

DOCUMENT RESUME

ED 297 240

CG 021 022

TITLE The Federal Role in Providing Services to the Mentally Ill. Hearing before a Subcommittee of the Committee on Government Operations. House of Representatives, One Hundredth Congress, First Session (May 19, 1987).

INSTITUTION Congress of the U. S., Washington, D. C. House Committee on Government Operations.

PUB DATE 88

NOTE 220p.

AVAILABLE FROM Superintendent of Documents, Congressional Sales Office, U.S. Government Printing Office, Washington, DC 20402.

PUB TYPE Legal/Legislative/Regulatory Materials (090)

EDRS PRICE MF01/PC09 Plus Postage.

DESCRIPTORS *Delivery Systems; *Federal Programs; *Government Role; Hearings; *Human Services; Individual Needs; *Mental Disorders; *Mental health Programs

IDENTIFIERS Congress 100th

ABSTRACT

This document presents witnesses' testimonies and prepared statements from the Congressional hearing called to review the United States Department of Health and Human Services' response to mental illness, focusing on the delivery of services for the severely mentally ill, and the leadership role of the National Institute of Mental Health in helping states and communities improve those services. Issues examined include the extent of the problems regarding lack of appropriate services for the severely mentally ill, why federal entitlement programs have been inadequate in providing basic living requirements and treatment for many of the severely mentally ill, and what federal programs have been most effective. Opening statements are included by Representatives Ted Weiss and Jim Lightfoot. Witnesses providing testimony include: (1) Ann Baxter, director, Calvary Shelter, Washington, D.C.; (2) Davis Pollack, representing the National Alliance for the Mentally Ill; (3) Shervert Frazier, psychiatrist in chief, McLean Hospital, Belmont, Massachusetts; (4) Charles Kiesler, provost, Vanderbilt University, representing the American Psychological Association; (5) Steven Sharfstein, vice president, Sheppard and Enoch Pratt Hospital, Baltimore, Maryland, representing the American Psychiatric Association; (6) Joseph Autry, acting associate administrator for policy coordination, Alcohol, Drug Abuse, and Mental Health Administration; (7) Frank Sullivan, acting director, National Institute of Mental Health; (8) Richard Surles, administrator, Office of Mental Health/Mental Retardation, Philadelphia Health Department, Pennsylvania; and (9) Martha Knisley, deputy director, Ohio Department of Mental Health. Letters, statements, and other relevant materials submitted for the record are included. (NB)

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ED297240

THE FEDERAL ROLE IN PROVIDING SERVICES TO THE MENTALLY ILL

CG 021022

HEARING BEFORE A SUBCOMMITTEE OF THE COMMITTEE ON GOVERNMENT OPERATIONS HOUSE OF REPRESENTATIVES ONE HUNDREDTH CONGRESS

FIRST SESSION

MAY 19, 1987

Printed for the use of the Committee on Government Operations

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THE FEDERAL ROLE IN PROVIDING SERVICES TO THE MENTALLY ILL

TUESDAY, MAY 19, 1987

HOUSE OF REPRESENTATIVES,
HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2154, Rayburn House Office Building, Hon. Ted Weiss (chairman of the subcommittee) presiding.

Present: Representatives Ted Weiss and Jim Lightfoot.

Also present: James R. Gottlieb, staff director; Diana M. Zucker-
man, professional staff member; Gwendolyn S. McFadden, secre-
tary; and Mary Kazmerzak, minority professional staff, Committee
on Government Operations.

OPENING STATEMENT OF CHAIRMAN WEISS

Mr. WEISS. The Human Resources and Intergovernmental Rela-
tions Subcommittee will come to order.

Today's hearing will review the Department of Health and
Human Services' response to the national tragedy of mental ill-
ness. We will focus on delivery of services for the severely mentally
ill, and the leadership role of the National Institute of Mental
Health in helping States and communities improve those services.

Approximately 29 million Americans suffer from some form of
mental illness that requires professional treatment. Virtually every
State is facing an increasing problem of homeless mentally ill
people on their streets, mentally ill citizens who refuse treatment
because they don't think there's anything wrong with them, and
private and public hospitals that dump patients in order to save
money.

And so, not only are there millions of mentally ill Americans not
receiving adequate services, but also millions of angry and frustrat-
ed parents and family members, who can't find help for their men-
tally ill loved ones, and citizens who are concerned or frightened by
the self-destructive or aggressive behavior of neighbors, but who
don't know where to turn for help.

The problems that America now faces are tied to the deinsti-
tutionalization movement, which took the mentally ill out of insti-
tutions with the promise that they would receive services through
community programs. This movement started in the 1960's during
the Kennedy administration, but was undermined by a wide range

(1)

of social and economic changes since then. The lack of community programs for the mentally ill is a nationwide problem, although lack of inexpensive housing in urban areas, and the farm crisis in rural areas, have contributed to different problems in different parts of the country. And yet, the Federal Government has tended to stay away from providing services to the mentally ill.

Federal funds and staff for NIMH programs have been cut drastically in recent years. The Alcohol, Drug Abuse, and Mental Health Block Grant has cut funds for those programs by 24 percent since 1980, when inflation is taken into account. Money to train mental health professionals has been cut 85 percent. The States have had to take over most of these responsibilities. However, the Congress continues to require NIMH to assist the States by providing funds for programs and technical information.

I believe it is appropriate to review what the Federal Government is doing to provide leadership to States and communities in their efforts to improve services for the severely mentally ill. The hearing will focus on how some States and cities are effectively using Federal funds, and how Federal efforts could be improved. The role of NIMH in providing funds for services, grants for evaluating the effectiveness of particular programs, and technical assistance to States and communities, will be discussed by experts from across the country.

At today's hearing, we will be seeking answers to a number of questions, including: (1) how widespread are the problems regarding lack of appropriate services for the severely mentally ill; (2) why have Federal entitlement programs been inadequate in providing basic living requirements and treatment for many of the severely mentally ill; and (3) what Federal programs have been most effective, and how can they be strengthened?

Our witnesses include experts in the field of services for the mentally ill, either from personal experience as parents, or as researchers, service providers, advocates, and current and former administrators at the city, State, and Federal levels. We are very pleased to have these distinguished panelists here with us today.

At this point I would like to recognize our distinguished ranking minority member, Mr. Lightfoot, for his opening comments.

Mr. LIGHTFOOT. Thank you, Mr. Chairman. I'd like to commend you for holding this hearing today to examine the role of the Federal Government in providing services to the mentally ill, an important topic in light of reports that many of society's mentally ill are not receiving adequate and appropriate services. The case of America's homeless, an increase in youth suicides, and an increase in mental health problems among rural residents, underscore the need for us to examine our mental health system to determine what is and is not working.

Throughout the last 20 years this country's approach to serving the mentally ill has changed considerably. We've attempted to go from a system of institutionalization to one of community-based programs. In some States and communities, effective community-based systems have been established. However, in others the mentally ill still lack appropriate services.

In rural America we have an especially critical need for mental health services. Recent studies indicate that the downturn in the

farm economy has created serious and possibly long lasting mental health problems among our rural residents.

An Iowa State University extension service poll shows that of 2,000 rural residents that were interviewed, 75 percent believe that their quality of life has declined during the last 3 years. Thirty-two percent indicated that the level of stress in their lives had increased during the last 3 years. Seventy-five percent reported an increase in disagreements and tensions among their spouses and children, and 49 percent of the children had experienced more problems in school.

Another study in Minnesota revealed that 3 out of every 100 adolescents in three rural counties had attempted suicide during the month prior to the study. The national average is 2 out of every 1,000.

Another study of 50 rural community mental health programs in 12 Midwest farm States found widespread emotional distress in rural areas with 64 percent reporting a moderate to very large increase in client dysfunctioning.

In the State of Iowa, an increase in demand of mental health services, coupled with declining State and local financial resources, has taxed the mental health care system. Iowa has sought to develop programs ensuring that limited resources are targeted effectively and efficiently among populations most at risk of having mental health problems.

Among some of the States' initiatives are continuing reliance on the community support program, a National Institute of Mental Health demonstration grant designed to serve the mentally ill elderly, and a grant proposal for funds under the NIMH rural health demonstration program.

The Federal Government, the State and local governments, and the private sector, all play an important role in ensuring that the mentally ill receive appropriate community-based mental health services. Coordination among these different parties is essential as we seek to provide services to a diverse population of people in need of assistance.

State and local governments should continue to have maximum flexibility in designing programs best suited to care for the mentally ill in their communities.

In addition, these entities should be able to draw upon Federal support and information to assist in the development of new and innovative programs. Moreover, the Federal Government should continue to focus its efforts and priorities on research into the causes and cure of mental illness.

Mr. Chairman, I look forward to hearing the suggestions of the witnesses on how we can make sure that our Nation's mentally ill receive the best possible care and services, and, again, I thank you for calling this hearing.

Mr. WEISS. Thank you very much, Mr. Lightfoot.

Before we begin to hear from our witnesses, let me just indicate that we will from time to time have additional members of the subcommittee joining us, and some of us departing. On the floor today there's some very active legislative business, and from time to time we'll be interrupted by demands for a rollcall vote, and our attendance will be required.

We will try to make those breaks as brief as possible, so that we can get the hearing concluded with as little difficulty as possible.

As is the custom of the Government Operations Committee, all our witnesses will be sworn in. From time to time during the hearing we will be inserting into the record, without objection, documents relevant to this hearing.

Before we begin, let me say to all our witnesses that the full text of your statements will appear in the record. Because of the long list of witnesses today, and because of the important business on the floor, we're asking all of you to summarize your testimony. There will be time for questions after each panel's presentation.

Let me now welcome our first panel of witnesses. Ann Baxter, executive director of the Calvary Shelter in Washington, DC; and Dr. Davis Pollack, a parent from Bay Shore, NY, who is representing the National Alliance for the Mentally Ill.

If you will take your positions at the witness table behind the chairs that are set aside for you, we can then proceed. Please raise your right hand.

Do you affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth?

Let the record indicate that both witnesses have responded in the affirmative. Please take your seats.

Ms. Baxter, we will begin with you. It is a pleasure to have both of you with us today.

STATEMENT OF ANN BAXTER, DIRECTOR, CALVARY SHELTER, WASHINGTON, DC

Ms. BAXTER. Thank you for allowing me to testify this morning.

My name is Ann Baxter, and as the director of Calvary Shelter for homeless women, I am responsible for caring for some of the most severely mentally ill in the District of Columbia. I speak to you today as both a shelter provider and as a member of the District of Columbia Advocates for the Mentally Ill Homeless.

At Calvary Shelter, over 90 percent of the residents suffer from mental illness. Before the shelter opened in January 1983 many of the residents were sleeping out on the grates, in parks, and in metro stations. A large percentage of them had just been released from St. Elizabeth's Hospital, the local mental health institute in the District of Columbia. And instead of being placed into a therapeutic permanent living arrangement, they were simply given a bus token and the address of a local shelter.

On one occasion a woman arrived at Calvary Shelter at 11 o'clock in the evening when it was 30 degrees outside. She was dressed in a cotton short-sleeved dress and slippers. She carried a prescription for psychotropic medication, though she had no money to fill it, the name and address of the shelter, and nothing else. This woman had just been discharged from St. Elizabeth's Hospital.

Other District hospitals have similar procedures. Attached to the wall in the emergency room of one District hospital are the telephone numbers and addresses of city shelters. Although emergency shelters are essential in providing clothing, food, and shelter, they are of questionable therapeutic value, and should only be used for

temporary emergency situations, for example, when there is a natural disaster.

As a shelter provider I envision myself as a provider of emergency shelter and do not want to be seen as a long-term solution to housing the mentally ill homeless. Shelters are not permanent housing situations.

The shelter is an extremely stressful environment, where strangers live in close quarters, where's there's little or no privacy, and where, most disturbing of all, there are not adequate mental health services to meet the needs of the population served.

I suggest that Federal guidelines for appropriate hospital discharge be set up so that shelters would no longer be seen as proper placements and referrals.

I would like to share another story with you concerning a former Calvary Shelter resident. This woman had lived in the shelter for 3 years. She spent every day panhandling outside the old Hecht's department store. She refused to go inside any building during the day, even during the winter months. As a result of her spending 12 hours outside, she was in poor physical health. Due to her schizophrenia, she was only able to speak in garbled sentences, and after knowing her for close to 2 years, I was still only able to find out her name and age.

Her behavior in the shelter was frequently bizarre and unpredictable. This was due to her mental illness. The woman would often become aggressive with the shelter staff, which was extremely intimidating as she weighed close to 200 pounds.

On one occasion she chased me around the room and I was forced to lock myself into a secluded area in order to get away from her. When I phoned the police, they arrived and refused to take her because she had calmed down by then and did not appear harmful to them.

It was not until bodily harm was done to the staff social worker that they agreed to take her in for a psychiatric evaluation. After the hospitalization, and treatment with medication, this woman now carries on a normal conversation, no longer lives outside, but in a group home for the mentally disabled. She is an example of how commitment to an institution can provide the type of supportive treatment some of the mentally ill desperately need.

I would urge you to conduct a study on the current effectiveness of the commitment laws. New liberalized mental health laws have made involuntary psychiatric treatment almost impossible, and although I am not advocating a return to the past, I do advise evaluating them.

Another common problem shelter workers have is obtaining medical and financial benefits for the mentally ill. One of the most tragic stories regarding the ineffectualness of the present benefit system involves the inability of a 73-year-old woman to obtain her supplemental security income check. She lived at Calvary off and on for 3 years. She was mentally and physically disabled, along with suffering from alcoholism. She frequently slept out in the park, and only liked to come to the shelter when it got too cold, or just to clean up in the showers. The first time she came to Calvary was just after she had been raped.

As with most clients, we established a trusting relationship with her, and then began the arduous task of applying for benefits on her behalf. We started the process for SSI in 1984, received the check in 1986. About 3 weeks before the check was received we were able to arrange for her to move into a home for the elderly with the understanding that the payment would soon be forthcoming. Unfortunately, this woman died before she ever saw the check. We received a back payment of \$5,000 one week after we had buried her in Potter's Field.

Health insurance and benefits are crucial support, yet most homeless mentally ill have neither. Applying for benefits is extremely complex and requires a lot of paperwork, visits to many different offices, and for the mentally ill, willingness to be evaluated by a psychiatrist.

In many ways this system was not designed to be accessible for the mentally disabled, and thus fails one of the very populations that should be served.

Society in general has seemed unwilling to accept the chronically mentally ill back into the community. The result has been that many of the chronic mentally ill have not been able to cope with life on their own, and have eventually become homeless, ending up on the streets. Yet, with proper care and support, they can become an integral part of our society.

The stories I have shared reflect the most severe, for this is a population we see in shelters. There are millions of mentally ill persons that lead normal, productive lives in our communities. By educating the public in order to remove the stigma of mental illness, by creating innovative programming, and providing housing and opportunities for job training, we shelter providers envision the day when our facilities will no longer be the new institutions for the mentally ill.

Thank you.

[The prepared statement of Ms. Baxter follows:]

TESTIMONY OF ANN BAXTER

for the

DC ADVOCATES FOR THE MENTALLY ILL HOMELESS

In January of 1983 when it became evident that steadily increasing numbers of homeless women were being forced to sleep in parks and Metro stations due to the lack of permanent living arrangements in the city, Calvary Shelter, an emergency night shelter for homeless women, was opened. As the Director of Calvary and as a shelter provider, I am responsible for caring for some of the most severely ill in the District of Columbia. I speak to you today as both a shelter provider and as a member of the DC Advocates for the Mentally Ill Homeless.

The homeless mentally ill population is the product of many factors. The deinstitutionalization movement of the last 20 years discharged hundreds of thousands of state mental hospital patients into the community with little planning and support. It was thought that the new psychiatric "wonder drugs," which were to be the panacea of the mentally ill, combined with the development of local community mental health centers would prevent the necessity of long-term psychiatric hospitalization. Unfortunately, the dollars never followed the patients, and only a fraction of the local community mental health centers were ever built. A system of community care and social support for the mentally ill was never developed.

It has been my experience that instead of releasing these patients to therapeutic, in-place living arrangements, many are simply given a bus token and the address of a local shelter. While some do indeed make it to shelters, others do not and often end up living in parks, shopping malls or on the grates. On one occasion- when it was 30 degrees outside- a woman arrived at Calvary in the late evening dressed only in a cotton short sleeved dress and slippers. This woman had a prescription for psychotropic medication in hand (though no money to fill it), the name and address of the shelter and nothing else. She had just been discharged from St. Elizabeth's Mental Health Hospital. And it seems to be established procedure for one particular DC hospital to routinely release its emergency room patients to area shelters. Attached to a wall in the emergency room are the telephone numbers and addresses of the city's shelters.

Although emergency shelters are essential in providing the homeless with food, clothing and shelter, they are of questionable therapeutic value and should be used only as a temporary measure. As a shelter provider, I envision myself as a provider of emergency shelter and do not want to be seen as a long-term solution to housing the mentally ill homeless. Shelters are not permanent housing situations. The shelter is an extremely stressful environment where strangers live in close quarters, where there is little or no privacy, and where most disturbing of all, there are no adequate mental health services to meet the needs of the population served.

I suggest that federal standards or guidelines for appropriate hospital discharge settings be set up so that shelters would no longer be

seen as "proper" placements or referrals. A hospital's failure to comply could be documented by the shelter and a fine or some other consequence be imposed upon the institution. I want to prevent a tragedy like this one that involved a former resident of Calvary. A woman who lived in and out of shelters for several months was eventually committed to our area's mental health facility. When she was told that she was going to be released again into the community she voiced strong fears about returning to the streets and shelters. Soon thereafter, she jumped from the 11th Street Bridge into the Anacostia River. She did not die in the suicide attempt but the policeman who made the rescue drowned.

Traditional mental health treatment approaches usually are not effective in reaching or treating homeless mentally ill persons. A mental health treatment program for the homeless mentally ill should include some stabilization of their immediate physical environment, the provision of shelter, food, and physical health care, and protection from violence--all significant aspects of the mental health treatment process. It is very difficult to help these people without first establishing rapport and trust. It is necessary to deliver the type of mental health care that these persons can accept and in a location where they will accept it. Often this means establishing and delivering mental health services in shelters. Shelters are important sites in which to make "contact" with the homeless and may constitute a first stage in the process of rehabilitation and resettlement. Thus, I would like to suggest that those students seeking financial aid to complete their study in psychiatry or clinical psychology work in the community with the mentally disabled in partial repayment for their federally guaranteed student loans.

I would also like to suggest that a study be done on the effectiveness of current commitment laws. New liberalized mental health laws have made involuntary psychiatric treatment almost impossible. And although I am not advocating a return to the past, I do advise evaluating them.

I'd like to share a story with you. A woman who lived at Calvary for 3 years spent every day of the year panhandling outside the old Hecht's Department Store. She refused to go inside any building during the day, even during the winter months. As a result of her spending 12 hours each day outside, she was in poor physical health. Due to her schizophrenia, she was only able to speak in garbled sentences. And after knowing her for two years, I still was only able to find out her name and age. Her behavior in the shelter was often bizarre and unpredictable. (This was also due to her mental illness). She frequently became aggressive with the staff which was extremely intimidating since she weighs close to two hundred pounds. On one occasion, she chased me around the facility and I was forced to lock myself into a secluded area in order to get away from her. When the police arrived they refused to take her because she was by now calmed down and she did not seem harmful to them. It was not until the staff social worker was physically hurt by this resident that they agreed to take her for psychiatric evaluation. After hospitalization and treatment with medication, this woman now carries on a normal conversation, no longer lives outside but in a group home for the mentally disabled. She is an example of how commitment to an institution can provide the type of supportive treatment some of the mentally ill desperately need.

While many homeless persons have no financial support at all, the level of disability of most homeless mentally ill patients is usually substantial enough to warrant Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Paradoxically, however, because of their severe mental symptoms, they are unable to follow the very difficult bureaucratic procedures necessary to gain access to the Social Security Disability Program. As a result, they are excluded from treatment in most voluntary and private facilities, some of which would treat the chronic patient if insurance was available.

One of the most tragic stories regarding the ineffectualness of the present benefit system involves the inability of a 73 year old woman to obtain her SSI check. She lived at Calvary off and on for three years. She was mentally and physically disabled and also suffered from alcoholism. She often slept in the parks and came to the shelter to clean up occasionally or when it got too cold to remain outside. The first time she came to Calvary was just after she had been raped. As with most clients, we established a trusting relationship with her and then began the arduous task of applying for benefits on her behalf. We started the process for SSI in 1984 and received a check in 1986. About three weeks before the check was received, we were able to arrange for her moving into a home for the elderly with the understanding that payment would be soon forthcoming. Unfortunately, this woman died before she ever saw the check. We received a back payment of \$5,000 one week after we buried her in Potter's Field.

Health insurance and benefits are crucial supports, yet most homeless mentally ill persons have neither. The SSI Program appears to be one of the few long-range assistance programs for the mentally disabled. Yet access to this program must be free from overwhelming obstacles. In many ways, this system and others like it were never designed to be accessible to the gravely mentally disabled, and thus fail one of the very populations that should be served.

Society, in general, has seemed unwilling to accept the chronically ill back in the community. The result has been that many of the chronically mentally ill have not been able to cope with life on their own and have eventually become homeless, ending up on the streets of America. Yet with proper care and support they can become an integral part of our society. The stories I have shared reflect the most severe for this is the population we see in the shelters. There are millions of mentally ill persons that lead normal productive lives in our communities. By educating the public in order to de-myth the stigma of mental illness, by creating innovative programming, by providing housing and opportunities for job training, we shelter providers envision the day when our facilities will no longer be the "new institutions for the mentally ill."

Mr. WEISS. Thank you, Ms. Baxter.
Dr. Pollack.

STATEMENT OF DAVIS POLLACK, D.D.S., BAY SHORE, NY, REPRESENTING THE NATIONAL ALLIANCE FOR THE MENTALLY ILL

Dr. POLLACK. Thank you, Mr. Chairman, and members of the subcommittee.

I am grateful for the opportunity you've extended to me as vice president of the National Alliance for the Mentally Ill, to share with you some of the perceptions and experiences of families of the seriously mentally ill.

This brief oral presentation will personalize and supplement the very lengthy written testimony that has already been presented to your committee.

The alliance represents 70,000 members and over 730 self-help and advocacy groups. It was founded in 1979. Our offices are in Rosslyn, VA.

I have a story to tell, a story that is not unique to my family; of a 37-year-old daughter, gifted, sensitive, loving, tormented with manic depression for 18 years, an extraordinary violinist, a beautiful, tender person, whose life has been shattered by the illness. Hospitalized at the moment. Very frightened, confused, exhibiting infantile behavior.

I have a 27-year-old son, brilliant, a National Merit semifinalist, outstanding athlete, struggling with schizophrenia for 10 long years. Often hallucinating, delusional, and exhibiting bizarre behavior.

Both have been hospitalized many, many times, indicative of the chronicity of this illness. The anguish and pain they live with day by day defies description.

My son has had three serious suicide attempts. He's now functioning on a minimal level, socially withdrawn, isolated, rejected by friends, attending a day program, trying to relearn the basic everyday living skills.

My daughter has manifested psychotic behavior for years, extreme mania and depression, traveling throughout the country with complete dependency on anybody she would meet, unable to think or function for herself. For the last 6 years she has been married to an alcoholic whom she met in the psychiatric unit. It has been one crises after another for both of them.

Despite it all, my children, as well as the others, who are ill, display remarkable courage in their attempts to get well and restore some dignity and normalcy to their lives.

My third child, age 30, a middle son, has nowhere achieved his potential. An honor student at Yale University for 3 years, his grades dropped dramatically, simultaneously with the onset of his brother's illness. He withdrew from school and lives with the typical reaction of a sibling, fear and guilt, why them? Why me?

My wife and I have been devastated emotionally, physically, and financially with the seemingly hopeless task of coping, and obtaining the optimum, and in many cases having to settle for the minimum care, treatment, and services for our loved ones, both at outpatient and inpatient settings.

Relatives and friends did not understand the illness, were frightened of it, and did not reach out with support and compassion. We fought a lonely battle before NAMI surfaced.

We and other families felt guilt and shame until science increased our knowledge of biological and biochemical causes of mental illness. The early theories led to my wife blaming me for our son's illness, and I blaming her for our daughter's illness. We become petty and irrational. You think illogically. The marriage suffers as the fabric of the family is torn apart. Ours was saved by professional help and support groups.

Respite care for families is sorely needed. About 800,000 seriously mentally ill people today reside with their families. This is due to the fact that most systems today rely on us to be the primary care giver. In my State of New York, over 60 percent of the deinstitutionalized people end up living with the family due to inadequate community services and residences.

The client and the family must learn to change their expectations. It helps to make the illness more bearable.

As a self-employed professional, the maximum insurance I could obtain was for 30 days inpatient care. There are some psychiatric facilities that cost as much as \$200,000 per year.

The Government has provided no direction or leadership in educating our society about mental illness, especially schizophrenia. How long must employment, educational, and housing opportunities be denied because of myth, and ignorance, and fear? When will the media stop equating mental illness with violence? How long will millions of ill people and their families stay in the closet and deny the illness?

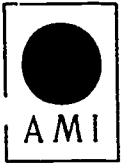
We at NAMI have an intensive public awareness antistigma campaign. This must be a top priority with the Federal Government. We can't do it alone. Also, increased research effort and funding must come out of the Federal Government.

Eighty-five percent of the total funding today comes from the Federal Government. We have started our own research foundation, National Alliance for Research for Schizophrenia and Depression, to try and increase the role of the private sector, but we have a long way to go.

I have come here today to raise my voice in protest, and anger, and frustration, to speak out against a shameful neglect of some of the most vulnerable and deprived citizens in this great land of ours. The mentally ill have committed no sin to rain God's wrath upon them, nor have they freely chosen unconventional lifestyles, or engaged in erratic behaviors. Their sole offense has been susceptibility to a particular form of physical illness which affects the brain.

We must not exclude, we must not abandon, we must not neglect those who cry out for help. Thank you.

[The prepared statement of Dr. Pollack follows:]



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**TESTIMONY
of
DAVIS POLLACK
on behalf of
THE NATIONAL ALLIANCE FOR THE MENTALLY ILL**

**before the
Subcommittee on Human Resources
and Intergovernmental Relations,
Government Operations Committee,
U. S. House of Representatives**

May 19, 1987

1901 North Fort Myer Drive Suite 500 Arlington, Virginia 22209 (703) 524-7600

STATEMENT OF DAVIS POLLACK ON BEHALF OF THE NATIONAL ALLIANCE
FOR THE MENTALLY ILL, BEFORE THE SUBCOMMITTEE ON HUMAN
RESOURCES AND INTERGOVERNMENTAL RELATIONS, COMMITTEE ON
GOVERNMENT OPERATIONS, U.S. HOUSE OF REPRESENTATIVES, MAY 19,
1987:

Good Morning, Mr. Chairman, Members of the Subcommittee.

I appreciate the opportunity you have extended for me to share with you some of the perceptions and experiences of families of mentally ill persons. While I will describe my personal story in my verbal narrative, I want to assure you that the Pollack family is not unique. The recital of what has happened to me, my wife, our son and our daughter is being replicated throughout this country over and over again. Every day, in every corner of this land, there are spouses and children and parents struggling with this seemingly hopeless task of obtaining care and treatment for their mentally ill loved ones. And even worse, there are at least two million persons who are struggling against all odds to vanquish the demons which stalk their minds. These are the people that my story, and the stories of other families, are really about.

Despite my gratitude to you for soliciting testimony from the National Alliance for the Mentally Ill*, I hope you will forgive me if I refrain from expressing my delight at being here with you today. I wish it were unnecessary, merely a pleasant formality, that I could praise our system of caring for the mentally ill in this nation and applaud the Congress for a job well done.

But I cannot. Instead, I have come here to raise my voice in protest and anger and frustration, to speak out against a shameful neglect of some of the most vulnerable and deprived citizens in this great land of ours. The mentally ill among us have committed no sin to rain God's wrath upon them, nor have they freely chosen unconventional lifestyles or engaged in erratic behaviors. Their sole offense has been their susceptibility to a particular form of physical illness which afflicts the most important organ in the body--the brain. The recent discovery of a genetic marker for manic-depression reaffirms the biological basis for mental illness. And only last Tuesday, Dr. Anne Bassett of the University of British Columbia announced discovery of genetic clues to schizophrenia, adding further weight to the linkage between mind and body.

* The National Alliance for the Mentally Ill (NAMI) represents 45,000 families members of the mentally ill, organized into over 730 self-help and advocacy groups across the country. Founded in 1979, its office are located at 1901 N. Fort Myer Drive, Suite 500, Arlington, VA 22209.

We are at last beginning to understand that the mentally ill are physically ill--yet somehow they are still placed outside the pale of compassion shown to cancer patients, AIDS victims, or others ravaged by disease. Instead of mercy and the healing hand of medicine bestowed so generously on those suffering other ailments, too often the mentally ill are left to their own devices, denied employment, shunted aside, humiliated and abandoned.

Once, lepers were ostracized by society. They had bells tied around their necks to warn people of their approach, so everyone could get out of the way. The lepers were left to sleep in doorsteps and beg for their survival. When a leper died, the only sorrow found was in the quiet weeping of a mother, too ashamed to openly wail at the fresh grave in a potter's field. Today, leprosy is no longer so dreaded a disease and yesterday's outcasts are now treated with the dignity they deserve.

The New Lepers

But look around you, Mr. Chairman. Go down to First Street, or over to the ledges of some of the buildings at Federal Triangle. You don't have to go far. There are new lepers there, huddled in the shadows, homeless, frightened, alone. They don't wear bells, but make no mistake. They are the lepers of today. People go out of their way to avoid them, to walk around them, to step over them. And at least 40% of those who are homeless are mentally ill, seriously mentally ill.

We call them "homeless" but often that is a misnomer. Many have homes and families who care for them. They are more aptly described as "being away from home," either because their illness has driven them to flight, or because they are disoriented and confused, or because their families could no longer bear the constant stress of being care-givers without respite. Some, of course, are truly homeless, a pitiful reflection of the lack of adequate housing for mentally ill adults in this country.

But whatever the reason for "homelessness" among the mentally ill, those living on the streets represent only one of many leper colonies in America today. It is estimated that there are over 2 million seriously mentally ill persons in this country--people with illnesses like schizophrenia (600,000 in active treatment on any given day, plus untold untreated cases) and bipolar and affective disorders (which are estimated to afflict 20 million people at some time in their lives). And each of those mentally ill lives in a leper colony of some form--either a private Hell or an institutional ghetto or in social exile.

The victims of mental illness are not characterized by any discernible demographic feature--they may come from wealth or poverty, from any race or creed, from rural as well as urban areas. They can be male or female, young or old. The disease of mental illness stalks its prey without regard for the sanctity of home or hearth. It honors no talisman of faith or upbringing. It can strike your child as readily as it did mine (although there are genetic predispositions to mental illness). And as I look about this room, I cannot help but wonder how many here today already can echo my feelings or will someday have to face the bitter reality of the shattered dreams they hold for their children.

The mentally ill do not usually bear any physical stigmata, but they do carry with them the wounds of suffering in an uncaring environment. They are all victims twice over--once as the unfortunate hosts of a misunderstood affliction and again as the pawns of a non-responsive treatment system.

Deinstitutionalization

Some, in the name of economy and compassion, were discharged from state mental hospitals only to find that communities were ill-prepared to accept them and offer them adequate treatment. Between 1955 and 1984, the long-term patients in mental hospitals decreased from 558,322 to 116,136. A large percentage became part of the "revolving door" variation of institutionalization. Released from a state hospital, they struggled to maintain themselves in the community. When a relapse occurred, they returned to the state hospital on a temporary basis and were recycled out the door until the next episode. Thus, despite the "downsizing" of our institutions, the number of state hospital admissions in this country increased from 178,003 in 1955 to 332,000 in 1984.

Other mentally ill persons, whose illness came after deinstitutionalization was an accepted norm, were denied access to the state hospital, even though they might have been admitted in earlier times. But there were few alternatives they available to them. They became the "non-institutionalized." And where did they turn, Mr. Chairman? How did society respond to them in the era of deinstitutionalization?

Home Care

Most simply stayed at home. Their parents and spouses and children remained as the primary care-givers and a major share of the costs which would otherwise have been borne by government were absorbed by their families. About 800,000

seriously mentally ill people today reside with their families. Public financial assistance is limited. Respite programs are practically non-existent. And a major worry of such families revolves around the question of who will assume the care-giver role when age takes its toll on parents or spouse? How will children starting families of their own be able to meet the extraordinary burden of providing a decent life for their mentally ill mother or father? Questions for which, in today's world, there are no ready answers.

Nursing Homes

Three hundred thousand seriously mentally ill persons live in nursing homes. According to Dr. Howard Goldman of the University of Maryland, there are more chronic mental patients in intermediate care facilities (ICF's) than any other institution. In these long term care facilities, they receive almost no active treatment. Medication is frequently administered, not for therapeutic reasons, but to render the person docile for administrative convenience. In fact, the Health Care Financing Administration (HCFA) has created disincentives for providing treatment in nursing homes by classifying homes which offer mental health services as "institutions for the mentally diseased" and threatening Medicaid funding.

Adult Foster Homes

Adult foster homes are a growth cottage industry in America, with facilities springing up around the country like desert wild flowers after a Spring rain. Many are fine establishments. But their rapid expansion in numbers has not been accompanied by adequate quality controls. The result is a plethora of foster homes that are often deplorable and sometimes scandalous. Exploitation and victimization of mentally ill residents is an unfortunate reality in far too many cases.

Group Homes

Many mentally ill persons can benefit from congregate living arrangements, group homes where support and supervision are available and a sense of belonging can develop. But group homes are in exceedingly short supply and many communities have adopted zoning laws and other restrictive artifices to prevent the establishment of suitable group living arrangements for chronically mentally persons capable of semi-independent living.

Life in the Streets

Perhaps 100,000 to 150,000 chronically mentally ill live in the streets or in temporary shelters. I don't need to remind you of the desperate circumstances of their existence. They are easy targets for hoodlums, rapists, pushers, and other criminals. They are harassed, hounded, mocked, and ignored. But treatment? It is as alien to them as a freshly pressed Brooks Brothers suit. Most of their care is delivered in the emergency room, where no one checks the label on their clothing.

Jails and Prisons

A significant number--25,000 or so--are residents of prisons and jails, where psychiatric care, if it exists at all, is clearly secondary to punishment as the treatment of choice for their illness. Sadly, for some the criminal justice system is a major entry point into the treatment system. The mentally ill person picked up for a minor crime may become a court-mandated client of the treatment system if a sympathetic judge hears the case. Or an uncontrolled psychotic may be confined to a forensic unit for treatment which should have been available without the commission of a horrendous offense against society. The mentally ill do not belong in jail or prison, but that is where we consign them when we can no longer cope.

Independent Living

The picture is not totally bleak. About 200,000 mentally ill persons have stabilized enough to live independently. Some reside in satellite apartments provided by centers like the Green Door here in the District of Columbia. Others can fend for themselves in the rental marketplace, either because they have independent means or are recovered enough to be gainfully employed and self-supporting. But 200,000 out of 2-million is small solace indeed.

And even these lucky few face tremendous challenges in finding decent housing. Many work at entry level jobs or are on Supplemental Security Income (SSI). Without financial assistance, through programs like Section 8, the cost of independent living would be prohibitive. In addition, a major source of housing for the mentally ill in the past is rapidly disappearing. Low-cost rooming houses and cheap hotels offering single-room occupancies (SRO's) are being torn down in the name of urban renewal. Between 1970 and 1980, nearly one million units were destroyed or converted to other uses. In New York City, well over half of the SRO's

have been removed from the housing market in the past five years. There is a critical need to maintain and expand the Section 202 housing program to assure the availability of adequate and suitable housing for those mentally ill persons capable of independent or quasi-independent living.

And so each of the alternatives to institutionalization has generated its own form of leper colony, making pariahs of those who suffer from mental illness. The "system" forces dependence and penalizes independence.

Community Mental Health Centers

Theoretically, state and Federal resources were supposed to follow the deinstitutionalized client into the community. It never happened.

At the dawn of the deinstitutionalization movement, its architects designed an elaborate system of community-based care for those who were released from state mental hospitals. The centerpiece of the system was to be the Community Mental Health Center (CMHC), which would provide outpatient services to the chronically mentally ill. After passage of the Community Mental Health Centers Act in the early 1960s, 700 CMHCs sprang up around the country. The nation appeared to be on the path toward a more humane and effective way to treat the mentally ill.

But somewhere between the planning of the "system" and its execution, something strange happened. The compassionate impulses of deinstitutionalization gave way to the cost containment necessities of tough fiscal times. The money never flowed into the system as anticipated. And so, the Community Mental Health Centers, anxious to prove their value but financially limited in their ability to meet their mandate, began to "skim" the easier patients, to treat those who could profit from the "quick fix" appropriate to relatively uncomplicated disorders. They tended to focus on the "worried well," who suffered from minor depressions, poor self-images, and the like.

The chronic schizophrenic and the manic-depressive were the least desirable clients, because they consumed scarce resources while providing fewer success stories. They also tended to have less third-party coverage to supplement a Center's income. Today, only about 20 to 30 percent of the patients treated at Community Mental Health Centers have had prior inpatient care at a mental hospital. Whether by volition, or by submission to the survival instinct, the CMHC's have clearly not met their early expectations as comprehensive systems of community care for the seriously mentally ill.

The National Alliance for the Mentally Ill and its member families are strong supporters of the concept of community-based care. We do not want our loved ones unnecessarily sequestered in far away institutions. We want them near to us, where we can visit, lend support and encouragement, and serve as active partners with professionals in the treatment and rehabilitation processes. But we cannot embrace deinstitutionalization without qualification, because we have seen the long, dark shadow cast across the landscape of our hopes by a sham "system" that isn't working. The covenant of care that offered so much promise has proved to lack sufficient substance to merit our confidence.

State Hospitals

Wherever you look within the mental health system, something is broken and needs fixing. The depopulated state hospitals remain expensive to operate and afford meager treatment. Many of the buildings are out-moded and badly in need of repair. Minorities occupy a disproportionate share of the beds in such institutions, strongly suggesting that the "system" of community-based care is less than effective in meeting their needs.

Continuity of Care

Continuity of care is a concept more honored in the breach than in the practice. When a mentally ill person is discharged from one treatment setting to another, elaborate plans are frequently drawn up to assure such continuity. But within a few weeks, those plans are forgotten because there is no fixed accountability for follow-up. Records may be kept by the discharging institution and shared only in summary fashion, if at all. The receiving treatment provider has no obligation to either participate in the discharge plan or assure compliance. Discontinuity is more characteristic of the "system" than continuity.

The absence of linkages pervades the "system." Looked at as a whole, all of the elements are present to provide continuity as a patient moves through levels of care--hospitals, nursing homes, half-way houses, community centers, private facilities, group homes, supported independent living. But each element, unfortunately, tends to be a discrete and autonomous integer, unrelated to the others except by the happenstance of common clientele. On occasion, they are at war with one another, with one segment of care "dumping" patients on a different element to save money or maintain a desired patient population mix. Philosophical disputes and incompatible treatment modalities perpetuate

cleavages within the "system." Competition for limited resources generate suspicions and inter-element hostilities. And through all the internecine squabbles, it is the vulnerable patient who suffers.

In those rare cases where cooperation and coordination exist--in places like Dane County, Wisconsin--the "system" works and patients benefit from a smoothly functioning therapeutic stream. Such places offer tried and tested models for fixing the ruptures in the "system" which have permitted so many mentally ill persons to fall through the cracks.

Vocational Rehabilitation

The lack of coordination is not restricted to treatment services. It is endemic to the whole range of programs which should play a role in restoring mentally ill persons to productive citizenship and enabling them to live up to their maximum potential. Vocational rehabilitation (VR) services have only recently begun to pay attention to the mentally ill, but their utility is limited by restrictive regulations which reflect a bias toward the needs of traditional clients among the physically disabled. And VR has few linkages with employment services or the providers of care for the mentally ill, so that treatment, rehabilitation, and employment are viewed as distinct activities without a relationship to one another.

The Health Care System

The health care system has tended to keep only an arms-length association with the mental health system, despite increasing evidence of the affinity between the two. We know that many ailments mask themselves with the symptomology of mental illness, yet misdiagnosis remains common because physical work-ups are not routinely performed. Inappropriate treatments, synergistic adverse drug interactions, and neglect of basic health care needs arise too often because the therapist and the primary physician do not communicate with one another. Ignorance of mental illness on the part of health care providers fosters a benign neglect at the patient's expense.

The mentally ill frequently experience side effects from their medications or suffer health complications arising from their illness. Many mentally ill self-medicate through the use of alcohol or illicit drugs, drinking to quiet their mania or popping pills to relieve their anxieties. Substance abuse among the mentally ill compounds treatment problems and may require the special expertise of a variety of providers.

But there is little recognition of the importance of interactions between the various disciplines. In fact, a mentally ill person suffering other physical ailments in combination with substance abuse, would likely be shuffled back and forth through separate systems. The picture that comes to mind is the game of musical chairs, only in this situation, there isn't any music to orchestrate the dance.

One of the great dangers in the fragmentation of service delivery is that the mentally ill will be overlooked in the planning for essential programs outside the mental health community. An awareness of and sensitivity to the unique circumstances of the mentally ill are vital among advocates and providers in the fields of health care, corrections, education, rehabilitation, employment, housing, and disabilities. But interdisciplinary coordination and cooperation has been slow to develop and the harvest of this professional myopia has been inadvertent neglect that is the dominant systemic feature of the environment in which the mentally ill dwell.

AIDS

To cite but one example, health professionals and policy-makers around the nation are focusing considerable resources and energy to combat the acquired immune deficiency syndrome (AIDS). The frightening specter of this incurable disease and its geometric progression through the population has made it the Public Health Service's number one priority. Efforts are being made to teach prevention in our schools, promote voluntary testing, and research the causes and possible cures for AIDS. New programs for hospice care are being initiated and existing Medicare and Medicaid laws are being changed to afford some relief to AIDS victims. Even the National Institute of Mental Health has gotten into the act, by promoting programs to counsel AIDS victims and ease them through their mental trauma.

But, Mr. Chairman, I have yet to see anything which focuses on the special vulnerability of the mentally ill in relation to AIDS. We know that many mentally ill persons are substance abusers who may be at risk of transmission of AIDS through shared needles. We know that others are hypersexual during manic episodes and could spread the disease if infected. At NAMI, we have heard reports of sexual attacks on the mentally ill--sometimes in hospitals or shelters, sometimes on the streets--and at least one such case of AIDS transmission has been brought to our attention. Yet who is studying AIDS in relation to this population? What programs are devoted to prevention among the mentally ill? Who is working with treatment facilities to teach them how to relate

to a mentally ill client with AIDS? I would submit that, particularly in this case, what we don't know can hurt us. And we don't know anything about AIDS among the mentally ill because it has been viewed as a health problem outside the context of mental illness.

Research

At the present time, there is no known cure for serious mental illness. We have no means to prevent its onset. But there is increasing evidence of its biologic origins. Every day, we are learning more and more about how to treat the illnesses, what is efficacious and what is not. We have learned that "talk therapies" which may have some value for healthy people under stress are largely useless in treating the seriously mentally ill. And just this year, two major research breakthroughs have occurred which offer the most exciting potential for progress in understanding the diseases--the identification of genetic markers for manic-depression and schizophrenia.

On the research front, then, this is a time of optimism for all of us who believe the only truly productive form of "prevention" lies in research into the causes and cure of mental illness. But our enthusiasm is dampened by the knowledge that mental illness research has been the stepchild of scientific inquiry, with sparse resources devoted to its pursuit. While our nation invests about \$529 per affected individual on research into multiple sclerosis and \$353 per patient on cancer research, schizophrenia research receives only \$12.45 per person and affective disorders, a paltry \$1.88.

Looked at from another angle, each American spends less than 12 cents per year to pay for affective disorder research and only 13 cents for schizophrenia research. Combined, that comes to two bits per year. Here in Washington, you'd have to double that amount to buy a cup of coffee.

Until recently, Federal support for mental illness research suffered a serious erosion in real dollars, losing 30.7% of its purchasing power between 1969 and 1975. At the same time, other medical research sponsored by the Federal Government rose by 34.5 percent. Some of that deficit has been restored by new initiatives through NIMH, but the young researcher can hardly be blamed for gravitating toward the more glamorous and lucrative fields of inquiry.

If we are to make headway in our battle against mental illness, we desperately need to commit more resources to research. We need to inspire and encourage young researchers to enter the

field. And now, when new discoveries are at the fore, we should strike while the iron is hot and dramatically expand our inquiry into the roots of the problem.

The families of the mentally ill no longer share the outlook of the 1930's. We will no longer sing the refrain of that old song which asks, "Brother, can you spare me a dime?" Ten cents, twelve cents, a quarter for research--that's simply not good enough anymore. My child is worth more than that. And so is yours.

A Friend's Story

I have a friend who told me about his feelings toward his mentally ill daughter. Because his story is somewhat typical, I would like to share it with you. He showed me a picture of the young lady. She was beautiful, talented, and had an engaging personality. But she was also manic-depressive and needed to stay on her lithium in order to function normally.

He told me that, as a father, he remembers vividly those wonderful early years of his daughter's life. As a baby, he would hold her in his arms and sing to her. She learned to read very early and would delight him by dancing like a top on the living room floor, giggling in that infectious way little girls have. When she entered school, she was placed in the talented and gifted student program, brought home report cards even Einstein would be proud of, socialized well and appeared to be a natural leader of her peers. He recalls her desire to be a doctor. He felt, he said, a bit like Kunta Kinte in that famous "Roots" episode in which he jubilantly held his infant up in the night air and gave thanks for the wonder of life.

Then came the teen-age years, when rebellion was expected as a natural part of the maturation process. But nothing had prepared him for what actually happened. His beautiful child of the laughing curls turned moody and depressed at age 14. She was convinced her legs were too long and surgery was the only cure. Her depression didn't go away and toward the end of the year, she attempted suicide. With the advent of Spring, things seemed to improve. She became active socially, but also began to "skip" school and fell in with an older crowd that included drop-outs and young adults. The school counselors became involved and strict curfews were imposed by the family, but to no avail. She ran away several times, sometimes sneaking out of the window at night. As Fall again approached, her mood shifted to a deep depression and she refused to leave her room. She was taken to a psychiatrist who subscribed to the "drug-free" school of

thought. He tested her and met with her several times to talk through her problems, but she didn't like the man and the family switched to a different therapist. Shortly afterward, the first psychiatrist was shot and killed by one of his patients.

The second psychiatrist diagnosed the young girl as a manic-depressive and put her on a lithium regimen. It helped a great deal and for a spell, things returned to near normal within the household. The girl got a summer job in a dentist's office, but lost it near the end of the Summer when she interrupted the dentist in front of a patient to correct him on one of his procedures. She ran away again and was seen wandering the streets and sleeping in doorways. She had entered another manic phase and had stopped taking her medicine. She was hospitalized at a university psychiatry ward, placed on her medicines and released after two weeks. One of her peers advised her to stop her medicines and she again plunged into a depression, trying to kill herself three different ways in a single day. She reentered a private psychiatric facility and was placed in a locked ward for adolescents. She remained there for a month. The week before she was released, she escaped with a boy from the ward and attempted a double suicide. When she was brought back to the facility, she was frightened and confused, but the hospital chose to discharge her anyway. It is perhaps coincidental, but her insurance coverage would have reached its maximum limit two days after the hospital released her. Her bill came to \$40,000, including one charge of \$600 for a half-hour "consultation" with a specialist no one could remember seeing at the facility. (Repeated inquiries failed to identify the service provided during the "consultation." and the insurance company refused reimbursement. That particular charge was given to a collection agency which still harasses the family.)

At any rate, the pattern of behavior continues through erratic cycles of depression and mania, getting progressively worse with each episode. Finally, during one manic phase, the young lady asked to be voluntarily committed to the State Hospital. The admitting psychiatrist refused, saying she wouldn't be safe within the institution. He told her that, since she had just passed her 18th birthday, no adolescent programs were open to her. He indicated that the Community Mental Health Center in the area would have to put her on a waiting list. And he concluded by saying, "If you committed a crime, we could probably help you, but as it is, you'll just have to try to get back on your medicines by yourself."

My friend's daughter left home that night and connected with some bikers who took her to another state, where she lived on the streets for three months. On one occasion, she was raped

and picked up by the police at 3:00 in the morning, wearing only a garbage bag. She was taken to a hospital, examined and released by 8:00 the same morning. As a transient, the hospital drove her to the airport and dropped her off, even though she had no money and was wearing only the muslin dress without under garments that the hospital had provided. Her father was able to trace her to the hospital that afternoon. After being informed of her discharge, he talked to the crisis team and related her history. They assured him that they would let him know if she returned to the hospital for any reason. As luck had it, the police picked her up at the airport and took her to the same hospital. The crisis team called and agreed with the father's assessment that she was seriously disturbed. The father made arrangements to fly to the area to pick her up, but as he was awaiting airline confirmation, the hospital psychiatrist called and told him she had again been released. The psychiatrist said, "It's not a crime to be crazy. I don't think she's a danger to herself or others." Shortly thereafter, a bill arrived at her home. The hospital was charging her \$300 for the examination following her rape. Appended to the bill was a note indicating that if it wasn't paid in 30 days, it would be turned over to a bill collector.

Back on the streets, she was raped at least two more times before she was convinced by a street friend to return home with him. When she got home with her friend, she attempted to kill him three times within the first week. The police were regular visitors at the house. After the third attempt, she was taken in for observation and eventually involuntarily committed to the same State Hospital that had originally refused her admission. In the hospital, she was placed in a room with an older woman who spent each day masturbating on the bed. Her treatment consisted of getting her medications, spending an average of five minutes per week with professional staff, watching television and eating popcorn. At the end of three months, she was stabilized by the medications and released.

As of this date, the story has a happy ending in that the young lady has been out of the hospital for almost two years and has faithfully taken her lithium and other medicines. But that father, like so many of us, still shudders when he hears a siren in the middle of the night. He still recoils when his daughter's speech seems pressured. And his sleep is still troubled by visions of his little girl wrapped in a garbage bag, dancing around his living room floor. Gone are the dreams of being a doctor. She is fortunate to have her entry level job in a fast-food store. She is now an adult. Her job does not provide insurance. Her medicines cost about \$60/month. She is fearful of marriage and the transmission of the illness to a new generation. Her victory over her

illness is taken a day at a time. But it is a great victory against tremendous odds.

And as you reflect on her story, ask yourself if the "system" helped her in any significant way? I would suggest that the "non-system" instead contributed to the terrors of her experience. And that, Mr. Chairman, is why so many families of the mentally ill are so outraged.

The Costs of Mental Illness

I have described in some detail an array of problems faced by the mentally ill trapped inside our non-system of care in this country, but even this narrative touches only the tip of the iceberg. Up and down the line, there are multiple variations on the theme of my remarks and manifold facets of this issue which have been left unexplored. But I hope enough has been conveyed to suggest that there are no easy answers to our dilemma, no single-shot initiative that will make things right, no cheap price tag on the remedy.

But if the answers will not come cheaply, they may, in fact, prove less expensive than costs of continued neglect. John Talbott and Steven Sharfstein have estimated that our society pays in excess of \$73 billion each year in treatment, support, and lost wages for the mentally ill, excluding treatment and services associated with substance abuse. The annual cost for schizophrenia alone is \$10-\$20 billion. Nearly one-quarter of all hospital beds in this country are occupied by mentally ill persons. And these figures calculate only the more easily estimated costs. They ignore the social cost of the sibling who never goes to college because Mom and Dad have diverted the education fund to pay for treatment for a mentally ill brother or sister. Or the family broken up by ceaseless stress. Or the replacement costs of personal possessions given away by someone in a manic state. These figures do not encompass the damage or injury caused by auto accidents involving substance-abusing mentally ill drivers. They do not quantify the grief of parents or lovers or children. They do not count the costs of autopsies or burials of suicide victims, or the budgetary impact of police or ambulance emergency calls responding to a psychotic crisis. They cannot estimate what might have been if a scientist's or surgeon's career had not been interrupted by an episode of illness, or how much productivity is lost to a family member distracted by worry or grief. And who among us is so callous as to even suggest a price tag for those fervent prayers of families which go unanswered or to place a market value on the subway grates which serve as beds in the dead of winter?

The societal financial costs of mental illness are staggering. The personal costs are enormous. But the greatest cost of all is borne alike by society and those individually affected. It is the erosion of human dignity--degrading the victim of mental illness and blighting all who permit it to occur. If our nation becomes dulled to injustices perpetrated against any of our fellows--but particularly the most vulnerable among us--it is nothing less than a fundamental betrayal of our heritage as a compassionate people. This nation is great, not from force of arms, but from the moral force of our values, from our abiding faith that the common good includes us all, that our common destiny is sustained and nurtured by mutual assistance when the need arises. We must not exclude, we must not abandon, we must not neglect those who cry out for our help. For if we do, the hollow echo of history will mock the hypocrisy of our professed beliefs. Then it will no longer be the mentally ill who are the new lepers. It will be the rest of us.

Mr. WEISS. Thank you very much, Dr. Pollack.

With that, the first vote has been called, so I think before we start with the questions we'll take a break. We'll try to be back within about 10 minutes.

The subcommittee stands in recess.

[Recess taken.]

Mr. WEISS. The subcommittee is now back in session. Ms. Baxter, Dr. Pollack, if you will resume your seats.

Let me thank both of you for the insight that you've given to us on the human dimensions of the problem that we're discussing today, because ultimately we're not talking about programs or policies in the abstract. We're talking about how they impact on people.

Ms. Baxter, what attempts have you made to prevent St. Elizabeth's Hospital from dumping patients at your shelter?

Ms. BAXTER. As a member of the District Advocates, we as a group began a monitoring system. When we received a call from a hospital we began to document these calls as inappropriate referrals. We then submit these statistics to the institution that made the referral, to the Mayor of the District of Columbia, and to the City Council and the press.

Mr. WEISS. Would you pull the microphone a little bit closer and raise it because it's voice activated. It's not very strong. OK?

In your testimony you mentioned that mentally disabled people are often too disabled to get the disability payments that they're entitled to. Could you describe that problem for us in a little bit greater detail?

Ms. BAXTER. Due to the mental illness, many of these people are intimidated by the procedure. It requires a lot of documentation. The mental illness sometimes causes irrational thoughts. They have a hard time processing their thoughts, and can't fill out these documents.

In addition, they're required to see a psychiatrist in a strange building. The people that we see at the shelter are afraid of strange buildings, and strange people. There should be more outreach in the shelters. A psychiatrist should come out to them instead of them having to go to the psychiatrist.

In addition, just the time it takes, as I mentioned, the one process took 2 years to go through because of the amount of paperwork entailed.

Mr. WEISS. In your experience, are the homeless mentally ill aware of their mental illness, and are they interested in seeking treatment?

Ms. BAXTER. Many of the homeless are not aware of the mental illness. The disease is very complex. It often makes them noncompliant to treatment. Though they're suffering they don't know how to go about seeking treatment. It requires a long period of time to develop a trust relationship with these people to show them the way that they could be treated.

Mr. WEISS. Approximately how much does it cost to house a mentally ill patient in your shelter, or in other shelters?

Ms. BAXTER. I can only speak for my shelter, and that's approximately \$10 each night for each homeless woman.

Mr. WEISS. Dr. Pollack, do you see any improvements in the availability of public services for the severely mentally ill in the last few years, and are there any Federal programs, or other programs, that you think are making real contributions?

Dr. POLLACK. I can't see any dramatic improvement in services. I think back to the fact, I did not mention in my testimony, that my wife's brother died at a State hospital in Brooklyn 30 years ago, and I'll be very honest with you, yes, there's been some improvement, but for a 30-year period it has been remarkably slow, and the essential services, especially in the community, are just not there.

I think the Federal Government has to set the initiative and take the leadership to get the States and the local communities to do something about lack of community services. As long as deinstitutionalization exists, we're going to have homelessness, and we're going to have a high prison population, and all the other problems, because the community has not—in most cases, has not created the services that these fragile people desperately need and deserve.

Mr. WEISS. Some Federal officials argue that the families and the private sector should take more responsibility for helping the mentally ill. How would you respond to that?

Dr. POLLACK. Would you repeat—I'm having trouble hearing you, Congressman.

Mr. WEISS. Some Federal people say that the families should take more responsibility, or private sector voluntary organizations should take more responsibility. How do you respond to that?

Dr. POLLACK. In terms of the family, I think I alluded slightly to that in my testimony.

As I pointed out, it's such a devastating illness to the family. It's almost an impossible situation. Unfortunately the anger and rage of the ill person are usually directed toward the family. They blame the family for the illness, and the slight amount of violence that is perpetuated by the mentally ill is usually toward the family members.

And it's really unfair. It's unfair for the system to expect us to be the primary care giver. I think it's the responsibility of the Government, of society, to help us. We can't do it alone. And therapeutically it's not in the patient's best interests. That environment is not the environment they should try and get well in because they are so hostile, and rejecting and isolated and we can't give them the services at home. We're just desperately trying to survive day by day.

To truly comprehend the situation, I would often suggest to people that they live in a home with a person with schizophrenia, for about a week, to get an indepth understanding—the slovenly appearance, the bizarre behavior—my son's room looks like Jack Klugman's on the "Odd Couple" on television. And it's just—it's an impossible situation.

It's rare, but it can work out—where the ill person is getting the therapeutic treatment that he or she really needs. The love and compassion is there, but it's an exhausting and really—it's an indescribable experience, it really is, to live with a person with serious mental illness. And the unpredictability.

One day that individual, my son, would be the most loving person in the world, and the next day he'll just attack us. Jump on us. Blame us for everything. And it's—I don't recommend it. I don't recommend it.

Mr. WEISS. Thank you, Dr. Pollack.

Ms. Baxter, you had mentioned a problem that exists when you as a shelter provider are expected to provide care for mentally ill people. Tell us a little more about the problems that that creates for you.

Ms. BAXTER. Well, first of all, most people that work in shelters are not professional mental health workers. We don't have the money to provide the type of care that the mentally ill need.

I, myself, come from a communications background, majored in Spanish in college. I was a Peace Corps volunteer. We need people that are professionals in the field to be serving this population. We've been forced to do it along with congregations in the community to provide the support where I guess the Federal Government fell, or other Government systems, fell through in providing it.

Mr. WEISS. Thank you very much. Let me yield at this point to my colleague, Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman.

Dr. Pollack, in your written testimony you mentioned the importance of medical research on the causes and a cure of mental illness. How would you rate the National Institute of Mental Health's current job in regard to research?

Dr. POLLACK. Please repeat—I'm sorry.

Mr. LIGHTFOOT. The NIMH's research they're doing now, how would you rate it? Are they doing a good job, a poor job, or rate it 1 to 10?

Dr. POLLACK. I feel that under the direction of Dr. Frazier, the immediate past Director, there was a major initiative toward the illness of schizophrenia, and research into schizophrenia.

It's an inadequate job, extremely inadequate. We quote figures where \$17 a year is spent per person in this Nation for schizophrenia, \$10 dollars for depression, \$300 for cancer, \$1,000 for muscular dystrophy, \$160 for multiple sclerosis, approximately \$140 for heart. It's woeful.

That is why we've started our own research foundation. As I indicated, a very small percentage of the funds have ever come from the private sector, and I personally feel that's because of the lack of public education and awareness. We can't have a telethon because people will not send money for mental illness. Why should they send money for an illness that the family created? Let them subsidize it. Let them suffer with it.

Until we can educate this society that we did not create the illness, that the patients are not responsible for their own illness, it's a no fault illness, until we educate society we will not get the funding from the private sector that we need.

We do have this new research foundation which was just founded. Hopefully, we will raise a considerable amount of money to fund many young scientists in major new research initiatives.

Mr. LIGHTFOOT. You also mentioned in your written testimony the success of a mental health system in Dane County, WI. Could you describe that program and tell us a little bit more about it?

Dr. POLLACK. What makes Dane County so successful, and I've never been there personally, but I've served on the board with people from Wisconsin, I've read about it, I think the key ingredient to the success of that program is the continuity of treatment.

By that I mean, and again I'll personalize, my son is in the hospital, he has a social worker and a psychiatrist, and a case manager. He comes to the home. He may have another case manager. He ends up living in a community residence. He gets a third treatment team. This is the only illness where there is no continuity of treatment.

Now, I don't mean if you're living in New York and then you move to Chicago. I'm talking within one county. In Dane County, WI they pay them well, so they have case managers who stay on for a long period of time, and the freestanding case manager follows that patient no matter where he or she goes, be it the home, be it the street, be it jail, be it in a hospital. So he has continuity of treatment. The patient has somebody they can relate to. And they're able to keep their hospitalization rate, or rehospitalization rate, down to a minimum because the ill person knows there is the same caring case manager always available, working with them, helping them with their everyday living skills, be it a Social Security problem, be it a housing problem, be it changing an address, and they really reach out to the individual. They follow the client wherever that individual goes.

And to me that continuity of treatment is the key ingredient in the success of that program, of keeping these people out of the hospitals. Or if they're rehospitalized, for shorter durations.

Mr. LIGHTFOOT. If we could pursue that a little further, in cases like your son, for example, do I understand you correctly that the lack of continuity of the treatment is probably more of a detriment than the fact that people giving the treatment are not qualified?

You've got qualified people but he gets switched around all the time rather than one person that follows him all the way through the system?

Dr. POLLACK. Well, certainly in the inpatient facilities, in the State facilities, and again I can talk about New York, which is my home State, there are many mental health professionals there who are not qualified. They're foreign trained psychiatrists who are coming here to do their residency in hospitals. Thank God we had a bill pass where they have to be able to speak and understand English. I'll never forget, I treated a psychiatrist in my private practice, and I didn't understand a word he would say to me. I said to myself, "oh, my God, and he's handling fragile, weak, scared individuals? He's their therapist?" I don't understand a word he's telling me when he's sitting in the chair.

I think you need better trained people. You have to pay them higher salaries to attract more qualified, caring personnel. In the programs in the community, social workers are paid like \$10,000-\$12,000 a year. Well, who are you going to attract to work with this vulnerable, difficult population? If anything, they should be paid more because it's such a demanding and unpredictable population to work with.

My son has case managers working through Catholic Charities in my county, Suffolk County, but they leave so rapidly, they are paid

so little, and they have a caseload of 40 and 45. They could see him perhaps 1 hour every 2 or 3 weeks at most. Or a little more frequently if there's an emergency. Most are dedicated, but they can't do a credible job. It just isn't fair.

The system has so ignored these patients, these sick individuals, we have not provided the proper salary scales and the proper education and training, and skills, necessary to attract the finest professionals to serve this population.

My feeling is that a case manager is a vital ingredient in the rehabilitation of an illness. My son had a case manager who took him to a hockey game, who sat and chatted with him, took him out to dinner, helped him with his SSI problems. They don't want the family to get involved. He resents his dependency on my wife and me. The case manager was a friend, confidant and companion to my son. Somebody who is available for him, or accessible to him. Somebody who can help him with the everyday problems, and I mean everyday living needs and skills.

They're so fragile, they're so weak. I don't have to tell you how many had their disability payments terminated. Many committed suicide. Others ended up homeless. NAMI's advocacy was primarily responsible for getting many of them restored to the disability rolls. How can you expect a mentally disabled individual who gets something through the mail, living in an SRO, saying report to the SSI office, to follow through? He doesn't show up, so he gets thrown off.

My son had his family the whole time interested and concerned about him, so we would be there to gently guide and direct him, but those who are living on their own, be it the street, or in an adult home, or in a shelter, they have nobody, nobody. They're just given their check every month and we pray and hope that they can fend for themselves.

And we must have freestanding case managers, a case manager who can follow the patient wherever he goes. I reiterate that. It's so important—freestanding case managers.

And you can never have too many case managers. The caseload should be no more than 5 or 10 at tops for any case manager. The clients require so much attention, and so much detail. Outreach means coming to the home when they don't go to the program, when they're lying in bed and vegetating, to talk to them, to try and get them to go out.

Many a day my son would just lie in bed and sleep. He didn't want to go to day programs. He didn't feel like it. Life wasn't worth living. Why should he go? He's not going to listen to us. He might listen to a loving, compassionate social worker or case manager who comes and spends time with him.

Mr. LIGHTFOOT. Do you find that the best potential result is a combination of a good case manager who stays with that individual all the way through, plus the backup from a family? Would that be the ideal situation? And then what would you do with the individual who doesn't have a family there to help him?

Dr. POLLACK. That is very prevalent today. There are many. It's interesting. I alluded to the fact that my brother-in-law died in the State hospital 30 years ago, and when I would go to visit him I used to come home and say "I can't understand it. Where are the

families? Nobody visits." My mother-in-law was the visitor for hundreds of unvisited patients at what was then Brooklyn State, which is now Kingsborough Hospital in Brooklyn.

But now that I've lived with this illness my whole life I realize what it does to a family. Some just abdicate. They can't handle it. It's a question of their survival.

And in many cases there is no family, and if there's no family, we hope this system would help them out. It is not that the families don't love the individual—they are weary—can no longer cope; especially the fathers who are often in denial.

You go to our conferences and meetings, 75 percent are women. The fathers can't handle it, they take off. Especially if it's a son and he is a macho father. "My son can't be ill. He's just going through a terrible stage in life."

We really can't count on the families. We shouldn't rely on 65 percent of the deinstitutionalized in New York State ending up back home. And most of us are older, and when we're gone it will be a major problem.

NIMH has tried to provide—many States now have it in effect, where we have guardianship programs, where if your child is orphaned there is—we have an organization set up within the States where AMI will serve as guardian, handle the financial end, set up trusts, et cetera.

We're concerned about that because the bulk of our members, active members, are older people. We had a committee, I thought it was an appropriate name, called WIAG, "When I Am Gone." When we are gone who is going to take care of these fragile people? Are we going to have a generation of homeless walking the streets, ending up in jail because they're stealing a few cents here, or they're stealing some food? And this is a great fear of ours, and it should be a great concern of the Government, because down the road when we older people who are involved in this movement die, you're going to have—you think you have a homeless population now, a severe problem with the homeless mentally ill. You haven't seen anything yet.

Mr. LIGHTFOOT. I have an aunt and uncle who had two children who were mentally retarded. One youngster passed away at a relatively young age. They tried to keep the second youngster at home, but he became violent.

We have a good State institution in Iowa, and the youngster was institutionalized. As he got older, he was a little more under control. He's back living at home now, but he spends his day in a sheltered workshop. And, quite frankly, it's worked out quite well for the family considering the circumstances they've gone through, which I think basically is what you're saying, that if you've got the combination of the two, it works quite well.

Ms. Baxter, this is more of an opinion question. I think you can answer it with facts and figures. Even with the focus that we've had on the "homeless" in the last several months, we still don't have a good definition of who the homeless are, and we really haven't identified how many of them are out there.

But one of the points of discussion you hear many times, is that the cause for homelessness is most likely mental illness and/or drug dependence, or chemical dependence of some type. Do you

think that's an accurate description of why many of the people that we consider homeless are in the position they're in today?

Ms. BAXTER. At Calvary Shelter we see many, many mentally ill, but I must include that in addition to this, many people are homeless due to the lack of permanent housing made available in this city, both permanent housing that is supervised for the mentally ill, and permanent housing that is simply for people on low incomes, such as for the elderly.

We see elderly women who have been evicted because they're living on such small incomes. We see the battered also. I'd say it's a combination though at Calvary we more or less specialize in housing the mentally ill just because no other program is willing to take them in.

Mr. LIGHTFOOT. Again, so what you're saying, is that most of the people you see are suffering from mental illness of some type?

Ms. BAXTER. Yes, over 90 percent of the residents at Calvary Shelter are mentally ill.

Mr. LIGHTFOOT. Thank you very much. Thank you, Mr. Chairman.

Mr. WEISS. Ms. Baxter, on that last point, you cited one instance where you tried to get disability coverage for an elderly woman. Do you make it a general practice to try to seek out governmental support, whatever they would qualify for?

Ms. BAXTER. Yes, we give individual attention to each resident at Calvary Shelter. I have a social worker on the staff that is responsible for assisting them in applying for medical and financial benefits.

In addition, we have a psychiatrist who recently joined our staff. So all of the clients—once you form a relationship with them, of course, we work toward getting this, and I must say we have been successful in moving on some of the most difficult clients, women who have been in an institution most of their lives, and were thrown out of the hospital about 5 years ago.

Mr. WEISS. And what rate of success do you have in getting coverage, whether it's SSI, or disability, or whatever?

Ms. BAXTER. We never stop trying, so I must say we have 100 percent success rate.

As I said, it took 2 years one time, but we don't stop trying. We keep going. We keep calling up those offices. We keep writing nasty letters. We eventually get it for everybody.

When the shelter was first opened no one had any sort of benefits. Now, I could say most women in the shelter are on their way to getting their benefits.

Mr. WEISS. What suggestions would you have, what thoughts do you have, as to reaching out to obtain coverage for those people who don't end up in your shelters, who are out in the streets?

Ms. BAXTER. I think you need to get more psychiatrists to work in this field. Maybe approaching students who are working toward a psychiatry or psychologist's degree, ask them to do outreach in the community. It's very difficult to get them into the shelter environment to do the psychiatric evaluation which is necessary for the benefits. The women in the shelter do not want to be seen by a psychiatrist. So you need somebody in the shelter who can establish a good relationship with them.

In addition, I would suggest cutting down on the paperwork somehow, making it a faster process.

Mr. WEISS. Thank you very much. Thank you both for giving us very important testimony.

Dr. POLLACK. Thank you.

Ms. BAXTER. Thank you.

Mr. WEISS. Our next panel of witnesses will include Dr. Shervert Frazier, psychiatrist in chief of McLean Hospital in Boston, and former Director of NIMH; Dr. Charles Kiesler, provost at Vanderbilt University; and Dr. Steven Sharfstein, medical director of Sheppard and Enoch Pratt Hospital in Baltimore.

Would you please approach the witness table and stand behind the chairs where your names are.

Do you affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth?

Let the record reflect an affirmative response from each of the witnesses.

First of all, let me thank all of you for taking time out from your very, very busy schedule to participate with us in this hearing. We will begin with you, Dr. Frazier.

We have your prepared testimony, and it will be entered into the record in its entirety. We would appreciate it if you would summarize it within a 7- to 10-minute timeframe.

STATEMENT OF SHERVERT FRAZIER, M.D., PSYCHIATRIST IN CHIEF, McLEAN HOSPITAL, BELMONT, MA

Dr. FRAZIER. Thank you, Mr. Chairman, members of the committee. I'm Shervert Frazier, M.D., psychiatrist in chief of McLean Hospital, Belmont, MA. From 1984 to 1986 I was the Director of the National Institute of Mental Health. I really appreciate this opportunity to comment on the Nation's mental health services system.

Mr. WEISS. Dr. Frazier, that microphone is such a problem because you have to speak directly into it. There you go.

Dr. FRAZIER. All right. Is that better?

Mr. WEISS. Fine.

Dr. FRAZIER. We possess in this country most of the elements in place for an adequate mental health system, in fact, an exceptional one. But our system frequently is inefficient, and more than the sum of its parts would suggest.

And the inefficiencies really have to do with inadequate comprehensive planning; biases in the reimbursement system which mitigate against mentally ill persons; obstacles to interagency coordination; and shortages and maldistributions of clinicians; failure of estimation or unawareness of general health, as well as mental health professionals, of the extent and the manifestation of mental health disorders or problems; and, without disparaging the tremendous progress we have made in the area of research in both the biomedical and the neurosciences, and the behavioral sciences, we have some gaps in our research base.

The effect of these inefficiencies apart from the misuse and the waste of economic resources, really is the unnecessary suffering of these very vulnerable, ill people, and we need to correct that.

I appreciate the focus of these hearings on services, and we obviously need to look at the service system, but the service system is driven and drives research, and research and clinical services, and education, are all a part of the same problem. I want to address these topics in summary.

Mental health services: For about two decades we have been developing a mental health service system that places predominant emphasis on the outpatient services, ambulatory care for mentally ill persons. I think this is a justifiable kind of way to follow the mentally ill group.

Seventy-five percent of the services are provided in the community, and 70 percent of the resources go to the hospitals, and that means that the dollars did not follow the patients where they are receiving the services.

It's tied up mainly in State hospitals. State hospitals have large bureaucracies, civil service employees, and there's a tradition, historical tradition there. We need hospitals. We need to know exactly what hospitals are about. We need to know precisely what they're for. We need to remove the obstacles to their specific use. We need to be certain they have the quality of professionals staffing them who possess the expertise, the knowledge to provide precise diagnoses, and very good treatment for individuals.

We keep these hospitals in the attic of our mental health system mainly because they're large, because there are lots of patients, and it's the only system we've ever adequately funded, so it turns out to be the system we know the most about. We need to take this into consideration and change, and look at the services system in the community, give it a chance at adequate funding, and I suggest that the community support system, or the CSP approach, is the beginning of a very adequate and workable alternative system to a State hospital system.

These strategies have been supported since 1970 by Federal demonstration programs, and there's no question that many very sick patients are adequately taken care of in the community. We do need hospitals for short stays, and for occasional hospitalization, but the adequate major services can be provided within the community.

The fact that within the States, and now across all 50 States CSP has been very, very avidly pursued, is indication that it's a working proposition.

I think we need to look at what needs to be done to it now because if we don't we're going to see a massive move of patients back to being reinstitutionalized, and as I go around the country and listen to various people in various States, they essentially are saying if we don't get good community services organized pretty soon, and get some dollars in the community, we're going to have to send the patients back to the hospital, and that's the beginning of the last chapter. We've already been through that.

If we're going to prevent this we need to look at what the Federal Government ought to do. It ought to provide national leadership, No. 1; it ought to do what never has been done, and that's provide a series of comprehensive community support program demonstration projects, and that means that we've got the opportunity to take some demonstrations in a comprehensive fashion, identify,

and organize, and coordinate within a major metropolitan area, or in a small State, all of the services required to target to this population.

This means we have to start with case finding. We have to look all the way to discharge planning. Look at all the potential clients, patients, in a given geographic region.

We have to also have the kinds of resources necessary for sheltered housing, and for sheltered employment, sheltered workshops, which Mr. Lightfoot referred to about his relative.

It certainly means that we have to also watch the entitlements, and recognize that psychiatric illnesses are episodic, people go in the hospital for a short time, and come out. We must see that the entitlements are somehow protected from termination when we go into a hospital. We need some flexibility in the mental health care system.

It includes routine health care. Many mental patients, including the homeless on the streets, have major health problems which are not being attended to: Nutritional problems, transportation problems, as well as all the other necessities for a life situation which would make the quality of life adequate.

This is not a way to save money. I think we need half a dozen projects costing from \$1 million to \$2 million. We've set up some demonstrations that will work, and then we can encourage States to transmit the dollars, the billions of dollars in the State hospital system, to these working projects, and I think it will catch on.

It requires Federal leadership. The Federal leadership really is what NIMH is about. It needs also to remember that the Federal role in the State Mental Health Planning Act of 1986 was the first step, and that needs to be continued.

That especially emphasizes the care of children. There are 3 million severely mentally disabled children in this country.

I also think we're going to have to do something about clinical training. Clinical training means enough adequately trained professionals providing a service where the services are needed, and we have a large shortage in the area of child mental health care. We don't have enough child psychiatrists, people to take care of the children who are sick.

We've been doing clinical training since—it's been debated in the Federal Government since 1970. We had a peak of nearly \$100 million for clinical training at that time. It has changed what we do.

Underserved populations are being served better now. It's very clear that we've changed our priorities about it. I think if we're going to have a successful community-based system of care, we're going to have some need for more skilled clinicians. I think we ought to have clinical training with a payback that says "you provide one year of service in the public psychiatric sector for every year of training you get." And that will insure bright young people in their first experience, the opportunity to go into the public sector and provide the kinds of care that these very bright graduates of our various programs could give.

This payback some people will see as a disincentive, and a lot of people don't like it, but I think it's very important to recognize that the public sector needs young psychiatrists. That's the only

way we're ever going to get them early and let them make a career in that area.

I think that the provision of care is very important, but I think there's a necessity of stimulating interaction between health care providers and mental health providers, and I can see that there are many areas that would lend themselves to this.

One of the biggest problems we have in this country today is domestic violence. More women who come to emergency rooms have been beaten or battered by their husbands. We have very serious domestic violence problems. And to top it all off, the kids in the home watch this violence, and then they have been psychologically abused, and often they're the next victims of the same problem.

The mental health sector, as well as the health sector, needs to look at this. Nearly 1.6 million wives were battered and abused by their husbands in 1985. The number is going down. We don't know why. We don't have enough research on it. We need to do it.

This whole business of child abuse, sexual abuse, physical abuse, the attempts that lead to suicide. These patients go on to be drug abusers and substance abusers. There are serious problems about it.

In the mental health services arena we also need service systems research. That is, to look at the problems that we have in our service system, to look at precise diagnosis, the beginning of treatment, the end of a treatment, to evaluate the outcome, how effective was it, how good—how many hours did it take, how good was it?

We've got a mix. This mix needs to be looked at. We obviously have to keep vigilant about every part of the system. The Federal Government, through NIMH, obviously is working on this, as it is working on research. Our emphasis on research in the biomedical and the behavioral sciences is a very important part of what we do, finding causes for these illnesses. That relates to good services.

[The prepared statement of Dr. Frazier follows:]

Statement of
Shervert H. Frazier, M.D.
Psychiatrist-in-Chief
McLean Hospital

before the
Committee on Government Operations
U.S. House of Representatives
May 19, 1987

Mr. Chairman and Members of the Committee:

I am Shervert H. Frazier, M.D., Psychiatrist-in-Chief of McLean Hospital, Belmont, Massachusetts. From 1984 to 1986, I served as Director of the National Institute of Mental Health. I appreciate this opportunity to comment on the Nation's mental health service system.

We possess in this country most of the necessary components of an exceptional mental health care system. Yet our system frequently operates less efficiently than the sum of its parts would suggest.

The causes for inefficiency are many: inadequate comprehensive planning; biases in reimbursement policies; obstacles to interagency coordination; shortages and maldistribution of clinicians; underestimation or unawareness on the part of health and mental health professionals of the extent and manifestation of mental health problems; and, without disparaging the tremendous progress we continue to make, gaps in our research base.

The effects of these inefficiencies, apart from misuse and waste of economic resources, are unnecessary suffering by vulnerable, ill people. We must correct that.

While I appreciate the focus of these hearings, I believe that we cannot "fix" the service system without attending, also, to problems and needs in the areas of clinical education and research. I would like to address each of these topics briefly.

Mental Health Services:

For more than two decades we have been developing a system of care that places predominant emphasis on outpatient service. Justifications for this emphasis were and are sound, but the implementation has been flawed. Today, with more than 75-percent of all mental health care episodes occurring in the community, some 70-percent of mental health dollars remain tied up in State hospitals.

The argument is made, correctly, that hospitals will always be needed. But it's high time that we decide precisely what they are needed for, remove the obstacles to that specific use, and make sure that they are staffed by professionals who possess the expertise and the enthusiasm to carry out that mission.

We keep the hospitals in the attic of our mental health system because for a disturbingly large group of patients, hospitals seem to be the only system of care that works. In fact, no other true system of care has ever been assembled and afforded resources comparable to those poured into State hospitals. But in the Community Support Program, or CSP approach, we have the beginnings of a true alternate system.

S. H. Frazier, Page 2

Community Support strategies, which were encouraged by a Federal demonstration program begun in the late 1970s, potentially will work for even the most troubled and troubling patients. CSP approaches have been adopted by the majority of States as the primary model of caring for chronically, mentally disabled adults. That the promise of CSP is being so avidly pursued by the States testifies to their willingness to provide needed and appropriate care.

Short of CSP, States are running out of options. If the hoped for "fix" doesn't materialize, we are going to see increasing pressure--as we now are in some locales--for massive reinstitutionalization.

Before we permit that, the Federal government, in its national leadership role, must do that which has never been done: That is, to support a series of Comprehensive CSP demonstration projects.

In the ten years that the NIMH-CSP has been active, the Institute has not had the opportunity to conduct a thorough, comprehensive demonstration and evaluation of this approach. I'm talking about a project that would identify and coordinate within a major metropolitan area or a small State all of the services required by the target population.

This would mean that we begin with case finding and/or discharge planning for all potential clients within the geographic region. It means assuring availability of sheltered housing and employment. It means procuring needed income entitlements and, recognizing that psychiatric illnesses often are episodic and will require brief hospitalizations interspersed with community residence, seeing that entitlements are somehow protected from termination upon hospitalization. In addition to flexibility in the provision of mental health care, it will mean attending to routine medical care, nutrition, transportation, and recreational opportunities.

I don't suggest this as a means of saving money. But I believe that a modest Federal investment--a half dozen projects costing perhaps \$1 million to \$2 million dollars annually--will go a long way toward encouraging States to shift the billions of dollars now tied up in State hospitals toward more effective and appropriate uses.

Federal leadership is essential, Mr. Chairman. To that point, in addition to these comprehensive demonstration grants, I want to underscore the need for the Federal role authorized in the State Mental Health Planning Act of 1986. Assisting in system planning is an appropriate Federal role. It is a particularly vital one in planning services for the estimated 3 million severely

mentally disturbed children in this country.

Mental Health Clinical Training

The question of mental health services for children underscores an issue which is perhaps most glaring in, but by no means restricted to, the arena of child mental health: the need for professional personnel.

The debate over the Federal role in mental health clinical training has been going on since 1970. It has been a healthy one, in that it has forced a clear exposition of the problems and prompted NIMH, in collaboration with the field, to place high priority on the needs of unserved populations and service settings. But these positive outcomes coincide today with an NIMH clinical education budget of less than one-sixth the amount it was when the debate began.

A successful community-based system of care creates more, not less, demand for skilled clinicians. If we are going to pursue that goal, we need to expand our clinical training program and require trainees to make a service payback in the public sector in the service of chronically mentally ill patients.

A payback requirement will be viewed by some as a disincentive. But I'm convinced that it will prove to be healthy for the mental health and health professions generally and for my own profession of psychiatry particularly. The entire system of health care practice patterns is in the midst of tremendous transition. Providing young trainees with a good, solid experience in organized public care settings will stand them--and all of us--in good stead in the years ahead.

Although my focus is on the provision of care to persons with chronic mental illness, I would add that anything we can do to stimulate interaction and mutual learning on the part of practitioners in the specialty mental health sector and the general health sector is of great benefit. Let me illustrate this point by mentioning a problem that too often fails to be viewed either as a mental health problem or as a particular responsibility of the general health system.

The problem is domestic violence, and the facet I wish to comment on is spousal violence. Today, in 1987, battering by a male intimate is suggested by available data to be the single most important source of injuries that bring women to hospital emergency rooms. Nearly 1.6 million wives were beaten severely by their husbands in 1985. While this figure represents a reduction from nearly 2 million episodes in 1975, it's unclear whether the decline is a result of more effective prevention or greater reluctance to report wife battering.

We do know that a woman's remaining in a battering relationship is associated with significant increased risk for subsequent alcohol abuse and drug abuse, for attempted suicide, for rape, for mental illness, and for child abuse. And we know that mental health and medical personnel seldom identify battering as the cause or possible cause of a woman's health problems.

Educating health care providers about the extent of the problem is an urgent task. A 1985 study which randomly surveyed 290 pregnant women seen in public and private prenatal clinics in Houston found 36-percent of the women to be battered or at risk for battering; but none of the women reported having been assessed for abuse by their health care provider. Most did not know where to seek help. We need to sharpen referral practice and we need controlled studies of innovative forms of diagnosis and treatment in a variety of settings. And that means research.

Mental Health Research

The service system we have today, and treatments provided in it, are increasingly the products not of social or professional ideology, or economic expediency, but of research.

Research on service systems is essential given the complex mix of systems required of a comprehensive community-based program. Constant vigilance is the only way to ensure that modifying one component of one system does not create problems in another component.

But the primary responsibility of the federal government, through the NIMH, is research aimed at determining the causes, refining the treatments, and enabling the prevention of severe mental disorders. The ultimate answers will be found in a fundamentally new understanding of the brain and its role in the expression of behavior. That is, through neuroscience and biobehavioral research.

Through a sustained commitment to research program which relates directly to the service and treatment needs of the mentally ill, the federal government can and will address most effectively the needs of people suffering severe mental disorders.

Thank you.

Mr. WEISS. Thank you, Dr. Frazier.
Dr. Kiesler, we'll hear from you next.

STATEMENT OF CHARLES A. KIESLER, PH.D., PROVOST, VANDERBILT UNIVERSITY, REPRESENTING THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Dr. KIESLER. Good morning. I am Charles Kiesler, provost of Vanderbilt University, professor of psychology, and senior fellow in the Mental Health Policy Center of the Vanderbilt Institute of Public Policy Studies. I was formerly executive officer of the American Psychological Association.

In my research, I have concentrated on national mental health policy, and particularly on reanalyzing the national data base regarding mental hospitalization. In my own work, I have found it useful to distinguish between de jure and de facto public policy in mental health.

The former refers to our intended legislative and regulatory public policy; the latter, the net outcome of the whole system, whether intended or not.

In mental health, our de jure public policy for almost three decades has been deinstitutionalization and outpatient care. Our de facto policy is represented by two extremes: Mental hospitalization or neglect.

If one had to point to the single most important flaw in our policy and our thinking about mental health in the United States, it would be our consistent failure to consider the whole system, de facto and de jure, at one time. We tend to consider one issue at a time, whether funding mechanisms, such as Medicare or Medicaid, or patient population, such as the homeless or nursing home residents.

Each of these individual issues is very important, of course, but we must be sure we understand the whole system, and the role of each of the individual issues and topics within it. We neglect a top-down policy analysis, and thereby often come to misleading conclusions about what we do to whom, with what effect, and at what costs.

In my attempts to reanalyze the national data base regarding mental hospitalization, I have come to some startling conclusions. Let me share some of these quickly; they are all based on analyses of existing national data, and on surveys by Federal agencies and private associations.

One, the rate of mental hospitalization in the United States has been increasing over the last 15 years rather sharply, a 60-percent increase in that time period.

Two, the increase is confined totally to general hospitals without psychiatric units. Little is known about those patients, their demographics, or their treatment, which is a problem I have been working on for the last 4 years.

Three, except for State hospitals and VA hospitals, the length of hospital stay has been constant over that time period. State hospitals and VA hospitals now account for only about 20 percent of the total inpatient episodes for mental disorders.

Four, the rate of rehospitalization has been constant over that time period, as far as anyone can tell.

Five, mental hospitalization accounts for almost one-fourth of all hospital days in the United States for all disorders. Forty years ago it was over 50 percent.

Six, in terms of hospital cost containment, we have read much about the decrease in total hospital days in the United States for all disorders. Contrary to popular impressions, the total decrease for all hospital days for all disorders in the United States is accounted for totally by the decrease in hospital days for mental disorders. There has been no decrease for nonmental disorders.

Seven, I have found 16 different research studies comparing the cost and the effectiveness of hospital care for serious mental disorders with care outside the hospital in an organized program. All of these studies involved the seriously ill people with random assignment, either to a hospital or to some program outside the hospital.

A consistent conclusion comes through in these studies; and that is that alternative care is more effective and less expensive.

Eight, there has been an increase in the rates of mental disorders in nursing homes. However, contrary to popular impression, that increase is not accounted for by discharges of the elderly from State mental hospitals. Those elderly represent a very small part of the total increase in nursing homes.

The increase in nursing homes is also not accounted for by increases in the number of elderly. There is an increase in the rates for mental disorders at every age group along the way: a new phenomenon in the United States, and one deserves a new attention.

I have covered six or seven other topics in my written comments, but I would like to share with you the six major approaches, the changes in Federal policy, which should enhance both the effectiveness and the cost-effectiveness of mental health care in the United States.

One, we need to invest in developing a better national data base, particularly regarding the outcomes of treatments.

This is a problem in physical health as well, and is contained in several reports of the National Academy of Sciences; it is especially true in mental health.

There has been little Federal effort to include data collection and evaluation in public policy, or policy analysis, in publicly funded research. Less than 1 percent of NIMH research grants in 1986 reported work that examined the financial and delivery systems that provide mental health care.

Two, we need to better understand the effects of different systems of service delivery. The NIMH development of mental service research centers should be strongly encouraged and well financed.

Three, we need to understand better the effects of health insurance coverage, both public and private, on the utilization of services and their outcomes. At present, there are no financial incentives for making the right decisions, and, in fact, there are often financial disincentives.

Four, we need to take a systemwide and comprehensive approach to these issues, with communication and collaboration between the agents of our de facto national policy of deinstitutionalization and outpatient care, furthered by NIMH, and our de jure policy, ad-

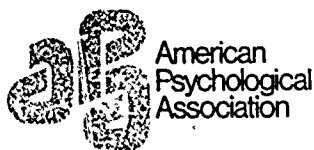
vanced by publicly funded health programs such as Medicaid or Medicare.

Five, we need adequate funding for alternative outpatient care involving teams of professional and support personnel, headed by a qualified mental health professional.

Six, the private sector care and treatment of mental disorders has developed very quickly in recent years, particularly in corporate hospital chains. The phenomenon used to be understood much better than it is; it is one that is moving very, very rapidly.

I appreciate your opportunity to testify today. Thank you.

[The prepared statement of Dr. Kiesler follows:]



TESTIMONY OF
Charles A. Kiesler, Ph.D.
Provost, Vanderbilt University

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

before the

UNITED STATES HOUSE OF REPRESENTATIVES
Committee on Government Operations
Subcommittee on Human Resources and
Intergovernmental Relations

on the subject of

THE FEDERAL ROLE IN MENTAL HEALTH

May 19, 1987

The Honorable Ted Weiss, Chair
2154 Rayburn House Office Building

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Mr. Chairman and Members of the Subcommittee, I am pleased to testify today on behalf of the 87,000 members of the American Psychological Association (APA) on the federal role in the area of mental health. I am Dr. Charles A. Kiesler, Provost of Vanderbilt University and Senior Fellow of the Vanderbilt Institute of Public Policy Studies. I was previously Bingham Professor of Psychology and Dean of the College of Humanities and Social Sciences at Carnegie-Mellon University. I have also held the positions of APA Executive Officer and founding Vice President of the Council of Applied Social Research. In my research, I have concentrated on national mental health policy, and particularly on re-analyzing the national data base regarding mental hospitalization.

In my own work I have found it useful to distinguish between *de jure* and *de facto* public policy in mental health. The former refers to our intended legislative and regulatory public policy; the latter to the net outcome of the whole system, whether intended or not.

In mental health, our *de jure* public policy for three decades has been deinstitutionalization and outpatient care. Our *de facto* policy is represented by two extremes: mental hospitalization or neglect.

If one had to point to the most important single flaw in our policies and our thinking about mental health in the U.S., it would be our consistent failure to consider the whole system, *de facto* and *de jure*, at one time. We tend to consider one issue at a time, whether funding mechanisms (e.g., Medicare or Medicaid) or patient populations (e.g., the homeless or nursing home residents). Each of these individual issues is very important, of course, but we must be sure we understand the whole system and the role of each of the individual issues and topics within it. We neglect a top-down policy analysis and thereby often come to misleading conclusions about what we do, to whom, with what effect and at what cost.

In my attempts to re-analyze the national data base regarding mental hospitalization, I have come to some startling conclusions. Let me just share some of these briefly. They are all based on analyses of various national data surveys by federal agencies and private associations.

1) The rate of mental hospitalization has been increasing over the last 15 years quite sharply (60% in that time period).

2) The increase is confined totally to general hospitals without psychiatric units (where patients, contrary to typical opinion, are not held for referral but actually receive active treatment). Little is known about these patients, their demographics or treatment. It is a problem I have been working on for four years.

3) Except for state hospitals and VA hospitals, the length of hospital stay has been constant over that time period. State hospitals and VA hospitals now account for only about 20% of total inpatient episodes for mental disorders.

4) The rate of re-hospitalization has been constant during that time period.

5) Mental hospitalization accounts for almost one fourth of all hospital days for all disorders in the U.S. Forty years ago, it was over 50%.

6) Much has been made of decreases in total hospital days for all disorders in the U.S. in recent years. Contrary to popular impressions, decreases in total days for mental disorders (primarily in state and VA hospitals) accounts for all of the national decrease for all disorders.

7) Both the National Institute of Mental Health (NIMH) and I have calculated the proportion of total monies for mental health care that goes for inpatient care. Despite very different methods of calculation, we came to the same conclusion: over 70% of total care dollars goes for inpatient care.

8) I have found 16 different research studies comparing the cost-effectiveness of hospital care for serious mental disorders with care outside the hospital in an organized program. All of these studies involved random assignment of the patients to hospital or non-hospital care (a minimum scientific methodological requirement for such studies). A consistent conclusion comes through in these studies: alternative care is more effective and less expensive.

9) There is an increase in the rate of mental disorders in nursing homes. However, the increase is not accounted for by discharges of the elderly from state mental hospitals. That represents a very small part of the increase. The increase of mental disorders in nursing homes is also not accounted for by increases in the number of elderly in our country. There is an increase of mental disorders in nursing homes per 100,000 population at every age level.

It is a new phenomenon in the U.S. which needs further research and explanation.

I note also that nursing homes do not play a role in the care of the non-elderly (under 65) who are released from state mental hospitals. Probably less than 2% of this population go to nursing homes.

In the remainder of my testimony, I will focus specifically on the nature and scope of existing federal programs for the chronically mentally disabled, the need for a system of care model for service delivery, and the impact of financing structures on the delivery of mental health services. I will also offer recommendations to improve the needed federal leadership role in mental health service, research, and prevention programs.

The role of psychologists in responding to the needs of chronically mentally disabled persons includes providing essential mental health services, conducting pioneering research, and developing and administering mental health programs. Psychological services provided to this population may involve diagnostic assessment, psychotherapy, clinical consultation, crisis intervention, community referral, and prevention and outreach services. In the area of research and program development, psychologists are examining the causes of severe mental disability and are actively involved in designing and evaluating new treatment approaches to traditional hospital-based care and drug therapy.

Federal Support for Services for Chronically Mentally Disabled Persons

A careful analysis of the federal role in mental health requires some attention to the evolving relationship between federal, state, and local levels of government. Prior to the enactment of federal legislation authorizing the establishment of community mental health centers and the Medicare/Medicaid programs, mental health care for the chronically mentally disabled was primarily a state responsibility handled largely through placement in state mental institutions. However, federal, state, and local governments have been unable, for a variety of reasons, to provide the continual care required to assimilate the chronically mentally disabled into the community.

The 1963 Community Mental Health Centers Act created a nationwide network of community mental health centers (CMHCs) and constituted the first step toward promoting a community-based system of outpatient care as an alternative to or following institutionalization. Despite the relative success of the CMHCs in the early 1970s, Congress responded to evidence showing that certain groups such as the poor, the elderly, and the chronically mentally disabled remained inadequately served. As a result, the number of "essential services" to be provided by the centers was increased, but sufficient funding did not accompany the changes. However, the creation of the CMHCs served to establish a relationship between the federal and local governments in the delivery of mental health services.

The enactment of the Mental Health Systems Act in 1980 attempted to add the states to this partnership, by giving them the option of contracting to be the sole provider of mental health services. In recognition of the unmet mental health needs of certain populations, the act added new provisions to encourage the development of outreach and service programs for the chronically mentally disabled, the elderly, severely disturbed youth, and other underserved populations. However, the funding level was far below what would be required to provide comprehensive services for these populations.

Alcohol and Drug Abuse and Mental Health Services Block Grant. A major shift away from federal support for mental health programs for special populations occurred in 1981 with the creation of the Alcohol and Drug Abuse and Mental Health Services (ADM) block grant and the repeal of the Mental Health Systems Act. The federal role in providing a nationwide network of community mental health centers was thereby reduced and the role of the individual states increased.

The mental health share of the ADM block grant is distributed primarily to community mental health centers and is intended to provide states with greater flexibility, with the chronically mentally disabled designated as a service priority. The block grant, which is up for reauthorization this year, serves to reduce government bureaucracy, thus giving states the opportunity to pool resources to provide a more comprehensive range of health, mental health, and social services. However, state savings from the block grant approach are not sufficient to compensate for the reduced levels of federal funding, a situation which has been compounded by the high rates of inflation in the 1970's.

In addition to the ADM block grant, other programs must be considered in an evaluation of the federal role in mental health care for the chronically mentally disabled. These programs include the Community Support Program and the Clinical Training Program which are both administered by the National Institute of Mental Health (NIMH).

Community Support Program. The Community Support Program (CSP) provides grants to states and private nonprofit agencies to establish more effective ways to deliver community mental health services to the chronically mentally disabled and other seriously underserved populations, such as children (through the Child and Adolescent Service System Program), the homeless, and the elderly. We believe that the current CSP models may be useful in determining some of the more effective ways to provide mental health services to special populations at the state level. However, the effectiveness of this program have been hampered by serious underfunding.

Clinical Training Program. This program is the major source of funding for training in the four core mental health professions — psychology, psychiatry, social work, and psychiatric nursing. The program prepares these professionals to meet the nation's mental health needs by requiring that students receiving stipends payback their support by working in a designated shortage area for each year of federal assistance. Funding for this program has declined drastically over the past decade, from an average of \$70 million per year to \$15 million in FY 87. A FY 88 funding level of at least \$28 million is a prerequisite for ensuring adequate numbers of mental health professionals to work with the chronically mentally disabled and other special populations.

The "System of Care" Model for Service Delivery

The chronically mentally disabled, whether children or adults, require a range of appropriate mental health services at varying levels of intensity in the least restrictive environment. The term "appropriate services" refers to those services that are essential to enable the individual to progress in the development of appropriate behavior and independent living skills, and to move from more restrictive to less restrictive settings.

The most central component of this model is the availability of a range of residential (e.g., inpatient care or therapeutic group homes) and nonresidential (e.g., outpatient care, day treatment, and psychosocial rehabilitation) mental health services. Other key components of an effective mental health service system include: (1) linkages among the various system components; (2) access to a full continuum of care; (3) flexibility in funding and decision-making to allow the movement of individuals through the system as their needs change; and (4) responsive management structures that allow for shifts in funds and staff. Moreover, since the multiple needs of the chronically mentally disabled population invariably require the intervention of other agencies and systems, it is critical that services be well coordinated to reduce fragmentation and duplication of services.

The APA encourages the Committee to explore how this model can be applied to the chronically mentally disabled. We are hopeful that implementation of the recently enacted State Comprehensive Mental Health Services Plan Act of 1986 (P.L. 99-660) will provide needed federal

assistance in this direction. Yet, we are particularly concerned about the influence of federal financing structures such as Medicare and Medicaid (which focus heavily on hospital care and minimally provide for appropriate outpatient care) on the development of systems of care.

Financing Structures as an Impediment to Services

Public and Private Financing and Community Care. The financing mechanisms for mental health exert a significant influence on the extent to which services are available to persons who need them. The various federal and federal-state mental health initiatives of the past several decades to provide services for the chronically mentally disabled have suffered as a function of the growing costs of care coupled with decreased federal support. The public and private financing mechanisms for service delivery to this population are further impediments to levels and appropriateness of care.

Care for the treatment of mental disorders was historically left to the family. Today, private health insurance and state and federally funded programs drive the health care system. We have moved away from institutionalization to community-based care in theory, but reimbursement mechanisms continue to demand hospitalization. This disparity is a significant barrier to care.

Both public and private insurance plans limit coverage for mental health care. With respect to Medicare, the focus is on acute hospital-based care, yet includes an inpatient benefit for mental and nervous disorders of only 190 days per lifetime. The limited outpatient benefit of \$500 per year with a 50/50 copayment is likewise a barrier to care. Typically, this provides for 10 visits to a private practitioner's office or to a clinic. This level of coverage for the chronically mentally disabled is patently inadequate.

In addition to outright limits on services or reimbursements, both Medicare and Medicaid have severe limits on both locus of care and on professional providers. For instance, a majority of states construe the federal requirement that Medicaid services be "medically necessary" as meaning that they must be provided under the authority and supervision of physicians, rather than independently by licensed nonphysician mental health professionals (i.e., psychologists, social workers, and psychiatric nurses). However, with the chronically mentally disabled in particular, there is a great need for interventions provided by teams of professionals and nonprofessionals, under the direction of a range of qualified mental health professionals.

Unfortunately, the private sector has followed the model provided by the federal government. Private insurance coverage for the treatment of mental and nervous disorders is, on the average, just as limited as in public plans. Copayments are generally 50/50 instead of the 80/20 commonly found for other health care. And without exception, there are use or dollar limits on reimbursement. A recent study of 300 private sector plans reported that over 30% of the plans had benefit levels for both the inpatient and outpatient treatment of mental disorders at a lower level than benefits for other types of health care. Nearly 60% of the plans had similar inpatient benefit levels for the treatment of health and mental

health conditions; however, these plans offered less coverage for the outpatient treatment of mental health conditions as compared to other health conditions.

Public Financing and Residential Care. The consequences of the Medicare limitations on type and place of care promote the costly and inappropriate use of alternative services and facilities. This is a critical issue for public policy. Also, Medicare inappropriately defers to the Medicaid program for certain long-term care needs of the older population, including those with chronic mental disabilities. In this regard, Medicare recognizes only hospitals as institutional providers for mental health care and denies payment to skilled nursing facilities (SNFs) for this care. Thus, this method of financing creates a significant barrier for beneficiaries who are in nursing homes rather than hospitals.

The long and debilitating course of many chronic diseases, which often includes certain mental health problems, leads to the eventual placement of many elderly patients in nursing homes — intermediate care facilities (ICFs) and skilled nursing facilities (SNFs). Medicare coverage for nursing homes is restricted to the SNF setting with many benefit limitations. When the criteria are met, a total of 100 days of nursing home reimbursement is provided; \$50 per day co-payment is required between the 21st and the 100th day. After these benefits are exhausted, the patient must either make personal payments (which account for 44% of all nursing home payments), rely on private long-term care insurance (less than 1% of all nursing home payments are from private health insurance sources), be discharged to the care of family or friends, or, if Medicaid coverage is available, "spend down" to meet Medicaid criteria. The extended course of many chronic conditions, including mental disorders, experienced by the elderly increases the likelihood that patients will exhaust their personal resources and become dependent on State Medicaid programs. At least one-half of Medicaid nursing home recipients were not initially poor upon entering the institutional setting, but had to "spend down" to meet state Medicaid eligibility levels. Medicaid's failure to address the long-term care needs of our nation's elderly will continue to "pauperize" patients with chronic disorders.

Intermediate Care Facilities (ICFs) are a more typical nursing home setting for the majority of elderly persons with chronic conditions requiring long-term care. Although it is not covered by Medicare, most states have opted to offer some type of ICF reimbursement through their Medicaid programs — despite the lack of a federal mandate. Medicaid, by default, provides payment for some of the long term care services neglected by the Medicare program. Once placement is located in an ICF, an elderly resident with a mental disorder is very likely to be at risk for receiving inappropriate treatment. This phenomenon results from federal policy which discourages treatment for mental diagnosis by denying reimbursement to facilities classified as institutions for mental diseases (IMDs).

The Medicaid statute expressly forbids reimbursement for "care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental disease (IMD)." Current Medicaid "Guidelines" define an IMD as a facility with a disproportionate share of its patients (i.e., over 50%) with mental disorders. Once designated as an IMD, Medicaid denies reimbursement for residents between the ages of 21 and

65. As a consequence, many nursing home administrators are reluctant to admit residents of any age with mental disorders -- or mislabel these residents with physical diagnoses -- so as not to characterize their facility as one caring for the mentally disabled. As a result, only around 5% of nursing home residents with diagnoses of mental disorders receive any mental health care.

Medicaid is the largest single source of financing for nursing home care, representing over 48% of all nursing home payments (a total of \$13.2 billion in FY 1982). It has been estimated that over one-half of the nation's nursing home residents have chronic mental disorders; the care of these residents accounts for almost \$16 billion per year.

Another barrier to appropriate mental health treatment for nursing home residents is that neither federal certification procedures for Medicare/Medicaid nor state licensure laws require that nursing homes provide mental health care when it is indicated. The Medicaid program should establish standards for appropriate care and treatment of the chronically mentally disabled elderly in nursing homes. Medicaid should also mandate mental health care to residents with mental diagnoses for those participating facilities. Further, the Medicare statute should require the certification of SNFs to provide inpatient mental health services so residents with mental disorders could receive direct care.

Federal Role in Mental Health Research

The National Institute of Mental Health (NIMH) is the nation's largest funding source for mental health research. The Administration has proposed drastic cuts in NIMH research funding for FY 88, which are particularly distressing in light of Congress' strong show of support last year for the many exciting scientific opportunities in mental health research. Important areas of research that are in need of increased emphasis in the years ahead include: mental health and behavioral aspects of AIDS; behavioral, biological, and social factors related to schizophrenia; prevention of mental disorders; rural mental health; and an increased effort to gather statistics on the nation's mental health needs. An increased commitment to basic research in the behavioral and biological sciences is also needed. Additionally, the decline in research training support over the past several years must be reversed, with particular attention to increasing funding for predoctoral support in the behavioral sciences.

The data also suggest the development of specific plans and programs to support the prevention of serious mental disability resulting in hospitalizations. Specific approaches might include the revision of professional review organizations and activities, the experimental development of alternative funding mechanisms for treatment of mental disability, or further development of public programs and research on prevention in general.

All of these considerations lead me to suggest six major approaches to changes in federal policy which should enhance both the effectiveness and cost effectiveness of mental health care in the United States:

- 1) Invest in developing a better national data base, particularly regarding the outcomes of various treatment approaches. This

demands research in which individuals are tracked across time. There has been little federal effort to include data collection and evaluation in public policy, or policy analysis in publicly-funded research. Less than 1% of NIMH research grants in FY 1986 supported work that examined the financial and delivery systems that provide mental health care.

- 2) We need to better understand the effects of different systems of service delivery. The NIMH development of Mental Health Service Research Centers should be strongly encouraged and well financed.
- 3) We need to understand better the effects of health insurance coverage (both public and private) on utilization of services. There are at present no financial incentives for making the right decisions and, in fact, there are financial disincentives.
- 4) We must take a system-wide and comprehensive approach to these issues, with communication and collaboration between the agents of our de facto national policy of deinstitutionalization and outpatient care furthered by NIMH and our de jure policy advanced by publicly funded health programs.
- 5) We need adequate funding for alternative outpatient care involving teams of professionals and support personnel headed by a qualified mental health professional.
- 6) The private sector care and treatment of mental disorder has developed very quickly in recent years, particularly in hospital chains. We need to study and understand this phenomenon much better.

Thank you for the opportunity to testify on behalf of the American Psychological Association on the subject of the federal role in the area of mental health. If I can be of any further assistance to the Committee, please call upon me.

Mr. Weiss. Thank you, Dr. Kiesler.
Dr. Sharfstein.

**STATEMENT OF STEVEN S. SHARFSTEIN, M.D., VICE PRESIDENT,
SHEPPARD AND ENOCH PRATT HOSPITAL, BALTIMORE, MD,
REPRESENTING THE AMERICAN PSYCHIATRIC ASSOCIATION**

Dr. SHARFSTEIN. Mr. Chairman, my name is Steven Sharfstein, and I am medical director of the Sheppard and Enoch Pratt Hospital in Baltimore, MD. Today, I am representing the American Psychiatric Association, a medical specialty society representing over 33,000 psychiatric physicians nationwide.

I would like to mention that I have spent 13 years in the Public Health Service with NIMH. Between 1976 and 1980, I was Director of the Division of Mental Health Service Programs of the NIMH, a division that no longer exists today.

You may recall that you and I met almost 10 years ago when you had me come up to the Upper West Side of New York to a community meeting you had organized at the Martin Luther King School. This was a meeting to deal with issues of deinstitutionalization and homelessness on the Upper West Side.

I am sure that you will remember that, when it came time for the question period, the microphone was grabbed by an obviously disordered gentleman who proceeded to rave for 15 minutes while you quietly asked him to please ask his question, at the end of which he just gave his phone number to the audience for anybody to try to contact him.

My parents were in the audience that day. You didn't know that. They still talk about the experience of that day. I am sorry to say that probably the situation since 1978 has only gotten worse.

When I was director of the service programs of the NIMH, we had oversight responsibility for the Federal Community Mental Health Centers Program, a program that initiated 790 comprehensive community centers across the country. During the time that I was director of this program, we began the community support program that Dr. Frazier mentioned, a program that has survived the changes that have gone on with the NIMH.

I should also mention that, in the next panel, you will hear from Dr. Robert Washington, the administrator of the Mental Health Services in the District of Columbia. During that time period, he was part of the community support program, and was one of the first people that saw the possibility of Federal leadership toward the chronically mentally ill through that initiative.

The mental health services program, at that time, had about 100 Federal officials in Rockville, MD, that reviewed the Federal programs. There were an additional 30 Federal researchers in a community mental research program in Prince George's County. In addition to that, there were 160 Federal officials and regional officials across the country, whose main task was to gather data, monitor programs, work with States, and work with local communities.

Today, there is a total of 35 Federal officials that are involved in the Federal Block Grant Program.

This is a hearing on Federal services, and I think it is important, as I elaborate in my written testimony, that one goes back to the

year of 1854 to see that it could have been quite different. At that time, Dorothea Dix and her allies, a citizens movement not that different from the National Alliance for the Mentally Ill, managed to get through the Congress the Indigent Insane Act of 1854, which would have provided for Federal funds for a major Federal initiative toward the mentally ill.

President Franklin Pierce vetoed that legislation. In his veto message, he felt strongly that it was not the role of the Federal Government, in his words, to be, "the great almoner of public charity throughout the United States."

That veto stood, and it was at that point that Dorothea Dix began her lobby State by State, for State asylum care for the mentally ill, personally leading to the founding of some 32 State mental hospitals over the next 20 years.

The State systems continue to be the major players in the delivery of services to the poor, which is the majority, of patients with severe mental illness. However, if one is to look at Federal policy, it would be extremely inaccurate to say that it has been the NIMH that has been the major force in the changes that have occurred in States and local communities.

The NIMH moneys, through the service programs, have represented less than 5 percent of the total Federal outlays since the mid-1950's for services to the mentally ill. It was in 1954, 100 years after President Pierce's veto, that title 2 of the Social Security Act was passed, which began the reversal of that veto. This was the Disability Program.

Federal dollars, through the major health insurance moneys, through the disability programs, through social services, have been the major force in the change that has occurred: The movement, the mass movement, of patients out of the State mental hospitals and into the community.

It is the Federal dollars, through Medicaid, through title 16 of the Social Security Act, that gave States the opportunity to shift the financial burden from themselves and from State tax dollars, to the Federal Government—not the NIMH Community Mental Health Centers Program, which was a very small initiative, comparatively speaking.

As I elaborate in my testimony, I think unless we begin to form the major Federal financing streams that deliver services to the mentally ill in local communities, we are going to have a very hard time understanding what needs to be done. We need to have major reform in the Federal health insurance programs, Medicare and Medicaid, and housing programs, disability, social services, and vocational programs.

In my testimony, I proposed that a block grant—an index capita-tion block grant—be provided to States, through the Social Security titles, in order to coordinate with the large State dollars to provide for the comprehensive community-based system that has been discussed already this morning.

I also think that it is essential for the NIMH to take and continue to have a leadership role in data gathering, in research, and in demonstrations. Without the NIMH, I think the overall State system would be much poorer. Thank you.

[The prepared statement of Dr. Sharfstein follows:]



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STATEMENT

OF

THE AMERICAN PSYCHIATRIC ASSOCIATION

ON

THE FEDERAL ROLE IN THE DELIVERY OF MENTAL HEALTH CARE

PRESENTED BY

STEVEN S. SHARPSTEIN, M.D.
VICE PRESIDENT AND MEDICAL DIRECTOR
SHEPPARD AND BROOK PRATT HOSPITAL AND
CLINICAL PROFESSOR OF PSYCHIATRY
UNIVERSITY OF MARYLAND

BEFORE

THE HUMAN RESOURCES AND INTER-GOVERNMENTAL
RELATIONS SUBCOMMITTEE,
COMMITTEE ON GOVERNMENT OPERATIONS
U.S. HOUSE OF REPRESENTATIVES

MAY 19, 1987

Mr. Chairman, my name is Steven S. Sharfstein, M.D., and I am the Vice President and Medical Director of The Sheppard and Enoch Pratt Hospital in Baltimore, Maryland -- a nonprofit private psychiatric health care facility which provides inpatient, day treatment, outpatient and community mental health services to a large population of both private and public paying patients. I am representing the American Psychiatric Association -- a medical specialty society representing over 33,000 psychiatric physicians nationwide. I would like to mention that I spent 13 years in the Public Health Service at the National Institute of Mental Health, and for five of those years was Director of the Division of Mental Health Service Programs which had responsibility for oversight and implementation of the Federal Community Mental Health Centers Program and the Community Support Program. I was very involved in the passage of the Mental Health Systems Act of 1980 and the development of the National Plan for the Chronically Mentally Ill. After leaving federal service, I co-authored the book, Madness and Government: Who Cares for the Mentally Ill? (American Psychiatric Press, 1983) which is a historical description of the federal role in the delivery of mental health services to our citizens.

I am pleased to have the opportunity today to reflect with you on my views on the federal role in assisting states in the delivery of mental health services. My testimony will consist of (1) a historical perspective on the federal role, (2) an assessment of the major changes that have occurred largely as a result of federal intervention in the past four decades, (3) an overview of current NIMH initiatives and (4) a suggestion for major change in the federal role in order to provide for a more coordinated and cost-efficient

array of opportunities for mental health care and related support services to the severely mentally ill.

I. Dorothea Dix, President Franklin Pierce, and the Indigent Insane Bill of 1854

Federal involvement in the treatment and support of our citizens with mental illness began essentially with the founding of the National Institute of Mental Health in 1946. The federal role could have begun almost 100 years earlier when in 1854, Dorothea Dix and her allies managed to get through the Congress the "12,225,000 Acres Act," also known as the Indigent Insane Bill, a large federal land grant sale to provide federal funds to build mental hospitals. It represented four years of intense lobbying of the Congress by a group of farsighted and idealistic social reformers and physicians who believed that the mentally ill could be cured through kind and firm moral reeducation in circumstances far from the chaos of cities and the corrupting influences of modern life. President Franklin Pierce vetoed this bill with the following message: "If the Congress has power to make provision for the indigent insane, the whole field of public beneficence is thrown open to the care and culture of the federal government...I readily... acknowledge the duty incumbent on us all...to provide for those who in the mysterious order of Providence are subject to want and to disease of body or mind, but I cannot find any authority in the Constitution that makes the federal government the great almoner of public charity throughout the United States. To do so, in my judgement, would be contrary to the letter and spirit of the Constitution... and be prejudicial rather than beneficial to the noble offices of charity."

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(President Franklin Pierce veto of Indigent Insane Bill, Washington, D.C., 1854.)

One can see in Pierce's veto of 1854 many of the themes of the current Reagan administration. Dorothea Dix, however, reorganized her allies and began the pursuit state by state for the provision of asylum care for the mentally ill. She personally led to the founding of some 32 state mental hospitals -- a most extraordinary accomplishment.

What began as an idealistic effort led in a relatively short period of time to a system of custodial asylum care and therapeutic pessimism. Waves of immigrants to the United States began to fill the state mental hospitals and clinical notions changed in the face of the unrelenting reality of chronic mental illness and the financial reality that only a few could truly afford the individualized attention recommended by Ms. Dix and her supporters.

II. 1947-1987: Federal Involvement in System Change

By the late 1940's and early 1950's, we reached the peak of public asylum psychiatry in the United States with over half a million Americans residing in state and county mental hospitals, that is one out of every two hospital beds were occupied by a psychiatric patient. Lengths of stay were averaging two to three years, and many could expect to spend their entire lifetimes in crowded and often anti-therapeutic circumstances. These state hospitals were the core of the care opportunities for a majority of Americans with mental illness. Today, they remain as scaled-down facilities (with less than 120,000 Americans

residing in state hospitals, and for new admissions, the median length of stay is less than three weeks).

The federal government has been a major player in the dramatic changes that have taken place in the mental health system, including psychiatric and general hospitals, private offices, community mental health centers, nursing homes, and other settings where the care and treatment of the mentally ill currently occurs.

The National Institute of Mental Health founded in 1946 provided the leadership in developing new treatments, new modes of understanding mental illness and mental health, and new settings for the provision of mental health care. Research supported by the NIMH in the 1950's helped forge the clinical consensus that was necessary to recommend changes focusing on shorter term facilities in local communities. Research in psychopharmacology and basic research into mental illness provided the technology to allow the discharge of thousands of patients into the community settings, often supported with federal funds either directly through the categorical seed money approach of the community mental health centers, or more profoundly through the major Social Security titles, Medicaid (XIX), Supplemental Social Security Income (XVII), and Social Services (XX). This influx of federal funds began in 1954, 100 years after President Pierce's veto, with the passage of Title XI of the Social Security Act, the disability income program. With the passage of that Act, the federal government began to assume from the states the support of the ill and the destitute. It is the major Social Security titles that now provide the greatest federal presence for the support and treatment of the mentally ill.

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Of course, there are many other factors at play, including the major legal changes supporting the rights of the mentally ill, the wholesale dumping of long term psychiatric patients on unprepared communities leading to an epidemic of homelessness in many of our major cities across the United States, and the filling up of nursing home beds by many people with mental illness because these beds could find mostly federal funding and represented an economic opportunity for the private sector.

III. Current NIMH Initiatives, The Homeless and APA

At this point, let me mention that the APA continues to be actively involved in the development of a workable public policy toward the care of our chronically mentally ill citizens. Clearly, a cornerstone of a successful policy must be an augmented federal presence in terms of financing, technical assistance, and planning to better assist state and local governments cope with a problem, often characterized as an "epidemic." Federal "opportunities" do exist under the auspices of the Public Health Service and, in particular, the National Institute of Mental Health.

Already, legislation to address both short and long-term needs of the homeless has been debated in this 100th Congress, and we applaud the Congress for its early and decisive action in responding to the multitude of socio-economic and medical needs of the chronically mentally ill. As I have been requested to address the role of the NIMH regarding the support of mental health service and community support programs, I must say that the 100th Congress has responded wisely by doubling the budget for the NIMH Community Support Program

(CSP), which, as you know, has demonstrated its effectiveness in stimulating better planning and coordination of state/local programs through federal technical assistance and model community-based programs. This modest expenditure will lead to a needed expansion of community-based services.

The APA and a coalition of more than 50 professional and citizen organizations applaud your action. Let me also add that we believe Senator Domenici's bill (S. 763), "The Services for the Homeless Mentally Ill Individuals Act" moves the Federal government in an appropriate direction and envisions five key service elements at the state/local level — outreach, transitional housing, treatment, case management, and clinical training. In the area of treatment, the bill articulates the need for a "continuum" of clinically appropriate individualized services — outpatient, partial hospitalization, diagnostic services, crisis intervention, and habilitation and rehabilitation. We are working closely with the Senator and his colleagues in defining and recommending appropriate federal and state roles.

I must also emphasize the importance of federal support for research under the auspices of the NIMH. Research is an important link in the continuum of care, yielding new and important information about more effective treatments for the major mental disorders. The federal government is the only jurisdiction which can undertake the support of research — both biomedical and systems oriented — of the size and scale necessary to further our collective knowledge base. The coalition of professional and citizen advocates is proposing a major expansion in NIMH research support, including research supported by the Division of Biometry and Applied Sciences. Funds are needed now for research that examines the availability, quality of care, use, cost, structure and

impact of mental health services, programs, organizations and systems; assessment of factors influencing the supply and use of facilities and services; assessment of the need for and access to services; effects of changes in different parts of the health care delivery system e.g., growth of private hospitals, corporate hospitals, nursing homes, health maintenance organizations, and preferred provider organizations; impact of legislation and regulations on the provision of mental health services; applications of information systems and other changing technologies to mental health service systems; and application of research results to managing and improving mental health services programs.

Opportunities for fiscal support to CSP, the ADM Block Grant, research, training, and the range of NIMH activities exist at the federal level today. I do have my own views, however, on a longer-term strategy related to the bulk of federal funds which provide treatment and support to the mentally disabled.

IV. A Proposal for Reform of Federal Funding

Dr. John Talbott, Professor and Chairman of the Department of Psychiatry at the University of Maryland, and myself have proposed a reform of the currently fragmented federal funding streams to provide for a federal presence in states for treatment and support of the episodic and chronically mentally ill.

Today, the majority of our psychiatric patients can only expect piecemeal treatment and care, unplanned and uncoordinated, that varies enormously in quality and cost among the different regions of our country. There is no "system" of treatment and care for the mentally ill today and no simple method for funding services. The costs, however, are considerable. In 1983, the

cost to society for all mental illness was estimated at \$73 billion, about half of which could be attributed to direct treatment and support costs. Approximately 43 percent of the direct costs of mental illness are related to treatment and care of the chronically mentally ill with the vast portion of these direct costs being paid to nursing homes (supported by federal and state dollars) and state and county mental hospitals (still supported by state dollars).

The cost of treatment of the chronically mentally ill is complicated by the fact that many of the services critical to successful transition into the community setting are not considered medical and are not included in estimates of the cost of treatment. Such costs include the costs of basic care, such as housing, clothing and food, and many of the costs involved in social and vocational rehabilitation, as well as social welfare costs including social services, legal services, and income maintenance. The monies for all of these critical supports are provided through a multiplicity of sources. Some funds come directly from the federal, state and local governments, while others filter through federal entitlement programs, such as Medicaid, Medicare, SSI and SSDI. Still others come from state and local, social, vocational, housing and other agencies.

We believe that the fragmentation of these funding streams complicates the delivery of comprehensive services, deters preventive interventions, and precludes systems change. There is virtually no support for families who are the primary caretakers of the chronically mentally ill. Funding rewards the most undesirable treatment or service; for example, nursing home care rather than home care or residence in supervised group homes.

We believe that a comprehensive care system should be developed to cover all the services that were once provided to the chronically ill in public state facilities. These services include treatment, support and shelter. Further, we believe a system should be devised to fix the fiscal, administrative and program responsibility for the implementation of treatment and care. Further financing should provide adequate monies for this chronic population; and finally, we believe that funding should integrate the needs of acute and chronic care with the needs for shelter and support, thus permitting the money to truly follow the patients.

The funding mechanism that we suggest would provide incentives for systems change in these desirable directions.

Therefore, it is our opinion that the size of the mentally ill population that is mostly supported by federal dollars today (somewhere between 1.7 and 2.4 million people) is so large and the amount of money spent on them so staggering and the resulting care so abysmal that a new federal entitlement program should be established. This program should take all existing funds regardless of the source and pool them into a new single Social Security title for the mentally ill.

To start, the federal program would take all existing monies from the various federal sources and lump them into one new program. These federal dollars would be channeled via index capitation grants through a state administered authority to local community programs. At the outset, the amount of each

state's grant should be established to reflect the state's current federal share of long term care expenditures for the mentally ill.

The federal funding authority would remove regulatory requirements of the current Social Security entitlements and provide for states an opportunity to develop a managed system of medical and mental health care, social services, residential alternatives, and personal care. States would be empowered to develop a single administrative agency with responsibility for coordinating all of the programs needed by the mentally ill population, including both institutional and noninstitutional care, and current categorical state dollars would be lumped with this federal capitation grant.

Actual services would be delivered by local agencies with whom the state would contract and they would be required to work with families, provide case management, perform gatekeeping functions for long term institutional care, and be responsible for a coordinated system of medical and nonmedical services through a variety of mechanisms, including vouchers to individuals or families.

It is important to underscore that this proposal recognizes that long term responsibility is best carried out by the state government and local service delivery agencies. Federal dollars are critical in the delivery of care to this population. Chronic mental illness is national in scope. The current funding is piecemeal and fragmented, and only by channeling federal funds and consolidating them together under one title as a capitation grant would it be possible to finance the coordinated long term service system that these individuals need.

Summary

I have presented a historical perspective dating from President Franklin Pierce's veto of the Indigent Insane Bill of 1854 to today of the federal role in the delivery of mental health care. Since World War II, the federal government, both directly and indirectly, contributed to a revolution in the delivery of psychiatric care, but has as one of its side effects a public health problem now second only to the AIDS epidemic, the homeless, chronically mentally ill. I have proposed one way of beginning to coordinate large federal funds, providing them to and through states to local agencies for a coordinated, nonfragmented approach for the care and the support of individuals with chronic mental illness.

I appreciate this opportunity to present my views and the views of my association, and we stand ready to assist you in the development of a workable federal policy for the care and treatment of our mentally ill citizens.

Mr. WEISS. Thank you very much, Dr. Sharfstein. Although the questions that I have may be directed to one of you individually, I hope that you will feel free to comment on any of the questions, to amplify or to clarify the responses.

Dr. Frazier, does NIMH have much input into the mental health policies of other Federal programs, such as Medicare and Medicaid? And how could such input or coordination of efforts be improved?

Dr. FRAZIER. First, NIMH needs more personnel who are qualified and who understand reimbursement policy. We have very few mental health economists in this country. As a result, we are dependent on health economists and, what happens is, mental health gets second string kinds of thinking about it.

We need the qualified people in NIMH to understand reimbursement policy, the same kind of thing Steve was talking about, and then begin to coordinate with State mental health program directors who provide the services and organize the services in the State.

The kind of well-trained, qualified personnel within the Federal Government, interacting on a regular basis with the State mental health program directors, I think, gives a chance for that coordination to occur.

Mr. WEISS. Can you tell us how the NIMH staffing levels were decided when you were there? And what was OMB's role, for example?

Dr. FRAZIER. We got FTE lists from OMB, and that was essentially what we lived with, with occasional exceptions. We also have programs without adequately trained, qualified people to run them. There are many very fine people at NIMH; don't get me wrong. There is just not enough of them.

I think the problem is the FTE requirements for getting the work done in coordinating mental health policy and getting some neuroscientists in the Institute to make the programs happen. We just don't have enough qualified people. I think that's an OMB determined issue; we had a few exceptions we got from exchanging in the agency in the Public Health Service. But that wasn't adequate.

Mr. WEISS. Yes, Dr. Sharfstein?

Dr. SHARFSTEIN. Two examples of how NIMH leadership, through the excellent staffing, can have an impact on other Federal programs. One is the Federal Social Security Disability Program. When the program got into major difficulty through the continuing disability investigations of 1980 and 1981, it was NIMH staff that went over to the Social Security Administration and helped develop revised criteria for disability determination.

I think that was a very important leadership role.

A second example is the NIMH leadership role around research and diagnosis-related groups under Medicare: DRGs. The NIMH, through the Division of Biometry and Epidemiology, has provided extraordinary leadership in providing information on what the impact would be on psychiatric patients of the Medicare prospective payment system.

Mr. WEISS. Dr. Kiesler.

Dr. KIESLER. I would agree with Dr. Sharfstein.

Mr. WEISS. Throughout the hearings that we have conducted, not just in relation to this subject, we have constantly run into the sit-

uation where OMB makes determinations either on a strict budgetary basis or, in some instances—and that probably is not the case in this situation—on other than scientific or fiscal bases.

How can NIMH, the example before us now, deal with the kind of restrictive budgetary determinations that OMB makes? And what position were you in, as the head of an agency, to react and to try to avert the mandates which you obviously feel are, in fact, harmful to the work of the agency? What has been your experience?

Dr. FRAZIER. It's pretty clear that in the present setup, it is very important that one follows the mandate of the agency. And that mandate is really not determined by the needs of people who are sick. Nor is it determined by service needs in the various communities.

One of the problems has been that CSP and clinical training essentially are year to year kinds of programs, so that the lack of adequate planning in order to have a comprehensive long-term view, hampers the opportunity for providing the kinds of services which are needed.

It is zeroed out of the budget each year. That makes a big difference in the planning, knowing what you can do when the Congress puts it back. That gives a problem in trying to make an adequate, organized, comprehensive plan. Planning doesn't work on a one year basis in services.

It has a long trajectory, and takes more than year to year reinforcement to make long-term plans. So we don't have a long term—within NIMH—a long-term comprehensive plan, mainly because we are not allowed to.

Mr. WEISS. Right. And I guess my question is, how can you fight that inside the administration? I'm not talking only about the Reagan administration at this point, but inside any administration. It seems to me that for the programs you have mentioned, Congress saw the value of them and refused to accept the determination by the OMB people.

But in the meantime, as you say, you are hampered because you can't plan ahead. You don't know from year to year what the outcome is going to be. What is your capacity to change the opinion or judgment of OMB? What do you do if you can't, and see that the mission that your agency is given simply is undermined and undercut and can't be fulfilled because of the kind of mandates that are given to you?

Dr. FRAZIER. There are several ways it happens. We are thankful that there are constituency organizations which advocate for services and needs for services. We are also very thankful that there are State mental health program directors who are organized in a reasonable way. They make loud noises, and they also demand services and demand plans.

So we have an externally generated demand, which essentially provides the greatest impetus for response. The taxpayer supported organization does respond to requests from the outside, so that's one way that it is addressed in a respectable and a responsible way.

I think also that there are knowledgeable people, both within and outside the ADAMHA who do keep in mind the longer term plans, so that they are not specifically related to one administra-

tion, but to the needs of the people. I think that's an important contribution in meeting the issue.

The problem also, up the line, is that there are not very many advocates for mental health services within the Department. There are not many people you can resonate with up the line, in order to understand the plight of the mentally ill.

Mr. WEISS. Yes, Dr. Kiesler?

Dr. KIESLER. If I could add to that, this has been a continuing problem for decades of course, and has to do with how mental illness is perceived by the average citizen. But I have seen surveys, for example, that indicate that the prevalence of mental disorders is quite similar to the prevalence of physical disorders. And that many people have both kinds of disorders.

Consider the statistic that I quoted, that we recently ascertained that one-quarter of all hospital days in the United States are for mental disorders, and then consider what we invest in research. The research budget of NIMH, I think, is around \$300 million. The research budget of NIH is \$6 or \$7 billion. It's a 3-to-1 ratio in hospital days, and a 20-to-1 ratio in investment in research regarding better treatment for those folks.

I think we are developing a data base from which we can make a more effective case for more research funds, but we are battling philosophy, not facts. It is a... approach to the problem that we have to fight, and not a cogent counterargument.

Mr. WEISS. Dr. Frazier, one final point in this area. We constantly find ourselves in the situation where very respected professionals, such as yourself, either having spent a career within the agency, or come in from the outside for a limited period of time, are given mandates by OMB without scientific or expert information, or concern really, but simply budgetary concern.

Then the professional comes before us, in essence justifying with their credibility what has been mandated upon them by nonprofessionals. Here we are in Congress, taking the information that you give us, your information—I'm using the generic you at this point—and it often takes us a great deal of effort to uncover the fact that it is not really the professional judgment that is being given to us, but it is the judgment of the budget staff of OMB that has been given to us.

How can we get a more forthright presentation of facts so that Congress can make the judgments without having to rely on the good fortune of having outside people come in and tell us, hey, what they've told you is really just not so, and it's inadequate, and they've been forced to give you that information?

Dr. FRAZIER. I don't think you can expect that the director of an institute will violate the orders given to him by his boss, or to her by her boss, saying, essentially, that this is the proposal. I think you have to understand that there is loyalty involved. If you play on a team, you have to give your loyalty to that team.

I think it's a problem in vulnerability. I think it's a problem in honesty; it's a problem in forthrightness or candor. I found myself in a position of being against things on a team that I had been for all my life. It's not a reasonable place to be comfortable.

I think you have to depend on understanding the nature of the process. I know you do, and because you understand the process,

you understand that it's all right when the budget is growing, but when the budget is restricted due to a deficit situation, that changes the ball game and changes the rules. This is the first time we've really come up against that kind of situation: When you had to pay attention to things bigger than the issue at hand at that moment.

The bigger issue was, what's the limit of available funds within a given situation that has been mandated.

Mr. WEISS. I'm sure that, in the course of the last 10 years, some of those drastic personnel cutbacks that were being referred to were considered by the authorizing and/or the appropriating committees. There were justifications given as to why it was perfectly appropriate to undertake those cutbacks, and they were not going to harm the quality of the services or research that was going to be performed. In fact, the professionals knew that that was just not the case at all.

Yet, here we are, arguing not with the budget cutters, but with the professionals, because they are the ones who are before us. It is just a very difficult process. I appreciate the loyalty to the team, but the question that always occurs to me is, what loyalty are you expected to appeal to most? Again, the generic you, not the individual you. The team that happens to be in charge of the administration at the moment, or the team comprised of the people whom you are there to benefit?

That's the problem that we face constantly, and I know people in your position do.

Dr. FRAZIER. Our loyalty, eventually, has to be to the mentally ill. That's where the basic loyalty should reside; that's where it ought to be. And that's where, I think, most of us in the profession feel it is.

If we don't care about them, and we don't stand up for them, we are letting down the major reason for our being.

Mr. WEISS. NIMH clearly focuses its activities on research, in my judgment, at the expense of services. Is that a legislative mandate?

Dr. FRAZIER. Yes, sir, it is. It is part of the mission statement of the National Institute of Mental Health and the research mandate is clearly defined, and has always been a part of the mandate of the Institute.

Mr. WEISS. That, in fact, you undertake research. But the kind of focus which, in my judgment, currently at least, seems to be tremendously out of balance between research and the provision of services.

Dr. FRAZIER. I don't think it is out of balance; I think that we just don't have enough services money. I think we need more research money. In the first place, we can go on the next 50 years doing what we've always done in services.

We have a window of opportunity now in the research sector for finding causes for mental illnesses, and with that opportunity, we need to follow it very carefully if we're going to take the chance to find that we can make precise diagnoses and have precise interventions which work.

I think that is a very important part of our interest in the mentally ill. We need not to just treat symptoms, we need to know

causes. To get at causes is the basic thrust of the behavioral sciences and neuroscientific research. I'm strongly in favor of it.

Mr. WEISS. Do you believe that the community support program is an effective program?

Dr. FRAZIER. I believe it is what?

Mr. WEISS. Is an effective program?

Dr. FRAZIER. Yes, sir. It certainly is effective. And everybody in every State will tell you it is.

Mr. WEISS. Right. And it has been tremendously diminished?

Dr. FRAZIER. Yes, sir. It certainly has. Far too much.

Mr. WEISS. And the question really is whether, in fact, given the limited resources that have been provided or permitted to NIMH, there has been an undue fiscal impact and, therefore, program impact, on the community support program?

Dr. FRAZIER. I believe it has been undue.

Mr. WEISS. Do you have any suggestions about where NIMH should focus its energy and resources regarding services for the severely mentally ill? I think you mentioned these demonstration projects. Maybe you would like to expand on that a little bit.

Dr. FRAZIER. Yes. The demonstration projects, say in a metropolitan area, big city, or in a small State, would provide a comprehensive evaluation of the number of people who need the services, find the cases, make the interventions, and have organization of all the resources among the various agencies coordinated in a central fashion, for the mentally ill.

Finding your way through the maze for a normal person is almost possible, among these various agencies. A mentally ill person is very, very disadvantaged in trying to get the resources needed, which are very often available.

The next thing we need to do is to have the services research centers operate to determine what is the effectiveness of the interventions which are being organized in the demonstration, and what are the outcomes, and how do we measure the outcomes. Then we need to know how much did each of these things cost, so we can study the impact and the eventual cost of such a demonstration of maximizing the services now available, and developing new services, and finding the gaps we need to fill.

Mr. WEISS. Dr. Sharfstein, do you want to add to that?

Dr. SHARFSTEIN. Mr. Chairman, in terms of the previous question on the OMB. One thing I think the Congress could do is to legislate a professional judgment budget that becomes available to the Congress, and then you could compare that to the OMB budget.

If there is a way that you can insist that the professionals sit down and give their best professional judgment who are closest to the task, you have that in front of you. There is also the administration's budget. Then you can get a sense of what is the priority from the point of the budget people compared to the priority of the professionals.

Mr. WEISS. It's an intriguing idea. I can't think of any administration—Republican or Democratic—that would be enthusiastic about the idea, though.

Dr. Kiesler, what kinds of evaluation should the Federal Government be funding in order to help States and communities provide more cost-effective services?

Dr. KJESLER. I think there are three. One is that we have not funded outcome research. For example, I have a grant from NIMH and we are looking at a national survey of patients in general hospitals with mental disorders. I can say what their diagnosis was and how long they stayed, and how they paid, and what they were referred to.

But I can't tell you what the effectiveness of the treatment was. I can't tell you if they, in fact, went home when they were referred home, whether they came back, or anything else. That's a problem that we have avoided.

We also need to look more closely at the effect of different systems of care; the notions of different economic systems within organized systems of care; the days of care allowed; and mechanisms of care and so forth. We've done very little in that respect.

That is a critical issue for public policy, in the sense of what incentives in the total system should you provide to tip the balance toward the patient going this way or that way.

The third is, we need the basic data to provide an evaluation. We can't compare systems of care or systems of treatment, unless we are following patients, unless we can say what happened to them after they left treatment: whether they came back, to whom, and at what cost.

Those three elements, systems of care, outcome evaluation, and basic data, are three things that we have not been able to fund very well. They have not been priorities, and they are expensive.

Mr. WEISS. Are there any States that you could point to as providing truly excellent services for the severely mentally ill, or any cities?

Dr. KJESLER. Well, truly excellent is the catch phrase there. No is the clear answer. There are some States that do a better job than others. I agree with Dr. Pollack that Wisconsin does a very good job. Over the last 50 years or so, Wisconsin had one of the smallest incidences of mental hospitalization.

There has been a continuing commitment in that State to keep people out of the hospital. One of the critical ways in which I think they do it is to channel funds for whole geographical areas to organizations under the control of professionals. If someone finds a more effective, less expensive treatment, that person saves the money to treat yet another person.

In many cases in our system, and certainly with Medicare and Medicaid, if you hospitalize someone, it is not in the best interest of the hospital to discharge them early. Except under a DRG system, they'll make more money if they keep them longer.

Somehow, we have to get the savings of the system into the hands of the people making the decisions about which treatment the patient is going to have. I think that is the critical element in the Wisconsin experience, and is a critical element in some private insurance.

Mr. WEISS. This, I guess, is for all of you. Some administration officials claim that services for the mentally ill are really the responsibilities of the States. Do you think it is unrealistic to expect the Federal Government to do more to help the severely mentally ill?

Dr. KIESLER. I think it's absolutely critical that the Federal Government do more. I don't think one can expect each State to keep on the cutting edge of basic research in terms of causes of mental illness. I don't think you can expect them to track systems of care.

I don't think you can expect each State to fund the kind of basic data that only makes sense at a national level. I don't think you can expect them to develop the system of communication among scientists regarding the effectiveness of treatment.

There's a great deal of sharing to be done, and the Federal role has always been critical for the care of the mentally ill; always, as far as one can recollect. I share with Steve the disappointment in Mr. Pierce's veto in 1354.

It would have been a vastly different country had that veto not occurred. We would not have State mental hospitals, perhaps, today. In many respects, they are the system that needs to be changed.

Mr. WEISS. Dr. Sharfs+ein.

Dr. SHAPFSTEIN. I agree with what Dr. Kiesler said. I do want to say that, in many States, there is a level of expertise and creativity that ought to be tapped across State lines.

In fact, the NIMH Community Support Program largely rests on the interchange of information among States as to what works and to try to get that going, and new kinds of circumstances, and settings. The Federal role in promoting that kind of exchange among States, I think, is quite important.

Also, I think, it is essential to note that mental health services are delivered at the community level. Even if you are talking about hospitals, and mostly general hospitals, they are community general hospitals. The State leadership is important, but the Federal dollars are often what makes the system go.

It is going to be, I think, in the future the capacity to integrate and coordinate the State programs with the Federal programs at the community level that is going to make the difference. The issue of developing core service agencies and the capacity to take care of the patient over a long period of time, with the right kinds of financial incentives, but clinical accountability in the local area—that's what is going to make the difference.

Mr. WEISS. Dr. Frazier, is there something you want to add to that?

Dr. FRAZIER. I was commissioner of mental health and mental retardation in Texas in the mid-1960's, and I can tell you that there are many States which do not have enough systems-oriented mental health professionals who understand the nature of developing systems which deliver services.

Some States, like New York State, for instance, has a very large cadre of very experienced professionals over a long period of time. So they have the professional systems experts who know how to deliver the kinds of innovative services which will change a system.

NIMH essentially has leadership because it has knowledge, and it has specialists who see the big picture. And who also have a comparative base to look at programs in all 50 States. You can say these are innovative programs; they've worked in Wisconsin, they've worked in Ohio; we know they are good.

These models, the ones in the States that work, can be transplanted and tried in a number of other States that lack qualified professionals and the service systems people.

I think that is an important part of this national leadership: the exchange of information, the exchange of innovative programs which are working, and the outcome of research about effective programs which have been tried in places which have the staff to make it happen.

If we are going to take care of the mentally ill, we are going to have to have some kind of national leadership to provide the information, to communicate ideas, and to keep the process going. Also, to have some policymakers thinking, like Chuck, working in the process, look at new kinds of policy innovations to be introduced within State systems.

Mr. WEISS. Thank you. Dr. Sharfstein, the public meeting that you recall that was held in my district about 10 years ago or so, came shortly after I was elected to Congress. I wanted to do it because when I was a member of the New York City Council, it was apparent to us that the mandate under which deinstitutionalization took place in the State of New York had required a number of components.

They included housing availability within the communities that the people who were being deinstitutionalized were being sent to, as well as social services and/or clinical services, to make sure that the people who were being released would have a way of maintaining themselves medically.

It was obvious that that simply was not being done, that people were being released to the communities of convenience, not necessarily communities that the patients had even come from. We were trying to see what the role of the Federal Government could be, and, I guess, encouraging the State government to do a better job in relation to the deinstitutionalized.

I am pleased that you remember that experience, although obviously with our presence here, things have not necessarily gotten better since that time.

When you were at NIMH, approximately how many staff worked in positions related to mental health services, including regional staff?

Dr. SHARFSTEIN. As I mentioned, there were about 100 people in the Parklawn Building in Rockville that administered the Federal programs. There were an additional 30 people in Prince George's County that ran a special research program in mental health services.

There were about 130 total that were part of the Division of Mental Health Services in Rockville. In the 10 regional offices, total, there were about 160 ADAMHA staff that also monitored and looked at the Federal programs, principally the Community Mental Health Centers Program.

Mr. WEISS. So that in total, you had about 290 people.

Dr. SHARFSTEIN. Total would have been about 290 Federal personnel.

Mr. WEISS. Do you know approximately how many there are today of that 290?

Dr. SHARFSTEIN. Yes. Today there are about 35. Almost all are in Rockville. It's an office, it's no longer a division. It has been totally reorganized.

Mr. WEISS. You had an almost 90 percent reduction in personnel?

Dr. SHARFSTEIN. That's correct.

Mr. WEISS. I understand that some of NIMH's responsibility, such as the ADM block grant, has changed since 1980. It is an enormous cut in NIMH staff. From your experience, you speculate on how difficult it would be for NIMH to provide leadership regarding services for the mentally ill with so few staff working on those programs?

Dr. SHARFSTEIN. I left my position as Director of Service Programs—actually, it was on election day, 1980, just a coincidence—and it is very clear that the major impact of such a reduction is the loss of expertise at the Federal level that can be used to understand what is happening across the country.

Mental health care is different, not only in the 50 States, but in many local communities. There are many things that we can learn from what's been, I think, a very experimental period of delivery of care. There has been an opportunity cost of the reduction in Federal expertise and the loss of data. The loss of information, the loss of the capacity to conduct research, to find out what is effective, what really works.

I think that has probably been the major cost. The few people who are left have exercised, I think, major leadership roles, despite the small numbers, for example, in the community support program area. They continue to work, I think, double duty in the context of the many demands that are put upon them.

It has, I think, a major impact in our capacity to understand and to study what is really going on.

Mr. WEISS. In one way or another, you've all answered this question, but let me ask it for the record. Should NIMH's role regarding services for the mentally ill be expanded?

Dr. KIESLER. Absolutely.

Dr. FRAZIER. Absolutely.

Dr. SHARFSTEIN. I think so. I think that there is an ongoing opportunity to do demonstrations, and to provide for a more effective service delivery systems through States and local communities, and it is the Federal Government that has not only the resources but the capacity to perform the leadership necessary.

Mr. WEISS. Dr. Frazier.

Dr. FRAZIER. Absolutely. Demonstration projects are an adequate way to do it.

Mr. WEISS. Dr. Kiesler.

Dr. KIESLER. I agree completely, and particularly regarding the demonstration projects and looking at the outcomes of different methods of treatment.

Mr. WEISS. Dr.—I mean, Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman. I appreciate the promotion. [Laughter.]

Gentlemen, I'll just throw this open to any of you who want to respond because you have hit on something that is interesting from a layman's perspective, I won't even pretend to have the expertise that any of you have in this particular area.

If we can make a quick analogy as to what is happening with a lot of the programs, I guess the first real job I ever had in life was as a customer engineer for IBM. If we had a problem with a piece of equipment, engineers would make a study and design, and decide possibly that, well, we need to add another 20-thousandths clearance, and so on and so on.

The memorandum would go out and every machine in the country would be changed another 20 thousandths, and then it would operate correctly. I think we try to do that here with people programs, not realizing that each individual is different, that they react differently, and that the causes of what might afflict them are different. Therefore, many times we put together programs that are ineffective because we try to come up with one solution for every problem, which is not correct. It can't work that way.

It goes back, I think, to what you were saying earlier, Dr. Kiesler, as far as the Wisconsin plan with the targeting of the funds. I'd like to expand upon that a little bit. How can we be more effective in targeting funds? Personally, I think that's the direction to go; we need to key in on these things.

They are different. Mr. Weiss, for example, is from New York. One reason I'm glad to be on this committee is that he represents a very concentrated, urban area. I come from exactly the opposite. We both have mentally ill people, but for different causes and in different situations.

Dr. KIESLER. That's a complicated question. Let me say that I agree with your analogy with IBM, in going back to the lab to see what was wrong with the part, and testing different alternatives to get something to work.

But you also make it work in different circumstances: in the different humidity of Alabama, and Alaska, and Michigan and so forth. So it is not so precise that it only works in an isolated situation but works in a broad variety of circumstances.

Some of our testimony implies that we should have the money to go back to the lab to see what works, so that we can come back and make it work somewhere else. There has never been enough support in the Congress, perhaps only during John Kennedy's administration in the White House, to try to look at the effectiveness of different alternative treatments and systems of treatment.

It is only in recent years that we have begun to see some of the conflicts and problems of competing systems of care. At one point we were spending more money in putting people into the hospital with Medicare and Medicaid for mental disorders than we were spending at NIMH on the whole community mental health center system.

The broad systems of care need to be disaggregated, as it were, and we need to look at which parts of it work best. The analogy that you make is exactly the analogy I would make. We need to find out what works best, and at what cost, and with whom. And not assume that everything we have always philosophically thought worked best does work, and not assume that one method of treatment is the best of all, simply because it's the most expensive.

We need to challenge those basic assumptions in the same pragmatic, fact-oriented way that you made with your IBM analogy. I would agree with that completely.

Mr. LIGHTFOOT. How do we do it?

Dr. KIESLER. Money is step one. Demonstration projects are important—we have a national project that has been going on in the treatment of depression, for example. We could have tested the costs and effectiveness of analogous treatments there. We could look more closely at the effects of systems of care. We are not looking at private insurance and its effects very much.

We need to be looking at that. We could go into the existing data base and draw out of that much more than we are now doing. The private sector is rapidly gaining in this element, and I think we need to take a look at that to see perhaps what other incentives we might offer, or disincentives, for them to do as well as they can do in this situation.

I have high hopes, personally, for the private sector. The private sector is very pragmatic. They want to do what works best at least cost. There are other issues and problems with the private sector, but I don't think we ought to be discouraged. We ought to see what they can do.

These kinds of notions of trying to fund pragmatic research about what works best and at what cost, is exactly the message I would hammer most heavily in Congress and at NIMH.

Mr. LIGHTFOOT. Do you other gentlemen have any comments you would like to make?

Dr. FRAZIER. I agree with that. I think we have to look at what has changed in the last two decades, certainly the last decade. The treatment of the major mental illnesses is changing rapidly. If we look at the affective disorders, depression, manic-depressive psychosis, it is very clear that we have a very definitive treatment which works.

The problem we have is that we need to have professionals who are trained in the field, especially in the State systems, to recognize and make the precise diagnosis so that the proper treatment can be instituted.

For schizophrenia, we don't have an effective trial at rehabilitation. We don't have good treatments, we haven't had major research breakthroughs. We have some leads, but it is very clear that if we had a major trial at rehabilitation of chronic mentally ill schizophrenics, and gave it a real good boost with some funds and some beginning evaluations so we would know where they started, and then give them the rehabilitation process, expose them to it and have them impacted by it, then at the end of the process, evaluate the progress that had been made.

And then evaluate how much it cost, from the beginning to the end. I think then we would have units of value which would also help us in our ability to understand how sick the patients were, how acute the illness was, how chronic the illness was, how much disability there was, and how much severity and how many people units it took to change them.

That's the kind of titration of the system, adjustment of the system, we are going to have to do if we are going to have an effective system that is measurable and replicable in other places.

Dr. SHARFSTEIN. I agree completely with the previous two speakers. I just want to make two points.

One is that there is a structure at the NIMH, which is the Federal agency to conduct the services research and demonstration. What is needed now is a renewal of purpose and an influx of money.

I also just want to state that I think there have been very important breakthroughs and we are on the threshold of understanding mental illness. The fund of basic research into mental disorders should not be sacrificed even as there are very pressing needs to figure out what is best for the thousands or hundreds of thousands of patients out there in communities who need better treatment.

The interface between the brain and behavior is finally being understood. We ought to be pouring money into that understanding the way we have poured money into the understanding of cancer, heart disease, and disorders of the immune system.

Mr. LIGHTFOOT. Is there a good system among all of you, and everyone that's involved with the treatment of mental illness, to transfer information? If you discover something that is working at point A, can that information rapidly be disseminated to point Y or Z or X, or anywhere along the scale, or do we need to improve that delivery system somehow?

Dr. FRAZIER. There are very good continuing educational ventures which allow the transfer of new information. I attended a symposium and ran a symposium at the American Psychiatric Association meeting last week in Chicago, and there were 2,000 psychiatrists in the audience, all trying to find out how to treat treatment-resistant depression, people who have serious problems, people with obsessive-compulsive disorder, which essentially was a psychologically disoriented disorder, and has now a biochemical and a pharmacologic intervention.

The new information coming out of the research laboratories published in the journals is now being taught on a regular basis to mental health professionals by qualified teachers in organized ventures, and I think that is an important point, in addition to the publications and the books, the seminars, and the regular conferences.

Most hospitals have grand rounds and have opportunities for education. I know that's true in other fields.

Dr. SHARFSTEIN. I do think there is tremendous system inertia, when you provide a set of information about what might be more effective in, for example, the delivery of psychiatric hospital care. There have been numerous studies that show that day treatment is an effective alternative to inpatient care. Despite this, I think there is a tremendous inertia for people to change the way they practice, as well as from the payors in terms of how they pay for the care, and we do have a long way to go in terms of the transfer of information to the field.

Dr. KIESLER. If I could add to that, some of that inertia is in Federal programs and some of it is in the private sector. Some of the difficulty in implementing the findings in both day care and other forms of alternative care is the lack of coverage in Medicare, Medicaid, and private insurance, Blue Cross/Blue Shield. I testified on an experimental study of alternative care that was done by Blue Cross/Blue Shield in the Senate a couple of years ago, in which they found more effective care and 40 percent savings. The next

day, when I arrived home, I had a call from the vice president of Blue Cross/Blue Shield saying, "We never heard of that. What study was that?" They had done the right study. It was a very nice study, well conceived and analyzed, but it was failing to even affect their policy in the private sector. So we have that same kind of problem for us, too. We know how to treat people effectively outside a mental hospital, but we don't have the programs or money to make it work.

Mr. LIGHTFOOT. Dr. Frazier.

Dr. FRAZIER. One of NIMH's greatest opportunities and responsibilities is its convening authority, and it certainly uses it within the bounds of its budget. The opportunity for the researchers and for the service systems people and for the community support people to bring various groups together to communicate with them, transfer the knowledge, give the technical assistance, is a major function of the Institute, and I believe it needs to be improved, increased, enhanced, and better supported financially. There are many, many things which can be done, which are limited by the present budget.

Mr. LIGHTFOOT. On the subject of finances, since that seems to come to the forefront many times, I'm getting a bit parochial in this perspective, I guess. As I mentioned earlier, my friend Mr. Weiss and I are from very different areas in terms of concentrations of population, social pressures and so on. But in a sparsely populated area, like rural areas, financing programs becomes much more critical because we just simply don't have the tax base and the people there to provide money for "public programs" to the degree that you would in a metropolitan area such as New York or Chicago or somewhere, although I realize the demands are different, too.

Unfortunately, it seems that mental health programs are way down on the priority list. However, we are seeing much more awareness of mental illness due to the economic pressures that a lot of people have been under in our part of the country. It has forced people to make their feelings known where in the past they tended to be very private, very stiff-backed people. We have even had several people contact my office because of a spouse that was talking about committing suicide.

What kinds of programs or incentives do we need to put together so that residents in those sparsely populated areas are made aware of what is available to them, and how do we reach these folks?

Dr. FRAZIER. I have been dealing with that problem all my life, since I grew up in Texas. There are 254 counties in Texas, and many of them don't have any mental health professionals at all, and none within 100 miles, some places. It is a serious problem.

It is very clear that the adequacy of mental health coverage in very rural places is probably never going to be met by existing means; that is people providing 1 to 1 kind of services. Mobile teams don't work because psychiatric services require continuity and require repetitive interventions, and also checking on what the intervention has done.

We have tried mobile teams. We have tried in Nebraska to pioneer video consultation from the Nebraska Psychiatric Institute to the various State hospitals and the various community mental

health centers. That works. There is no question that you can get a certain kind of expertise transmitted on a video consultation with a live telephone kind of interaction. That's one way to go.

That doesn't essentially provide enough care in the right places. It is clear that the only sufficient way is to bring the people who require the care to some regional place, hopefully not longer than 40 or 50 miles away, where the central group of team providers can make a diagnosis, plan an intervention, plan a management program, and organize what needs to be done, and educate the family at the same time. That is the only way I know it's going to happen. And that means that these taxpayers who are living out in a rural area don't have equal access to the kinds of care which the rest of the country has. I think that is a serious problem.

Mr. LIGHTFOOT. Yes, sir.

Dr. SHARFSTEIN. Two other aspects Dr. Frazier mentioned in his testimony, the potential for payback if the Federal Government supports the training of professionals, and clearly through the National Service Corps there has been some opportunity for scarce mental health professionals to work in rural communities.

The other is that in the Federal Community Mental Health Centers Program about, as I recall, 25 or 30 percent of the grantees were in rural areas. That program, which was a regional type of program, for the first time attracted psychologists and psychiatrists to work in rural areas. It was an organized program. The seed money came from the Federal Government, and it was up to the States and local government to continue and maintain those programs. But you weren't put into a situation as a provider where you were totally just in an office in the middle of a very sparsely settled area. There was an organized program, and often that had an affiliation with the university. You were tied through telecommunications into the university. There were a variety of ways of sustaining the competence of those professionals.

So I do think that both in the training and the service area, there are things that can be done from the Federal level.

Dr. KIESLER. It's been shown in other areas that the use of paraprofessionals with supervision is very effective. One way to deal with underfunding is to develop a large cadre of paraprofessionals that are in contact with a small group of professionals. That should help in rural areas as well.

Mr. LIGHTFOOT. This is one of the biggest problems we have at the Federal level, which is our funding formulas where we try to determine where money goes for everything from airport improvements to the JTPA program. We identify where the people are, but we don't necessarily identify where the problems are. As a result, many times the money goes into areas where it could be much better used somewhere else.

One final question, and again I keep going back to what you said, Dr. Kiesler, because it makes such eminent sense about the Wisconsin experience and the targeting of the funds into the areas where things are happening. What can we learn from Wisconsin and the other States that are successful in serving the mentally ill? I guess the question is, to be a little more precise, how do we ferret out those areas where we are achieving success and then move that knowledge into a broader spectrum?

Dr. KIESLER. Well, I think a good deal of that work has been done, either directly by NIMH or through their grant funds in the past. I think we can identify excellent programs. There's a lot of work to be done, as has been mentioned, on the economics of mental health, and that needs to be worked on better. I think we have sufficient experience to extrapolate from the scientific knowledge, but we don't have the flexibility in the Federal programs to produce an overall net impact. We do need to look more closely at how can we coordinate existing Federal programs and possibly how we relate the private sector to those programs in order to have the maximum impact on particular areas?

Wisconsin has been a leader all along. That's half the battle -- to get straight what you are trying to accomplish, and then bring the funds together for that purpose.

But the concentration of funds has been difficult to accomplish in the past. The block grant has increased the flexibility of funds, but it has decreased the funds so much that the flexibility is less important than it otherwise would be.

Mr. LIGHTFOOT. Unless you have someone responsible for doing something, it usually doesn't get done. Should NIMH take up the banner and be the leader in this march?

Dr. KIESLER. I think they should. It is a question of funding, though. It would be difficult to see how they could switch much of their priorities to get a major effort. It would really have to be enhanced funding to get a good program going, although I think, Shervert, you should address that.

Dr. FRAZIER. The problem is in the funding, especially when you have limited funds, and you have existing programs. Continuation of existing programs takes up a vast majority of the funding from year to year, and that means that the programs have a longer life than 1 year, and they are over 3 or 4 years, and continuations are an important part, and that's how progress is made. So that in recent years, there has been a very grave shortage of increased funding for innovation of new programs.

Essentially we have been limited to providing continuity of the existing program which was being reduced by the value of the dollar and by the lessened funding over time. No question that leadership resides in people, and good leaders can make good things happen if they have the resources. So we have to develop the people, get them trained, make them available, give them enough funds to teach other people how to do it, to put it in practice, and it's all people, as you said.

Mr. LIGHTFOOT. Good. One of my colleagues made the comment the other day that when they died, they hoped they came back as a Federal program, because it was the only thing on Earth they knew that had eternal life. And that does cause some problems for us. Of the programs you mentioned, are there some that are being continued simply because of the bureaucratic process? Would we be much better off if they were discontinued, and have they outlived their usefulness? Should those funds be made available to the programs that are necessary and are working?

Dr. FRAZIER. NIMH has done very well in this particular area. They have looked at programs. With the shortage of funds and with the necessity of looking at every program very critically,

there has been kind of zero-based funding, looking at every program initially to be sure it's valid, necessary, working, efficient, and really contributing.

I think it's done a very good job in that respect. I don't see any fat in NIMH. I think most of the fat has been excised by various techniques and methods. There's a large number of personnel who were quite qualified who were cut back in the RIF of 1981, and that lost for the Institute some of its best brain power and some of its very knowledgeable leadership.

Since that time I think that has changed a lot of things. It also hurt morale over a long period of time.

Mr. LIGHTFOOT. Gentlemen, thank you all very much.

Thank you, Mr. Chairman.

Mr. WEISS. Thank you, Mr. Lightfoot.

Just one followup question to the funding problems in the continuation of programs. Dr. Frazier, you spent a great deal of attention on the clinical mental health program, and I think justifiably. The fact is that during every year of this administration, they have tried to zero that program out, to eliminate it totally, and in fact, although they have not achieved that, there has been a total reduction in that program by some 85 percent since the year 1980. So, it seems at the very time when there is grave need for that program, the administration is taking us exactly the opposite way. Right?

Dr. FRAZIER. That's true.

Mr. WEISS. Thank you again very, very much. I appreciate the testimony that you have given us, and the good work that you are doing.

The next panel that we will hear from is the Alcohol, Drug Abuse, and Mental Health Administration. I am going to ask Dr. Joseph Autry, who is the Acting Associate Administrator for Policy Coordination in that agency, to come forward, and to join him, Dr. Frank Sullivan, the Acting Director of the National Institute of Mental Health.

Before you make yourselves comfortable, would you stand and raise your right hand?

Do you affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth?

Let the record indicate an affirmative response by each of the witnesses.

STATEMENT OF JOSEPH AUTRY, M.D., ACTING ASSOCIATE ADMINISTRATOR FOR POLICY COORDINATION, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, ACCOMPANIED BY JAMES STOCKDILL, DIRECTOR, DIVISION OF EDUCATION AND SERVICE SYSTEMS LIAISON, AND CARL TAUBE, PH.D., ACTING DIRECTOR, DIVISION OF BIOMETRY AND APPLIED SCIENCES

Dr. AUTRY. Mr. Chairman, before we start, we would like to ask two other NIMH staff to join us at the table, with your permission.

Mr. WEISS. Of course. Would you identify them by name?

Dr. AUTRY. Mr. Jim Stockdill, the Director of the Division of Education and Service Systems Liaison, and Dr. Carl Taube, who is

the Acting Director of the Division of Biometry and Applied Sciences.

Mr. WEISS. Step forward, gentlemen, and again, please raise your right hand.

Do you affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth?

Let the record indicate an affirmative response from the staff who are joining us.

Dr. Autry, I think that we will begin with you, and you can indicate how the other members of the panel will proceed.

Dr. AUTRY. Thank you, Mr. Chairman.

I am Dr. Joseph Autry, Acting Associate Administrator for Policy Coordination.

Mr. WEISS. Doctor, that microphone is not very strong, so you have to speak really loud into it.

Dr. AUTRY. OK. The Alcohol, Drug Abuse, and Mental Health Administration.

Let me first apologize for Dr. Ian MacDonald, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, who was originally slated to be here. Dr. MacDonald could not join you today due to the fact that there's a meeting of the National Drug Policy Board, so he sends his regrets at not being here.

Let me introduce Dr. Frank Sullivan, who is the Acting Director of the National Institute of Mental Health, and who will be presenting our testimony today.

Mr. WEISS. Dr. Sullivan.

STATEMENT OF FRANK J. SULLIVAN, PH.D., ACTING DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH

Dr. SULLIVAN. Thank you. I am pleased to have the opportunity of appearing before you today to address the issue of the Federal role regarding services for the mentally ill. As the Federal entity assigned primary responsibility for the mentally ill, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), and its National Institute of Mental Health, welcome the subcommittee's oversight. Attention to the serious concern of America's mentally ill citizens is always needed, and we appreciate the opportunity to discuss the agency's initiatives on their behalf.

During any 6-month period, nearly 30 million Americans suffer from some form of mental illness that requires professional treatment. One-and-a-half million Americans suffer from schizophrenic disorders, and 300,000 new cases occur each year. More than 9 million Americans suffer from serious depression, manic depression, and related depressive disorders. About 30 million, or 15 percent of the population, will experience at least one episode of major depression during their lifetime. Three million children are afflicted with autism, childhood depression, and other serious mental disorders which interfere with normal development. And we estimate that 30 to 35 percent of the homeless population suffers from some form of mental illness.

Additionally, nearly a quarter of the elderly who are diagnosed as senile actually have a treatable mental illness. The personal and social costs of mental illnesses are similar in scope to those for

heart disease and cancer, with direct cost of mental illness estimated to be \$20.9 billion annually.

Yet only about 20 percent of our mentally ill citizens seek professional help. The last several years have seen significant changes in the system of care for providing services for the mentally ill, as well as promising findings in mental health research.

Most significant is the move by the majority of States to designate long-term severely mentally ill persons as the priority population for funding and services. Up to 70 percent of these clients have a primary diagnosis of schizophrenia.

In addition, a large portion of Federal funds for direct services have been consolidated into a single block grant, giving the States greater authority and decisionmaking responsibility for the use of these funds.

With regard to the Federal role in serving the mentally ill, we have established productive relationships with key components in the mental health service delivery system, most particularly the State mental health authorities, and have achieved an unprecedented level of cooperation and coordination between NIMH and other Federal agencies.

The Institute's 1987 budget includes \$247 million for research, \$18 million for research training, \$15 million for clinical training, \$15 million for service demonstration programs for severely mentally-ill adults and children, and \$10.5 million for protection and advocacy for the mentally ill.

In 1985, NIMH made research on schizophrenia its No. 1 priority, and has made organizational and budgetary changes to support that decision. A long-term plan for research on schizophrenia is being developed. In fiscal year 1986, the NIMH initiated the Depression Awareness Recognition and Treatment Project (Project D/ART), the aim of which is to disseminate information on the etiology, diagnosis, and treatment of depression to general health professionals and mental health professionals and to the general public.

In addition, we are continuing to give high priority to mental disorders of children, adolescents, and the elderly. We are justifiably proud of the progress and quality of our research program, especially with regard to the causes and treatment of several mental illnesses.

We have significantly increased our efforts for research on schizophrenia, Alzheimer's disease, depression, and most recently, AIDS.

The Institute's research program is the underpinning of our efforts to improve the prevention and treatment programs for the mentally ill throughout the Nation. Our research program is integrally related to our efforts at disseminating the best available information to scientists, to primary health care providers, to the specialty mental health sector, policymakers, and to the American public.

The major share of the Institute's funds and staff are deployed to the production and support of our research program and the causes and treatment of the major mental illnesses, including research on services-related concerns.

While the direct responsibility for planning, financing and administering mental health service programs lies with State and

local governments and the private sector, the Federal Government retains an important role in supporting their efforts.

We view the NIMH role to be one of national leadership with regard to services for mentally ill persons, focused in four major areas.

The first is developing, evaluating and promulgating effective service models. The Institute supports a range of mental health services development activities, including the funding of service demonstrations, technical assistance and knowledge transfer activities to States and communities, assistance to improve State and mental health services' planning capacity, national evaluation studies, and activities to protect and advocate for the rights of the mentally ill.

By 1985, we had initiated funding of all States, the District of Columbia, and territories for a basic State-level strategy Community Support Program (CSP) grant. Beginning in 1985, the CSP program has emphasized community level demonstrations which target underserved populations.

In addition to the adult program, the Child and Adolescent Service System Program (CASSP) is providing funding to 28 States and three localities for the development of service systems for severely emotionally disturbed children and adolescents.

These demonstration projects are an effective way to test new approaches identified through services research. The demonstrations are being documented and evaluated so that, if the new approaches are found to be effective, they can be replicated in other sites and/or adopted by other systems.

The activities are backed by a range of services, technical assistance, knowledge transfer, and evaluation activities. We seek to identify "best practices" and see that they are widely disseminated to other systems for replication in whole or in part.

In addition to the service demonstration and technical assistance activities, the Institute is carrying out congressionally mandated programs which help States to improve their planning and patient protection and advocacy activities. The Institute currently makes grants to State protection and advocacy systems on a formula grant basis to help protect the mentally ill who are in hospitals or in residential facilities, and for 90 days following discharge from such facilities.

Based on Public Law 99-960, the State Mental Health Planning Act of 1986, the Institute is currently planning to implement a new formula grant program to assist States in the development of State comprehensive mental health service plans for the chronically mentally ill.

The second major area of our national leadership role is concerned with disseminating knowledge to mental health practitioners and to administrators. This congressionally mandated role is aimed at enhancing the quality and effectiveness of practitioner education in the mental health professions and in assisting States in the effective utilization of mental health human resources.

The priority populations for this program are long term, seriously mentally ill adults, and severely emotionally disturbed children.

The Federal support over the years has resulted in a national training capacity which can continue to function without further

Federal subsidies. While the administration's policy is to phase out the direct training of clinical practitioners, we remain committed to other and more indirect methods of educating mental health personnel.

In addition to these educational activities, the State Human Resource Development Program enhances the capacity of State mental health agencies to improve mental health services by supporting activities at State and multi-State levels. The program also promotes linkages and collaboration between State and community health service agencies, on the one hand, and the institutions within the State that educate and train mental health personnel for the State mental health delivery system.

The third area of our national leadership role concerns the stimulation of policy discussion. The Institute analyzes and convenes State and community officials to discuss major mental health service policy issues, including financing.

The voluntary interaction of a variety of mental health providers, policymakers, consumers, and researchers, in an array of service settings, and the voluntary collection and analysis of data from these settings, are important aspects of the translation of knowledge and putting the knowledge into operation, in this very complex field.

The fourth area of our national leadership role relates to the conduct of services-related research. A major new thrust for ADAMHA is the conduct of studies of economic cost and appropriate mechanisms of financial coverage. These activities are coordinated within the Office of the Administrator, in the Office of Financing and Coverage Policy, ADAMHA. Within the NIMH, the primary locus for these activities is the Division of Biometry and Applied Sciences.

Over \$3 billion is spent annually for the mentally ill as the Federal share of Medicaid, Medicare, SSDI, rehabilitation programs, and housing and welfare. The public mental health system now is implementing major experiments to improve its management capacity: case management; competitive contracting for services; performance contracting, capitation experiments, and contracting for managing of State facilities. NIMH's research and evaluation capacity serve as an appropriate national resource to States and communities in conducting these experiments.

The adoption of proven State and local programs is a very cost-effective way to maximize the dissemination of research results. Over the next 5 years, a number of demonstration projects will be occurring that may enable evaluations of major service system changes and interventions. These include an initiative by the Robert Wood Johnson Foundation and HUD for reorganizing the delivery system for the chronically mentally ill in nine cities; the Robert Wood Johnson Foundation Services Development Program, to improve access to appropriate services for this population; NIMH-supported demonstration projects targeted at the homeless, young adult chronic patients, the elderly and rural populations, and HUD demonstrations for transitional housing.

In addition, the Institute supports the National Mental Health Statistics Program to collect data on the entire national mental

health system, both public and private, through a longstanding cooperative relationship with the States.

Included in this effort are the mental health statistics improvement program, which is a developmental and capacity-building program, and the national reporting program, which is an ongoing survey and analysis effort.

We also support research on antisocial and violent behavior, including national surveys of family violence, studies of delinquent behavior and drug abuse among youth, and studies of the prevalence of mental illness in jails. We also have an active research program on sexual assault, as well as studies of the relationship between the law and mental health.

One of our newest efforts is research on the delivery and financing of mental health services, in which we seek to expand the focus of the field and to attract health economists to apply their skills to the mental health services field. One program is concerned with research on mental health delivery in primary care settings; another is directed at the mental health economics. These programs are expected to provide a basis for future policymaking and, as such, represent a critical resource to the Nation.

I have touched only briefly on some of the major service-related activities of the National Institute of Mental Health. However, I have attempted to convey the considerable intellectual and policy-related ferment currently underway. ADAMHA and the NIMH have always played a major role in the direction of resources to current mental health needs. Although our role has shifted in recent years due to the increased role played by States and communities in meeting the needs of the severely mentally ill, ADAMHA and the NIMH continue to serve in a variety of critical roles, and to hold this population's concerns uppermost in our mission.

That concludes my statement, and I and other members of the panel will be happy to answer any questions you have.

Mr. Weiss. Thank you, Dr. Sullivan.

[The prepared statement of Dr. Sullivan follows:]



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

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TESTIMONY BEFORE

HOUSE SUBCOMMITTEE ON

HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

ON

OVERSIGHT OF

THE NATIONAL INSTITUTE OF MENTAL HEALTH'S

ROLE IN SERVICES AND SERVICES RESEARCH

BY

FRANK J. SULLIVAN, Ph.D.

ACTING DIRECTOR

NATIONAL INSTITUTE OF MENTAL HEALTH
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

TUESDAY, MAY 19, 1987

Mr. Chairman, Members of the Subcommittee on Human Resources and Intergovernmental Relations, I am Dr. Frank Sullivan, Acting Director of the National Institute of Mental Health (NIMH) of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). I am pleased to have the opportunity of appearing before you today in addressing the Federal role regarding services for the mentally ill. As the Federal entity assigned primary responsibility for the mentally ill, ADAMHA and the National Institute of Mental Health welcome the Subcommittee's oversight. Attention to the serious concerns of America's mentally ill citizens is always needed, and we appreciate the opportunity to discuss the Agency's activities in their behalf. We regard our national leadership role as a vital relationship between the Federal Government and each of America's most vulnerable citizens--the severely mentally ill.

During any 6-month period, nearly 30 million Americans are suffering from some form of mental illness that requires professional treatment. One and one-half million Americans suffer from schizophrenic disorders, and 300,000 new cases occur each year. More than 9 million Americans are suffering from depression, manic depression and related depressive disorders. About 30 million (or 15 percent of the population) will experience at least one episode of major depression during their lifetimes. Three million children are afflicted with autism, childhood depression, and other serious disorders which interfere with normal development. We estimate that 30-35% of the homeless population suffers from some form of mental

illness. Additionally, nearly one-fourth of the elderly who are diagnosed as senile actually have a treatable mental illness. The personal and social costs of mental illnesses are similar in scale to those for heart disease and cancer, with the direct costs of mental illness estimated to be \$20.9 billion annually. Yet, only 20 percent of our mentally ill citizens seek professional help for themselves.

The last several years have seen significant changes in the system of care providing services for the mentally ill, as well as promising findings in mental health research. Most significant is the move by the majority of States to designate long-term severely mentally ill persons as the priority population for funding and services. Up to 70 percent of these clients have primary diagnoses of schizophrenia. In addition, a large portion of Federal funds for direct services have been consolidated into a single block grant, giving the States greater authority and decisionmaking responsibilities for the use of these funds.

With regard to the Federal role in serving the mentally ill, we have established productive relationships with key components in the mental health service delivery system--most particularly, the State Mental Health Authorities--and have an unprecedented level of cooperation and coordination between NIMH and other Federal agencies.

The Institute's FY 1987 budget includes \$247 million for research, \$18 million for research training, \$15 million for Clinical Training, \$15 million for Service Demonstration programs for severely mentally ill adults and children, and \$10.5 million for Protection and Advocacy.

In 1985 NIMH made research on schizophrenia its number one priority and made organizational and budgetary changes to support that decision. A long-term plan for research on schizophrenia is being developed. In Fiscal Year 1986 NIMH initiated the Depression Awareness, Recognition, and Treatment (D/ART) program to disseminate information on the etiology, diagnosis, and treatment of depression to general health professionals, mental health professionals, and the general public. In addition, we are continuing to give high priority to mental disorders of children, adolescents, and the elderly.

As the States and local communities have increasingly assumed responsibility for treatment and rehabilitation of their mentally ill citizens, the National Institute of Mental Health has concentrated its resources to support the service mission of others in the mental health system. A major form of this support is the generation and dissemination of knowledge about the fundamental causes and efficacious treatments of mental illness.

We are justifiably proud of the progress and quality of our research program, especially with regard to the causes and treatment of several mental illnesses. We have significantly increased our research

efforts in schizophrenia, Alzheimer's Disease, depression, and, of course, Acquired Immunodeficiency Syndrome (AIDS). Many exciting and important discoveries have recently emerged from research we have conducted.

New technologies and new findings are creating vastly expanded opportunities and heightened prospects for improving our understanding of the genetic, biologic, and environmental bases of the major mental disorders. Most significantly, the role of brain chemistry and genetics in mental illness is becoming increasingly clear. Utilizing brain imaging techniques which were not even in existence a few years ago, we now can more effectively study brain function as well as brain structure. Scientists have, for the first time, a way to compare and quantify normal and abnormal brain function and structure in living subjects without causing tissue trauma. This holds vast promise for a number of research areas, including schizophrenia, AIDS, Alzheimer's Disease, manic depression, and mental disorders of childhood and adolescence (including childhood depression and youth suicide). This is an exciting time in research, as scientists make significant progress in cracking what has often been called "the last frontier" of science--understanding the human mind.

The Institute's research program is the underpinning for our efforts to improve prevention and treatment programs throughout the nation; it is integrally related to our efforts at disseminating the best available information to scientists, primary health care providers,

the specialty mental health sector, policy makers and the American public. A major share of the Institute's funds and staff are deployed to the production and support of research into the causes and treatment of the major mental illnesses, including research on services-related concerns.

While the direct responsibility for planning, financing, and administering mental health service programs lies with State and local governments and the private sector, the Federal Government retains an important role in supporting their efforts. The Institute is drawing on a long history of stimulating the development of appropriate mental health service delivery models. In addition, our staff is anticipating and addressing the new mental health problems which have and can be expected to surface continuously, such as those related to the private and public tragedy of the AIDS epidemic and the suffering of the homeless mentally ill.

We view the NIMH role to be one of national leadership with regard to services to mentally ill individuals, in the following areas:

- o developing, evaluating, and promulgating effective service models;
- o disseminating knowledge to mental health practitioners and administrators;
- o stimulating serious discussion of critical policy developments and issues; and
- o conducting services-related research.

Although these activities may be undertaken throughout NIMH, the primary loci for their accomplishment are the Division of Education and Service Systems Liaison (DESSL) and the Division of Biometry and Applied Sciences (DBAS). Their activities are discussed below.

Developing, evaluating, and promulgating effective service models

We are supporting a range of mental health services development activities, including the funding of service demonstrations, technical assistance and knowledge transfer to States and communities, assistance to improve State mental health services' planning capacity, national evaluation studies, and activities to protect and advocate for the rights of the mentally ill within the mental health care system.

By FY 1985, NIMH had initiated funding all States, the District of Columbia, and territories for basic (State-level strategy) grants concerning seriously mentally ill adults through the Community Support Program (CSP). Beginning in 1986, CSP emphasized community-level demonstrations which target underserved populations. The CSP demonstration program provides grants to improve the planning, coordination, and delivery of community-based services for: 1) homeless persons with long-term, severe, disabling mental illness; 2) elderly individuals with long-term, severe, disabling mental illness; and 3) young adults with a combination of mental illness and substance

abuse. Special emphasis on women and members of racial and ethnic minority groups within these populations is expected. Graduates of the old (State-level) CSP can apply for small State Service System Improvement Grants which provide technical assistance to community organizations to encourage the development of community-based mental health programs and to assist in the development of State profiles. In addition to the adult program, the Child and Adolescent Service Systems Program (CASSP) is providing funding to 28 States and 3 localities for the development of service systems for severely emotionally disturbed children and adolescents.

These demonstration projects are an effective way to test new approaches identified through services research. They are being documented and evaluated so that if the new approaches are found to be effective, they can be replicated in other sites and/or adopted by other systems. Most States and communities do not have the fiscal resources to develop and test new, alternative services that are required by the homeless mentally ill and other special populations who are inadequately served by traditional service models. A small amount of Federal funds for a community support program demonstration in one community can have a significant multiplier effect in improving services across the country.

To be most effective, the service demonstration activities are backed by a range of technical assistance, knowledge transfer and evaluation activities. "Best practices" are identified and widely disseminated to other systems for replication in whole or in part.

NIMH's Division of Education and Service Systems Liaison employs a variety of mechanisms to carry out these activities. DESSL staff has worked with all 50 States and the District of Columbia using the following technical assistance and knowledge transfer mechanisms and products:

- o staff consultation to individual States and/or community programs,
- o State Mental Health Commissioners Common Concerns Conference on major policy issues,
- o rehabilitation research and training centers to develop new approaches for community-support systems for the seriously mentally ill,
- o workshops to bring together researchers and service providers in order to disseminate new research findings,
- o national and regional conferences on major issues, such as the needs of the homeless mentally ill and seriously emotionally disturbed children,
- o national technical assistance contracts for other national organizations to broker technical assistance and policy development. NIMH components have or have had such contracts

with the National Association of Counties, National Council of Community Mental Health Centers, U.S. Conference of Mayors, and the National Conference of State Legislators, and

- o technical assistance manuals in such areas as child mental health service systems and quality assurance activities.

In addition to the service demonstration and technical assistance activities, we are carrying out Congressionally-mandated activities which help States to improve their planning and patient protection and advocacy activities. NIMH currently makes grants to State protection and advocacy systems on a formula grant basis to help protect the mentally ill who are in hospitals or residential facilities and for 90 days following discharge from such facilities.

Based on P.L. 99-960, the State Mental Health Planning Act of 1986, NIMH is currently planning to implement a new formula grant program to States to assist in the development of State Comprehensive Mental Health Service Plans for the long-term seriously mentally ill, both adults and children. All of the above capacity building efforts are an important aspect of the Federal role.

Disseminating knowledge to mental health practitioners and administrators

Another Congressionally-mandated role related to mental health service programs is enhancing the quality and effectiveness of practitioner education in the mental health professions and assisting States in the effective utilization of mental health human resources. The priority populations for clinical intervention are the long-term seriously mentally ill and severely emotionally disturbed children. Within the seriously mentally ill population, special attention is paid to important subpopulations, such as racial and ethnic minorities, the homeless mentally ill, and young adults combining serious mental illness and substance abuse problems. NIMH is supporting grants for graduate education for mental health professionals to better meet the needs of mentally ill individuals whose services are funded predominately through public tax dollars. This has resulted in a national training capacity which can continue to function without further Federal subsidies. While the Administration's policy is to phase out the direct training of clinical practitioners, we remain committed to other, more indirect methods of educating mental health personnel.

In addition to these educational activities, the State Human Resource Development Program (SHRD) enhances the capacity of State mental health agencies to improve mental health services by supporting HRD

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activities at State and multi-State levels. The program also promotes linkages and collaboration between State and community mental health service agencies and the institutions that educate and train mental health personnel for the delivery of mental health services. State government is generally responsible for licensure, certification, and reimbursement policies which affect the deployment and utilization of the mental health work force. Through capacity building and demonstration grants, the Federal Government can play a critical role in assisting States to improve these activities.

Stimulating discussion of policy issues

The Institute analyzes and convenes State and community officials to discuss major mental health service policy issues. These analytic and convening activities help improve both Federal and State policy and legislative development in financing and other areas affecting mental health services in the States. The voluntary interaction of a variety of mental health providers, policymakers, consumers, and researchers in a variety of service settings, and the voluntary collection and analysis of data from these settings is an important aspect of the translation of knowledge and the operation in a very complex field.

These processes perform the valuable function of informing problem identification and the setting of new research priorities.

Conducting services-related research

A major new thrust for ADAMHA is the conduct of studies of economic costs and appropriate mechanisms of financial coverage. These activities are coordinated within the Office of Finance and Coverage Policy, ADAMHA. The primary locus for the agency's mental health studies is the Division of Biometry and Applied Sciences (DBAS), NIMH.

Over \$3 billion is spent annually as the Federal share of Medicaid, Medicare, SSDI, rehabilitation programs, and housing and welfare for the mentally ill. The public mental health system is implementing major experiments to improve its management capacity--case management, competitive contracting for services, performance contracting, capitation experiments, and contracting for management of State facilities. The NIMH research and evaluation capacity serves as an appropriate national resource to States and communities conducting these experiments. The adoption of proven State and local programs is a very cost-effective way to maximize research results.

A number of demonstration projects will be occurring over the next 5 years on a scale that may enable evaluations of major service system changes and interventions. These include the Robert Wood Johnson Foundation/HUD program reorganizing the delivery system for the chronically mentally ill in 9 cities; the Robert Wood Johnson Foundation's Services Development Program to improve access to

appropriate services for this population; NIMH demonstration projects targeted at the young adult chronic patient, the homeless mentally ill, the elderly, and rural populations; HUD's demonstration for transitional housing; the Rehabilitation Services Administration's program of supported employment; newly permitted funding of case management services by Medicaid and, for communities participating in the Robert Wood Johnson Foundation program, the possibility to capitate for Medicaid services.

Among the research issues which need to be addressed by the mental health field are:

- specifying and evaluating the system of care;
- evaluating and designing financing systems;
- evaluating the interface between the legal and mental health systems;
- specifying service needs of special subgroups of the severely mentally ill;
- matching the individual needs of patients and their families with services; and
- assessing effectiveness in actual practice by patient, practitioner, and facility involved.

NIMH will continue to monitor developments in these areas.

The NIMH Division of Biometry and Applied Sciences (DBAS) is concerned with improving mental health services for the population at large as well as for minorities, victims of violence, and persons who exhibit antisocial and violent behavior. Among the services-related research activities underway are the following:

- o The National Mental Health Statistics Program collects data on the entire national mental health system, both public and private via a longstanding cooperative relationship with the States. Included in this effort are the Mental Health Statistics Improvement Program which is a developmental and capacity building program, and the National Reporting Program which is an ongoing survey and analysis program.
- o Research on antisocial and violent behavior including national surveys on family violence; a study of delinquent behavior and drug use among male and female youth; and a study on the prevalence of mental illness in a large urban jail; an active research program on sexual assault; and studies of the relationship between law and mental health. Efforts also are underway to explore the problems of violence in minority communities.
- o The minority research and development centers program includes the production of research relevant to minority populations, technical assistance, information dissemination

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and a Visiting Scholars program. Recently, the funding level of each Center was raised to \$250,000 a year for 5 years.

- o One of our newest efforts is research on the delivery and financing of mental health services which seeks to expand the focus of the field and attract health economics experts to apply their skills to the mental health services field. One program is concerned with research on mental health delivery in primary care settings; another is directed at mental health economics. These programs are expected to provide the basis for future policy making and, as such, represent a critical resource to the nation.

Conclusion

I have touched only briefly on some of the major service-related activities of the National Institute of Mental Health. However, I have attempted to convey the considerable intellectual and policy-related ferment currently underway. ADAMHA and NIMH have always played a major role in the direction of resources to current mental health needs. Although our role has shifted somewhat in recent years, due to the increased role played by the States and communities in meeting the needs of the severely mentally ill, ADAMHA and the NIMH continue to serve in a variety of critical roles and to hold this population's concerns uppermost in our mission.

Mr. WEISS. We have a vote on the floor at this time, so we will recess for about 10 minutes.

[Recess taken.]

Mr. WEISS. The subcommittee is back in session.

Dr. Sullivan, I understand that most mental health professionals like to work with patients and clients who are not severely ill. Sometimes these clients are referred to as "the worried well."

Why is it difficult to persuade new people entering the field to work with the most severely mentally ill?

Dr. SULLIVAN. Over the last 5 to 10 years, there has been a changing emphasis, certainly with respect to the programs that the Institute has been sponsoring, to better train people to treat severely mentally ill persons.

The question of how the professional work force is balanced and stacked up against the range of mental disorders is a complicated one. The States are focusing increasingly on the seriously mentally ill, and therefore, the professional communities are starting to see that this is where there will be needs in the future. We're starting to see some turnaround as to where people work and who they treat. That's a result of many factors, including personal preferences and economic rewards.

I think it is fair to say that in both research and in services the seriously mentally ill are difficult to work with. Researchers find it difficult; service providers find it even more difficult. There are problems of burnout. There are problems of dealing with the potential for disruptive behavior. They are difficult patients with whom to work.

Mr. WEISS. Does NIMH provide incentives for students and new professionals to work with the most severely mentally ill?

Dr. SULLIVAN. The current clinical training programs are targeted on the seriously mentally ill, on children and adolescents with emotional disorders, and now with the homeless. We are trying to use the limited educational funds that we have to target on those—

Mr. WEISS. How do you do that?

Dr. SULLIVAN. Pardon?

Mr. WEISS. How do you do that?

Dr. SULLIVAN. We encourage educators and trainers when they submit grant applications to develop relevant curriculums, and to provide practical experience for the students dealing with these types of patients. Those are criteria on which we review applications.

Mr. WEISS. And do you also provide stipends, with conditions regarding where people are going to be working, as well as a payback arrangement in service contributed after they finish their training?

Dr. SULLIVAN. Yes, any trainee who gets a stipend from one of our grant awards is required to meet the provisions of the payback law. The payback requires service dealing with one of these priority populations. There also is a provision for alternative service related to teaching and research dealing with these priority populations.

Since the payback law was passed in 1981, just over 5,000 trainees have incurred the payback provision. Over 1,000 of them have

completed and discharged the obligation, and over 15,000 months of documented payback service have been recorded in our system.

Mr. WEISS. For the last 6 years, the President's budget request has called for phasing out or terminating the clinical training program. Congress has refused to go along and saves the program every year. But the funding levels have dropped, as I indicated in questions to Dr. Frazier before, 85 percent since 1980, when inflation is taken into account.

What is the current status of the clinical training program?

Dr. SULLIVAN. The current status for the clinical training program in 1987 is that we expect to spend our budget of about \$15 million, and that our 1988 request calls for that to be phased down, with a subsequent phaseout after that.

That is, unlike the case in 1981, in 1988 the administration is making a budget request for the clinical training program.

Mr. WEISS. But if there's a shortage of mental health professionals who are trained to work with the most severely mentally ill, or want to work with them, don't we need training fellowships with strict requirements that the trainees pay back their grants by working with these patients? Shouldn't that program, if anything, be expanded rather than phased out?

Dr. SULLIVAN. Well, the administration's stance is that the training capacity is basically there. It's now a matter of trying to target and to get the currently established training system to focus more on these priority populations. For example, one of the programs funded through the clinical training authority, the State Human Resources Development Program, is demonstrating that the States are starting to influence the educational system within their own States. We think this is the general direction in which to be going, and we want, in the future, to continue to promote that approach.

Mr. WEISS. But the numbers that you cited for us, the number of people who have been trained, and the number of hours, and months that have been, in fact, contributed to service on the payback basis, have all occurred since the administration began its request to phase out the program, and to eliminate the program.

Dr. SULLIVAN. That's true.

Mr. WEISS. Right. So, you couldn't make, or the administration couldn't make that argument when they first started making requests for phaseout, because at that time you didn't have all these people who have been trained, correct?

Dr. SULLIVAN. When the phaseout request was started, which I believe was actually back in the early 1970's, there were two main sources of concern. One was the appropriateness of a Federal role in providing training support for a segment of health care providers, and the second one was the question of whether or not the national training capacity had been built, and whether or not the level of professionals available in each of the various disciplines related to mental health had grown to a point of being generally sufficient for mental health needs.

What we're seeing now, as you have pointed out, is the need for the Nation to continually target new populations and new needs. And we think that the soundest philosophy is to encourage programs in the States to do that.

Mr. WEISS. The administration's position then is at variance with the opinions expressed by the panelists on the last panel, correct?

Dr. SULLIVAN. Yes.

Mr. WEISS. And again, taking into account the testimony of Dr. Frazier about the problems that ongoing administrators of NIMH, or any other program directors for that matter, have in maintaining loyalty to the team of which they're a part, would it be fair to suggest that you might not give the same individual response, if you were not holding the position that you hold as the administration takes on this issue?

Dr. SULLIVAN. The administration's position is one of encouraging the States to increase their efforts in mental health training and education and to encourage the Institute, through its convening and technical assistance programs, to encourage the States to direct the—

Mr. WEISS. Right, but how about the adequacy? How about the adequacy of personnel?

Dr. SULLIVAN. Pardon me?

Mr. WEISS. How about the adequacy of personnel in the field at this point, and the desirability of having the Federal Government cut back on its commitment to train clinicians in the field?

Dr. SULLIVAN. With regard to the adequacy of personnel, I think the focus ought to be very heavily on the quality and mix of personnel rather than on production of personnel per se.

Mr. WEISS. Well, without pressing you on the issue, it just seems to me that we constantly run into this situation. We have people who, after they've held the office, tell us how they really were not in a position to state their position publicly in opposition to that of the team. But at the same time, it puts not only us, but the people to whom, I assume, your ultimate loyalty really lies, which is the people who require the support, the mentally ill in this instance, in a very, very unfortunate position.

How many mental health professionals have been trained to work with the homeless mentally ill? Do you know?

Dr. SULLIVAN. We have just begun to target some of our educational programs on that, and I am not in a position now to give you a definite number on that.

Mr. WEISS. Do any of your support people know? Mr. Stockdill?

Mr. STOCKDILL. We cannot give you a specific number. The projects under which some professionals are being trained to work with the homeless mentally ill were just initiated in: fiscal year 1986. We could review those projects and try to get a number for you.

Mr. WEISS. I'd appreciate it if you'd submit it for the record.

[The information requested is in app. 1, p. 188.]

Mr. WEISS. Are there many professionals trained to work with the elderly mentally ill through the NIMH clinical training program?

Dr. SULLIVAN. Yes, one of the major focal points of our clinical training activity is the elderly, the aged with mental illness and emotional problems, and Alzheimer's patients. We've been concentrating in two areas in that arena. One has been on faculty development, figuring that it is a good idea to invest resources in train-

ing faculty, which will then have a multiplier effect to increase the overall number of practitioners.

Second, we've been emphasizing postgraduate fellowships in that arena. Again, we could provide some specifics for the record as to how many people have been trained, in which of the categories, and what they're doing now.

Mr. WEISS. You don't have any of those numbers at hand at this point?

Dr. SULLIVAN. Not at hand, no.

[The information requested is in app. 1, p. 188.]

Mr. WEISS. What do you see as the role of the NIMH in helping to assure that there are enough appropriately trained professionals to address America's total need for mental health services?

Dr. SULLIVAN. Our role is one of providing leadership, by which I mean having and developing the capacity and developing needed manpower statistics to have a picture of what is going on nationally. We work cooperatively with States and local providers to determine their perceptions of their needs and how we can help share amongst them effective models in meeting manpower needs at the State and local levels.

Dr. AUTRY. Mr. Chairman, might I add to that?

Mr. WEISS. Please.

Dr. AUTRY. I think, also, as the last panel said, a critical mission is our continuing effort in the area of research to improve diagnosis, to improve treatment approaches to specific disorders, and then to disseminate those best practices into demonstration programs.

Mr. WEISS. Dr. Sullivan, your testimony includes some impressive examples of how NIMH provides a leadership role. What do you see as the role of NIMH in improving mental health services, and service systems, in the next 2 years?

Dr. SULLIVAN. Our role is a very important one, it is one of leadership, of knowledge, of dissemination, of stimulation, of carrying forward important demonstrations to meet emerging national needs.

As an example, the administration has requested in the 1988 budget an increase of \$5 million for the community support program, for demonstrations aimed at improving services, mental health services for the homeless mentally ill.

We feel this is a very important and appropriate Federal role. We're looking forward to expanding the CSP program to consider the special needs of the homeless.

I think the important nature of the Federal role is that we provide an opportunity to test approaches at the cutting edge, to stimulate knowledge and then to pass that information on through conferences, workshops, and meetings—vehicles for exchange among people. I think we have a very important and critical role in this regard.

Mr. WEISS. Are there major trends in services that need to be analyzed, or are you doing that, will you be doing that?

Dr. SULLIVAN. We have a program of data and statistics on the overall service system in the country. It is run via a cooperative mechanism between NIMH and the States. We've found, I might add, that working in this cooperative collaborative relationship has been very effective, and that the overall quality of the data volun-

tarily supplied by the States is better than data that used to be available when reporting was strictly mandatory.

We have a statistics improvement program which serves as a technical assistance vehicle for the Institute in dealing with each of the 50 States, through the State coordinators for data and information.

The trends from these surveys are under analysis, and I might ask Dr. Carl Taube if he would comment on some of the major issues.

Dr. TAUBE. You're familiar, I'm sure, with many of the——

Mr. WEISS. You'll have to bring that microphone very close to you.

Dr. TAUBE. You're familiar, I'm sure, with many of the trends that are occurring in health, and many of these are replicated in mental health. The ones that would come to mind would be the growth of the private sector which several of the witnesses had mentioned, and the increasing management of the public programs by increasingly more trained public sector managers who contract for services delivery or for management of services. There has been varied experience in different States for this; Massachusetts has not had a good experience; California has had a good experience, and it's important to understand why it works in one State and not in another.

There's the growth of capitation programs, the extension via the Federal programs toward capitation from the CHAMPUS program to the Medicare program, Medicaid program, and the implications of this for the mentally ill, particularly the chronic patient, are unknown. This will be a major trend I think in the 1990's that we'll need to pay a lot of attention to.

Mr. WEISS. Dr. Sullivan, what will the needs be in terms of providing grants to States for demonstration projects and evaluation of services, disseminating information, and so on?

Dr. SULLIVAN. I'm not sure I fully understand the question, Mr. Chairman.

Mr. WEISS. What kind of funding, total funding, will you need in terms of providing grants to States? What——

Dr. SULLIVAN. Well, in 1988, as I mentioned, we are going to expand the CSP program by \$5 million up to \$20 million. We're going to be launching this year a \$1.2 million rural demonstration program aimed at trying to demonstrate and evaluate how to put in place a package of mental health services in the rural areas. We will be looking to see how these programs develop, what our experience is with them, before trying to chart future directions.

Mr. WEISS. For that rural demonstration program, for example, how many programs do you expect to be conducted out of that \$1.2 million?

Dr. SULLIVAN. We expect to fund four programs in this current fiscal year.

Mr. WEISS. Currently, the basic community support programs are funded right about \$125,000 each. Is that right?

Dr. SULLIVAN. No, the average size in the community support program, Jim, has gone to?

Mr. STOCKDILL. The average size of the——

Mr. WEISS. Bring the microphone closer to you; otherwise we won't hear you.

Mr. STOCKDILL. The average size of the demonstration grants under the community support program for adults is about \$130,000. For children, about \$150,000.

I believe the rural demonstrations that you were referring to would be much larger.

Mr. WEISS. About \$300,000 for the program, is that right? Because it occurred to me that, in fact, you can get very little, and you are getting very little, for \$125,000, \$130,000 a program, and I just don't think that the money really achieves very much when it's spent in small amounts. And that's why Dr. Frazier was suggesting these larger demonstration grants running \$1 million, \$2 million each, that you could really get a clear demonstration as to what can be done at the outpatient level of mental health support services, rather than hospitalization, because what you get with the small amount of moneys may be an indication the program doesn't work, when, in fact, it can't work because of the amount of resources that are given to it.

Would you agree with that?

Dr. SULLIVAN. The question of the adequacy of funding for the service component in a demonstration is a very important one. It's one with which we grapple all the time—the question of making fewer, large grants, as opposed to making more small grants. We often find that a grant from the Federal Government serves as a stimulus and enables a State to attract within its own system some additional funds, and possibly some funds from outside sources.

Mr. WEISS. Does NIMH provide standards, mandatory or otherwise, for specifying the type or quality of patient care provided by community mental health centers?

Dr. SULLIVAN. When the community mental health centers program was started, there was a requirement that each of the programs provide a number of essential services. We have supported research and provided technical assistance, over the years, to try to operationalize outcome criteria related to each of those services: (a) to see that they're in place and (b) to see what their effect is on patients.

There is no "standard," though, of outcome in place now.

Mr. WEISS. Would you agree that NIMH guidelines or standards would be appropriate since the centers receive Federal funds?

Dr. SULLIVAN. The entire question of standards is important, and one that would be worth working on in a collaborative way with State and local governments, so that whatever one would develop would make sense, both nationally and locally.

Mr. WEISS. Right. Is that in process? Do you have such a guideline or a standards proposal underway?

Dr. SULLIVAN. Not in a formal sense. We have a number of activities aimed at: (a) doing research and (b) doing analysis to further specify some of the components of effective programs.

Dr. AUTRY. Mr. Chairman, may I add to that?

Mr. WEISS. Yes, Dr. Autry.

Dr. AUTRY. It should also be noted that most of the standards setting in terms of medical care is, in point of fact, a prerogative of the State and is handled through professional associations.

Mr. WEISS. Would you pull the microphone just a little closer to you.

Dr. AUTRY. Most of the standard setting in terms of clinical care is the prerogative of the State and is handled either by the States or through such organizations as the JCAH (the Joint Commission for Accreditation of Hospitals). And the Federal Government, by and large, does not set those sorts of standards.

We do, as Dr. Sullivan said, work with the States to try and help them develop effective standards. We conduct research on civil commitment. We make recommendations for States to consider. But that's a joint collaborative venture.

Mr. WEISS. But Dr. Sullivan suggested that you don't really have that program underway at this point. The question is when do you think that you will have it sufficiently underway so you can say when to expect results?

Dr. AUTRY. There's not underway a formal program, per se. It's an ongoing dialog between us and the research community and between us and the States.

Mr. WEISS. Can you tell me something about the staffing at NIMH for programs related to services for the mentally ill? Earlier this morning we heard that there were approximately 290 staff people between the regions and the central staff in 1980, compared to 35 today. Does that sound correct?

Dr. SULLIVAN. There has been a reduction in the number of staff within the Department, both within NIMH and in the regional offices concerned.

Mr. WEISS. Are the numbers accurate?

Dr. SULLIVAN. In our 1985 reorganization our Division of Education and Service Systems Liaison was staffed out at about 55 people, so that level of staffing is what we currently have on board for that program.

In addition, we have 54 people assigned to the Division of Biometry and Applied Sciences, which is concerned with statistics and health services research.

Mr. WEISS. No, we're talking about services, and the numbers that we have.

Dr. SULLIVAN. The 35 figure, I would say, is a bit low, but in the ballpark.

Mr. WEISS. Right. And the 290 figure was accurate?

Dr. SULLIVAN. To the best of my knowledge, yes.

Mr. WEISS. Now, what efforts has NIMH made since 1980 to hire new staff with expertise to meet the changing demands of mental health services? For example, have you hired experts on the homeless mentally ill or community support systems?

Dr. SULLIVAN. Since the initiation of the block grant in 1981, the composition of our staff has changed considerably. The bulk of our staff is concerned with research programs, either the direct conduct of research, or with program development.

Mr. WEISS. No, no, I'm talking about services again, service programs.

Dr. SULLIVAN. In the services area we've added some additional staff—two in the homeless area. We have also been diverting staff from other areas to cover programs such as the protection and advocacy program.

Mr. WEISS. But your answer is that you have hired two people to deal with the problem of the homeless, is that correct?

Dr. SULLIVAN. Specifically, and in addition to some internal staff realignments.

Dr. AUTRY. Mr. Chairman, I might make a clarification here, and that is the block grant is administered out of the Office of the Administrator, and has some 30 people who handle the administrative end of the services component. That number is down due to the decreased requirements in administering that program with a shift of the—

Mr. WEISS. Pull the microphone closer or speak up louder because we can't hear you.

Dr. AUTRY. I might add that the block grant is administered in the Office of the Administrator of ADAMHA, out of the Office of Financing and Coverage Policy. That office has approximately 30 people who administer the block grant. That number is down from the number of people who administered the community mental health centers due to the decrease of the administrative burden on the Federal Government, and a transfer of that to the States.

Mr. WEISS. What do those 30 people do?

Dr. AUTRY. They administer the block grant, and they conduct in-house research on finance and coverage.

Mr. WEISS. By administering the block grant, what do you mean?

Dr. AUTRY. They review applications from the States to assure that the applications are complete; send the money to the States; and receive annual reports from the States, synthesize those reports, and send them in.

Mr. WEISS. That has nothing to do with services to people directly?

Dr. AUTRY. Not to people directly, but that is in point of fact where most of the services money is administered. Most of what Dr. Sullivan is talking about is services research and demonstrations. That is direct people to people, but it's not the old CMHC program.

Mr. WEISS. Well, I know that money ultimately means services, but the services that we had spoken about before were direct services which now for the most part are not being provided at all? Is that right?

Dr. SULLIVAN. That's right.

Mr. WEISS. What kinds of expertise in the field do the community support program staff have?

Dr. SULLIVAN. I'd like to ask Mr. Stockdill to answer that.

Mr. STOCKDILL. Mr. Chairman, was the question about the expertise in NIMH or in the States?

Mr. WEISS. The kind of expertise of the community support program staff people, your people, NIMH people.

Mr. STOCKDILL. We no longer have any regional office staff. In our central office staff we have expertise in community systems development. We have professional staff in social work, nursing, and generalists who work on community systems development. We have about eight staff total who work on the adult community support program, and six for the child and adolescent service systems program, and then other managerial support such as myself.

Mr. WEISS. Let me rephrase the question. In your central office, how many of the people in the community support program have field expertise?

Mr. STOCKDILL. For the adult program I would say three of the five professionals and for the children's program, all three of the professionals have field experience.

Mr. WEISS. My information is that there are five to six, that they include two social workers and a nurse, but no psychologist, no psychiatrist, and no one with expertise in psychopharmacology. Is that correct?

Mr. STOCKDILL. The child and adolescent service systems program is headed by a child psychiatrist who has a national reputation, has worked in the field, does consultation across the country, and he is supported by a person with a doctorate in public health and a master's level psychologist.

Mr. WEISS. How about the adult program?

Mr. STOCKDILL. The adult program is headed by a generalist.

Mr. WEISS. A generalist?

Mr. STOCKDILL. Yes. It is headed by a generalist who is supported by two social workers, a nurse, and another person with a generalist background.

Mr. WEISS. Right. Would you think that the quality of work that the NIMH does, is able to do, is affected by the lack of professionals with field experience?

Mr. STOCKDILL. Somewhat, I suppose. In the adult program we could use the services of a psychiatrist. We've now hired a psychiatrist as a consultant who spends some 30 days a year working on the community support programs.

But in direct answer to your question, I think having a psychiatrist would help the community support program.

Mr. WEISS. Right. Would you pull the microphone just a little bit closer to you as you respond to questions.

Dr. Sullivan, in the late 1970's, NIMH brought in professionals for 1 to 2 years under the Intergovernmental Personnel Act. These professionals, called IPA's, had expertise that enriched the NIMH.

In the last few years, have any IPA's or visiting scientists been brought in to NIMH to work on the programs that deal with services for the mentally ill?

Dr. SULLIVAN. We have several IPAs on board. I'm not sure if any are in the service program.

Carl.

Mr. STOCKDILL. We currently do not have any in the services program. We're proposing one right now.

Dr. SULLIVAN. Dr. Taube.

Dr. TAUBE. We have had Dr. Schulberg from Pittsburgh on an IPA appointment, working on primary care and mental health services.

A biostatistician from the School of Public Health in Texas will be coming on board hopefully this fall to help in the statistical programs.

Mr. WEISS. Right. But how about for services for the mentally ill?

Dr. TAUBE. No, this will be the research side.

Mr. WEISS. Mr. Stockdill's statement was accurate then, that there have been none, there are none, for the services for the mentally ill?

Mr. STOCKDILL. Just one being proposed right now.

Mr. WEISS. Right. Pull the microphone closer.

Mr. STOCKDILL. One is being proposed at the present time for the children's program.

Mr. WEISS. Right. When was the last time that you had an IPA?

Mr. STOCKDILL. 1982.

Mr. WEISS. Why would you not have reached out for others?

Mr. STOCKDILL. Why would we not have?

Mr. WEISS. Why haven't you reached out for any others since then?

Mr. STOCKDILL. In the past, having people under the Intergovernmental Personnel Act has taken FTE full-time equivalent slots; we have not had those positions.

In the last year or so I believe the policy has changed, and it does not require a full-time slot to bring someone in under an IPA.

Dr. SULLIVAN. We expect the situation to be more flexible in the future than it has been in the last couple of years because of—

Mr. WEISS. That FTE requirement, where does that emanate from?

Dr. SULLIVAN. The agency operates with a ceiling on full-time equivalent positions, and the NIMH ceiling is determined within the agency. We have been over ceiling for some time. We have recently turned the corner with respect to personnel, and have started to be able to bring some new people into the Institute in a number of program areas.

In addition, there has been a change in policy with respect to whether people brought on board under the Intergovernmental Personnel Act do or don't count as an FTE. Now the interpretation is that they don't, so we'll have more flexibility in bringing them on in the future.

Mr. WEISS. In the last few years Congress has enacted new legislation for mental health services, such as the Protection and Advocacy Act and the State Mental Health Planning Act of 1986. What additional staff or new operating funds were made available at NIMH to support these programs?

Dr. SULLIVAN. To administer the Protection and Advocacy Program, which is run basically on a formula grant basis, we assigned a program specialist. With regard to the State Mental Health Planning Act, we have done some initial planning and preparation for the legislation, but have not done anything specific about staffing it yet, waiting to see what the level approved by the Congress is going to be.

Mr. WEISS. So, in essence, very little has been done so far?

Dr. SULLIVAN. True.

Mr. WEISS. How is it possible for the Protection and Advocacy Program to be effectively implemented with only one staff person and such limited funds?

Dr. SULLIVAN. The main thrust of the program is to dispense money to the existing protection and advocacy agencies within each of the States. The application process, the review, and the management of the awards, really has gone very, very smoothly. It

has not been a staff intensive program; that was the intent of the Congress.

The staff person has been working mostly on the technical assistance activities, bringing the Protection and Advocacy Programs in the States together to meet to talk about how they're going to set it up, how they're going to set up community boards, et cetera.

Would you like to expand on that, Jim?

Mr. STOCKDILL. Yes. The one staff person is supported by myself and others, with some background help, but she has done a heroic job over the last year in getting the P&A Program implemented.

Mr. WEISS. Is it your impression that, in fact, you are fulfilling the mandate of Congress with regard to these two areas?

Dr. SULLIVAN. I would say yes.

Mr. WEISS. You don't think that you need additional people?

Dr. SULLIVAN. I think we're able to fulfill the mandate of the program with what we're doing now. Certainly additional resources might enrich what we're doing, but we are certainly fulfilling the intent of the Congress.

Mr. WEISS. Most experts believe that at least one-third of the homeless are mentally ill. What does NIMH see as its role in relation to this national problem?

Dr. SULLIVAN. Our role is a very critical one. It includes mounting in the coming year expanded demonstrations in the CSP Program, to demonstrate how programs for the homeless can be put into place.

Our role involves conduct of research in gathering information, to get a better handle on the nature of the homeless problem. In addition to the estimated one-third of the homeless who have a mental illness, there's another third who are estimated to have a serious alcohol problem. There is some overlap between those two populations, and so the overall estimate is that about a half of the homeless population has either a mental illness, or a serious substance abuse problem.

Our role is to find out this kind of information, see that States, localities, policymakers, are aware of it, so that their planning, their tailoring of programs, their funding of programs, that these services will be targeted to help the homeless mentally ill, and the homeless who have an alcohol problem.

We need to share information. We need to make sure that the best information is available.

Mr. WEISS. You're saying, in essence, that as far as you're concerned, as far as the Federal Government is concerned, the problem is that of the States and the localities. It's not a Federal problem.

Dr. SULLIVAN. Most programs for the homeless are being run at the State, local, and city levels. Our role is one of doing demonstrations, helping to show what can work, how it can work, and then getting that information out to the States and communities who have the ultimate responsibility.

Mr. WEISS. What staff and other resources will HHS make available to NIMH to support the mental health provisions of the Urgent Relief for the Homeless Act?

Dr. SULLIVAN. That is not clear at this moment. As you know, there are a number of bills relating to the homeless pending in

both Houses of the Congress. We have done some initial planning, but would need to see the actual outcome of those bills before we see how we're going to carry out the legislation.

Mr. WEISS. We have a letter dated April 9 from Secretary Bowen to Senator Byrd, opposing the Urgent Relief for the Homeless Act. In it, Secretary Bowen states that new Federal programs for the homeless are not necessary, and that existing block grants are sufficient.

[The letter referred to is in subcommittee files.]

Mr. WEISS. In two previous hearings, and in two reports that our subcommittee has issued on the topic of the homeless, we have found homelessness to be a national problem. The numbers of homeless have increased by one-third to one-half in New York City, and some other areas, during the past year.

The National Conference of Mayors has issued reports indicating the increase in homelessness of something like 28 percent a year across the country.

Does NIMH believe that no new programs are needed?

Dr. SULLIVAN. We feel that the proposed demonstration programs that we're going to mount in 1988 are certainly needed. We feel that the issue of homelessness in the country involves a range of concerns extending beyond the mentally ill. This is not to say that the mentally ill are probably not among the most vulnerable of the homeless population, but to deal effectively with the problem, one must consider housing, social supports, and the availability of health care, to the full range of the homeless population.

Mr. WEISS. Right. But you're not involved in those other aspects of it. You have enough responsibility dealing with your portion of it, and what we're trying to find out is what do you think is needed, from your perspective, to deal with this broad national problem?

Dr. SULLIVAN. I think what is needed are the demonstration programs that we're going to mount in 1988, the continued provision of technical assistance, of convening, of dialoging, of promoting "best practices," of identifying the elements of a good program of mental health services for the homeless mentally ill including outreach, residential support, alternative services, rehabilitation, insuring access to the already available supports through SSI.

Mr. WEISS. You don't think that the Federal Government has a responsibility to provide some of those services?

Dr. SULLIVAN. I think we have a responsibility to demonstrate and promote—to demonstrate effective services and to promote best practice models.

Mr. WEISS. By all the people?

Dr. AUTRY. May I add to that, please?

Mr. WEISS. Yes, of course.

Dr. AUTRY. I think the other element that is important is cooperation across all agencies of the Federal Government in trying to synthesize their efforts in dealing with what is not only a State and local problem, but a national problem. It's the fostering of that cooperation, collaboration, to get all of the agencies to work together, that you may be looking for.

Mr. WEISS. Well, the President at one point created a task force, and did NIMH participate in that joint agencies' task force?

Dr. SULLIVAN. NIMH has the lead for our agency within the departmental task force, and Mr. Stockdill has been one of our representatives.

Mr. STOCKDILL. Yes, we have directly participated in the work of the task force.

Mr. WEISS. And when was the last time that the task force met, with your participation?

Mr. STOCKDILL. Near as I can recall, probably a couple of months ago.

Mr. WEISS. How many times in the last year?

Mr. STOCKDILL. I'm not sure—I do not have that information.

However, there has been a permanent task force staff with which we have had ongoing interaction.

Mr. WEISS. Secretary Bowen also wrote that block grants are necessary to enable States to have maximum latitude to deal with the homeless "because the problems of the homeless are both complex and not well understood."

Perhaps you can help me understand that approach. If the problems of the homeless mentally ill are complex, and are not well understood, does that justify the Federal Government itself doing nothing? Why can't the Federal Government provide leadership in finding out what kinds of services are most cost-effective?

If each State develops independent programs there could be a lot of duplication of that effort. What kinds of effort has NIMH made to understand the need for the homeless mentally ill?

Mr. STOCKDILL. Mr. Chairman, in 1983 we funded six studies that were directed at needs assessments in six different communities. These were supported with service demonstration funds. We also have supported four research projects, partly funded by research funds, partly by service demonstration funds.

Since the original 10 projects, we have funded 14 additional communities that are currently active. We funded 14 community demonstrations in 14 different States and communities. And as Dr. Sullivan mentioned, we plan to expand that in fiscal year 1988.

So we currently have 14 projects that are active. We feel that we have demonstrated the kinds of case management services that are needed, and in some cases creative outreach approaches; and in other cases transitional housing. What hasn't been demonstrated is putting all that together into a comprehensive care system.

Mr. WEISS. Have you disseminated that information to the States and the localities?

Mr. STOCKDILL. Yes, I think the area in which we've done probably done our best dissemination job has to do with the homeless mentally ill. We've conducted national meetings and workshops. We fund a clearinghouse on the homeless mentally ill that any State or community person can come to for information, and I think we've done a very good job in that area.

Mr. WEISS. I have some questions about mental health care provided by Medicare and Medicaid. Although this hearing does not focus on those two programs, I'm interested in how NIMH provides input regarding mental health services provided through them. I'm also interested in your professional views of what needs to be done to improve those services.

Dr. SULLIVAN. We have several people on our staff who consult regularly with HCFA on Medicare and Medicaid, trying to bring to their attention issues related to the adequate coverage of care for the mentally ill.

In addition, as I've mentioned, the Office of the Administrator has established a group concerned with overall financing and coverage policy for mental health, alcoholism, and drug abuse.

Mr. WEISS. Dr. Autry, do you have anything to add?

Dr. AUTRY. No, just to say that we do, in fact, have a group which has been very active in working with HCFA. The head of the Office for Finance and Coverage Policy was recruited from HCFA, so we have very close working ties with them.

Mr. WEISS. I understand that Medicaid funds are available for mental health services under very limited circumstances. For example, nursing home care is reimbursed in nursing homes and intermediate care facilities that do not specialize in serving the mentally ill, but are not reimbursed in facilities that specialize in caring for the mentally ill. That means that the approximately 750,000 psychiatric patients who are in nursing homes are in facilities that are not designed to care for them.

I realize that NIMH does not control this situation, but I wonder from a treatment point of view does that policy make any sense to you?

Dr. SULLIVAN. A staff member of ours is working in a very intensive way on issues related to coverage and care for the elderly and for Alzheimer's patients.

We are in the process of working with HCFA, which is planning to mount a large 5 to 10 site demonstration of improved care in nursing homes for those patients, and we are working to see that there is a significant mental health component as part of that.

Dr. Taube might want to expand on some of the activities that his group has been engaged in with regard to research on services for the elderly mentally ill.

Dr. TAUBE. We have also worked very closely with the National Center for Health Statistics on their surveys for nursing homes to look at the issue you raised of the quality of care being provided, and I think the current survey that we're in the middle of analyzing with them will provide some very useful data, to provide some program directions for different levels of government.

We have worked also very closely, as was mentioned by some of the earlier witnesses, with the Health Care Financing Administration on this whole range of issues in terms of the switch to the prospective payment system, and how that might impact on psychiatry. We took the lead with HCFA to prepare the report to Congress on this issue, and have been working very closely with the State Medicaid agencies, and with the Medicaid program in HCFA. The Robert Wood Johnson nine city program for the chronically mentally ill will be able to provide some very important information on the nine cities, and can look at ways of improving the way Medicaid benefits are dispersed, and what kinds of services are paid for under Medicaid. I think that will be the major mechanism by which we can really see what kinds of changes are both effective and economical to be able to implement.

Mr. WEISS. I have some other questions, but let me at this point yield to Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman. You have pretty well covered the gamut. A couple things though that I would like to ask.

We were talking a moment ago about cooperating with the States. I don't expect you to go through all 50 States but how would you rate them as far as their ability to provide community-based mental health care services? Are they doing a decent job, poor job? Maybe you could cite an example of both positive and negative attributes.

Dr. SULLIVAN. There's a great deal of variation. As some of the previous witnesses indicated, even some of the strongest States do not have perfect programs. Certainly coming to mind always are Wisconsin, and Ohio, as areas where effective programs are being put in place, and where there is a general building of support and recognition for the needs of the mentally ill.

I would hark in back to the earlier testimony by Dr. Davis relating to the area of stigma, the awareness of the problem of mental illness, and the issues related to mental health in this country. I think that public awareness and sustained public support is what you will find as a key ingredient in any of the effective programs.

I would ask if Mr. Stockdill or Dr. Taube would want to highlight one or two programs.

Mr. STOCKDILL. I think we can cite several States that have made tremendous progress in the last few years. I would put the State of Oregon in that category. They have as their central system a community support system. They have financial incentives to reallocate funds from institutions to community programs, and they have county control of their system.

I would also say that New Hampshire, Vermont, and Rhode Island have made tremendous strides, and have excellent plans for redoing their total systems. And Colorado is also, I would say, near the top.

If I had to comment about Iowa, I would say they've had an excellent system. It's almost unique in the sense that it's mainly county funded up until now, and now those counties have very serious financial problems. And I'm not sure which way they're going in terms of quality of the future system.

Mr. LIGHTFOOT. Would it be a fair statement then that those States that have tight local control, at least at the county level, tend to be more successful than others?

Mr. STOCKDILL. If they also have a State financing system that provides incentives for them to reallocate resources, such as Ohio is planning and is the heart of Wisconsin's system, and Oregon's, yes.

Mr. LIGHTFOOT. You mentioned earlier that the States have gradually worked into community-based programs, particularly in Wisconsin and Ohio. The analogy we might make to human beings could apply to States as well, that they earn the respect, they don't go out and buy it. They have developed programs that people have responded to in a positive sort of way.

If you see a State that's maybe having a very difficult time in developing some of their community-based mental health services, are you in a position to assist them in any way, and if so, how?

Mr. STOCKDILL. Yes, we are. For example, we frequently hold single State workshops. We bring in a group of national consultants and we bring them together with a group from across the State. We usually try to bring together researchers, mental health providers, family members, and consumers and try to help them both with the substance of their problems, and also with strategic planning.

We'll be doing that in West Virginia next week, for example.

Mr. LIGHTFOOT. I basically asked this same question of an earlier panel. I don't know if you were in the room; but I'd like to give you an opportunity to respond as well.

There's a University of California study evaluating the alcohol, drug abuse, and mental health block grant funding formula. The study recommended that the allocation formula might need to be changed to provide for a more equitable distribution of Federal block grant funds.

Again, do you perceive that we have a problem with the funding formula and that we're basically identifying large groups of populations and not necessarily where the problems lie?

Dr. SULLIVAN. There has been a lot of attention paid to the block grant formula. The Department wishes to exchange in a dialog with the field, and with the Congress, as to what changes need to be made. The subject came up in our hearings before Mr. Waxman, and we would support a careful look at the current formula, and what changes the mental health field and the Congress think would make some sense.

There have been changes in the system since the original formula was put in place, and most people seem to think that a reassessment is in order. We have not formulated a position on exactly how it should come out.

Mr. LIGHTFOOT. Is the block grant approach the best direction to go?

Dr. SULLIVAN. It certainly is an efficient way to get resources into the hands of the people who have the primary responsibility. As we have stressed, it's probably not the only way. There is a definite role for limited Federal demonstrations. But in terms of promoting services and systems that are workable, that are tailored to local needs, it has many, many, many strong advantages.

Mr. LIGHTFOOT. Ms. Baxter from Calvary Shelter made a comment earlier today about one of the people who stayed at the shelter had had trouble qualifying for SSI. We find in operating a congressional office that it is not limited strictly to people who are afflicted with mental illness. It affects a lot of people who are trying to deal with SSI and other Federal programs.

We find, too, that women who were reared in the period of time when the wife basically stayed home and took care of the kids, and who have been widowed, all of a sudden find Social Security and other decisions forced upon them. It becomes a very frightening and bewildering situation for many of them, and sometimes they turn to us for assistance. I view that as one of the roles of our office, which is to try to help people work through problems with Federal and State agencies.

The basic point I'm trying to make is that going the block grant route, which I happen to favor because I think that the people ac

the local level can make better decisions than we can here, eliminates much of the trauma of going through the paperwork.

In your opinion, are we improving on the amount of paperwork required? Are we making it a little bit easier for those community-oriented groups to perform the things that we think they should, or would like to have them do?

Dr. SULLIVAN. As more good ways of doing it are found and promulgated, we are going to make it a little easier. Certainly in the Robert Wood Johnson Foundation demonstration program they will be looking at some of these very issues: how to make it easier, how to coordinate SSDI and Medicare payments, and make it easier for the patients and the providers to do that.

Dr. Sharfstein mentioned earlier a notion about the size of the overall Federal stream of funding in proportion to the mentally ill—that needs attention. Some solutions that will come out of the innovations that are going on can only help, but I think it will be a process of needing to recognize the problem, and getting people to work on it in a way that makes sense at their level. We can do a lot though to show how it can be done.

Mr. LIGHTFOOT. It might be due to good coverage, but the awareness of mental illness problems in rural areas has been brought more to the forefront than in the past.

Are you targeting resources to inform people of mental illness?

Dr. SULLIVAN. We have a major effort that we are mounting that we see as being probably a 5- to 7-year effort in our D/ART program, which refers to depression, awareness, recognition, and treatment. This is a public education and practitioner education program that's being funded by direct operations and through our clinical training authority.

The aim of this is to get out the word that depression can be treated. The estimates are that some 80 to 90 percent of people with serious depression can receive effective treatment, but only about a third of them go for treatment.

So the idea is to make people aware that treatment is available. In order to do that, we need to have practitioners more up to speed with the fact that over the last 10 years considerable knowledge has been generated with respect to the characterization of depression, and the most appropriate treatments.

So we have a job on our hands of educating not only the public that they should seek services, but also practitioners as to the knowledge base on service efficacy.

We're trying to get out the message that depression can be treated. Needless suffering can be prevented.

We're implementing this program not only through some training of practitioners, but also through State and community partnerships where we're working with local mental health associations, local chapters of the National Alliance for the Mentally Ill. We're enlisting their members to help get the message out on depression.

As I mentioned, we see this as a long-term—5- to 7-year—project. The day is over, if there ever was a day, when somebody could say there is an answer to a serious mental disorder. We need to raise public awareness. We need to raise practitioner awareness. We're in the process of building from the research base a level of aware-

ness and support for mental health and mental illness that is somewhat unprecedented.

The extent to which research is verifying a biological, biochemical basis, although perhaps not solely, of mental illness demonstrates these are real illnesses, real disorders, real problems. That can only help to raise public awareness, and hopefully public and community support.

Mr. LIGHTFOOT. Do I understand that you're looking more at preventative medicine to some degree by making physicians more responsive to that phase of human behavior in which problems occur and maybe head off something a lot more serious by detecting it early?

Dr. SULLIVAN. Yes, in the framework of early detection and early treatment as a rubric for prevention, yes. Certainly in the depression area.

Mr. LIGHTFOOT. Better to prevent it than to try and cure it.

Dr. SULLIVAN. We don't have a cure. In fact, one of the unfortunate spinoffs, related to the depression program, is the notion that there's a cure. There is a treatment, but it's not a cure. The people need continuous treatment.

You might find it interesting that while it's estimated that perhaps 15 percent of the population has a mental disorder of some form at some time in the course of a year, corresponding figures for recurring cardiovascular and respiratory illnesses are in the 20 to 25 percent range.

Mr. LIGHTFOOT. Thank you very much. Speaking of being depressive, I think we're supposed to go vote on nerve gas, aren't we?

Thank you, gentlemen.

Mr. WEISS. Right. We'll recess for about 10 minutes. Again we'll resume after that time. Thank you.

[Recess taken.]

Mr. WEISS. The subcommittee is now back in session.

Dr. Sullivan, I understand that Medicare coverage of mental illness is limited to 190 days of inpatient care in a psychiatric hospital during the patient's lifetime, although inpatient care on psychiatric wards at general hospitals is not limited at all.

Does this make sense from the point of view of providing the most cost-effective services?

Dr. SULLIVAN. This certainly seems to be a direction in the current Medicare policies that would promote inpatient treatment in general for the mentally ill. We would hope to talk with HCFA and others concerned with reimbursement policies and related issues about programs, steps, and activities that might help to rectify that situation, to get some of the coverage directed more towards outpatient care.

Mr. WEISS. I understand that NIMH is responsible for research on the violently mentally ill, including commitment laws and the use of the insanity defense. The Antisocial and Violent Behavior Branch Office has funded a study involving the State of Washington, which changed their commitment law to allow the involuntary commitment of patients who are not necessarily dangerous.

Researchers found that this caused the mental hospitals to become terribly overcrowded, so that services deteriorated.

I have a letter from the author of that study, which we'll enter into the record, without objection.

[The letter referred to follows:]



University of Washington
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School of Public Health and Community Medicine

Department of Health Services, SC-37
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May 7, 1987

Honorable Ted Weiss
Chair, Subcommittee on Human
Resources and Intergovernmental Relations
B372 Rayburn Bldg.
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Weiss:

I am writing to share information about my ongoing research on involuntary civil commitment with the subcommittee. I am an associate professor at the University of Washington, School of Public Health and Community Medicine in Seattle. I am also the Associate Director of the Center for Health Studies, the research component of Group Health Cooperative of Puget Sound, the largest consumer-owned health maintenance organization in the United States. My colleague, John Q. LaFond and I co-authored an article entitled "The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Involuntary Civil Commitment" which was recently published in 3 Yale Law and Policy Review 395 (1985). We have provided your staff with a copy of the article. That article reports the major findings of a five year study, funded by the National Institute of Mental Health, of the effects of 1979 amendments to Washington's Involuntary Treatment Act (ITA).

Washington's Involuntary Treatment Act was revised in 1979 to make it easier to commit persons considered by mental health professionals to be mentally ill and in need of treatment. This was accomplished primarily by expanding the definition of "gravely disabled" to permit commitment of any person considered mentally ill and who "manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety". With minor exceptions, the 1979 ITA did not make significant changes in commitment procedures. Our research showed what effects the change in the law had on actual commitments for 72 hours or longer and on requests for detentions which came from the community (e.g., police, treatment personnel, families, etc.).

Our work showed that broadening involuntary commitment laws did not protect the community from dangerous people and it did not solve problems of homelessness. Instead, it wasted precious resources and it created a dependency on the involuntary commitment system that brought people back to it again and again.

Emblem "Soul Catcher" - a Northwest Coast Indian implement used by shamans or spiritual healers to ward off spirits that brought physical or mental illness. These instruments were usually carved from the long bones of large animals and handed down from generation to generation.

Expansion of the commitment law brought a very large number of new people into the involuntary commitment system. Washington experienced a 91% increase in state hospital admissions during the first year following the 1979 expansion of commitment authority. This rapid expansion of the commitment system resulted in several significant changes.

- **VOLUNTARY PATIENTS DISAPPEARED.** Voluntary patients, the patients for whom the most good can be done because of their willingness to be treated, virtually disappeared from the treatment system.
- **RESOURCE DEMANDS EXPLODED.** System costs surpassed even the most generous predictions. Washington State saw a 62% increase in the administrative costs alone (e.g., investigation time, court time, transportation, etc.) and enormous increases in hospital (clinical) costs associated with commitment. That expansion of the commitment system will be permanent, overwhelming the budget and treatment capacities.

The Washington State hospital system now represents the worst of both worlds: it excludes from inpatient treatment patients who voluntarily seek treatment and provides inadequate treatment for those patients who are committed for treatment against their will because funding and therapeutic resources are spread too thin.

- **LEGAL PROBLEMS DEVELOPED.** The increased involuntary commitment caseload required increased public attorney staffing, more petitions, more informal and formal hearings, and more judges. Legal problems began to surface as a result of **OVERCROWDING**. Washington state's largest hospital became so crowded that people were (and still are) being housed in crowded rooms and in hallways. These conditions are ripe for patient lawsuits demanding treatment for which people have been involuntarily detained.
- **LAWSUITS WERE FILED.** More legal problems developed when overcrowding at the major Washington state hospital became so severe that the hospital established a "cap" on admissions at 90% of their bed capacity. The cap frustrated Washington's county-based mental health officials who could no longer send committed patients to the state hospital; they sued and won an injunction that forced the state hospital to take all involuntary patients sent by the counties, regardless of the available bed space.
- **THE STATE ASSUMED LIABILITY FOR RELEASE.** Expanded commitment authority means increased exposure to civil liability for clinicians, hospitals and the state which will likely result in higher insurance premiums and additional lawsuits and judgements. The Washington Supreme Court held (in Peterson v. State, 100 Wn.2d. 421, 671 P.2d 230), that the state and its mental health professionals can be held financially responsible if they are grossly negligent in releasing or failing to commit someone who is mentally ill and dangerous and then harms anybody. [The award for Peterson was \$250,000 for injuries received by the plaintiff in an automobile accident.] This important case emphasizes the **RISK OF LIABILITY** that may be imposed on public institutions when they release a person from state authority who goes on to

commit a crime, or otherwise causes harm. Expanded commitment laws make commitment easier, while cases such as Peterson make release risky, thus ballooning hospital caseloads. All systems make mistakes; a more inclusive system doesn't insure against mistakes. It only creates a larger population of mentally ill patients.

- **PEOPLE BECAME MORE DEPENDENT ON HOSPITALIZATION.** In Washington, expanded commitment authority made people dependent on hospitalization who had never been hospitalized before, creating a new population of "chronically mentally ill" people.

Beyond the empirical findings in Washington, psychiatrists and other mental health professionals **CANNOT RELIABLY PREDICT DANGEROUSNESS**. Expanding civil commitment laws increases costs without assuring prevention of tragedies like the widely publicized Sylvia Seegrist incident in Pennsylvania or the Staten Island Ferry murders. **TOUGH CASES MAKE BAD LAW.** The best system in the world won't reach everyone. The question is "How do we make a law that helps as many people as possible within the budget constraints that will remain with us into the future?"

When working with states around the U.S. which are considering expansion of their civil commitment laws, we recommend the following:

- States should not expand involuntary commitment. They should work within the involuntary commitment law that they have to provide community-based services that have been shown to be as effective and less costly than hospital-based care.
- State and local authorities need to provide better training for mental health professionals (including the police) on commitment laws, when and how to use them, and when and where to locate resources other than hospitals.
- States need to consider the possibility that they do not need new laws but that they need to improve the implementation of their current laws.

If I can answer questions regarding our research, please do not hesitate to contact me.

Sincerely,

Mary L. Durham

Mary L. Durham, Ph.D.
Associate Professor
(206) 326-4437

Mr. WEISS. How does NIMH make that kind of information available to other States that may be considering similar changes in their legislation?

Dr. SULLIVAN. We discuss, have a dialog and interact with the field in a number of ways. One is through conferences and workshops to promote the results of research, including natural experiments, such as this one.

In addition, we support research directly on this problem. We're now supporting a project looking at the Oregon system, which has set up an independent five-person State-level board, composed of a psychiatrist, psychologist, lawyer, citizen advocate, and someone with a parole background.

So we're supporting research on how the different States are handling this. In addition to having meetings, conferences, and workshops on these topics, we are seeking to continue publishing manuscripts, documents, and other materials, as resources for those involved in all of these very complicated forensic issues.

As you know, each of the States has their own civil commitment law as relates to the mentally ill, and there has been a great deal of interest and variation in this area in the last couple of years.

Mr. WEISS. I understand that the professional staff in the Antisocial and Violent Behavior Branch has been cut almost 50 percent since 1980. There are only four professional staff people working in that branch now. Is that correct?

Dr. SULLIVAN. That sounds correct to me.

Dr. Taube, is that correct?

Dr. TAUBE. That's correct. There are four professionals and two secretaries at the moment.

Mr. WEISS. All right. Thank you.

NIMH used to have a National Center for the Prevention and Control of Rape. I understand that the responsibilities of that center are now also included in the Antisocial and Violent Behavior Branch.

Did the Antisocial and Violent Behavior Branch get the staff from the National Center for the Prevention and Control of Rape?

Dr. TAUBE. In the reorganization there were one or two of those positions that were supposed to move as part of the organization. The individuals involved opted to choose other positions.

Mr. WEISS. The answer is no, right?

Dr. TAUBE. That's correct. But—

Mr. WEISS. OK. Did they get any additional staff or funds to deal with the problem? The answer to that is no also, isn't that correct?

Dr. SULLIVAN. With respect to staff, it's no. With respect to funding for research in that area, the budget for that branch increased from \$7.4 million in 1986 to \$9.4 million in 1987.

As a matter of fact, the overall budget increase for research in the Institute was 17.5 percent. We increased the budget for the Antisocial and Violent Behavior Program by 26 percent. So we have expanded our support for research on this range of concerns.

Mr. WEISS. I understand that a few years ago evaluations of the community support program indicated that it had helped to cut down the number of psychiatric hospitalizations of program participants, and that for every Federal dollar spent, \$18 was spent by

State, local, and private sources to assist in providing these services. That sounds like an excellent record.

What kind of evaluations have been done in the last 2 years?

Mr. STOCKDILL. In the last 3 years an evaluation has been going on in selected sites regarding the impact of the community support systems. They're finding that a greatly expanded number of people are being reached. There's continuing to be a reduction in hospitalization in those sites that do have community support systems, and generally a higher quality of life.

This evaluation has been directed at developing methodology that each State can use to evaluate their own efforts, and that methodology is being disseminated to all the States.

Mr. WEISS. Do the community support program grants usually include funds for evaluation?

Mr. STOCKDILL. No, the evaluation funds are provided separately out of direct operations funds.

Mr. WEISS. But you just said that that's only being done in selective sites, right?

Mr. STOCKDILL. That's right.

Mr. WEISS. For the past few years there has been a 1-percent set-aside for the NIMH evaluation of services, including but not limited to the community support grants. That doesn't seem like much money, but what has happened to that set-aside?

Mr. STOCKDILL. Are you talking about the total set-aside for—

Mr. WEISS. For NIMH evaluations of services, including but not limited to community support grants.

Mr. STOCKDILL. There's a variety of projects going on. I can only speak to those that relate to the community support systems.

We are using some parts of that money to evaluate our homeless demonstrations. Another study will be directed at evaluation of our demonstrations of improved services to the elderly.

We have three new projects this year that will look at those specific demonstrations.

Dr. AUTRY. May I speak to that also, Mr. Chairman?

Mr. WEISS. Please.

Dr. AUTRY. The 1 percent evaluation tap is not all maintained by the Institute. Part of that money is taken back by the Department and by PHS, the Public Health Service, to fund a variety of evaluation activities having to do with the Department's programs also.

The money that is maintained at the agency level, or the Institute level, is either used for evaluation activities, or goes back into the individual program budgets from which it began if it's not all used.

Mr. WEISS. So that what you're saying is that a significant portion of it is taken away by other agencies to begin with, and then what remains isn't even used for the purpose that it was originally set aside for?

Dr. AUTRY. That's correct. Approximately half of it goes back to PHS or the Department, but it is either used for program evaluation or is returned to the appropriate program budget.

Mr. WEISS. We heard testimony this morning about St. Elizabeth's Hospital, which has been under Federal jurisdiction for years, and will be transferred to the District Government in October. We heard that St. Elizabeth's patients are often released with

nowhere to go except shelters for the homeless. How does the Federal Government explain or justify that?

Dr. SULLIVAN. One of the advantages of transferring responsibility for the hospital to the District in compliance with the congressional bill to that effect is expected to be better integration of the inpatient and outpatient aspects of the system.

Mr. WEISS. I know, but given the current situation and given the Federal Government's responsibility, the question is how does the Federal Government currently justify its system of pushing people out of a Federal facility into shelters?

Dr. SULLIVAN. I think that there's no question that everyone would agree that there needs to be a stronger and more comprehensive community-based system in the District, and we need to make improvements in that.

Mr. WEISS. Well, that concludes my prepared questions. There are a couple of statistical questions we asked which you'll submit information on, and I will submit several additional questions to you.

[These questions and responses are in app. 1, p. 161.]

Mr. WEISS. In closing, I must say that it always presents a problem to me, and I tried to establish to Dr. Frazier, that you folks are expected to come here and justify whatever deprivations are forced upon you by people who know not, or care not, about the programs that you are expected to administer and undertake.

And I can understand their position, that is, their acting out of no knowledge. What I don't understand is your willingness to, in fact, support those positions when I assume that you don't agree with them. And if you do agree with them, then I suspect that you're in the wrong business.

I thank you very much for your participation, and I hope that you would recognize in your work that the whole country really is depending on what you guys are doing. The homelessness problem is growing by leaps and bounds. Mental health problems are very prevalent—you've testified to that.

And yet, we have the Federal Government either taking the position that it ain't our problem, it belongs to the States or localities, or drawing back to a very significant extent from even the limited role that it had been playing up to this point.

And I don't think that really is a fair, appropriate way for the Federal Government to be reacting, and in this instance, the Federal Government is you.

Thank you very, very much for your testimony.

I'd like now to welcome our final panel and to express my apologies and appreciation to them for having had to persevere through this entire morning.

The panel is composed of Dr. Richard Surles, administrator, Office of Mental Health/Mental Retardation, City of Philadelphia Health Department; and Ms. Martha Knisley, deputy director, Ohio Department of Mental Health. Dr. Robert Washington, Acting Administrator for the Washington, DC, Mental Health Services Administration, was scheduled to join this panel, but unfortunately is unable to join us.

[Dr. Washington's prepared statement and his responses to questions submitted to him appear in app. 2, p. 202.]

Mr. Weiss. First, let me swear you in.

Do you affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth?

Let the record reflect that both of the witnesses answered in the affirmative.

Again, I thank you for joining us. Ms. Knisley, I understand you had to change your schedule twice. My apologies.

Dr. Surles:

**STATEMENT OF RICHARD J. SURLS, PH.D., ADMINISTRATOR,
OFFICE OF MENTAL HEALTH/MENTAL RETARDATION, CITY OF
PHILADELPHIA HEALTH DEPARTMENT**

Dr. SURLS. Yes. I am Richard Surles, the administrator of mental health for the city of Philadelphia. Mr. Chairman, I would like to thank you very much for inviting me to testify.

I've been the administrator of mental health in the city of Philadelphia for the last 5 years. Before that, I was a State commissioner for mental health in Vermont and previous to that, the deputy commissioner in North Carolina. Currently, I'm the administrator of a mental health system in a city of 1.7 million people of which about 55,000 people a year use the public mental system in Philadelphia. Our estimate is that at least 18,000 of those would be classified as seriously or chronically mentally ill.

We are one of the nine Robert Wood Johnson cities that has been referred to in previous testimony today and have been in the last several years attempting to undertake major changes in what we ourselves viewed as a failed public mental health system.

The city itself has for the first time in its history, put major city dollars into services that previously were viewed as the responsibility of State and Federal Government. Most of our funding today is State funds. We receive a small amount of Federal funds and a significant amount of city funds.

The city funds came about primarily in the recognition that in the last 4 to 5 years, we had experienced some serious and unexpected changes in presenting problems of the seriously mentally ill. In terms of trying to describe those changes, I've identified three major groups who were requiring services, a number of which have already been referred to in previous testimony.

First, we have seen a dramatic increase in the homeless chronically mentally ill. Prior to 1978, persons on my staff indicate there were very few mentally ill on the streets of Philadelphia. Since that time, we have experienced a major increase in homelessness. In the early 1980's, most of that population were older and many of them were former State mental hospital patients. The group that we see today are younger and frequently combine both mental illness and substance abuse.

Second, we have also experienced a very dramatic increase in the use of psychiatric emergency services. The city mental health authority operates through contracts, seven 24-hour-a-day psychiatric emergency rooms, five of which are in general hospitals. In 1983, we had 19,000 admissions to those emergency services. Last year, 31,000. Among those persons, the vast majority are under 35 years of age. Most fit the profile of what some describe as the young

chronically mentally ill. Most are single. Almost all are unemployed and a surprising number are living with their own families.

Sometimes disappointingly, we find those persons are well known in the mental health system but the existing organization services does not serve that group of patients well.

The third population is children. We have experienced a fourfold increase since 1983 in the number of young children presenting for psychiatric emergency services. Many of those children come from the child welfare system; about half of all the admissions are in some form of protective custody with child welfare. The vast majority of those children coming to psychiatric emergency services present, in part, because of family violence or suicide attempts.

One of the things that is becoming clear to us, even though the research is at its infancy, is that many of those children come to be the young mentally ill adults; thus, the next generation of mentally ill persons is now appearing through the mental health crisis system.

Also disappointingly, the age of persons presenting is dropping. Two or three years ago, seeing a 9- or 10-year-old in an emergency room would have been rare. It is no longer rare.

The thing that is fascinating to me in terms of listening to the previous testimony is we all recognize there is a budget crunch but I for one as an urban administrator have been watching a great deal of Federal money and State money and local money being spent on public mental health services, but being spent poorly and frequently in the wrong places.

The problem around the population that you have been discussing, the group that I describe as the seriously mentally ill, is that the traditional mental health services do not serve them well. In general, the seriously mentally ill have special mental health treatment needs, requiring extraordinary effort, which simply do not fit into the traditional "brief therapy" modality of the mental health outpatient system. Nor are acute hospitals a viable treatment option for many of the most seriously mentally ill.

Many of the most seriously mentally ill make extensive use of the acute care hospital system in the city. Again, that service is paid through the Medicaid program. Patients cycle in and out, coming in, staying 20 days, going home for 3 weeks, cycling back in.

All three of these populations of seriously mentally ill require significantly more than traditional mental health therapy. In almost all cases, these populations require assistance with housing, health care, and income maintenance. Once some stability has been returned to the life of the patient, rehabilitation services and an opportunity for meaningful work and activity are also required.

In order for services to be effective, especially for these most in need patients, special attention is required to arrange and coordinate services. Federal recognition of need and some new initiatives have begun. Most promising was congressional action in 1985 that permitted the States to alter the State Medicaid plan to permit case management services for Medicaid recipients who required coordinated services.

Again this morning, illusion was made to the need and importance of the single case manager. Within the changes to the Medi-

caid program, there has been an effort to address that issue.

The major recommendation I make is that there is a need to recognize these special populations, and unlike many of the other public problems, there are significant public expenditures available for the seriously mentally ill. They are fragmented, uncoordinated, and disorganized. From a local point of view, the serious need for assistance at a Federal level to coordinate the Federal initiatives and the Federal programs in relationship with State government, I, for one, as a local administrator can see some optimism, but I cannot see much optimism as long as we have the discoordinated competing sources of Federal and State funds and the fragmentation of an approach to this most needy population that currently exists.

[The prepared statement of Dr. Surles follows:]

HEARINGS ON THE FEDERAL ROLE REGARDING SERVICES
FOR THE MENTALLY ILL

TESTIMONY OF
RICHARD C. SURLES
OFFICE OF MENTAL HEALTH/MENTAL RETARDATION
DEPARTMENT OF HEALTH
CITY OF PHILADELPHIA

BEFORE

HUMAN RESOURCES AND INTERGOVERNMENTAL
RELATIONS SUBCOMMITTEE OF THE
COMMITTEE ON GOVERNMENT OPERATIONS
HOUSE OF REPRESENTATIVES

MAY 19, 1987

The topic before the Subcommittee, Services for the Mentally Ill, is both broad and complex. Estimates of those experiencing episodes of mental illness in the American population ranges into many millions, but most episodes are brief and most persons return to a normal pattern of living after short-term treatment. Within the overall category of the mentally ill are sub-populations of persons with very serious mental illnesses which I believe require the special attention of Congress. These special populations include 1) the mentally ill among the homeless; 2) young, mentally ill persons who repeatedly utilize acute hospital and psychiatric emergency services and 3) children, especially the abused and neglected, who present under emergency conditions for psychiatric hospitalization. There are other groups who also require special attention, including the elderly cultural minorities, forensic patients and patients in state psychiatric hospitals.

My recommendation for focusing only upon the three priority groups (the homeless, mentally ill young persons, and children) is based upon two primary factors. First, I believe the American public is becoming increasingly impatient with government for failing to respond adequately to the very visible problems of the mentally ill on the streets and to news accounts of multiple suicide attempts and violence among the young. Second, many members of the priority population I have indicated are already using significant tax resources - especially through psychiatric inpatient hospitalization funded under the Federal Medicaid Program.

The plight of homeless mentally ill persons is clearly the most visible problem. Estimates of the mentally ill among the homeless generally range between 25 - 35% of all homeless persons. While many of these mentally ill persons are former state hospital patients, many of these persons have not ever been hospitalized in a state facility. Most have had multiple, short-term or episodic contacts with mental health services and most are fearful of traditional mental health programs.

Among the young, mentally ill, is a sub-category of seriously mentally ill young adults who, prior to the mid-1970's, would probably have been committed to State psychiatric hospitals. Several Supreme Court rulings resulted in most states changing their mental health commitment act such that these patients are now treated in community hospitals for short periods of time and then released (some only to be readmitted within weeks). Most urban areas, like Philadelphia, are experiencing dramatic increases in young persons presenting for psychiatric emergency. For example, psychiatric emergency room admissions in Philadelphia increased from 19,000 in 1982 to over 30,000 in 1986. Recent overcrowding has been so great that all seven of the City's 24-emergency services have had to refuse new admissions requiring seriously ill persons to remain at home or be held by the police.

Children are increasingly appearing for emergency psychiatric treatment. Many of these mentally ill children are also well known to the Child Welfare System since many have been subject to abuse and neglect. Currently, approximately 50% of all children admitted for emergency psychiatric treatment in Philadelphia come from child welfare placement - foster care, residential placement or juvenile placement. Many are sent to mental health services after a serious suicide attempt. It is becoming increasingly clear from studies of the seriously ill young adults I mentioned earlier had their first episodes of serious mental illness occur in their teens; thus many of the child admissions are the early presentation of persons who will later become heavy users of public mental health services.

All three of these priority groups have common characteristics. The nature of their mental illness prevents them from functioning within the norms of American Society - they are unable to work or continue schooling; many are or become alienated from their family; many place an incredible burden of care upon their family or public caregivers; and all require multiple, coordinated services over an extended period of time.

In general, these seriously mentally ill persons have special mental health treatment needs requiring extraordinary efforts which do not fit into the traditional "brief-therapy" model of outpatient mental health care. Nor, (with increasing limitation upon length of hospital stay by Medicaid and insurance authorities), can they be provided treatment as long-term patients in psychiatric hospitals. In other words, the current organization and financing of public mental health care is largely limited to short term acute care hospitalization. Many mentally ill young persons tend to extensively use this expensive inpatient care in large part because the lack of resources for after-hospital care results in their significant readmission to psychiatric hospitals.

Moreover, all three of these populations of seriously mentally ill require significantly more than mental health therapy. In almost all cases, these populations require assistance with housing, health care, and income maintenance. Once some stability has been returned to their life, rehabilitative services and an opportunity for meaningful work and activity are also required. Finally, in order for services to be effective for these priority populations, special attention is required to arrange for and coordinate services.

The very title of this Subcommittee, "Human Resources and Intergovernmental Relations", suggests what this population of seriously mentally ill persons require most. Various Federal Programs combined with State Programs are needed if government is to respond to the growing problems of serving some of its most disabled citizens.

Federal recognition of need and some new initiatives have already begun... Most promising were Congressional actions in 1985 that permitted states to alter their State Medicaid Plan to permit Case

Management Services for Medicaid recipients who required an array of coordinated services coordination. In addition, the Federal Housing and Urban Development Authority (HUD) is participating in a new housing initiative with the Robert Wood Johnson Foundation in nine urban areas. Special attention in these nine cities will also be provided by the Federal Health Care Financing Administration and the Social Security Administration. In effect, these actions represent the beginning of a comprehensive approach to serving the most seriously mentally ill.

My recommendation to the Subcommittee is that special attention be given to improving the planning and coordination of various federal programs towards providing more integrated mental health and social support services to priority populations of the most seriously mentally ill. Specifically, this means to coordinate and integrate the policies and funding of the Social Security Administration (SSI and SSDI)/ the Health Care Financing Administration (Medicaid and COBRA Case Management) HUD (Section 8) and the Rehabilitation Services Administration (Vocational Rehabilitation) with state and local mental health programs.

Specifically, Congress should establish a new authority within one branch of government to see that federal assistance needed by the most seriously mentally ill is provided. Priority should be given to relating the service needs of mentally ill Social Security recipients with HUD Section 8 housing programs as well as assuring access to needed health and mental health services through the Federal Medicaid Program. Such a federal authority could work with other federal agencies to develop and coordinate policies, plan programs, and formulate administrative regulations that will assure access to services as well as collaborate with the states in developing an overall plan for identifying the most in need groups and coordinating financing and service delivery efforts.

For the past 15 years, State and Local governments have turned to the National Institute of Mental Health as a point of reference and agent of national assistance. In recent years, however, the Institute has been increasingly reduced in size, resources, and responsibility. To achieve coordinated federal assistance and to merge that assistance with State government requires a fixed point of responsibility within the Federal Government. I encourage the Subcommittee to consider either revitalizing NIMH or creating a new entity coordinate these several large federal programs. In fact, my testimony seeks to advocate for a renewed effort to strengthen NIMH especially in the areas of technical assistance to the states Human Resource Training and Development, and in the development and evaluation of effective service models. Much of the new technology in public mental health to respond to needs of the seriously mentally ill has in fact, emerged from exemplary NIMH efforts such as the Community Support Program. Moreover NIMH has been extremely helpful in stimulating major university training programs to modify their curricula toward training and retraining professionals to

serve the priority populations of most interest to State and Local governments. Finally, the isolation of State government and mental health programs is being increasingly felt since NIMH has been less able to support national efforts that bring the states together to examine effective programs and policies.

As indicated earlier today, estimates by the National Association of State Mental Health Program Directors indicate that State Government is spending in excess of \$8 billion on services to the nations most seriously mentally ill. In addition, a multitude of Federal programs provide billions more. The revitalization of a National effort to coordinate and integrate a service response to the nation's most seriously mentally ill can produce effective treatment results. A rational and coordinated national program that effectively uses tax resources can occur through promoting a coordinated and managed care approach to the seriously mentally ill. Federal leadership is needed to promote leadership, training, and coordination between federal programs and the service efforts of State and Local Government.

Mr. WEISS. Thank you, Dr. Surles. Ms. Knisley.

**STATEMENT OF MARTHA B. KNISLEY, DEPUTY DIRECTOR, OHIO
DEPARTMENT OF MENTAL HEALTH**

Ms. KNISLEY. Mr. Chairman, I am appreciative of the opportunity to speak with you today during a very busy time at home. My boss, Director Pam Hyde, could not be with you because we are presently shepherding a bill through the General Assembly in Ohio that would change the financing of mental health services in the State of Ohio, similar to what you have heard already mentioned here today, similar to Wisconsin, funds are provided through the local community. We presently have a dual system of funding in the State of Ohio where the department runs 17 State hospitals and we fund community mental health through local boards. When and if they come together for the betterment of services to all persons, it sometimes is by accident rather than by plan.

We are presently in session in Ohio putting that bill through the legislature and along with that, our budget bill is going through at the same time, so this is a very busy time for us.

I would like to, since most of what I had to say today has already been said in one form or the other, summarize my comments, first by giving you some of the context for the State of Ohio and the state of mental health in the State of Ohio at this point in time.

Four years ago, I think it would be fair to characterize the mental health system in Ohio as mediocre at best and the indictment not so much on the amount of services delivered but the lack of vision, direction, and leadership, which again has been alluded to by both yourself and many of the witnesses here today, about the importance of a direction, coming together, working together, and providing the leadership.

Many things have happened in the past 4 years in terms of improvement of services. We paid particular attention to case management, and a single line of accountability as you heard today. We have spent a tremendous amount of energy and time in the area of benefits, improving the access to benefits, emergency services, as Dr. Surles just mentioned, and a variety of other system changes at the local level, to make services make more sense for seriously mentally ill persons.

I would also like to report, as you asked today, about exemplary programs. I would have to say that we have quite a distance to go and if our efforts in 4 years measure up to anything, it is just a further recognition of the fact that there is much yet to do.

On the comment of the seriously mentally ill persons, who these folks are and who we are seeing in our State, let me first just describe Ohio a bit. There are about 11 million people in the State of Ohio, many of whom are concentrated in our urban centers, but many of whom live in rural poverty, in southern Ohio and in our farm areas.

The problems that we observe, for example, would be that in our State hospital system, we admit three times the State average of persons who are minority, yet those folks, minorities, are dramatically underserved in our community systems.

You've heard quite a bit of discussion today about the phenomenon of homelessness and the rise of problems in serving persons who are at risk of being homeless or are homeless. That is a problem that we are also dealing with. We have just completed a major research study in that area and I would be happy to answer more questions on that if you like.

Last but not least, as Dr. Surles has just mentioned, what I would consider to be disenfranchised youth, whom, if we are not preparing for as a government and as a nation, will become the new burden for the future, because we have not yet learned how to serve this group of people well.

In terms of the Federal Government and the role of the Federal Government, I would like to summarize my comments in three particular perspectives.

The first is on the whole issue of leadership, and we have heard much discussion today about the role of leadership. Let me just give you a micro example of the relationship between the State of Ohio and the Federal Government.

Four years ago, as I mentioned to you, the State of Ohio did not participate much at all in what was going on nationally in terms of finding out and working with the different Federal agencies, demonstrating what could be done in new programs and whatever. During this past 4 years, we have worked very closely with the Federal Government, particularly through the CSP program and I might add that our State strategy grant will run about \$127,000 this year. That small amount of money coupled with a child and adolescent service systems grant and some other activities, where we are actually interacting with other States, other local communities, and with the Federal Government, has been the single most important corollary event in the turnaround of the state of mental health in the State of Ohio.

Our central office budget is now largely supported by these small grants. It's not the money that is important. It is our ability to find out what other people are doing, work with other people, and to try to make systems change.

Our own experience, if it would prove out across the Nation, it would be very important.

You have heard today discussion about Public Law 99-660, the State Mental Health Planning Act from last year. I would suggest again in terms of Federal leadership, what resources within the Federal Government and particularly within NIMH are going to be available to in fact enact that law, and I was hoping we would be on before the fellows from NIMH so you could ask just exactly specifically what resources they have for leadership for implementing that act.

The question was asked about protection and advocacy. I would suggest that you might want to go back and ask that question as well.

Another item in terms of leadership is across agencies. I don't think this can be stated too strongly in today's discussion. Even though the attempts are there, I would suggest to you that they need to be elevated to the highest policy level within the different entities, the Health Care Financing Administration, Social Security Administration, and Rehabilitation Services Administration. It's

one thing to coordinate, but we really have not negotiated through at the highest levels. The types of activities that need to happen for the leadership have not been there.

Second would be the adequacy of the resources themselves and the Federal role. There is no question, as Dr. Surles has just mentioned, there is a hefty amount, if I can use that term, of resources through the Federal entitlement programs, particularly Medicaid and Social Security Disability, and SSI.

The question here is the use of the funds, to make sure that funds that are available are used well.

With respect to the NIMH budget, there is no question that the service systems research and service systems liaison is grossly underfunded in relationship to the overall NIMH budget. I'm not suggesting by this that we reduce what we are doing already in basic research, but to relook at the fact that less than 1 percent of funds in research in 1986 was directed to service systems, both service system design and the financing of that service delivery, and basically looking at the care that we are providing in the local and State communities.

I would suggest to you that even though the Federal Government provides SSI and SSDI, psychiatric illnesses represent 19 percent of the overall program, but only 12 percent of persons with serious mental illnesses are receiving SSI and SSDI benefits. One could ask, perhaps they have other income. That is absolutely not true.

If you are on combined SSI and SSDI as an individual, you will receive, I believe, \$4,380 a year to live on. The average income of the 65,000 seriously mentally ill persons in the State of Ohio in 1985 was \$2,000 a year.

Nationally, \$2.2 billion is going into benefits for persons with psychiatric illnesses in SSI and SSDI. The fact of the matter is it is both not enough and we are not sure if it is being well spent.

My question here is, how much research and leadership is being provided to see that those funds are well spent?

The third and final aspect that I was going to talk about has to do with the coordination between State agencies, and I was going to provide for you an elaborate discussion about the fact that case management, even though it was proved in 1985 as Dr. Surles has mentioned, it has taken us 2 years in the State of Ohio and we hope to be drawing down our first funds for case management within a few weeks, 2 years of discussion with the variety of people at central and regional offices of HCFA in order for case management to be approved in the State of Ohio for seriously mentally ill persons. I might add that we are moving more rapidly than most States and have had more success in this area than most people have.

I think in summary, some of the Ohio turnaround that you have heard about today, some of the other States that Jim Stockdill was talking about earlier in terms of turn around, can be traced to our activities and our ability and capacity to work with the Federal Government. I would submit to you that it is very acute in terms of the amount of effort, leadership and direction that is necessary if we are going to turn around the problems in this country for seriously mentally ill persons. Thank you.

[The prepared statement of Ms. Knisley follows:]

TESTIMONY PROVIDED BEFORE THE
HUMAN RESOURCES AND INTERGOVERNMENTAL
RELATIONS SUBCOMMITTEE

OF
THE HOUSE OF REPRESENTATIVES
CONGRESS OF THE UNITED STATES
COMMISSION OF GOVERNMENT OPERATIONS
THE HONORABLE TED WEISS, CHAIRMAN

MARTHA B. KNISLEY, DEPUTY DIRECTOR
OHIO DEPARTMENT OF MENTAL HEALTH
MAY 19, 1987

Chairman Weiss, members of the Committee, on behalf of Governor Richard F. Celeste and Director Pamela S. Hyde, I am appreciative for the opportunity, representing a state government perspective, to speak to you today on the leadership role of the federal government in assisting states and communities in providing appropriate services for persons who are mentally ill, particularly, persons who are the most seriously mentally ill. Director Pamela S. Hyde cannot be with you this morning due to the fact that we are shepherding a major mental health reform bill through the Ohio General Assembly this session. The time frame for that activity during the Assembly's spring session in Columbus necessitates her being in Columbus today.

Before I begin with the topic at hand, I would like to set the context for my presentation from the perspective of the State of Ohio, particularly in view of the activities in Ohio over the past four years. Four years ago, Ohio's mental health system was considered less than effective. While there were some good programs in Ohio what was missing was strong leadership at the State level, with a direction and vision for the total system. Under the Celeste Administration, the Ohio Department of Mental Health set about to create a vision and begun translating that vision into action. I am proud to say that the results to date have been positive for the severely mentally disabled persons we have targeted to serve. I might add, also, that there is much more to be done.

The best example of more to be done in terms of the persons we serve in our state, is our lack of ability to provide the most appropriate care for minorities. For Blacks, percentage representation of admissions in state hospitals is three (3) times higher than percentage representation of the total state population. On the other hand, Blacks receive significantly fewer hours of service in the community system than whites once they are released from the hospital. Coupled with this discrepancy are ongoing problems of serving persons both poor and living in rural areas, our inability to serve youth who are seriously mentally ill and disenfranchised and persons who are at risk of being homeless. Fortunately our experience leads us to believe that by changing our approach (both clinical and organizational) we can better serve

disenfranchised groups. Indeed, blaming the victim is not an acceptable response and clearly does not solve the problem. Over the past 4 years we have initiated numerous changes particularly in increasing case management and other mental health services, increasing and improving access to benefits and entitlements, providing new job and vocational opportunities, taking bold new steps to combat the problem of homelessness and the general lack of resources for persons with serious mental illness. One dramatic result has been the awarding of grants to three Ohio cities by the prestigious Robert Wood Johnson Foundation and the Department of Housing and Urban Development. The significance of receiving three grants in Ohio, out of nine awarded in the country, is, hopefully, a sign of what can be done in a State that has commitment and real leadership to serving the needs of seriously mentally ill persons.

Ohio is, as I mentioned earlier, in the midst of a major legislative reform activity so that changes we are making can be translated into long term results. The cornerstone of that particular legislation is a major shift in financing and creating new incentives for the development of community support systems in each Ohio community. Fortunately the federal government, particularly, the National Institute of Mental Health is assisting us as we move through these changes.

On the topic at hand, I will speak to three crucial aspects of the role of the Federal Government in assisting States and communities. First, is the value and necessity of the leadership role of the Federal Government; secondly, the adequacy of resources and third, future direction of the combined and coordinated role of federal, state and local governments.

On the topic of leadership, as I mentioned earlier, the National Institute of Mental Health (NIMH) has been helpful, particularly, the assistance of the Division of Education and Services Systems Liaison and more recently the Division of Biometry and Applied Science. This appears to be the result of several key persons who have been personally willing to assist us, and Ohio's ability to take advantage of the small demonstration grant opportunities particularly in Community Support Programs (CSP), including small state strategy grants for Community Support Programs, Child and Adolescent Service Systems and Human Resource Development (HRD) and several clinical training grants. Ohio has also conducted a major Homelessness Study funded by the NIMH. These funds have translated into Ohio's central administrative budget for the Department of Mental Health over a 5 year period, going from being 3% federally supported in 1982 to being 27% federally supported in 1987. This funding increase in and of itself is not nearly as important as what can and should be translated from this fact -- Ohio's dramatic turnaround in its mental health system can be directly correlated with an increased relationship and support from the National Institute of Mental Health. As Ohio's Community Support Program Director, I can tell you that we have taken every

advantage of contacts and new information we gain from NIMH to move our mental health system forward. Ohio's turnaround in this area can be attributed to leadership. We believe leadership is important at all levels of government, and is critically important at the national level.

However, it is important that the leadership role of the federal government be viewed in a broader context than the present activities of the National Institute of Mental Health. The Federal role must be viewed in the context of the demands for responsive services and well coordinated support systems for persons with serious mental illness. This illness affects the lives of 1.7 million American citizens and their families. It requires national attention and national leadership, if we are to solve the mysteries and problems of serious mental illness. And it requires a great deal of attention and thought, with a clear federal presence, if we are to reduce the stigmatizing subsistence that most seriously ill persons face.

In the area of the need for basic research, this response and leadership is becoming more clear, Congress is responding; the NIMH is responding. In the area of service systems, the presence is less clear. A bold plan, The National Plan for the Chronically Mentally Ill, completed in 1981, remains a valid document but largely untouched. Combined efforts to increase the effectiveness and understanding the consequences of the Medicaid, SSI/SSDI, rehabilitation and housing support programs has not been given strong combined federal agency leadership and attention. The Division of Education Service Systems Liaison's efforts are limited in size and scope.

A small endeavor in systems change is community support. Fortunately Congress has seen the wisdom to continue funding the Community Support Program even when the Administration has not. This small program has kept alive ideas and strategies for strengthening well proven approaches to assisting persons with serious mental illness. Another example of systems change is Title V of Public Law 99-660, which calls for State Comprehensive Mental Health Services Plans. However, this law is silent on the need for increased federal support, and to this date, funds are not appropriated for this important new legislation. The Robert Wood Johnson Foundation efforts through their Program for the Chronically Mentally Ill, speak to the type of "service system" change that I speak of here. While, I believe, we all applaud and appreciate their effort and direction, it will need a strong federal presence to be successful. That presence will require a commitment and leadership across agencies including the Health Care Financing Agency, Housing and Urban Development, Rehabilitation Services Administration, Social Security Administration and the National Institute of Mental Health and requires top priority at the highest Administrative levels to be effective.

The second crucial aspect of the Federal role is the adequacy of resources. I have already commented on the lack of appropriation for Title V of Public Law 99-660. However, more importantly the bill itself is notably silent on the need for Federal resources for states to be successful in carrying out the charge of the legislation. The Division of Education Service System Liaison's budget is approximately one-tenth of the NIMH budget. And while I do not mean to imply the Division of Education Service System Liaison's budget should cut into the research budget of NIMH, the \$40,000,000 available in the Division of Education Service System Liaison's budget for Community Support Program (CSP), Child and Adolescent Service System Program (CASSP), Homelessness and other service system demonstrations and activities, Human Resource Development (HRD), Clinical Training and technical assistance to States, is not adequate to meet the growing demands for information dissemination, new knowledge development, transfer and service systems coordination, ADAMHA Block Grant administration, and most recently, the much needed Protection and Advocacy Legislation, which is now being implemented. In the area of the research budget I think it is also important to note that less than 1% of the NIMH Research grants in FY 1986 went to financing and delivery systems that provide mental health care.

A case in point is the reliance on SSI/SSDI as a major income support for persons with serious mental illness. The facts are clear that lack of income and poverty are inextricably linked to the dismal lives led by many seriously mentally ill persons. This is not to say persons who are poor are mentally ill, but to emphasize that one of the most serious consequences of serious mental illness is the loss of personal income associated with low or no income or benefits, lack of employment and the high cost of treatment. The combined SSI/SSDI costs for persons with psychiatric disorders in 1986 in this country was \$2,237,478,190. This constituted 19.9% of all SSI/SSDI expenditures and psychiatric disorders ranked second as type of disorders for SSI/SSDI expenditures. These statistics are astonishing, however, when only 12% of eligible persons are receiving these benefits and, in fact, in Ohio the average annual income of persons with serious mental illness is approximately \$2,000. This is less than the \$4,380 income an average recipient of SSI/SSDI receives. This major expenditure combined with the long term care expense borne by Medicaid and state governments for seriously mentally ill persons remind us that we have a responsibility as a nation to look at the institutionalizing effects and burdens of income supports, the influence of these supports on our practice patterns, how and where people are treated and the chronicity associated with this illness. When one looks at the service systems research, or the lack thereof, within NIMH and the federal government, one has to be concerned with the lack of attention to seriously mentally ill persons. Who gets benefits and who does not and why? How can we develop better practice patterns to assist persons with serious mental illness in leading a more productive and economically stable

lives? What happens to persons in our system over time? One would not think of introducing a new drug or a new technique without clinical trials. We should not continue entitlement programs or provide long term care assistance without the same research. I urge you to look at the budget and priority for service systems research and clinical training, human resource development and the relationship and coordination of the activities of HCFA, NIMH, SSA and RSA.

Another example is the paucity of funding for program demonstrations in the area of community support. In the past three years, such demonstrations have produced valuable information but the projects are small (\$100,000 annually) and run for only three years maximum. Long term systems change activities can not be tested out without federal support.

The third and final aspect is in the area of federal, state and local government relationships. I would add into this paradigm, foundations and universities as much needed partners and resources. In fact, I would suggest, for example, that using clinical training is an area wherein federal and state priorities and resources can be matched together to support university-based preservice clinical and residency programs so that we can take advantage of limited dollars to help accomplish mutual goals. We have begun to work in this area in Ohio and I urge Congress and the National Institute of Mental Health to explore and strengthen these ideas further.

Another example would be in the collective strategy for appropriate Medicaid Utilization that would enhance community based care. The Medicaid program functions under an immensely complex set of law, rules, and administrative guidelines and is administered through an often confusing system comprised of regional and central administrative entities. These factors result in inconsistent rule interpretations from region to region and between regional and central offices. All of this becomes extremely critical when a State attempts to modify its existing Medicaid program in an effort to make Medicaid reimbursement adaptive to advances in service technology. For example, Ohio has been working with HCFA officials for more than 2 years to include case management in its State Medicaid Plan. Although we are about to achieve resolution in this issue, the process has been extremely frustrating.

What needs to happen is that HCFA needs to understand better the Federal, State and local mental health systems and the mental health system needs to achieve a better understanding of HCFA and the Medicaid program. HCFA needs to learn more of the changes that have occurred in where and how mentally disabled persons are provided mental health services. Mental health providers need to get better information about how the Medicaid system works and needs better ways to communicate with HCFA officials. If some type of effective dialogue between the two systems could

be achieved, this would go a long way in resolving the current problems.

Similar to the Medicaid program, the SSDI and SSI programs function under an exceedingly complex set of laws, rules, and administrative guidelines. The Social Security legislative reform efforts of several years ago, however, initiated a process of communication between the mental health system and the Social Security Administration. In Ohio, we have followed up on this, and have an extremely effective relationship with both the SSA district office and the SSA contracted State Disability Determination agency. We are working with both entities in piloting model programs to expedite the disability determination process and in efforts to disseminate information about new work incentive provisions in the SSI program. Interestingly, we have found that the SSDI/SSI reform measures of several years ago necessitate this type of relationship developing because of requirements for more extensive medical evidence and reliance on treating source information. These requirements really necessitate the involvement of the public mental health system in order to avoid what can be substantial delays in the disability determination process.

In talking with our counterparts, in other areas, we have found that the type of relationship we have forged has not been experienced in other States. We may be fortunate in that the leadership in the Regional and District SSA offices and in the State Disability Determination agencies have been very receptive to having the two systems work together. Perhaps SSA Central Office needs to take a greater initiative in encouraging better communication between the two systems in other areas of the country.

In summary, we believe the opportunities are clear. The Federal government plays a central role in the lives of seriously mentally ill citizens and only with a strong presence of NIMH and particularly its role in service systems liaison, service demonstrations, service systems research and cooperative ties between federal agencies, can we begin as a nation to tackle the devastation of serious mental illness. Ohio's turnaround can be traced to increased relationships with federal agencies, but we can only go so far, and we have so far to go.

Mr. WEISS. Thank you very much.

We have the bells for another set of votes. I am going to ask you a few questions so you don't miss your next plane and excuse you.

Ms. KNISLEY. All right.

Mr. WEISS. Ohio has the reputation of being very active in improving services for the mentally ill. In your testimony, you have mentioned how Federal support and support from the private foundations are helping to make that possible.

Can you give more specific information about how Federal funding has been used to improve services?

Ms. KNISLEY. Yes, Mr. Chairman. I forgot to mention in my verbal testimony that we happen to be very fortunate to have three cities funded by the Robert Wood Johnson Foundation. We get to see this fellow next to me quite a bit.

I think in terms of the Federal resources that have been available to us, although it is a very, very small strategy grant, we did not have a CSP grant until just 4 years ago. It can be correlated almost directly with our turnaround. That has to do, I think, with the amount of time and effort by what I would call some rather valiant officials within NIMH in terms of carrying out their responsibilities with respect to community support.

I might add the community support funds, even though they are going up to \$20 million next year, this is the first year that community support has been in this administration's budget. Congress has always seen the wisdom to put it back in.

I think that single program has been very important. Most of the other activities where we have used Federal funds, we have jury rigged the system. For example, money that comes into our State for vocational rehabilitation services, we match that through our mental health department at the State level, in order to target a portion of those funds specifically for seriously mentally ill persons. Fortunately, we were able to work that out with another State agency to make that happen.

There has been very little discussion about how to do that or how one makes that work at the Federal level and between States, but until we were able to target those funds for seriously mentally ill persons, the funds were coming into the State without much direction and leadership.

I'm not suggesting that we specifically tie those funds and then in some rule somewhere in the Federal Government, you do that, but the creativity that was necessary at the State level in order to put those funds together almost happened by accident, not because we were planning or had the resources to do that, just that our other budget was short that year and we saw an opportunity to make it work.

More to the point, we have been able to take some of these Federal programs and because we know about what is going on in the rest of the country, try to make them work for us in very creative kind of ways.

Mr. WEISS. When is your next plane? I have to go vote at this point. Can you stay a little longer?

Ms. KNISLEY. Sure.

Mr. WEISS. We will take a break for about 10 minutes.

[Recess taken.]

Mr. WEISS. We are back in session. Ms. Knisley, have economic problems in rural areas caused new problems in providing services in the last few years?

Ms. KNISLEY. Mr. Chairman, economic problems in rural areas in the State of Ohio are nothing new. The county I grew up in has about 18 percent unemployment, and that is on a good day. We have had rural poverty problems in our State for quite a long time.

The farm crisis, if we want to use that term, even though at least half, if not two-thirds, of our State is in the farming area and agricultural areas, has not seemingly been that dramatic for us at this point.

I don't want to disagree with earlier witnesses, but we have had so many problems for so long with rural poverty in southern Ohio, that the farm crisis does not appear to be a crisis. It appears to be more like what we have experienced in those poor rural areas for some time.

I might add that we have almost the same rate of admission to our State hospitals in rural southern Ohio as we have in Cleveland. It is a problem for us in terms of reliance on the State hospital system, simply because we don't have community support systems cut in the very rural areas.

Mr. WEISS. I was going to ask that of you and Dr. Surles, because of your previous position in Vermont. What thoughts do you have on dealing with the isolated rural communities in regard to mental health problems?

Ms. KNISLEY. Dr. Surles has obviously had much more experience in this area. I can tell you more from growing up, more than I can from delivering services. I have spent most of my professional service career in urban areas.

To me, the issue again goes back to what you have heard over and over again today; and that is, community support, and finding unique and informal ways in which the system can be brought together in local areas.

I have often been troubled by, for example, bringing a professional in once a month, or bringing in even some of the public health service efforts, even though they have been dramatic and been helpful. We need to find a better way to do some of the informal service systems development in rural areas and getting support to people out there, rather than bringing someone in from outside and then taking them away in a couple of years.

The whole matter of payback, for example, even though that is one mechanism I think has been, to a limited extent, helpful. When we are putting professionals out in rural areas, they are going to leave unless we help train those professionals in rural areas and help provide some incentives to stay there more than the 2 or 3 years that they are there.

So I think we really have to relook at giving 1 year service to public service, or 2 years, and then be gone. I think we have to think more about how we teach, and where we teach, and how organized we are within State and local communities to have the services more connected in some way.

Richard may have a better handle on that than me.

Dr. SURLES. I had to undergo the cultural shock of leaving the mountains of Vermont and spending 5 years in Philadelphia. I had to think about that a second.

The thing I remember the most was the frustration of trying to operate in rural areas within policies and regulations and rules that were basically created by a sophisticated urban culture. A lot of the things that are appropriate in Philadelphia—because I have access to psychiatry and nursing and psychology in schools of social work—a lot of the models and a lot of the reimbursement systems—are not appropriate in rural Vermont. For example, in the entire 10,000 square miles of northeastern Vermont, there was one psychiatrist; fortunately, that person worked for the community mental health center.

Rural areas generally lack an adequate number of trained professionals. The fact that many Federal rules required the supervision of services by licensed professionals become inhibitors in rural areas. Frequently rural communities are very creative, and fewer are unserved because the town selectmen demand that responsible officials respond to unique needs.

Regulatory control often developed for sophisticated communities should be reexamined and rural communities given some opportunity to adapt different approaches to their problems.

Mr. WEISS. How do we deal with the problem that Ms. Knisley raised, which is attracting people to the rural areas? Or even beyond that, attracting people to deal with the problems of the most difficult mentally ill patients, rather than focusing solely on a lucrative private practice?

Dr. SURLES. One of the things I think I learned in Vermont that we put into practice in Philadelphia, in Philadelphia mental health professionals would sit in an office and wait for somebody to come. In a rural area, you go to people.

Ninety percent of all the psychiatric emergency services in Vermont occurred either in the home or on the road with the State policemen, or the mental health worker got up in the middle of the night and came to the local hospital.

I think rural areas tend to have much more mobility with their services, and a much greater expectation that someone is going to go to a crisis, determine what is wrong, and then call in backup forces. Urban areas, we tend to be much more passive, and we wait for problems to present.

Ms. KNISLEY. I think, Mr. Chairman, there is an interesting analogy here that we can apply to how we prepare and train, and actually implement our services for clinical training and residence. And the analogy is, that for the first 15 years of the community mental health systems—and I'm speaking here from about the mid to early 1960's, until 1980—we had a system where the Federal Government dealt directly with local communities in fostering community mental health centers.

I worked in one of those community mental health centers that was federally funded, and I really knew very little about what went on with the States, with my State government. I was fairly naive, too, about the problems associated with the State trying to run State hospitals.

And we had a Mental Health Systems Act, I might add, that was to have been implemented in 1980, which, of course, was never implemented, which recognized that problem, and recognized some of what the State mental health commissioners had been saying for years about the relationship that has to include Federal, State, and local levels.

We have the very same interesting dilemma with clinical training, and this is the second part of the analogy. And that is, not only have we seen a major reduction in clinical training between the Federal and the universities, but the interesting thing that happened was now the universities are talking to the States.

The clinical training grants that have gone out from the Federal Government have not had any direct relationship to State government. In my State, the highest priority for our State budget is higher education, as in most States, and secondary and primary education. We could have a tremendous amount of leverage—and we are beginning to have now, by rewriting the rules for clinical training and residency in our State—we could have a tremendous amount of leverage with respect to how professionals are trained; where they are trained, and the interdisciplinary aspects of training that need to occur in mental health, particularly for seriously mentally ill persons.

If, in fact, State government was in that triangle some way, in a meaningful kind of way, not just shake hands, we are going to be good friends kind of way, but in a meaningful kind of way between the Federal Government and clinical training grants, and the universities; I think that's an important step that we need to take.

I think that we could bear much more fruit with our clinical training and residency programs. When it comes back to the subject Dr. Surles was talking about in the specifics of your question, I think that where and how we train professionals has a lot to do with the fact that people are going off to make their fortune.

But frankly, the amount of time and effort spent on knowing how to serve seriously mentally ill persons is very minute in the overall scheme of things for psychiatry, psychology, and any of the other core disciplines. Even working with each other; it's very important when we are talking about seriously mentally ill persons. The least amount of time spent with the seriously mentally ill person is spent with the psychiatrist.

It is the nurse and the social worker and the paraprofessional that spend the most time with the individual. Yet they are not in the room when the psychiatrist is being trained. So we continue to set up some of the patterns that are not working for us.

I think that there is a body of knowledge of how to do the training, and where to do the training, that would be helpful in spreading out some of the activities. The State of Oregon has an excellent track record in this regard.

They have no—I shouldn't say they have no trouble—they have little trouble finding a psychiatrist and other professionals who will work out in those rural areas, or work even in the difficult areas, because that was the focus of their training.

I think we need to, both in our urban areas where we have very few people actually trained in these clinics or out on the street—

they train in these magnificent, beautiful hospitals which has very little to do with the life of the seriously mentally ill person.

Dr. SURLS. I would add quickly to that, that I have seen virtually no training programs that I know of that really, truly, address the population that we are discussing. Most of the training programs are very isolated unto themselves. We train people in social work, in nursing, in psychiatry, and psychology; but for the patient group that we are talking about, you have to know how to work among professionals. And you must know also how to work with nonprofessional support systems.

We are doing very little, to my knowledge, to train the next generation of mental health professionals to work with the most seriously mentally ill in the community.

Mr. WEISS. Dr. Surles, what Federal programs have been most useful to you, in Philadelphia or in your prior position in Vermont?

Dr. SURLS. In the last 4 or 5 years, the Federal programs have had very little impact on city mental health services. Probably the community support program, through a demonstration grant we received for the homeless for case management, was most effective.

There have been, in the last year, an initiative with the teaching hospitals which required that the clinical training program come to the local mental health authority and develop a collaborative relationship. That was very beneficial.

But there are very few Federal NIMH programs at this time which are having an impact on the organization and delivery of services within my city.

Mr. WEISS. You were here for much of the testimony, perhaps all of the testimony, of the NIMH people. I guess the question that occurs to me is, from your perspective, how much of the research that they are doing, in fact, percolates itself down, effectively, to where you are working? Do you get any benefit?

Do you get their work product or research results on a regular basis? What kind of interaction is there between you and the NIMH?

Dr. SURLS. Let me comment on that, for what is left at NIMH, the group of people there are incredibly dedicated, and when we call, work with us. There are just so few of them. The work that has been helpful to me has primarily come out of the community support program and biometry areas such as statistical data, and understanding the profiling characteristics of patients.

We are currently doing a joint project with NIMH in the city with no Federal funds. We have a grant from the Glen Mew Trust Co., looking at the issues of violence and at-risk for hospitalization; and two of the NIMH staff members are serving on the advisory board to that work.

At this juncture, with such limited resources and with such limited staff, most useful services research comes in the relationship with the individuals, and provide some of the most recent studies and information that might be applicable to the situation I face.

I do not think that the staff at NIMH—I think they do know what to do. I just think the resources are so incredibly limited that, when they look at the full country, there is little they can do. My central office staff in Philadelphia, I was listening to the numbers

this morning, is three times larger than the mental health services staff at NIMH.

You can't relate to a nation with that staffing and resource level.

Ms. KNISLEY. I couldn't agree more. What has been the most valuable to us has been the connections that we have been able to make because of those few people who have been there. Earlier we were talking about the Planning Act from last year. The problem isn't that there is new staff to implement the Planning Act.

They are not ready to implement. First of all, the money hasn't been appropriated for it. And secondly, they will divide up the duties among themselves; there will be no new staff at NIMH to assist the States and the commissioners in putting together the necessary implementation of that act.

They are using existing staff. They are already working on it. As a matter of fact, they have a committee that has been looking at the planning efforts. But it is with those few existing staff that they have. The value has been in that area.

I may be slightly off on my numbers, but I think in the area of service systems demonstration, they only have six or seven grants nationwide. We are watching those very carefully to see what we can learn from them. But the amount of new knowledge will be very limited, compared to the type of knowledge that we need for what it is that we are facing.

Dr. SURLS. I would add, quickly, that the current work is very creative. Their convener functions—what they have been doing is bringing a group of States together to, for example, focus on model Medicaid programs, or to look at innovative ways of organizing emergency residential services.

But, with such limited resources, that is happening less and less. I think that one of the things that many of us feel is a sense of isolation right now; that the lack of that convener function, the lack of their sources to bring the States and the urban/rural areas together to look at what is the emerging technology, and what are the data, is being very sorely missed.

Ms. KNISLEY. One of the things that was mentioned earlier was the qualifications of the staff, for example, in the CSP program. I can tell you quite frankly, if you are going to have three people, three people that you need, are not necessarily your most skilled professionals.

There are three people who are very skilled at getting a bunch of people together on a very shoestring kind of budget, as Dr. Surles was mentioning, and get the States that are doing something in Medicaid together, and convene them.

The National Association of Mental Health program directors and the Commissioners Association does this as well, simply because they are having to fill a void. They are doing a lot of the work as well, but convening is the best thing that they can do for us. What two or three people can do is very limited in the overall scheme of things.

Mr. WEISS. My understanding is that very few mentally ill people are violent, and many are vulnerable to being hurt by others. In the past year, there have been several stories in the media about violent, mentally ill people—for example, last year on the Staten Island Ferry, after the Fourth of July celebration and earlier this

year, when several women were tortured and killed in a Philadelphia basement.

In both cases, neighbors expressed concerns long before the murders took place, but nothing was done to prevent them. Even though few mentally ill people are violent, the public is understandably concerned about the apparently unpredictable behavior of those that are.

Could NIMH do anything that would help prevent those kind of tragedies? At all?

Ms. KNISLEY. I'll give a stab at this. I really don't think so. In those particular situations, I think they are going to continue to be occurring, particularly be continued to be highlighted, as you said, very few people.

I think that again, not to go back again and harp on something that has been discussed over and over and over again today, the service delivery systems, how they work for people who are not good patients, is something that we really need to spend a lion's share of our effort.

What NIMH could do, and could be helpful in, is again, in the services systems research. We know very well what to do with good patients; I'm talking about folks who are not compliant. Perhaps, rather than thinking about not compliant, what is it that we are doing that, in our mental health service delivery systems, for ill persons to want to participate and take part in, and get something out of.

I mean, we don't have that single system of care. They are shuffled off here, there, and everywhere. If you come into one of our waiting rooms and you are a young adult today, what you see is older people who have been beaten down with the chronicity of long-term mental illness. And being on some kind of disability system, and never being able to get off it, because once you're off, you'll never get Medicaid again, you'll never get care again.

The service delivery systems that we have put in place: we are not looking at those to see how they work for the people who aren't there. And we are really not spending much time and effort in the service systems research area.

There is one thing that NIMH could do when it comes to the people out there who are not a part of our system. That would be it. It is not going to dramatically change those headlines anytime soon, but we started today. We aren't going to change those headlines for many years to come.

Dr. SURLS. I would give you a definitive answer of yes and no. I don't think, in the case of a cold, calculating killer, that the mental health system is an effective intervenor. However, I think there are persons who are seriously mentally ill who use mental health services, who want treatment, and who sometimes are so ill that they deny they want treatment.

For some persons who are seriously mentally ill there are two things we could do. The current service design is such that we have to wait for the person to absolutely fall apart before we can start treatment. The person that was first to testify this morning, I couldn't agree with more. The one national strategy that all of us are coming together on is a whole concept of fixed point of responsibility with case management.

From hospital data we know that, without even a lot of study and research, the introduction of the social worker function or, in health care for a case manager, reduces rehospitalization. If we could do something nationally to design a responsible case management system for this most in need, and most potentially at-risk group, both of being violent or being injured themselves, I believe that we could make a dramatic difference and cease waiting for the casualties to show up.

So I would suggest that NIMH could do a great deal if they would spend the next year-and-a-half, 2 years, dealing with the issue of improving, if you will, another form of prevention: the prevention of patient collapse.

The second piece of that is related to the first. I think that there is a need for service system research on identifying the risk factors associated with violence. By that, I mean that we have not undertaken sufficient research to understand why people collapse, why they commit violence, why they are rehospitalized.

There are, we believe, some factors that would permit us to develop an early warning system. There was another case, about a year-and-a-half ago in Philadelphia, in which there was a shooting and several people were killed. When one reexamines the facts in that case, it should have been prevented. There should have been early intervention, because that was a very treatable person.

So I think there are some cases that no, I don't think that mental health is the answer. But yes, there is a significant group of people, especially among the young mentally ill, that if we did a better job of understanding who they are, and how they use services, and where they enter treatment and what their presenting characteristics are, we could prevent some of the tragedies that are occurring.

I believe there are far more unreported domestic tragedies than there is major public violence. I believe that we can help impact and reduce some of the violence within families. I think we can help reduce some of the casualties of someone that goes off their medication, and we have to wait until they become so ill that they are picked up by the police and taken to an emergency room.

Mr. WEISS. In your work, what have you learned about the young, heavy users of mental health services that can be helpful on a national level?

Dr. SURLS. I guess sometimes for an administrator, you get into researching an issue after you have been affected by it. We had two deaths in our emergency services in 1985, within a 24-hour period, both of them involving the police. We started to raise the question of what's going on, what's going wrong.

Our research, and some recently published data, really focused on what others in the field have referred to as the uninstitutionalized patient. In the mental health field, we talk about the prior State mental hospital patient; the person that we have deinstitutionalized, if you will.

Former State hospital patients tend to be some of the more easy persons to treat in the community. After they have spent 20 years in the hospital; their mental illness has cooled; they tend to be compliant; they tend to take medications; they go to their program.

The new generation of young people that have largely not experienced long-term State hospital stay tend to deny their illness; they do not want to participate in programs with older mental patients. They basically will tell you—even though they could still be actively psychotic—that they want a job, an apartment, or to get married. The system we have designed isn't responding very well to this younger group.

Our data are showing that those persons are showing up increasingly in prisons, in police vans, in psychiatric emergency rooms, in shelters, in welfare centers. We really are creating the next generation of what we've referred to as the chronically mentally ill.

Our figure in a city with the population of 1.7 million, we have been able to document since 1979, what we call the entering class. About 300 people a year are coming forward in the city of Philadelphia who fit the profile of the young, seriously mentally ill. They tend to be the population I described in my opening testimony: young, 17 to 35, unemployed, single, 60 percent with family, 20 percent in boarding homes, well-known to the mental health system, and periodically cycling in and out of crisis services.

I think the work that we have done, and we did it basically on our own, has caused us increased concern about what is happening to us. But it also caused us to re-think the way we organized and delivered service. And I would add that that's one of the functions that I would hope NIMH would start to give a priority.

NIMH should give priority to examining existing phenomena. Yes, do the basic biological research, and eliminate schizophrenic illnesses through good medical treatment. But in the 20 years, or 10 years, that it takes us to do that, let's do a better job of examining existing phenomena, and developing those treatment strategies that will work for these new populations that are really becoming increasingly made aware to the public at large and to the mental health system.

Ms. KNISLEY. I think that an interesting way to look at this is that first wave, if you want to call it that, in our State the 20,000 or so people that we brought out of State institutions, we really got away with, if one wants to call it that, and that's not a very good term—as a nation we really got away with continuing those folks being institutionalized in our communities.

They were institutionalized in our income maintenance programs; they were institutionalized in being hidden away or in old boarding homes, or being in nursing homes. So we continued the practice of institutionalization, even as we began community mental health services for 15 years.

Now we're having, all of a sudden, an emerging group of people which Dr. Surles is talking about, and we're having to deal with the fact that this group does not want to be institutionalized, refuses to be institutionalized, because they happen to be younger.

They happen to be of the age group who doesn't want anything to do with institutions, at a period in time when our country values the sense of, for me, kind of syndrome in this country, rather than some of the liberties that we fought for earlier and said that it was the good of a broader range of people.

Now we are into a phenomenon of whatever is best for me, is best for the country kind of thing. Yet we don't accept that for

young mental patients. And we say, aha, you're resistant, you're this, you're that; when, in fact, they really reflect what is going on nationally.

They refuse to adopt our community institutional way of looking at things. We desperately need to find, as Dr. Surles is talking about, a new and different way to deal with this group of people. Which, in fact, they are presenting what we should have been prepared for, and we really weren't.

Dr. SURLES. Like someone said this morning, too, I think one of the other dangers, one of the things that should be said by the two of us: there is also a tendency to want to talk about changing involuntary commitment acts, and increasing the liberalization of hospitalization.

It's another way of blaming a person for their mental illness, rather than the professions gearing up and changing the way they deliver service. We describe a person as a noncompliant patient. Which is another way of saying, we don't know what to do.

Mr. WEISS. Finally, in our questioning of the Federal people and the former Federal people—we pressed on what the role of the Federal Government is and what it should be, in regard to provision of services. And I'd like your thoughts on that issue.

Ms. KNISLEY. I think that the two to three key areas that have been spoken to over and over and over again today—the whole issue of there has to be a Federal presence. Most of the life of a mental patient is dependent on the presence of not the National Institute of Mental Health, necessarily, but the income streams that are provided by the various benefit programs of the Federal Government.

So, from the national viewpoint, if, in fact, we are going to be involved in income and benefits and the relationship of health care delivery system, which is largely directed from the Federal Government, then there has got to be a leadership role within NIMH, but also within the Federal Government in a broader sense, about the best way to do that.

That leadership role has to be much beyond what it is now. We have heard about the lack of just plain leaders. We did hear about some efforts to work together between agencies. I would submit to you that that needs to be elevated to the highest level of decision-making.

In terms of the resources themselves, it's a very complicated issue: if we are going to increase resources, at the same time we do that, we have to examine the relationship between Federal resources, State resources, and local resources, to make sure they are all working in sync together.

There are many ways that we could be spending more money. But, in the process of doing that, we have got to spend it well. And we've got to be working more closely together to do that. State commissioners in this country today are facing, as we heard earlier, a large and overwhelming responsibility with respect to State hospital care and local care.

When the Federal streams come down, and the State streams come down in the local areas: if those aren't in sync in some way, then we really are missing the boat. Those two things, I think, are the most important.

And third, we've got to be in balance between looking for the magic bullet—or the silver bullet, I'm sorry—the silver bullet, and what it is that we are doing in our services today. We have got to continue our pursuit in basic research; we are far behind in that area.

But we are even farther behind in looking at how our services work. I think the Federal Government does have a role to play. They have had a historic role. Only the Federal presence, through national efforts, are going to bring about the amount and degree of new knowledge that we need to have.

States and local communities cannot do that in isolation.

Dr. SURLS. I think I would start out by saying what I hope they don't do. I would not want to see the Federal Government going back into directly funding mental health services, except through modeling service demonstration. I think that bypassing State and local government created part of the problem.

I would, though, highlight the emphasis upon a national responsibility for service coordination and policy for the most seriously mentally ill, as my No. 1 priority. The recognition that the Federal Government and the States are spending a vast amount of taxpayers' money on mental health services for this most disabled population, and yet it is incredibly uncoordinated, and there is almost a cost shifting, if you will, a passing of responsibility, among Federal and State governments.

It is a real tragedy, what we are doing to people, and there is tremendous need for national leadership in understanding that phenomenon and providing national leadership to coordinate the efforts of the variety of Federal bureaucracies that impact this population and the States, the service coordination.

Second, would be services research. I think the testimony today you've heard repeatedly, and you are hearing from is, somebody who has to do it everyday: there isn't good data out there about the population, their characteristics. And especially, as Dr. Frazier said, service models that work for well-diagnosed population.

We also need to bring psychiatry and medicine and good health care back into working with this population, so that we do good screening and diagnosis, and then I think where we really need some national help, is developing those services models that respond to the population, once identified.

Three, we need a lot of help with data, one of the real problems we had. I was involved, back in the 1970's, with some negotiations with the Health Care Finance Administration, trying to improve mental health services for the mentally ill. There is no Medicaid national data system for mental health. It is very fragmented.

We need a lot of work on the characteristics of the population, incidence and prevalence, and the financing of mental health services. Clinical training and clinical training which focuses upon partnership models and knowing how to work with other professionals—one of the things that we are seeing with working with this population is the concept of creating clinical service teams; that you bring together a psychiatrist and a social worker, and they work with other people around a group of patients. Very effective models of care.

Yet our training programs aren't recognizing those modalities. We know a lot, but we need to influence, at a national level, what the new generation of trained professionals should look like.

We need technical assistance and technology transfer. We need help to know the good programs that work in other areas, and to bring people in to help us improve our service system and develop models.

And I think, lastly as I kind of started out by saying don't do services, but I do think that service demonstration and the modeling of large-scale demonstrations would be very, very useful and very important. Two hundred million dollars for direct services spread across the 50 States, while I'm glad to get a little of the block grants in Philadelphia, it's a very small percentage of my overall service delivery system.

We are spending about \$100 million on mental health services in Philadelphia. Four percent of that is from the block grant. While I wouldn't like to give it up; I would contend that probably the money could be better spent than is currently being spent.

Mr. WEISS. I want to thank both of you very much for very important testimony. We appreciate your spending so much time with us, and we look forward to hearing from you again as we proceed in this investigation.

Ms. KNISLEY. Thank you.

Mr. WEISS. The subcommittee now stands adjourned, subject to the call of the Chair.

[Whereupon, at 3:30 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

APPENDIXES

APPENDIX 1.—DOCUMENTS REFERRED TO IN THE HEARING RECORD

TED WEISS, NEW YORK, CHAIRMAN
*THOMAS C. SHAWVER, OHIO
JOHN COFFEE, JR., MICHIGAN
HENRY A. WALLMAN, CALIFORNIA
BARRY FRANK, MASSACHUSETTS

ONE HUNDRETH CONGRESS

Congress of the United States House of Representatives

HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE

COMMITTEE ON GOVERNMENT OPERATIONS

RAYBURN HOUSE OFFICE BUILDING, ROOM 8-372

WASHINGTON, DC 20515

(202) 226-2648

June 5, 1987

JIM LIGHTFOOT, IOWA
BRADLEY L. COHEN, *ALABAMA
JAMES M. BISHOP, *LOUISIANA

The Honorable Ian Macdonald, M.D.
Administrator
Alcohol, Drug Abuse, and Mental Health
Administration
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Macdonald:

I regret that you were unable to participate in the May 19 hearing on the Federal role in providing services for the mentally ill.

I am writing to request that you respond to the following questions as specifically as possible, to complete the hearing record. I would appreciate receiving your responses by June 15, 1987.

1. Medicaid services are limited to "on-site" services, and thus can't be provided at shelters or other facilities used by the homeless. Does ADAMHA believe that "off-site" services could be more effective than on-site services for reaching the homeless mentally ill?

2. Medicaid does not fund psychiatric rehabilitation services, such as training in community living skills, specialized vocational services, and activities that support the individuals ability to function in the community. Does ADAMHA consider those kinds of services cost-effective, and what recommendations, if any, has ADAMHA made to include those types of services in Medicaid coverage?

3. At the May 19 hearing, the subcommittee heard testimony that Medicare and Medicaid services for the mentally ill do not reflect the often superior cost-effectiveness of outpatient services and services that are provided by non-medical personnel. What specific efforts is ADAMHA or NIMH making to influence mental health services that are available through Medicare and Medicaid?

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4. In 1983, HHS and HUD issued a joint report entitled "Federal Efforts to Respond to the Shelter and Basic Living Needs of Chronically Mentally Ill Individuals." This report was the result of several years of collaborative work, and included many sound recommendations. Two of the recommendations were that HCFA and the Social Security Administration would seek to identify and remove barriers that impede State and local efforts in meeting SSI recipients' shelter and basic living needs, and that the Public Health Service would "collaborate with and seek to assist HCFA and SSA in an effort to develop cost-effective policy options for better meeting the needs of this population." What specific actions has HHS undertaken since 1983 to implement these recommendations?

5. What national statistics does NIMH collect on mental health, and how does this reporting system compare, in size and scope, with statistics on physical health collected by the National Center on Health Statistics?

6. What specific changes would need to be made in the current NIMH research and statistical reporting program in order to provide nationwide information about the need for community support services, and other gaps in mental health services that were discussed at the May 19 hearing?

7. Please provide information about NIMH's dissemination of research findings on the most effective treatment of the violent mentally ill.

8. Please provide statistics on the number of NIMH publications for the Antisocial and Violent Behavior Branch for FY 1985 and FY 1986 compared to the number for FY 1980 and FY 1981.

9. Please provide the number of technical information visits to States by staff of the Antisocial and Violent Behavior Branch for FY 1980 and FY 1986, and the number of requests for visits that were denied.

10. What amount of money has been set aside for NIMH evaluations of service programs for FY 1987? What evaluation studies have been funded, how much has been spent, and how does the funding level compare with the amount set aside for FY 1985 and FY 1986?

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11. Please describe in detail the current status and ongoing activities of the HHS Homeless Task Force, including but not limited to the number of meetings during FY 1987 compared to FY 1985-86.

12. For the past two years, NIMH has provided funding support for a national clearinghouse to assist providers working with homeless mentally ill persons. Does NIMH plan continued funding of this project in FY 1988 and FY 1989?

13. What special activities has NIMH undertaken to help States and localities address the unique needs of various recognized subgroups of the homeless mentally ill population, such as minorities, families, and substance abusers? Please describe any programs or service systems research regarding these subgroups.

14. Please describe the staffing and administration of the rural mental health demonstration projects, including any coordination with other service demonstration programs such as the Community Support Program and the Child and Adolescent Service Systems Program.

15. When appropriations are approved for the State Mental Health Planning Act of 1986, what staffing is planned to implement the program?

16. At the May 19 hearing, the subcommittee heard testimony that St. Elizabeth's Hospital patients are often released with no where to go except shelters for the homeless. Since this is a Federal facility, what is HHS doing to prevent this from occurring while St. Elizabeth's is still under Federal control?

17. In order for psychiatric hospitals to be eligible for Medicare and Medicaid reimbursement, they must be accredited by the Joint Commission on Accreditation of Hospitals (JCAH). St. Elizabeth's will lose its JCAH accreditation when it is transferred to D.C., and will then reapply for accreditation. This could take at least several months, and, in the meantime, patients will not be eligible for Medicare and Medicaid reimbursement. What steps has ADAMHA taken to prevent this loss of coverage?

18. What is the current status of NIMH's search for a Director?


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19. In FY 1986, OMB disapproved a NIMH study proposal entitled "Mental Health Utilization and Reimbursement Patterns Survey", and in FY 1985, OMB disapproved a study entitled "ADM Knowledge Outcome of Primary Care Residents." Please provide the Subcommittee with the research protocols for these studies, the Initial Review Group documents, and all other HHS and OMB documents regarding these proposals. Include any information about plans to resubmit these proposals to OMB.

20. Please submit the information regarding the number of mental health professionals that are trained to work with the homeless mentally ill and the elderly mentally ill, referred to on pp. 118-119 of the hearing transcript.

Thank you again for your cooperation.

Sincerely,



TED WEISS
Chairman



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the Assistant Secretary
for Legislation
Washington, D.C. 20201

JUN 22 1987

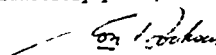
The Honorable Ted Weiss
Chairman
Subcommittee on Human Resources
and Intergovernmental Relations
Committee on Government Operations
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your letter to Dr. Ian Macdonald, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, requesting answers to a number of questions as part of the Subcommittee's May 19 hearing record. Enclosed are those responses. We appreciate your consideration of extending the deadline to June 22.

If we can be of further assistance, please call the Office of Health Legislation (245-7450).

Sincerely yours,


Ronald F. Dockstai
Assistant Secretary
for Legislation

Enclosures

1. QUESTION: Medicaid services are limited to "on-site" services, and thus cannot be provided at shelters or other facilities used by the homeless. Does ADAMHA believe that "off-site" services could be more effective than on-site services for reaching the homeless mentally ill?

ANSWER: Medicaid funding of "off-site" clinic services at facilities serving the homeless population would likely reach many more homeless mentally ill people than are currently being served through "on-site" services. However, we recognize that there are problems and complexities with eligibility determinations, record keeping, and quality control which need to be taken into account with "off-site" services and defer to the Health Care Financing Administration and the Congress in this regard.

States have the option of covering Medical or remedial services provided by licensed practitioners within the scope of practice as defined by State law. Thirty-six States provide these optional services. States also have the option of providing diagnostic, screening, preventive and rehabilitative services provided by licensed practitioners within the scope of practice as defined by State law. There is no "on-site" provision for these optional services.

2. QUESTION: Medicaid does not fund psychiatric rehabilitation services, such as training in community living skills, specialized vocational services, and activities that support the individuals ability to function in the community. Does ADAMHA consider those kinds of services cost-effective, and what recommendations, if any, has ADAMHA made to include those types of services in Medicaid coverage?

ANSWER: Psychiatric rehabilitation services can reduce the need for inpatient services, can reduce symptomatology, and can improve the level of functioning and quality of life for persons with serious mental illness. For example, research by Professors Stein, Test, and Weisbrod found that patients trained in community living skills had spent a mean of only 6.51 days in the hospital while the control patients had spent a mean of 10.74 days. However, existing studies are incomplete and comprehensive replication studies have not yet been performed.

There is no research which permits us to identify the optimal treatment to meet specific patient needs. As Dr. John Talbott pointed out in a recent summary of research on persons with chronic mental illness, we need to know more about the cost-effectiveness of various treatments, or even what specific treatment and care elements work for which types of patients and in what settings.

Thus, while psychiatric rehabilitation services clearly can be very helpful, there is insufficient research on which to base recommendations concerning coverage of such services under Medicaid.

3. QUESTION: At the May 19 hearing, the subcommittee heard testimony that Medicare and Medicaid services for the mentally ill do not reflect the often superior cost-effectiveness of outpatient services and services that are provided by nonmedical personnel. What specific efforts is ADAMHA or NIMH making to influence mental health services that are available through Medicare and Medicaid?

ANSWER: ADAMHA has two distinct types of efforts underway--basic research and policy analysis--that may influence the coverage of mental health services under the Medicare and Medicaid programs.

- o First, NIMH is supporting basic research into the effectiveness and cost-effectiveness of various mental health treatment modalities. At present, little is known about which kinds of treatments are most effective for different types of mentally ill patients. Even less is known about the relative cost-effectiveness of alternative treatments.
- o To improve our understanding of cost-effectiveness, NIMH is developing two specialized national research centers that will specifically focus on the "Organization and Financing of Mental Health Services to the Seriously Mentally Ill." The centers will bring together clinical, organizational management and economic specialists for the conduct of cross-disciplinary studies. This initiative has generated considerable interest nationwide, with ten applications received for the first center, to be funded in Fiscal Year (FY) 1987. Subject to the availability of funds, a second center is planned for FY 1988.

Other research efforts include \$2 million available through NIMH in FY 1987 for support of special research on the provision of mental health services to persons with serious mental illness. We hope that an improved knowledge base regarding both treatment effectiveness and cost-effectiveness will facilitate development of sound alternatives to the present system.

- o Secondly, ADAMHA has established a Financing and Reimbursement Steering Committee composed of representatives from NIMH, NIAAA, and NIDA. The Committee will address a broad range of coverage issues related to mental health and substance abuse services. The group's mandate includes reimbursement issues related to both public (Medicare and Medicaid) and private sector policies and, as appropriate, works in collaboration with other parts of the Department, including the Offices of the Assistant Secretary for Health (ASH), the Assistant Secretary for Planning and Evaluation (ASPE), and the Health Care Financing Administration (HCFA). A current initiative is a reexamination of the outpatient psychiatric benefit in the context of evolving high-quality medical practice and implications that may come from the Department's prospective payment and catastrophic initiatives.

4. **QUESTION:** In 1983, HHS and HUD issued a joint report entitled "Federal Efforts to Respond to the Shelter and Basic Living Needs of Chronically Mentally Ill Individuals." This report was the result of several years of collaborative work, and included many sound recommendations. Two of the recommendations were that HCFA and the Social Security Administration would seek to identify and remove barriers that impede State and local efforts in meeting SSI recipients' shelter and basic living needs, and that the Public Health Service would "collaborate with and seek to assist HCFA and SSA in an effort to develop cost-effective policy options for better meeting the needs of this population." What specific actions has HHS undertaken since 1983 to implement these recommendations?

ANSWER: The NIMH Community Support Program (CSP) has supported numerous activities to assist States and communities, as recommended in the report. Among these activities are:

- o Co-funding, with the National Institute on Disability and Rehabilitation Research, Department of Education, a 3-year research and training project at Boston University on rehabilitative residential services. The project has developed a data base to support needed future research, provided telephone and on-site consultation to almost every State, developed several useful technical assistance manuals, and identified and disseminated information nationally on effective residential models and financing mechanisms.
- o Developing a major monograph on the use of private sector financing for housing the population and a manual on housing development issues for family members.
- o Supporting, through a contract with the University of Vermont, intensive consultation to nine States on planning and implementing residential programs. A second major contract is planned for FY 1988.
- o Convening approximately 20 workshops during the past 2 years for State and local mental health staff and family members on effective residential service models and financing issues.
- o Working collaboratively with State mental health commissioners on joint problem solving and information dissemination related to meeting the residential service needs of the population.

In addition to the above, the Program is planning to support in FY 1988, two national research and technical assistance centers focused on residential services for the general long-term mentally ill population including the homeless mentally ill population.

4. QUESTION (continued)

The NIMH Division of Biometry and Applied Sciences has been engaged in a cooperative agreement with the University of Maryland Medical School to conduct an evaluation of the joint Robert Wood Johnson Foundation/HUD/HHS Program for the Chronically Mentally Ill. This joint private/public sector initiative is designed to demonstrate and evaluate model service programs for chronically mentally ill persons in nine of our Nation's largest cities. A primary objective of this collaborative endeavor is to develop urban mental health authorities that will assume clinical, administrative, and fiscal responsibility for the entire chronically mentally ill population within each urban area, including those that are homeless.

5. QUESTION: What national statistics does NIMH collect on mental health and how does this reporting system compare in size and scope, with statistics on physical health collected by the National Center for Health Statistics?

ANSWER: The NIMH Survey and Reports Branch collects national statistics primarily through mail surveys on specialty mental health organizations and the patients they serve; conducts applied demography research; engages in the development and refinement of minimum data sets that serve as standards for the field; and operates the annual National Conference on Mental Health Statistics. Attachment A details representative projects currently being conducted by the Branch.

NCHS is the Federal government's principal general purpose health statistics agency. NCHS collects data on a wide range of health topics through the National Vital Statistics Program, and through an extensive program of interview, examination, provider, and institution based surveys.

The scope of the surveys undertaken by NIMH Survey and Reports Branch focuses primarily on mental health organizations and facilities. Thus, these facilities surveys are not comparable to the range of activities and surveys conducted by NCHS, and any attempt at comparison would be more misleading than instructive.

Attachment A

REPRESENTATIVE PROJECTS FROM THE NATIONAL MENTAL HEALTH STATISTICS PROGRAM

The Survey and Reports Branch collects national statistics on specialty mental health organizations and the patients they serve; conducts applied demography research; engages in the development and refinement of minimum data sets that serve as standards for the field; and operates the annual National Conference on Mental Health Statistics. Representative current projects include:

- ° The 1986 Inventory of Mental Health Organizations and General Hospital Mental Health Services -- A periodic, complete enumeration survey of specialty mental health organizations, designed to collect information on organizational characteristics, programs offered, aggregate patient characteristics, patient movement statistics, staffing, revenues, and expenditures.
- ° The 1986 Client/Patient Sample Survey of Inpatient, Outpatient, and Partial Care Program -- A sample survey designed to collect sociodemographic, clinical, and service information on admissions, terminations, and persons continuing care.
- ° The Inventory of State Prison Mental Health Services -- A complete enumeration survey designed to collect information parallel to that of the 1986 Inventory of Mental Health Organizations and General Hospital Mental Health Services. This survey will be implemented in 1987-88.
- ° Economic Market Behavior of Mental Health Organizations -- A project designed to investigate the impact of demographic and service characteristics of different geographical areas upon the behavior of specialty mental health organizations within those areas.
- ° Health Demographic Profile System -- A series of mental illness risk indicators derived from the decennial U.S. census available for different geographical aggregations from census tracts to States.
- ° Minimum Data Sets for the Mental Health Statistics Improvement Program -- Sets of recommended variables for recording information on organizations, patients, staffing, and finances that are currently being revised. These revisions will be available early in 1988.
- ° 1987 National Conference on Mental Health Statistics -- The 36th annual conference for state mental health statisticians designed to address statistical, research, and policy issues of current interest. Meeting was held in Denver, Colorado on May 17-20, 1987.

6. QUESTION: What specific changes would need to be made in the current NIMH research and statistical reporting program in order to provide nationwide information about the need for community support services, and other gaps in mental health services that were discussed at the May 19 hearing?

ANSWER: With respect to the development of nationwide information about the need for community support services, the National Mental Health Statistics Program has undertaken evaluation studies, under the 1 percent set aside, to pilot test a methodology for estimating the size of the seriously and persistently mentally ill population in the State and local areas. This pilot work has shown considerable promise as a tool for planning the delivery of services to this population.

In order to further refine and assess this methodology, additional research is needed to develop (1) a nationwide indicator system, for application in State and local areas, that defines need for mental health services on the basis of variables provided by the U.S. Bureau of the Census, and (2) the validation of this system using unidentified records from Social Security Administration (SSA) Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) recipient files for persons with mental disorders. The latter system has already been successfully piloted by NIMH.

The Institute's analysis of the organization and adequacy of current mental health service systems is conducted primarily through research project grants and through the recently announced Centers for the study of organization and financing of mental health services to the seriously mentally ill. We anticipate that the statistical indicator system noted above would aid in the identification of gaps in mental health services, but the full development of this system will depend on cooperative funding arrangements with other interested Federal agencies.

7. **QUESTION:** Please provide information about NIMH's dissemination of research findings on the most effective treatment of the violent mentally ill.

ANSWER: The Antisocial and Violent Behavior Branch of NIMH addressed the treatment of the violently mentally ill. It sponsored a workshop in North Carolina in May 1987 and published a monograph topic, "Clinical Treatment of the Violent Person." About 2,000 copies of this monograph were distributed by NIMH, focusing especially on people directly involved in working with the mentally ill and mentally disordered offenders, including the directors of Forensic Mental Health Programs in the States.

Another monograph is now being developed on current knowledge and research directions concerning children and youth who are both emotionally disturbed and aggressive/violent. This monograph is based on the aforementioned NIMH-cosponsored conference on North Carolina's program to identify such youth who do not receive adequate services in least restrictive settings. The program constitutes a unique resource for learning more about the characteristics of these youth, the treatments that seem most effective, and the course of their development.

8. QUESTION: Please provide statistics on the number of NIMH publications for the Antisocial and Violent Behavior Branch for FY 1985 and FY 1986 compared to the number for FY 1980 and FY 1981.

ANSWER: In 1985-1986, the Antisocial and Violent Behavior Branch funded 4 monographs: "The Mentally Disordered Offender" (Seymour Halleck, M.D.), "Clinical Treatment of the Violent Person" (Loren Roth, M.D.), "Developing Juvenile Mental Health Services" (Henry Steadman, Ph.D.), and "Directory of Programs and Facilities for Mentally Disordered Offenders" (Jeffrey Roth, Ph.D. and Charlotte Kerr, Ph.D.).

In 1980-1981, the Branch (then called the Center for Studies of Crime and Delinquency) funded the development and publication of 3 monographs: "Civil Commitment and Social Policy: An Evaluation of the Massachusetts Mental Health Reform Act of 1970" (Louis McGarry, M.D., et al.), "The Clinical Prediction of Violent Behavior" (John Monahan, Ph.D.), and "Future of Crime" (Gresham Sykes, Ph.D.).

9. QUESTION: Please provide the number of technical information visits to States by staff of the Antisocial and Violent Behavior Branch for FY 1980 and FY 1986, and the number of requests for visits that were denied.

ANSWER: The Chief of the Antisocial and Violent Behavior Branch, Dr. Saleem Shah, made six technical assistance visits to State agencies and programs in 1980: Texas, New Mexico, Maine, Oregon, Illinois, and Washington. No requests for technical assistance consultation were denied that year.

In 1986, Dr. Shah made five technical assistance visits: Massachusetts, Ohio, New York, South Carolina, and Colorado. Staff of the Antisocial and Violent Behavior Branch made four technical assistance visits in 1986: Alaska, Indiana, California, and Florida. The Branch was unable to respond to requests for technical assistance from Utah, Wisconsin, Maine, Rhode Island, Oregon, Hawaii, and Guam.

10. QUESTION: What amount of money has been set aside for NIMH evaluations of service programs for FY 1987? What evaluation studies have been funded, how much was spent, and how does the funding level compare with the amount set aside for FY 1985 and FY 1986?

ANSWER: The 1 percent evaluation funds contributed by NIMH are pooled, with other ADAMHA 1 percent funds, within the Office of the Administrator. One-half of this 1 percent pool is available for expenditure by ADAMHA. All ADAMHA evaluation projects which are approved by the Office of the Assistant Secretary for Health and the Office of the Assistant Secretary for Planning and Evaluation for funding, compete for these available funds. Projects are selected for funding based upon their relative priority ranking among the universe of projects eligible for funding.

Three additional evaluation projects (amounting to \$339,500) are eligible for funding later in FY 1987 should funds be available. These projects include: Development of Evaluation Methodologies for Community Support Program Homeless Demonstration Projects; Access and Availability of Services for Severely Emotionally Disturbed Children and Adolescents; and Evaluation Assistance to the Elderly Community Support Program Demonstration Projects.

It is still too early to say what amount of funds will be expended for evaluation projects in FY 1987. For FY 1986, \$203,282 were expended; and for FY 1985, \$387,027 were expended.

11. **QUESTION:** Please describe in detail the current status and ongoing activities of the HHS Homeless Task Force, including but not limited to the number of meetings during FY 1987 compared to FY 1985-86.

ANSWER: The Federal Task Force on the Homeless is currently located in the Office of Community Services (OCS) in the Family Services Administration (FSA), HHS. The Task Force is under the direction of Robert W. Lewis, Deputy Director of OCS. The former Chairman of the Task Force, Harvey Vieth, left the Federal Government May 1. The Vice-Chair is James Stimpson, Deputy Assistant Secretary for Policy Development, Department of Housing and Urban Development. The Task Force is presently staffed by the Deputy Director, two other professionals, and a secretary.

Two meetings of the Task Force have been held in FY 1987; one in October and one in April. Three Task Force meetings were held in FY 1985 and three in FY 1986.

The Task Force works to: 1) identify and coordinate existing Federal resources for use by State, local, and private agencies; 2) cut red tape and remove impediments to the use of Federal resources for the homeless; 3) serve as a broker between Federal agencies and State, local and private agencies; 4) gather and disseminate practical information useful to State and local governments and shelter and soup kitchen providers.

Specific ongoing activities include:

- o Responding with letters, information packages and referrals to 30-75 requests for information and assistance per week;
- o Preparing for implementation of new Clearinghouse activities authorized by the President's FY 1988 budget;
- o Coordinating the transfer of surplus food from Department of Defense Commissaries to food banks around the country.

12. QUESTION: For the past 2 years, NIMH has provided funding support for a national clearinghouse to assist providers working with homeless mentally ill persons. Does NIMH plan continued funding of this project in FY 1988 and FY 1989?

ANSWER: NIMH competitively awarded a 2-year, \$287,174 contract to Macro Systems, Inc., on June 30, 1986, to support CHAMP, the National Clearinghouse on Homelessness Among Mentally Ill People. The contract will terminate on June 29, 1988. Under Federal regulations, this contract cannot be continued or extended after the termination date without being re-competed.

One of the tasks of the second year of the CHAMP contract requires the contractor to develop a long-term funding strategy for the project. After that task is completed, NIMH will assess the need for the project's continuation in relation to the availability of Federal and alternative sources of funding support.

13. QUESTION: What special activities has NIMH undertaken to help States and localities address the unique needs of various subgroups of the homeless mentally ill population such as minorities, families, and substance abusers? Please describe any programs or service systems research regarding these subgroups?

ANSWER: Since 1983, NIMH has supported a broad range of research, service demonstration, and technical assistance projects at the State and local level. These activities have focused on the homeless mentally ill population. Significant samples include:

- o Minorities - Under contract to NIMH, Dr. Marsha Martin of the Hunter College School of Social Work reviewed NIMH-funded research on the homeless mentally ill to assess its implications for ethnic and racial minority persons. This report has been widely disseminated to both researchers and service providers. Additionally, several NIMH-funded researchers have undertaken secondary analyses of their data to also examine its relevance for this subgroup of the homeless mentally ill population.
- o Families - In April, 1987, NIMH convened a workshop to examine the mental health needs of homeless families and children. These national experts helped define the issues relevant to service delivery for this population and made specific suggestions about appropriate mental health interventions.
- o Substance Abusers - In 1985, NIMH awarded a 2-year grant to the University of Maryland Department of Psychiatry to examine the research, training, and service needs of the dually diagnosed population with mental health and substance abuse disorders. The University established a Task Force on this population and has produced a report documenting the problems of the broader population, including those who are homeless.
- o Women - In October, 1986, NIMH convened a colloquium of ethnographic researchers to report on their experience with homeless and less mentally ill women. The findings of this meeting are being finalized and will be widely disseminated to service providers.

13. QUESTION (continued)

Also, NIMH is undertaking service systems research on the homeless mentally ill population. It is funding research on the provision of mental health services to homeless persons who are mentally ill through a grant to Johns Hopkins University. It is cooperating in the evaluation of the Robert Wood Johnson Foundation--U.S. Department of Housing and Urban Development Program for the Chronically Mentally Ill which is funding 9 cities to put in place a system of care for the chronically mentally ill, including the mentally ill who are homeless. This evaluation is jointly funded by the Robert Wood Johnson Foundation and the Federal Government. NIMH is the lead agency for the Federal effort to evaluate the effectiveness of the \$100+ million public-private initiative.

NIMH consults with States and localities on various methodologies for estimating the number and subcategories of homeless persons who are mentally ill and is conducting a state-of-the-art conference on research methodology which will enable more researchers to submit research projects in this area.

14. QUESTION: Please describe the staffing and administration of the rural mental health demonstration projects, including any coordination with other service demonstration programs such as the Community Support Program (CSP) and the Child and Adolescent Service Systems Program (CASSP).

ANSWER: The review of the applications for the rural mental health demonstration will occur in the next few weeks. The program announcement and evaluation plan is being coordinated with the HRSA and USDA, as well as the CSP and CASSP programs within NIMH. We are also coordinating this initiative with the NCHSR rural activities. The staff consists of two project officers, both physicians.

15. QUESTION: When appropriations are approved for the State Mental Health Planning Act of 1986, what staffing is planned for the program?

ANSWER: Present plans call for the assignment of one full-time professional to direct and administer this program.

16. QUESTION: At the May 19 hearing, the Subcommittee heard testimony that SEH patients are often released with no where to go except shelters for the homeless. Since this is a Federal facility, what is HHS doing to prevent this from occurring while SEH is still under Federal control?

ANSWER: The hospital policy is that patients should only be discharged after appropriate after-care planning, which includes arrangements for housing. We have investigated several allegations that the policy was not followed in the past; these allegations received media attention, adding to the misperception of the hospital's policy and practices. Only one such case has been verified; however, this occurred under very specific and unusual circumstances. The others have not been verified.

For example, two local shelters have charged that the hospital discharges patients to them. These charges have been thoroughly investigated and found to be erroneous or without foundation. Contrary to charges by the largest homeless shelter operator, the hospital does not drop patients off one block from the shelter. The largest homeless shelter for women presented a list of 118 persons they believed were present or former patients of SEH; the hospital reviewed its records and determined that only 18 from the list were known by St. Elizabeths, of which only 3 had contact with the hospital during the preceding 6 months.

Obviously, a serious problem exists because of these misperceptions. In addition, if a voluntary patient leaves the hospital precipitously (within 48 hours after request) against medical advice, she or he may not have adequate after-care. The law prohibits holding voluntary patients against their wishes and prohibits changing their status as inpatients from voluntary to an emergency or committed status while they are voluntary inpatients.

We recognize there is a legitimate need for psychiatric services for many of the homeless population. Discharges of patients from St. Elizabeths who no longer need active psychiatric care in an institutional setting number almost 3,000 per year. The majority of these individuals do return to their homes, to their families, and to their jobs as productive citizens. Occasionally, when support and services are not available, rehospitalization may be required, and the more unfortunate may end up among the homeless population. Addressing this problem is of high priority to the hospital and to the National Institute of Mental Health. We believe the solution requires a commitment and collaboration of local government, private and philanthropic organizations, and community based health and mental health systems. An extensive array of health, mental health, housing and social services are required to meet the needs of the homeless population. We will continue our efforts to provide technical assistance, consultation and collaboration both at the Institute and the hospital to address this difficult problem which exists throughout the Nation.

17. QUESTION: In order for psychiatric hospitals to be eligible for Medicare and Medicaid reimbursement, they must be accredited by the Joint Commission on Accreditation of Hospitals (JCAH). St. Elizabeths will lose its JCAH accreditation when it is transferred to D.C., and will then reapply for accreditation. This could take at least several months, and, in the meantime, patients will not be eligible for Medicare and Medicaid reimbursement. What steps has ADAMHA taken to prevent this loss of coverage?

ANSWER: ADAMHA and District officials are working together to assure that the Joint Commission on Accreditation of Hospitals (JCAH) will provide an extension to the accreditation of Saint Elizabeths Hospital and its affiliated programs until such time as a survey of these programs, operated by the new Commission on Mental Health Services, can be conducted during the first half of FY 1988. At the present time, after a series of discussions with representatives of JCAH, Medicare, Medicaid, and the D.C. Department of Consumer and Regulatory Affairs, we are confident that accreditation and necessary certification will be uninterrupted.

There has been a great deal of confusion surrounding the continued certification and accreditation of the components of the newly created Commission on Mental Health Services. While it is possible that the JCAH may issue a technical disaccreditation on the change of ownership of a hospital, this type of disaccreditation would have no immediate bearing on Medicare or Medicaid certification. Medicare and Medicaid are prohibited from withholding certification based on a change of ownership unless the new owner requests removal from the entitlement programs.

Medicare certification for psychiatric facilities can be based on JCAH accreditation. Usually, Medicare conducts an independent survey of two special conditions, adequacy of staffing and patient records. Inasmuch as the transfer involves responsibility for St. Elizabeths' patients, programs, staff and facilities, we expect Medicare will make a new determination based on a survey of the D.C. Commission on Mental Health Services.

18. QUESTION: What is the current status of NIMH's search for a director?

ANSWER: The search committee met on June 22 and 23 to conduct interviews with the 14 candidates certified as highly qualified. Of the 14, 4 are Federal employees and 10 are from outside the government. Two of the 14 are psychologists; the rest are psychiatrists. Two candidates are female, one of whom is also a minority. In the interim, Dr. Frank Sullivan, Deputy Director, NIMH, has been serving as Acting Director.

19. QUESTION: In 1986, OMB disapproved a NIMH study proposal entitled "Mental Health Utilization and Reimbursement Patterns Survey," and in FY 1985, OMB disapproved a study entitled "ADM Knowledge Outcome of Primary Care Residents." Please provide the Subcommittee with the research protocols for these studies, the Initial Review Group documents, and all other HHS and OMB documents regarding these proposals. Include any information about plans to resubmit these proposals to OMB.

ANSWER: Requested documents are attached. NIMH has no plans to resubmit these projects given the OMB response.

20. QUESTION: Please submit the information regarding the number of mental health professionals that are trained to work with the homeless mentally ill and the elderly mentally ill, referred to on pages 118-119 of the hearing transcript.

ANSWER: Homeless Mentally Ill--Information on actual numbers of students being trained to work with the homeless mentally ill under NIMH training grants is not available. Unfortunately, progress reports provided by NIMH training grantees do not include specific information on the numbers of students influenced by grants supporting faculty development and specialized curricula.

However, many of the NIMH disciplinary training grants focus on the preparation of graduate mental health professionals to work with the homeless mentally ill population. For example, one of the four psychiatric nursing clinical training grantees addressing the mentally ill homeless has developed a new course which focuses on case finding, case management, and patient advocacy for the mentally ill who are homeless. Clinical practice sites for students include shelters, soup kitchens, and mobile crisis units. Both social work and psychology training programs contain training projects addressing rural mentally ill homeless persons. Another social work project addresses minority mentally ill homeless persons.

Mentally ill older persons--Through 1986, the NIMH supported training of 157 fellows for work with mentally ill older persons. These fellows, 91 post-residency in psychiatry, 55 post-doctoral in psychology, 11 post-masters in social work and nursing have taken the following positions:

- 60 percent academic
- 34 percent general hospital, VA, community mental health, state hospital
- 6 percent private practice

Currently the NIMH is supporting the training of 65 fellows for work with mentally ill older persons. This includes 36 psychiatrists, 23 psychologists, and 5 social workers. In addition, the NIMH is providing stipends for 9 psychology interns or doctoral students, 18 nursing students, and 18 social work students to work with this population.

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ONE HUNDREDDTH CONGRESS

Congress of the United States

House of Representatives

HUMAN RESOURCES AND
 INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
 OF THE
 COMMITTEE ON GOVERNMENT OPERATIONS
 RAYBURN HOUSE OFFICE BUILDING, ROOM 8-372
 WASHINGTON, DC 20515
 (202) 225-2648

July 10, 1987

The Honorable Ian Macdonald, M.D.
 Administrator
 Alcohol, Drug Abuse, and Mental Health
 Administration
 5600 Fishers Lane
 Rockville, Maryland 20857

Dear Mr. Administrator:

I am writing to request responses to four questions in my June 5, 1987, letter, which were not adequately answered in your letter of June 22.

In Question #5, I asked about the size and scope of national statistics gathered by NIMH on mental health. The response did not include information about the size, and only vague information about the scope of such statistics. Please provide specific information about the number of surveys, the samples involved, the specific information gathered, and the data analyses conducted.

In Question #10, which pertained to evaluations of NIMH service programs, I asked "What evaluation studies have been funded, how much was spent, and how does the funding level compare with amount set aside for FY 1985 and FY 1986?" The response essentially said that it was too soon to tell, since the year is not over yet. I am well aware that FY 1987 is not over yet, but request that the response include information about how much money was spent through the third quarter of FY 1987, and exactly what the spending plans are for the remainder of FY 1987.

In Question #14, I asked about the coordination between rural mental health demonstration projects and other service demonstration programs, such as CSP and CASSP. The response provided merely says they are coordinated, but provides no information about this coordination. Please describe any coordination activities, such as meetings, within NIMH, or within the States, that have taken place as of June 1, 1987, or since then.

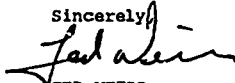
The Honorable Ian Macdonald, M.D.
July 10, 1987
Page Two

In your response to Question #16, you state that HHS has investigated accusations that St. Elizabeth's patients have been released to shelters for the homeless, and that "These charges have been thoroughly investigated and found to be erroneous or without foundation." Please provide documentation and other information about these investigations.

I would appreciate receiving these materials by July 20, 1987. If there are any questions about the information that we are requesting, please contact Dr. Diana Zuckerman of the subcommittee staff.

Thank you again for your cooperation.

Sincerely,



TED WEISS
Chairman



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

The Honorable Ted Weiss
Chairman, Subcommittee on Intergovernmental
Relations and Human Resources
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing in response to your letter of July 10, 1987, in which you requested supplementary information concerning four specific answers from our original submission of twenty answers submitted on June 5.

Please find enclosed the additional information you requested including relevant documentation concerning each of these questions. I regret any inconvenience that this may have caused in completing the hearing record.

Sincerely,


Donald Ian Macdonald, M.D.
Administrator

Enclosures

Answer Number 5, Revised
Answer Number 10, Revised
Answer Number 14, Revised
Answer Number 16, Revised

Additional information to question #5

Attachment A (expanded from the earlier submission) details representative projects currently being conducted by the Survey and Reports Branch, NIMH. In 1986 the NIMH conducted two major surveys (referred to as items 1 and 2, Attachment A), each of which is described below:

The latest biennial inventory of Mental Health Organizations and General Hospital Mental Health Services covered fiscal year 1986. It included approximately 4,000 specialty mental health organizations known to NIMH. Results are currently being compiled. The inventory provides overall descriptive information about specialty mental health service organizations both for a given year and trend data for comparisons with previous years. Analyses include numbers of persons served, brief demographic and clinical characteristics of the persons served, staffing information, and revenue and expenditure data that are presented by major program type (e.g., inpatient, outpatient, etc.), type of ownership, as well as by State. The information is reported for each of these program characteristics.

The most recent Client/Patient Sample Survey covered approximately 25,000 patients served during a sampling period in fiscal year 1986. Patients admitted, under care, and terminated from inpatient, outpatient, and partial hospitalization/day care programs were sampled. The sample permits the estimation of the count of persons served within such program types. Detailed data on their demographic characteristics, clinical profiles (diagnoses, sources of referral, prior mental health care), and types of services received. The data represent both the 1986 time period and permit contrasts with the previous sample survey data, collected approximately every five years. Analyses are conducted for particular cohorts of patients (e.g., elderly, schizophrenic, those continuing under care, terminations, etc.) as well as for the full sample which produces estimates for the United States.

Attachment A

REPRESENTATIVE PROJECTS FROM THE NATIONAL MENTAL HEALTH STATISTICS PROGRAM

The Survey and Reports Branch collects national statistics on specialty mental health organizations and the patients they serve; conducts applied demography research; engages in the development and refinement of minimum data sets that serve as standards for the field; and operates the annual National Conference on Mental Health Statistics. Representative current projects include:

1. The 1986 Inventory of Mental Health Organizations and General Hospital Mental Health Services -- A periodic, complete enumeration survey of specialty mental health organizations, designed to collect information on organizational characteristics, programs offered, aggregate patient characteristics, patient movement statistics, staffing, revenues, and expenditures. The survey included approximately 4,000 specialty mental health organizations.
2. The 1986 Client/Patient Sample Survey of Inpatient, Outpatient, and Partial-Care Programs -- A sample survey designed to collect sociodemographic, clinical, and service information on admissions, terminations, and persons continuing care. The survey included approximately 25,000 sample patients.
3. The Inventory of State Prison Mental Health Services -- A complete enumeration survey designed to collect information parallel to that of the 1986 Inventory of Mental Health Organizations and General Hospital Mental Health Services. This survey will be implemented in 1987-88 and will include approximately 950 State prisons.
4. Economic Market Behavior of Mental Health Organizations -- A project designed to investigate the impact of demographic and service characteristics of different geographical areas upon the behavior of specialty mental health organizations within those areas.
5. Health Demographic Profile System -- A series of mental illness risk indicators derived from the 1980 decennial U.S. census available for different geographical aggregations from census tracts to States. A similar system is planned for the 1990 census.
6. Minimum Data Sets for the Mental Health Statistics Improvement Program -- Sets of recommended variables for recording information on organizations, patients, staffing, and finances that are currently being revised. These revisions will be available early in 1988.
7. 1987 National Conference on Mental Health Statistics -- The 36th annual conference for State mental health statisticians designed to address statistical, research, and policy issues of current interest. Meeting was held in Denver, Colorado on May 17-20, 1987.

Additional information to question #10

One Percent Evaluation Program:

The NIMH sets aside up to one percent of the funds allocated for research (both extramural and intramural), and research training, for evaluation activities (Section 2313, Public Health Service Act).

In FY 1987 to date, \$119,500 has been committed or obligated for evaluations of services research, training, or demonstration Programs. (Some awards are not scheduled until the 4th quarter of the fiscal year.) The funds will support the project - Evaluation of the Utility of National Reporting Programs (NRP) Data for Local Facilities. An additional \$96,000 has been authorized for FY 1987 obligation for the Development of Evaluation Methodologies for Community Support Program Homeless Demonstration Projects.

A comparison of NIMH expenditures of 1 percent funds for services-related research amounted to \$387,027 in FY 1985, \$203,282 in FY 1986, and an expected \$215,500 in FY 1987. Therefore, projected FY 1987 expenditures are slightly above the FY 1986 level but somewhat below the FY 1985 level.

Other Services-related Evaluation Activities:

The NIMH also funds evaluations as integral components of its services activities.

CSP -- Ten percent, or approximately \$97,000, of the funds awarded to the 17 CSP demonstration projects funded in FY 1987 is earmarked for evaluation of the projects. Another CSP evaluation project being conducted in FY 1987 (cost: \$25,000) is the development of a monograph on evaluation methodologies for local psychosocial rehabilitation programs. The monograph will be disseminated to each State shortly. In addition, approximately \$150,000 is planned to be earmarked for evaluation, in association with Project awards to be made in September 1987, to approximately 12 new demonstration projects for the young adult with mental illness and substance abuse problems.

CASSP -- CASSP projects are evaluated by project staff, using uniform self-assessment instruments developed by NIMH. In addition, \$60,000 of FY 1987 funds are obligated to conduct a feasibility study to evaluate systems-level change from the perspective of parents of seriously emotionally disturbed children.

There were no evaluation Projects funded by CSP in FY 1985. In FY 1986, \$159,000 of CSP funds was used to evaluate the 13 CSP demonstration projects funded in that year.

Additional information to question #14

In Fiscal Year 1986, the National Institute of Mental Health cosponsored with the Council of State Governments two regional meetings on the psychological problems being experienced by rural Americans living in States affected by the farm economy. The meetings brought together mental health and agriculture officials at Federal, State, and local government levels; national mental health and agricultural organizations; researchers; and providers to share knowledge, assess the extent of mental health problems in rural areas, and recommend policy and program directions to local, State, and Federal governmental levels. The first meeting was attended by representatives from 17 mid-western States; the second concentrated on the southeastern States and was represented by over 30 States. A series of recommendations for State, county, and Federal actions were generated at each meeting. The input and recommendations from these meetings helped shape the content of the Institute's Rural Mental Health Demonstration Program.

The Division of Biometry and Applied Sciences (DBAS) administers this program. The Division of Education and Service Systems Liaison (DESSL), which administers the CSP and CASEP programs, participated in the design and scope of the grant activities and preparation of the announcement. The USDA and HRSA were also consulted in the development and implementation of the program.

In addition, the Institute has a contract with the National Association of Counties (NACo) to provide information and consultation on rural mental health service planning, organization, and delivery to county officials in seven States affected by the farm economy. The contract is designed to assist county officials in understanding the mental health needs of their rural residents and to become knowledgeable about existing program models which they could replicate in their counties. In addition, the association is compiling a profile of the rural mental health service delivery needs in these seven States. These contract activities are coordinated with the relevant NIMH Divisions and their ongoing programs.

Additional information to question #16:

A September 22, 1986 letter, addressed "To Whom it May Concern," was sent to St. Elizabeth's Hospital (SEH) on behalf of 6 local shelters stating the shelters' policy not to accept discharges from psychiatric facilities and, by implication, alleging improprieties in SEH's discharge practices. SEH requested that the shelters provide specific information which could then be checked; the House of Ruth submitted a list of 104 names of "women who have stayed at the House of Ruth in 1986, and who have previously been treated at St. Elizabeth's Hospital." At that time and, again, subsequent to the Committee's July 10 request for documentation, SEH staff reviewed its patient data base. The second review of all available documentation indicated that only 34 of the 104 were former (1980-1986) patients at SEH. An additional 13 names provided by the House of Ruth were possible matches. A November 6, 1986 letter from SEH (Attachment A) requested further information to assist in the verification of these 13 names; however, no response was received.

Meanwhile, SEH staff conducted a detailed review of the patient records for 30 of the 34 individuals who were known "matches"; the patient records of the remaining four individuals were not available for review at that time. This review indicated that SEH was only aware of 2 (of the 30) individuals having gone to shelters following discharge. Both of these individuals were well-known to the shelters as habitual shelter users and were discharged with the full knowledge and consent of the shelters. One of these individuals was continued as an active case by SEH staff after discharge with the cooperation of the shelter. Attachment B is a summary of the records review; the names and SEH identification numbers have been blacked out for confidentiality.

A November 6, 1986 letter (Attachment C) from SEH's Chief Clinical Advisor invited the shelters' representative to a meeting to discuss these issues further. The letter states: "If individuals are being sent by staff as an outplacement, we can certainly stop this." SEH staff have met on several occasions with shelter representatives, in a continuing effort to forge productive collaborations. In the Winter of 1986 another shelter spokesman charged to local television stations that SEH was dropping patients off near shelters each night in vans. An SEH official contacted the spokesman to request specific details regarding the spokesman's allegations; however, none were provided.

Further information on SEH policy with regard to admissions and discharges and its relationship to shelters is provided as Attachment D; it is a statement by William G. Prescott, M.D., in an appearance before the Senate Committee on Appropriations (Subcommittee on the District of Columbia), January 23, 1985.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTE OF MENTAL HEALTH
WASHINGTON, D.C. 20032

Q.16 Attachment C

November 6, 1986

SAINT ELIZABETHS HOSPITAL

Celeste T. Valente, MSW
Mt. Carmel House
471 G Place, N.W.
Washington, D.C. 20001

Dear Ms. Valente:

I am writing in response to your letter of September 22, 1986 addressed "To Whom It May Concern" regarding the homeless mentally ill. As Chief Clinical Advisor of Saint Elizabeths Hospital and as a psychiatrist I have been concerned with this issue for some time. As I am sure you are aware, staff at Saint Elizabeths Hospital have worked many, many years to assure appropriate community placements for patients who no longer need hospital care. This is sometimes a difficult task.

I am pleased that we can meet to discuss this issue further on December 2, 1986 at 2:00 p.m. I hope that meeting can lead to a productive collaboration on issues of mutual concern.

Meanwhile, in order for us to address the immediate issue of individuals leaving Saint Elizabeths Hospital for shelters we must know the specifics of such situations. If individuals are being sent by staff as an outplacement, we can certainly stop this. If, on the other hand, individuals are voluntarily leaving and coming to a shelter, the solution will be much more complex. Please convey any such specifics to Mr. Arthur E. Scarpelli, Director, Dixon Implementation Division, Saint Elizabeths Hospital.

Sincerely,

Bernard S. Arons, M.D.
Chief Clinical Advisor
Saint Elizabeths Hospital



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

Statement of
William G. Prescott, M.D.,
Superintendent, Saint Elizabeths Hospital,
for United States Senate,
Committee on Appropriations,
Subcommittee on the District of Columbia
on
January 23, 1985

202

Senator Specter and Members of the Subcommittee:

Thank you for the opportunity to appear before you today. I am William G. Prescott, Superintendent of Saint Elizabeths Hospital and have been in that position for slightly more than one year. I am a career officer in the Commissioned Corps of the Public Health Service and have served in a variety of posts; most recently, before Saint Elizabeths Hospital, I directed the Cuban-Haitian Refugee Mental Health Program. Prior to that I was in charge of psychiatric services at the Public Health Services Hospital in San Francisco.

My colleague, Mr. Stockdill, has already presented national information. I wish to inform you briefly on current practices at Saint Elizabeths Hospital and on some of the efforts underway jointly with the District of Columbia to develop a single, unified mental health system in the District for operation by the District government beginning in October, 1987.

At Saint Elizabeths Hospital, admissions come primarily under the D.C. law known as the Ervin Act (21 D.C. Code 501 et seq) which provides for voluntary admissions, emergency admissions, and court ordered indefinite commitments. Under the terms of the statute, the court may commit only if there is likelihood of injury to self or others because of mental illness. Commitment may be to an appropriate setting, other than Saint Elizabeths; thus there may be commitments to nursing homes or to outpatient treatment depending on the patient's needs.

Voluntary admissions do not have to meet the standard of dangerousness but the person seeking admission must be in need of inpatient services for mental illness or eligible to register as a District patient at the Area D Community Mental Health Center operated by Saint Elizabeths Hospital. Emergency admissions — frequently brought in by the police — must by law be discharged within strict time limits unless the Hospital seeks commitment or the patient becomes voluntary.

Court committed patients are not permitted to leave the hospital except on either temporary or convalescent leave; however voluntary patients may sign themselves out—that is choose to leave against medical advice. Both voluntary patients and committed ones do sometimes leave without authorization. For committed patients who are still considered dangerous, a warrant for their return is sought. Voluntary patients who sign themselves out must be released within 48 hours.

Most who leave the hospital do so, however, because they are discharged either because they no longer need psychiatric treatment or no longer need treatment in an inpatient setting and are planning to receive outpatient treatment elsewhere, or because they are placed on outpatient status — called convalescent leave at Saint Elizabeths. (Let me state parenthetically here that the process I have been describing refers only to civil patients — it does not include forensic patients whose admission and discharge is controlled by the courts.)

What does this brief description of patients entering and leaving Saint Elizabeths Hospital have to do with shelters and the homeless? There are several important points:

- 1) The Hospital is, by law, prohibited from admitting persons unless they need inpatient psychiatric treatment.

2) Persons who cannot be admitted may on occasion be given a shelter address if they have no other place to go.

3) The Hospital can not legally keep persons against their will if they do not meet commitment standards.

4) Many voluntary patients do leave against medical advice and some of those may go to shelters. .

5) It is not Hospital policy to discharge a patient to a shelter or to the streets.

6) Hospital policy requires aftercare planning which includes careful attention to the living arrangements for those leaving inpatient treatment.

Research done by Hospital staff shows that many persons in the shelters in the District do have a history of some former contact with Saint Elizabeths Hospital and/or the District mental health services, but there has been little evidence that persons go directly from the Hospital to the shelters or the streets. It also shows that a large portion of those in shelters are mentally ill and could benefit from treatment but not necessarily from inpatient hospitalization.

We are continuing our efforts to learn more about people in the shelters and on the streets so that Saint Elizabeths Hospital may be appropriately involved in providing mental health services. Some Saint Elizabeths Hospital physicians currently volunteer on their own time to provide services in the shelter. The Hospital is arranging for psychiatric residents to work with the District to provide services for the homeless mentally ill under supervision in locations selected by the District. Finally we are extensively involved with the District in planning for the District to assume authority over the entire mental health services system in October, 1987. That planning effort is specifically mandated to consider what is needed for the homeless and will do so. I feel that we have the opportunity to develop solutions for this complex problem which recognizes and makes services available to meet the mental health needs of the homeless in the District. Again, thank you for the opportunity to appear. I will be happy to answer your questions.

APPENDIX 2.—MATERIAL REGARDING THE DISTRICT OF COLUMBIA
MENTAL HEALTH SYSTEM REFERRED TO IN HEARING RECORD

STATEMENT OF

ROBERT A. WASHINGTON, PH.D.
COMMISSIONER-DESIGNATE
COMMISSION ON MENTAL HEALTH SERVICES

DISTRICT OF COLUMBIA

BEFORE THE

COMMITTEE ON GOVERNMENT OPERATIONS

SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS

U.S. HOUSE OF REPRESENTATIVES

May 19, 1987

(202)

GOOD MORNING MR. CHAIRMAN, I AM ROBERT WASHINGTON, COMMISSIONER-
 DESIGNATE OF THE DISTRICT OF COLUMBIA'S COMMISSION ON MENTAL
 HEALTH SERVICES AND I AM PLEASED TO SPEAK TO YOU REGARDING NIMH'S
 LEADERSHIP ROLE IN ASSISTING STATES AND COMMUNITIES IN PROVIDING
 APPROPRIATE SERVICES FOR THE MENTALLY ILL.

HISTORICALLY, NIMH HAS PLAYED AN AGGRESSIVE AND VERY HELPFUL
 LEADERSHIP ROLE THROUGH ITS GRANTS AND TECHNICAL ASSISTANCE
 PROGRAMS. COMMUNITY SUPPORT PROJECT (CSP; AND HUMAN RESOURCE
 DEVELOPMENT (HRD) GRANTS HAVE ENABLED STATES TO APPROACH THE
 TREATMENT OF THE SEVERELY MENTALLY ILL IN A SYSTEMATIC AND
 CONCEPTUALLY SOUND MANNER. TECHNICAL ASSISTANCE IN SUCH AREAS
 AS DATA COLLECTION AND ANALYSIS, OUTCOME EVALUATION,
 MINORITY CONCERNS, AND VIOLENT BEHAVIOR HAS BEEN OF IMMENSE
 VALUE. THAT IS NOT TO SAY THAT MORE SHOULDN'T AND COULDN'T BE
 DONE IN THESE AND OTHER AREAS. CHILDREN'S SERVICES, FORENSIC
 SERVICES, AND SERVICES TO THE ELDERLY ARE BUT THREE AREAS WHERE
 MUCH MORE NEEDS TO BE DONE.

UNFORTUNATELY, IN RECENT YEARS, NIMH'S MOMENTUM HAS SLACKENED
 IN THE FACE OF SEVERE BUDGET CUTS. THIS MUST BE REVERSED SO
 THAT NIMH CAN MAINTAIN AND INCREASE ITS LEADERSHIP ROLE AND CAN
 CONTINUE TO ASSIST STATES IN DEVELOPING THEIR MENTAL HEALTH
 DELIVERY SYSTEMS TO BETTER MEET THE MENTAL HEALTH NEEDS OF
 OUR CITIZENS.

SPECIFICALLY, I JOIN OTHERS IN RECOMMENDING INCREASED FUNDING IN THE NIMH RESEARCH BUDGET TO SUPPORT THE DEVELOPMENT OF MENTAL HEALTH SERVICE RESEARCH CENTERS AND RESEARCH ON THE FINANCING AND DELIVERY OF CARE. PROPOSALS FOR SUCH CENTERS ARE NOW BEING REVIEWED, AND FUNDING IS AVAILABLE FOR ONE. FUNDS ARE RECOMMENDED TO SUPPORT ADDITIONAL CENTERS IN FY 88, AND FOR RESEARCH GRANTS ON SERVICE SYSTEM STUDIES.

NIMH DEVOTES A CONSIDERABLE PORTION OF ITS RESEARCH GRANTS BUDGET TO STUDIES OF CLINICAL TREATMENT BUT LESS THAN 1% OF THE RESEARCH GRANTS IN FY 1986 (\$1.35 MILLION) SUPPORTED WORK THAT EXAMINED THE FINANCING AND DELIVERY SYSTEMS THAT PROVIDE SUCH CARE. THERE ARE SIGNIFICANT OPPORTUNITIES NOW AVAILABLE TO STUDY THIS ASPECT OF MENTAL HEALTH SERVICES INCLUDING THE USE OF MEDICAID WAIVERS, THE \$42 MILLION DEMONSTRATION PROJECTS SUPPORTED BY THE ROBERT WOOD JOHNSON FOUNDATION FOR SERVICES TO THE CHRONICALLY MENTALLY ILL, AND VARIOUS ALTERNATIVES TO TRADITIONAL MODELS OF SERVICE DELIVERY THAT USE CASE MANAGEMENT, UTILIZATION REVIEW, AND OTHER FORMS OF COST-CONSCIOUS SERVICE DELIVERY MECHANISMS.

ALSO, ADDITIONAL FUNDING IS NEEDED TO INCREASE SUPPORT FOR THE MINORITY RESEARCH CENTERS. SERVICE DELIVERY ISSUES POSE SPECIAL COMPLEXITIES FOR MINORITY GROUPS. ADDITIONAL SUPPORT FOR THE

EXISTING MINORITY RESEARCH CENTERS SHOULD ENHANCE THEIR ABILITY TO ADDRESS THESE ISSUES. FOR THE DISTRICT OF COLUMBIA THIS IS AN AREA OF PARTICULAR IMPORTANCE.

I APPRECIATE YOUR INTEREST AND HOPE THAT YOU WILL FIND THE MEANS TO ENHANCE NIMH'S LEADERSHIP ROLE IN ASSISTING STATES TO DEVELOP SYSTEMATIC APPROACHES TO THE DELIVERY OF MENTAL HEALTH SERVICES.

TED WRESS NEW YORK, CHAIRMAN
THOMAS C. SWANSON OHIO
JOHN COFFEY JR. INDIANA
HENRY A. WALLACE CALIFORNIA
BARRY FRANK MASSACHUSETTS

JIM LIGHTFOOT IOWA
ERNEST L. BOWEN CALIFORNIA
JAMES H. HENRY OKLAHOMA

ONE HUNDRETH CONGRESS

Congress of the United States

House of Representatives

HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE
COMMITTEE ON GOVERNMENT OPERATIONS
RAYBURN HOUSE OFFICE BUILDING, ROOM B-372
WASHINGTON, DC 20515
(202) 226-2848

May 29, 1987

Robert Washington, Ph.D.
Acting Administrator
Commission on Mental Health Services
1875 Connecticut Avenue, N.W., Suite 1130
Washington, D.C. 20009

Dear Dr. Washington:

I regret that you were unable to provide testimony at the subcommittee's May 19 hearing on the Federal role in providing services for the mentally ill.

For the hearing record, please answer the following questions as specifically and completely as possible. I would appreciate receiving your responses by June 8, 1987.

1. According to a report that was issued by the Public Citizen Health Research Group last year, D.C. spends \$176 each year per capita on mental health services, more than twice as much as New York State, and five times as much as the average State. Nevertheless, according to the report, D.C. has relatively poor services, especially for outpatient community care. What kind of Federal assistance could improve the situation in Washington?

2. At the May 19 hearing, we heard testimony about St. Elizabeth's patients being dumped in homeless shelters. When the responsibility for St. Elizabeth's Hospital is transferred from the Federal Government to D.C., what will you do to prevent the dumping of former patients into shelters?

3. How many mentally ill people living in shelters were placed in permanent community housing in D.C. in FY 1986? Of those people who were released from the hospital and placed in housing, how many remain in that housing?

Robert Washington, Ph.D.
May 29, 1987
Page Two

4. According to the plan for transferring St. Elizabeth's Hospital from the Federal Government to D.C., 500-800 patient beds will be eliminated over the next 5 years, but only about 200 community units are planned to replace them. Since there are already hundreds of homeless mentally ill people on the streets of D.C., what will happen to the additional approximately 500 people who will no longer be served at St. Elizabeth's?

5. In most States, mentally ill people who are judged to be dangerous to themselves or others are involuntarily committed to a psychiatric hospital. In Washington, mentally ill people who are found to be dangerous to themselves and others by the Commission on Mental Health are sometimes returned to their homes if they promise to seek treatment. Can you provide us with statistics on how often that happens, and explain why D.C. does not consider that to be sufficient reason to require inpatient care?

6. When St. Elizabeth's becomes a D.C. facility, it will lose its accreditation by the Joint Commission on the Accreditation of Hospitals, and have to reapply. In the meantime, for at least a few months, patients' care will not be reimbursable by Medicaid or Medicare. What will be done to provide funding for those patients?

Thank you in advance for your cooperation.

Sincerely,



TED WEISS
Chairman



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
WASHINGTON, DC 20002

JUL 7 1987

OFFICE OF THE DIRECTOR

Mental Health Services
Administration
Suite 1130
1875 Connecticut Avenue, N.W.
Washington, D.C. 20009
(202) 673-7783

Honorable Ted Weiss
Chairman, Human Resources and
Intergovernmental Relations
Subcommittee
Rayburn House Office Building,
Room B-372
Washington, D.C. 20515

Dear Representative Weiss:

Unfortunately, I was unable to provide oral testimony at the Subcommittee's May 19th Hearing because of the necessity of my presenting testimony on the deficiencies in the Department of Health and Human Services budget for Saint Elizabeths Hospital before the House Appropriations Subcommittee on the District of Columbia on that same day.

I appreciate the opportunity to place the answers to the questions contained in your letter of May 29, 1987 in the hearing record. The answers are:

1. Question:

According to a report that was issued by the Public Citizen Health Research Group last year, D.C. spends \$176 each year per capita on mental health services, more than twice as much as New York State, and five times as much as the average State. Nevertheless, according to the report, D.C. has relatively poor services, especially for the outpatient community care. What kind of Federal assistance could improve the situation in Washington?

Answer:

The relatively poor services, especially for outpatient community care, provided in Washington, D.C. in the past are currently being improved. It is my expectation that

with the implementation of the new Community-Based Mental Health System, the District's outpatient community care will become a model for the nation. Federal assistance through planning grants, community support project (CSP) and human resource development (HRD) grants, and technical assistance in such areas as data collection and analysis, outcome evaluation, minority concerns, violent behavior, children's services, forensic services, and services to the elderly will be especially helpful in making this happen.

2. Question:

At the May 19 hearing, we heard testimony about St. Elizabeths' patients being dumped in homeless shelters. When the responsibility for St. Elizabeths' Hospital is transferred from the Federal Government to D.C., what will you do to prevent the dumping of former patients into shelters?

Answer:

The dumping of patients into homeless shelters is currently against hospital policy. This policy will be enforced more strictly following the transfer of the hospital to the District government on October 1, 1987. Of course, there is nothing to prevent patients from choosing to go to homeless shelters and a few will undoubtedly continue to do so. In the meantime 469 independent living slots (case management) have been contracted for beginning in late January, 1987. As of the end of April, 152 slots were still to be filled. All are expected to be filled by September 30, 1987. An additional 200 slots will be contracted in fiscal year 1988. Also, 200 slots have been activated in 1987 through the District operated community mental health outreach units.

3. Question:

How many mentally ill people living in shelters were placed in permanent community housing in D.C. in FY 1986? Of these people who were released from the hospital and placed in housing, how many remain in that housing?

Answer:

Unfortunately, your question cannot be answered. The data collection and tracking systems are not able to provide this information for Fiscal Year 1986. In the future, this will be corrected.

4. Question:

According to the Plan for transferring St. Elizabeths' Hospital from the Federal Government to D.C., 500-800 patient beds will be eliminated over the next 5 years, but only about 200 community units are planned to replace them. Since there are already hundreds of homeless mentally ill people on the streets of D.C., what will happen to the additional approximately 500 people who will no longer be served at St. Elizabeths?

Answer:

Placements will be found for all of the additional 500 patients that you have identified. 150 will be placed in a transitional community residential facility (CRF) on the hospital grounds, 150 in a nursing home on the hospital grounds, 68 in a transitional facility for mentally retarded persons, 100 in apartments being renovated by the D.C. Department of Housing and Community Development, and the remaining are expected to return to their own homes. In addition, some of the housing slots discussed in the answer to question 2 could be utilized for this population.

5. Question:

In most States, mentally ill people who are judged to be dangerous to themselves or others are involuntarily committed to a psychiatric hospital. In Washington, mentally ill people who are found to be dangerous to themselves or others are sometimes returned to their homes if they promise to seek treatment. Can you provide us with statistics of how often that happens, and explain why D.C. does not consider that to be sufficient reason to require inpatient care.

Answer:

The civil commitment process is a legal process used in all states and the District to involuntarily commit

patients. The legal requirements for commitment and discharge vary from state to state. Some jurisdictions provide for outpatient as well as inpatient commitment for those patients whose dangerousness can be clinically managed on an outpatient basis. In the District, no patient who has been involuntarily committed as an inpatient is discharged until dangerousness is found to be no longer present in the judgment of clinicians.

6. Question:

When St. Elizabeths becomes a D.C. facility, it will lose its accreditation by the Joint Commission on the Accreditation of Hospitals, and have to reapply. In the meantime, for at least a few months, patients' care will not be reimbursable by Medicaid or Medicare. What will be done to provide funding for these patients.

Answer:

Accreditation and federal reimbursement are not directly related. Certification for federal reimbursement is not dependent on accreditation nor is it automatic with accreditation, although most of the elements of both are similar or identical. Further, accreditation at Saint Elizabeths can be administratively extended, pending re-survey, for up to six months after the transfer to the District. Such an extension will be sought and is expected to be granted. Medicare certification does not terminate on transfer of ownership and will continue regardless of extension of accreditation.

Thank you for this opportunity to go on record.

Sincerely,

Robert A. Washington

Robert A. Washington, Ph.D.
Acting Administrator, MHSA
Commissioner Designate, CMHS

DC Advocates for the Mentally Ill Homeless
19 Eye Street, Northwest
Washington, D.C. 20001

October 9, 1987

Ted Weiss, New York, Chairman
Congress of the United States
House of Representatives
Committee on Government Operations

Dear Mr. Chairman,

We are writing at this time to reiterate our previous testimony regarding the problem revolving around the mentally ill who are now homeless and residing in shelters.

As service providers we continue to see large numbers of mentally ill homeless in our facilities. At Calvary Shelter alone twenty-one of the twenty-eight residents suffer from some form of mental illness and fifteen of the twenty-eight are being treated with psychotropic medications. In other emergency shelters the numbers are similar.

We are very concerned about these persons who are not receiving the proper treatment they require and are deteriorating as a result. Many of our clients are former patients of mental health hospitals and can not care for themselves. They require supervised housing, daily emotional support and proper mental health care. The shelters in the District of Columbia can not provide all of these services.

In the testimony we presented before your committee, we stated that St. Elizabeth's Hospital was discharging patients directly to the shelters. Thanks to the attention brought to this problem by your committee, the problem of direct referrals has been alleviated. However, because there are so few alternatives for the mentally ill in the community and because Social Workers at the hospital are forced to discharge patients under stringent deadlines, many patients end up in unsuitable living arrangements. And, we are finding that although the patients are not directly referred to our facilities, they eventually end up at our doors.

- 2 -

We urge you to continue investigating this problem of inappropriate discharges. Whether or not the hospital is directly discharging to the shelters the fact is: the mentally ill make up a large percentage of the population living in shelters.

As advocates for the mentally ill we believe these individuals deserve suitable living arrangements that enable them to live decent and productive lives. Shelters are not appropriate settings for the mentally ill and currently that is where many are forced to live.

With the transfer of administration of St. Elizabeth's Hospital from Federal to District, we are hopeful that there will be a new awareness and a new set of policies regarding inappropriate discharges. The attention that your committee brought to this matter was of great assistance in making this a public issue. We are grateful to you for this and look forward to your continued review and evaluation of these policies.

D.C. Advocates for
the Mentally Ill

Enclosure

Calvary Shelter Residents , medications prescribed by Neal Barnard, M.D.

<u>Initials of Client</u>	<u>Current Diagnosis</u>	<u>Medication Prescribed</u>
CT	Paranoid Schizophrenic	Haldol
JB	Alcohol Dementia	Medication deferred
MJB	Paranoid Schizophrenic	Prolixin
MB	"	Medication refused by client
AD	Paranoid Schizophrenic	Prolixin
CK	"	Haldol
BHJ	Paranoid Schizophrenic	Prolixin
TH	Schizoid Personality	Medication refused by Client
CB	Depressive Personality	Medication refused by Client
PP	Paranoid Schizophrenic	Prolixin
EP	Alcohol Dementia, Psychosis Apparent	Prolixin
ZR	Paranoid Schizophrenic	Medication refused by Client
VS	Schizoid Personality	Chlorpromazine
MM	Schizophrenic	Prolixin
NB	Manic/Depressive	Therapy

Clients not yet seen by Dr. Barnard diagnosis made by Social Worker

FC	dual diagnosis, Mental Retardation, Schizophrenic
JK	Schizophrenic
DS	Psychotic, actively hallucinating violent behavior
EW	Violent Behavior
EW	Violent Behavior
RA	Paranoid Schizophrenic



RECEIVED
 SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

1987 SEP 22 AM 10:02
 WASHINGTON, D. C. 20001

SEP 17 1987

Honorable Ted Weiss
 Congress of the United States
 House of Representatives
 Rayburn House Office Building, Room B-372
 Washington, D. C. 20515

Re: Human Resources and Intergovernmental
 Relations Subcommittee

Dear Congressman Weiss:

This is to acknowledge receipt of your letter dated September 11, 1987 regarding committed patients from FY 1986 to the present.

Since the beginning of FY 1986, the Commission on Mental Health has recommended and the Superior Court for the District of Columbia has committed 192 patients for inpatient treatment. Included in this figure are approximately 50 elderly patients that were committed to nursing homes because no one in the family could care for them. Since the beginning of FY 1986 there have been 109 patients committed for outpatient treatment at Saint Elizabeths Hospital and to the Community Mental Health Centers in the District of Columbia. In cases where the patient is in need of specific treatment, supervision and care, the Commission on Mental Health will make this recommendation to the Court. The Court will incorporate this recommendation in its commitment order.

If further information is needed, please contact me.

Sincerely,

James S. Gardiner
 James S. Gardiner
 Chairman and Attorney for the
 Commission on Mental Health



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
WASHINGTON D.C. 20002

Commission on Mental Health
Services
Suite 1130
1875 Connecticut Avenue, N.W.
Washington, D.C. 20009

IN REPLY REFER TO

OCT 16 1987

M E M O R A N D U M

TO: Diana Zuckerman, Ph.D.
Professional Staff Member
House of Representatives
Human Resources and Intergovernmental
Relations Subcommittee of the Committee
on Government Operations

FROM: Kenneth E. Briggs, Chief
Office of Mental Health System
Development

SUBJECT: Request for Information on Individuals Judged to
be Dangerous to Selves or Others

In response to Chairman Weiss' letter dated
September 11, 1987 addressed to Commissioner
Gardiner, the number of persons committed for
treatment (i.e., judged to be dangerous to selves
or to others) during FY 1986 and FY 1987 was:

<u>Total Committed</u>	<u>319</u>
Committed to Inpatient Psychiatric Treatment	160
Committed to Outpatient Psychiatric Treatment	109
Committed to Nursing Home Treatment	50

All persons found to be mentally ill and dangerous
to self or others were committed.

These statistics were determined using a combination
of data provided by Commissioner Gardiner and the
SEH database.

If you have any questions please do not hesitate
to contact me at 673-7783.

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