WHAT ARE THE FACTS ABOUT

MENTAL ILLNESS IN THE UNITED STATES?

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I. HOW MANY PEOPLE IN THE UNITED STATES ARE SUFFERING FROM SOME FORM OF MENTAL ILLNESS?

1. An estimated 19,000,000 people in the United States are suffering from some form of mental or emotional illness, from mild to severe, that needs psychiatric treatment. (1)
   a. This means that about one in every 10 persons is now suffering from some form of mental illness of varying degrees of severity.
2. Mental illness or other personality disturbances are usually significant factors in criminal behavior, delinquency, suicide, alcoholism, narcotics addiction, and very often, in cases of divorce. (2)
   a. About 60,000 persons in the U.S. are drug addicts. (2)
   b. An estimated 20,510 people committed suicide in 1964. (3)
   Suicide is now the tenth leading cause of death in this country.
3. Mental illness is known to be an important factor in many physical illnesses, even heart disease and tuberculosis. (1)
4. At least 50% of all the millions of medical and surgical cases treated by private doctors and hospitals have a mental illness complication. (1)
5. An estimated 500,000 mentally ill children in the U. S. are classified as psychiatric or borderline cases. Most of these children are suffering from the psychiatric disorder known as childhood schizophrenia. (1)
   a. Only a very small percentage of the total are receiving any kind of

psychiatric treatment. (1)

6. Emotional disturbances and mental illness are an important factor in the cause of 75% of all accidents. (1)

II. HOW MANY ALCOHOLICS ARE THERE IN THE UNITED STATES TODAY?

1. About 5,000,000 people in the U.S. are alcoholics, affecting 20 million family members. An estimated 200,000 new cases develop each year.(5)

   a. FBI reports showed 1.5 million arrests for "drunkenness" in 1963, and an additional 215,000 arrests for "driving while intoxicated."(5)

   b. One out of every 7 admissions to state and county mental hospitals is an alcoholic. (5)

   c. Losses to industry from absenteeism, and other occupational problems, associated with alcoholism are about $1 billion annually. An additional $1.25 billion is spent each year to provide care, financial support and treatment for alcoholics and their families. (5)

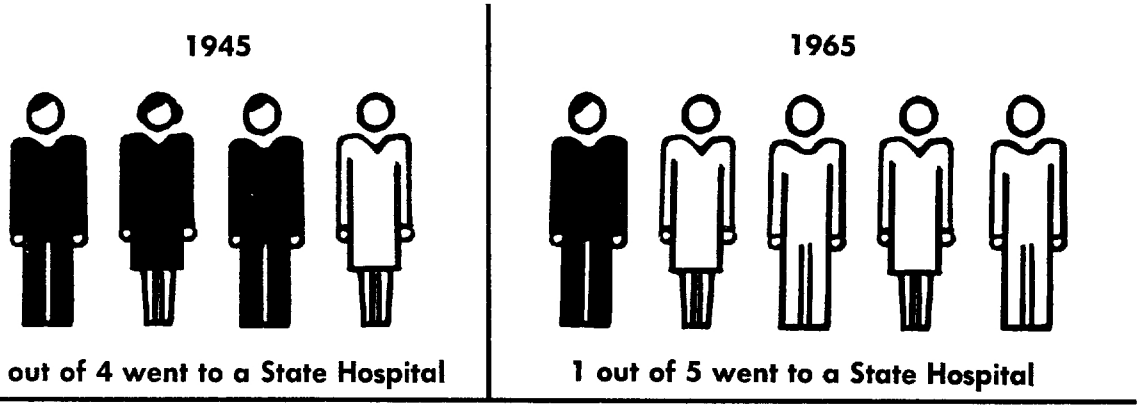
d. A recent study of cases of Aid to Families with Dependent Children found alcoholism as a major factor in 14% of the families receiving tax monies under this program. (5)

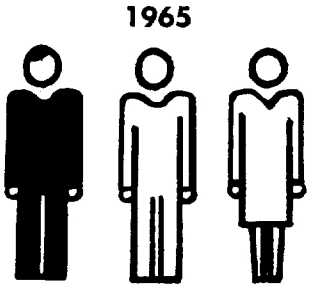
e. A national public opinion survey in 1965 found that 1 in every 5 adults questioned admitted constant worry because they "drink too much for their own good." (5)

III. HOW MANY PEOPLE ARE BEING TREATED FOR MENTAL ILLNESS?

1. An estimated 3,921,000 Americans were treated for mental illness in 1965. (7)

2. There is an increasing trend away from the state mental hospital as the primary source of treatment. Twenty years ago, state institutions handled 3 out of every 4 mental patients; in 1965, they cared for only 1 in every 5 persons receiving psychiatric treatment. (7)





of patients treated in mental health clinics or by psychiatrists in private practice only

1 out of 3 has to be hospitalized

There is a parallel trend increasingly emphasizing outpatient care and partial hospitalization as an alternative to 24-hour hospitalization. In 1965, almost 2 in every 3 patients were not hospitalized; they received private office psychiatric care or were treated in one of the 2,000 mental health clinics in the U.S. (7)

3. The following table lists where the 3.9 million mental patients received treatment in 1965: (7)

State & county mental hospitals	807,000
Private mental hospitals	110,000
General hospitals	600,000
Outpatient clinics	950,000
Psychiatric day-night units	14,000
V.A. hospitals	140,000
Private office care	1,300,000
	3,921,000

IV. WHAT IS THE EXTENT OF MENTAL ILLNESS AMONG CHILDREN?

1. An estimated 4 million children under the age or 14 are in need of some kind of psychiatric help because of emotional difficulties. Of these, between 500,000 and 1,000,000 children are so seriously disturbed that they require immediate psychiatric help. (8)
2. An amazingly high percentage of the long-term residents of state institutions were first admitted as children or young adults. (8)
   a. An analysis of a 5,000 bed hospital at Tuscaloosa, Alabama, reveals that more than half of the male schizophrenic group who have been in that hospital 20 years or more were first admitted between the ages of 14 and 29.

3. Many young children are so emotionally disturbed that they cannot be reached by educational programs. (8)

   a. A preliminary analysis of reports from Operation Head Start, a pre-kindergarten program which served 600,000 children last summer, indicates that at least 10% of the children were in deep emotional trouble so severe that it had already crippled their development by the age of 4. (8)

V. ARE EMOTIONALLY DISTURBED CHILDREN RECEIVING ADEQUATE CARE? NO!

1. According to the Joint Commission on Mental Illness and Health there is not a single community in this country which provides an acceptable standard of services for its mentally ill children, running the spectrum from early therapeutic intervention to social restoration in the home, the school and the community.
2. Although close to 300,000 children were seen in outpatient psychiatric clinics in 1963, in most cases the "treatment" consisted of one or two diagnostic interviews followed by the admission that there were no facilities in the particular area for prolonged treatment. Because of staff shortages, especially of psychiatric time, many clinics tell parents seeking aid for deeply troubled children to come back in 6 months or even a year. (8)

VI. WHAT LEGISLATIVE AND OTHER DEVELOPMENTS ARE MOVING TOWARD INCREASED TREATMENT OF CHILDREN IN THE HEART OF THE COMMUNITY?

1. Legislation passed by Congress in 1965 authorizes $120 million over a 4-year period for the training of teachers of the handicapped, with particular emphasis upon teachers for emotionally disturbed children.
   a. 100,000 of these specialized teachers are needed right now to staff classes, of not more than 10 children each, for the approximately 1 million children, estimated to need these individual psychological and educational services. At present, there are less than 3,000 teachers specially qualified to handle emotionally disturbed children. (8)
2. This legislation also authorizes $41 million over a 4-year period in support of research and demonstration projects designed to produce

more effective methods of teaching and re-educating the handicapped and the emotionally disturbed. (8)

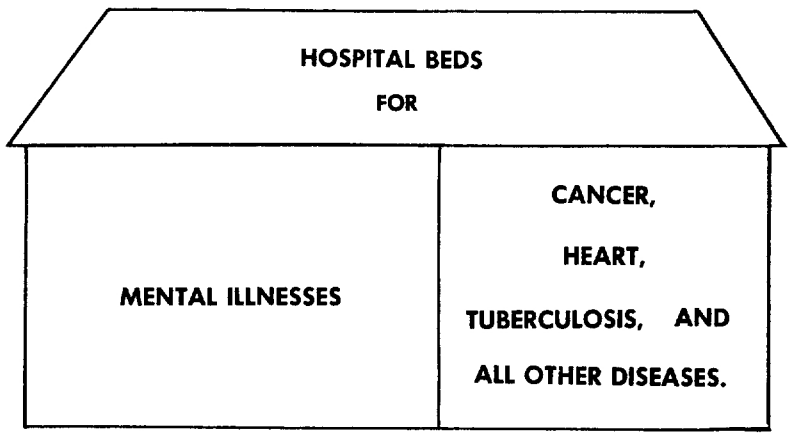
3. Over the past few years, the National Institute of Mental Health has joined in the support of a number of pilot projects designed to prevent institutionalization of children by developing alternative treatment services in specialized schools or in the community. (8)

4. Legislation has also been enacted authorizing federal support for a non-governmental study of the extent of mental illness among children directed toward specific proposals to combat it. A Joint Commission on Mental Health of Children, representing more than a score of organizations active in the field, has been formed and is already under way with a number of task force studies.

5. A companion legislative effort, the Elementary and Pre-school Child Development Bill of 1965, introduced last September by Rep. Sam Gibbons of Florida, would provide funds over a 10-year period to train child development specialists to work with children in the pre-school years and in the first three grades of elementary school. Hearings on the bill, which also provides grants to state educational agencies to employ these child development specialists, have been completed in the House. A groundswell of support for its imaginative attack upon the current shortage of child mental health workers is increasing. (8)

VII. HOW MANY PEOPLE ARE HOSPITALIZED FOR MENTAL ILLNESS?

1. Slightly more than one out of every two hospital beds in the United States is occupied by a mental patient. (10)
2. 712,174 or 51% of the 1,406,818 patients comprising the average daily hospital census in 1962 in all hospitals were patients in psychiatric hospitals (public and private). (10)
   a. The average daily resident patient population in public mental hospitals (state and county hospitals) in 1965 totaled 488,400. (13)
3. A large percentage of all State mental hospitals are still overcrowded. (32)
4. Admissions to psychiatric hospitals (Federal and non-Federal) totaled 511,262 in 1964. (10)
5. There are more people in hospitals for mental illness than for polio, cancer, heart disease, tuberculosis and all other diseases combined. (1)



VIII. HOW MANY PEOPLE ARE IN ALL TYPES OF PUBLIC MENTAL HOSPITALS?

1. Of the hospitalized mentally ill, 98% are in public hospitals (state, county, city, Veterans Administration and other federal hospitals). (10)

Only about 2% of mental patients are cared for in private and voluntary hospitals. (10)

IX. WHICH MENTAL ILLNESSES AFFECT THE GREATEST NUMBER OF PEOPLE?

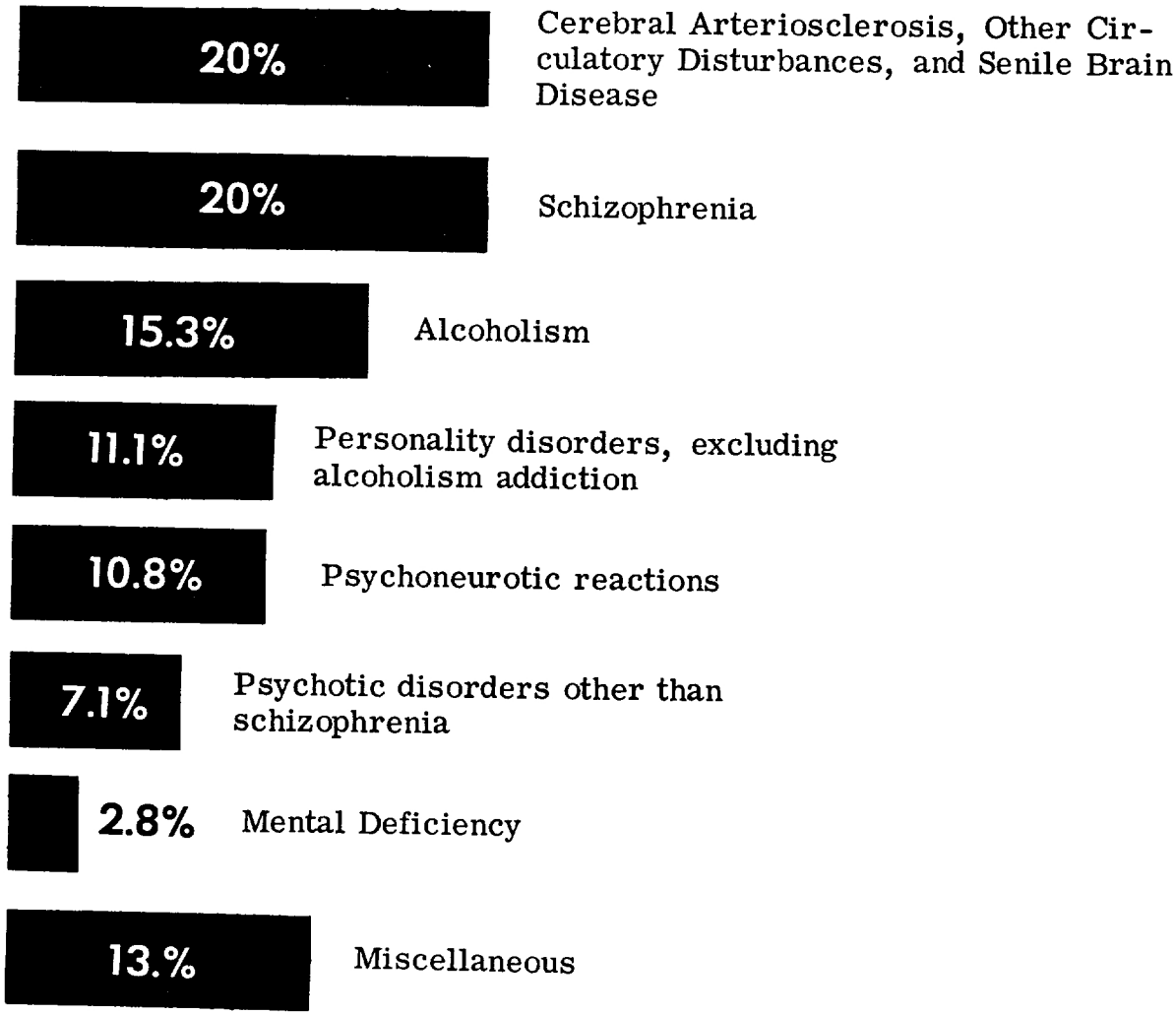
1. About 20% of first admissions to state and county mental hospitals in 1963 were patients with schizophrenia. (14)
   a. Because of the relative youth of schizophrenic patients on admission to hospitals and their relatively low death rate, those schizophrenic patients who are not discharged tend to accumulate from year to year and to make up half of the resident populations of these hospitals (14)
2. About 20% of first admissions to state and county mental hospitals in 1963 were patients with cerebral arteriosclerosis, other circulatory disturbances, and senile brain disease. (14)
   a. Patients with cerebral arteriosclerosis, other circulatory disturbances and senile psychosis, because of their high death rate, made up only about 13% of the resident population of these mental hospitals in 1963. (14)
3. Other causes of first admissions to public non-federal mental hospitals in 1963 included: (14)

Alcoholism including alcohol intoxication	- about 15.3% of all new admissions
Personality disorders excluding alcoholism addiction	- about 11.1% of all new admissions

Psychoneurotic reactions	- about 10.8% of all new admissions
Psychotic disorders other than schizophrenia	- about 7.1% of all new admissions
Mental deficiency	- about 2.8% of all new admissions

4. The remaining 13% include a variety of other disorders no one of which alone has a very high incidence. (14)

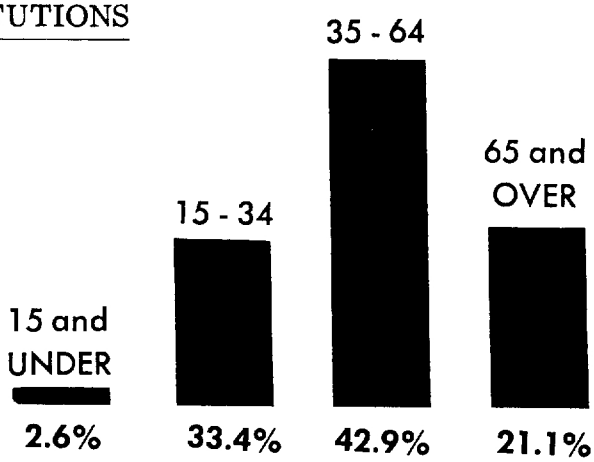
PERCENTAGE OF FIRST ADMISSIONS TO PUBLIC MENTAL HOSPITALS BY CAUSE -- 1963



X. IN WHAT AGE GROUPS DO VARIOUS TYPES OF MENTAL DISORDERS TAKE THEIR GREATEST TOLL?

1. Very few cases of psychosis occur before the age of 15. (14)
   a. Of all first admissions in 1963 to state and county mental hospitals: (14)
      (a) 2.6% were under 15 years of age
      (b) 33.4% were between 15 and 34
      (c) 42.9% were between 35 and 64
      (d) 21.1% were 65 and older.
2. In the age range 15-44 years, schizophrenia and personality disorders predominate. (14)
3. During the next decade of life (40-50), the involutional psychoses and alcoholic psychoses attain considerable importance. (14)
4. In the sixties, psychoses with cerebral arteriosclerosis and senile psychoses assume prominence, and these mental diseases of the senium continue to rise until the end of the life span. (14)

FIRST ADMISSIONS INTO MENTAL INSTITUTIONS IN THE FOLLOWING AGE GROUP PERCENTAGES - 1963



XI. WHAT IS THE COST OF CARE AND MAINTENANCE OF THE MENTALLY ILL IN PUBLIC MENTAL HOSPITALS?

Estimated total maintenance expenditures of state and county mental hospitals in 1965 were $1,201,979,234. (13)

XII. WHAT IS THE COST OF MENTAL ILLNESS TO THE VETERANS ADMINISTRATION?

Mental illnesses presently cost the Veterans Administration over $1 billion annually.

1. The estimated operating costs in fiscal 1966 for VA psychiatric hospitals was $314,284,000. This does not include the costs for care of psychiatric patients in general hospitals. (21)

   The estimated average daily patient load in VA psychiatric hospitals for fiscal 1966 was 52,470. This is 48% of the average daily patient load in all VA hospitals. (21)

2. The net operating cost in fiscal 1963 for VA outpatient mental hygiene clinics was $7,761,146. (9)

3. As of June 1965, 601,367 veterans were receiving compensation and pension payments whose major disability involved a psychiatric or neurologic condition. The annual value of these awards was $744,977,004. (15)

XIII. HOW MUCH IS BEING SPENT BY PUBLIC INSTITUTIONS FOR CARE OF THE MENTALLY RETARDED?

1. There were an estimated 188,332 resident patients in all public

institutions for mentally retarded at the end of 1965. (16) First admissions totaled 15,033 and net releases during the same period (1965) were 9,385. (16)

a. During 1965, maintenance expenditures of public institutions caring for the mentally retarded totaled $439,349,514. (16)

XIV. WHAT IS THE ESTIMATED COST OF PUBLIC ASSISTANCE TO MENTALLY ILL AND MENTALLY RETARDED PERSONS?

According to the Bureau of Public Assistance of the Social Security Administration, a 1951 study of aid to the permanently and totally disabled disclosed that 11% of the cases were mentally ill and mentally retarded persons. Assuming the estimated 1966 case load of 581,500 is similar in composition, 63,965 persons with mental illness or mental retardation receive public assistance from the Federal, state and local government amounting to $66,165,000 per year. (21)

XV. WHAT IS THE LOSS OF EARNINGS OF THOSE PEOPLE ADMITTED TO MENTAL HOSPITALS?

1. The income loss in 1964 of resident patients in State and county mental hospitals is estimated to total $1.7 billion. (19).
2. Income losses during the first year for first admissions (1964) total an estimated $424 million. (19)

XVI. IN SUMMARY, WHAT IS THE OVER-ALL ANNUAL COST OF MENTAL ILLNESS IN THE UNITED STATES TODAY?

It is estimated that mental illness costs annually approximately $5,018,497,698 as follows:

a. Total maintenance expenditures of public mental hospitals for 1965 (13)	$1,201,979,234.
b. Proprietary & non-profit voluntary mental hospitals' expenses (1964) (10)	107,829,000.
c. Estimated payments for private psychiatric care (22)	100,000,000.
d. Estimated annual cost of care of neuro-psychiatric patients in Veterans Administration hospitals and out-patient care for veterans with neuropsychiatric conditions. (9) (21)	$ 322,045,146.
e. Veterans Administration compensation & pension payments to veterans with neuropsychiatric conditions - 1965 (15)	744,977,004.
f. Expenditures of Federal agencies other than the Veterans Administration for mental patients 1964 (U.S. Public Health Service hospitals, Depts. of Defense, Justice Bureau of Prisons, Interior) (10)	36,178,000.
g. 1965 expenditures of public institutions for mentally retarded (16)	439,349,514.
h. Cost of public assistance to mentally ill and mentally retarded persons (21)	66,165,000.
i. Estimated income loss of 1964 resident patients in mental hospitals (19)	1,676,188,800.
j. Estimated earnings losses in 1964, of first admissions to mental hospitals in that one year alone (19)	423,786,000.
	$5,018,497,698.

XVII. HOW MANY PUBLIC AND PRIVATE HOSPITALS FOR MENTAL DISEASE ARE THERE IN THE UNITED STATES?

1. About 531 hospitals. The average daily hospital census of mental patients in all psychiatric hospitals, public and private, in 1964 was 695,087. (10)

   a. Of these 531 public and private psychiatric hospitals, 326 are state and local governmental mental hospitals. (10)

      73 are voluntary psychiatric hospitals
      88 are proprietary psychiatric hospitals
      44 are Federal government psychiatric hospitals (includes Veterans Administration and Public Health hospitals)

XVIII. HOW MANY PSYCHIATRIC CLINICS ARE THERE IN THE U.S.?

1. There are 2,000 psychiatric clinics in the U.S. as of the end of 1965. (7)
2. Half the clinics are located in the northeastern portion of the country which contains only 25% of the population. The south and west have fewer clinic resources than other areas of the nation. Only 4% of the clinics are located in rural areas where 30% of the population live. (7)
3. At least one clinic for every 50,000 in the population - or about 4,000 full-time clinics - are needed.
4. Because of severe mental health personnel shortages, many clinics operate at a level far below full-time capacity. 2/3 of the clinics in the country are unable to obtain the services of a full-time

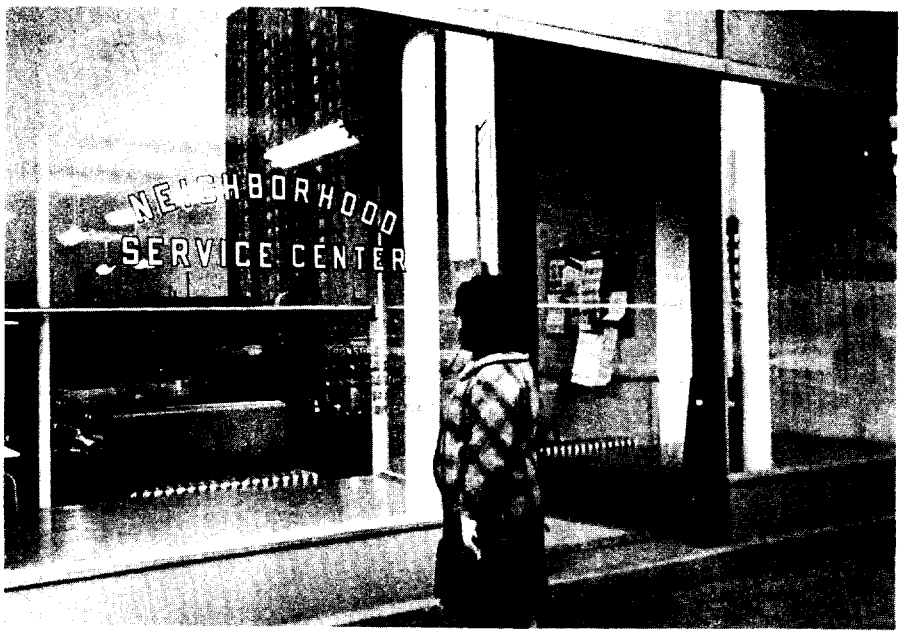
psychiatrist. (7)

5. A total of 950,000 persons were treated in outpatient clinics in 1965. This is a 42% increase over the 669,000 treated in 1961, and 89% over the 502,000 treated in 1959. (7)

6. Children and young adults form an increasing percentage of the treatment load of these clinics. Between 1961 and 1963, there were the following increases in numbers of children and young adults handled: (7)

5 to 9 years	19% increase
10 to 14 years	22% increase
15 to 17 years	38% increase
18 to 19 years	38% increase
20 to 24 years	47% increase

7. In recent years, emergency walk-in clinics which offer around-the-clock services to troubled people have been opened in a number of cities, such as New York, Boston, Los Angeles, Berkeley, Detroit, etc. (7)



One of the three neighborhood centers run by the Department of Psychiatry, Albert Einstein College of Medicine, serving the psychiatric and social needs of the community.

XIX. HOW MUCH IS THE UNITED STATES PUBLIC HEALTH SERVICE SPENDING FOR ESTABLISHMENT OF MENTAL HEALTH CLINICS AND SERVICES THROUGH THE NATIONAL MENTAL HEALTH INSTITUTE?

1. $6,750,000 has been allotted in fiscal 1966 in federal matching grants to the states for the support of psychiatric clinics and related mental health services.
2. In addition, $50 million has been appropriated in fiscal 1967 for the third year of a program of grants for the construction of public and other non-profit community mental health centers.

XX. HOW MUCH IS BEING SPENT FOR RESEARCH ON MENTAL HEALTH BY THE STATES AND BY THE MAJOR FEDERAL AND NATIONAL VOLUNTARY AGENCIES INTERESTED IN MENTAL HEALTH?

1. Approximately $141.7 million is spent, as follows:

   Federal funds - $113,770,000:

   1) Nat'l Institute of Mental Health, U.S. Public Health Service, fiscal 1965:

Intra-mural research	$12,149,000	
Research grants	85,230,000	
Research fellowships	8,364,000	
Collaborative studies	3,702,000	$109,445,000 (25)

   2) Out of fiscal 1965 medical research appropriations totaling $37 million, the Veterans Administration spent for research in mental illness an estimated 4,325,000 (27)

Fiscal 1966 appropriations for medical research to the VA totaled $40.8 million, although how much will be spent specifically for research in mental illness is not known.	
Total Federal Funds	$113,770,000.

Non-federal funds - $27,994,188

1) National Association for Mental Health - 1964	$ 336,014 (28)
2) The Foundations' Fund for Research in Psychiatry (New Haven, Conn.) total grant expenditures, July 1, 1964 - June 30, 1965	458,174 (29)
3) Other estimated annual research support from private national granting agencies (18)	3,200,000 (18)
4) Estimated annual state expenditures for mental health research	24,000,000 (30)
Total Non-Federal Funds	27,994,188
Total Funds	$141,764,188.

2. On the basis of 695,087 (10) patients in psychiatric hospitals in 1964, this would indicate that the amount spent for research per individual hospital case, employing Federal, State, national voluntary health agency, and other private funds, is only approximately $204.

3. In contrast to the approximate total of $141.7 million currently being spent for research against mental illness:

   a. The Nation spent $12.6 billion - OVER 93 TIMES AS MUCH - for alcoholic beverages alone in 1964 (31), an average of $66 annually for each man, woman and child. We are spending about 70¢

annually per each man, woman and child in the United States for research against mental illness.

b. Mental illness is costing the Nation over $5 billion annually. Yet our annual research investment to combat this toll is less than 3% of this cost.

XXI. HAS MEDICAL RESEARCH PAID OFF IN THE FIELD OF MENTAL ILLNESS? YES!

1. The tranquilizing drugs (reserpine, chlorpromazine) and many of the new drugs, including the psychic energizers have, over the past 10 years, revolutionized the care of state mental hospital patients and brought about an unprecedented, sustained annual reduction in state hospital populations.

At the end of 1955, there were 558,922 resident patients in state and county public mental hospitals. During that same year there were 178,000 admissions to, and 126,500 net releases from, these hospitals. (13)

At the end of 1965, even though admissions had soared approximately 136,000 to a total of 314,443, there were 83,161 less patients in these same hospitals in 1965 as compared to 1955. (13) (Up until 1955, before the general use of the drugs, the mental hospital patient populations increased each year.)

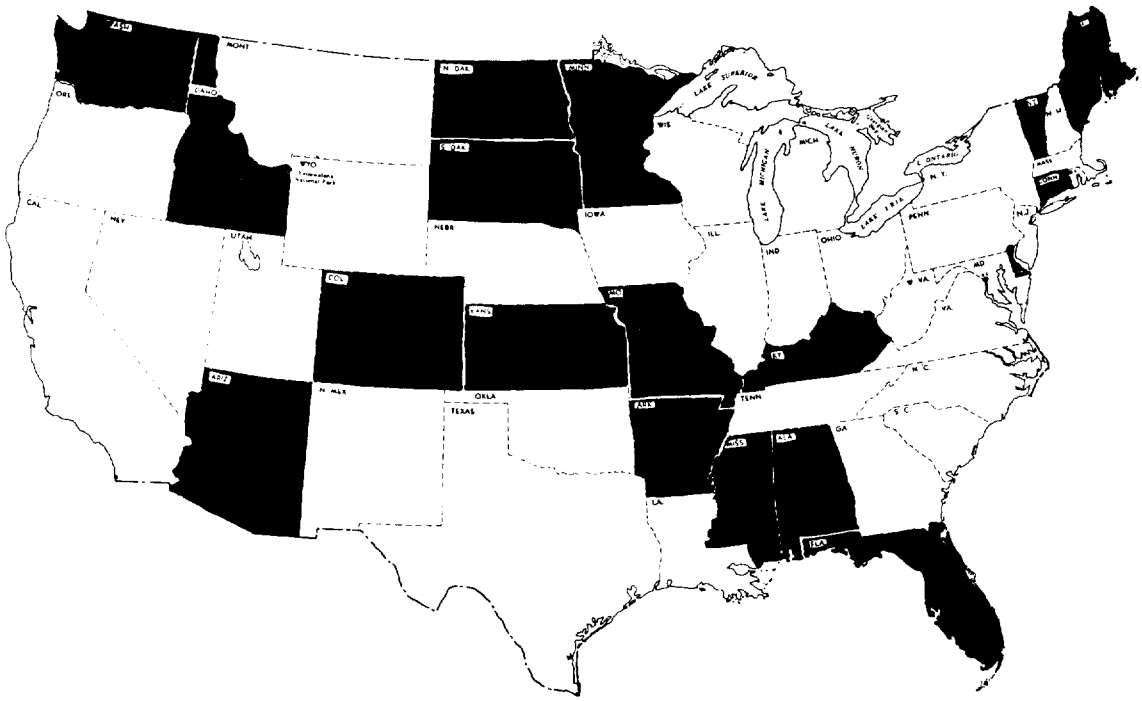
This is a remarkable reduction of 15% in the total number of

patients in these hospitals over the short span of 10 years. Even more remarkable, this downward trend in hospital populations has accelerated over the past five years, reaching a record reduction of 15,000 patients in 1965. The total drop of 52,000 patients since 1961 is more than double the average rate of drop during the preceding six years (1955-1961).

The key to this spectacular reduction is the 126% increase in number of patients released each year -- from 126,500 in 1955 to 287,000 in 1965.

This total reduction in institutionalized patients over the past 10 years is roughly equivalent to the combined mental hospital populations of 19 states: Alabama, Arizona, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho,

REDUCTION IN STATE HOSPITAL POPULATION EQUIVALENT TO THE COMBINED MENTAL HOSPITAL POPULATION OF 19 STATES



Kansas, Kentucky, Maine, Mississippi, Missouri, North and South Dakota, Minnesota, Vermont, and Washington.

2. This dramatic reduction in hospitalized patients has resulted in enormous savings to the states. In the decade following the close of World War II, the over-all rise in number of patients in our state mental hospitals averaged 13,000 a year. If this trend had continued during the past 10 years, the states would have been forced to construct 130,000 additional beds. Instead of an increase, this reduction of 83,000 patients resulted in an aggregate saving of approximately 213,000 beds over the 10-year period. (32)

   Figured at the estimated cost of $20,000 a bed, this is a saving of $4.3 billion in construction costs alone! (32)

3. This steady reduction in state mental hospital populations has been achieved in spite of the fact that each year since 1955 has witnessed a record increase in admissions to these hospitals. The following are the admission figures for the past 10 years: (13)

1955 - 178,003	1959 - 222,791	1963 - 283,591
1956 - 185,597	1960 - 234,791	1964 - 302,946
1957 - 194,497	1961 - 252,742	1965 - 314,443
1958 - 209,823	1962 - 269,854	

4. Of particular importance is the fact that an increasing number of states are sharing in these significant population reductions. In 1965, 40 states reported decreases, as against only 30 during 1959. (13)

PERCENTAGE DECLINE IN NUMBER OF PATIENTS RESIDING IN PUBLIC MENTAL HOSPITALS AT END OF YEAR EXCLUSIVE OF VETERANS ADMINISTRATION:

State	Number of Resident Patients 1955	1965	Decline 1955-65	Percent Decline
Iowa	5,374	2,222	3,152	58.6%
Utah	1,337	592	745	55.7%
Washington	7,361	3,851	3,510	47.6%
Colorado	5,786	3,138	2,648	45.8%
Arkansas	5,086	2,779	2,307	45.4%
Minnesota	11,449	6,592	4,857	42.4%
Oregon	4,886	2,845	2,041	41.7%
Kansas	4,420	2,622	1,798	40.7%
Idaho	1,221	740	481	39.4%
Kentucky	7,700	4,887	2,813	36.5%
Oklahoma	8,014	5,454	2,560	31.9%
Nebraska	4,826	3,398	1,428	29.5%
Massachusetts	23,302	17,253	6,049	25.9%
North Dakota	1,993	1,479	514	25.8%
Ohio	28,662	21,830	6,832	23.4%
North Carolina	12,125	9,335	2,790	23.0%
Louisiana	8,271	6,448	1,823	22.0%
Illinois	38,883	30,818	8,065	20.7%
Montana	1,919	1,518	401	20.4%
California	37,277	30,349	6,928	18.6%
New Hampshire	2,733	2,239	494	18.1%
District of Columbia	7,318	6,131	1,187	16.2%
Missouri	12,021	10,316	1,705	14.2%
Michigan	21,798	18,711	3,087	14.2%
New Jersey	22,262	19,428	2,834	12.7%
Pennsylvania	40,920	35,958	4,962	12.1%
Wisconsin	15,008	13,315	1,693	11.2%
Maryland	9,273	8,346	927	10.0%
West Virginia	5,619	5,060	559	9.9%
Rhode Island	3,442	3,114	328	9.5%
New York	96,729	87,661	9,068	9.4%
Connecticut	8,668	7,908	760	8.7%
Maine	2,996	2,768	228	7.6%

Vermont		1,294	1,207	87	6.7%
New Mexico		950	890	60	6.3%
Indiana		11,342	11,048	294	2.6%
Delaware		1,694	1,667	27	1.6%
Texas	(1959)	15,857	15,652	205	1.3%
Wyoming		655	648	7	1.1%
Arizona		1,690	1,684	6	less than 1%

PERCENTAGE INCREASE IN NUMBER OF PATIENTS RESIDING IN PUBLIC MENTAL HOSPITALS AT END OF YEAR, EXCLUSIVE OF VETERANS ADMINISTRATION:

	Number of Resident Patients			
State	1955	1965	Increase 1955-65	Percent Increase
Florida	8,026	9,992	1,966	24.5%
Nevada	440	523	83	18.9%
Alabama	7,197	7,691	494	6.9%
South Carolina	6,042	6,406	364	6.0%
South Dakota	1,603	1,648	45	2.8%
Virginia	11,303	11,544	241	2.1%
Mississippi	5,295	5,367	72	1.3%
Georgia	11,710	11,823	113	1.0%
Tennessee	7,730	7,767	37	less than 1%

Sources:
1955 Patients in Mental Institutions, Part II. Tables 1 & 2.
Provisional Patient Movement and Administrative Data, State and County Mental Hospitals United States 1965. Mental Health Statistics. Current Reports, January 1965. National Institute of Mental Health, Bethesda, Maryland.

5. In some of the states where more intensive application of the drugs has occurred, patient population reductions have far exceeded the national average.

6. A recent study reported in the Archives of General Psychiatry on the use of powerful tranquilizers to help acute schizophrenia patients quickly states the following: (32)

   a. The patients in the study were young schizophrenics averaging 28 years of age, usually suffering either their first psychotic breakdown or their first hospitalization. All were judged markedly ill.

   b. In six weeks 95% of the patients on the drugs improved. The improvement in 75% of the cases was classified "marked to moderate improvement."

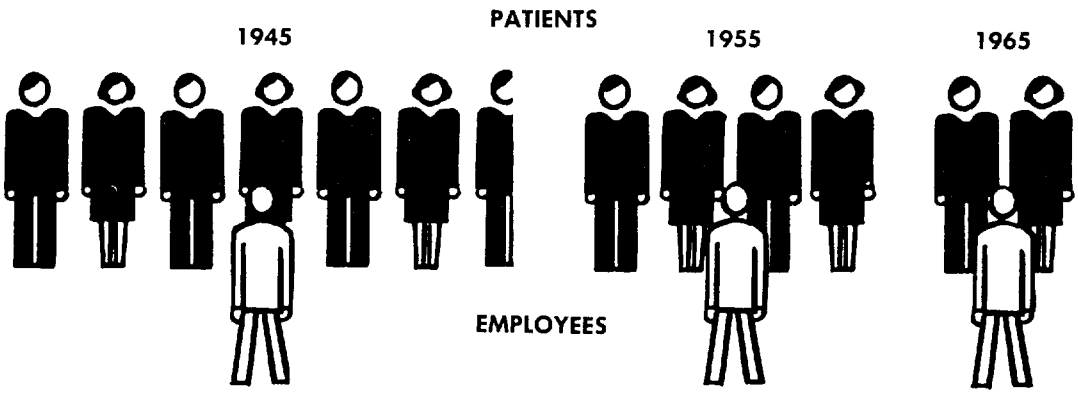
XXII. WHAT HAS CAUSED THIS REDUCTION IN THE NUMBER OF RESIDENT PATIENTS IN OUR STATE MENTAL HOSPITALS?

1. Extensive statistical documentation shows that increased state legislative appropriations to provide intensive treatment with tranquilizing drugs, and anti-depressant drugs, and more medical personnel to provide treatment, have now begun to pay off in dramatic fashion, and have finally achieved the cumulative force needed to reverse the seemingly inevitable annual rise in mental hospital populations:

   a. In 1945, the average daily expenditure on each resident mental patient was $1.06, ten years later (1955) it had risen slowly to

$3.06 per day. In 1965, this had risen to $6.74, more than six times the 1945 figure and a considerable increase even when the rising cost of living is taken into account, (13) although by any hospital standard a per diem expenditure of $6.74 is grossly inadequate.

b. In 1945, there was one full-time employee for every 6.8 patients in mental hospitals - an impossibly low treatment personnel-to-patient ratio. A decade later, considerable improvement was achieved when the ratio rose to approximately one employee for for every four patients (146,392 full-time employees for 558,922 patients). (7)



By 1965, a ratio of almost one full-time employee for every 2 patients was achieved (230,564 full-time employees for 475,761 patients). The biggest yearly jump occurred in 1965, when 31,000 employees were added to the staffs of state mental hospitals. Much of this significant increase in 1965 reflects the impact of the Nat'l Institute of Mental Health's Hospital Improvement Grant program - over the past 3 years,

$36 million has been awarded to mental institutions to improve their treatment potential; 80% of the funds awarded in this exciting program are being used to employ additional and new kinds of psychiatric personnel. (7)

c. However, the personnel shortage in state mental hospitals is still critical. For example, 25% of budgeted positions for staff psychiatrists remain unfilled. Many of the filled positions are held by foreign doctors - in a number of states, as high as 50% of the total physician complement is made up of foreign-born doctors.

According to a recent survey published by the Nat'l Institute of Mental Health, 21 state hospitals are without a single psychiatrist, and 91 state hospitals have only one to four psychiatrists. (8)

d. In spite of the tremendous shortages which still exist, there have been the following increases in psychiatric personnel during the past decade, largely the result of increased salaries and a great expansion of budgeted positions. They are probably the most significant evidence of how many state legislatures have given to the state mental hospitals the increased treatment potential needed to step up discharge rates: (12) (14)

Superintendents & Physicians (including psychiatrists, residents and interns)

1945 - 1,458 1963 - 5,214

Psychologists & psychometrists

1945 - 69 1963 - 1,161

Social Workers

1945 - 410 1963 - 2,659

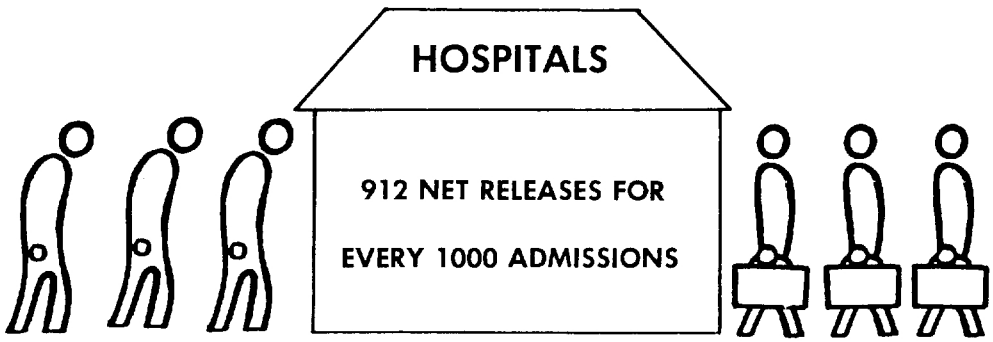
Graduate Nurses

1945 - 2,583 1963 - 10,644

Other Nurses & Attendants

1945 - 33,147 1963 - 103,109

2. All of the foregoing factors led to a steady rise in discharge rates--a rise so gradual that it was frequently obscured by the increasing flood of admissions. In 1945, the net release rate per 1,000 average resident patients was only 153; in 1965, it had almost quadrupled to a level of 592 patients discharged for every thousand still resident in the hospital. (12) (13)



An even more significant barometer of progress is the ratio of net releases to the total number of hospital admissions. In 1965, this soared to the record level of 912 net releases for every one thousand admissions. (12) (13)

XXIII. WHAT NEW LEGISLATIVE DEVELOPMENTS HOLD OUT PROMISE FOR A FURTHER REDUCTION IN OUR STATE MENTAL HOSPITAL POPULATIONS?

1. In October, 1963, the Congress passed the landmark Community Mental Health and Mental Retardation Centers bill (P. L. 88-164.) This bill provides $150 million through 1967 in federal matching money to the states for the construction, expansion or remodeling of community centers for the mentally ill. (20)

   In order to qualify for this matching federal aid, each state is required to submit a construction plan describing its comprehensive blueprint for the location and priority assignment of all mental health centers in the state. Despite the extraordinary difficulty of this task, and the fact that Congress did not vote the first monies for the centers until the fall of 1964, the states responded so enthusiastically that as of July 15, 1966, federal matching grants totalling close to $60 million were awarded for the construction and/or staffing of 128 new community mental health centers in 42 states, Puerto Rico and the District of Columbia.

   As a result of this first year funding, mental health services will soon be available to approximately 22 million Americans in their home communities. Assuming that states and communities apply with the same enthusiasm for the matching funds that will be available during the remaining period of the present authorization, the National Institute of Mental Health estimates that over a third of the nation's 200 million people will have access to community mental

health center services by 1970.

2. In order to strengthen the state and local capability in supporting these centers, the Congress last year amended the basic 1963 act by providing a seven-year authorization of approximately $224 million in federal matching monies in support of the personnel and other operating costs of the centers. The federal staffing grant for any one center may not exceed 51 months, and it drops from 75 percent of total operating costs during the first 15 months to 30 percent during the last year. (23)
3. Because of the enthusiastic acceptance of the new program, combined with a widespread feeling among public officials that the unprecedented citizen demand for these centers would soon exceed available monies, the 1965 National Governors' Conference unanimously passed a resolution requesting the Council of State Governments to convene a conference "for a thorough consideration of the future role of each level of government in multiple-source financing of community mental health programs."

At the three-day conference, held in Chicago in December, 1965 and co-chaired by Governor Otto Kerner of Illinois and Senator A. M. Spradling of Missouri, scores of state legislators and county commissioners hammered home the point that the federal contribution to community mental health services, even with the inclusion of the 1963 and 1965 legislation, fell far below that made by most states and many local communities. Arguing for a renewal and broad expansion of the Community Mental Health Centers Act of

1963, the major resolution of the conference -- unanimously adopted by the delegates -- stated:

"Of the total annual public mental health expenditures of $2 billion in this country, only $115 million, less than four percent, is available for ongoing local community mental health services. The share of the Federal Government in this funding is less than ten percent . . . It is therefore imperative that the Federal Government, which receives the largest share of the tax dollar from our people, provide critically needed additional seed money for these programs.

"It is the consensus of the conference that the national goal of 2,000 new community mental health centers to be established by 1975, as envisioned by the landmark 1963 and 1965 Federal legislation, will not be realized without expanded Federal, State and local support."

XXIV. CAN THE AMERICAN PEOPLE AFFORD ADDITIONAL EXPENDITURES FOR MENTAL HEALTH SERVICES?

1. Proponents of additional appropriations for mental health services are frequently told that state taxes have reached a confiscatory level, and that the individual citizen is "groaning under a tax

burden which he is increasingly unable to handle."

What are the facts? How much of our personal income do we spend on state taxes?

In 1963 we spent, measured in constant dollars, 4% of our personal incomes for state taxes as against 3.7% in 1948. In other words, in a period of 15 years there was a rise of only three tenths of one percent in the portion of our individual incomes which went to state government in the form of taxes. (50)

In 1964, total general state expenditures -- including federal grants and other sources of revenue -- averaged out to $195.47 per person, as compared to $115.37 in 1956. But per capita personal income increased at a record rate in that same span of time -- from $1,767 in 1956 to $2,550 in 1964. (50)

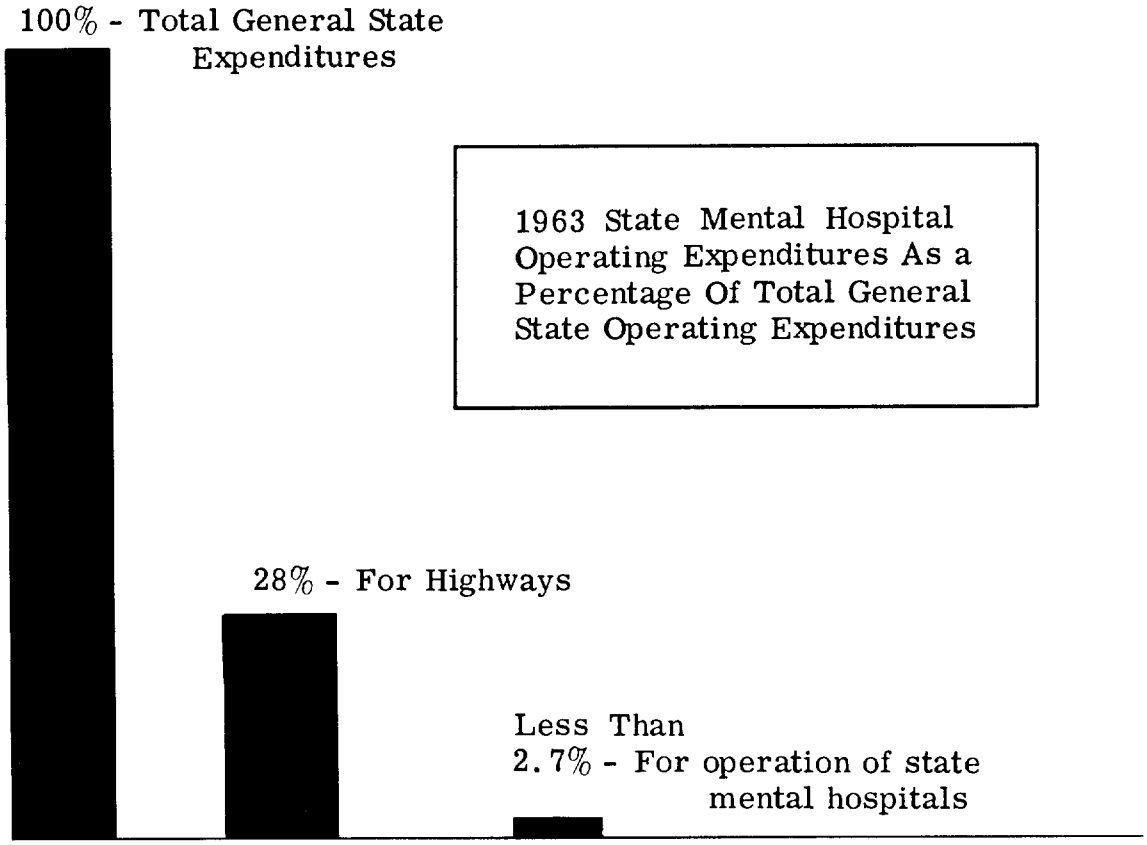
2. How about state mental hospital operating expenditures as a percentage of total general state expenditures?

Only 2.7% of general state funds went to mental hospitals in 1964, a significant drop from three and a third percent which was budgeted for these facilities in 1956. (50)

Is this a fair proportion of state expenditures? By way of contrast, state governments in 1963 devoted 28% of their funds to highways. (50)

In that year, as a nation, we spent $10 billion for highways. (50) Furthermore, the Department of Commerce recently estimated that the accelerated national highway program inaugurated in 1957

would, upon completion in 1972, cost the American people $55 billion.



When we consider the needs created by the explosive rise in our population, -- a record growth of 50 million people in the last 16 years, -- added to an unprecedented, sustained rise in individual income, we cannot but conclude that the so-called heavy burden of increased taxes for public services is an undocumented myth.

3. What about federal, state and local expenditures for community mental health services?

In 1955 -- before the big push for community services -- the per capita expenditure for clinics and other community facilities was only nine cents per year. In 1964, it had increased appreciably to 59 cents per person per year -- hardly an excessive drain on the solvency of the individual taxpayer. Furthermore, in 1965, less than four percent of the $2 billion spent by all levels of government for mental health expenditures was budgeted for community mental health services. (50)

XXV. WHAT ARE WE SPENDING OUR MONEY ON THESE DAYS?

In 1964, we spent for:

Recreation - $22.7 billion (11)

Alcoholic Beverages - $12.6 billion (31)

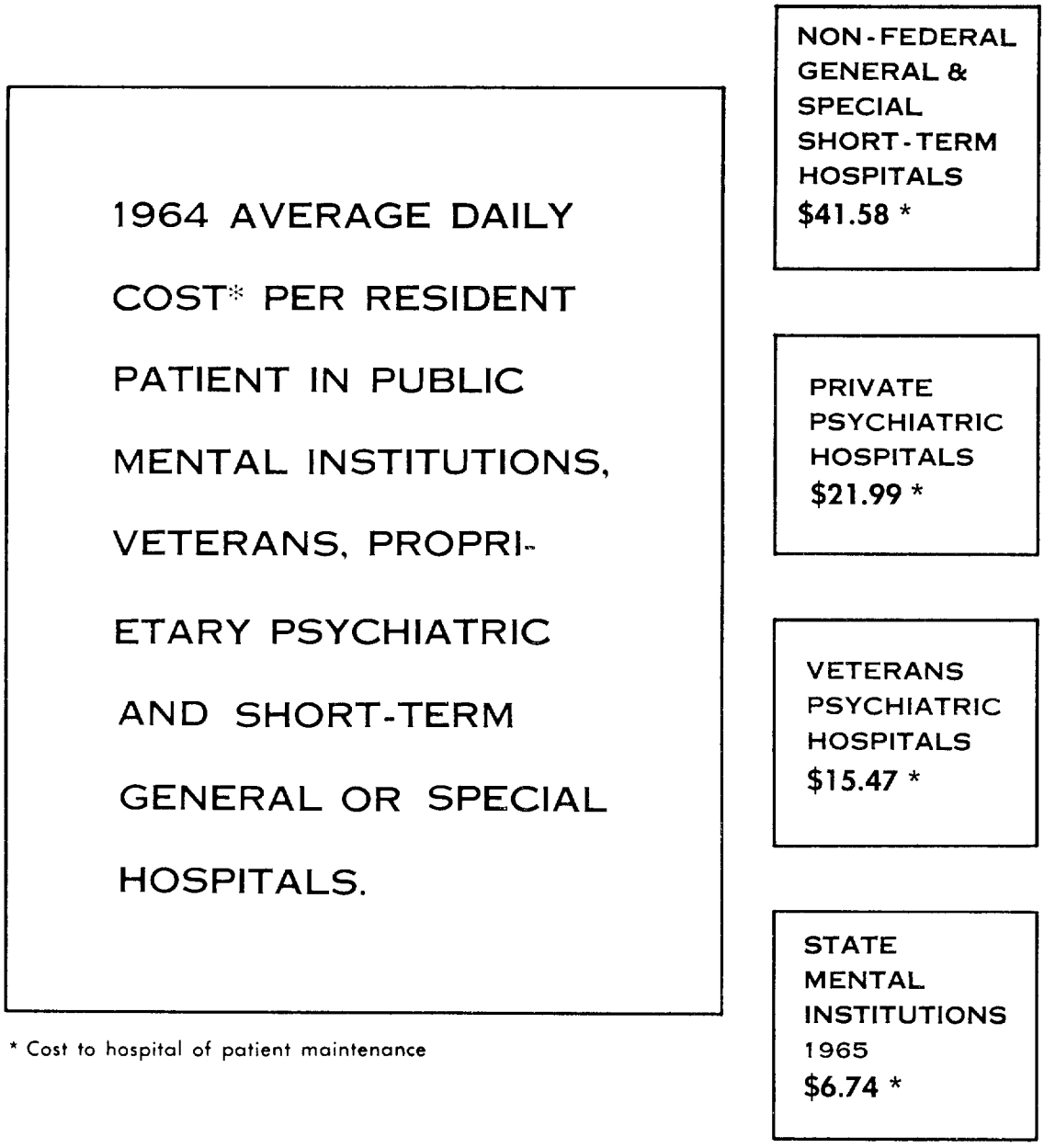
Tobacco Products - $7 billion (31)

Foreign travel and remittances - $3.5 billion (11)

We also managed in that same affluent year to spend $359 million for chewing gum! (31) This compares with a total of approximately $141.7 million spent by all sources -- federal, state and local governments, voluntary health organizations and private foundations -- for psychiatric research to get Americans out of state mental hospitals which are mostly "human warehouses". (51)

XXVI. WHAT ROLE WILL THE PSYCHIATRIC UNIT IN THE GENERAL HOSPITAL PLAY IN THE EXPANSION OF EARLY, INTENSIVE TREATMENT SERVICES DURING THE YEARS AHEAD?

1. Over the past few years, the general hospital has assumed a tremendously increased role in the care of mental patients. A



recently completed nationwide survey reveals that general hospitals treated and discharged almost 600,000 psychiatric patients in the 12-month reporting period ending in April, 1965. This represents a 40 percent increase in psychiatric services rendered by general hospitals during the past decade. The survey also highlights the fact that the public mental hospital is no longer the major locus for in-patient treatment of mental illness -- in 1965, general hospitals discharged more than twice as many mental patients as did state and county mental hospitals. (26)

2. There are 3,183 general hospitals that now admit psychiatric patients. Of this total, 1,046 either have separate psychiatric units or regularly and routinely treat psychiatric patients on the general wards of the hospital. The other 2,137 hospitals admit mentally ill patients on an emergency basis for diagnosis, treatment or for retention pending admission to other facilities. (26)

3. The 467 general hospitals which maintain separate psychiatric units are by far the most active in terms of patients treated. In the 1964-65 reporting year, they accounted for 54 percent of all discharges from general hospitals (321,144) and for 81 percent of all psychotic discharges (72,079). (26)

4. Under the impetus of the 1963 and 1965 Community Mental Health Center legislation, the general hospital of the future will become an even more important community resource. More than 50 per-

cent of the new community mental health centers being constructed with federal aid have a general hospital psychiatric unit as the key facility.

5. The average length of stay of a patient in the psychiatric unit of a general hospital varies from 23 to 33 days in such representative cities as Sacramento, Louisville, Hartford, Ann Arbor, Philadelphia, Chicago, New York, Dallas and Washington, D.C. (24)

   In Illinois, the average stay in psychiatric units in general hospitals is 16 days. Although the per diem cost of some of these units has run as high as $35 per patient, the total cost per patient has been approximately 50% of the total cost per patient treated in the state mental hospitals in Illinois. (24)

6. A number of states and cities are subsidizing psychiatric beds in general hospitals for patients unable to afford them. Since 1960, Georgia has supported psychiatric units in general hospitals in its major cities. Although the daily cost to the state has been high -- $30 to $35 - the approximate cost per patient treated has been only about $1,000, considerably less than the cost of long-term treatment in the 12,000 bed state hospital at Milledgeville. (32)

   More than half of the states which have passed Community Mental Health Services laws over the past decade, providing state and local matching monies for these services, use a percentage

of the funds for the support of psychiatric beds in general hospitals. (32)

7. Part-time hospitalization through the use of either day or night hospitals has increased remarkably over the past decade. 175 day-night hospital programs in operation in all parts of the land. (26)

XXVII. WHAT ARE WE DOING TO INCREASE THE PSYCHIATRIC SKILLS OF THE GENERAL PRACTITIONER AND THE NON-PSYCHIATRIC SPECIALIST?

1. In 1958, Congress allocated the first monies for a national program devoted to training the general practitioner in psychiatric skills. The program was divided into two parts: (34)
   a. Provision of stipends at a level sufficient to permit non-psychiatric physicians to give up their practice and undertake three years of residency training with the objective of becoming full-time psychiatrists.

      In fiscal 1959, the first year of the program, 94 non-psychiatric physicians were enrolled in this program. In the current year, 676 physicians are in residency training programs leading to certification as psychiatrists.

      Since the inception of the program, 800 fully qualified psychia-

trists have been added to the manpower pool. They are serving in many facilities which have been critically short of psychiatrists for years; for example, a significant percentage are directing mental health clinics which now, for the first time, have acquired psychiatric leadership for their programs. However, this number is still inadequate for the needs.

b. Grants to institutions qualified to offer postgraduate courses designed to enable the general practitioner, internist, pediatrician or other non-psychiatric specialist to function more effectively in a therapeutic, referral or preventive role in dealing with problems of mental illness.

Since the inauguration of this program, close to 10,000 physicians have been reached in formal courses, and many additional thousands have attended refresher courses sponsored by local and state medical societies and by university medical centers. Physicians taking these postgraduate courses receive no stipend whatsoever for the period of training -- the individual grants cover only the faculty costs of the training institutions. Physicians enrolled in these programs range in age from 23 years to 93 years, with a median age of 46.

2. In fiscal year 1961, a third type of training was offered under this program. Intensive, full-time psychiatric training for periods of not less than six months nor more than one year was offered to non-psychiatric physicians, residents and interns who intend to

practice, or continue practicing, in a field other than psychiatry. In the first five years of this program, 242 special residency stipends were awarded for training at 55 different institutions. (34)

3. In the eight years since the activation of the General Practioner Training Program, (fiscal 1959 through 1966) the Congress has appropriated $51 million for the three basic training programs. For the fiscal year beginning July 1, 1966, President Johnson has recommended $11 million for a continuation of this highly successful effort. (34)

4. In addition to the federal program, many of the country's leading medical organizations are intensifying their activities in training the general practitioner in psychiatric skills.

   Since 1957, the American Psychiatric Association has had a full-time psychiatrist heading its General Practitioner Education Project. The APA, in conjunction with the Western Interstate Commission on Higher Education, The Southern Regional Education Board and a number of national medical organizations, has sponsored a series of regional seminars for general practitioners.

   In addition, the director of its GP project travels across the country each year speaking to many state and local medical associations and academies of general practice. The APA also publishes a newsletter covering developments in this field. (37)

   The American Academy of General Practice gives official credit to those of its members who take approved postgraduate courses in psychiatry. (37)

As a result of all of these efforts, more postgraduate courses are now offered in psychiatry than in any other medical specialty. The August 11, 1965 issue of "The Journal of the American Medical Association" noted that 253 formal postgraduate courses in psychiatry were conducted in 1965, as against 114 only three years ago.

XXVIII. WHAT ARE THE STATES AND LOCALITIES SPENDING ON COMMUNITY MENTAL HEALTH SERVICES?

1. In 1965, state and local governments spent approximately $115 million for community mental health services. (4)

   This compares with $6 million spent by state and local governments for these services in 1952, and $37 million in 1959.

2. As of December, 1965 twenty-six states had enacted legislation which provides matching money on a formula basis to local governments for the provision of community mental health services. (4) These twenty-six states are:

California (1957)	Michigan (1963)	Oregon (1961)
Colorado (1963	Minnesota (1957)	Rhode Island (1962)
Connecticut (1955)	Nevada (1965)	South Carolina (1961)
Idaho (1965)	New Hampshire (1965)	Texas (1965)
Illinois (1961)	New Jersey (1957)	Utah (1961)
Indiana (1955)	New York (1954)	Vermont (1957)
Kentucky (1964)	North Carolina (1963)	Wisconsin (1959)
Louisiana (1964)	North Dakota (1965)	Wyoming (1961)
Maine (1959)		
Maryland (1966)		

3. The typical state matching provision is 50 percent of eligible expenditures, but several states have moved up to 75 percent matching for augmented services or for areas with low incomes. Only seven states have per capita limitations (50 cents per capita is typical) on state expenditures. (4)

   Typical eligible expenditures include operating costs for out-patient, consultation, prevention, information and education and rehabilitation services, with at least ten states also sharing in the support of in-patient services in general hospitals. (4)

   Heretofore, the Acts have usually specifically excluded capital outlay as an eligible expenditure. However, following the passage of the federal Community Mental Health Centers Act in 1963, several states have begun to reconsider this item. For example, New York has already amended its program by authorizing State participation of one-third the total cost of community mental health facility construction. (4)

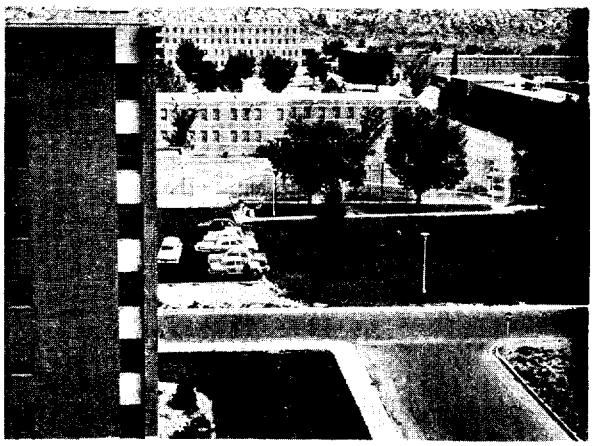
4. Even before the enactment of the federal legislation, a number of states had pioneered in the opening of comprehensive centers designed to provide early, intensive treatment on a flexible basis.
   a. As a result of the passage of a bond issue in 1961, Illinois will eventually have six small regional centers covering designated mental health zones in various parts of the state. All of the centers will have inpatient facilities in addition to a host of additional community services.

b. In 1962, Colorado opened a 125-bed comprehensive mental health center near Denver. During the past two years, it has added separate geriatric and children's units. The Fort Logan Center provides day and night hospitalization, outpatient services, a half-way house and psychiatric home-treatment teams which work out of regional clinics set up in the city of Denver. (6)

Although it takes patients from a population area of close to a million people, it hospitalizes only a small proportion of those it screens. For example, as of July 31, 1963, there were 399 patients in its Psychiatric Division, distributed as follows: (6)

24-hour	69	Halfway House	6
Day Hospital . .	173	Follow-up	93
Night Hospital. .	20	Family Care.	38

The scale of fees at the Fort Logan Mental Health Center indicates how considerable the savings can be through a reduction in



The State Hospital at Pueblo, Colorado.

The Fort Logan Mental Health Center near Denver.

expensive, 24-hours hospitalization. For example, the average cost per day for inpatient care is about $20. For day patient care, it is only $8, and for outpatient follow-up care it is $8 per week. (6)

c. The Massachusetts Mental Health Center in Boston, the oldest community mental health center in the country, has approximately 150 beds. With a full-time staff of 14 psychiatrists, plus 59 psychiatric residents and a number of Harvard medical students on rotation, it handles 4,000 patients a year. It operates a 24-hour hospital, day and night hospitals, and an emergency walk-in clinic which alone handled more than 2,000 patients in 1963. (32)

d. The Boston State Hospital operates a home-treatment service for the Dorchester area, which has 180,000 residents. Working out of the state hospital, the psychiatric team collaborates closely with family physicians in visiting homes and preventing hospitalization. The Boston State Hospital also runs five day-hospitals and a half-way house for patients about to be discharged to the community. (32)

XXIX. WHAT PERCENTAGE OF THE STATES' MENTAL HEALTH BUDGETS IS BEING DEVOTED TO RESEARCH IN MENTAL ILLNESS?

While the States were spending in 1965 over $1 billion 201 million in total maintenance expenditures for patients in public non-federal mental hospitals (13), they were spending only about 1.9% of this amount for research in mental illness.

XXX. HOW MUCH DOES THE COUNCIL OF STATE GOVERNMENTS RECOMMEND THE STATES SHOULD SPEND FOR RESEARCH & TRAINING?

1. It was the general consensus of the National Governors' Conference on Mental Health held in Detroit, Michigan, in February 1954, that 10% of each state's mental health budget should be allocated for research and training.
2. The average percentage of the States' total mental health budget which the state mental health officials feel should be devoted to research is 4% - some even suggest 7%. (40)

XXXI. DO THE PATIENTS IN STATE MENTAL HOSPITALS RECEIVE ADEQUATE CARE?

1. NO. In 1965, the maintenance expenditure in public non-federal mental hospitals in the United States per resident patient was only $2,461.05 per year (13), or $6.74 per day. In the same year, Alaska was high with $23.02 per day. Mississippi was low with only about $3.18 per day. (13)

a. In contrast, the average expense per patient day in Veterans Administration psychiatric hospitals was $15.47 in 1964, and the total expenses per patient day in proprietary mental hospitals was $21.99 in the same year. (10)

b. In 1964, the expenses per patient day in non-federal short-term general and other special hospitals in the United States, where

research and surgery have brought new treatments and cure for patients, were $41.58. (10) This contrasts with $6.74 per day per capita maintenance expenditure in public mental hospitals in 1965. (13)

(a) The average length of stay in short-term general and special hospitals in 1964 was 7.6 days (10)

XXXII. WHAT ARE THE STANDARDS FOR CARE OF MENTAL PATIENTS?

1. The latest approved American Psychiatric Association minimum standards for care are: (41)

   a. For clinical psychologists: admission and intensive treatment service, 1 clinical psychologist to each 100 patients; continued treatment service, 1 - 500 patients.

   b. For physicians: admission and intensive treatment service, 1 physician to each 30 patients; continued treatment service, 1 - 150 patients; geriatric service, 1 - 150 patients.

   c. For registered nurses: admission and intensive treatment service, 1 registered nurse to each 5 patients; continued treatment service, 1 - 40 patients; geriatric service, 1 - 20 patients.

   d. For attendants: admission and intensive treatment service, 1 attendant to each 4 patients; continued treatment service, 1 - 6 patients; geriatric service, 1 - 4 patients. ("Attendants" means practical nurses, barbers, beauticians, domestics, orderlies, janitors and mess attendants.)

XXXIII. WHAT ARE THE ACTUAL CONDITIONS OF CARE IN MENTAL HOSPITALS COMPARED WITH APPROVED STANDARDS?

1. The actual average ratio in state mental hospitals in 1964 was one physician for each 103 patients; one professional staff member (includes physicians, psychologists, psychometrists, psychiatric and other social workers, registered nurses, occupational and other therapists) for each 20 patients; and one full-time employee (includes attendants, maintenance employees, kitchen employees as well as medical record librarians, teachers, business office employees, dentists) for each 3 patients. (50)

XXXIV. HOW MANY DOCTORS AND OTHER MEDICAL PERSONNEL SPECIALIZE IN THE CARE OF MENTAL PATIENTS?

1. In 1965 there were approximately 14,200 psychiatrists in the United States who were members of the American Psychiatric Association. Of these, about 600 (4%) are administrators, superintendents or commissioners (some of these undoubtedly practice part time). (44)

2. In 1965, there were 8,468 diplomates of the American Board of Psychiatry and Neurology. Of these: (45)

   6,802 were certified in psychiatry only
   674 were certified in neurology only
   992 were certified in psychiatry and neurology both
   8,468

3. There were approximately 10,644 graduate nurses employed full-

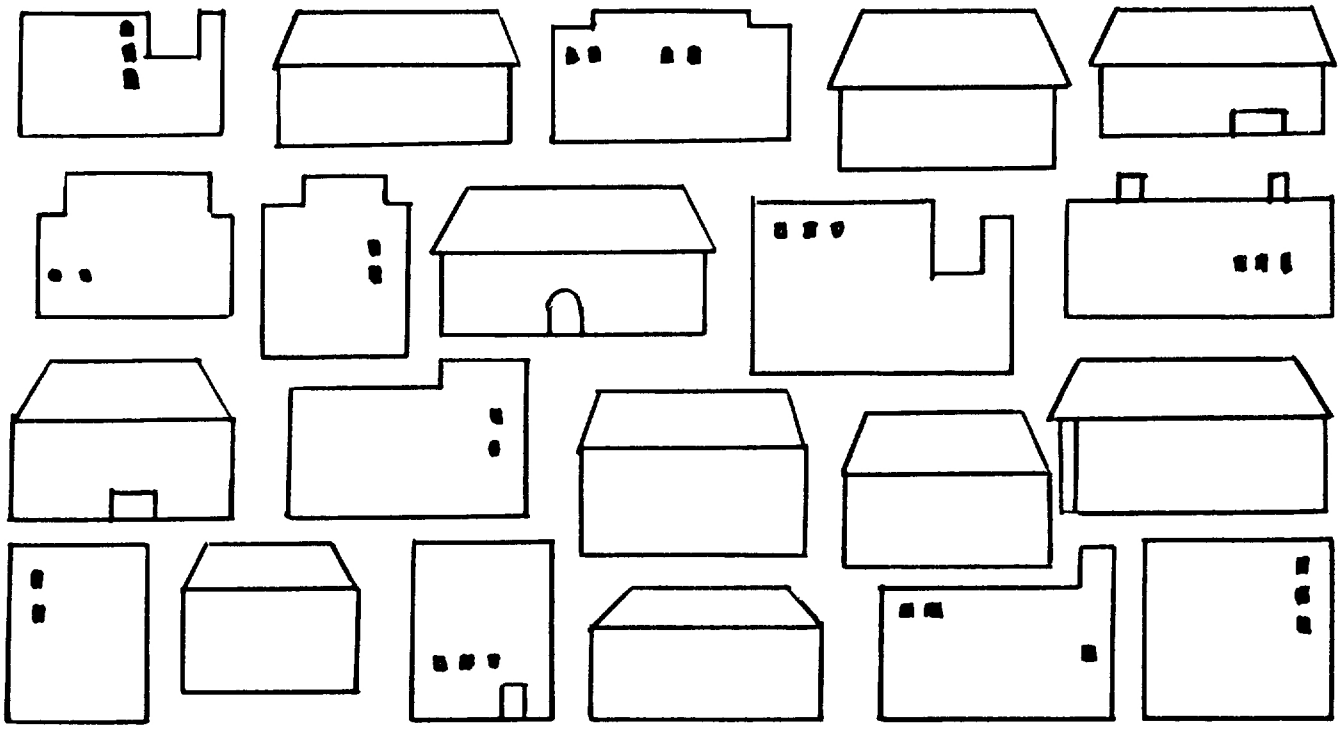
time in public mental hospitals in the United States in 1963 (14); 103,109 other nurses and attendants (14). An estimated 7,500 social workers were employed in mental health hospitals, clinics and institutions in 1963 (46); however, only 2,048 were employed full-time in public mental hospitals (14)

4. There were 1,734 members of the American Psychological Association who are diplomates of the American Board of Examiners in Professional Psychology in 1965. This is the highest rating obtainable in psychology, and the number includes persons who have specialized in clinical, counseling, or industrial psychology. The 1965 membership of the American Psychological Association is 23,561; anticipated 1966 membership, roughly 24,500. (47)

XXXV. WHAT ARE THE SHORTAGES IN PSYCHIATRIC PERSONNEL?

1. It is conservatively estimated that we need an additional 10,000 psychiatrists to fill present and projected positions in state mental hospitals, general hospitals, clinics and community mental health centers. (17)
   a. About one in every four budgeted positions for staff psychiatrists is unfilled in Veterans Administration hospitals and in state hospitals for the mentally ill and the mentally retarded. (33)
   b. According to a recent survey published by the National Institute of Mental Health, 21 state hospitals are without a single

21 STATE HOSPITALS WITHOUT A SINGLE PSYCHIATRIST



psychiatrist, and 91 state hospitals have only one to four psychiatrists. (35)

c. Many of the filled positions are held by foreign born physicians. Nationally, approximately 40 percent of the psychiatrists and psychiatric residents working in state hospitals come from other countries and, in a number of states, more than half of the total psychiatric complement is made up of foreign born physicians. (35)

2. The shortage of clinical psychologists is equally grave. The most recent figures provided by the American Psychological Association Placement Office show that, in 1963, there were seven positions offered for every three applicants. (36)

3. One out of every four budgeted positions for professional registered

nurses in state mental hospitals and institutions for the mentally retarded was unfilled as of September 30, 1963. (38)

4. The ratio of mental health professionals to patients in state mental hospitals in 1964 falls far below the minimum personnel standards recommended by the American Psychiatric Association, as illustrated in the following table: (39)

No.		Ratio: Average Daily Resident Pts.	Pts. under Treatment	American Psychiatric Association Recommended Minimum Standards: Admission & Intensive Treatment Service	Continued Treatment Service	Geriatric Service
4096	All physicians including psychiatrists	110:1	180:1	30:1	150:1	150:1
1086	Psychologists and Psychometrists	416:1	678:1	100:1 (The APA Standards relate only to clinical psychologists)	500:1	(None)
10,089	Registered Nurses	45:1	73:1	5:1	40:1	20:1
1787	Psychiatric social workers	253:1	412:1	APA standards state: "One to 80 new admissions per year. One to 60 patients on convalescent status or on family care. One supervisor to every 5 case workers."		

XXXVI. ARE WE MAKING ANY HEADWAY IN REDUCING SHORTAGES OF PSYCHIATRIC PERSONNEL? YES!

1. In 1965, the number of psychiatrists, psychologists, social workers

and psychiatric nurses working in the field of mental health totaled about 65,000 as compared to 23,000 only fifteen years ago. (36)

2. The National Institute of Mental Health has played the major role in this dramatic expansion of psychiatric personnel. From 1948 to 1965, the annual number of NIMH training stipends rose from 219 to over 9,000. In this span of time, the Institute provided training for approximately 30,000 individuals in the four core disciplines in the mental health field. (36)

3. In 1963, approximately 11% of all medical specialty residencies were in the field of psychiatry, as against only 6% in 1950. Furthermore, psychiatrists in 1963 comprised 7% of all medical specialists, as against 3% of all medical specialists in 1953. (42)

4. Despite these remarkable increases, the burgeoning demand for mental health services has required personnel in the mental health field to divide their working hours among a number of facilities. For example, a 1963 survey covering outpatient clinics, public and private hospitals for the mentally ill and public and private institutions for the retarded noted that 30% of the psychiatrists and 16% of the psychologists were providing services in more than one institution. Even more striking were the number of professionals in outpatient clinics who had multiple employment – 46% of the psychiatrists, 23% of the psychologists, 22% of the nurses and 13% of the social workers. (43)

5. It is estimated we will need between 120,000 and 125,000 professionals in the four core disciplines by 1975 to overcome existing shortages and to meet anticipated demands generated by the new community mental health centers, the Medicare legislation, expanded psychiatric benefits for workers achieved through the bargaining process, the rapid growth of psychiatric units in general hospitals, etc. (36)

An adolescent patient is interviewed at the Philadelphia Psychiatric Center.

XXXVII. ARE WE MAKING PROGRESS TOWARD FULLER HEALTH INSURANCE COVERAGE OF MENTAL ILLNESS?

1. Under increasing pressure from subscribers, from public officials at the federal and state level, and from labor's increasing militancy at the bargaining table, the commercial insurance companies and Blue Cross-Blue Shield are slowly increasing their coverage of mental illness.

However, a comprehensive 1965 Blue Cross Association study of the economic aspects of mental illness, while noting appreciable improvement in coverage of psychiatric illness by its member

plans, is frank to admit that insurance benefits for mental illness are still far more limited than for physical illness. Quoting from the Blue Cross report:

> "Restrictions on these benefits are common and among those covered for mental illness the proportion with full coverage (the same benefits as any other illness) was somewhat less than one-third of those covered."

2. The commercial and non-profit insurance companies, while more willing to cover full, 24-hour hospitalization of mental patients, are quite resistant to efforts to get them to cover partial hospitalization and out-patient treatment in community facilities and in the doctors' office. (6)

The 24-hour bed is no longer a venerated receptacle for the mental patient. In fact, there is an increasing recognition that continuous hospitalization is frequently an anti-treatment device, making it all the more difficult for the mental patient to resume his duties in society. (6)

Day hospital coverage is much more economical for the insurance companies. For example, in January of 1964, Colorado Blue Cross began covering 30 days of day hospital care at the Colorado General Hospital. Figures on the first year of coverage show an average treatment period of 12 days, at a cost of $18 per day. This day care cost compares with $34 per day for 24-hour hospital treatment at Colorado General. At the Fort Logan Mental Health Center in Denver – a public facility – inpatient care is $20 per day, while day hospitalization is only $8 per day. (6)

3. The importance of adequate insurance coverage of mental illness, particularly for short term community-based care, was heavily stressed in President Kennedy's historic 1963 message on mental illness and mental retardation when he told the Congress:

> "Mental health services should be financed in the same way as other medical and hospital costs. At one time, this was not feasible in the case of mental illness, where prognosis almost invariably called for long and often permanent courses of treatment. But tranquilizers and new therapeutic methods now permit mental illness to be treated successfully within relatively short periods of time – weeks or months, rather than years."

President Kennedy directed the Department of Health, Education and Welfare to set up a task force on insurance to meet with the major carriers and develop a minimum set of standards for psychiatric insurance. Late in 1964, the Task Force on Insurance released a set of principles designed to promote broader coverage of mental illness. The major principles are:

a. Emphasis should be placed on early referral and short-term intensive therapy. With regard to out-patient benefits, this would indicate low deductible features and low co-insurance to encourage early care.

b. In-hospital benefits should be increased and partial hospitalization should be included in all benefits. Included within the definition of "allowable hospital expenses" should be those incurred within day and night hospital programs.

c. Increased coverage should be given to all the professional skills essential to treatment and rehabilitation of the mentally ill –

not only psychiatrists and other doctors, but clinical psychologists, psychiatric social workers, psychiatric nurses, etc.

d. Comparable coverage should be provided for all accepted types of treatment. The objective should be continuity of care, so that the patient receives the most appropriate treatment at each stage of his illness. When deemed necessary, treatment visits by members of the patient's family (collateral visits) should be covered in addition to the patient's visits.

e. Prescribed drugs should be covered for ambulatory as well as for hospitalized patients. Drugs are a vital resource for the treatment of mental illness, whether the patient is ambulatory or hospitalized; moreover, drugs may be the very factor keeping some patients ambulatory instead of having to be hospitalized.

XXXVIII. WHAT ARE SOME OF THE BREAKTHROUGHS IN RECENT YEARS IN INCREASED COVERAGE OF PSYCHIATRIC ILLNESS? (48)

1. The Federal Employees Health Benefits Program, enacted by the Congress in 1959, covers more than two million federal employees and their four million family members for both basic psychiatric hospitalization and, under an optional major medical plan, for out-patient care including a limited number of visits to a private psychiatrist. A survey of the first three years experience with the plan reports one annual admission for psychiatric illness for every 500 members, and an average hospital stay of only 11 days per admission. This is much less than the admission rate for most other illnesses — for example, there are ten times as many admissions under the federal plan for respiratory diseases.

2. Retail Clerks Local 770 of Los Angeles has pioneered in providing psychiatric services for its members since 1960. The employers contribute two and a half cents an hour in fringe benefits for the psychiatric program. This generates about $600,000 a year and, for this amount of money, the Southern California Permanente Medical Group provides psychiatric hospitalization and unlimited out-patient care. Any clerk or his dependent can, in the course of a year, come in for any kind of program: a long, chronic problem, an educational program, a problem concerning the speech difficulty of a child, parent-child guidance, diagnostic evaluation, marital and pre-marital counselling - in other words, the whole

spectrum of psychiatric services as we know them today.

Only a small number of retail clerks – one for every thousand eligible members – is hospitalized; the median hospital stay is less than 20 days. Family therapy accounts for the bulk of the case load – at present, about 40 percent of the total service provided.

3. The biggest breakthrough in coverage of psychiatric illness for workers was the landmark United Auto Workers Contract of 1964, covering two and a half million workers and their dependents in 77 major American cities. The plan, which went into effect on September 1, 1966, not only provides generous inpatient benefits,

but it allows each worker $400 per year in out-patient benefits. Its emphasis upon out-patient treatment either in the doctor's office or in day hospitals, community mental health centers and clinics; its coverage of drugs dispensed by a hospital or community mental health facility; its use of group psychotherapy and family counselling, and its coverage of services, including psychological testing, provided by various members of the mental health team embody the most enlightened principles of progressive psychiatric coverage.

Furthermore, and this may be its most important contribution, it encourages the worker to seek treatment by providing the first five visits for therapy at no cost, and then slowly increasing the co-insurance contribution over the duration of the period of treatment. This is the obverse of most existing plans, which insist upon a high deductible and heavy early co-insurance to deter utilization.

Dr. Daniel Blain, President of the American Psychiatric Association, when the UAW contract was negotiated, and now an active participant in its implementation, recently hailed the UAW plan as establishing "a prototype which, if emulated in future bargaining contracts throughout American industry will, for the first time in history, make adequate psychiatric care available to millions of Americans who have been deprived of it."

XXXIX. HOW DOES THE 1965 MEDICARE LEGISLATION INCREASE BENEFITS FOR THOSE OVER 65 AND FOR MEDICAL INDIGENTS GENERALLY? (49)

1. Under the basic Social Security provision (Part A of Title 18), persons over 65 with a diagnosed mental illness are entitled to up to 90 days of care in a general hospital or community mental health center for each spell of illness, with the patient paying a $40 deductible for the first 60 days, plus $10 a day for the 61st and subsequent days. The mental patient is also entitled to up to 100 days of post-hospital extended care per duration of illness in a nursing home, or other facility which is not primarily for mental patients. He is also entitled to 100 home visits by health workers representing agencies not primarily engaged in the treatment of mental illness.

   If the patient is placed in a public or private institution solely engaged in the treatment of mental patients, there is a lifetime limit of 190 days on such coverage.

2. Under the voluntary section of the Medicare legislation (Part B of Title 18), the individual who elects to enter the plan pays $3 a month and the federal government matches this sum. Subject to a $50 deductible, the plan covers 80 percent of the patient's bill for physicians' services in and out of the hospital, home health services, drugs, diagnostic tests, etc. The only restriction on

psychiatric benefits relates to out-patient care – during any calendar year, the limit is $250 or 50 percent of the expenses, whichever is smaller.

3. Under the revised Kerr-Mills program, as outlined in Title 19 of the Medicare legislation, medical services are extended to include larger categories of the medically indigent (as opposed to aged on public assistance rolls); dependent children ; and relatives responsible for their care, under the Aid to Families of Dependent Children; the permanently and totally disabled, the blind, etc.

   With regard to mental illness, state plans which qualify for increased federal matching monies may include psychiatric in-patient services in a public or private mental institution for patients over 65 years of age, and in a general hospital for those patients who are under 65. After July 1, 1967, states planning to qualify for matching monies must provide a minimum medical assistance program also including outpatient hospital services, laboratory and X-ray services, skilled nursing home services and physicians' services regardless of where they are provided. On an optional basis, states may provide a broad range of additional services such as prescribed drugs, dental services, eyeglasses, etc.

4. Under another section of the Medicare legislation, covering public assistance recipients, federal funds to the states are authorized for the first time to share in meeting the costs of patients over 65 years

of age in mental institutions. This provision, which went into effect on January 1, 1966, will give the states an estimated $75 million a year in additional monies for the care of aged patients. However, in order to qualify for these funds, states must submit evidence that this additional money is being used for improved services.

Patients on public assistance under 65 years of age in general hospitals who have a diagnosis of mental illness are now eligible – again for the first time – for federal matching payments. However, states wishing to qualify for this additional federal money must submit plans, including provisions designed to insure the best possible care for each mental patient covered. The state plan must stress alternatives to institutional care, with particular emphasis upon the development of community mental health center treatment facilities for these individuals.

5. During the first year of implementation of the Medicare legislation, it is estimated that about $200 million in additional federal monies will be provided for better treatment of the mentally ill. This figure does not include the large sums which will go into the Health Insurance Trust Fund for coverage of psychiatric hospitalization under Part A of Title 18, nor does it include the additional state expenditures required as matching funds for expanded coverage of the medically indigent and recipients of public assistance who require psychiatric care.

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