In developing a truly national program which will encompass the needs of emotionally disturbed children in a variety of settings, there is the obvious first step of acquiring some hard and generally accepted data on the dimensions of the problem of childhood mental illness.

At the present time, we are confined to impressionistic projections based upon rather small samplings. For example, several national organizations in the field of childhood mental illness estimate that there are about four million children who are in need of some kind of psychiatric intervention because of emotional difficulties, and that anywhere from a half million to a million of these children are so seriously disturbed that they require immediate psychiatric help.

These estimates give a general idea of the magnitude of the problem, but they don't pinpoint the specific deficiencies, nor do they relate them to the types of mental illness encountered in children. I much prefer the strategy of the Center for Studies of Mental Health of Children and Youth of the National Institute of Mental Health which has, over
the past year, initiated a series of studies on disturbed children in different treatment settings. For example, in a report to the Congress last year the Center noted that, during 1965, about 4,000 children under 15 years of age, and 27,000 youths between 15 and 24 years of age, were admitted to mental hospitals. At the end of that year, 25,000 children were confined in these mental institutions.

A careful examination of rates of admission of children to state mental hospitals over the past five years indicates, according to the Center studies, that we can expect a doubling of mentally ill children in these institutions by 1973. Such information is extraordinarily helpful in planning, for it suggests that we not only take a look at the treatment capabilities of these residential institutions, but that we pursue the development of alternatives to the tragic and lengthy hospitalization of these children.

We have no comparably valid data on other settings in which emotionally disturbed children are handled. It may seem meaningful to point out that approximately 300,000 children are seen in our outpatient psychiatric clinics each year, but such an estimate gives us a false picture of actual treatment activity. From a number of studies of these clinics, we know that only one in every three children seen actually receives any more than a routine diagnostic interview, followed by the plaintive admission that there are no facilities in the particular area for prolonged therapy.

All figures currently used on the extent of emotional disturbance among school children are subject to question. The widely used yardstick of one emotionally disturbed child for every ten children in the classroom -- based upon a small sampling done in New York City more than a decade ago -- is hardly the kind of concrete evidence upon which to base expanded or new services for these children.

Dissatisfaction with these kinds of data, and a vital conviction that very little attention was being given to the problem of the emotionally disturbed child, led the American Academy of Child Psychiatry, the American Psychiatric Association and other
professional and lay organizations to urge upon the Congress the establishment of a Commission which would address itself both to the question of the incidence of childhood mental illness and to the formulation of recommendations designed to rectify the disgracefully inadequate treatment approaches to these children currently in effect.

As most of you know, the Congress responded to these pleas and, in 1965, created a Joint Commission on Mental Health of Children. Although some of its funds are received from the Congress, it is an entirely independent body free to pursue its own lines of inquiry. During the early months of its existence it sought the active participation of many national organizations, including a number whose major activities were not primarily in the field of childhood mental illness. In gaining a wide perspective the involvement of the National Educational Association, the National Congress of Parents and Teachers, the National Association for Mental Health and many other such organizations will, I am sure, contribute significantly to the eventual outcome of the Commission's work.

As one who enjoys the privilege of being a member of the Board of Directors of this Commission, I am confident that its conclusions will lead to a revolution in the care of emotionally disturbed children similar in impact and pervasiveness to the historic recommendations in 1961 of the Joint Commission on Mental Illness and Health in the field of adult mental illness.

Let me be frank in admitting that the Commission's mandate is far-reaching, but it has devised a very successful mechanism for achieving its various goals. To bring all relevant data to the attention of Commission members for final deliberation and recommendation, it has set up three Task Forces carrying out child-centered studies from infancy through adolescence, and three additional broad-gauged Task Forces dealing with such important problems as research, manpower, prevention, organizing and financing of services and, most importantly, socially innovative approaches to the handling of the emotionally disturbed child.
Over the past year, these aforementioned Task Forces have forwarded to members of the Commission hundreds of pages of their preliminary findings and suggestions. Time does not permit a detailed description of this material, but here is a sketch of some of the data being collected and some of the exciting plans being proposed:

1. We are finally getting some hard testimony on the extent of the problem of childhood mental illness. These data include an analysis of the numbers and types of children handled in institutional care facilities; a quantitative and qualitative survey on outpatient services for children, conducted by the American Association of Psychiatric Clinics for Children; an estimate of the number of disturbed children identified in the schools, undertaken by the University of Chicago, and a number of other studies which I believe will give us the first accurate picture of the dimensions of the problem of childhood mental illness in America.

2. Six separate studies are being conducted on the crucial question of psychiatric and allied manpower in the treatment of children. These include analyses of the present utilization of such manpower in the field, the projected needs over the next decade or so and, most importantly, the recruitment and training of new kinds of professional and non-professional workers to deal with children.

3. Running as a powerful theme through several of the Task Force documents is the recommendation that the first three years of life be singled out as a major priority in the development of children's services in the future. These reports raise the point that, up until now, the application of mental health services has been concentrated on the later stages of development, despite the evidence in a number of studies that children under the age of three already show the severe marks of socio-cultural deprivation.

4. In almost all of the Task Force material which we have received, there is sharp criticism of the chaotic nature of children's services in this country today. Continuity
of treatment -- following the child from infancy through adolescence -- is practically unheard of. One paper cites the case of a disturbed child in Los Angeles who was buffeted about among 17 agencies over a period of one year. Various critiques note the absence of a comprehensive model of services which would encompass the varying needs of the child. Several Task Forces have suggested the establishment of regional child development centers for both treatment and case record-keeping purposes, with center-connected satellites reaching out to the peripheral points served within the total regional complex. Another document, pointing out that agencies constantly lose contact with their child clients, proposes regular examinations, including psychological factors, at regular intervals in the child's life.

It is obvious that we cannot provide more adequate services for emotionally disturbed children unless we develop new kinds of child-caring personnel on a large scale. In contrast to many other countries, we are hung up on the stiff-necked professional model -- the psychiatrist dealing with the child on a one-to-one basis. Hopefully, we have learned during the past several years from Project Head Start and from the VISTA and Foster Grandparents programs, that the warmth, attention and time of another person is a tremendous therapeutic force in the life of a child.

Over the past five years, Peabody College has conducted an experiment in which selected teachers were taught psychiatric skills and then used as teacher-counsellors in specialized schools for disturbed children in both Tennessee and North Carolina. This is called Project Re-Ed and its philosophy, so similar to much that is coming out of the Task Force reports of the Joint Commission, is stated quite clearly in this description of its goal:
"The problem of providing for emotionally disturbed children is a critical one requiring bold measures. Society will not continue to tolerate the assignment of disturbed children to detention homes, to hospitals for adults, or to institutions for the mentally deficient... The United States does not have and will not be able to train a sufficient number of social workers, psychiatrists, psychologists and nurses to staff residential psychiatric facilities for children along traditional lines. It will not be possible in the foreseeable future, with manpower shortages becoming increasingly more acute, to solve the problem of the emotionally disturbed child by adhering to limited patterns... For effective work with children, the worker's personal attributes weigh more heavily than his professional knowledge and technical skills."

As a follow through to this original project, Peabody College is now providing a two-year graduate program for training child development consultants. The child development consultant will facilitate the prevention of developmental and learning problems through the identification of, and assistance to, children experiencing difficulties; through consultation with parents and teachers to provide optimal conditions for the development of particular children, and with administrators and others regarding the general program of the school and community.

I am happy to note that the role definition and training requirements for child development specialists are receiving increasing attention. At the November meeting of the National Mental Health Advisory Council, we approved five projects for such pilot training. One of these is at Florida State University in Tallahassee, which has developed an 18 month course leading to a Master's degree in child development. These projects add to the experimental training of child care workers now being conducted in programs at the Judge Baker Guidance Center in Boston, the Devereux Foundation and at Western Psychiatric Institute in Pennsylvania.

At the same November Council meeting, we approved a large grant to the National Congress of Parents and Teachers so that it could use its national staff and part-time
consultants to train all its state PTA presidents, state mental health chairmen and other key personnel to recognize children's unmet needs and to increase parent participation in local mental health activity.

The National Institute of Mental Health is also supporting a number of projects in junior colleges throughout the country leading to the preparation of many kinds of community mental health workers, including child-care workers. The largest grant went to the Southern Regional Education Board for the encouragement and design of community college training programs and curricula for mental health workers. The Board has selected Florida as one of three states in which the community college movement is at a point where it can develop and train a sizable number of these community mental health workers. As some of you may know, Daytona Beach Junior College was the first in the country to inaugurate a two year course for the training of non-professional mental health technicians.

While these demonstration projects are quite heartening, they are really no substitute for a national effort to provide new kinds of personnel in the child care field. As some of you know, Congressman Sam Gibbons of Tampa introduced a bill in 1965 providing several hundred million dollars in federal assistance to train child development specialists to work with troubled children in kindergarten and the first three grades of elementary school. Although this legislation received the strongest possible endorsement from every professional organization in the field of childhood mental illness, it has not moved to the floor of the Congress because of the restrictive nature of our domestic federal budget.

I think we can afford the Gibbons bill and any other measures designed to rescue mentally ill children from lives of total despair. In his 1962 State of the Union message, President Kennedy said: "A child uneducated is a child lost." Yet, with only rare exceptions, we have been prolonging and perpetuating the difficulties of seriously disturbed children by barring or dismissing them from public education. I submit that if we can spent $5 billion a year for a conjectural trip to the far side of the moon, we can spend a few hundred million dollars in the next few years to help our own children walk on this planet.
There are so many who could help. For example, as the Joint Commission report notes, there are 15,000 pediatricians in this country but the great majority of them lack sufficient psychiatric orientation to capitalize on their professional potential.

We have just begun to scratch this great potential of people who can help people. In Washington, D.C. we are using mothers whose own children have completed their education. They are given a year's training in psychiatric concepts and then work on the psychiatric service at Children's Hospital.

In many cities in the country, trained youth workers are going into neighborhoods where trouble exists and applying their knowledge and affection to those children who are in revolt against the "norms" of modern society. As the noted psychiatrist Dr. Kenneth Appel has pointed out, there is a deep and tragic irony in the fact that millions of Americans -- unemployed, retired, or otherwise rendered unproductive by society -- seek a meaningful role in life, while millions of our children, our mental patients and others sunk in despair seek a helping hand. Dr. Appel pleads for a linkage between this great untapped human potential and the vast needs of the troubled and submerged in our democracy. Automation may eventually provide most of the material wants of our society, but it cannot ever replace the hand-to-hand and heart-to-heart relationship which is at the core of the helping services.

During this past summer's experience with Project Head Start -- which reached more than 600,000 children under the age of six -- thousands of adults and children served as volunteers. As the program continues this winter, the goal is to reach down to children three years of age and to expand voluntary and community participation.

Several thousand trainees of VISTA -- Volunteers in Service to America -- are now serving in all regions of the country. A sizable percentage of these dedicated people have chosen to work in the mental health field and, having addressed several groups of VISTA trainees, I can assure you they will make wonderful workers in the vineyard of childhood mental illness.
There have been exciting developments in other areas of childhood mental illness which have highlighted the necessity for a comprehensive survey of existing needs and the selection of a set of priorities for the next decade and beyond.

In a democratic society, this kind of planning is never easy. Where you have a mixture of services in both the public and private sectors of medicine, and a whole complex of jurisdictional walls fencing off various segments of child care, it is extraordinarily difficult to create a comprehensive, workable model for the treatment of the emotionally disturbed child.

In September and October of last year, I had the opportunity to visit a number of children's facilities in Russia. Because all care is free and provided only in public facilities, it is relatively easy to fix responsibility and to provide a related set of services for the total needs of the child.

Child care begins on an intensive and meticulous basis with the pregnant mother. From the fifth month of pregnancy, there is the beginning of an accumulation of a vast amount of physiological data on the child yet to be born. After the mother delivers the child, the children's polyclinic is immediately notified by the hospital. These polyclinics are the medical hub of all services for children -- there is one in each district of approximately 40,000 people. The children's polyclinic also provides most of the medical and psychiatric services for children in the kindergartens and in the schools. When the child is ready for kindergarten at the age of three years, it is the polyclinic which gives him a physical and psychological examination. The same process is repeated when he enters elementary school at the age of seven years.

Emotional problems in children are usually detected by the pediatrician. A high level of individual care is possible because there are 70,000 pediatricians in the USSR, as compared to about 15,000 in this country. The pediatrician knows the family situation
intimately. From the time of the child's birth, she has spent a great deal of time with the family in the home situation, and she can make a judgment based on a whole set of factors which would not be known to her in a perfunctory outpatient visit. If psychiatric treatment is needed, she refers the child to the child psychiatrist on the staff of the polyclinic. It is obvious to any visitor that it is a tremendous advantage to combine pediatric and psychiatric services under one roof -- to have what amounts to a continuing consultation between the two disciplines which have so much to do with the successful maturation of the child.

Where treatment is indicated, there is an amazingly varied constellation of resources tailored to the severity of the child's problem:

1. For children under the age of three, there is a vast network of nurseries. It is estimated that more than 50% of Russian children get their early upbringing in these nurseries. Working parents may leave them in these nurseries during the entire working week, just bringing them home for weekends. In addition to intensive pediatric care, the nurseries in recent years have concentrated on developing educational staffs to motivate the child and introduce him to the learning process. If the psychiatric consultant to any of the regular nurseries detects an emotional problem in a child, he can transfer him to one of the specialized nurseries which handle psychiatric disorders in children.

2. From the ages of four to seven, the child goes to a kindergarten which may be located in the district where he lives, or in the factory in which his father and/or mother works. Here again psychiatric consultation is available, and there are several specialized kindergarten schools for disturbed children.

3. For children who cannot perform adequately in the educational system, there are a host of options open to the psychiatric-pediatric team which is treating him. If the child suffers from a neurotic or learning difficulty, there are special sanatoria where children reside full-time and receive both psychiatric and educational help over a period of from three to six months designed to return them as soon as possible to the regular schools.
For more disturbed children, there are residential Forest schools which have year-round programs emphasizing both work and study activities directed toward bringing about motivational changes in the child. For severely ill, but treatable emotionally disturbed children, there are specialized children's hospitals which have a staff-to-patient ratio which would be impossible to achieve in this country at the present time.

Although there are a wide variety of treatment situations into which particular types of childhood mental illness can be fitted, the most impressive strength of the Russian system is the delegation of responsibility for each child. For example the neuropsychiatric dispensary psychiatrist, who actually works at the children's polyclinic, is expected to follow the emotionally disturbed child from the initial date of contact until the child reaches 15 years of age.

There is no doubt that the Russian children's polyclinic -- strongly backed up by the children's department of the outpatient neuropsychiatric dispensary -- is far superior to the American child guidance clinic. In America, continuity of service is almost totally absent, the child may be buffeted about between a pediatrician, a child psychiatrist, a clinic welfare agency or what-have-you, with very little in the way of mutual consultation and medical follow up. The Russian system is impressive because it is based upon joint pediatric and psychiatric responsibility for the child. He is not lost in a welter of agencies -- the district polyclinic is home base for him and it has all his records, medical and psychiatric, from infancy. Furthermore, the polyclinic takes care of the total child -- the doctors see him in the home or in the kindergarten or grade school. They don't have to break down any jurisdictional walls to do this. The dispensary child psychiatrist, for example, must spend an assigned number of hours each week in home visiting, or in consultations in the schools.

I do not mean to imply that child psychiatric care in the Soviet Union is perfect. Far from it. There is a rigid, almost theological predisposition favoring organic etiology
in childhood mental illness. This flagrant bias causes Russian psychiatrists to overlook the psychological and inter-personal difficulties which are at the root of so much troubled behavior in children. Having said this, and having admitted the difficulty of assessing the quality of psychiatric care in the USSR, we must be fair and acknowledge that the delivery of such services -- of whatever quality -- is in vivid contrast to the chaotic nature of most child care services in America.

We have, or we can generate, the resources to do an infinitely better job for our children in America. However, we will make no forward progress until we admit very frankly and openly that our present services for children are in a very sorry state. One of the Joint Commission's Task Forces is dealing with this very area of the social innovations needed to break down our traditional, discredited system of fragmented child care. I would like to quote from a subcommittee report which points up the seriousness of the fierce resistances to any fundamental changes:

"We of the United States are refusing to see the social crisis that is already upon us. We are in a major internal crisis today, as serious as any external war crisis this nation has ever faced. The old ways of child rearing, family, church, school and community have broken down. New ways have not developed. Enormous numbers of our youth are growing up without internal strength and controls. They have not had the love, spiritual and mental guidance essential to being independent and healthy, yet responsible and contributing adult citizens.

The crisis of our young is our own crisis. The rearing of our children and youth cannot be separated from our society and the world they grow up in. We have not had the wisdom, strength and foresight to see that we have exploited, neglected and despoiled our children's personalities, our own particular social groups, and our entire society in the same way we have fouled and destroyed the air we breathe, the water we drink, and the land we inhabit."

We must multiply the number of experimental approaches to the treatment and education of the emotionally disturbed child. Project Re-Ed is just one example of what we should be doing in a number of settings, and in many parts of this country.

I am delighted, for example, that a child study project in Sumter, South Carolina, which screened pre-schoolers over a five-year period to identify those in need of emotional
first aid received the top award of the American Psychiatric Association last year. The Sumter project, which preceeded Head S$tart by several years, discovered that 25 to 30% of the hundreds of children screened had impairments which interfered with physical, social and emotional development. At the conclusion of the five-year project, supported in part by the National Institute of Mental Health, the Sumter school district has added 33 full-time "interventionists" who will continue this valuable screening service.

In a much broader program emphasizing continuity of care, the University of North Carolina is planning a Child Development Center for culturally deprived children. The Center will provide a program covering the first twelve years of life, including a day care facility for infants and young children of working mothers, and an elementary school for older children. The Center program will be organized around a study of the whole family unit and, wherever possible, all children from a given family will be cared for in a single entity.

If time permitted, I could describe a number of additional pilot projects, but the two I have cited are hopefully a beginning toward both intervention in the early years of child development and continuity of care from infancy through the school years. These are the things we can and must do if we are to create in the foreseeable future a system of psychiatric care for children which is comprehensive, accessible and within the financial reach of all American families.

In a nation which spends $20 billion for recreation, $11 billion for alcoholic beverages, $7 billion for tobacco products, and $1 billion for candy, there is room for the additional expenditure of a few hundred million dollars so that four million of our children who are emotionally troubled can be helped so that they may lead useful and productive lives.