or brought to a halt. Mental patients have had a bad time of it for a number of years. Lack of space, of personnel, of funds have dogged them always; theirs is not a popular cause and they have little appeal to the public at large. We can only depend upon you gentlemen for help. Down through the ages the public has come to believe that our patients are a government responsibility and in the main the citizens have failed to see the necessity for taking care of them, even as they do patients with physical illness.

It is probable that as long as man lives he will have emotions and, if he has emotions, they will get out of order and emotional disorder will never be popular or command sympathy or understanding in our culture. Man cannot go on his way unemotionally; God reserved that mood for cows. Therefore, when he gets upset, we must take care of him; hence this urgent appeal to you. Thank you for your courtesy and attention.

NIMH FISCAL 1967 BUDGET INCREASES PROPOSED BY CITIZENS

Mental Health Activities	1966 Budget	1967 President's Budget	1967 Citizens' Budget
Research:			
Regular	$40,130,000	$37,756,000	$40,756,000
Demonstration (Title V)	17,985,000	18,357,000	20,357,000
Hospital Improvement	18,000,000	18,000,000	24,000,000
Clinical Res. Centers	1,750,000	1,750,000	1,750,000
Gen. Research Support	5,839,000	6,313,000	6,313,000
Research Cost Sharing	811,000	2,100,000	2,100,000
Children's Commission	500,000	500,000	500,000
Scientific Evaluation	215,000	225,000	225,000
TOTAL RESEARCH	$85,230,000	$85,001,000	$96,001,000
Research Fellowships	$ 8,364,000	$ 9,133,000	$ 9,133,000
Training:			
Undergraduate	$ 8,300,000	$ 8,500,000	$ 8,500,000
Graduate	59,811,000	62,948,000	74,948,000
General Pract.	11,000,000	11,000,000	13,000,000
Inservice	6,850,000	6,850,000	9,000,000
Scientific Evaluation	120,000	150,000	150,000
TOTAL TRAINING	$86,081,000	$89,448,000	$105,598,000
Mental Health Staffing	$ 18,899,000	$33,907,000	$40,000,000
State Control	$ 6,750,000	$ 6,750,000	$ 6,750,000
Direct Operations	$ 27,326,000	$28,876,000	$29,876,000
TOTAL REQUEST	$232,650,000	$253,115,000	$287,358,000

Total Increase Requested - Citizens' Budget $34,243,000

Construction of Community Mental Health Centers	$50,000,000	$50,000,000	$65,000,000

Increase for Community Mental Health Centers $15,000,000

TESTIMONY BEFORE

SENATE APPROPRIATIONS SUB-COMMITTEE

on

Labor, Health, Education and Welfare

Senator Lister Hill, Chairman

on

FISCAL 1968 BUDGET
for the
NATIONAL INSTITUTE OF MENTAL HEALTH

by

Francis J. Braceland, M. D.

Presented on behalf of
The American Psychiatric Association
June 6, 1967

I am Francis J. Braceland and I have been a psychiatrist for nearly 36 years. I graduated from Jefferson Medical College in 1930 and was an intern and Chief Resident at Jefferson Hospital. I began my psychiatric fellowship training at the old Pennsylvania Hospital in Philadelphia in 1932. I was then a Rockefeller Fellow in Psychiatry in Zurich, Switzerland, and at the National Hospital, Queen Square, London. I returned to be Clinical Director at the Pennsylvania Hospital until 1941, when I was appointed Professor of Psychiatry and Dean of the School of Medicine, Loyola University.

I have since occupied the following positions:

1942-46 - Special Assistant to the Surgeon General, U. S. Navy, and war-time Chief of the Psychiatric Section. I am a Rear Admiral, Medical Corps, USNR, Retired.

1946-51 - Head of the Section of Psychiatry, Mayo Clinic, and Professor of Psychiatry, Graduate School, University of Minnesota.

1951-65 - Psychiatrist-in-Chief, The Institute of Living, Hartford, Connecticut; since 1965 Senior Consultant in that institution; also Clinical Professor of Psychiatry, Yale University; since 1960, Lecturer on Psychiatry, Harvard Medical School.

I have been in the past:

President, American Board of Psychiatry and Neurology, 1953.

President, American Psychiatric Association, 1956-57.

President, Association for Research in Nervous and Mental Disease, 1957.

President, Board of Examiners for Certification of Mental Hospital Superintendents, 1955.

Chairman, American Medical Association, Section on Nervous and Mental Disease, 1956.

Chairman, National Health Forum, 1958.

Vice-President, World Psychiatric Association, 1961-66.

I am now Editor of <u>The American Journal of Psychiatry</u>, the official organ of American Psychiatry, and am a psychiatric consultant to the Surgeons General of the Army, Navy, and Public Health.

Mr. Chairman and Members of the Committee:

I am appreciative of your willingness to hear me. I appear before you as a representative of the American Psychiatric Association; the official body of American psychiatry which numbers approximately 17,000 psychiatrists. I am here to express the support of that association for the citizens' budget for the National Institute of Mental Health, the budget detailed for you by my dedicated colleague and worker for the betterment of the condition of mentally sick people -- Mr. Mike Gorman.

There is no need for me to recall to you the number of times I have appeared before this distinguished committee. I am a hardy perennial having appeared first in a navy uniform as Chief of Navy Psychiatry in World War II, fresh from first-hand knowledge of the havoc wrought by emotional and mental disorders in our nation's youth detected as we mobilized for war. Disorders which led to hundreds of thousands of rejections for military service and an equal number of psychiatric casualties abroad and on the home front. You may recall that so serious was this situation that at one time General Marshall complained that we were sending more men home with psychiatric diagnoses than we were sending abroad to fight the enemy.

Each year as we come before this committee, we have hopes of bringing to you information regarding some remarkable breakthrough in our work which, like polio vaccine, will solve many of our problems. But, the mental and emotional make-up of man is much too complex to allow for a

simplistic advance such as this. Fortunately there has been, however, a slow steady advance in our knowledge due largely to the research and training funded by this committee and its counterpart in the House, both of which have consistently recognized our problems and many times have helped us even to the point of markedly increasing the budget recommended by the administration in so doing.

Though neither the NIMH nor psychiatry are brash enough to claim credit for it, there is at least one bit of good news out of the Vietnam conflict, namely, the reduction of losses from the military service due to psychiatric causes. A number of factors have combined to make this highly desirable situation possible. I shall not take your time to expand upon these factors but, certainly, psychiatric insight gleaned from two world wide holocausts contributed to this welcome turn of events. To be rejected by, or surveyed out of military service for psychiatric reasons, is a traumatic event which has deleterious effects which even reach into a man's life in his civilian capacity. This says nothing of the effect of the serious drain upon the nation's military manpower supply.

I have been a psychiatrist for 36 years, a clinician and a teacher who has lived mostly in the mental hospital milieu and it is my hope that I may address you on one or two clinical aspects of mental illness, for that is my only competence. Some of the things I say here today have been said before but they seem even more pertinent here and now. One of those

is to note that I had the privilege of writing the mental health portion of the Hoover Commission Report. I said then and want to repeat now that, were it not for the foresight of this committee and its counterpart in the senate in furnishing the NIMH with sufficient funds and the wisdom and skill of the NIMH officials in distributing them for training and research, the mental hospital and psychiatric picture in this nation would be in chaos.

However, Mr. Chairman, we are appearing today in a different psychiatric world than the one in which we began our testimony 20 or even 10 years ago and I repeat that much of the progress which we have made over that period was aided, abetted, encouraged, and financed by your assistance. Apropos of this fact, the March 1966 issue of The American Journal of Psychiatry, which I have the honor to edit, had a special section of 10 papers on community psychiatry and an editorial by Dr. Robert H. Felix, which is entitled "Community Mental Health, A Great and Significant Movement." I quote two short statements taken from Dr. Felix's commentary, for I know that you know he played an important part in our mental health advances. He said:

(1) It is not a dream, but a reality. More progress has been made in psychiatry in the last 30 years than in all the span of recorded medical history before that time.

(2) Now mental illnesses and their prevention have become in fact the community concern we have said for so long they should be. Mere words cannot express the great debt the American people and, in fact, people everywhere owe to the late President Kennedy and the Congress of the United States for translating the findings and recommendations of the Joint Commission on Mental Illness and Health into law, thus making possible action at the community level.

When the martyred president expressed the hope that our state hospital population might be halved within a decade, I was one of those who did not believe it could be done, but, gentlemen, it is beginning to look like it might be done.

The Joint Commission he spoke about, you will remember, was made up of representatives of numerous and varied national organizations. You sponsored that group and it, after a careful study of the mental health situation in the nation -- a study extending over five years -- issued a report, the now famous Action for Mental Health, which has been called the magna carta of the mentally ill.

The figures Mr. Gorman has given you regarding mental hospital statistics are dramatic indeed; they are worthy of careful study. Prior to the new lease on life which the advent of new concepts and new drugs gave us in the middle of the last decade, we were in a fair way to have to continue to build new mental hospitals and continue to increase the size of those already extant. With the more than 700,000 patients in state hospitals that he mentioned, plus nearly an equally large number in private hospitals, general hospitals, and combined institutions, we would have been in serious trouble as the population continued to expand.

Instead, today these institutions house only half the number who might have been incarcerated, but that is still too many. With 452,000 individuals in these institutions at present, some of them in places hardly conducive to recovery or rehabilitation, it is obvious that our work is far from being completed. Therefore, though I shall in the interest of time only touch upon certain aspects of the overall program, we in the profession heartily endorse the request in the citizens' budget that $45 million dollars be added to the administration's budget request, for a total of $293,860,000.00, in order that good work already started may continue.

It is probable that in no year but this present one has the progress of the national mental health program been so specific, nor has there been an immediate future in which the decisions of the Congress will be more crucial in making possible a continuity of effort on the part of all concerned toward solving what has been called the nation's No. 1 health problem. The money which Congress has appropriated thus far, in addition to its prime purpose, also has acted as seed money and called forth appropriations by the various states far in excess of those provided by the federal government. An article in one of the journals published by the American Psychiatric Association notes the progress made by one state in meeting its problem. Undoubtedly, seed money for training and research spurred the initiation of this work and the resourcefulness of its citizens and community interest

carried it to fruition. Since 1946 the resident state hospital population in Iowa has dropped 75%, from more than 6,600 in that year to 1,683 in October 1966.

This notable change is due largely to Iowa's effort to get the patients out of large institutions, to decentralize and treat sick people in clinics, half-way houses, mental health centers and institutes. The active workers in the mental health field give a large number of people credit for this change -- governors, state senators and representatives, U. S. congressmen, county supervisors, clerks, auditors, psychiatrists, family doctors, clergymen and others.

The citizens in all states are not quite so fortunate, however, and it will be a long time before some of them will be able to leave the grim fortresses which house them. Plans were made in 1963 to improve these institutions in all of the states and, hopefully, this year was to see a budget of $36 million dollars to accomplish this. You have before you the administration's budget and know that the hopes for bettering the lot of these patients vanishes. It is our hope that an additional $6 million dollars will be added to the administration's request in order to continue good work already begun and start in some hospitals which are badly in need.

For nearly two years now the grant support program in aid of both construction and staffing of community mental health centers has been in full operation. As a result, more than 120 centers' grants have been funded.

The year 1967 marks the turning point at which the concept of high quality care and treatment of sick people changes before our eyes from a hope to a reality for hundreds of thousands of our fellow citizens. When the plans were made originally, Congress authorized $65 million dollars for construction of these centers for fiscal 1967 and fiscal 1968. It is a severe blow, therefore, to note that the $15 million dollars cut from last year's budget is again recommended for this year. Thus, the national fervor which was worked up with the hope that people would receive treatment near their homes and loved ones, is to end in disappointment.

It is in these centers that various agencies, clergymen, family doctors and mental health personnel were to labor, and in them the blue collar worker was to receive treatment instead of being shipped off to a distant institution. We urge that the $65 million dollars originally authorized by Congress for the construction of comprehensive community mental health programs be appropriated in the FY 1968 budget.

The proposal to extend the provisions of the Community Mental Health Centers Act certainly is a wise one. Dr. Yolles has announced that should Congress extend construction and staff aid for centers, community health centers will be available to about one-half the nation's population in the next five years. Grants have already been made to centers in 44 states and territories and Federal aid has encouraged communities to marshall their own resources. The new ways and new and expanded mental health services are being brought to a variety of populations.

It was reported to Congress last year that the progress being made by the Institute in its continuing efforts to improve the mental health of the American people is, indeed, impressive. That progress must be accelerated in 1968, in my opinion, if we are to maintain our momentum.

Therefore, my initial request is urgent; it concerns manpower. There continues to be a critical shortage of trained manpower in the mental health fields. This has been said time and again; but we can now add something else to this statement. In the past two or three years, the potential of universities and other training facilities has grown to the point that knowledgeable men in this field believe that manpower can be trained in sufficient quality and quantity to meet the public demand for services -- if sufficient funds in support of training are made available immediately.

All of us are acutely aware of both the manpower shortages in all the mental health professions and the unequal distribution of this manpower throughout the country. When I ponder the manpower problem today, I am reminded of a quotation from Abraham Lincoln. Lincoln said: "The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty and we must rise with the occasion. As our case is new, so we must think anew, and act anew."

While training programs in the core mental health disciplines are increasing in number and capacity, their total output continues to fall short of demand, even for the limited mental health facilities now in operation.

It is estimated, gentlemen, that by 1970 we will require at least 87,000 workers in the core professions of psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing. About 22,000 of them will be needed to staff the community mental health centers we hope to see built by then. It is obvious that we will not be able to provide the mental health personnel we will need in the next decade -- or even in the next two decades -- unless we can greatly increase existing training programs for which NIMH is the major source of support. A lack of yearly increases in training appropriations for NIMH can seriously hamper the efforts to reach the projected manpower goal.

The President's budget, now before you, includes $100.7 million for the training program of the NIMH. This is an increase over last year's training appropriation which totaled $94.5 million. But it is still some $8 million short of the $15 million annual increase in training funds previously accepted by the Congress, at the outset of this program, as a minimum requirement to meet the projected goals of the nation's mental health program. In fact, due to increases in costs, the NIMH will be able to award even fewer training grants than in this present year.

That $15 million annual increase is not a mythical figure, I submit. It was arrived at thoughtfully and accepted generally. But only in FY 1963 was it actually appropriated. I would sincerely hope, Mr. Chairman, that the FY 1968 budget could be increased by this amount and I would like to present to you some of the reasons why it is vital this year.

Translated into actual manpower, the loss of even ten million dollars means the loss of one year's training for about 1,425 people and produces a shortage almost impossible to make up. It also can have a profound effect upon the quality and stability of training centers which are forced to reconsider their goals if funds are not forthcoming at the national level.

The impact on persons needing treatment is greatest of all. According to recent calculations, a shortage of 1,000 professionals makes it impossible to provide direct clinical services to about 100,000 patients. A loss of 1,000 trainees for one year would mean that about 39 community mental health centers could not be staffed and that services would not be available to nearly four million people in areas the centers are designed to serve.

The health legislation of the recent past gives us an opportunity to establish new, experimental and special training programs to provide mental health services for the people. The profession of psychiatry is rapidly accepting and practicing the precepts of treatment within the community and treatment based on public health methods.

To work with psychiatrists, we must train more persons as allied health personnel, to meet new needs and to carry out new treatment methods. It is time, now, to introduce training programs of this type even in the junior colleges of our land and to support their initial efforts.

In today's complex world, mental health professionals must also have available opportunities to continue their education. For a number of years now, the Institute has established as a solid base for its Continuing Education Program, the means of providing postgraduate training in psychiatry for general medical practitioners and other medical specialists. All the other mental health professions are now in need of similar programs and a Continuing Education Branch has recently been established within the Institute to support these activities. Thus far 11,000 non-psychiatric physicians have received short term training in psychiatry.

Professionals and non-professionals alike can update their skills with this sort of federal support. Any public or private non-profit institution, including hospitals, community mental health centers, professional organizations, state and local agencies, and universities and colleges can request aid in establishing such programs. But the amount of aid to be forthcoming will depend explicitly on the amount of funds available. In 1968, I feel that funds for continuing education should have an exceedingly high priority.

Of course, the major portion of funds in support of training will be expended to continue expansion in the core professions of mental health.

But we now know that the number of professionals must be augmented by allied personnel. If the nation does not provide for this kind of team approach to mental illness and its proliferating problems of poverty and stress, funds expended to train professionals will not be spent to maximum effectiveness.

A survey done in 1963 indicated that almost 30 per cent of the psychiatrists and 16 per cent of the psychologists are providing services in more than one institution, moonlighting if you will, and the proportion of psychiatrists working in out-patient departments who have multiple jobs is 46.1 per cent for psychiatry, 23.8 per cent for psychology, 22.4 per cent for nursing. Unless additional core personnel to cover the psychiatric aspects of Medicare, community centers, psychiatric wards in general hospitals and psychiatrists for other burgeoning needs are provided, the mental health situation will be in a sorry state.

Due to the demands of the times, the once neglected medical discipline which I represent, has slowly come from behind hospital walls and spread its influence and attracted the interest and help of the community. It now makes contributions to its sister medical disciplines, to military medicine, to industrial medicine, to religious counseling and to education and these demands are bound to continue to increase as new services are demanded of this already overworked medical specialty.

As to psychiatry's growing importance in education, let me quote a few statistics for you. Federal figures indicate that in 1966 six million students were enrolled in our colleges and universities, 68% of them in publicly controlled institutions. It is to these students that the nation will look for its future leaders. Yet Farnsworth, Harvard's Director of Student Health, one of the most knowledgeable and experienced of college psychiatrists, points out that surveys indicate that for every 10,000 students, 1,000 will have emotional conflicts of sufficient severity to warrant some professional help. Three to four hundred will have depression severe enough to impair their efficiency, and of the five to twenty who will attempt suicide, one to three will succeed. Fifteen to twenty of these students will become ill enough to require treatment in mental hospitals. These statistics have serious connotations and one of the wisest and most understanding comments on the subject that I have heard was made by Harvard's Dean of Freshmen, Dr. F. S. von Stade, who said: "When so many capable youngsters are on the beach, it makes good sense to have expert lifeguards when some of them go beyond their depth."

This, gentlemen, is one of the important roles of the college psychiatrist and this is only one of the services performed by one group of men who are trained by means of government funds.

This committee, last year, communicated to the House its concern that mental health research efforts continue to expand. I concur in that concern and I sincerely hope that research funds will be appropriated for FY 1968 in an amount not only necessary but as generous as possible.

The light shed by research can be illusive and flickering. There are periods in which that light seems shadowed and uncertain. But mental health research is today providing some exciting and hopeful findings. It would be catastrophic to tell the research investigators to hold still, or at best to tread water. Service, training and research must proceed simultaneously, benefiting one from the other.

With your permission, I shall not go into detail regarding overall mental health research here but, rather, will comment upon that mental illness known as depression which has fascinated me since my advent into the profession.

I gave one of the scientific papers on depression in Madrid, that Mr. Gorman mentioned, and in fact was chairman of that section of the World Psychiatric Congress. Also I was a member of the NIMH Ad Hoc Committee appointed to investigate this illness and it is true that depression is one of the most painful and tragic diseases known to man. Strangely, too, it often seems to be an accompaniment of greatness. Many great men in world history and in our own nation's history were depressed and some lost their lives during periods of depression. I am sure you can recall the sad histories of some of them.

Presently in our own nation approximately 20,000 deaths by suicide are reported annually, but that is only part of the story for there are many accidents which are well thought out and contrived and basically are suicidal acts. Most of these individuals are depressed; a number of them psychotically depressed.

Approximately 200,000 individuals in this country were treated last year for depression and there were equally as many depressed people treated under other diagnoses because of accompanying physical symptoms. The illness occurs in individuals of both sexes, all ages, all income levels and in all parts of the country. The predominating, and often all enveloping feeling in these patients, is one of despair, often so intense that it leads to suicide. Strangely, now it is the psychiatric diagnosis most often made and, strangely too, it often is found in men in middle life -- good, conscientious, hard working individuals.

In earlier years, depression in middle life was thought to be the exclusive property of the female; now it is known that it affects many men particularly those in their fifties in the so-called prime of life. In this period, there is a lessened ability to tolerate loss, frustration, or disappointment as one notes the beginnings of declining physical powers and personal resources.

It should be noted that even the man of achievement in middle life may also suffer severe depression. The statesman, the editor, the business

executive, the professional man, all are prey to the onslaughts of this illness. You can recall instances well known to you I am sure, and you know that in these periods society loses worthwhile and capable individuals. Occasionally a man in this age group goes through a so-called "success" depression, a feeling of being pushed beyond his powers, a frightened look-down from a high position from which there is always a danger of falling. Severe depressions occuring in women at the time of middle life, when youth is fading, family leaving home, and husband preoccupied with work, have long been known and are well documented.

Finally, severe depressions often occur in the older age groups. Some of these people make suicidal attempts; some succeed. Often these illnesses appear to be due to senile change, but closer inspection reveals that they are due to depression and, if the illness is caught in time, it will respond to treatment.

The impact and urgency of this problem is better understood when one realizes that over the next five years in the range of one million people will be seriously affected by feelings of depression and despair, much more than the ordinary attack of hives, and that more than one hundred thousand Americans, most of whom are depressed, will take their lives in the same span of time.

The issue of suicide is even more distressing in that it is the fourth most frequent cause of death in the productive ages of 18 to 45. It is said to be the third but it is more likely the second cause of death in

college students. Serious depression, unrecognized or untreated, has a high risk of suicide and in a real sense is a malignant disease that kills. Depression and suicide are inexorably linked together.

The toll of depression in our society, however, goes far beyond the malignant illness we have just mentioned. It is often an intermittent and recurrent disease; many individuals suffer from it and are unable to function, or function at a minimal level during the depressed period. Within a given year, 150,000 individuals are hospitalized for psychotic or psychoneurotic depressions in the United States. Another serious concomitant result of depression is the psychological impact of the illness on the family of the individual sufferer, particularly if the illness culminates in tragedy. The toll of depression in our society is further reflected in time lost from work and in students who drop out of high school or college. Some of the well known loss of interest and apathy in students, so frequently reported, is due to depression. There is also repeated evidence suggesting a close relationship of depression with other medical problems such as alcoholism and drug addiction.

I have no desire to dwell at length upon further clinical aspects of this or other illnesses, nor can I presume further on your time. The fact is that now, with careful planning, intelligent utilization of resources and recently developed methods and hypotheses, it is possible for the first time to launch an attack on this illness and to make inroads upon it and the quiet desperation and suffering that accompany it. Three bodies of

data in the basic sciences, the areas of catecholamines, the electrolytes and steroid metabolism, have progressed to a point where they may be immediately applicable to the understanding of the biochemical abnormalities in depression. I would like to urge, therefore, that a special NIMH laboratory for the study of depression be created and that the Ad Hoc Committee's recommendations regarding it be followed. They have already been presented to you.

This laboratory could be the center for the collection of all information extant upon this subject. It will have intra-mural and extra-mural components and will coordinate all research material upon the subject, in addition to training necessary personnel. I would strongly urge this committee to add $4 million dollars to the present research budget in order that this important project may be gotten under way.

As an instance of the possibilities of advances in the immediate future, on Friday, March 31, 1967, the NIMH published a bulletin outlining a potentially effective drug treatment for manic-depressive psychoses. This drug is thought to control the recurrence of this devastating illness and a mechanism is now suggested as to the manner in which lithium salts may act in the treatment of mania, a problem which has plagued doctors and patients alike for more than a hundred years. Apparently it checks the intense manic excitement, and overactive patients are said to become calm under its influence. More importantly, it seems to act as a preventive of both manic and depressive attacks. Heretofore we have been able to treat and wait out individual attacks of this illness but we were never able to prevent recurrences,

and patients and their families lived in dread of their reappearance.

The drug is lithium carbonate. It is no miracle drug. It requires expert care in its administration and in the handling of the patient. It needs much more research. It has promising possibilities; it is a prototype of the drugs which are in the offing which hold hope for greater relief of emotional disorders and for the possibility of treating patients without having to hospitalize them.

I shall say nothing about alcoholism, narcotic addiction, or drug abuse; they have been covered by Dr. Yolles and Mr. Gorman. I, too, urge that an additional $13 million dollars over the administration's budget be added to finance research needs against these destroyers of men.

There are numerous other aspects of the program I would like to discuss with you, but it is not fair to take up your time. You have heard Dr. Yolles and Mr. Gorman and we all agree on the needs.

If I seem a bit enthusiastic or intense in my statements or efforts, I would ask your indulgence. Please remember that I have watched this situation for over 35 years and I have seen people neglected, humiliated and otherwise badly treated, and now with the present new enthusiasm and community interest, we may be pardoned for wanting their lot to improve. We live in dread that the clock will strike 12 and the royal coach which has carried our Cinderella of medicine to its present knowledgeable heights will turn into a pumpkin. I know that this committee will not allow that to happen.

In back of the various jokes about psychiatrists, mental hospitals and sick people, and beneath the cartoons in which couches and men with beards are prominent, there is still a certain amount of dread about these illnesses. In the present partnership of the professions, the government and aroused citizens, we are sure we can remove most of that. It is our sincere hope that we can do so soon.

Thank you, gentlemen, for allowing me to come before you.

NIMH FISCAL 1968 BUDGET INCREASES PROPOSED BY CITIZENS

	1968 President's Budget	Citizens Budget
RESEARCH	$ 76,477,000	$ 89,477,000
HOSPITAL IMPROVEMENT	10,610,000	16,610,000
TRAINING	100,762,000	114,150,000
RES. FELLOWSHIPS	9,859,000	11,859,000
DIRECT OPERATIONS	50,764,000	61,764,000
TOTAL	$248,472,000	$293,860,000

TOTAL INCREASE REQUESTED - CITIZENS BUDGET $45,388,000

COMMUNITY MENTAL HEALTH SERVICES		
Construction Grants	$ 50,000,000	$ 65,000,000
Center Staffing	46,168,000	46,168,000
Narcotic Facilities	4,000,000	4,000,000
TOTAL - Community Resources	$100,168,000	$115,168,000

INCREASE FOR COMMUNITY MENTAL HEALTH SERVICES - $15,000,000

TESTIMONY BEFORE

HOUSE APPROPRIATIONS SUB-COMMITTEE

on

Labor, Health, Education and Welfare
Representative Daniel J. Flood, Chairman

on

FISCAL 1969 BUDGET
for the
NATIONAL INSTITUTE OF MENTAL HEALTH

by

Francis J. Braceland, M. D.

Presented on behalf of
The American Psychiatric Association

April 25, 1968

I am Francis J. Braceland and I have been a psychiatrist for nearly 36 years. I graduated from Jefferson Medical College in 1930 and was an intern and Chief Resident at Jefferson Hospital. I began my psychiatric fellowship training at the old Pennsylvania Hospital in Philadelphia in 1932. I was then a Rockefeller Fellow in Psychiatry in Zurich, Switzerland, and at the National Hospital, Queen Square, London. I returned to be Clinical Director at the Pennsylvania Hospital until 1941, when I was appointed Professor of Psychiatry and Dean of the School of Medicine, Loyola University.

I have since occupied the following positions:

1942-46 - Special Assistant to the Surgeon General, U. S. Navy, and war-time Chief of the Psychiatric Section. I am a Rear Admiral, Medical Corps, USNR, Retired.

1946-51 - Head of the Section of Psychiatry, Mayo Clinic, and Professor of Psychiatry, Graduate School, University of Minnesota.

1951-65 - Psychiatrist-in-Chief, The Institute of Living, Hartford, Connecticut; since 1965 Senior Consultant in that institution; also Clinical Professor of Psychiatry, Yale University; since 1960, Lecturer on Psychiatry, Harvard Medical School.

I have been in the past:

President, American Board of Psychiatry and Neurology, 1953.

President, American Psychiatric Association, 1956-57.

President, Association for Research in Nervous and Mental Disease, 1957.

President, Board of Examiners for Certification of Mental Hospital Superintendents, 1955.

Chairman, American Medical Association, Section on Nervous and Mental Disease, 1956.

Chairman, National Health Forum, 1958.

Vice-President, World Psychiatric Association, 1961-66.

I am now Editor of The American Journal of Psychiatry, the official organ of American Psychiatry, and am a psychiatric consultant to the Surgeons General of the Army, Navy, and Public Health.

Mr. Chairman and Members of the Committee:

I am appreciative of your willingness to hear me. I appear before you as a representative of the American Psychiatric Association; the official body of American Psychiatry which numbers nearly 18,000 psychiatrists. I am here to express the support of that association for the citizens' budget for the National Institute of Mental Health, the budget just detailed for you by my respected colleague, Mr. Mike Gorman.

As a hardy perennial in appearance before you, I have risked boring you by repeating snatches from our early testimony spanning a period of twenty years. There are two main points I would like to emphasize in that regard. The first is that our initial appearances here followed rather closely upon the end of World War II and the early beginnings of the National Institute of Mental Health. This repetition is important this year for the reason that the funds which you appropriated in those early years have paid off handsomely insofar as psychiatric casualties in modern warfare are concerned.

In World War II, the number of psychiatric casualties was alarming, and the cause of great concern. Now, due to careful research and observation, the number of psychiatric casualties from the Viet Nam war is remarkably small. The second point I would like to emphasize is that when we came before you twenty years ago, an unconscionably large number of our fellow citizens were confined to large state hospitals, and the prospect was that this number would increase markedly as the population increased.

Now, again due in great part to your help in supplying research and manpower funds, the appropriations have paid off and the number which was expected to be over 700,000 is down to 426,000. Fortunately, it even dropped by 26,000 in the past year. I am especially pleased to bring these reports to you.

In those early years of our reporting to you, and for some times afterwards, the attention of our medical specialty was focused sharply upon individual emotional problems and mental illnesses and, mostly, upon hospitalized patients. Our appeal to you encompassed an apologia and an explanation that our work was with some wonderful people who were ill temporarily and recovery was possible if the person was not isolated and forgotten. And we said, in fact, that if the person was properly and skillfully treated, recovery would be made by a large proportion of them. Our theses was that these good people were really representatives of ourselves under different circumstances and the differences between us were those of degree, rather than of kind. We were actually saying to ourselves and to others, with Lowell:

> "Console yourself, dear man and brother; whatever we may be sure of, be sure at least of this: That we are dreadfully like other people. Human nature has a much greater genius for sameness than originality."

This is still true. The differences between us and sick people is one of degree rather than of kind. Fortunately, however, you are aware of the fact that the situation has changed markedly since those early days.

Not only has the mental health picture itself changed but, also, our approach to it has changed. Steady advances have been made due to research and more enlightened attitudes and also we have moved out from behind large stone walls and into the community at just about the right time to be of help with the general unrest which is evident all around us. Federal funds have helped bring this desirable situation about.

My only competence is that of a clinician; a psychiatrist for thirty-six years and, with your permission I will confine my remarks to the nation's mental health as a clinician sees it today, touching upon important segments with which the clinician deals, and accenting finally the widespread anxiety and depression which besets the population at the present time.

Our situation of general unrest is not altogether unique or unprecedented. There have been other times like this but, in my opinion, the nation has not witnessed a time like the present with its widespread rioting, draft resistance, and violence, since that time more than one hundred years ago when the nation was at war with itself.

Basically, what is common to such periods, Dr. George Rosen says, is that "They are times when societies and their culture, or segments within them, are changing to something else; when the accustomed structure of order, power, beliefs, and meaning, disintegrate and man confronts the inscrutable future not knowing what is to come."

Well, there is no need for me to tell you gentlemen that the old order is changing rapidly and the new directions are not clear as yet. So people

will react to the unprecedented changes in a fashion depending on their backgrounds and the weight of outside pressures upon them. Present day anxieties and turmoil will be used constructively by some people, and they will set about to do what they can to be of help to others. Other people will be overwhelmed by the rapidity of change and some will become sick and depressed. Another group will become angry and prejudiced. Still others will take matters into their own hands and be moved to violence. Each person will handle his anxieties in his own fashion.

It is obvious to us now as clinicians that societal factors, such as poverty, urban overcrowding, lack of education and all factors which lead to despair and personal futility, are as important in populating mental hospitals as are the physical and emotional disorders which we heretofore have studied so carefully.

As yet there is no consensus on how violent behavior can be stopped. The only thing we can agree on is that it must be prevented. To paraphrase the late President Kennedy's apt phrase regarding war, and substituting the word "violence" for it, we might say that: "Mankind must eliminate violence or violence will eliminate mankind." The NIMH has been involved in research efforts to develop understanding of the forces of violence as they relate to behavioral sciences, but much more needs to be done, particularly research in the behavioral sciences and in mental health efforts to understand the factors which cause violence.

Behavioral research has already provided us with a relevant body of knowledge on motivation, emotion, attitude, and on individual group and social processes. This information can be collected and refined, but we need to know much more. Today we are face to face with various aspects of general unrest, including its mental health implications. At the level of prevention, there is already significant and useful information about the nature of the system which stimulates social disquiet and leads to mass violence. Some of this material was furnished to the Kerner Commission. The commission requested the data available from behavioral science research which might be of aid to them, and a staff paper was prepared in answer to that request. This material was assembled from various projects in univetsities and other diverse departments being funded by NIMH grants.

What is being done is to support the training of individuals to study and deal with the issues and problems thought to be related to riots. Thus, social institutions, economic forces, urban planning, human relations, family life, discrimination, cultural forces and other factors affecting the lives of the poor and minority groups, all are receiving increased attention by mental health and related professionals.

At this point I should interject a note of caution. I, by no means intend to imply that psychiatrists are soothsayers or, indeed, that they know how to settle the problems which beset an unsettled nations. No one pretends that this is so. What I do intend to imply is that psychiatry and its co-workers do

possess a body of knowledge gleaned from research and experience which might be utilized, among other things, in trying to understand what is going on. The Director of NIMH said on one occasion: "Much of this material is dispersed. It needs to be collected and refined and put in context with other findings, and then judged on the basis of field trials." One of the problems is that the scientific community appears to be talking to itself, since neither the public or the policy makers act very often as though the word had gotten through to them.

The point here is that this is not the time for budgets to be cut, especially those connected with manpower, research, community and behavioral sciences. Rather, it is a time to increase them markedly and to encourage efforts to correlate all available material,for the mental health of the nation is involved.

I am cognizant of the heavy demands for funds being made upon the Congress, and aware of some of the dilemmas you face. I have confidence in your wisdom in meeting these problems, however, and I know too that you will keep in mind the importance of sound mental health in communities, and know that there are large numbers of sick and distressed individuals who cannot speak for themselves in this regard. The mentally disturbed, the addicts, the alcoholics, all of them are poorly understood and, sometimes, they are badly treated.

When you helped to bring us out of isolated mental hospitals, into the community, neither you nor we knew the extent of the demands which would be made upon us for services and for assistance. The old point of view

that mental illness was chronic and refractory to treatment is gone. The new point of view is that most mental illness serves its purpose and disappears, and it does so more rapidly and completely when it is well understood and skillfully dealt with. We see patients now, Karl Menninger says, not as much as persons afflicted with certain diseases, but as human beings obliged to make awkward and expensive maneuvers to maintain themselves, Isolated from their fellows, harassed by faulty living techniques, their reactions are intended to make the best of a bad bargain, and at the same time to forestall a worse one. In other words to insure survival even at the cost of suffering and social disaster.

While social change in the past was measured in terms of historical epochs, centuries or generations, the rates of economic, social and technological change move so quickly today as to impose a perpetual pressure upon every individual. Changes in the nature and distribution of the population of the nations have intensified the problems of mental health and have created a general awareness of concern about them. The disappearance of frontiers and the rapid shift from rural to urban living have reduced the opportunities for disaffected or non-conforming persons to escape close scrutiny. There is no longer a satisfactory place for them to migrate.

The increasing trend toward crowded dwelling units in cities has concentrated more people in situations which tend to intensify stress, and at the same time reduces both individual and social tolerance for the

inevitable disturbing behavior which arises. We all know of the major social conditions which have stressful effects upon people's mental health. They are reported regularly, sometimes tragically, in our news media. In mentioning these events, please understand again that psychiatrists do not pose as oracles. We cannot change these social conditions, but we can make efforts to prevent illnesses arising from them and we must take care of the people who become disturbed as a result of them. Like Spinoza, we make ceaseless efforts not to ridicule, bewail, or scorn human actions, but to understand them.

We point out that harsh treatment, the feeling of being unloved, quarrels and insecurity, all bring out hostility and strengthen anti-social inclinations in individuals and groups. Emotional deprivation in childhood accounts for later anti-social and sometimes criminal behavior, as well as assorted kinds of mental disorders. Hostility and resentment may show up in defiance of parents and all authority -- fathers, teachers, police, military officers, judges, God. It can remain covered up for a long time and emerge later tragically. In families where there is acute tension, children feel isolated and displaced and deformed characters can ensue which will be evidenced later as anti-social or emotionally distressed individuals. Just how do we propose to go about helping with these problems? By moving further into the community with the community mental health centers which you funded and which you have heard so much about. We will go into storefront clinics in underprivileged neighborhoods

wherever necessary to really get to people who need help.

Realize, if you please, that the funds which you appropriate for research and for psychiatric manpower have vast implications for mental health far beyond the uses made of them in the purely mental health field. This once neglected discipline has now spread its influence and slowly attracted the help and the demand for help from the community. It began to make contributions to its sister medical specialties and to military and industrial medicine, shortly after World War II. Its help has also been solicited by educational and religious institutions, and these contributions are slated to increase. I would just like to mention briefly our contributions to these varied disciplines. This will tell you of the company we keep, give you an account of our stewardship, and inform you of the widespread effect of the funds which you are asked to appropriate here.

As to the present day applications of our findings to general medicine, the work of psychosomatic research is well known. Though we have not satisfactorily solved the age old body-mind problem, our findings are constantly becoming more important. Everything from the diurnal rhythm of our bodies, our so-called "biologic clocks," the optimal time to administer drugs, the influence of rapidly changing time zones upon flyers and travelers, the phenomena of sleep, the various chemical and biological phenomena which underlie depressions -- all of these have psychological and physiological components. These, plus the remarkable contributions of the sociologists and anthropologists regarding man's behavior, hold

exciting prospects for future research in man's mental well-being and in his behavior.

As to the contributions made by psychiatric clinical observation and basic research to military psychiatry already mentioned, they are remarkable as evidenced by the fact that in the Viet Nam conflict thus far there is a remarkably low number of psychiatric casualties. This is due to a number of factors, the most important of which are a more careful selection of men, and a more efficient and immediate treatment of emotional upsets at the front and close to the man's own unit.

The knowledge which we have gained from our researches also has helped us to be of assistance in industry. Psychiatry can make noteworthy contributions, and in some instances is already doing so. Its role is consultative and preventive. It can pinpoint causes of time lost and reasons for turnover of personnel. Obviously it is not the function of business or industry to act as nursemaid or psychiatric clinic, but it does seem wise in these days of manpower shortages to eliminate road blocks to emotional satisfaction and to conserve skillful personnel wherever possible.
This utilization of skilled psychiatric help in industry will grow. Unfortunately, however, at present there are not enough consultants to go around.

As to the contributions to education, with the personnel aided by funds from NIMH, I went into detail last year on the type of the problems encountered and their incidence. I shall not take up your time repeating those remarks. You know, however, of the importance of these young

people in high school and in college. From them will come tomorrow's leaders. Fortunately many of their problems are minor and transient. In general, these are basically admirable youngsters, even if they are occasionally difficult. Twice in the month of March 1967, our military leaders in Viet Nam spoke of those young men whom they had encountered -- mostly drafted men. They said of them, "Let me tell you, they are the bravest, smartest soldiers we have seen in twenty-six years in the military. They are resourceful on a battlefield. They are giving of their all and doing a fantastic job." It is evident that once committed, these young people acquit themselves creditably. The problem, of course, lies in the question,how to inspire them? More help in advising them and careful attention to the mental health of these young people is essential. They represent the nation's hope for the future.

All of this is by way of report to you and this fantastic array of needs and of efforts, of work being done in the mental health field is being offered to you in justification of the budget which Mr. Gorman has just presented to you. The preventive possibilities are evident. These budgets are not simply for mental hospitals though they, too, benefit from all that is going on in the field.

Mental health research and mental health workers were obviously needed to fill the breech in a number of pressing situations. So true is this that psychiatry, one of the major disciplines called upon for assistance, is having an identity crisis of its own. It must be careful not to spread itself too thinly

in an effort to be all things to all people. Basically it has a medical mission. It did not seek these other tasks. They evolved as the specialty evolved in its modern dress. It cannot, however, under any circumstances, fail to respond to the call of the community for mental health is an absolute necessity to it.

Your committee has in the past communicated to the House its concern that mental health research efforts continue to expand. This is essential in these present times of great national unrest. We are in a period as brilliant and as violent as that which surrounded the period of the French Revolution. Mental Health research today is providing some exciting findings which portend hope for the future. To interrupt investigators, to ask them to tread water and see their research teams disintegrate and disappear, would be calamatous in this period of great anxiety. I would urge you, therefore, to continue and increase the support of research funds both for internal and external NIMH programs and, like the Bank of Monte Carlo, one cannot guarantee a payoff, but when one occurs it is great in its extent.

With your permission, I shall not go into further detail regarding overall mental health research here, nor comment further on the dire results of any cut-back in research funds. That has been ably taken care of by my colleague. Rather, I would like to comment upon several situations which are in need of continued and expanded attention.

We mentioned that in one major preventive approach to the general social unrest which is so evident nationally, the NIMH is supporting the development of community mental health centers throughout the land. When the concept of these centers was evolved, they were thought of primarily as a means of group mental health services -- mostly for the deprived -- but, in general, as places that patients could be treated in their own communities. Now, however, they loom in addition to be centers with possibilities for research and training facilities for programs quite directly related to civil disorders, social unrest and violence; because, on the findings of this research and on our ability to train workers who can understand and influence deprived people, will rest our ability to give them the services they need in the places where they live.

Some 260 of these centers have received Federal grants to help finance construction and initial staffing, and almost 100 of them are operating today. Their staffs are treating mental illness and emotional disturbance but they are also beginning to meet many more needs in their communities than they originally expected to do. Communities are looking to set up and expand the use of these centers and it is certain that their preventive and consultative services will contribute toward social changes that can ease the pressures and stress underlying violence. This will not be done by mental health workers alone. Rather, it will be a base where physicians, clergymen, and other capable professionals will pool their knowledge and apply their competence to the problems which are presently disturbing communities.

To neglect to expand the number of these centers, to cut budgets now, to fail to help bring these concepts to a broad fair trial, would be tragic. One fears a return of our dispirited group to isolated hospitals if we fail in our efforts to help broaden the base of community centers.

The capable Director of NIMH has told you, I am sure, of his plans to implement President Johnson's statement that one of the immediate objectives of his administration will be to develop "a child health program; to provide for families unable to afford it, access to health services from pre-natal care of the mother through the child's first year." I shall not go into detail regarding the programs which have been worked out -- in the interest of time -- suffice it to say they are, indeed, well conceived and they merit your strong support.

I would like to discuss many more important clinical aspects of problems which face us, but I realize that your patience should not be tried. I would certainly talk about alcoholism and urge you to markedly increase the budget for research and training to help with that scourge. It attacks the high and the low, breaks up families, and distresses children in untold numbers. I would reiterate what I said to you last year, and earnestly seek your help in establishing laboratories to further the understanding of the phenomenon of depression, one of the most painful congeries of symptoms known to us. I say this because usually there is no visible symptom which accounts for the person's distress, and that makes understanding more difficult and the illness harder to bear.

Melancholy is a phenomenon as old as man. The question has been asked why so many great men have been melancholy. Some have lost their lives during periods of depression. I am sure you can recall the sad histories of some of them. Of all of the emotional illnesses treated by psychiatrists in the present culture, depressive phenomena are in the forefront. Depression is the psychiatric diagnosis made most frequently today.

The Medical World News, in a March issue, surveys the subject under the apt title "New Faces of Depression," and a sub-title, "An Old Syndrone with a 1968 Look." The article begins with a quotation from the Greek biographer, Plutarch: "When a man is depressed, every little evil is magnified by the spectres of his anxiety." Plutarch's observation is as apt today as when he made it 2000 years ago.

I think we are justified in bringing this subject to your attention again for several important reasons:

1. The incidence of depressive phenomena.
2. The basic scientists have gone far in the past several years in determining many of the chemical and physiological accompaniments of the illness.
3. The condition is eminently treatable today. Often self-limited, the condition can be alleviated by drugs and other modern methods of treatment.

Feelings of sadness, hopelessness or despondency, may arise due to adverse external circumstances in which the individual finds himself. Whether the conditions be really overwhelming or whether for some reason the individual finds himself inadequate to deal with them, the resulting depression is the same.

Fortunately for most of us, our depressive feelings are only transitory and either disappear spontaneously or after we have worked out some type of positiive solutions to the problem responsible. These depressions are obvious and easily recognized, but there are others which are masked to the point where no one but an expert can detect their presence until a full-blown deep depression appears. Here the situation is much more serious, the depressed mood becomes longer lasting, and the attitude of dejection and the train of symptoms which follow in its wake render the individual ineffectual. These depressions are the illnesses most difficult to bear, for unlike medical or surgical illnesses, there are no visible physical symptoms apparent to the sufferers or to others that might explain his distress.

These depressive episodes must be differentiated from grief, a normal phenomenon, and should not be confused with it. In grief the loss is personal, objective, external, and readily understandable. The response it calls forth is realistic and proportionate to what has been lost. Grief, which is the normal expression of sorrow and bereavement which follows the loss of a loved one, is self-limited and gradually subsides.

Psychotherapists call attention to the great effort expended by these individuals who feel that they do not deserve anything in their own right, but must continue to strive and achieve if they are to get someone to love them or to continue to love them. It has long been recognized that these good people are extremely vulnerable to loss of position or status or the loss of material possessions. They are vulnerable, too, to the decline of physical abilities essential to their continued achievement or even with

advancing age the loss of certain future possibilities of achievement. Examples of these situations are plentiful today in our period of merges, strict rules for retirement, and the pressures of our economic situation.

Children and adolescents may become depressed and some of their destructive behavior may mask a mild depression as they search for meaningful relationships. They are not our concern here, but we should mention that much of the apathy, boredom, and willingness to enlist in almost any cause except study in college students is of the same genre. The complaints that they don't know what they want to do, the lack of interest in education in general, the feeling of the uselessness of it all, and the coupling of education and attainment with the older generations from whom they are separated, all may be due to underlying mild depressions. It is no longer easy for them to take a moratorium and drop out of college for a while to catch up with themselves, for the draft must be kept in mind. Some of the students deliberately arrange to fail, which fact distresses their parents and brings their plight sharply into focus.

Under these situations, the attractiveness of trying drugs in some form is apparent. They have heard of the pleasure of attaining a "high" and they are influenced to try it by the pressures of their peers. If they are fortunate, the experience will be disappointing or scary; if it proves attractive, they will have some serious decisions to make. While it is true that so-called "pot" is not addicting in the physical sense, as are the narcotic drugs,

nevertheless, there is a psychological attractiveness to it and it is not at all the harmless substance that enthusiasts make it out to be.

We have talked several times about depressions of middle life and earlier thought to be the exclusive property of women and due to the change of life. We decried both of these assumptions and noted the occurrence of depression in men a decade later, and suggested that the only relation to change which was present was the individual's inability to change in accordance with the surrounding changes which faced their age group in the present culture.

We noted, too, that persons who were rigid, conscientious, and inclined to perfectionism, were vulnerable to depression in this period. They were not easily influenced even though circumstances around them were changing rapidly. These are usually fine people but their rigidity becomes a hazard when their external circumstances call for marked change and they are unable to comply.

As to the reactions of older people to the present general unrest and rapidly changing cultural and economic environment, they are understandable. In the present era, with youth in the center of attention and in "children's crusades" in politics and the search for young people to occupy executive and top positions, men in the older age groups are understandably insecure. Very often they find themselves unable or unwilling to keep up with the pace and they withdraw, react in a depressive manner and become chronically ill.

Mr. Chairman, if I have become too clinical in this presentation again, I assure you that it is my only competence. I chose this method of presentat ion to you rather than repeat line for line the budget needs which has been done so ably by my colleague, Mr. Gorman. I do want to emphasize heartily, however, our agreement with him. The mental health field has opened up. It has great possibilities, and I know that you and your committee members will insist that it continue its activities. The mental health of the community depends upon the health of its individuals, and the mental health of the nation depends upon the health of its communities.

TESTIMONY BEFORE

SENATE APPROPRIATIONS SUB - COMMITTEE

on

Labor, Health, Education and Welfare

Senator Lister Hill, Chairman

on

FISCAL 1969 BUDGET
for the
NATIONAL INSTITUTE OF MENTAL HEALTH

By

Francis J. Braceland, M.D.

Presented on behalf of
The American Psychiatric Association

June 25, 1968

I am Francis J. Braceland and I have been a psychiatrist for nearly 36 years. I graduated from Jefferson Medical College in 1930 and was an intern and Chief Resident at Jefferson Hospital. I began my psychiatric fellowship training at the old Pennsylvania Hospital in Philadelphia in 1932. I was then a Rockefeller Fellow in Psychiatry in Zurich, Switzerland, and at the National Hospital, Queen Square, London. I returned to be Clinical Director at the Pennsylvania Hospital until 1941, when I was appointed Professor of Psychiatry and Dean of the School of Medicine, Loyola University.

I have since occupied the following positions:

1942-46 - Special Assistant to the Surgeon General, U. S. Navy, and war-time Chief of the Psychiatric Section. I am a Rear Admiral, Medical Corps, USNR, Retired.

1946-51 - Head of the Section of Psychiatry, Mayo Clinic, and Professor of Psychiatry, Graduate School, University of Minnesota.

1951-65 - Psychiatrist-in-Chief, The Institute of Living, Hartford, Connecticut; since 1965 Senior Consultant in that institution; also Clinical Professor of Psychiatry, Yale University; since 1960, Lecturer on Psychiatry, Harvard Medical School.

I have been in the past:

President, American Board of Psychiatry and Neurology, 1953.

President, American Psychiatric Association, 1956-57.

President, Association for Research in Nervous and Mental Disease, 1957.

President, Board of Examiners for Certification of Mental Hospital Superintendents, 1955.

Chairman, American Medical Association, Section on Nervous and Mental Disease, 1956.

Chairman, National Health Forum, 1958.

Vice-President, World Psychiatric Association, 1961-66.

I am now Editor of The American Journal of Psychiatry, the official organ of American Psychiatry, and am a psychiatric consultant to the Surgeons General of the Army, Navy, and Public Health.

Mr. Chairman and Members of the Committee:

I am appreciative of your willingness to hear me. I appear before you as a representative of the American Psychiatric Association; the official body of American Psychiatry which numbers nearly 18,000 psychiatrists. I am here to express the support of that association for the citizens' budget for the National Institute of Mental Health, the budget just detailed for you by my respected colleague, Mr. Mike Gorman.

As a hardy perennial in appearance before you, I have risked boring you by repeating snatches from our early testimony spanning a period of twenty years. There are two main points I would like to emphasize in that regard. The first is that our initial appearances here followed rather closely upon the end of World War II and the early beginnings of the National Institute of Mental Health. This repetition is important this year for the reason that the funds which you appropriated in those early years have paid off handsomely insofar as psychiatric casualties in modern warfare are concerned.

In World War II, the number of psychiatric casualties was alarming, and the cause of great concern. Now, due to careful research and observation, the number of psychiatric casualties from the Viet Nam war is remarkably small. The second point I would like to emphasize is that when we came before you twenty years ago, an unconscionablylarge number of our fellow citizens were confined to large state hospitals, and the prospect was that this number would increase markedly as the population increased.

Now, again due in great part to your help in supplying research and manpower funds, the appropriations have paid off and the number which was expected to be over 700,000 is down to 426,000. Fortunately, it even dropped by 26,000 in the past year. I am especially pleased to bring these reports to you.

In those early years of our reporting to you, and for some times afterwards, the attention of our medical specialty was focused sharply upon individual emotional problems and mental illnesses and, mostly, upon hospitalized patients. Our appeal to you encompassed an apologia and an explanation that our work was with some wonderful people who were ill temporarily and recovery was possible if the person was not isolated and forgotten. And we said, in fact, that if the person was properly and skillfully treated, recovery would be made by a large proportion of them. Our theses was that these good people were really representatives of ourselves under different circumstances and the differences between us were those of degree, rather than of kind. We were actually saying to ourselves and to others, with Lowell:

> "Console yourself, dear man and brother; whatever we may be sure of, be sure at least of this: That we are dreadfully like other people. Human nature has a much greater genius for sameness than originality."

This is still true. The difference between us and sick people is one of degree rather than of kind. Fortunately, however, you are aware of the fact that the situation has changed markedly since those early days.

Not only has the mental health picture itself changed but, also, our approach to it has changed. Steady advances have been made due to research and more enlightened attitudes and also we have moved out from behind large stone walls and into the community at just about the right time to be of help with the general unrest which is evident all around us. Federal funds have helped bring this desirable situation about.

My only competence is that of a clinician; a psychiatrist for thirty-six years and, with your permission I will confine my remarks to the nation's mental health as a clinician sees it today, touching upon important segments with which the clinician deals, and accenting finally the widespread anxiety and depression which besets the population at the present time.

Our situation of general unrest is not altogether unique or unprecedented. There have been other times like this but, in my opinion, the nation has not witnessed a time like the present with its widespread rioting, draft resistance, and violence, since that time more than one hundred years ago when the nation was at war with itself.

Basically, what is common to such periods, Dr. George Rosen says, is that "They are times when societies and their culture, or segments within them, are changing to something else; when the accustomed structure of order, power, beliefs, and meaning, disintegrate and man confronts the inscrutable future not knowing what is to come."

Well, there is no need for me to tell you gentlemen that the old order is changing rapidly and the new directions are not clear as yet. So people

will react to the unprecedented changes in a fashion depending on their backgrounds and the weight of outside pressures upon them. Present day anxieties and turmoil will be used constructively by some people, and they will set about to do what they can to be of help to others. Other people will be overwhelmed by the rapidity of change and some will become sick and depressed. Another group will become angry and prejudiced. Still others will take matters into their own hands and be moved to violence. Each person will handle his anxieties in his own fashion.

It is obvious to us now as clinicians that societal factors, such as poverty, urban overcrowding, lack of education and all factors which lead to despair and personal futility, are as important in populating mental hospitals as are the physical and emotional disorders which we heretofore have studied so carefully.

As yet there is no consensus on how violent behavior can be stopped. The only thing we can agree on is that it must be prevented. To paraphrase the late President Kennedy's apt phrase regarding war, and substituting the word "violence" for it, we might say that: "Mankind must eliminate violence or violence will eliminate mankind." The NIMH has been involved in research efforts to develop understanding of the forces of violence as they relate to behavioral sciences, but much more needs to be done, particularly research in the behavioral sciences and in mental health efforts to understand the factors which cause violence.

Behavioral research has already provided us with a relevant body of knowledge on motivation, emotion, attitude, and on individual group and social processes. This information can be collected and refined, but we need to know much more. Today we are face to face with various aspects of general unrest, including its mental health implications. At the level of prevention, there is already significant and useful information about the nature of the system which stimulates social disquiet and leads to mass violence. Some of this material was furnished to the Kerner Commission. The commission requested the data available from behavioral science research which might be of aid to them, and a staff paper was prepared in answer to that request. This material was assembled from various projects in universities and other diverse departments being funded by NIMH grants.

What is being done is to support the training of individuals to study and deal with the issues and problems thought to be related to riots. Thus, social institutions, economic forces, urban planning, human relations, family life, discrimination, cultural forces and other factors affecting the lives of the poor and minority groups, all are receiving increased attention by mental health and related professionals.

At this point I should interject a note of caution. I, by no means intend to imply that psychiatrists are soothsayers or, indeed, that they know how to settle the problems which beset an unsettled nations. No one pretends that this is so. What I do intend to imply is that psychiatry and its co-workers do

possess a body of knowledge gleaned from research and experience which might be utilized, among other things, in trying to understand what is going on. The Director of NIMH said on one occasion: "Much of this material is dispersed. It needs to be collected and refined and put in context with other findings, and then judged on the basis of field trials." One of the problems is that the scientific community appears to be talking to itself, since neither the public or the policy makers act very often as though the word had gotten through to them.

The point here is that this is not the time for budgets to be cut, especially those connected with manpower, research, community and behavioral sciences. Rather, it is a time to increase them markedly and to encourage efforts to correlate all available material,for the mental health of the nation is involved.

I am cognizant of the heavy demands for funds being made upon the Congress, and aware of some of the dilemmas you face. I have confidence in your wisdom in meeting these problems, however, and I know too that you will keep in mind the importance of sound mental health in communities, and know that there are large numbers of sick and distressed individuals who cannot speak for themselves in this regard. The mentally disturbed, the addicts, the alcoholics, all of them are poorly understood and, sometimes, they are badly treated.

When you helped to bring us out of isolated mental hospitals, into the community, neither you nor we knew the extent of the demands which would be made upon us for services and for assistance. The old point of view

that mental illness was chronic and refractory to treatment is gone. The new point of view is that most mental illness serves its purpose and disappears, and it does so more rapidly and completely when it is well understood and skillfully dealt with. We see patients now, Karl Menninger says, not as much as persons afflicted with certain diseases, but as human beings obliged to make awkward and expensive maneuvers to maintain themselves, Isolated from their fellows, harassed by faulty living techniques, their reactions are intended to make the best of a bad bargain, and at the same time to forestall a worse one. In other words to insure survival even at the cost of suffering and social disaster.

While social change in the past was measured in terms of historical epochs, centuries or generations, the rates of economic, social and technological change move so quickly today as to impose a perpetual pressure upon every individual. Changes in the nature and distribution of the population of the nations have intensified the problems of mental health and have created a general awareness of concern about them. The disappearance of frontiers and the rapid shift from rural to urban living have reduced the opportunities for disaffected or non-conforming persons to escape close scrutiny. There is no longer a satisfactory place for them to migrate.

The increasing trend toward crowded dwelling units in cities has concentrated more people in situations which tend to intensify stress, and at the same time reduces both individual and social tolerance for the

inevitable disturbing behavior which arises. We all know of the major social conditions which have stressful effects upon people's mental health. They are reported regularly, sometimes tragically, in our news media. In mentioning these events, please understand again that psychiatrists do not pose as oracles. We cannot change these social conditions, but we can make efforts to prevent illnesses arising from them and we must take care of the people who become disturbed as a result of them. Like Spinoza, we make ceaseless efforts not to ridicule, bewail, or scorn human actions, but to understand them.

We point out that harsh treatment, the feeling of being unloved, quarrels and insecurity, all bring out hostility and strengthen anti-social inclinations in individuals and groups. Emotional deprivation in childhood accounts for later anti-social and sometimes criminal behavior, as well as assorted kinds of mental disorders. Hostility and resentment may show up in defiance of parents and all authority -- fathers, teachers, police, military officers, judges, God. It can remain covered up for a long time and emerge later tragically. In families where there is acute tension, children feel isolated and displaced and deformed characters can ensue which will be evidenced later as anti-social or emotionally distressed individuals. Just how do we propose to go about helping with these problems? By moving further into the community with the community mental health centers which you funded and which you have heard so much about. We will go into storefront clinics in underprivileged neighborhoods

wherever necessary to really get to people who need help.

Realize, if you please, that the funds which you appropriate for research and for psychiatric manpower have vast implications for mental health far beyond the uses made of them in the purely mental health field. This once neglected discipline has now spread its influence and slowly attracted the help and the demand for help from the community. It began to make contributions to its sister medical specialties and to military and industrial medicine, shortly after World War II. Its help has also been solicited by educational and religious institutions, and these contributions are slated to increase. I would just like to mention briefly our contributions to these varied disciplines. This will tell you of the company we keep, give you an account of our stewardship, and inform you of the widespread effect of the funds which you are asked to appropriate here.

As to the present day applications of our findings to general medicine, the work of psychosomatic research is well known. Though we have not satisfactorily solved the age old body-mind problem, our findings are constantly becoming more important. Everything from the diurnal rhythm of our bodies, our so-called "biologic clocks," the optimal time to administer drugs, the influence of rapidly changing time zones upon flyers and travelers, the phenomena of sleep, the various chemical and biological phenomena which underlie depressions -- all of these have psychological and physiological components. These, plus the remarkable contributions of the sociologists and anthropologists regarding man's behavior, hold

exciting prospects for future research in man's mental well-being and in his behavior.

As to the contributions made by psychiatric clinical observation and basic research to military psychiatry already mentioned, they are remarkable as evidenced by the fact that in the Viet Nam conflict thus far there is a remarkably low number of psychiatric casualties. This is due to a number of factors, the most important of which are a more careful selection of men, and a more efficient and immediate treatment of emotional upsets at the front and close to the man's own unit.

The knowledge which we have gained from our researches also has helped us to be of assistance in industry. Psychiatry can make noteworthy contributions, and in some instances is already doing so. Its role is consultative and preventive. It can pinpoint causes of time lost and reasons for turnover of personnel. Obviously it is not the function of business or industry to act as nursemaid or psychiatric clinic, but it does seem wise in these days of manpower shortages to eliminate road blocks to emotional satisfaction and to conserve skillful personnel wherever possible. This utilization of skilled psychiatric help in industry will grow. Unfortunately, however, at present there are not enough consultants to go around.

As to the contributions to education, with the personnel aided by funds from NIMH, I went into detail last year on the type of the problems encountered and their incidence. I shall not take up your time repeating those remarks. You know, however, of the importance of these young

people in high school and in college. From them will come tomorrow's leaders. Fortunately many of their problems are minor and transient. In general, these are basically admirable youngsters, even if they are occasionally difficult. Twice in the month of March 1967, our military leaders in Viet Nam spoke of those young men whom they had encountered -- mostly drafted men. They said of them, "Let me tell you, they are the bravest, smartest soldiers we have seen in twenty-six years in the military. They are resourceful on a battlefield. They are giving of their all and doing a fantastic job." It is evident that once committed, these young people acquit themselves creditably. The problem, of course, lies in the question,how to inspire them? More help in advising them and careful attention to the mental health of these young people is essential. They represent the nation's hope for the future.

All of this is by way of report to you and this fantastic array of needs and of efforts, of work being done in the mental health field is being offered to you in justification of the budget which Mr. Gorman has just presented to you. The preventive possibilities are evident. These budgets are not simply for mental hospitals though they, too, benefit from all that is going on in the field.

Mental health research and mental health workers were obviously needed to fill the breech in a number of pressing situations. So true is this that psychiatry, one of the major disciplines called upon for assistance, is having an identity crisis of its own. It must be careful not to spread itself too thinly

in an effort to be all things to all people. Basically it has a medical mission. It did not seek these other tasks. They evolved as the specialty evolved in its modern dress. It cannot, however, under any circumstances, fail to respond to the call of the community for mental health is an absolute necessity to it.

Your committee has in the past communicated to the House its concern that mental health research efforts continue to expand. This is essential in these present times of great national unrest. We are in a period as brilliant and as violent as that which surrounded the period of the French Revolution. Mental Health research today is providing some exciting findings which portend hope for the future. To interrupt investigators, to ask them to tread water and see their research teams disintegrate and disappear, would be calamatous in this period of great anxiety. I would urge you, therefore, to continue and increase the support of research funds both for internal and external NIMH programs and, like the Bank of Monte Carlo, one cannot guarantee a payoff, but when one occurs it is great in its extent.

With your permission, I shall not go into further detail regarding overall mental health research here, nor comment further on the dire results of any cut-back in research funds. That has been ably taken care of by my colleague. Rather, I would like to comment upon several situations which are in need of continued and expanded attention.

We mentioned that in one major preventive approach to the general social unrest which is so evident nationally, the NIMH is supporting the development of community mental health centers throughout the land. When the concept of these centers was evolved, they were thought of primarily as a means of group mental health services -- mostly for the deprived -- but, in general, as places that patients could be treated in their own communities. Now, however, they loom in addition to be centers with possibilities for research and training facilities for programs quite directly related to civil disorders, social unrest and violence; because, on the findings of this research and on our ability to train workers who can understand and influence deprived people, will rest our ability to give them the services they need in the places where they live.

Some 260 of these centers have received Federal grants to help finance construction and initial staffing, and almost 100 of them are operating today. Their staffs are treating mental illness and emotional disturbance but they are also beginning to meet many more needs in their communities than they originally expected to do. Communities are looking to set up and expand the use of these centers and it is certain that their preventive and consultative services will contribute toward social changes that can ease the pressures and stress underlying violence. This will not be done by mental health workers alone. Rather, it will be a base where physicians, clergymen, and other capable professionals will pool their knowledge and apply their competence to the problems which are presently disturbing communities.

To neglect to expand the number of these centers, to cut budgets now, to fail to help bring these concepts to a broad fair trial, would be tragic. One fears a return of our dispirited group to isolated hospitals if we fail in our efforts to help broaden the base of community centers.

The capable Director of NIMH has told you, I am sure, of his plans to implement President Johnson's statement that one of the immediate objectives of his administration will be to develop "a child health program; to provide for families unable to afford it, access to health services from pre-natal care of the mother through the child's first year." I shall not go into detail regarding the programs which have been worked out -- in the interest of time -- suffice it to say they are, indeed, well conceived and they merit your strong support.

I would like to discuss many more important clinical aspects of problems which face us, but I realize that your patience should not be tried. I would certainly talk about alcoholism and urge you to markedly increase the budget for research and training to help with that scourge. It attacks the high and the low, breaks up families, and distresses children in untold numbers. I would reiterate what I said to you last year, and earnestly seek your help in establishing laboratories to further the understanding of the phenomenon of depression, one of the most painful congeries of symptoms known to us. I say this because usually there is no visible symptom which accounts for the person's distress, and that makes understanding more difficult and the illness harder to bear.

Melancholy is a phenomenon as old as man. The question has been asked why so many great men have been melancholy. Some have lost their lives during periods of depression. I am sure you can recall the sad histories of some of them. Of all of the emotional illnesses treated by psychiatrists in the present culture, depressive phenomena are in the forefront. Depression is the psychiatric diagnosis made most frequently today.

The Medical World News, in a March issue, surveys the subject under the apt title "New Faces of Depression," and a sub-title, "An Old Syndrone with a 1968 Look." The article begins with a quotation from the Greek biographer, Plutarch: "When a man is depressed, every little evil is magnified by the spectres of his anxiety." Plutarch's observation is as apt today as when he made it 2000 years ago.

I think we are justified in bringing this subject to your attention again for several important reasons:

1. The incidence of depressive phenomena.
2. The basic scientists have gone far in the past several years in determining many of the chemical and physiological accompaniments of the illness.
3. The condition is eminently treatable today. Often self-limited, the condition can be alleviated by drugs and other modern methods of treatment.

Feelings of sadness, hopelessness or despondency, may arise due to adverse external circumstances in which the individual finds himself. Whether the conditions be really overwhelming or whether for some reason the individual finds himself inadequate to deal with them, the resulting depression is the same.

Fortunately for most of us, our depressive feelings are only transitory and either disappear spontaneously or after we have worked out some type of positiive solutions to the problem responsible. These depressions are obvious and easily recognized, but there are others which are masked to the point where no one but an expert can detect their presence until a full-blown deep depression appears. Here the situation is much more serious, the depressed mood becomes longer lasting, and the attitude of dejection and the train of symptoms which follow in its wake render the individual ineffectual. These depressions are the illnesses most difficult to bear, for unlike medical or surgical illnesses, there are no visible physical symptoms apparent to the sufferers or to others that might explain his distress.

These depressive episodes must be differentiated from grief, a normal phenomenon, and should not be confused with it. In grief the loss is personal, objective, external, and readily understandable. The response it calls forth is realistic and proportionate to what has been lost. Grief, which is the normal expression of sorrow and bereavement which follows the loss of a loved one, is self-limited and gradually subsides.

Psychotherapists call attention to the great effort expended by these individuals who feel that they do not deserve anything in their own right, but must continue to strive and achieve if they are to get someone to love them or to continue to love them. It has long been recognized that these good people are extremely vulnerable to loss of position or status or the loss of material possessions. They are vulnerable, too, to the decline of physical abilities essential to their continued achievement or even with

advancing age the loss of certain future possibilities of achievement. Examples of these situations are plentiful today in our period of merges, strict rules for retirement, and the pressures of our economic situation.

Children and adolescents may become depressed and some of their destructive behavior may mask a mild depression as they search for meaningful relationships. They are not our concern here, but we should mention that much of the apathy, boredom, and willingness to enlist in almost any cause except study in college students is of the same genre. The complaints that they don't know what they want to do, the lack of interest in education in general, the feeling of the uselessness of it all, and the coupling of education and attainment with the older generations from whom they are separated, all may be due to underlying mild depressions. It is no longer easy for them to take a moratorium and drop out of college for a while to catch up with themselves, for the draft must be kept in mind. Some of the students deliberately arrange to fail, which fact distresses their parents and brings their plight sharply into focus.

Under these situations, the attractiveness of trying drugs in some form is apparent. They have heard of the pleasure of attaining a "high" and they are influenced to try it by the pressures of their peers. If they are fortunate, the experience will be disappointing or scary; if it proves attractive, they will have some serious decisions to make. While it is true that so-called "pot" is not addicting in the physical sense, as are the narcotic drugs,

nevertheless, there is a psychological attractiveness to it and it is not at all the harmless substance that enthusiasts make it out to be.

We have talked several times about depressions of middle life and earlier thought to be the exclusive property of women and due to the change of life. We decried both of these assumptions and noted the occurrence of depression in men a decade later, and suggested that the only relation to change which was present was the individual's inability to change in accordance with the surrounding changes which faced their age group in the present culture.

We noted, too, that persons who were rigid, conscientious, and inclined to perfectionism, were vulnerable to depression in this period. They were not easily influenced even though circumstances around them were changing rapidly. These are usually fine people but their rigidity becomes a hazard when their external circumstances call for marked change and they are unable to comply.

As to the reactions of older people to the present general unrest and rapidly changing cultural and economic environment, they are understandable. In the present era, with youth in the center of attention and in "children's crusades" in politics and the search for young people to occupy executive and top positions, men in the older age groups are understandably insecure. Very often they find themselves unable or unwilling to keep up with the pace and they withdraw, react in a depressive manner and become chronically ill.

Mr. Chairman, if I have become too clinical in this presentation again, I assure you that it is my only competence. I chose this method of presentation to you rather than repeat line for line the budget needs which has been done so ably by my colleague, Mr. Gorman. I do want to emphasize heartily, however, our agreement with him. The mental health field has opened up. It has great possibilities, and I know that you and your committee members will insist that it continue its activities. The mental health of the community depends upon the health of its individuals, and the mental health of the nation depends upon the health of its communities.

ADDENDA TO TESTIMONY

Since this testimony was written, the United States Supreme Court ruled by a 5-4 decision that criminal punishment of a chronic alcoholic did not constitute a violation of the Eighth Amendment prohibiting cruel and unusual punishment. The decision strongly reenforces the importance of NIMH activities in the field of alcoholism.

All nine Justices expressed dissatisfaction with the present criminal system of handling alcoholics. The majority (5 Justices) stated that, "The picture of the penniless drunk propelled aimlessly and endlessly through the law's 'revolving door' of arrest, incarceration, release and re-arrest is not a pretty one." The minority (4 Justices) stated, "It is entirely clear that the jailing of chronic alcoholics is punishment. It is not defended as therapeutic, nor is there any basis for claiming that it is therapeutic (or indeed a deterrent). The alcoholic offender is caught in a "revolving door" leading from arrest on the street through a brief unprofitable sojourn in jail back to the street and, eventually, another arrest."

These comments from the highest court in the U. S. further reenforce a major goal of the NIMH alcoholism activities, i.e. to develop appropriate social-medical alternatives to the present inhumane and ineffective system of dealing with homeless chronic alcoholics. The growing number of community mental health centers present an unusual opportunity to assist communities throughout the country in establishing the network of services needed for the care and treatment of alcoholics.

An important argument in the majority opinion is that current information about alcoholism and its treatment still is rather limited. Justice Marshall, speaking for the majority, describes the state of knowledge on the subject as "comparatively primitive."

This argues strongly for the expanding of current NIMH research activities dealing with the nature, causes and treatment of alcoholism.

Another important argument of the majority is that facilities for the "treatment of alcoholics are woefully lacking throughout the country." This is cited by the justices as a reason for continuing reliance on the criminal system for handling chronic alcoholics.

Clearly the development of more adequate care and treatment services -- through the expansion of the community mental health centers program and other medical-social services -- is a major means of overcoming this lack.

All nine of the Justices agree that alcoholism is a major medical-social problem. The majority opinion states that the "destructive use of alcoholic beverages is one of our principal social and public health problems." The other four Justices describe alcoholism as "a major medical problem."

The importance of strengthening and expanding NIMH training programs is emphasized by the majority's statement that there is an "almost complete absence of . . . manpower for the implementation of a rehabilitation program."

While only a minority of the Court was willing, on constitutional grounds, to bar the criminal incarceration of chronic alcoholics for the offense of public drunkenness, all of the Justices agreed that:

1). Alcoholism is a major medical-social problem.

2). Current criminal procedures are ineffective.

3). Current facilities for the treatment of alcoholism are inadequate.

4). Further research is urgently needed on the nature, causes and treatment of alcoholism.

5). There is a severe shortage of personnel trained to work in this area.

NIMH FISCAL 1969 BUDGET INCREASES PROPOSED BY CITIZENS

	1969 President's Budget		Citizens Budget
RESEARCH	$ 81,159,000		$ 91,659,000
HOSPITAL IMPROVEMENT	10,610,000		16,610,000
TRAINING	109,046,000		133,200,000
RESEARCH FELLOWSHIPS	10,641,000		11,641,000
EARLY CHILD CARE PROJECTS	14,500,000		14,500,000
DIRECT OPERATIONS	52,875,000		59,875,000
TOTAL	$278,831,000		$327,485,000
TOTAL INCREASE REQUESTED - CITIZENS BUDGET		$48,654,000	
COMMUNITY MENTAL HEALTH RESOURCE SUPPORT			
Construction Grants	$ 15,000,000		$ 60,000,000
Center Staffing	64,300,000		70,300,000
Narcotic Facilities	8,000,000		8,000,000
TOTAL - COMMUNITY RESOURCES	$ 87,300,000		$138,300,000
INCREASE FOR COMMUNITY RESOURCES		$51,000,000	

TESTIMONY BEFORE PUBLIC HEALTH SUBCOMMITTEE ON THE BILL H. R. 2550, CITED AS THE "NATIONAL NEUROPSYCHIATRIC INSTITUTE ACT"

by

Captain Francis J. Braceland (MC), USNR
Chief, Neuropsychiatric Branch
Professional Division
Bureau of Medicine
and Surgery

and

Lt. Comdr. Howard P. Rome (MC), USNR
Asst. Chief, Neuropsychiatric Branch
Professional Division
Bureau of Medicine
and Surgery

The opinions and assertions contained herein are the private ones of the authors and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service as a whole.

There is little question of the merit of a program which promises an all-out attack on the problems of mental illness and human behavior. These, as well as others of our post-war problems, have a common denominator--the human factor which requires much study and constructive effort. Accelerated research and the rapid advances which have come about in the fields of physics, commerce, and chemistry will be of little good if unpredictable human behavior is allowed repeatedly to lay waste our civilization.

Up to now the job of Psychiatry has been to apply scientific techniques and methods to the problems of mental illness and human behavior. Its task has been not only the recognition and treatment of the mentally sick but also the discovery of better ways and means to prevent these illnesses. Again and again the war has demonstrated that in order to understand mental illness, what is first required is an understanding of men; how they live, what they want from life, where they have come from, and what their backgrounds have been. Men do not get mentally sick "out of the blue" so to speak; in a large measure, their illness or well being depends upon their relations to other men. The war's smashing climax at Hiroshima and Nagasaki hammered into the consciousness of all men one irrefutable fact: More than ever before, man's very existence is dependent upon his fellowmen. This realization, great though it is, is not enough. Ways and means have to be created for better understanding human behavior and doing something about its training. It is tragically significant that our civilization found it easier to split an atom than it has to join man with man.

The ultimate benefits of an increased understanding are implicit in a program as comprehensive as this. It is imperative that a central foundation be established upon which each additional block of knowledge can be laid. Admittedly the final goal is a long way off, but it is well to remember that there is no end without a beginning.

There are some immediate and tangible rewards to be gained. But before we can hope to accomplish a full and complete understanding of the larger issues at stake, we have to appraise our present status.

There is a considerable block of our population which does not enjoy mental health. This Committee, in these sessions, will have been given data which will amply testify to this indisputable fact. Each analysis which has been made clearly indicates that mental disease is not restricted to any one group or any particular level in the nation. Still further, it is apparent that mental disease itself is only part of the mental health problem. The experiences of the Armed Forces show that 90% of the psychiatric problem is concerned with mental disorders other than insanity. Despite the fact that as a group the Armed Forces are the most fit of the young adults of the nation, every branch of the Services has had its quota of the unstable, the emotionally disordered and the mentally ill. The psychiatric problem pervades every aspect of our national life, and collectively these disorders constitute the largest single medical problem which confronts the nation.

The inventory of the health of the nation's manpower, which has been made by the Selective Service System and the Medical Departments of the Armed Forces, leaves no doubt that health is a national resource

more vital to our economy than coal or oil or chemical reserves. And yet it must also be recognized that we have done little to conserve it. We have spent far less on mental health research than we have in the research which led to the development of high octane gasoline, for instance. We have done less on a national scale for the prevention of mental illness than we have to prevent soil erosion and the wastage of our lumber reserves. We have less coordination on a national scale as concerns mental health than we have in the mining and distribution of coal. The analogies and comparisons might be extended.

It adds up to this: Despite the excellent beginnings made by isolated private groups and agencies and even in some instances, communities, real progress toward the goal of mental health has not been accomplished because of the limited scale and the lack of coordination of their endeavors.

We have seen in the development of the atomic bomb the enormous profit in pooled production and research. Fundamental research on this scale requires the cooperative enterprise of many groups. Particularly in matters as complex and as far-reaching as mental health is it desirable to have the advantages of a collective approach by many persons and groups. The scale on which this has been possible heretofore has been limited. Few if any teaching institutions or communities or philanthropic foundations have been in a position to either afford or command the personnel and facility resources necessary for such an undertaking.

Pilot studies have given leads which indicate the value of the more extensive roles with which psychiatry has to be concerned both inside and outside of the mental hospitals. The advancing progress of scientific medicine has made us a nation of older people--subject to the diseases and disabilities of older life. This change in events has had a marked effect upon the population of the mental hospitals. Twenty or twenty-five years ago by and large mental disease was regarded as a problem of adolescence. At the present time, because of the marked shift in the age characteristics of the general population, the mental disorders of old age predominate in the mental institutions. Relatively little research has been done on this aspect which promises to be a most important problem ten or fifteen years hence. The adequacy of mental institutionalization for all mentally diseased patients has to be investigated. The development of foster home care and the possibility of extra-institutional colonization have to be considered by an agency which can study the issue in its broadest aspects.

The entire matter of the prophylactic measures which can be used to prevent mental illness brings to the fore a most important phase. Psychiatry in the future will not content itself with the belief that it is doing a full job when it merely provides care for disease. The job of tomorrow's Psychiatry is large-scale prevention. The conquest of the infectious diseases (and certainly the war statistics testify to this) did not come about until there were such measures as vaccination and immunization. In the same manner in which Medicine has overcome such diseases as lockjaw and smallpox by prophylaxis, Psychiatry

can do likewise by providing information and a public understanding which will prevent much unnecessary unhappiness. We believe that the technique of more successful living can be taught.

Such a community educational program, to be wholly successful, would necessarily have to be comprehensive. Adult and child guidance clinics, counselling and professional assistance to the courts, and consultation clinics for the public schools are some of the subsidiary projects which come to mind. The training program for this role of psychiatry will require coordination and pooled resources.

Perhaps the greatest hiatus in the over-all psychiatric program appears when the facilities and opportunities for education are stacked against the needs. Without trained people to do the job, these plans are merely academic speculations. There are not enough psychiatrists, psychiatric training opportunities or qualified psychiatric teachers at the present time to meet the demands of the expanding Veterans Administration, the post-war Army, Navy, and the Air Forces, the Public Health Service, and the civilian institutions and schools. Without materially augmented support such as this Bill will provide, it is not likely that this deficit will be overcome.

There is a need for a radical revision of the entire structure of psychiatric education. It is not necessary that every person with an emotional disorder be seen by a psychiatrist. The first line of psychiatric defense is the general medical practitioner. He, if properly trained for his task, can handle competently the majority of his patients' psychiatric complaints. However, not a little of the bottlenecking in

psychiatry is attributable to a failure of this first line defense. There is need for considerable research in teaching techniques which will overcome this deficiency which is generally recognized. The use of training motion pictures is an example of one improved method which deserves exploitation.

A large number of medical officers in the Armed Forces have expressed their desire for further post-graduate education in psychiatry. Existing training facilities are not adequate to meet these immediate post-demobilization demands, and it is necessary that they be created if we ever hope to progress to a solution.

Psychiatric education cannot be content to confine itself to the medical school student or even the psychiatric intern or resident or fellow. Psychiatric education has to include the public at large. For example, the families and the employers of the mentally ill patients need to know simple basic psychiatric fundamentals if they are to be expected to aid the patient's future adjustment. It is futile to consume weeks and months in the treatment of a mentally sick patient only to have such benefits nullified by the ignorant rejection of a prospective employer or the well-intentioned but poorly directed questions of his family. People have to be taught not only that the mentally ill are sick people, but also that a large percentage recover. We as a nation have to learn that there is much to be gained in using the partial services of the temporarily disabled and even in some instances the permanently disabled. The huge cost of forcing a high percentage of these persons to be economic invalids is not only wastefully extravagant

but detrimental to the national morale. The punitive attitude which characterizes most persons' intolerance of the emotionally disturbed is as anachronistic in our day and time as it is to cry at a leper "Unclean." This is a job to be done which requires operations on a community scale.

We have no desire to prolong this discussion, the issues at stake and the benefits to be achieved appear to be quite obvious. It seems to us to be mandatory that something be done quickly to coordinate and correlate the individual contributions of isolated groups and individuals who are struggling with a task which is beyond their personal resources. The scientific potentialities of coordinated action in education, research and development have already been favorably demonstrated in other fields; the impetus which is needed in the field of Psychiatry is provided by this Bill. In order to begin to solve the mental health problem, it will be necessary to make possible:

1. An opportunity to do large-scale research;
2. An opportunity to coordinate the products of such research on all levels;
3. An opportunity to assist both public and private agencies in their worthwhile endeavors in this field;
4. An opportunity to make this worthwhile contribution available so that continued profit from further research can accrue;
5. And finally, to provide training and instruction for the men upon whom the great responsibility for the successful carrying on of this work will devolve--the teachers.

To quote a statement in the 1944 Report of the Rockefeller Foundation:

> "It is not too much to assert that in its actual and potential contribution to general medicine, to education, to sociology, indeed to the general business of living, psychiatry, without claiming omniscience in itself, is cast for a role of fundamental importance in helping to shape any world that may come out of the present one."