should supply the nuclei for future regional, comprehensive, health and social service systems.

Pedro Ruiz, director of the Lincoln Hospital Center, says that Lincoln is moving in this direction. It not only already has a well-developed set of social service programs, such as vocational rehabilitation and a pediatric collective, it also has all the medical connections to qualify as an HMO. "In 2 years," he says, "we hope to be functioning as a community health center."

Stanley Matek, executive director of the Milwaukee County Mental Health Planning Committee, believes it is time for all centers to move beyond an exclusive mental health orientation. They are "doomed," he believes, if mental health services (which, if left to themselves, are unlikely to become self-supporting) remain a separate system. "Mental health in our society will never come from mental health systems. It will come from our educational systems, our family developments, our recreational patterns, our employment practices, and our media communications."

He believes mental health centers must undergo a two-stage expansion—first to include outposts of all other social services, such as welfare, family planning, and legal aid, and later to be merged with health care, to produce, finally, an "HMO plus."

Bourne has gone so far as to recommend a state health plan for Georgia that would incorporate many of these concepts. First, he wants to take mental health care out of the state health department and make it a separate department. He then proposes that an overall human resources agency be created to fuse the activities of the two departments. With this setup, he believes, the state would be in a better position to carry the centers to their next stage of evolution. Neither the 75,000 to 200,000 catchment areas nor a full range of services is appropriate to all populations. Nor is a full-fledged center for each of Georgia's 33 catchment areas economically feasible. Rather, he proposes that there be some "primary" centers to provide a full repertoire of health and social services, as well as "secondary" centers that may offer only one or two services, such as outpatient treatment and aftercare.

Such a rearrangement would be a daring step for any state, let alone Georgia, whose latest mental health budget of $93 million allots only $3 million for the centers. (Pennsylvania, by contrast, puts $40 million of its $70 million mental health budget into them.) This sort of reorganization might alleviate some of the difficulties of centers in rural areas, where services are dissipated by vast distances, lack of transportation, and the fact that circuit-riding psychiatrists and psychologists have to spend much time on the road.

Although fusion of services is the ultimate objective, some proponents of the mental health centers are wary of being prematurely pushed in with medical services. In their experiences, such a link-up invariably results in the mental component's getting short shrift. As Mike Gorman, Washington lobbyist and chief booster for community mental health centers, declares: "We have built a better mousetrap. We know how to deliver services." Now, to neighborhood health centers and HMO's, "we say to hell with you, because we've built the best mousetrap in the world."

Reimbursement Problems

But the major flaw in the mousetrap —inadequate financing mechanisms— remains. There is widespread agreement that the refusal of most insurance plans to supply coverage for outpatient mental care is a serious and potentially deadly drawback. Gorman says commercial insurance carriers see such coverage as a Pandora's box that would lead to uncontrollable insurance demands, despite numerous studies which show that it is cheaper to provide outpatient care and thereby avoid hospitalization costs. Bill Goldman, a prominent member of the National Council of Community Mental Health Centers (a lobby group made up of center directors), points out that health insurance for federal employees functions well, despite the fact that it is one of the nation's most advanced examples of psychiatric outpatient coverage. Irving Chase, president-elect of the National Association for Mental Health, said recently in testimony before the House Ways and Means Committee that two studies of prepaid group practice plans showed that those people who had received outpatient psychiatric therapy showed a reduction of 30 percent in their use of physicians' services and laboratory and x-ray procedures. They also showed a "significant decrease" in the most expensive drain on insurance resources—hospitalization.

This evidence notwithstanding, the outlook for ambulatory mental care in the national health insurance plans now before Congress is grim: of dozens of bills floating about, only one—sponsored by Senator Edward Kennedy—provides for this kind of coverage.

Next to money is the question of staffing. As one former director of a large urban center points out, an increase in involvement with a community usually means a weakening of ties with hospitals and universities, which are the sources of well-trained staff. If a center is to give first-rate care, he says, it must have ready access to first-rate talent. People who have not had training in community psychiatry will not be drawn to community mental health centers, or if they are, they are likely to approach their job with a naive missionary zeal that is as much of an aggravation as a help to a community. Without professional backup of high quality, says this psychiatrist, centers will stagnate and become just another "second-rate social agency," no matter how much they involve the community in care and decision-making. In his view, the only way to avoid this is for community psychiatry to become a much more important part of university and medical school curricula than it is now.

The American landscape is littered with the hulks of federal social programs—launched amid noisy trumpetry from on high—which have subsequently been dismembered, truncated for lack of funds, or strangled by the problems they set out to conquer.

Community mental health centers were launched on a tide of high hopes and good intentions. They have unquestionably been of service to the public, although statistically speaking their single sure accomplishment has been the reduction of mental hospital admittances in certain regions. The program will have fulfilled its federal mandate if it succeeds in shifting the locus for public mental health care from the hospital to the community. The most significant question, though, is whether the program can achieve its self-ordained mission of becoming a cogent force for the democratization of all health and human services.—CONSTANCE HOLDEN

Erratum: In the report "Neuronal Soma and Whole Neuroglia of Rat Brain: A New Isolation Technique" by W. T. Norton and S. E. Podulso [**167**, 1144 (1970)], sentence 2, paragraph 3, column 1, p. 1144, should read: "The brains are trimmed of cerebellum and chopped fine (approximately 1 mm^3) in an ice-cold medium consisting of 5 percent glucose, 5 percent fructose, and 1 percent bovine serum albumin (*14*) in 10 m*M* KH_2PO_4-NaOH buffer (*p*H 6.0)."