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A REVIEW OF THE FEDERAL COMMUNITY MENTAL HEALTH CENTERS PROGRAM

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Table of Contents

A REVIEW OF THE FEDERAL COMMUNITY MENTAL HEALTH CENTERS PROGRAM

Federal Efforts

The Federal Legislation

Federal Support for Staffing

Concepts and Services

Administration of the Federal Program

Resources for Community Mental Health Centers

Conclusion

Bibliography

A REVIEW OF THE FEDERAL COMMUNITY MENTAL HEALTH CENTERS PROGRAM

Much of the history of the federal community mental health centers program can be traced to events that occurred during and just after World War II. During the war, there developed a great emphasis on acute treatment in the setting of the war zone itself. After the war, there arose a great public concern about the problem of mental illness and our national efforts to deal with the problem. Together, these two sets of circumstances paved the way for the efforts of the federal government to reshape the delivery of mental health services throughout the nation.

Statistics collected during World War II made it abundantly clear that mental illness was indeed a significant problem for this nation. Selective Service records showed that mental illness was present to a considerable degree even among young males, those who were considered for possible military service. Of all the men who were examined for the draft, approximately 5 million were rejected as medically unfit. Of those rejected, approximately 40 percent were excluded because of some neuropsychiatric defect. What is more, neuropsychiatric disabilities accounted for the largest single group of medical discharges from the military service.

The military and draft records were clear. Equally clear was the growing

number of patients who were hospitalized in large state-run institutions for the mentally ill. At the time that World War II ended, there were approximately 450,000 patients hospitalized in these institutions. Most of them could be expected to remain in these institutions for long periods of time, and many of them had already been there for many years by the time the war ended.

Much of the public concern can be attributed to these and similar statistics. To a perhaps even greater extent, however, the general public was aroused by a series of state hospital exposes published in magazines and books. The general public was made painfully aware of the fact that those patients hospitalized in state institutions were receiving little, if any, active treatment, and their living conditions were close to intolerable. The writers of the exposes were still further stimulated in their work by the fact that the state hospital populations continued to rise for many years after the end of the war. Indeed, by 1955, the nation's mental hospitals housed some 550,000 patients.

Authors, legislators, and the general public all decried the deplorable state of mental hospital services. In addition, they called for a new approach to the problems of mental illness, one that in their view would be more humane and more effective. In part at least, the potential for a new approach seemed to lie in the experiences of World War II military psychiatrists. During

the war, these psychiatrists substituted short-term treatment for the traditional long-term practices of prewar civilian psychiatry. A mental disorder developing on the battlefield was seen as an acute problem and not as the beginning of a chronic one. What is more, military psychiatrists quickly learned that their treatment efforts were more successful when the patients were provided with care close to the front lines. Traditional methods had called for the return of neuropsychiatric casualties to hospitals in the United States where they were scheduled to receive long-term care. Now, however, these practices were abandoned, and the neuropsychiatric patient was taken only a few miles from the front; he was treated on a short-term basis and was returned to duty as quickly as possible. The results of this method clearly demonstrated its effectiveness. Mental patients could indeed be treated quickly and returned to their premorbid routines.

Psychiatrists returning to civilian life after the war looked for opportunities to apply their new short-term methods. They were helped in this regard by two other postwar developments. One was the growth of available services for the mentally ill in community general hospitals. Prior to World War II there had been few general hospitals that offered psychiatric services. After the war, however, more and more general hospitals began to accept psychiatric patients. This made it possible for the mentally ill patient to receive needed hospital care locally and conveniently. The new general hospital psychiatric units thus provided the psychiatrist with a setting in

which to practice his newly developed treatment methods. Both the establishment of the general hospital psychiatric units and the development of short-term methods of care were aided in turn by the second postwar development, namely, the introduction of tranquilizers and related psychotropics. The drugs made it possible for periods of treatment to be shortened; they also made it possible for general hospital staff and board members to become increasingly accepting of the mentally ill as regular patients.

Despite the use of new methods, the availability of new drugs, and the development of general hospital psychiatric units, however, the first ten years after World War II brought little in the way of change in patterns of treatment of mental illness. Most mentally ill patients were still confined to state hospitals, and their care typically continued to be a matter of many years' duration. Some psychiatrists applied the methods and the lessons of war time, but most maintained the traditional practices. Public demands seemed clear and professional expertise seemed equally clear, but little was done to implement change on a broad scale.

Federal Efforts

The first step in the direction of federal involvement in the development of new types of mental health programs was the enactment of the Mental

Health Study Act of 1955. As passed by the Congress, the Act provided for a thorough study of the nation's mental health problems and needs. Moreover, the study was to identify present and potential resources for dealing with the problems of mental illness.

The study was undertaken by the Joint Commission on Mental Illness and Mental Health, and the report of the commission, *Action for Mental Health,* is regarded by many people as having provided the origins of the federal community mental health centers program. The report did indeed emphasize the provision of services for the mentally ill on a local basis. Moreover, it called for the increased use of local general hospitals and local psychiatric clinics as principal resources for this care, and it proposed that the long-standing reliance on state hospitals be abandoned. In fact, the report recommended that existing state hospitals be reduced in size and that no new large institutions be constructed.

Action for Mental Health appeared in 1961, and it served as a statement of mental health needs and goals at the national level. During the years that followed, Congress sought to support similar efforts at assessment at the state level. Between ig62 and 1964, several million dollars were made available for state surveys and the development of state comprehensive mental health plans. Each state was to develop a plan consistent with its own situation, but it was expected that each plan would provide the basis for developing mental

health services on a local level.

While the state planning efforts were underway, federal officials were planning for a large-scale national program to support the development of local mental health resources. The planning for this national program began even before the final report of the Joint Commission on Mental Illness and Mental Health had been filed, and the work culminated in the delivery of President Kennedy's mental health message to Congress and the passage of the Community Mental Health Centers Act.

The President's message referred to a "bold new approach" to the care of the mentally ill. Specifically, this new approach referred to the emphasis on community-based services offering local care. Whereas the mentally ill had previously been cared for in isolated state-supported institutions, now they were to be treated in local community-based facilities.

Clearly, this emphasis on local care was the major thrust of the new federal program, but for many observers there was a second, equally important, new approach introduced by the program: the concept of providing federal assistance for the provision of services for the mentally ill. State governments had assumed almost total responsibility for the care of the mentally ill since the middle of the nineteenth century; prior to that time, it had been local governments that had provided such services as were

available. The federal government was involved in providing mental health services only for certain specified populations, for example, American Indians, military personnel, merchant seamen, drug addicts, and residents of the District of Columbia. Otherwise, the federal role had been restricted to the support of research and training. Now, however, in 1963, the President and Congress were proposing that the federal government begin to play a major role in the provision of mental health services for all Americans.

The federal government, of course, was not seen as being about to assume full responsibility for the care of the mentally ill. Instead, the federal Community Mental Health Centers Act called for the joint participation of federal, state, and local governments in this work. In addition, the legislative history of the act clearly shows the expectation that the new local programs would utilize both public and private funds for their support.

Still another element of basic strategy in the federal program was that the federal dollars were to be used as “seed money.” Federal grants were to be made in a manner that would help local communities in establishing their own mental health programs, but once established it was anticipated that the federal support would quickly be phased out. In its place, the local program was expected to rely on financial resources in its own state and community.

The Federal Legislation

As originally conceived, the federal support for local mental health programs was to be provided in two forms: (1) grants for the construction of new mental health facilities and (2) grants to assist in meeting the costs of staffing the new facility. In effect, the construction and staffing grants were originally intended to complement each other, for the initial proposal provided that staffing grants would be available only to those local mental health programs that had received support for construction.

When Congress considered the proposed legislation, there was already a long history of federal support for the construction of health facilities. Indeed, the Hill-Burton hospital construction program had provided funds to assist in the cost of building local hospitals since 1946. Moreover, hospital groups throughout the country actively supported the idea of another health facility construction program, particularly one that might give further support to building programs in general hospitals. While federal construction support was well established, however, the concept of direct federal support for the provision of services was essentially unknown. There were very few federal programs providing funds to help nonfederal agencies to meet the costs of staffing a health care program. Moreover, there was active opposition to the idea of providing such federal support. Much of this opposition came from medical groups throughout the country. At the time, these groups were concerned about the development of any new federal program that supported services as opposed to facilities.

Given the history of federal involvement in health and mental health programs, the active support that was available for a new federal construction assistance program, and the active opposition to federal financial support for services themselves, it is hardly surprising that the legislation that was enacted in 1963 provided authorization only for a construction program. The Community Mental Health Centers Act of 1963 made no provision for staffing support. Nevertheless, the Act did depart significantly from previous federal health facilities construction legislation. Specifically, the Community Mental Health Centers Act established eligibility for federal support in terms of a carefully defined program of services. Earlier federal health facilities programs had defined eligibility simply in terms of construction requirements, but the new community mental centers program set forth rigid guidelines in regard to the services to be provided within the new facilities.

The 1963 legislation authorized federal construction support on a formula or grant-in-aid basis. This meant that, of the total amount to be appropriated by the Congress in any given year, a specified proportion would be allocated for each state. The state allocations were based on a formula that had been well established during the history of the Hill-Burton program. It provided for the distribution of funds on the basis of such factors as population and per capita income. Requests for federal assistance had to be initiated by the sponsors of individual community mental health centers, but

it was required that each application be consistent with a previously approved plan for the development of community mental health services throughout each state. The development of this plan was the responsibility of a designated state agency, and this agency was also to be responsible for the administration of the federal grant program within the state. It was required that the state agency's plan identify the various geographic regions of the state and, furthermore, indicate the relative priority of need for additional mental health services within each region. Having done this, it was then the responsibility of the state agency, acting through a public advisory committee, to pass on each application for federal construction funds.

The federal construction program was thus heavily dependent on administration at the state level. To be sure, each request for a federal construction grant had to be reviewed by a national committee. Before reaching this committee at the federal level, however, each applicant agency had to receive the support of the public advisory group (or state construction council as it was often known) within its own state.

Because of the emphasis on administration at the state level, the operation of the program could not help but vary somewhat from state to state. In some states there was emphasis on the development of services in urban areas, while in others the emphasis was on the development of services in rural communities. In some instances the state mental health authority

provided a considerable amount of assistance to local agencies involved in the development of construction grant applications, while in others the state agency played a much more passive role. What is more, the program was so structured that there was variation among the states in regard to the level of federal support. This variation was another feature derived from the existing federal program for the construction of hospitals. The level of federal support for each construction project varied from one-third of the costs of the construction to two-thirds of the cost. This proportion, the federal share, was predetermined for each state, and the same percentage was applied to all projects within that state. Each state’s federal percentage, like its proportion of the total federal appropriation, was determined on the basis of the state’s socioeconomic level.

This concept of a fixed federal share for construction grants in each state was reaffirmed by the Community Mental Health Centers Act Amendments of 1967. These amendments renewed the construction program authorization in its original form. In 1970, however, the program was somewhat modified. Amendments adopted in that year provided for a higher level of federal construction support for community mental health centers in poverty areas. More specifically, the amendments authorized a uniform 90 percent federal share for centers serving poverty areas in all states.

Federal Support for Staffing

Although the original Community Mental Health Centers Act of 1963 failed to provide for staffing grants, the amendments of 1965 provided for this staffing support. During the two years following passage of the original Act, much had happened to clear the way for this additional form of federal support. For example, as the comprehensive mental health planning projects continued in each state, the concept of the community mental health center became more widely known and more readily accepted. This growing acceptance led citizens' groups, legislators, and professionals to become increasingly concerned about the availability of financial resources that could support the new centers. As a result, there was a steady increase in the extent of public support, and indeed public demand, for federal staffing assistance.

The federal staffing grants were authorized in such a way that they were to be administered quite differently from the construction grants. Rather than being a formula or grant-in-aid type of program, the staffing support was to be administered through project grants. This meant that each application was to be considered in nationwide competition, and each grant was to be awarded from the total pool of appropriated funds. There were to be no state allocations, and as a result, the state mental health agencies were to play a somewhat less significant role in regard to staffing grant applications than they had become accustomed to playing in regard to construction grant applications. The state agencies were asked to review each request for staffing support, but these agencies were denied the veto power that they

were able to exercise in the case of individual construction applications.

The 1965 amendments also specified a standardized federal share for staffing support. Whereas states differed in the level of federal construction support to which they were entitled, every state was to receive the same level of federal staffing support. Each eligible community mental health center could receive federal support at the level of 75 percent of staffing support during the first fifteen months of operation. During the next twelve months, the center was eligible for federal support at a level of 60 percent of staffing costs. The federal percentage was then to drop to 45 percent for twelve months, and finally it was to drop to 30 percent for the final three months of the grant. This meant that each center could expect federal support for staffing during a total period of fifty-one months.

Another significant feature of the original staffing grant authorization was its rather narrow definition of eligible staffing costs. Under the terms of Public Law 89-105, community mental health centers could receive federal staffing support only for the costs of professional and technical personnel. These personnel were defined as staff members with responsibility for direct patient care. Clearly, the legislation provided no federal support for costs of operation other than those relating to personnel, for example, rent, utilities, and supplies. Moreover, because of the definition of eligible staff, the federal support could not be used to help pay the salaries of purely administrative

personnel, clerical staff, maintenance and housekeeping staff, or kitchen help.

The more recent history of the federal staffing legislation is similar to that of the construction legislation. The 1967 amendments to the Community Mental Health Centers Act renewed the program of staffing support with little change in its format. In 1970, however, the additional amendments broadened the staffing program in several respects.

One major element of change was a lengthening of the period of time during which a community mental health center might receive federal staffing support. Whereas the initial legislation had provided for a maximum of fifty-one months of support, the 1970 amendments increased the length of support to a total of eight years. Moreover, the 1970 amendments specified that a center could receive federal assistance at a level of 75 percent of eligible staffing costs during the first two years of this grant period, at a level of 60 percent during the third year, at a level of 45 percent during the fourth year, and at a level of 40 percent during the final four years. By increasing the level of the federal share and the length of time of federal support, these amendments substantially increased the federal government's financial commitment to each new community mental health center.

In addition, the 1970 amendments provided for preferential support for community mental health centers in poverty areas. Just as these centers were

to be eligible for construction support at a level of 90 percent, so too they were to be eligible for staffing support at a much increased level. The length of federal support for staffing was again set at eight years, just as for centers serving non-poverty areas. During the first two years of the grant period, however, a community mental health center serving a poverty area became eligible for federal staffing support at a level of 90 percent of eligible costs. The amendments further provided that the federal share was to be 80 percent during the third year of the grant, 75 percent for years four and five, and 70 percent for the final three years.

Also of great significance was the 1970 change in the definition of eligible staff costs. This change also provided for a substantial increase in the extent of federal support for each community mental health center. Prior to the passage of the 1970 amendments, centers could receive federal support only for those technical and professional personnel who met the rather narrowly defined criteria outlined above. Under the terms of the 1970 amendments, the federal staffing funds could be applied to the salaries of almost all center personnel. The only personnel excepted were to be those considered to be minor clerical staff, maintenance staff, and housekeeping personnel. Otherwise, all staff—clinical, administrative, and clerical—might be included in the federal grant.

Concepts and Services

As originally conceived for the federal program, a basic purpose of the community mental health center was the provision of local services. The goal was the care of the mentally ill patient within his own community. In this way he was to have the advantage of having the support of family, friends, and job available to him. In order for local care to be provided, however, it is necessary that the community mental health center make its services maximally accessible. The accessibility must be achieved not only through the physical placement of the center within the community that it serves but also through the development of center services that are available on a twenty-four hour per day, seven day per week basis.

Clearly, for the community mental health center to serve a local population, it was necessary that there be created a mechanism for specifically identifying the community to be served by each center. In the course of developing the federal community mental health centers program, considerable thought and attention were paid to the issue of defining the community to be served. The mechanism chosen was to define the community in terms of a specified geographic area having a predetermined number of residents. This geographic area was designated the catchment area, and according to the federal regulations each center must serve a specific catchment area having a population of 75,000 to 200,000 residents.

These population limitations were based on an awareness of the

center’s need to develop economically feasible programs, on the one hand, and its need to relate to many other community agencies, on the other. Accordingly, the 75,000 minimum population was chosen because it appeared that a center serving fewer than 75,000 persons would not be able to mount an economically efficient program. On the other hand, the 200,000 maximum figure was chosen because it appeared that a center serving more than that number of people would be unable to develop strong program ties with other human service agencies. In actual fact, as community mental health center grant applications were processed, it soon became clear that these figures could not be applied to all communities. In some cases it was more reasonable for a center to serve fewer than 75,000 persons, and in other cases it was more reasonable for the center to serve more than 200,000 persons. Accordingly, many mental health centers were awarded federal grants and at the same time granted an exception to the basic population requirements.

The concept of offering local and accessible services has constituted one of the basic principles of the federal community mental health centers program since its inception. Another basic principle has been that of offering comprehensive services to the population served. In regard to the community mental health center, the word “comprehensive” was defined as having several meanings. In order to be comprehensive, it was anticipated that a community mental health center would have to provide a variety of types of

care, and it would have to provide this care for a variety of types of illness. Thus, each community mental health center must provide services for all residents in the community—the young as well as the old, the psychotic as well as the neurotic, the alcoholic as well as the school dropout. Moreover, the center must offer services that are appropriate for each individual patient's specific problem.

In an effort to provide the necessary variety of services, the federal community mental health centers program requires that each center offer a minimum five essential services: (1) inpatient care; (2) outpatient care; (3) emergency services on a round-the-clock basis;

partial hospitalization (at least day hospital care and, optionally, night hospital care); and (5) community consultation and education. In addition, it is recommended that each center offer an additional five services: (1) pre-care and aftercare for patients hospitalized in long-term care facilities; (2) diagnostic services; (3) rehabilitation services; (4) research and evaluation programs; and (5) training and education programs. A center that offers the five essential services is eligible for federal support, but according to the definitions of the federal program, a center is not comprehensive unless it offers all ten services.

It is easily noted that both the list of essential services and the list of

comprehensive services emphasize the care of the patient who presents himself at the center with a mental disorder. In public health terminology, these services are oriented to secondary prevention (the reduction of prevalence of disease through early and active treatment) and tertiary prevention (the reduction of residual disabilities through rehabilitation and follow-up programs). In addition, it is a clear intent of the federal community mental health centers program that each center develop an active program of primary prevention. Such a program is one designed to reduce the incidence of mental disorders, that is, to reduce the number of new cases of mental illness that develop within the catchment area. In terms of the original concept of the federal program, the service to be principally involved in a center's efforts at primary prevention is its program of consultation and education. Consultation and education are seen as the mechanism through which the professional staff of the community mental health center can help other local caregivers to maximize their own ability to identify and help the person who is potentially mentally ill. Consultation and education efforts are directed largely at those professionals outside the mental health field who work with people in times of personal crisis. Thus, most community mental health centers have focused their consultation and education programs on schoolteachers, clergymen, probation officers, welfare workers, and others in similar positions.

Although a consultation and education program constitutes one of the

required elements of service in a community mental health center, it is clear that consultation and education activities have received only limited emphasis in many of the early centers. The major emphasis has been placed upon the development of direct patient care services, while preventive programs of consultation and education have been given a much lower priority. Indeed, the typical early center has devoted only about 10 percent or less of its program efforts to consultation and education.

This limited development of consultation and education programs has been attributed to several factors. One of these is the relative newness of these activities as part of the mental health professional’s work. Most mental health professionals have been trained in the provision of direct patient care services, both diagnostic and therapeutic. The practice of preventive psychiatry is a rather new development, and as a result it has not been included in the traditional training program curricula. A second reason for the limited emphasis on consultation and education services can be found in the fiscal circumstances of many centers. Even when a community mental health center receives a large federal staffing grant, the center must still find funds not only to match the grant but also to pay for those aspects of its operation that are not covered by the grant at all. Accordingly, most centers have emphasized the provision of services for which they could receive direct reimbursement or some other kind of financial support. Unfortunately, financial support for consultation and education programs is not readily

available. Indeed, in many instances, the centers themselves have been expected to pay for the consultation services they have provided to other agencies. This has been particularly true during the early phases of the development of consultation programs.

Those responsible for the administration of the federal community mental health centers program have been well aware of and much concerned about the limited development of consultation programs. As a result, it is not surprising that the 1970 amendments to the federal Community Mental Health Centers Act included a special provision to increase the amount of federal support available for these consultation and education services. Specifically, the amendments authorized supplemental grants to community mental health centers to assist them in meeting the costs of staffing their consultation units. These supplemental awards are to be provided in addition to any support for consultation and education services that is included in a basic staffing grant.

It must be noted that consultation and education services are not alone in having suffered from limited emphasis in the typical new community mental health center. As the first centers began operation, it quickly became evident that even their direct diagnostic and treatment services were restricted in respect to some patient groups. In particular, services were typically available on only a very limited basis for alcoholic patients, drug-

abuse patients, and, to a lesser extent, children and adolescents. Accordingly, in an effort to strengthen the direct services for these patient groups, the Community Mental Health Centers Act amendments of 1970 included special provisions for supporting services for these groups. Specifically, the measure authorized special staffing grants to support these highly specialized services.

Many of the early centers found it difficult to establish specific services for children and other groups, and many centers found it difficult to establish specific consultation and education programs. In addition, many centers faced a more general developmental problem. The federal program guidelines required that a community mental health center offer all five essential services in order to be eligible for a federal grant. The regulations further required that all five services be operational within approximately ninety days of the starting date of the grant. For many centers, it was indeed difficult to establish all the services within the required time period. In many instances the problem was one of getting all the services going at the same time. Other communities faced a problem in organizing a planning effort that was adequate to lay the necessary groundwork for the creation and opening of a community mental health center. Both problems were particularly severe in communities that had previously had extremely limited mental health resources, and these problems were perhaps most severe of all in those poverty areas that lacked human service resources of almost every kind.

The existence and persistence of these problems made it clear that the federal community mental health centers program as originally conceived was deficient in regard to its support for local planning. Although state level planning had been emphasized by the comprehensive mental health planning support and by the construction plan requirements of the community mental health centers program itself, the original Act paid little attention to the need for local planning.

In an effort to correct this deficiency, the Act was amended in 1970 to provide assistance for local planning and also to give individual centers a longer period of time in which to implement their services. Specifically, these new provisions of the federal program were aimed at centers being established in poverty areas, and they were also aimed at centers in the process of establishing services for children and adolescents, alcoholics, and narcotic addicts. The 1970 amendments authorized grants to assist in the "initiation and development" of those centers that are to serve poverty areas and those that are establishing services for one or more of the special population groups. These initiation and development grants can be made for a term of one year and can provide the recipient with up to $50,000. In addition, the amendments of 1970 allowed those centers that serve poverty areas to begin operation of their five essential services over a period of eighteen months. As a result, it is possible for centers to receive special federal support during the planning stage and also to receive staffing support

while phasing in their programs.

Amendments to the original Community Mental Health Centers Act of 1963 have thus introduced continual modifications into the original program. One aspect of the program, however, has not been changed. This is the requirement that federal staffing funds be used only for the support of new services. The intent of Congress was originally and has continued to be that federal money be made available to help in the development of services that have not previously been available.

For operational purposes, however, it should be noted that a “new service” can be defined in any one of several ways for purposes of determining eligibility of federal support. Clearly a service is new and thus eligible for federal support if it has not been previously provided by the applicant agency or any predecessor of the applicant agency. Alternatively, a community mental health center can receive support for a new service if this particular service is to be provided through the use of a treatment method or delivery mechanism that has not been previously available. Finally, the federal law and regulations make it possible for a community mental health center to be funded for the operation of a service that has been in operation on a pilot or trial basis for a period of not more than nine months prior to the time of application for a federal staffing grant.

Administration of the Federal Program

Responsibility for the operation and administration of the federal community mental health centers program has been vested in the National Institute of Mental Health (NIMH). Staff members of the NIMH have been assigned the task of reviewing and passing on each application for center funds. When considering a staffing grant application, the NIMH staff has exercised final and full authority. Each staffing grant applicant essentially makes his request directly to the NIMH, and it is the NIMH that acts directly on the application. As noted above, however, the mechanism of operation of the construction grant program is somewhat different. Essentially, the NIMH shares its authority for the review of construction grant applications with a governmental agency designated for each state. The federal reviewers have the final but not full authority. A construction grant application can be reviewed at the federal level only if it has been approved and forwarded by the state agency.

Originally the administration of the community mental health centers program was assigned primarily to the staff of the NIMH central office in Washington. As the program was first structured, the work of the several NIMH field officers was to provide consultation to those applicants who sought federal funds. More recently, however, the review and approval role of the regional offices has been considerably strengthened. Construction grants

are still reviewed by committees established in each of the ten regional offices, and the recommendations of these committees now go directly to the National Advisory Mental Health Council for final review. It is the council, which has been established by federal statute to advise the surgeon general of the Public Health Service in regard to matters pertaining to mental health, that now makes the final recommendation regarding the approval or disapproval of each staffing grant application.

Resources for Community Mental Health Centers

The operation of a community mental health center is dependent on three basic resources: money, staff, and physical facilities. The purpose of the federal community mental health centers program has been to provide assistance for centers in obtaining needed resources in all three areas. The federal approach has been to provide direct assistance in regard to financial resources, and thus indirectly the federal program has provided assistance to centers in obtaining the needed physical plant and personnel resources.

Unfortunately, the federal program has never provided funds at the rate originally intended. During the first four years of the operation of the construction program, Congress authorized a federal expenditure of $200 million. In actual fact, however congressional appropriations provided only $180 million during this time, and, moreover, because of administrative

decisions made by the executive branch of the federal government, the amount of money actually available for expenditure by the NIMH during this time was only $135 million. In addition, it must be noted that in subsequent years the amount of money available for construction grants has been substantially less than the level anticipated by the original planners of the program.

The same unfortunate fiscal history can also be seen in regard to the staffing grant program. During the first three years of the program's existence, the congressional authorization amounted to a total of $73.5 million. Of this amount, less than $60 million was actually available for distribution to applicants. As in the case of the construction grants, the amount of federal money available for staffing grants has been less than the amount originally anticipated.

Clearly, it was never intended that federal money alone be used to bring about the creation of community mental health centers. It was anticipated that state and local governments would provide some of the needed financial support and that private resources would also be used in the development of local centers. Unfortunately, however, it has turned out that the availability of funds from all these sources has been quite limited. As a result, at a time when centers have been faced with limitations in availability of federal funds, they have often been unable to find alternative sources of financial support in

their local communities or state governments.

Federal, state, and local governmental bodies have all been attempting to deal with expanding resources necessary to meet the total needs of the community mental health centers program. In a like manner, private resources have not been able to expand with sufficient rapidity. Originally it was expected, for example, that the growth of private health insurance would significantly aid in the funding of community mental health centers. In actual fact, however, the growth of health insurance benefits for mental illness has not fulfilled expectations. A case in point is the insurance coverage of day hospital care. Many health insurance policies still do not cover such care, and as a result centers are frequently denied this potential resource for the development of their partial hospitalization programs.

Conclusion

As of early 1971, the federal community mental health centers program had funded approximately 400 local programs, and approximately half of these had begun operation. Some of the funded centers had received both construction and staffing grants, but the majority had received only one type of federal support. The typical center was established to serve a catchment area of about 150,000 persons, and the usual organizational structure included a general hospital and one or more affiliated mental health service

agencies.

The original intent of the federal program was the establishment of 2,000 centers to serve the nation’s entire population. This total number of centers is still the goal, but as the program has functioned for the past several years, the target date for achieving the goal has been pushed further and further ahead. At this point it appears that a nationwide system of centers could not be achieved prior to the 1980s. The gradually increasing delay is a function of limitations in the availability of both federal dollars and local and state matching dollars. Ultimately, however, it continues to be the intention of the NIMH that local mental health programs be established throughout the nation and that these programs take the form of community mental health centers. As such they will be able to offer comprehensive mental health services, and in addition they will be designed to function as one component in a still more comprehensive system of total human services.

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