A review of the National Mental Health Program clearly indicates that a benchmark has been established by recent federal legislation and the programs that are being established as a result. We are moving into a new situation of which the goal is community-centered, comprehensive psychiatric care.

THE NATIONAL MENTAL HEALTH PROGRAM

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In view of the speed with which events in the mental health field have moved in the past year, and of the gratifying advances which have been achieved in the National Mental Health Program, it is time that a report be rendered to our colleagues in this Association.

This has, indeed, been a momentous year for all of us who have a concern for the over two million persons who, each year, seek assistance for mental and emotional illnesses and disturbances. As I look back over the events of the past year, I realize I am looking back at the close of an era in the history of our care of the mentally ill from which we are emerging. We are in transition from an era of primarily custodial care for many of our mentally ill to an era of comprehensive and dynamic treatment for all mentally ill: treatment that is both comprehensive at any particular point in the patient’s illness, and over whatever period of time—whether short, continuous, or intermittent—such treatment is needed.

We are now concerned with a framework of service which admits no separation of prevention, treatment, and rehabilitation. This is the crux of the new concept of community medicine which focuses on the social aspects of medicine as well as on the specific actions intended to prevent or cure disease in the individual patient. It implies that all organized services in the health field are mutually dependent one upon the other, and that care in any one setting—the home, the private practitioner’s office, the public clinic, the hospital, or other institution—is not an isolated experience.

Report of the Joint Commission on Mental Illness and Health

Eleven months ago the committee appointed by the President to analyze the recommendations of the “Report of the Joint Commission on Mental Illness and Health” and to develop courses of action which would be appropriate to the federal government submitted their report to the President.

Those recommendations which could be implemented under the existing law were included in the President’s budget, submitted to Congress nine months ago. Others contained in his Message on Mental Illness and Mental Retardation which was sent to Congress last February were introduced as new legislation.

Now, eight months later, the Congress of the United States, representing all the people in the country, have expressed our common will to create new facilities
and new programs for the mentally ill, and the President has signed into law the legislation making this possible.

To implement this new legislation and the programs for which funds have already been made available will require time, money, and effort in the years to come. But we have crossed the great divide between the new era and the old. The new climate in which we now work is better, more invigorating. Some of our outworn and out-of-date concepts and equipment have been discarded. Our system of care for the mentally ill has changed for the better, and we shall never be the same again.

In general, both the new Community Mental Health Center legislation and the other new programs reflect the concept that many forms and degrees of mental illness can be prevented or ameliorated more effectively through community oriented, preventive, diagnostic, treatment, and rehabilitation services than through care in a large state mental hospital. The program is designed to stimulate state, local, and private action in this field, and it is based on the belief that it will be possible within a decade or two substantially to reduce the number of patients for whom only custodial care is available.

New Mental Health Programs

The new national mental health program is comprised of four interrelated programs. These are: (1) the grants-in-aid program for planning, for which Congress this year and last year has appropriated over $8 million; (2) the Community Mental Health Centers program, for which Congress passed authorization to appropriate a total of $150 million for grants to construct comprehensive Community Mental Health Centers in the three years beginning next July; (3) the Hospital Improvement Projects program, for which Congress has appropriated $6 million for demonstration projects to assist state mental hospitals strengthen their therapeutic services and become an integral part of the developing mental health programs; and (4) the Inservice Training Program, for which Congress has appropriated $3.3 million for the in-service training of personnel in state mental hospitals and institutions for the mentally retarded. The appropriations for the Inservice Training Program are part of the additional $15.8 million Congress appropriated for training grants in 1964 over 1963.

I would like now to review, very briefly, the provisions for, and implications of, each of these programs. Considerable progress has already been made in implementing the planning grants program. Since announcement of the availability of the funds for planning appropriated in 1963 was made early this year, the plans for planning of all the state mental health authorities have been approved by the Public Health Service, thus enabling them to use these matching, grants-in-aid funds.

For the first time in the history of our country, each of our states will be able to formulate a comprehensive community approach to the problems of the mental illnesses as they affect the citizens of that state. And while it may be years before the full effect of such comprehensive planning is felt, it is of extraordinary significance that we are trying to plan now to meet the mental health needs of all our citizens.

What is of even greater significance, however, is the fact that this is the first time such a total planning effort has been made in any health area. Thus, the mental health field, which for so long lagged behind other health areas, has an opportunity to demonstrate, on a national scale, the value of comprehensive, long-term planning in a broad medical-social problem area.

In reviewing the plans, digests of which have been published by the
NIMH in a pamphlet entitled "State Mental Health Planning Grant Proposals," we were impressed by the uniformity with which they were community oriented, established common goals, and reflected a firm commitment on the part of the states to the principle of broad participation by all agencies and groups interested in mental health.

An analysis of these plans for planning indicates that 36 states have budgeted more than 75 per cent of their share of the federal funds available for salaries, travel, and consultants. An average of six new planning positions per state will be supported by these funds—a total of 337 new planning positions—and 28 states plan to create mental health districts or otherwise to divide their state geographically for planning purposes.

Many of the states are setting up task forces to investigate problems of particular interest. Thus, 29 states will have task forces investigating legislative and legal problems, 25 task forces have been established on the problems of financing, 24 on the recruitment and training of personnel, 23 on the problems of children and youth, and so forth.

In a number of states, special studies are planned. Thus, Connecticut is planning a study of classroom facilities for emotionally disturbed children, and North Dakota is planning to evaluate the effectiveness of present programs by the study of random samples of juveniles released from the industrial school, and of emotionally disturbed children placed in foster homes. In Georgia, one community has been chosen for concentrated study and planning, and the experience developed in the course of this study will be used elsewhere in the state.

All told, the states' "plans for planning" indicate that many creative efforts are being undertaken, and this, I feel, is not so much a product of the planning grants as an indication that the planning grants themselves are a sign of the times. In this respect, we are in tune with history in that we are all working on the same kinds of problems at the same time.

Since I will be participating in the session devoted to Mental Health Centers, I will discuss this very important aspect of the new national mental health program only briefly.

**Community Mental Health Centers Act**

The Community Mental Health Centers Act was signed into Law in October.* It is estimated that the funds authorized under this enabling legislation—$150 million for the three-year span beginning next July—will provide funds for the construction of approximately 145 community mental health centers. Regulations establishing standards and procedures for the administration of this legislation are now being drawn up by the secretary of the Department of Health, Education, and Welfare (DHEW), and will be issued sometime within the next six months. DHEW components assisting the secretary in writing these regulations are the NIMH, the Division of Hospital and Medical Facilities of the Public Health Service, and the Office of the General Counsel of the DHEW.

States seeking to qualify for the use of these funds must submit for the approval of the secretary of DHEW state plans that: (1) designate a single state agency for the administration of the plan; (2) provide for a state advisory council; (3) set up a program for the construction of the centers; and (4) provide for a system of determining priorities among center projects. After the state plan has been approved, individual project applications may be submitted for approval through the designated

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state agency charged with administering the plan. In brief, the Community Mental Health Center as it has been conceptualized would be more broadly based than either the traditional outpatient clinic or the usual institution, and it would serve as the pivot of future mental health activities within the community.

It would be close to the patient’s home, and would provide preventive services, diagnostic services, outpatient and inpatient treatment, and transitional and rehabilitative services. Basically, the patient would be able to proceed from diagnosis through treatment and rehabilitation to social restoration—and, if the need arose, back to treatment. Other essential services provided by the center would be consultative, educational, and informational services to the public and to professional persons. Skilled staff would be available to help physicians, teachers, clergymen, police, and probation officers; lawyers and social agency personnel deal with the mental health problems of those they face in their day-to-day work.

While these centers would be primarily designed to serve the mental health needs of the community, they would also be available to provide assistance to those of the mentally retarded whose emotional and psychiatric problems cannot be met in other community resources.

The third program which is being initiated this year is the Hospital Improvement Projects program, for which Congress appropriated $6 million. The purpose of the program is to assist each state mental hospital and institution for the mentally retarded, improve their therapeutic service, and make the program changes that are important to the hospital’s positive role as part of a comprehensive community program. The key word here is change: to develop changes inside each hospital and institution for the mentally retarded that will help move the institution or hospital from the era of custodial care to the era of community-centered care.

An individual hospital or institution may receive a maximum of $100,000 in any one year for a project or a series of projects, with projects of more than three years’ duration being reviewed every three years. The superintendent or director of the hospital or institution must submit application for these project grant funds that are available under the Mental Health Project Grant (Title V) mechanism. As principal investigator of these projects, the superintendent or director of the hospital or institution can mesh the Hospital Improvement Project into the in-service training program and other hospital programs, and can coordinate the hospital’s efforts with those of the total state program. The applications for these projects must be endorsed by the state agency responsible for operation of the hospital or institution, and each application must describe how the project is coordinated with the comprehensive state plan for mental health or mental retardation, with the in-service training program, and with other NIMH grant programs.

Projects will compete for the $6 million appropriated for this program, but they will not have to compete with all applications for Title V funds. It is our hope that we will have at least one project in each state approved in the first year, and eventually will have all state hospitals and institutions for the retarded included in the program. A new Mental Health Project Grants Committee consisting of persons selected for their experience in the operation and administration of mental hospitals and institutions for the mentally retarded is being appointed to review these applications. The applications will then go to the National Advisory Mental Health Council for final approval and recommendations to the Surgeon General.
Inservice Training Program

Finally, some brief words about our new Inservice Training Program, for which Congress has appropriated some $3.3 million for this fiscal year. The long-range objectives of this program are: one, to increase the effectiveness of the staff in mental hospitals, in institutions for the mentally retarded, and in other community mental health agencies and services; and, two, to translate rapidly increasing knowledge into more effective services to people.

Under this program, an individual hospital or institution may receive up to $25,000 a year for inservice training. Applications must be submitted by the superintendent or other person administratively responsible for the mental hospital or institution involved, and the applications must be endorsed by the responsible state agency. In addition, the applications must include information on the resources available at the state level for the coordination and further development of inservice training in all state mental health facilities, and in facilities devoted to the care of the mentally retarded.

A new Training Subcommittee on Inservice Training is now being formed. The subcommittee will probably review applications in late February for submission to a special meeting of the National Advisory Mental Health Council in April.

In case of both the Hospital Improvement Projects program and the Inservice Training Program, the Mental Health Staff in the Regional Offices will provide consultation to the applicants. The Research Utilization Branch of the NIMH will administer the program of Hospital Improvement Projects, and the NIMH Training Branch will be responsible for administering the Inservice Training Program.

I have, up to now, outlined in very brief form the four new programs which comprise the new National Mental Health Programs. I wish I had a great deal more time with you, for I would like to discuss each of them in greater detail. However, I hope that even this brief review will give you some sense of the distance we have covered in the last 12 months in preparing for our new era of community centered mental health services.

We at the NIMH have worked longer hours in the past year, than any of us care to recall, in our effort to get these programs moving. We feel a great sense of accomplishment that they are so fully developed.

With the addition on the national level of these new programs to our already well-developed programs of research, training, and grants-in-aid, the rate at which changes are occurring in the mental health field should accelerate. I use the term “should” advisedly, for the task ahead—to implement these new programs and new concepts—is a difficult one. While the new programs appear simple to state in general terms, they do represent many problems which will need careful consideration.

First, if the Community Mental Health Center is to be effective, it will have to be able to provide for a wide variety of services, but there may be difficulties in developing all of these resources within a short period of time. It will be necessary, therefore, to cope with the problem of developing these services over shorter than desirable span of time in such a way that the lack of a total program does not negate the value of the newly developed activities. A tremendous amount of administrative resourcefulness and community cooperation must, therefore, be developed.

In achieving this goal, there will need to be an open system of discussion and interaction, characterized by good will and good faith, but also characterized by discussion, difference of opinion, and proof of position. Finally, this inter-
change must be characterized also by flexibility, cooperation, compromise, and continuing change.

In addition to developing administrative resourcefulness and a consensus within the community of how the community programs should be developed, we need to know a great deal more about the epidemiology of the mental illnesses—knowledge upon which plans of operation can be built. It will become increasingly important to know the sequence of treatment experiences that any one person experiences—and his psychosocial history during the periods in his life when he has no treatment—for it is only in this way that we can come to understand the logistics involved in the provision of mental health services.

The task ahead demands that we solve many other problems, for a major change in the organization of services in a major health area affects, either directly or indirectly, many aspects of our society. For example, mental health programs and services affect the budgets of the patients and their families, of course. But they also compete for public funds, affect the distribution of public funds, and have an impact upon the national economy. We must learn a great deal more about the economics of the mental illnesses, and see to it that these facts are understood by the public, by professional persons working in the mental health field, by public officials, and by legislators.

Finally, the future will demand major alterations in the attitudes of many groups of people toward the mental illnesses. Some of these changes will occur as the natural result of a changed situation. As more people receive help in their own communities for all gradations of the mental illnesses, the attitudes of the patients, their families, and the communities will gradually become more realistic, less based on outmoded negative stereotypes on the one hand and falsely optimistic hopes on the other. Other changes in attitudes will be brought about partially, at least, through carefully thought out information and education programs.

Much more could be said about the really difficult and complex problems which must be solved as we move forward into the era of community centered, comprehensive psychiatric care. However, I am convinced that we have passed the point of no return in our long journey from a shelter-skelter system of mental health services, either divorced from community life or at least not geared to it, without real grass roots support, often crippling to the patient, and self-defeating in terms of the state of our medical and scientific knowledge. Whatever difficulties we shall face in the future cannot be more difficult than those of the past—and the seeds of the future which we have sown and are now nurturing give every promise of bearing good fruit.

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