

"THE CHALLENGING NEW FRONTIER IN MENTAL HEALTH"

Text of an address delivered by Luther W. Youngdahl,
Governor of Minnesota, at the annual meeting of the
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Mr. Chairman, ladies and gentlemen:

It is appropriate that here in Topeka, the home of the Menningers we discuss "The Challenging New Frontier in Mental Health." For the Menningers - and I use this term representatively to include all members of the staff down to the fellow who pushes the broom and the girl who sharpens the pencil - have successfully blazed so many trails in mental health that the direction is clearly marked for those of us who follow in our respective specialties.

I cannot over-estimate the value of the work done at Topeka. If the work is important, even more important is the spirit in which it is performed. For those of you who have been attending the annual meeting of the Menninger Foundation and have contributed to its finances and to its direction, I offer my most sincere congratulations for the privilege you have of being numbered among its prime supporters. I include myself, morally if nothing else, in this group.

For the people of Minnesota, I express appreciation for the signal honor of representing them in this capacity tonight.

Man is searching blindly and desperately for the answer to a vital problem - one which pertains, in fact, to his very survival. His frantic efforts are due to the amazing success he has achieved in unlocking the mysteries of science, while remaining ignorant in the realm of human relations.

It is becoming more and more apparent that man is in a crisis because of the dreadful lag in his understanding of himself. This sounds

like an over-simplification of the problem, yet is true. It is the lesson of the "backwards" for the people in the communities.

Yesterday's challenge was that of geographical and technological frontiers- of materialistic goals. Today's challenge is - and must be - the challenge of social concepts and human values; the challenge to apply these concepts and values in human relationships.

Today it was your privilege to discuss many facts of these values - of this challenge - with some of our leading contemporary thinkers. Tonight it is my privilege to discuss other facets with you from the specific point of view of how state governments discharge responsibilities for the maintenance of mental health and the treatment of mental illness.

Thirty years ago I attended a small college in the vicinity of one of our state hospitals. On free evenings we used to go up the hill to see the "nut house"; our curiosity carried us up to a certain point; beyond that point our fears kept us from going farther.

Not much more than a year ago in making a supposedly unannounced visit to another hospital, a friend stopped me in the street. An eminent citizen of his community, he said, "Governor, I hear you are going to visit the "nut house."

Thirty years had passed; thirty years in which psychiatry had made great strides. Despite these strides, the state hospital remained the "nut house," an institution whose roots were still in the asylum stage. Isolated from the world, its patients were forgotten and stigmatized by attitudes and conditions reminiscent of the dark ages.

Thirty years had passed, thirty years in which I had little direct contact with the problem until, as Governor, I had occasion to visit the hospitals of our state. I visited the hospitals; I visited the barns.

The cows were clean, tuberculin-free, well-fed, well-bedded, and provided with attention which would make the ratio of the American Psychiatric Association seem conservative.

The same could not be said of the patients.

Something had gone wrong. Not only in Minnesota, but in many other states as well. A nation which had learned to discharge the atom bomb had not learned how to discharge its duty to sick people; a nation fighting the cold war had left its moral flank exposed.

Perhaps in terms of the vast numbers of lost lives and distorted personalities which would result from an atomic war, the 14,000 psychotic, mentally deficient, and epileptic patients in the mental hospitals of my state to some may seem relatively unimportant. Yet the care of these patients is the most accurate barometer I know of our real concept of human values. It is an indicator of the strength or weakness of such moral counterpart as we may have to the totalitarianisms which hold the individual -- particularly the weak individual -- insignificant.

The neglect of these patients constitutes a mirror in which you and I may look and see in ourselves a dark age morality glossed over by the cosmetic covering of 20th century materialism.

If I make reference to Minnesota, it is not my position that Minnesota is the only state that is now concerning itself with mental health. It is because Minnesota is the state with which I am most familiar. It is a state whose people in the past 100 years have cleared their forests, built up their soil, established their cities, and laid out systems of government, education, and communication. It is a state which is entering its second century by pioneering in the conservation of human resources. This conservation will be concerned to no small degree with the maintenance of mental health and with providing the most modern possible treatment for mental illness.

The care of the mentally ill is one of the most important problems facing every governor in the country and is recognized as such by each of them. This may be seen in the unanimous action of the Governor's Conference in making it a major study of the year, for action at next year's meeting. Historically it will may be that the outcome of this study may have consequences for the good

comparable to the passage of the National Mental Health Act. Cooperative action by the Governors' Conference can result not only in improvements on state levels, but in unified support for the neuropsychiatric and mental health services of both the Veterans Administration and the United States Public Health Service.

I am quite conscious that mental health problems are solved on no one level, be it federal, state or local. Nor are these problems to be solved by governmental or private action alone. I am equally conscious that there is far more to the mental health movement than mental hospitals.

But blueprint the ideal program as we may, the truth of the matter is that 85% of the hospitalized patients in this country are in state mental hospitals. The great majority of practitioners identified in the public mind as psychiatrists are in state mental hospitals. The overwhelming percentage of clinical material for research is in state mental hospitals. Public enlightenment is tied in with concepts concerning state mental hospitals and psychotic patients in those hospitals.

Were I to indict the state for its discharge of public psychiatric functions I would do so on two grounds: first, the nature of our hospitals; and, secondly, the development of a system based almost exclusively on hospitals.

In using the figure of thirty years to show a span of time in which there were few changes in public attitudes and the resulting status of the hospital, it is only to mark highlights in my own personal observations of the problem. Actually, this monstrosity which in our own naivete we choose to term "hospital" is the only major social institution which has remained fundamentally unchanged since the abolition of its moral counterpart, slavery. To be sure, there are means of change on hand today, but these have not taken appreciable effect yet.

The history of Minnesota, in relation to its discharge of public psychiatric functions, is similar to that of most, if not all states. We built

our first hospital in the 1880's, a fairly late date in mental hospital history; we built it on patterns obtained from other states.

We called this institution an asylum. We built it not because we understood mental illness, but because we did not. We built it to confine people whose actions brought fear to others and who were considered to be dangerous either to society or to themselves. Later we expanded its function to include the helploss.

These were the "insane," the lost and feared group of shunned individuals. When not left to wander the fields and the forests, they were subjected to horrors in jails and almshouses. To a large extent such progress as we made thereafter was to transfer the scene of these horrors to an institution under state jurisdiction.

From the very beginning our policy had been to build fortresses, monstrous constructions of brick and mortar in which to keep the patients in and the public out. Today we are reaping the inevitable result of a custodial approach in an ever-increasing backlog of patients. Problems of overcrowding are still being solved by the expensive procedure of building more buildings. The truth of the matter is not that we have too little bed-space; but because of the absence of prevention, early detection, active treatment, and follow up activities, we do not have a balance between admissions and discharges.

The custodial, non-therapeutic characteristics of state hospitals can be understood only in terms of the asylum. The logic behind the asylum was (1) patients were incurable and destined for life-long institutionalization, necessitating the lowest possible expenditure; (2) patients had neither feelings nor human attributes.

Of course, upset these assumptions, either on the psychiatric-economic level or on the humane level, and the custodial-asylum-out-of-sight-out-of-mind system must be upset too. Mental patients are human beings with illnesses responsive to treatment and feelings susceptible to humaneness. When people

realize this, then that is the end of the asylum system; that is precisely what we are now experiencing in Minnesota.

Brick-and-mortar, the corner-stone of the asylum, contains no ingredient with which to heal the sick human mind. Only people progressively trained and possessing humane attitudes can do that. Yet as time went by and psychiatry developed new methods of treatment which were dependent on trained personnel, state hospitals were so bound to their asylum roots and asylum appropriations that they could not keep pace.

It is important to remember the asylum base from which our state hospitals spring. For while the art of psychiatry has been refined within our memory span, the system in vogue was designed for a pre-psychiatric era.

Since 85% of hospitalized psychiatric cases are in these state hospitals, psychiatry generally is moored by an anchor of no mean weight. No matter how serene the sea may be or how much we lengthen the anchor chain, the anchor is still there. For example, while I for one very much appreciate the work of the V.A. psychiatric services, the veteran's family is anchored not to the V.A., but to the state hospital.

With one major exception of very recent development there has been little change or no change in the asylum-state hospital system beyond a change in nomenclature. To be sure, psychiatry has introduced new therapies and refined old ones; it has even appended certain services such as social work and out-patient clinics; but all these merely represent an attempt to build the superstructure of psychiatry on an asylum base.

I do not wish to be too harsh on the old asylum, for in many ways it represented something superior for the level of knowledge then existing to what we have today. Even to return to the standards then existent in some asylums would be an improvement over what we find today in many hospitals. Certainly, the connotation of refuge and sanctuary in the term "asylum" had many elements of hope for the combat casualties of life's war of stress and strain who are our patients.

For those who might take exception to my contention that the asylum roots are still there, let us observe several features of no little significance. The asylum did not recognize mental illness as a sickness. Because of false concepts the asylum was based on what for want of a better term we today can only call "economy." False economy, if you please, or if you prefer, penny-pinching.

Inherent in the practice of low operating costs was the fact that the asylum was based on patient-labor. Here apparently were able bodied men and women who could relieve the drain on the tax-payer by working in the institution. The patient-labor basis of hospital operations is today a fact so accepted that it receives little attention. Of Course, we are now a little bit more refined and rationalize many of the menial tasks performed by patient-labor as occupational or industrial therapy.

Probably for every patient helped by the type of work he is doing, at least one other, if not more, is emotionally injured by it. Farm work is a good example. I have known farmers whose breakdown has been precipitated by the monotony, loneliness, and drudgery of farm life. What happens when he goes to a hospital? We practice "potato psychiatry."

Here is someone with farm experience. Before you know it he is out doing perhaps the very same thing which helped to precipitate his breakdown. While at the same time a patient in whom the dissatisfactions of clerical work contributed to his breakdown is in the state hospital office filing or pounding a typewriter.

For those of you who are familiar with state hospital operations, am I unfair in mentioning patient-labor as a fundamental cushion in budgeting? Our hospitals are operated not by the psychiatric team, but by the patient-labor crew.

Were we to accept a hospital pattern and base the activities of patients in terms of therapy alone, our boilers would stop operating; farms would stop producing; kitchens would cease food operation, sewage would go uncollected.

Even patients would go unattended. The well-kept laws characteristic of most hospitals would soon revert to weeds.

I am not criticizing genuine industrial or occupational therapy. I am merely pointing out what you well know; with this situation we cannot have confidence that the institution exists for the patient - the patient perhaps more often than not exists for the institution.

Now add to this setting many of the things which you yourselves have had occasion to do cry, such as the immoral and therapy-negating double standard of food. You all have had experience of sitting down with a state hospital superintendent or staff member to a steak or chicken dinner, served in almost palatial surroundings (probably better than the governor's mansion), or outing in the employees' mess while the patients downstairs were eating a different diet. Regardless of the quality of the patients' food and food services, a distinct difference existed between what they were served and what the employees were served. And this difference was neither in the patient's favor nor was it to his benefit, nor did it contribute to his recovery.

Take the patient-labor base, take the double-standard of food, throw in a few choice ingredients, such as the self-respect-destroying mechanical restraint and regimented ward life, and you end up with that vicious hangover of the asylum days - the caste system.

Is it any wonder then that the patient-centered state mental hospital is the rare exception rather than the rule? As a layman speaking to practitioners in and friends of psychiatric work, I seriously present you with the question of whether therapy - despite the best staffing plans in the world - can be successfully superimposed.

I will not elaborate before an audience of this nature on the personnel situation and the relationship between shortages in personnel and the brick-and-mortar basis of the asylum.

On one hand, state hospitals are so inadequately staffed and have adopted so few opportunities to increase staff through training that rare is the doctor who has time to listen to his patient, much less to engage in a meaningful physician-patient relationship. On the other hand, with few exceptions, the person closest to the patient--the person who represents the hospital environment to the patient--the person who is the major link between the patient and the world of unreality is the guard-attendant. Except for small islands of enlightenment, he still carries out the supervisory and non-therapeutic job originally assigned him in the asylum days. No livery stable would permit a person to handle horses who had as little training as we furnish attendants who work the most closely with the complex mental patient.

However, I wish to recall to you my remark of a few minutes ago that there is one attempted change away from the asylum base in today's state hospital system. One of the most outstanding attempts to break the backbone of the asylum system lies in the recently inaugurated one-year psychiatric aide training program at the Topeka State Hospital.

We congratulate the citizens of Kansas, its state administration, and the Menningers for this enlightened development. At the same time, I wish to announce that plans for a similar program have been underway in Minnesota, with its inauguration to take place in the near future.

Have we changed the asylum base when state governments financially fail to encourage with finances research into both causes of mental illness and improved treatment techniques - when we have held on to improving only what we have had, rather than to discover what we never have had. I know that there are isolated exceptions to this, but limited as research is and great as the need for it is, our research is not being conducted in these great reservoirs of clinical material, but more and more is being conducted in centers away from state hospitals and so is training.

Have we changed the asylum base when we appropriate chiefly for custody, rather than treatment? Of the 10,500 patients in our seven mental hospitals,

we have 2,266 who have been there an average of thirty years. At an average cost to the state of \$1.00 a day for their care, their total cost already has been \$36,142,700. I call your attention to such a figure which I can multiply many times with different groups of patients because the expensiveness of mere custodial care is a consideration during these periods when we are called on to practice economy in government. The only effect of custodial care and low operating costs is to conceal the expense involved and to transfer from one year to the next an ever increasing financial and social liability.

Whoever originally designed the current system of budgeting, separating operating and capital costs - hiding the actual case-cost - must himself have been a candidate for the admission ward of a state hospital, who missed the turn in the road and ended up instead in a career in fiscal management.

The criterion of hospital management is not how cheaply can we maintain a bed, but how many times can we use the same bed for successive numbers of patients.

However, I caution here against any consideration of fiscal policy which confines its attention solely to those who under present levels of scientific knowledge are deemed curable. Even the most hopeless patient in our hospitals has something so precious that he cannot be judged in values other than human and divine.

The challenge is increased training, research, and intensive public education. But without increased public education there can be little else.

You would be surprised how willing the public is to support changes in our asylum structure. The public has been used as a scape-goat for many things, including bad hospital conditions, but before I am willing to put the blame on the public, I would want to make sure that we have done everything humanly possible in interpreting institutional conditions and in providing understanding of emotional problems.

Although no two states present the same problems, I believe that conditions which I had found in Minnesota were representative of much that can be found in most sections of the country. They certainly are similar to the descriptions portrayed by men like Deutsch and Gorman.

In order to seek guidance, before visiting any hospitals, I appointed what is known as the Governor's Advisory Council on Mental Health. The membership included representation from the medical profession, the psychiatric speciality, the University psychiatric department, the neuro-psychiatric section of the Mayo Clinic, and two laymen. In addition, the Minnesota Unitarian Mental Hospital Committee, spiritual descendants of Dorothea Lind Dix, herself a Unitarian, cooperated by undertaking a preliminary survey of all state hospitals.

I met with these advisers, intellectually accepting the facts as they were presented and the conclusions of months of personal research, but emotionally I was not quite prepared to believe that these conditions could exist in my state; nothing prior to visiting the hospitals could prepare me for what I was to find.

I have visited all the hospitals in Minnesota by now, most of them many times, but I vividly remember my first - the row upon row of unattended human beings, figures created in the image of God whom we were desecrating by plunging them into this inferno which had the name "hospital" on its gate.

With my own eyes I saw nude men and women, thoroughly shackled to slats and benches, whole wards of men and women with bare feet on a stone floor with many confined in strait-jackets. I looked and could hardly believe my eyes. Of what significance was Pinel when we used the very chains he struck off more than 150 years ago?

And those that were not restrained, what of them? Sitting in crude benches, their eyes downcast, with the grim silence of the ward interrupted only by the strident voice of the attendant, "Sit down, sit down."

I saw the boiled potatoes and cabbage served the patients. Neither could I eat the patients' food nor could I eat upstairs with the staff while knowing what the patients downstairs had before them.

Why the restraints? Why the strong-rooms? "Not enough help to supervise them."

Why the conditions? Why the unattended mass of humanity, each of whom to someone on the outside represented something dear and loved - and something which hurt?

Not enough help; not enough money; not enough anything except patients.

And throughout the state hospital system the ravages of years of neglect could be seen. While not two hospitals presented the same picture and one was actually restraint-free, all presented the same problems; lack of help, lack of money, and an ever increasing backlog of patients who were overflowing into every nook and cranny.

Wherever I went I saw the fight - of a psychiatric corps strong enough for a combat zone of only 4,000 patients attempting to spread itself thin to cope with 10,500. Yes, there was treatment going on, but mainly for a limited number of patients - and then only because our staffs had overextended themselves. I want to acknowledge the devotion of institutional personnel in Minnesota and throughout the country for their efforts. Let not our criticism of a system be interpreted as a criticism of those in the system.

There were two things we were determined to do upon returning from the first tour of the hospitals: first, we were going to improve the hospitals to the utmost of our administrative ability; we were at least going to remove one symbol - mechanical restraints.

I will put in here that out of almost 1,000 patients formerly in restraints, today we are now down to a disappearing 50. Most hospitals in Minnesota today are restraint-free. The remaining are almost free of restraints. As a result of eliminating restraints we have fewer ward problems and greatly increased morale on the part of employees. The elimination of

restraints is not only a humane obligation, it is an institutional necessity.

The second thing we were determined to do was to let the public know what the conditions were and to inaugurate a mental health drive which would acquire support to put the asylum system where it belonged - back in the history books. We were going to demonstrate not only man's inhumanity to man, not only the valuable human resources being poured down the drain of social neglect, but the fantastic expensiveness of a custodial approach in an era in which psychiatry has proven the effectiveness and true economy of treatment.

While our program was based on the human and financial losses of the present system, at no time did we attempt to make a distinction between a so-called curable patient and a so-called incurable patient - we recognize only one type of patient... and that is a sick patient.

If there is any significance to the challenge of new frontiers in mental health, it is the challenge of an aroused public opinion. Such challenge as I present here tonight is not a personal one, but that of the people of Minnesota, who, from the first moment these conditions were reported in the Governor's office to the press, rallied behind the banner of human dignity.

We made no charges and offered no scapegoats. Particeps criminis we stated. We were all guilty of a social crime.

We formed the non-partisan Governor's Citizens Mental Health Committee of 50 members whose job it was to arouse the public. This committee, in turn, had the active support of editors, the working press, and the broadcasting industry.

Then a remarkable thing happened. The people spontaneously rose to the challenge. There was not enough room on the original state-wide committee for all who wished to participate. The committee became a movement, including legislators, civic leaders, plain citizens, many relatives of mental patients, and institutional personnel from superintendents to the employees' union.

There were no dues or regulation. Each member was a committee of one, dedicated to bringing about a new era in the conservation of human resources.

In most key counties of the state supporters of the program banded together in local and county citizens committees.

Such was the interest in the drive that shortly after its inauguration and months prior to the legislative session, poll after poll showed that the overwhelming majority of voters were for the program; one actually showed that a majority of citizens regarded mental illness as a sickness from which people recovered.

We emerged from the legislative session with a body of continuing informed public opinion, a bill of rights for mental patients, and favorable action on our budgetary requests.

Prior to the actual vote on appropriations we introduced under bipartisan sponsorship a bill unique in the legislative annals of Minnesota. It was a policy bill, which put it squarely before the people as to whether the obligation of the state was to patch up an antiquated and unworkable asylum system, or to appropriate for modern services.

The bill declared that the official policy of the State of Minnesota is to recognize mental illness as a sickness and not as a stigma or disgrace, and appropriations are to be guided by the requirements for preventing, detecting, and treating a sickness.

By unanimous vote of both houses this bill of rights was enacted into continuing law, expressing for future legislative sessions, too, the wishes of the sovereign people of Minnesota. I want to acknowledge here the invaluable contribution of Dr. Daniel Blain, Medical Director of the American Psychiatric Association, who came to Minnesota to testify in its behalf. At the same time, I also wish to acknowledge the great contributions made by members of the profession at home and in other states, the University, the Mayo Clinic, and the Mcnninger constituency generally.

Once the policy was established, we considered the matter of appropriations; the legislature was very responsive. There was only one major difference of opinion; whether this was to be a two-year program enacted in two years

or a two-year program spread out over a hundred years. The two-years-in-two-years program won out.

We introduced a minimum appropriations request, free of all frills, on which we would stand or fall without compromising a single penny. Appropriations requested were based on the minimum standards of the APA, which we accepted as our base for this session.

The legislature not only passed the mental health policy act, but appropriated \$28,000,000 of the \$30,000,000 requested as well as an additional \$17,000,000 to continue building programs started in preceding sessions. The per diem was increased from approximately \$1.50 to approximately \$3.00.

The monies provided for substantial increases in personnel, a 40-hour work week, a reclassification of the attendant group to that of psychiatric aides, a single standard of food, improved clothing, the inauguration of a research and training program, two clinics plus as many out-patient clinics as increased personnel would permit, increased staff for the central office, and authority for a Commissioner of Mental Health, to whom would be entrusted not only the institutional program, but the development of preventive and public educational programs, utilizing all resources and agencies of the state government for this purpose.

We did not claim then, - and do not claim now - that the amounts requested would do the full job. The program called for only those factors which would be administratively absorbed during this biennium. The request was intended to be the bare minimum to start us on the long road ahead to modern mental health services; just adequate enough to make the mental hospital in Minnesota a house of hope, rather than a habitation for the living dead.

"Characterized by research and active training of personnel, it would have links with the home and community through clinics and social work services, which would in turn provide early detection, possible non-hospital treatment, follow-up care, and consultative and other services to courts, schools, and welfare agencies."

With the powers granted in the mental health policy act to the yet to-be-appointed Commissioner of Mental Health, we will be able to enter preventive fields not embraced in the asylum system.

Without going out on a limb in predictions, one thing is clear: for us the day of brick and mortar is over. Except for replacement of obsolete plants or the establishment of training, research, or service units, we will be able to look forward to a continuing treatment program without the addition of a single new building. Minnesota has irrevocably committed itself to a program leading to modern services and not incarceration.

In talking of legislative gains, it is only to demonstrate the understanding and power of the people and the responsiveness of the legislature. Between the mental health policy act - the bill of rights - and the strength of the continuing non-partisan mental health drive there are assurances of continuity of program.

The significance of Minnesota does not lie in appropriations to date or possibly in those of tomorrow. Money alone cannot purchase program and philosophy. It certainly cannot purchase understanding of that most complicated of all mechanisms - the sick human mind.

The significance of Minnesota is the significance of public understanding. Once Minnesota was a wide-open state for gambling; now it is a wide-open state for psychiatry.

It is a laboratory without the ceiling of mediocrity; a laboratory in which social blinders have been removed and in their place substituted the freedom to discard the traditional and to try the new. It is a laboratory not isolated by the walls of apathy, but one through whose open portals flows the life-giving strength of public understanding and support.

There are things which appropriations can stimulate, but not alone provide. The new program offers progressive psychiatry the opportunity to practice a philosophy which is completely oriented to the needs of the patients . . . of every member of the psychiatric team so endowed with insight, so

inspired by the human challenge present, so committed to a relentless search for new answers, so dedicated to the affirmation of human dignity...that any patient coming into our service will have the feeling that everything we do is for one and only one reason - and that is to help him get well.

The laboratory which Minnesota provides is the opportunity to establish programs oriented to the elimination of stress and strain and to the maintenance of the highest possible level of mental health - to build better family relations, education systems, health and welfare services, youth projects, housing development and improved race and labor-management relations.

The laboratory furnishes the opportunity to develop a relationship between public psychiatry and the community so meaningful and so significant that the voodooism, fears, superstitions, and misconceptions which gave rise to the asylum will in time completely disappear from all areas of human relationships.

This, then, is the challenge - a challenge not of destroying, but of building - a challenge to explore not yesteryear's wilderness, but today's plateau of human dignity and welfare.

"If we can love," says Dr. Karl Menninger.

"If we can love; this is the touchstone. This is the key to the entire therapeutic program of the modern psychiatric hospital. It dominates the behavior of its staff from director to gardener. To our patient who cannot love, we must say by our actions that we do love him. We say to him:

"You can be angry if you must; we know you have had cause. We know you are afraid of your anger, your own-self punishment - afraid, too, that your anger will arouse our anger and that you will be wronged again and disappointed again and driven mad once more. But we are not angry - and you won't be either after a while. We are your friends; those about you are all your friends. You can relax your defenses and your tensions. As you - and we come to understand your life better, the warmth of love will begin to replace your present anguish, and you will find yourself getting well."

The challenge for public psychiatry and for individuals is the translation of this, not only into therapeutic activities, but into the whole field of human relations.

As the warmth of this philosophy, as the application of it to both patients and the general public seeps in, the challenge of the mental health frontier of today will be answered in terms of a richer and happier people tomorrow.

We shall make mistakes and on more than one occasion lose the trail leading beyond the summit. But pray God that these be not the mistakes of faithlessness or mal-motivation, that these not be mistakes due to fear of climbing untrod trails - that in the people's quest we be not without guidance and the support of men and women of good will.

The frontier today is in human relations.

And in the words of the poet Kipling, the frontier is waiting:

"There's no sense in going further
'Tis the end of cultivation
So they said and I believed it
Till a voice as bad as conscience
Rang interminable changes
On one everlasting whisper day and night repeated,
Something hidden, Go and find it
Go and look beyond the ranges
Something lost behind the ranges
Lost and waiting for you, go."

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