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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 **Commeree** and ordered to be printed

To the Congress of the United States:

It is my intention to send shortly to the Congress a message pertaining to this Nation's most urgent needs in the area of health improvement. But two health problems—because they are of such critical size and tragic impact, and because their susceptibility to public action is so much greater than the attention they have received-are deserving of a wholly new national approach and a separate message to the Congress, These twin problems are mental illness and mental retardation.

From the earliest days of the Public Health Service to the latest research of the National Institutes of Health, the Federal Government has recognized its responsibilities to assist, stimulate, and channel public energies in attacking health problems. Infectious epidemics are now largely under control, Most of the major diseases of the body are beginning to give ground in man's increasing struggle to find their cause and cure. "But the public understanding, treatment, and prevention of mental disabilities have not made comparable progress since the earliest days of modern history.

Yet mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by

the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the Public Treasury and the personal finances of the individual families than any other single condition.

There are now about 800,000 such patients in this Nation's institutions—600,000 for mental illness and over 200,000 for mental retardation. Every year nearly 1,500,000 people receive treatment in institutions for the mentally ill and mentally retarded. Most of them are confined and compressed within an antiquated, vastly overcrowded, chain of custodial State institutions, The average amount expended on their care is only $4 a day—too little to do much good for the individual, but too much if measured in terms of efficient use of our mental health dollars, In some States the average is less than $2 a day.

The total cost to the taxpayers is over $2,4 billion a year in direct public outlays for services—about $1.8 billion for mental illness and $600 million for mental retardation. Indirect public outlays, in welfare costs and in the waste of human resources, are even higher, But the anguish suffered both by those afflicted and by their families transcends financial statistics—particularly in view of the fact that both mental illness and mental retardation strike so often in childhood, leading in most cases to a lifetime of disablement for the patient and a lifetime of hardship for his family.

This situation has been tolerated far too long, It has troubled our national conscience—but only as a problem unpleasant to mention, easy to postpone, and despairing of solution. The Federal Government, despite the nationwide impact of the problem, has largely left the solutions up to the States. The States have depended on custodial hospitals and homes. Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release.

The time has come for a bold new approach. New medical, scientific, and social tools and insights are now available. A series of comprehensive studies initiated by the Congress, the executive branch, and interested private groups have been completed and all point in the same direction.

Governments at every level—Federal, State, and local—private foundations and individual citizens must all face up to their responsibilities in this area. Our attack must be focused on three major objectives:

First, we must seek out the causes of mental illness and of mental retardation and eradicate them. Here, more than in any other area, "an ounce of prevention is worth more than a pound of cure." For prevention is far more desirable for all concerned. It is far more economical and it is far more likely to be successful. Prevention will require both selected specific programs directed especially at known causes, and the general strengthening of our fundamental community, social welfare, and educational programs which can do much to eliminate or correct the harsh environmental conditions which often are associated with mental retardation and mental illness. The proposals contained in my earlier message to the Congress on education and those which will be contained in a later message I will send on the Nation's health will also help achieve this objective.

Second, we must strengthen the underlying resources of knowledge and, above all, of skilled manpower which are necessary to mount and

sustain our attack on mental disability for many years to come. Personnel from many of the same professions serve both the mentally ill and the mentally retarded. We must increase our existing training programs and launch new ones, for our efforts cannot succeed unless we increase by severalfold in the next decade the number of professional and subprofessional personnel who work in these fields. My proposals on the health professions and aid for higher education are essential to this goal, and both the proposed youth employment program and a national service corps can be of immense help. We must also expand our research efforts if we are to learn more about how to prevent and treat the crippling or malfunction of the mind.

Third, we must strengthen and improve the programs and facilities serving the mentally ill and the mentally retarded. The emphasis should be upon timely and intensive diagnosis, treatment, training, and rehabilitation so that the mentally afflicted can be cured or their functions restored to the extent possible. Services to both the mentally ill and to the mentally retarded must be community based and provide a range of services to meet community needs.

It is with these objectives in mind that I am proposing a new approach to mental illness and to mental retardation. This approach is designed, in large measure, to use Federal resources to stimulate State, local, and private action. When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability, Emphasis on prevention, treatment, and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away.

In an effort to hold domestic expenditures down in a period of tax reduction, I have postponed new programs and reduced added expenditures in all areas when that could be done. But we cannot afford to postpone any longer a reversal in our approach to mental affliction. For too long the shabby treatment of the many millions of the mentally disabled in custodial institutions and many millions more now in communities needing help has been justified on grounds of inadequate funds, further studies, and future promises. We can procrastinate no more. The national mental health program and the national program to combat mental retardation herein proposed warrant prompt congressional attention.

I. A NATIONAL PROGRAM FOR MENTAL HEALTH

I propose a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill, This approach relies primarily upon the new knowledge and new drugs acquired and developed in recent years which make it possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society.

These breakthroughs have rendered obsolete the traditional methods of treatment which imposed upon the mentally ill a social quarantine, a prolonged or permanent confinement in huge, unhappy mental hospitals where they were out of sight and forgotten. I am not unappreciative of the efforts undertaken by many States to improve conditions in these hospitals, or the dedicated work of many hospital staff members. But their task has been staggering and the results too often dismal, as the comprehensive study by the Joint Commission on

Mental Illness and Health pointed out in 1961. Some States have at times been forced to crowd five, ten, or even fifteen thousand people into one large understaffed institution. Imposed largely for reasons of economy, such practices were costly in human terms, as well as in a real economic sense. The following statistics are illustrative:

Nearly one-fifth of the 279 State mental institutions are fire and health hazards; three-fourths of them were opened prior to World War I,

Nearly half of the 530,000 patients in our State mental hospitals are in institutions with over 3,000 patients, where individual care and consideration are almost impossible.

Many of these institutions have less than half the professional staff required—with less than 1 psychiatrist for every 360 patients,

Forty-five percent of their inmates have been hospitalized continuously for 10 years or more.

But there are hopeful signs. In recent years the increasing trend toward higher and higher concentrations in these institutions has been reversed—by the use of new drugs, by the increasing public awareness of the nature of mental illness, and by a trend toward the provision of community facilities, including psychiatric beds in general hospitals, day care centers, and outpatient psychiatric clinics. Community general hospitals in 1961 treated and discharged as cured more than 200,000 psychiatric patients,

I am convinced that, if we apply our medical knowledge and social insights fully, all but a small portion of the mentally ill can eventually achieve a wholesome and constructive social adjustment. It has been demonstrated that two out of three schizophrenics—our largest category of mentally ill—can be treated and released within 6 months, but under the conditions that prevail today the average stay for schizophrenia is 11 years. In 11 States, by the use of modern techniques, 7 out of every 10 schizophrenia patients admitted were discharged within 9 months. In one instance, where a State hospital deliberately sought an alternative to hospitalization in those patients about to be admitted, it was able to treat successfully in the community 50 percent of them. It is clear that a concerted national attack on mental disorders is now both possible and practical

If we launch a broad new mental health program now, it will be possible within a decade or two to reduce the number of patients now under custodial care by 50 percent or more. Many more mentally ill can be helped to remain in their own homes without hardship to themselves or their families. Those who are hospitalized can be helped to return to their own communities. All but a small proportion can be restored to useful life. We can spare them and their families much of the misery which mental illness now entails. We can save public funds and we can conserve our manpower resources,

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 Ms 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 Healthy 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

projects, to improve the quality of care, and to provide inservice training for personnel manning these institutions.

This should be done through special grants for demonstration projects for inpatient care and inservice training. I recommend that $10 million be appropriated for such purposes.

8. Research and manpower

Although we embark on a major national action program for mental health, there is still much more we need to know. We must not relax our effort to push back the frontiers of knowledge in basic and applied research into the mental processes, in therapy, and in other phases of research with a bearing upon mental illness. More needs to be done also to translate research findings into improved practices, I recommend an expansion of clinical, laboratory, and field research in mental illness and mental health,

Availability of trained manpower is a major factor in the determination of how fast we can expand our research and expand our new action program in the mental health field. At present manpower shortages exist in virtually all of the key professional and auxiliary personnel categories—psychiatrists, clinical psychologists, social workers, and psychiatric nurses. To achieve success, the current supply of professional manpower in these fields must be sharply increased—from about 45,000 in 1960 to approximately 85,000 by 1970. To help move toward this goal I recommend the appropriation of $66 million for training of personnel, an increase of $17 million over the current fiscal year.

I have, in addition, directed that the Manpower Development and Training Act be used to assist in the training of psychiatric aids and other auxiliary personnel for employment in mental institutions and community centers.

Success of these specialized training programs, however, requires that they be undergirded by basic training programs. It is essential to the success of our new national mental health program that Congress enact legislation authorizing aid to train more physicians and related health personnel. I will discuss this measure at greater length in the message on health which I will send to the Congress shortly.

II. A NATIONAL PROGRAM TO COMBAT MENTAL RETARDATION

Mental retardation stems from many causes, It can result from mongolism, birth injury or infection, or any of a host of conditions that cause a faulty or arrested development of intelligence to such an extent that the individual's ability to learn and to adapt to the demands of society is impaired. Once the damage is done, lifetime incapacity is likely. With early detection, suitable care and training, however, a significant improvement is social ability and in personal adjustment and achievement can be achieved.

The care and treatment of mental retardation, and research into its causes and cure, have—as in the case of mental illness—been too long neglected. Mental retardation ranks as a major national health, social and economic problem. It strikes our most precious asset-our children. It disables 10 times as many people as diabetes, 20 times as many as tuberculosis, 25 times as many as muscular dystrophy, and 600 times as many as infantile paralysis. About 400,000 children are

so retarded they require constant care or supervision; more than 200,000 of these are in residential institutions. There are between 5 and 6 million mentally retarded children and adults—an estimated 3 percent of the population. Yet, despite these grim statistics, and despite an admirable effort by private voluntary associations, until a decade ago not a single State health department offered any special community services for the mentally retarded or their families.

States and local communities spend $300 million a year for residential treatment of the mentally retarded, and another $250 million for special education, welfare, rehabilitation, and other benefits and services. The Federal Government will this year obligate $37 million for research, training and special services for the retarded and about three times as much for their income maintenance. But these efforts are fragmented and inadequate.

Mental retardation strikes children without regard for class, creed, or economic level, Each year sees an estimated 126,000 new cases. But it hits more often—and harder—at the underprivileged and the poor; and most often of all — and most severely—in city tenements and rural slums where there are heavy concentrations of families with poor education and low income.

There are very significant variations in the impact of the incidence of mental retardation, Draft rejections for mental deficiency during World War II were 14 times as heavy in States with low incomes as in others. In some slum areas 10 to 30 percent of the school-age children are mentally retarded, while in the very same cities more prosperous neighborhoods have only 1 or 2 percent retarded.

There is every reason to believe that we stand on the threshold of major advances in this field. Medical knowledge can now identify precise causes of retardation in 15 to 25 percent of the cases. This itself is a major advance. Those identified are usually cases in which there are severe organic injuries or gross brain damage from disease. Severe cases of mental retardation of this type are naturally more evenly spread throughout the population than mild retardation: but even here poor families suffer disproportionately. In most of the mild cases, although specific physical and neurological defects are usually not diagnosable with present biomedical techniques, research is rapidly adding to our knowledge of specific causes: German measles during the first 3 months of pregnancy, Rh blood factor incompatibility in newborn infants, lead poisoning of infants, faulty body chemistry in such diseases as phenylketonuria and galactosemia, and many others.

Many of the specific causes of mental retardation are still obscure, Socioeconomic and medical evidence gathered by a panel which I appointed in 1961, however, shows a major causative role for adverse social, economic, and cultural factors. Families who are deprived of the basic necessities of life, opportunity and motivation have a high proportion of the Nation's retarded children. Unfavorable health factors clearly play a major role. Lack of prenatal and postnatal health care, in particular, leads to the birth of brain-damaged children or to an inadequate physical and neurological development. Areas of high infant mortality are often the same areas with a high incidence of mental retardation. Studies have shown that women lacking prenatal care have a much higher likelihood of having mentally retarded children. Deprivation of a child's opportunities for learning slows development in slum and distressed areas, Genetic, hereditary, and other biomedical factors also play a major part in the causes of mental retardation.

The American people, acting through their Government where necessary, have an obligation to prevent mental retardation, whenever possible, and to ameliorate it when it is present. I am, therefore, recommending action on a comprehensive program to attack this affliction, The only feasible program with a hope for success must not only aim at the specific causes and the control of mental retardation but seek solutions to the broader problems of our society with which mental retardation is so intimately related.

The panel which I appointed reported that, with present knowledge, at least half and hopefully more than half, of all mental retardation cases can be prevented through this kind of "broad spectrum" attack—aimed at both the specific causes which medical science has identified, and at the broader adverse social, economic, and cultural conditions with which incidence of mental retardation is so heavily correlated. At the same time research must go ahead in all these categories, calling upon the best efforts of many types of scientists, from the geneticist to the sociologist.

The fact that mental retardation ordinarily exists from birth or early childhood, the highly specialized medical, psychological, and educational evaluations which are required, and the complex and unique social, educational, and vocational lifetime needs of the retarded individual, all require that there be developed a comprehensive approach to this specific problem.

1. Prevention

Prevention should be given the highest priority in this effort. Our general health, education, welfare, and urban renewal programs will make a major contribution in overcoming adverse social and economic conditions. More adequate medical care, nutrition, housing, and educational opportunities can reduce mental retardation to the low incidence which has been achieved in some other nations. The recommendations for strengthening American education which I have made to the Congress in my message on education will contribute toward this objective as will the proposals contained in my forthcoming health message.

New programs for comprehensive maternity and infant care and for the improvement of our educational services are also needed. Particular attention should be directed toward the development of such services for slum and distressed areas. Among expectant mothers who do not receive prenatal care, more than 20 percent of all births are premature—two or three times the rate of prematurity among those who do receive adequate care. Premature infants have two or three times as many physical defects and 50 percent more illnesses than full-term infants. The smallest premature babies are 10 times more likely to be mentally retarded.

All of these statistics point to the direct relationship between lack of prenatal care and mental retardation. Poverty and medical indigency are at the root of most of this problem. An estimated 35 percent of the mothers in cities over 100,000 population are medically indigent. In 138 large cities of the country an estimated 455,000 women each year lack resources to pay for adequate health care during

pregnancy and following birth. Between 20 and 60 percent of the mothers receiving care in public hospitals in some large cities receive inadequate or no prenatal care—and mental retardation is more prevalent in these areas.

Our existing State and Federal child health programs, though playing a useful and necessary role, do not provide the needed comprehensive care for this high-risk group. To enable the States and localities to move ahead more rapidly in combating mental retardation and other childhood disabilities through the new therapeutic measures being developed by medical science, I am recommending;

(a) A new 5-year program of project grants to stimulate State and local health departments to plan, initiate, and develop comprehensive maternity and child health care service programs, helping primarily families in this high-risk group who are otherwise unable to pay for needed medical care. These grants would be used to provide medical care, hospital care, and additional nursing services, and to expand the number of prenatal clinics, Prenatal and post partum care would be more accessible to mothers. I recommend that the initial appropriation for this purpose be $5 million, allocated on a project basis, rising to an annual appropriation of $30 million by the third year.

(6) Doubling the existing $25 million annual authorization for Federal grants for maternal and child health, a significant portion of which will be used for the mentally retarded.

(c) Doubling over a period of 7 years the present $25 million annual authorization for Federal grants for crippled children's services.

Cultural and educational deprivation resulting in mental retardation can also be prevented. Studies have demonstrated that large numbers of children in urban and rural slums, including preschool children, lack the stimulus necessary for proper development in their intelligence. Even when there is no organic impairment, prolonged neglect and a lack of stimulus and opportunity for learning can result in the failure of young minds to develop. Other studies have shown that, if proper opportunities for learning are provided early enough, many of these deprived children can and will learn and achieve as much as children from more favored neighborhoods, This self-perpetuating intellectual blight should not be allowed to continue.

In my recent message on education, I recommended that at least 10 percent of the proposed aid for elementary and secondary education be committed by the States to special project grants designed to stimulate and make possible the improvement of educational opportunities particularly in slum and distressed areas, both urban and rural. I again urge special consideration by the Congress for this proposal, it will not only help improve educational quality and provide equal opportunity in areas which need assistance; it will also serve humanity by helping prevent mental retardation among the children in such culturally deprived areas.

2. Community services

As in the case of mental illnesses, there is also a desperate need for community facilities and services for the mentally retarded. We must move from the outmoded use of distant custodial institutions to the concept of community-centered agencies that will provide a

coordinated range of timely diagnostic, health, educational, training, rehabilitation, employment, welfare, and legal protection services. For those retarded children or adults who cannot be maintained at home by their own families, a new pattern of institutional services is needed.

The key to the development of this comprehensive new approach toward services for the mentally retarded is twofold. First, there must be public understanding and community planning to meet all problems. Second, there must be made available a continuum of services covering the entire range of needs, States and communities need to appraise their needs and resources, review current programs, and undertake preliminary actions leading to comprehensive State and community approaches to these objectives. To stimulate public awareness and the development of comprehensive plans, I recommend legislation to establish a program of special project grants to the States for financing State reviews of needs and programs in the field of mental retardation.

A total of $2 million is recommended for this purpose. Grants will be awarded on a selective basis to State agencies presenting acceptable proposals for this broad interdisciplinary planning activity. The purpose of these grants is to provide for every State an opportunity to begin to develop a comprehensive, integrated program to meet all the needs of the retarded. Additional support for planning health-related facilities and services will be available from the expanding planning grant program for the Public Health Service which I will recommend in my forthcoming message on health.

To assist the States and local communities to construct the facilities which these surveys justify and plan, I recommend that the Congress authorize matching grants for the construction of public and other nonprofit facilities, including centers for the comprehensive treatment, training, and care of the mentally retarded. Every community should be encouraged to include provision for meeting the health requirements of retarded individuals in planning its broader health services and facilities,

Because care of the mentally retarded has traditionally been isolated from centers of medical and nursing education, it is particularly important to develop facilities which will increase the role of highly qualified universities in the improvement and provision of services and the training of specialized personnel. Among the various types of facilities for which grants would be authorized, the legislation I am proposing will permit grants of Federal funds for the construction of facilities for (1) inpatient clinical units as an integral part of university-associated hospitals in which specialists on mental retardation would serve; (2) outpatient diagnostic, evaluation, and treatment clinics associated with such hospitals, including facilities for special training; and (3) satellite clinics in outlying cities and counties for provision of services to the retarded through existing State and local community programs, including those financed by the Children's Bureau, in which universities will participate. Grants of $5 million a year will be provided for these purposes within the total authorizations for facilities in 1965 and this will be increased to $10 million in subsequent years.

Such clinical and teaching facilities will provide superior care for the retarded and will also augment teaching and training facilities for

specialists in mental retardation, including physicians, nurses, psychologists, social workers, and speech and other therapists. Funds for operation of such facilities would come from State, local, and private sources. Other existing or proposed programs of the Children's Bureau, of the Public Health Service, of the Office of Education, and of the Department of Labor can provide additional resources for demonstration purposes and for training personnel

A full-scale attack on mental retardation also requires an expansion of special education, training, and rehabilitation services, Largely due to the lack of qualified teachers, college instructors, directors, and supervisors, only about one-fourth of the 1,250,000 retarded children of school age now have access to special education. During the past 4 years, with Federal support, there has been some improvement in the training of leadership personnel However, teachers of handicapped children, including the mentally retarded, are still woefully insufficient in number and training. As I pointed out in the message on education, legislation is needed to increase the output of college instructors and classroom teachers for handicapped children.

I am asking the Office of Education to place a new emphasis on research in the learning process, expedite the application of research findings to teaching methods for the mentally retarded, support studies on improvement of curriculums, develop teaching aids, and stimulate the training of special teachers,

Vocational training, youth employment, and vocational rehabilitation programs can all help release the untapped potentialities of mentally retarded individuals. This requires expansion and improvement of our vocational education programs, as already recommended; and, in a subsequent message, I will present proposals for needed youth employment programs.

Currently rehabilitation services can only be provided to disabled individuals for whom, at the outset, a vocational potential can be definitely established. This requirement frequently excludes the mentally retarded from the vocational rehabilitation program. I recommend legislation to permit rehabilitation services to be provided to a mentally retarded person for up to 18 months, to determine whether he has sufficient potential to be rehabilitated vocationally, I also recommend legislation establishing a new program to help public and private nonprofit organizations to construct, equip, and staff rehabilitation facilities and workshops, making particular provision for the mentally retarded.

State institutions for the mentally retarded are badly underfinanced, understaffed, and overcrowded. The standard of care is in most instances so grossly deficient as to shock the conscience of all who see them.

I recommend the appropriation under existing law of project grants to State institutions for the mentally retarded, with an initial appropriation of $5 million to be increased in subsequent years to a level of at least $10 million. Such grants would be awarded, upon presentation of a plan meeting criteria established by the Secretary of Health, Education, and Welfare, to State institutions undertaking to upgrade the quality of residential services through demonstration, research, and pilot projects designed to improve the quality of care in such institutions and to provide impetus to inservice training and the education of professional personnel:

3. Research

Our single greatest challenge in this area is still the discovery of the causes and treatment of mental retardation. To do this we must expand our resources for the pursuit and application of scientific knowledge related to this problem. This will require the training of medical, behavioral, and other professional specialists to staff a growing effort. The new National Institute of Child Health and Human Development which was authorized by the 87th Congress is already embarked on this task.

To provide an additional focus for research into the complex mysteries of mental retardation, I recommend legislation to authorize the establishment of centers for research in human development, including the training of scientific personnel. Funds for 3 such centers are included in the 1964 budget; ultimately 10 centers for clinical, laboratory, behavioral, and social science research should be established. The importance of these problems justifies the talents of our best minds. No single discipline or science holds the answer. These centers must therefore, be established on an interdisciplinary basis.

Similarly, in order to foster the further development of new techniques for the improvement of child health, I am also recommending new research authority to the Children's Bureau for research in maternal and child health and crippled children's services.

But, once again, the shortage of professional manpower seriously compromises both research and service efforts. The insufficient numbers of medical and nursing training centers now available too often lack a clinical focus on the problems of mental retardation comparable to the psychiatric teaching services relating to care of the mentally ill,

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We as a Nation have long neglected the mentally ill and the mentally retarded. This neglect must end, if our Nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower.

This tradition of neglect must be replaced by forceful and far-reaching programs carried out at all levels of government, by private individuals and by State and local agencies in every part of the Union*

We must act-

to bestow the full benefits of our society on those who suffer from mental disabilities;

to prevent the occurrence of mental illness and mental retardation wherever and whenever possible;

to provide for early diagnosis and continuous and comprehensive care, in the community, of those suffering from these disorders;

to stimulate improvements in the level of care given the mentally disabled in our State and private institutions, and to reorient those programs to a community-centered approach;

to reduce, over a number of years, and by hundreds of thousands, the persons confined to these institutions;

to retain in and return to the community the mentally ill and mentally retarded, and there to restore and revitalize their lives through better health programs and strengthened educational and rehabilitation services; and

to reinforce the will and capacity of our communities to meet these problems, in order that the communities, in turn, can reinforce the will and capacity of individuals and individual families.

We must promote—to the best of our ability and by all possible and appropriate means—the mental and physical health of all our citizens.

To achieve these important ends, I urge that the Congress favorably act upon the foregoing recommendations.

JOHN F. KENNEDY.

THE WHITE HOUSE, *February 5, 1968.*

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