McIntyre, who will be chairing the R & D subcommittee, has let it be known that his vote last year for the Trident procurement is not to be regarded as a commitment to a continued accelerated development of Trident. Having handily won reelection last November despite criticism by the ultraconservative Manchester *Times-Union*, McIntyre will be under less pressure to conform to the wishes of the Pentagon and White House. Senator Stennis is still recuperating from bullet wounds inflicted during a holdup last winter, and the Armed Services Committee's acting chairman is Senator Stuart Symington of Missouri, who not only voted against the Trident procurement but later critcized some of his colleagues for yielding to lobbying pressures. Also, the special atmosphere that existed last year because of the SALT negotiations and presidential politics has now dissipated, and there is perhaps a greater likelihood that this year Congress will treat military programs on their merits.

Nevertheless, being one year further along the road to deployment, Trident has gained that much more momentum and is not likely to be stopped, although a stretch-out of this extraordinarily expensive program is possibile. By deciding to build the first Trident base near Bangor, Washington, the Navy has assured itself of the not inconsequential support of Washington's Senator Henry M. Jackson, who last year voted with Bentsen in committee but against him on the Senate floor.

But, all ploys by Pentagon lobbyists aside, the really critical factor with respect to Trident's fate may simply be whether members of the Senate are willing to trust themselves and hold important military programs up to the same critical standards of review applied to some of the less sacrosanct domestic programs.—LUTHER J. CARTER

Mental Health: NIMH Reeling over Proposed Budget Cuts

"All is flux," said Heraclitus, and nowhere in the federal government does this seem more true than at the National Institute of Mental Health. NIMH, which in recent years has been a more or less tripartite research-training-service organization, is now faced with a radical realignment of most of its nonresearch functions. The biggest news is the planned phase-out of support for community mental health centers, the institute's central community service activity.

The other major wrench for the institute, as is the case throughout the National Institutes of Health (NIH), is the elimination of most of its training grant and fellowship programs. The budget of the manpower and training division, which totaled $97 million in fiscal 1972, is expected to drop precipitously to $60 million by 1975.

Nervousness reigns at NIMH. No one knows what things will look like when the smoke clears. Director Bertram S. Brown has for weeks been turning down interviews with the press, and those officials who will talk prefer not to be quoted. "This is a punitive Administration," one explained. Outsiders, though, are expressing themselves. "Mental health has been dealt a staggering blow," says the American Psychiatric Association. Daniel X. Freedman of the University of Chicago has warned that the nation's capacity to educate mental health professionals may revert to the "abysmal" state it was in in 1946.

The NIMH has expanded enormously over the last decade or so, with an accompanying change of focus from the basic problems of mental illness to service programs and special work on drug and alcohol addiction. Now it appears the focus will again be turning, this time toward becoming a leadership enterprise engaged in aiding states and localities in developing their own service and training capacities.

Brown, for one, is putting the best face on things. Basically the NIMH will be moving out of its grant-giving role, he said last January, and into what he calls a "policy-wisdom-technical assistance mode."

What is happening is all part of the Administration's design to get the government out of long-term, categorical aid programs and into more experimental, time-limited projects, leaving long-term support up to the states—through federal revenue-sharing programs—and other local sources.

Because prior commitments, stretching as far ahead as 1980 in the case of the mental health centers, will be honored, the NIMH budget does not yet reflect what is happening to it. Estimated new obligations for the entire institute in fiscal 1974 amount to $645.5 million, compared to $604 million in the revised presidential budget for 1973. However, as present commitments are fulfilled, it is safe to predict that the institute's budget will be reduced significantly in future years.

Community mental health centers, authorized in 1963, have consumed an ever-larger portion of the NIMH budget since funding for them began in 1965. The program has always found greater favor in Congress than with the Nixon Administration—witness the fiscal 1973 appropriations bill passed by Congress, which allotted the centers $60 million more than requested by the President. The government has poured well over $700 million into the centers, peaking at $150 million in fiscal 1972.

Now, they are being pushed willy-nilly out of the nest. Some 400 centers are in operation, ranging from neighborhood storefront operations to slick, hospital-based clinics (see *Science*, 10 and 17 December 1971 and 4 August 1972). Although this number is well below the network of 1500 the NIMH originally envisaged for the country, the centers seem to have established a foothold in the health and social services landscape. The federal contribution is now down to about 23 percent, owing to the fact that they are funded on a declining scale over 8 years and most have been in existence for several years. Most of the remaining cost is picked up by the states, supplemented by other private and public sources and patient fees.

Nonetheless, NIMH officials are dubious about the willingness of many states to furnish adequate support unless specific requirements are built into health revenue-sharing plans, and they believe the disparity among centers will become even more pronounced. The architects of the program have long

maintained that long-term survival of the centers depends on coverage of mental health services by national health insurance. Now this kind of coverage is more critical than ever.

On the manpower side, it looks as though the manpower and training programs division, as we know it, will become a thing of the past. No longer will awards be made along specific disciplinary lines—psychiatry, psychology, social work, and psychiatric nursing. The only programs to be retained will be experimental and training programs for various kinds of nonacademic mental health workers; short-term grants for continuing education; and new careers grants, which mainly go to helping indigenous mental health workers move up the career ladder.

In addition to experimental programs, the division will emphasize program evaluation, the study of manpower needs, and the provision of technical assistance to institutions, states, and localities in order to help them develop training capacities.

The sudden curtailment of training money is hitting institutions with varying degrees of severity. One hard-hit school is Stanford Medical School, where, says Bert S. Koppell, the number of new graduate students accepted will have to be curtailed next year, and acceptance will have to be biased toward those who can pay their own way. Koppell says there will also be serious impact on the quality of training. The idea of a psychiatric residency, for example, is to expose residents to as much variety as possible, which means doing a good deal of community work. Now residents will have to be placed in hospitals where they can do income-producing work. This means, too, that mental health centers are being squeezed from both ends, since they have relied heavily on the voluntary services of these professionals.

One area in which the predominance of the NIMH seems assured is drug abuse, which is getting cancer crusade–type treatment. If the Office of Management and Budget has its way, the budget will go up from an estimated $205 million in 1973, to $243 million in 1974 for research, training, matching grants to states, and individual project grants.

As of the end of next year, the Division of Narcotics Addiction and Drug Abuse will become the National Institute of Drug Abuse, parallel in stature to the National Institute for Alcoholism and Alcohol Abuse (NIAAA) and considerably more richly endowed. The institute will take over the primary functions—policy-making and coordination of federal drug abuse prevention activities—of the Special Action Office for Drug Abuse, which is due to expire in June 1975. Meanwhile, the treatment and rehabilitation programs of the almost-defunct Office of Economic Opportunity, the Model Cities program, and the Law Enforcement Assistance Administration are being transferred to the NIMH.

The NIAAA, the newest service-oriented division at the NIMH, will not have the opulent future originally planned for it. Matching grants to states will continue, but project grants are being phased out. However, Director Morris Chafetz says that all of the states have set up the single alcoholism authority required to receive federal money, and enthusiasm is such that local support is likely to be continued. Again, this optimism is not shared by private groups such as the National Council on Alcoholism, which believes fledgling programs will fall flat when the federal rug is pulled out from under them.

Research at the NIMH is feeling the pinch too, although, as one official said, "We're lucky compared to the rest of the institute." The proposed 1974 budget for general (nondrug, nonalcohol-related) research is $79.9 million, down $6.5 million from 1972. Extramural research is slated to get $41.9 million, the same as for 1973.

Research throughout the NIMH will become more oriented to high-priority areas such as child mental health, crime and delinquency, drug and alcohol abuse, social problems such as violence, and basic research on the major mental disorders: schizophrenia and depression.

Intramural research, traditionally oriented to basic research on mental diseases, is being funded at an annual level of about $16.5 million. Here, too, reduced resources are being concentrated on high-priority areas.

Further slippage in the total research budget may be slowed by a major, year-long study now being made of all NIMH research conducted over the last 25 years. The task force, headed by Julius Segal, is divided into ten study groups, which are expected to produce a report next month assessing past efforts and outlining future research strategies.

The NIMH has a reputation for getting into research that is relevant to current social problems—which has earned it the nickname of the "band-aid institute" in some quarters. Some officials fear these areas may be emphasized to the detriment of the agency's original purpose, which is to find causes and cures for major mental diseases.—CONSTANCE HOLDEN

Herbicides: AAAS Study Finds Dioxin in Vietnamese Fish

Fish and shellfish from areas of South Vietnam that were heavily sprayed during the U.S. defoliation campaign contain significant quantities of dioxin, according to two Harvard scientists, Robert Baughman and Matthew Meselson. Dioxin, a contaminant of some herbicides, is known to be an extremely potent agent in causing birth defects. The finding is the first solid evidence that dioxin entered the diet of the Vietnamese people and could, thereby, have posed a hazard to human health there.

The fish were bought in 1970 from markets where Vietnamese housewives also obtained their fish. "We will not say this poses an immediate problem to health . . . but there is plenty of room to be worried," said Meselson. "There is no evidence for catastrophic illness, but whether it was making significant, but not catastrophic, health problems, we don't know."

The two scientists have cautiously refrained from asserting that finding dioxin in fish proves that U.S. herbicides are responsible for reported rises in stillbirths and birth defects in heavily