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To Members of the Sixty-First Legislature:

During recent years a radical suggestion has been made in facing the problems of mental illness---the development of community centers. On the national scene no voice has had quite the authority or the respect given to Mike Gorman. To a large degree he has been a one man crusader who has brought revolution to the care and the treatment of the mentally ill for whom the individual states have had responsibility. Even as he struck the consciences of citizens in his crusade over twenty years ago against the "snake pits" (a name given to our mental institutions), today he speaks on behalf of the development of community centers where people can be treated humanely near home, and restored quickly to the framework of society.

His most recent speech before the Massachusetts Association of Mental Health which included the Governor and members of that Legislature should speak to us all as we consider the need to develop, to a broader degree, the community services within our own state. With the present appropriation of three and one half million dollars, we have made the first steps in the development of the program, but it will be needful during the next biennium for us to take the next step of increasing this appropriation to at least eight million dollars a year. In due time, if there is not too great a surge in our population, we should see our present institutions decrease in population. The monies that are appropriated stimulate both local and federal dollars being used in the program.

Your continued interest and support of the programs for the mentally ill and mentally retarded is deeply appreciated, and we stand ready to answer questions which might develop as this phase of our program unfolds.

Sincerely,

Robert S. Tate, Jr.
Chairman of the Budget Committee
Board of Mental Health and Mental Retardation

Enc. ("Comprehensive Community Mental Health Centers: Myth or Reality")

COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS: MYTH OR REALITY

Speech to

Sixth Legislative Dinner

Massachusetts Association for Mental Health

8 PM Tuesday, February 11, 1969

Sheraton Plaza Hotel, Boston, Mass.

by

MIKE GORMAN, Washington, D.C.

Executive Director
National Committee Against Mental Illness

Member
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Member
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Fellow
American Psychiatric Association (Hon.)

Fellow
American Public Health Association

Governor Sargent, Dr. Greenblatt,
Members of the Legislature, Guests:

When I received a letter inviting me to address this distinguished and by now institutionalized dinner convocation, it was also suggested that I participate in a panel earlier this afternoon on "Comprehensive Community Mental Health Centers: Myth or Reality". I was to join Dr. Greenblatt and his staff in fielding questions from the chairmen of the 37 area mental health boards "who are getting very frustrated about their role and about their feeling that the new community program is not getting anywhere".

I thought a good bit about the myth or reality issue. Going back into my rather bulky Massachusetts folder, I re-read your Community Mental Health Act which went into effect less than two years ago. If I were being unkind, I might point out that Massachusetts was just about the last of the major states to adopt such an act. Furthermore, I remembered conversations over the past year with some of your most dedicated professional and lay leaders who were becoming increasingly aware of the fact that it is one thing to pass a boldly-worded law, and quite another to bring its lofty concepts down to the working level. In other words, they were wondering why Massachusetts was lagging behind so many of its sister states in the financing of community mental health centers.

In recent months, as I have traveled about the country visiting a number of these community mental health centers, I have encountered a mixed bag of evaluations directed at the level of their performance. In the main, the patients, their families, local mental health associations and local officials are, for the most part, quite high on the centers. On the other hand, a fairly appreciable minority of professionals—particularly psychiatrists—is restive, threatened and ready to verbalize at a moment's notice about the failure of the centers to achieve what they regard as the "exaggerated" promises made for them. The more honest critics do not deny

that centers in various parts of the country have ended the practice of jailing mental patients by providing beds for these people until a medical determination is made; they do not deny that many very sick individuals, whose only previous recourse was the state mental hospital, are now being handled totally in the community. But in a rather peculiar but understandable way, they don't want to discuss the successes of the centers; they want to discuss the threat to private practice and the so-called superficial nature of some of the services rendered by these centers.

I was reminded of the penalties of success in reading a recent observation by President Nixon's Science Advisor, Dr. Lee A. DuBridge, appropriately entitled: "Can Success Be the Cause of Failure?". Dealing with the rather fierce criticism of higher education in this country, Dr. DuBridge writes:

> "One must inevitably conclude that the troubles of today are attributable not to the failures of our university system, but to its successes. It has brought higher education to 50 percent of our young people. Why not 100 percent? It has brought scholarly inquiry to bear on a host of areas of human concern. Why not on all?"

In an analogous manner, we are bringing a fairly good level of psychiatric care to thousands of people whom we did not reach before, but we are not reaching more than 10 percent of those who need help. We know this. We were mindful of the difficulties and obstacles when we drafted the community mental health center legislation. For our commitment is to the long pull—we hope, as we have stated many times, to have an adequate number of centers covering most of the United States by 1980.

But our critics cannot wait—they rush heroically into the breach to attack the infant for low scores on the full maturity scale; we are delighted with this opportunity to reply to them.

At the most recent Mental Hospital Institute of the American Psychiatric Association Dr. Lawrence Kolb, the current President of that organization, pulled together some of the hoary critical chestnuts about the community mental health center, and we are grateful to him for this second-hand research.

Dr. Kolb starts off his bill of particulars by complaining that there has not been a precise definition of a community mental health center. I won't go into the fact that there has not yet been a precise definition of schizophrenia, of the ideal state mental hospital, or of the American Psychiatric Association. I will only point out that to those of us who are forced by the nature of our work to maintain a reasonable contact with reality, the charge is most ironic. In the guidelines accompanying the 1963 legislation, the National Institute of Mental Health insisted upon a precise delineation of five mandatory services which all centers must provide. To say that we have had trouble with these guidelines is the understatement of the year. Governors, state legislators and, in many cases, state mental health commissioners have tried to cut corners on these five mandatory services; I am not at liberty to reveal the names of several Governors who called me and, after blasting the rigidly bureaucratic definition of services, asked me why they couldn't get an approved federal grant starting with just one service.

One of the virtues of the 1963 federal legislation is that it allows a considerable degree of flexibility beyond the provision of the five basic services—in-patient care, out-patient care, partial hospitalization, emergency psychiatric services and education and consultation to agencies in the community. As a result of much community planning, some centers are concentrating a considerable amount of effort on alcoholics; others are devoting a major portion of their time to emotionally ill children; still others are trying to develop strong after-care services, and so on.

I am shocked, not by the lack of a precise definition of a community mental health center,

but by those centers which have received federal grants but are not providing the five basic services required by law. In several states which I visited recently, the community mental health center is still a psychiatric unit in a general hospital. It provides the usual in-patient and out-patient services it did formerly; it has a token number of patients on partial hospitalization; it does not take emergency patients because "it has no room for them", and it has little or no connection with any community efforts in the field of mental health. I respectfully submit that these centers are failures—they are, at most, feeble extensions of the practice of private psychiatry. They are not reaching out to those in need—they are still treating the upper-income or middle-income neurotics who have the proper Blue Cross certification.

Then there is the old chestnut about shortages of mental health manpower. We obviously don't have enough to run the projected number of centers at an optimum level, so therefore we should pull back and adjust to the status quo.

I would remind Dr. Kolb that for almost two centuries the state mental hospital system operated at a level far below even minimal professional standards. More than 20 years ago, Albert Deutsch and I were turning out reams of newspaper stories, magazine articles, and an occasional book pointing up the shocking personnel deficiencies in the vast majority of our state mental hospitals. At that time, we received little encouragement from the leaders of the American Psychiatric Association.

Now we find Dr. Kolb shedding crocodile tears because he feels the mental health centers will compete with the state hospitals for psychiatric personnel. This is, to put it politely, unadulterated nonsense. For the most part, state hospitals still depend upon foreign trained physicians for anywhere from 30 percent to 100 percent of their medical staff. Here in Massachusetts you know what I am talking about; at Danvers State Hospital, for example, the entire medical staff consists of eight foreign doctors,

none of whom is a certified psychiatrist. The problem today is essentially what it was 20 years ago, or even 200 years ago; it was stated most clearly by your own distinguished Dr. Harry Solomon in his 1958 APA Presidential Address, when he observed that we can continue to build these state hospitals, but we cannot staff them. It is about time that we faced the fact that the young psychiatrist trained in the last decade or so will not immure himself in an isolated, custodial institution.

I think it most unfair that our critics do not do a better job of informing themselves as to the tremendous job we have done in this country in the training of new mental health manpower.

Over the past 15 years, the number of people with approved graduate training in the four core disciplines—psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing—jumped from 12,000 to 65,000. The National Institute of Mental Health has been the focal point in this remarkable development; in the first year of its operation it awarded 219 training stipends, whereas last year it awarded close to 10,000 stipends.

I admit to some irritation when I read statements to the effect that those of us who planned the community mental health center program gave little attention to the manpower needed to staff it. From the very first legislative drafting session, we tied the center concept and the acceleration of training of manpower closely together. When President Kennedy sent up his historic Mental Health Message of 1963, he also sent to the Congress a five-year projection pinpointing the increased training monies needed to staff the new centers. We achieved his manpower goal in the 1964 budget, but the tightening of domestic appropriations since that year has dropped us far below the original 1963 projections. Despite these recent shortcomings, I have no hesitation in stating that the growth in trained mental health manpower over the past 20 years is an achievement without parallel in the annals of American medicine.

How this psychiatric manpower is distributed is a legitimate area of concern, and the various professional organizations must face up to it. Dr. Kolb does not face up to it; he pushes the anxiety pedal when he says that: "Many see the trend toward directing psychiatric training to community needs as a threat to excellence in education." In other words, the "superb" training given psychiatric residents today will be diluted by teaching them to function in the milieu where the sickness resides and festers. There isn't time here to raise a number of questions about the narrow, parochial training of a great number of psychiatric residents; I might just point to a recent study by a joint committee of the American Psychiatric Association and the American College of Neuropsychopharmacology which criticized the virtual absence of training courses in the use and supervision of drug treatment.

This "excellence in education" is really a bit of Marie Antoinette arrogance. What are the elegant products of this rarified education trained to do – treat a few score high-income neurotics in the course of an entire professional lifetime? I don't want to repeat here what I have said at several APA meetings and elsewhere—the psychiatrist coming into practice today must join his peers in the public arena or risk moral and intellectual bankruptcy.

Under the community mental health center concept, many psychiatrists are going to have to stop playing God and learn to collaborate on equal terms with other professionals and yes, with non-professionals who have roots in the community. With rare perception, the recent Group for the Advancement of Psychiatry publication, "The Dimensions of Community Psychiatry", notes that this collaborative role is probably the hardest one for the psychiatrist to assume because his narrow training gives him no superior technical competence in working with others. Despite the acknowledged difficulties, the GAP report recognizes the radical need for a profound change in the role perception of the psychiatrist in these words:

"The implications of community psychiatry outlined in this report are far-reaching. Without rejecting psychoanalytic insights, it is recognized that a theoretical framework based only on intrapsychic processes is inadequate for realistic consideration of today's complex psychiatric problems.... We are no longer content to banish the mentally ill to a world that we shun and deny. Instead, with all the unpleasantness, difficulties and trials that accompany professional role changes, we seek ways to bring the mentally ill into the life of the community."

From all of the foregoing, some of you may gain the mistaken impression that I find no fault with the current state of the community mental health movement. I assure you that I have many criticisms of the way in which this idealistic concept is being translated into less than beguiling reality; I have commented publicly in a number of states on those centers which are not reaching out to encompass the hardcore mentally ill among the less favored segments of our society. However, on many an occasion when I returned from a trip somewhat depressed and discouraged, I gained some perspective by thinking about the bleak situation which faced the mentally ill before we made the national decision to care for them in the community rather than shipping them off to warehouses far out of sight and out of mind. Those of us who participated in this revolution were quite aware that to overthrow an entrenched custodial system which had existed for almost two centuries was an extraordinarily difficult task, but we knew it had to be done.

I want to remind you, in the strongest possible terms, that the custodial mental institution had powerful and fierce defenders. Walking the back wards in the 1940's and seeing the chains, the leather restraints, the nakedness and the filth, I naively believed for some time that no one could, in good conscience, defend this system. Although I had read my Margaret Mead very carefully, I was not prepared for the savage

resistance to change. The rationalizations were potent and pervasive, and they came from professionals and politicians alike: This was the way things always had been done, so why upset it; since these people were hopeless incurables, custody at $1.00 a day was the best society could do for them; criticizing the level of care in the institutions alarmed the families who had been relieved for so long of anxiety and guilt about the patients formerly in their midst, and so on.

In 1956, after 11 years of battling and frequently being vanquished by the persistent refusal of so many to face up to the moral and therapeutic bankruptcy of the state mental hospital system, I wrote these words in "Every Other Bed":

> "What is it that these defenders of the past are trying so zealously to preserve? Is it really the present state mental hospital system, with its freightage of despair, defeatism, despondency, filth, futility and failure?"

Twelve years later, in an address to the Mental Hospital Institute of the American Psychiatric Association Dr. Stanley Yolles, Director of the National Institute of Mental Health, expressed the same puzzlement about the continuing sharp resistance to moving away from custody of the mentally ill. I quote him:

> "In moments of truth, no one here would claim, for example, that 'preventive detention' of a person in a mental hospital was anything more than an admission that we were either ignorant of a better alternative, or unable to support a better alternative.... In the face of the evidence, however, there are certain attitudes, traditions and practices within the health professions that can only be termed defensive, blocking formations. It is strange that some of these defenses continue to be so strong, because what some of us have been defending wasn't all that good."

We also seem to have forgotten that the community mental health movement has been in various and sporadic states of maturation over the last 50 years. Dr. Adolf Meyer is generally regarded to be the father of community psychiatry in America. His writings and lectures on the subject appeared most frequently in the first two decades of the present century. The real thrust against the old custodial system, however, came with the Congressional establishment in 1955 of the Joint Commission on Mental Illness and Health. Its final report in 1961 proposed a clear alternative to the warehousing of the mentally ill; two years later President John F. Kennedy, in his Message to Congress recommending the new community mental health center legislation, excoriated the custodial concept and called for a revolutionary change in these eloquent words:

> "Every year, nearly 1,500,000 people receive treatment in institutions for the mentally ill and the mentally retarded. Most of them are confined and compressed within an antiquated, vastly overcrowded, chain of custodial State institutions.... This situation has been tolerated far too long. The Federal Government, despite the nationwide impact of the problem, has largely left the solutions up to the States. The States have depended on custodial hospitals and homes. Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release. ...The time has come for a bold new approach.... When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away."

In the two years subsequent to the Kennedy message, more than 30,000 people in all parts of this land participated in an unprecedented citizen

effort in planning and designing mental health services at the state and local level.

Let me recall to you what I said about the importance of this planning effort when I had the privilege of addressing the First Legislative Conference of the Massachusetts Association for Mental Health in February of 1964:

> "Hundreds of professional workers will be involved in hammering out these plans over the next several years, but they must be augmented and guided by thousands upon thousands of citizens who care so deeply that they will insist upon a clean break with the custodial past.
>
> First and foremost, we must realize that this is a long, uphill fight. Equally important, we must abandon the mendicant, somewhat apologetic approach we take when we ask for a few crumbs from our national bounty. Our stance must be vigorous, aggressive and unwavering in our continued efforts to shape a new and enlightened national policy for the care and treatment of the mentally ill.
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> In doing this, we must adhere to a boldly proclaimed set of minimum standards short of which we will not compromise under any circumstances.
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> In testifying before a Congressional Committee last year, I said that in the same manner as we talk of the right of a child to a good public eduation, we must talk of the right of every individual who needs it to early psychiatric treatment designed to make him a happier and more effective individual."

The Massachusetts planning effort was one of the finest in the Nation; at the time the final report was released in 1965, I read it with a great deal of excitement. However, I must say regretfully that the implementation of the Massachusetts plan has moved rather slowly and halt-

ingly, and I will make some observations on that later in this talk.

There is one additional major trend which deserves mention in any discussion of the present and future care of the mental patient. Over the past 13 or 14 years, we have displaced the state mental hospital as the major, and frequently only, recourse for the mental patient. In 1955, there were 558,000 patients in approximately 300 state institutions. Preliminary figures which I have just received for 1968 indicate that we have proved that Dr. Harry Solomon was and is a prophet with honor in his own land when he chose as the major theme of his 1958 APA Presidential Address the increasing obsolescence of the big mental hospital.

In 1963, President Kennedy included in his Mental Health Message a projection that by 1973 the population of our state mental hospitals could be halved if we both intensified our treatment capabilities and developed alternate services. This "mythical" projection was greeted with polite derision and/or massive skepticism by the superintendents' club—they informed their colleagues and the public that such a projection was obviously "unrealistic". I must confess, my friends, that they were right—it was unrealistic. In the past several years, the downward trend in mental hospital populations has been so sharp that Dr. Yolles recently predicted that in five years the state hospitals may house only 186,000 patients—two-thirds below the 1955 peak and far in excess of President Kennedy's modest projection of a 50 percent reduction.

In light of these similar statistics which crowd my files, I ask the follicle-splitting critics of the community mental health center to spell out the directions in which they want us to move. If community psychiatry is not the answer, then it seems the only alternative is a return to Bedlam. In the face of all the conflicting demands and pressures generated by the community revolution, one can wax nostalgic about the ordered universe of the mental patient just a couple of decades ago. There were no difficult options;

for practically all mental patients except those in the high-income brackets who could afford private care, there was just one place—the state hospital. This made it simple for families, judges, sheriffs, and the great body of people in the community who wanted no part of these pariahs. State hospital superintendents, who ran these institutions as feudal baronies, appeared before state legislatures and boasted how they expended less than $1.00 a day for the custody of these deranged bipeds. Legislators, who used the institutions as patronage farms for their political toadies, beamed their approval of such exemplary frugality.

The system was great for the overseer, just as slavery was beautifully structured for the plantation owner. But the system was dehumanizing and cruel for the person whom it supposedly served, the mental patient. It flourished because of the twin conspiracies of silence and distance; it collapsed when journalists and, finally, governors and state legislators spanned the distance and ended the centuries-long silence which had protectively enshrouded these institutions.

I, for one, do not want to return to the nightmare of the state institution as the only resource, or the major resource, for the mental patient. By the same token, I am keenly conscious of the many hardships and difficulties in developing a truly democratic, citizen-oriented alternative to the seemingly comfortable, autocratic system of the past.

I don't want to repeat here the burden of my Congressional testimony over the past several years, in which I expressed unhappiness with the slow rate of growth of these centers. Since the inception of the program five years ago, the Congress has appropriated only about $200,000,000 for the construction of centers. This is far behind the Kennedy timetable; this level of support is beginning to discourage communities who want to come in for matching support. Although we have awards to some 330 community mental health centers, only about 100 are operational at this date. A fundamental disappointment has

been the lack of strong matching support from state government, all the more frustrating since much of our effort was directed toward the Governors during the early 1960's. At the present time, state governments are providing only 17 percent of the funding of these centers, as against 30 percent from the federal government and 53 percent from county and private resources.

I am still amazed at the local grass root support for the centers. A recent Wall Street Journal article noted that taxpayers in recent elections had turned down more than 55 percent of local bond issues and, in some states, had turned down 75 percent or more of bond issues to keep schools going. By way of contrast, special bond issues to construct or support mental health centers have had a more than 90 percent approval rate; in last November's election, for example, voters in all 10 counties in which it appeared on the ballot in Illinois voted for a special mill tax to underwrite community mental health costs.

Despite my previously expressed reservations about the lag in the timetable for these centers, the disappointing level of state support and the restrictive nature of some of the services provided by the centers, I must tell you in all candor that I am exhilarated by so many of the things the most progressive centers are doing. They are not waiting passively for patients, as the traditional mental health clinic used to do. They are reaching out into the community, they are leading neighborhood group therapy sessions, they are working with the teachers and the parents in the schools, and so on. Because they exist, families in trouble, for the first time in this country, have a place to go in their own neighborhood and obtain help during the initial manifestations of an emotional disturbance.

I am convinced that these centers have already prevented thousands of patients from going on to jails and then to state hospitals. In cities where there are no such centers, patients are still being jailed awaiting admission to state

hospitals. On December 13, 1968, the Dade County jail in Miami, Florida, held 77 mental patients awaiting hearings for admission to South Florida State Hospital. Many of these patients had been in the jail for three weeks or more.

In Philadelphia, there are seven centers serving the entire city. Several of these centers are located in ghetto areas; they serve the poor and minority groups who have never been touched by psychiatry before. Many of the caseworkers from these centers are neighborhood people who have been trained to go into the homes and work with the families. They have initiated a number of training courses for the police in the handling of disturbed individuals—the same police who just a few years ago used to arrest a disturbed individual, handcuff him and rush him to Philadelphia State Hospital. Today, Philadelphia State Hospital has a joint administrative arrangement for the treatment of mental patients in its area with a medical school and a local community mental health center. This is one wave of the future I never expected to see, but then there is only one Daniel Blain.

In Brooklyn, New York, where a few trees still grow, there is a magnificent mental health center whose director is a psychoanalyst. He has 35 psychiatrists and an additional staff of 200 social workers, nurses, community organizers, and the like. The center serves a very poor neighborhood populated largely by Italians, Puerto Ricans and Jews. The Maimonides Center takes on all comers. Many of its patients have been hospitalized one or more times in the past in state mental hospitals. Its professional personnel practice what they call street psychiatry; they pick up most of their clients by immersing themselves in the life of the neighborhood. There are no locks or bars on the doors at this center; the patients wear their own clothes, and they can go out to work, or to shop, in the neighborhood.

Turning to the Massachusetts scene, I have reached the reluctant conclusion, after leafing through a mound of reports and newspaper clips

sent to me by some of your good people, that you are lagging somewhat badly in bringing the new era of community psychiatry into being. I am deeply conscious of the fact that I speak in the heartland and core of the original American Revolution, but I am also aware of the agonizing 14 year period of struggle spanning the period from the dumping of the tea into the Boston Harbor to the establishment of the American Republic. If you can't move more rapidly in the immediate years ahead in the community mental health field, I am afraid that you will not achieve the 14 year timetable of your distinguished ancestors.

Over the many years I have been coming up to Massachusetts, I have gained the impression that you are long on glittering brochures and short on performance. I remember, for example, a 1959 brochure "Blueprint for Better Mental Health", put out during the administration of Governor Foster Furcolo. It pointed with pride to a 1922 Act of the Massachusetts Legislature which authorized the then Division of Mental Hygiene to assist in the establishment of community mental health clinics. The pamphlet noted that, 37 years after the enactment of the law, the Legislature still had not provided the first monies for clinics for adults. It disclosed that 10 communities in 1959 had organized and were ready to support such clinics, but "they are anxiously waiting for the State to staff them".

This seems to a sympathetic outsider to be the central problem in this Commonwealth—you constantly celebrate local initiative in pamphlets and hand-outs, but in actuality the State Department of Mental Health maintains a degree of professional control unprecedented among your sister states.

In December, 1966, Governor John Volpe signed into law the Massachusetts Community Mental Health Act. A month or so later, I received a nice little pamphlet from the Massachusetts Association for Mental Health which hailed the new law as somewhat comparable in importance to the invention of the wheel. The

first paragraph of the report indicates the fictional nature of much of the material, and I quote:

> "On March 28, 1967, the new law officially sets in motion reorganization of the Department of Mental Health. Decentralized administration and the introduction of citizen participation in area planning will help establish and effective program of comprehensive and coordinated mental health services at the community level throughout the Commonwealth."

Reading the fine print of the Act and comparing it with comparable legislation in a number of states with which I was familiar, I came to no such euphoric conclusion. I conveyed my doubts at the time to several state mental health officials and to Steve Rosner, but they assured me that a new day had dawned in Massachusetts.

In your 1966 law, as the Pennsylvania Dutch would say, "The Commissioner is still All". He appoints the 37 Area Directors and Associate Area Directors. He also appoints, and this I have seen nowhere else in the country, the 21-member citizens mental health and mental retardation boards which are supposed to represent the voice of the people. Furthermore, it is my understanding that when Area Directors are appointed and select subordinate personnel these appointments must, in themselves, clear three or four levels of state government. Now it is true that there is a lot of semantic palaver in the 1966 Act about the powers of the Area Boards; for example, they will "advise on the recruitment and selection of Area Directors and Associate Area Directors and other personnel and appointment policies". No real power is designated by giving someone an advisory function; advice can be given freely, but it doesn't have to be taken.

I respectfully suggest that these important boards should be chosen through some local appointive or elective mechanism devised after full consultation with voluntary and professional organizations in the fields of mental health and

mental retardation and with appropriate municipal or other elected officials. These democratically selected boards should be empowered —without any interference or veto at the state level—to choose the Area Directors. Maybe this can be done by administrative directive, or if that is not possible, you can amend the 1966 law in the present session of the General Court. This is not too difficult to do—over the past five years, we have amended the national Community Mental Health Center legislation three times.

The point I am making is not a minor one. Over a two-year period, the good citizens of this State were deeply involved in hearings and planning meetings leading to the Massachusetts Mental Health Plan of 1965. I was up here during that period, and I was delighted at the extent of citizen involvement. You cannot continue to benefit from this citizen involvement unless you give the 37 area mental health and mental retardation board the power to develop <u>their own services</u> responsive to their own felt needs.

I have also been innundated with material from your people on the low salary scales for mental health personnel in Massachusetts. I don't have to review this data here, which shows you to be on the bottom rung of a 15-state survey of salaries paid to mental health personnel. It is obvious that the state hospitals are now, and will continue to lose, people to neighboring jurisdictions paying higher salaries; it is also obvious that you will not be able to hire qualified area mental health directors until you lift the prospective salaries by at least 50 percent.

The problems I have just referred to are contributory to the lagging community mental health center movement in the State. According to a June 30, 1968 listing by the National Institute of Mental Health, you had only two centers operating at that time—the Massachusetts Mental Health Center and a Center in Lowell. It is hardly accurate to describe these as new centers—the Massachusetts Mental Health Center, formerly known as Boston Psychopathic, is generally regarded as the first true mental

health center in this country. It started operation at about the time Dr. Jack Ewalt entered elementary school in Kansas. The Lowell Center, as I understand it, has been state-financed and existed before the federal legislation.

In a check just a week ago with National Institute of Mental Health officials, I was informed that additional centers are in operation at Boston State Hospital and at the New England Medical Center here in Boston. Again, it is hard to describe the Boston State Hospital Center as a new one, or one generated by federal legislation; under your distinguished Commissioner, Dr. Milton Greenblatt, Boston State provided the essentials of a community mental health service for years. Furthermore, three of the four centers I have enumerated are in Boston, where you have the heaviest concentration of medical schools, mental hospitals and psychiatric personnel. What about the rest of the State—where are all those outlying centers projected in the 1965 Massachusetts Mental Health Plan?

I won't recite for you the dreary statistics on how you rank among your sister states in the initiation of community mental health centers. I won't abjure you to catch up with Pennsylvania, which has 26 centers funded and 10 in operation. I just want you to get within shouting distance of Kentucky, which has 16 centers funded and 12 in actual operation. I might remind you that Kentucky has little more than half your population, and ranks 45th among the states in personal income, whereas you rank 11th.

When we talk about increased services for the mentally ill, including decent salaries for those who tender to them, we run up against the persistent myth that state and local taxation has reached a confiscatory level and no further increases are possible. In my talk here in 1964, I devoted a major part of my remarks to a careful documentation of the essential point that while state taxes have risen, there has been an even sharper rise in the real income of those who pay the taxes.

In 1967, four percent of our income went to state taxes, as compared to 3.7 percent in 1948. In other words, this is an "outrageous" rise of 3/10 of one percent in 19 years. Taxes are naturally up—we are an expanding country whose people are demanding more public services, but their salaries and incomes are up too, so you have what amounts to a stand-off.

Apart from the over-all argument about taxes, it is perfectly clear that mental health is getting a decreasing portion of the state tax dollar. For example, 10 years ago state mental hospital operating expenditures were about 3-1/3 percent of total state budgets. Last year, state mental hospitals received only 2-1/2 percent of the state tax dollar.

I suppose you venerate state government here in the Commonwealth, but I have just reviewed some telling figures indicating that you don't put your money where your heart is. The last time I was here, you were 27th in the Nation in the amount each person paid out in taxes to support state government. In 1966, the last year for which figures are available, you were 38th in this category, placing you far behind Alabama and Mississippi. Zeroing in on the subject of tonight's oration, 1966 figures released by the American Psychiatric Association show that you spent 48¢ per person for community mental health, as against the national average of 75¢ per person.

Can we afford this leap into the future?

According to a recent issue of The Wall Street Journal, as a nation we achieved a Gross National Product of close to $900 billion last year. This is approximately double our Gross National Product of just a decade ago, and even when the GNP is adjusted for inflation and interpreted in 1958 prices, the current GNP is 50 percent higher than that of a decade ago.

Of equal significance is the fact that the per capita disposable income of individuals today—adjusted for inflationary increases since 1958—

stands at approximately $2,500, a gain of 35 percent in real income in a decade. Total personal income of the American people is at a record before-tax rate of $700 billion, a fantastic $60 billion over the level just a year ago.

These figures are quickly translated into spending levels. For example, last year the American people spent $20 billion on recreation; $12 billion for alcohol, and $7 billion for tobacco products.

Despite these various and persuasive evidences of increasing prosperity, those of us who worked closely with the Congress last year were told repeatedly that the American economy was in perilous condition, and therefore it was necessary to cut all such "luxury" expenditures as those for health, education and welfare. As a result, the budget for the National Institute of Mental Health was cut by close to $15 million, the budgets of the National Institutes of Health were reduced, Federal Aid to Education was slashed sharply, the Office of Economic Opportunity received its usual annual cut, and so on.

That very same Congress, however, significantly increased funds for highway construction. Since the passage of the original Federal Highway Act of 1956, providing that the federal government finance 90 percent of the cost of an enlarged interstate highway system, the highway program has been one of the sacred cows of the Congress. In 1956, the goal was 41,000 additional miles of interstate highway; the cost was estimated at $27 billion. In 1961, the cost estimate was raised to $41 billion; in 1965, to $47 billion, and in the Congressional debate last year, the cost estimate escalated to $62 billion. Think of the lashings we in the health and welfare field would have received from the Congress if we had underestimated costs of a program by thirty-five billions of dollars!

Despite all the cries for economy in the 90th Congress, its leaders rammed through a new interstate highway construction bill adding 3,000 miles to the original program and pro-

viding $12 billion in authorizations for the program over the next three years. Last year, all levels of government spent $10 billion for highways to accommodate eighty million cars which killed 58,000 Americans and seriously injured two million Americans. In that same year, we spent less than $100 million for highway safety programs and approximately $350 million for all of the research, training and service activities of the National Institute of Mental Health.

I would like to close in the same manner as I did five years ago because all of us need a strong reminder that the battle for a new day for the mentally ill is a long and hard one and will require both patience and dedication.

In his magnificent Inaugural Address in January, 1961, our late President John F. Kennedy told us that the road would not be easy:

> "All this will not be finished in the first one hundred days. Nor will it be finished in the first one thousand days, nor in the life of this Administration, nor even perhaps in our lifetime on this planet. But let us begin."

Here in Massachusetts and throughout this great land, let us continue.

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