of the new program is toward centering all mental health services within communities, however, a much larger contribution toward the cost of operation will have to come from the communities.

For the relatively few construction grant applications approved thus far, construction support is to be borne by (*a*) Federal Government (average 50 percent), (*b*) State government (20 to 30 percent) and (*c*) local public and private funds (20 to 30 percent).

*Sources of operating funds.*—There are 25 States which provide State moneys to assist communities in assuming part (indeed up to 75 and 80 percent) of the costs of public mental health services (as through Community Mental Health Services Acts). Several other States are in the process of considering new legislation which would authorize similar support programs of their own. In large measure, of course, these represent new State expenditures—but it is anticipated that they also will begin to represent some redirection of State funds from the State hospital system to the new community care programs.

There is an encouraging movement among the Nation's health insurance carriers to liberalize the coverage of the treatment costs of mental illness. At the present time, substantial benefits are widely available for mental health services on an inpatient basis. The promising new developments lie in outpatient and partial hospitalization areas, though in these areas, too, two caveats must be added: Actual coverage of outpatient and partial hospitalization services at this time are extremely inadequate, and the high rising costs of health insurance may put such coverage out of the reach of too many people anyway. On the other hand, the 1964 contract agreement between the UAW and the automotive industries includes rather comprehensive mental health insurance coverage for the UAW members and their dependents (some 2.5 million people), the cost of which will be borne entirely by the employers. This agreement may set a precedent rapid developments throughout the insurance industry. The major groups of the uninsured will then be the unorganized workers in the less industrialized and more service-oriented occupations.

While the per hour and per diem costs of treating mental illnesses have continued to rise (along with all medical costs), the new methods of short-term intensive treatment are making the per case costs gradually decrease. Hence, the percentage of costs which can be borne by patient fees—out of the patient's pocket or from third party payments—should continue to increase.

With the passage of Public Law 89–105 authorizing initial staffing grants for community mental health centers, a great many local programs will be able to get started. Once started, and once their value is demonstrated, the resources to keep them going are likely to be found.

### C. Trend of Capital Outlays

As indicated above, there are at present no community mental health centers in operation, in terms of the comprehensive program envisaged. However, some of the existing mental health facilities as indicated below will be adaptable for use in the program.

Assumptions regarding use of existing resources. For many reasons, it is unlikely that more than one-half of the facility resources and administrative footholds presented by existing hospitals and clinics