Community Mental Health Centers Program After Four Years' Experience

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A NEW nationwide system for delivering mental health services was created when Congress passed the Community Mental Health Centers Act in 1963 (Public Law 88–164) and then added the Staffing Amendments in 1965 (Public Law 89–105). For more than 150 years, mental health services had been primarily available first in the small, private, highly effective mental hospitals, and later in public mental hospitals whose effectiveness decreased over the years as they grew larger. Public attention became focused on the field of mental health when the events of World War II disclosed a high proportion of Selective Service rejections for mental and emotional reasons, and the casualties of war included thousands of persons with the diagnosis of psychiatric disorder. In 1946 the National Institute of Mental Health was established within the Public Health Service by Congress and given the responsibility for providing national leadership in the mental health field and for administering a wide range of programs. These programs were organized to train manpower, to conduct research into mental illness, and to assist communities in providing community mental health services.

In 1955 Congress passed the National Mental Health Study Act which authorized a study of the mental health needs and resources in this country. The Joint Commission on Mental Illness and Health, an organization of 36 voluntary and professional organizations, conducted a 5-year study which culminated in a report to the Congress and the President titled "Action for Mental Health." This document contained numerous recommendations to deal with the inadequacies in mental health care that had been uncovered. A major discovery was that the public mental hospital system was not able to meet the needs of the people and was not applying all the available scientific knowledge and technology. The commission noted that hospitals were located far from residences of many of the people they served, that they were grossly understaffed, that hospital stays were prolonged, and that the physical facilities were often overcrowded and substandard.

Soon after the joint commission's report, Congress appropriated money for the National Institute of Mental Health to distribute to the States for comprehensive mental health planning. An intensive program of State and local planning was carried out between 1963 and 1965. Participation in planning, directed by State mental health authorities, led to widespread community organization. Not only did public and private agencies participate, but more than 30,000 private citizens took part individually or as members of organizations.

In February 1963 President John F. Kennedy sent a message to the Congress on mental illness

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and mental retardation. He proposed sweeping changes for providing mental health services, including the establishment of community mental health centers. He said, "Merely pouring Federal funds into a continuation of the outmoded type of institutional care which now prevails would make little difference. We need a new type of health facility, one which will return mental health care to the mainstream of American medicine and at the same time upgrade mental health services."

Congress acted on the President's recommendations by enacting the Community Mental Health Centers Act of 1963, making funds available to support the construction of community mental health centers, and in 1965 amended the act to support the staffing of new services in centers. The National Institute of Mental Health administers the programs in collaboration with the Division of Hospital and Medical Facilities, Bureau of Health Services.

The construction program has many similarities to the Hospital Survey and Construction (Hill-Burton) Act passed in 1946. Each State has designated a State agency to administer the mental health center construction program and funds are allocated on the basis of population and need. The State agency, assisted by an advisory committee, submits a State plan for the construction of centers which includes a system for establishing priorities based on regionalization and an inventory of needs and resources. Staffing is administered through project grants made directly to an applicant by the Public Health Service with the advice of the State mental health authority.

Criteria for Eligibility

The criteria for eligibility for Federal support require that the care offered be comprehensive, readily accessible, and available to people. Other requirements are that continuity of care be provided as long as needed and that preventive measures now available in mental health be included. As specifically stated in the regulations which implement the legislation, a comprehensive program must contain a minimum of five program elements including inpatient, outpatient, emergency, and partial hospitalization services as well as consultation and education services. Five additional services may also be supported: diagnostic, rehabilitative, precare and aftercare services, training programs, and research activities. The location of the proposed centers must be easily accessible to the population to be served and available when service is needed, and the program must be organized so that patients, staff, and information move freely between the various elements. The services may be under one roof or under several roofs, but mechanisms must exist to provide for coordination and continuity of care. Each center serves between 75,000 and 200,000 persons and is available to all regardless of income level and length of residence in the community.

New Mental Health Care System

Over a 3-year period, Congress appropriated $135 million for construction and over a 2-year period, $51 million for staffing new services. The 90th Congress in the spring of 1967 extended both programs for an additional 3 years, authorizing $180 million for construction and $88 million for new staffing.

As of June 30, 1967, a total of 322 awards have been made, 191 for construction and 131 for staffing. More than 60 applicants have received both types of grants. Successful applicants include public general hospitals, voluntary general hospitals, public mental hospitals, private mental hospitals, university hospitals associated with medical schools, outpatient psychiatric clinics, children's clinics, and residential facilities. The largest group of applicants are voluntary general hospitals which provide the five essential elements of service or additional elements, either under their own administration or in conjunction with one or more facilities in the community. The most frequent combination is a general hospital which affiliates with a community psychiatric clinic. Rehabilitation and other service agencies have also formed agreements to become integral parts of a center program although there may be only one applicant for a grant.

One-third of the applicants are in cities with a population of more than half a million, one-third in smaller cities, and a third in rural areas. Although all centers must satisfy the basic requirements, no two centers are identical in the way in which their services are planned. Obviously, the program of

each center must be based on the needs and resources in its own area.

In one southern city of 200,000, two voluntary and one county-owned general hospital became affiliated with a community clinic to provide the services. Six local psychiatrists, who take turns in answering emergency calls, are members of the staffs of all three hospitals and also provide part-time services at the local clinic. The clinic staff, who also serve the hospitals, includes full-time social workers, psychologists, and other staff.

In a five-county, rural small city area with a population of 170,000, the local health department officer spearheaded efforts to organize a community mental health center. The health department's child guidance clinic was expanded to serve outpatients of all ages and consultation services were added. An agreement was made with the general hospital across the street from the health department to furnish inpatient, partial hospitalization, and emergency services. Three local psychiatrists and the State mental hospital, 60 miles away, agreed to provide psychiatric services.

In a large suburban county with a population of more than half a million in a western State, the health department took the lead in organizing countywide mental health planning. The department organized services for four catchment areas, using the resources of the health department-based outpatient clinics, the single county general hospital, and three voluntary general hospitals.

The average cost of constructing a mental health center is $1.2 million, and the center serves approximately 165,000 people. The average center employs four psychiatrists, three psychologists, seven social workers, eight professional nurses, three licensed practical nurses, six rehabilitation staff members, and 11 psychiatric aides (*1–3*).

Many centers deal with the immediate crisis and then continue to see the patient and family for as many as six visits to assist in resolving the crisis while the patient remains with his family. Some centers have a small ward or a room in the emergency area where persons may stay a day or two without formal admission to the hospital.

Inpatient care in these centers is usually used to help patients weather a crisis. Afterwards the patient is transferred to another part of the center's program for continuing services (*4*). The usual length of stay as an inpatient is between 2 and 3 weeks, and then the patient is transferred to day or night care for 4 to 6 weeks, or if circumstances warrant it, he is treated as an outpatient.

In practice 80 to 90 percent of all patients receiving inpatient care can be treated for an acute episode within 2 to 3 weeks. About 10 to 20 percent, depending on the skills and the facilities available, may require transfer, usually to a long-term facility such as a mental hospital (*5*).

Partial hospitalization is a relatively new concept in this country although it has been used successfully for a number of years in other countries. Partial hospitalization allows the patient to live at home while receiving treatment for all or part of the day, or when an evening or night program is available he may continue with his usual work or school activities (*6*). Group methods of treatment are used in many centers, which not only allow more patients to be treated but also are highly effective (*7*). Much attention is given to mobilizing the strengths of the patient and family to cope with stress and problems. Milieu therapy and structured communication channels between all participants in the center program, including staff and patients, help resolve crises. Psychotherapy and somatic therapy, such as electroshock, are available, and psychotropic drugs are widely used.

The consultation and information services contain the preventive part of the center program (*8, 9*). Based on the premise that many community agencies and agents have frequent contact with persons who are reacting unfavorably to stressful situations, these firstline community caretakers, within the framework of their own contacts, identify and provide help to persons who may require it. These caretakers include physicians, public health workers, teachers and school administrators, court and probation officers, police, welfare workers, and personnel of other community agencies. By providing inservice training and consultation to these caretakers, many more people can be reached and assisted with their problems.

Some centers rely heavily on consultation as the core of their community mental health services. One center in the rural Midwest has arranged for all eight small hospitals in its catchment area with a population of 100,000 to admit psychiatric patients to their general wards. In each hospital two single rooms are available for use by patients who require intensive psychiatric care. Patients are admitted and treated by community physicians, who are not psychiatrists, and the center psychiatrist serves as the physician's consultant. This same center provides regularly scheduled consultation to all the agencies in the community. Because the catchment area is small, it is possible for the center staff to have formal and informal relationships with community caretakers and with the necessary political, social, and financial leaders. The center staff also maintains communication and keeps track of patients throughout the period they are receiving care.

Communities have been ingenious in arranging their programs. One small community with an outpatient clinic could not afford to construct or finance hospital beds. The public mental hospital, 30 miles away at the edge of the catchment area, agreed to provide the inpatient care, and the other services were available in the community. Continuity of care was obtained through interstaff visits and exchange of records.

Setting up satellite centers is another pattern followed in rural areas. The central base in the largest town houses the psychiatric inpatient service and the core staff. Satellite bases are established in surrounding towns which may be more than 50 miles away. A resident mental health professional is usually assigned to each satellite to serve as the local representative for the center and to provide services such as followup care of ex-hospitalized patients and consultation to community professionals. He also arranges the schedule for outpatient visits with the central staff who come on regular schedule.

One center in a mountain State, serving only 45,000 people in an area 100 miles by 200 miles, has made arrangements with a physician and hospital in one town in each of the five counties in its catchment area to take care of emergencies and hospitalize patients if necessary in the small county hospitals. The centrally based center staff also provides a consulting service to the local physicians who may telephone or see the staff about patients.

Large cities, because of the structure of city government, have another kind of a problem. Cities must be subdivided into catchment areas of 200,000 people or less. Philadelphia, Boston, Denver, New Orleans, and other cities, however, have successfully been regionalized. Facilities have been identified and services are being developed for community centers in each catchment area. In one western city, as a result of the leadership of the division of health and hospitals, a medical school has taken responsibility for one part of the city, a private mental hospital for a second section of the city, and the city hospital for two other catchment areas. Responsibility for the last segment of the city is being negotiated with a State hospital. The relationship between the community-based program and the public mental hospitals is growing as the two systems of care interrelate and are used interchangeably to meet patients' needs.

Both the geographic and administrative location of the center largely determine its clientele and often its programs. Centers in rural areas or in small communities usually serve the entire population because they are often the only source of psychiatric help for many miles. Public hospitals in medium and large cities tend to serve the lower socioeconomic classes, particularly in their inpatient services, and those patients who can pay for services seek private care. Centers in voluntary hospitals admit both private and indigent patients. Since voluntary hospitals are dependent on fees for service, payment for care of indigent patients is arranged through a third party such as Medicare, Medicaid, or other welfare sources.

Implications for Health Care Programs

Developments in the new community mental health center program have implications for the entire health field. In the past most outpatient psychiatric clinics had been independent organizations. Now that they are affiliating with hospitals to form a center program, the clinics are being moved physically into hospitals or into an adjacent or nearby building. Many hospitals, particularly voluntary hospitals in small cities, have not offered outpatient care in the past.

The advent of specialized outpatient care may affect other services of a hospital. New types of personnel and new functions for personnel are being introduced by the mental health centers. Most general hospitals do not employ psychologists and many smaller hospitals have no social workers. Nurses from the inpatient psychiatric or day care services may make home visits or consult with local nursing homes, and public health nurses are also being employed.

Partial hospitalization is new in many general hospitals. To some extent, this service has similarities to rehabilitation services but partial hospitalization in mental health centers is highly structured and uses a broad base of techniques from the behavioral sciences and rehabilitation.

One of the most rewarding aspects of the development of community mental health centers has been the extent to which communities have organized their participation, including the use of volunteers. It is impossible to effect a successful center program without good community organization. The complexity of operating the center requires clear and well-developed communication channels between departments of local government and a variety of community agencies. The center usually requires public funding, since it takes care of indigent patients and provides other nonreimbursable community services such as education and consultation. The centers also require city planning to organize and place services.

Summary

The community mental health center program is a new way of organizing and arranging comprehensive mental health services to a defined population. The center uses public health techniques to prevent morbidity, identify and treat early illnesses, and limit disabilities.

The mental health center is a community-based institution bound in a complex web of social, political, economic, legal, medical, and paramedical relationships. At present center programs use existing knowledge and technology. This form of organization should change to meet new community problems as they emerge and to incorporate new scientific discoveries. Flexibility and responsiveness to community needs underlie the comprehensive community mental health center program.

As of June 30, 1967, a total of 322 awards had been made, 191 for construction and 131 for staffing under the Community Mental Health Centers Act passed in 1963. More than 60 applicants have received both types of awards. One-third of the applicants are in cities with a population of more than half a million, and a third are in rural areas.

The average cost of constructing a mental health center is $1.2 million, and each center serves approximately 75,000 to 200,000 persons. The average center employs four psychiatrists, three psychologists, seven social workers, eight professional nurses, three licensed practical nurses, six rehabilitation staff members, and 11 psychiatric aides.

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