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MENTAL ILLNESS AND MENTAL RETARDATION

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

RELATIVE TO

MENTAL ILLNESS AND MENTAL RETARDATION

FEBRUARY 5, 1963.—Referred to the Committee on Interstate and Foreign Commerce and ordered to be printed

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1. *Comprehensive community mental health centers*

Central to a new mental health program is comprehensive community care. Merely pouring Federal funds into a continuation of the outmoded type of institutional care which now prevails would make little difference. We need a new type of health facility, one which will return mental health care to the main stream of American medicine, and at the same time upgrade mental health services. I recommend, therefore, that the Congress (1) authorize grants to the States for the construction of comprehensive community mental health centers, beginning in fiscal year 1965, with the Federal Government providing 45 to 75 percent of the project cost; (2) authorize short-term project grants for the initial staffing costs of comprehensive community mental health centers, with the Federal Government providing up to 75 percent of the cost in the early months, on a gradually declining basis, terminating such support for a project within slightly over 4 years; and (3) to facilitate the preparation of community plans for these new facilities as a necessary preliminary to any construction or staffing assistance, appropriate $4.2 million for planning grants under the National Institute of Mental Health. These planning funds, which would be in addition to a similar amount appropriated for fiscal year 1963, have been included in my proposed 1964 budget.

While the essential concept of the comprehensive community mental health center is new, the separate elements which would be combined in it are presently found in many communities: diagnostic and evaluation services, emergency psychiatric units, outpatient services, inpatient services, day and night care, foster home care, rehabilitation, consultative services to other community agencies, and mental health information and education.

These centers will focus community resources and provide better community facilities for all aspects of mental health care. Prevention as well as treatment will be a major activity. Located in the patient's own environment and community, the center would make possible a better understanding of his needs, a more cordial atmosphere for his recovery, and a continuum of treatment. As his needs change, the patient could move without delay or difficulty to different services—from diagnosis, to cure, to rehabilitation—without need to transfer to different institutions located in different communities.

A comprehensive community mental health center in receipt of Federal aid may be sponsored through a variety of local organizational arrangements. Construction can follow the successful Hill-Burton pattern, under which the Federal Government matches public or voluntary nonprofit funds. Ideally, the center could be located at an appropriate community general hospital, many of which already have psychiatric units. In such instances, additional services and facilities could be added—either all at once or in several stages—to fill out the comprehensive program. In some instances, an existing outpatient psychiatric clinic might form the nucleus of such a center, its work expanded and integrated with other services in the community. Centers could also function effectively under a variety of other auspices: as affiliates of State mental hospitals, under State or local governments, or under voluntary nonprofit sponsorship.

Private physicians, including general practitioners, psychiatrists, and other medical specialists, would all be able to participate directly and cooperatively in the work of the center. For the first time, a large proportion of our private practitioners will have the opportunity to treat their patients in a mental health facility served by an auxiliary professional staff that is directly and quickly available for outpatient and inpatient care.

While these centers will be primarily designed to serve the mental health needs of the community, the mentally retarded should not be excluded from these centers if emotional problems exist. They should also offer the services of special therapists and consultation services to

parents, school systems, health departments, and other public and private agencies concerned with mental retardation.

The services provided by these centers should be financed in the same way as other medical and hospital costs. At one time, this was not feasible in the case of mental illness, where prognosis almost invariably called for long and often permanent courses of treatment. But tranquilizers and new therapeutic methods now permit mental illness to be treated successfully in a very high proportion of cases within relatively short periods of time—weeks or months, rather than years.

Consequently, individual fees for services, individual and group insurance, other third-party payments, voluntary and private contributions, and State and local aid can now better bear the continuing burden of these costs to the individual patient after these services are established. Long-range Federal subsidies for operating costs are neither necessary nor desirable. Nevertheless, because this is a new and expensive undertaking for most communities, temporary Federal aid to help them meet the initial burden of establishing and placing centers in operation is desirable. Such assistance would be stimulatory in purpose, granted on a declining basis and terminated in a few years.

The success of this pattern of local and private financing will depend in large part upon the development of appropriate arrangements for health insurance, particularly in the private sector of our economy. Recent studies have indicated that mental health care—particularly the cost of diagnosis and short-term therapy, which would be major components of service in the new centers—is insurable at a moderate cost.

I have directed the Secretary of Health, Education, and Welfare to explore steps for encouraging and stimulating the expansion of private voluntary health insurance to include mental health care. I have also initiated a review of existing Federal programs, such as the health benefits program for Federal personnel, to determine whether further measures may be necessary and desirable to increase their provisions for mental health care.

These comprehensive community mental health centers should become operational at the earliest feasible date. I recommend that we make a major demonstration effort in the early years of the program to be expanded to all major communities as the necessary manpower and facilities become available.

It is to be hoped that within a few years the combination of increased mental health insurance coverage, added State and local support, and the redirection of State resources from State mental institutions will help achieve our goal of having community-centered mental health services readily accessible to all.

2. Improved care in State mental institutions

Until the community mental health center program develops fully, it is imperative that the quality of care in existing State mental institutions be improved. By strengthening their therapeutic services, by becoming open institutions serving their local communities, many such institutions can perform a valuable transitional role. The Federal Government can assist materially by encouraging State mental institutions to undertake intensive demonstration and pilot

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