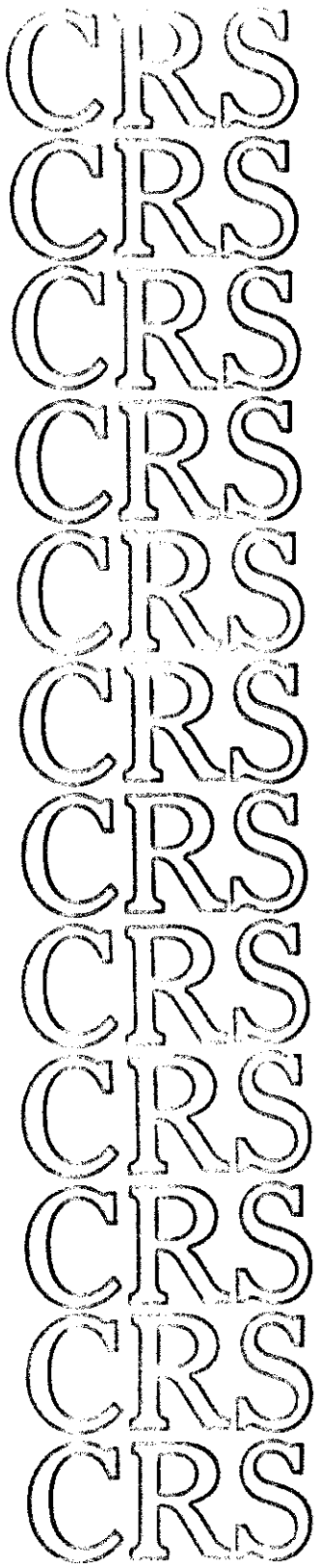

78-45 ED

COMMUNITY MENTAL HEALTH CENTERS

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February 28, 1978

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COMMUNITY MENTAL HEALTH CENTERS

I. PROGRAM DESCRIPTION

Congress created the Community Mental Health Centers (CMHC) Program in 1963 with the passage of the Mental Retardation Facilities and Community Health Centers Construction Act (P.L. 88-164). The centers program was designed to enable most mentally ill persons to be treated in their own communities. Centers were required to provide five essential services in the form of inpatient, outpatient, day care and partial hospitalization, emergency, and consultation and education services.

Since 1963, the program has been amended to broaden and strengthen it. For example, in 1975, P.L. 94-63 prescribed for the first time a definition of a "CMHC" and of the comprehensive services a center must provide. In addition to the previously required five essential services, centers were required to provide specialized services for children and the elderly; assistance to courts and other public agencies in screening individuals being considered for admission to State mental hospitals; follow-up care and half-way houses for those discharged from State mental hospitals; and programs for alcohol and drug abuse, if such services were warranted in the center's catchment area. At the same time, a new grant structure was designated. Six grant programs were defined to provide financial aid to CMHC's. They included planning, initial operation, consultation and education, conversion, financial distress, and facilities assistance grants.

The most recent legislation was a simple extension of the program for one year in the form of P.L. 95-83. Consequently, the legislation will

again go up for renewal during the second session of the 95th Congress. Two legislative initiatives have already been introduced. They include S. 2450 by Senator Kennedy and H.R. 10553 by Representative Rogers. President Carter has also taken some action in the mental health field by creating a Commission on Mental Health. The commission's preliminary report was released in September 1977, with final report due out in April 1978.

II. BUDGET

The fiscal year 1978 budget of $269 million appropriated by Congress for CMHC's allowed for minor increases in the figures for new operations, financial distress and conversion grants. However, even this minor increase represented an improvement compared to the President's original recommendation. President Carter's fiscal year 1978 recommendation would have allowed for no new starts in any category of CMHC grants. Congress' slightly higher figures in the three categories were enough to cover a few new grants but not enough for all applications approved but not funded. No new grants were available for planning, consultation or facilities. The President's fiscal year 1979 budget of $292 million represents a slight increase in funding but no funds were being requested to start new centers. This request would support 452 centers providing services to approximately 1.9 million patients. It is estimated that by 1979, a total of 704 CMHC's will have been assisted since the program's inception.

III. LEGISLATIVE OBJECTIVES

The main legislative objective behind the creation of CMHC's was to establish a community based alternative to county and State mental hospitals for the treatment of mental illness. The 1963 legislation was based on recommendations made by President Kennedy in the first separate special message to Congress on the mental illness and mental retardation problems in the U.S. The core of that message was its emphasis upon community mental health centers and on treatment of patients outside of the large traditionally isolated State mental institutions. In its report on the legislation, the House Interstate and Foreign Commerce Committee said:

> Either we must develop the quantity and quality of community services which will ultimately replace these institutions or we will strengthen the State mental hospitals. The committee believes that the development of new methods of treatment, the impressive evidence of the possibilities for rehabilitating the mentally ill, and a lessening of our disposition to reject and isolate sufferers, all argue strongly for the treatment of mental illness in the community. 1/

The centers program would allow for the delivery of community mental health services by developing a coordinated system of care. In order to meet this goal of community based care for the mentally ill, the National Institute of Mental Health (NIMH) has developed certain program objectives known as process goals to measure the delivery of services.

IV. EVALUATIONS

A. Overview

Program evaluation studies under NIMH may take several forms. These forms include process goal evaluation; development of methodology for evaluation purposes; technical assistance to the individual centers to aid them

in their own evaluation efforts; and policy analysis studies which take a prospective look at programs or look at another agency's programs for insight into one's own.[2/] This paper concerns itself mostly with process goal evaluations. The only real exceptions to this are two studies by the General Accounting Office. A 1974 study reviewed Federal administration of the center program, management activities of 12 centers, and the use of construction grants by 9 centers. A 1977 study looked at the government's role in returning the mentally disabled to the community.

Regarding CMHC's, process goal evaluation refers to the method of taking a concept of the program as it was intended in the original 1963 legislation or in the planning efforts that went on in the middle 1960's, and studying a sample of centers to see if that part of the program is working. NIMH has admitted that most of things they do are not a total program evaluation answering the question once and for all, "are CMHC's effective, that is, having a positive impact on the community?" In 1976, Mitre Corporation and the National Institute of Law Enforcement and Criminal Justice Studies held a symposium, "Administration on the Use of Evaluation by Federal Agencies". In an address during that conference, James Stockdill, Director of NIMH's Office of Program Development and Analysis, said that no cases existed where the institute had done any evaluations which would answer a comprehensive question that would make a change in the total program. He commented:

> What has been useful are projects which were directed at carefully delineated questions about discrete program questions, areas or functions. That is the kind of study that has yielded useful information. There is no way, I think that we could currently design a study to answer the comprehensive question: are CMHC's generally assisting the communities they are located in? That is too long-ranged a proposition, there are too many uncertainties. [4/]

Consequently, instead of addressing the total question of whether the center program is effective, process evaluation looks at a certain concept of that program as an indicator of its success.

B. Process Goals

Certain process goals have been designated by the Centers Program to better serve the larger goals of increasing mental health and reducing mental illness in this country. These goals simply represent various aspects of service delivery in mental health. They include (1) increasing the quantity and range of services; (2) less use of State mental hospitals; (3) responsiveness of services to needs; (4) accessibility of services; (5) equity or a single system of care which is equally available to those with and without the ability to pay; (6) increasing participation in providing services; and (7) organizing for continuity and efficiency of services. 5/

1. Increasing the Quantity and Range of Services

Various data indicate that some progress is being made in meeting the goal of increasing the quantity and range of CMHC services. For example, at the time of the passage of P.L. 95-83, 650 centers had been funded, and 547 were operational. In 1975, approximately 1,600,000 persons received direct services from CMHC's, an increase of 312 percent since 1970. It was estimated that over two million persons would receive direct care from CMHC's in 1977. 6/ In addition, certain legislative initiatives have supported this goal. For example, P.L. 94-63 added to the list of required services for centers.

One 1974 study by the General Accounting Office[7] indicated that required services were being provided by centers. That study reviewed 12 centers, all of which had established the five services then considered essential by NIMH. In addition, the GAO study determined that centers had increased the accessibility, quantity, and type of community services available and had enhanced somewhat the responsiveness of mental health services to individual needs.[8]

One other study focused on a smaller service area. The Joint Information Service[9] found that services covered children in 98 of 143 centers responding to their survey in 1970. However, 31 percent of these centers provided no partial hospitalization to children and 21 percent provided no inpatient care.

2. Less Use of State Mental Hospitals

As previously mentioned, the original intent behind the CMHC program was to provide a system of community-based care. That involves a possible decrease in the State mental hospital population. The Senate Labor and Public Welfare Committee report on the original legislation concluded that if CMHC's were given the go-ahead, it was estimated that the resident population at public mental hospitals could be drastically reduced.[10] Evidence conflicts as to the effect that CMHC's have had on this goal.

One study by Scully and Windle[11] collected data from 16 States to compare counties which were or were not served by federally funded centers. They found no overriding consistent relationship between the emergence of federally funded centers and a change in the inpatient rate in State mental hospitals. In some cases, a decrease in State hospitals resident rate

occurred in counties with centers. However, in others, less decrease was found following the opening of a center. However, the study revealed a trend for the 16 States with a larger decrease in State hospital admission rates occurring in counties with centers as compared to areas in the same State without centers. Consequently, this data appears to support the conclusion that centers have contributed to reducing the admission rate but not the residency rate of State mental hospitals.

A Texas study[12/] observed that greater increases in total admissions to mental hospitals between fiscal year 1967 and fiscal year 1973 occurred in areas served only by hospital outreach (outreach programs refer to services in local and rural communities which operate under the auspices of State mental hospitals) and areas with no facilities. Their admission rate increase amounted to approximately 85 percent. Areas served by community centers and areas served by multiple facilities incurred a 60 percent increase in such rates. The study also determined that a trend was apparent where there was lower utilization of State hospital facilities where center utilization was high. One additional trend was observed. The study found that the greatest hospital utilization was consistently associated with areas containing centers with the shortest average length of time per visit. Overall, admissions increased while residents (with the exception of alcohol and drug clients) decreased during this same period with respect to all groups serviced. A study[13/] by Missett found that the opening of the Connecticut Mental Health Center had resulted in a greater number of patients seeking psychiatric assistance in a community setting than at a State hospital.

A 1977 GAO study looked at the Government's role in returning the mentally disabled to the community. It counters that CMHC's had some positive impact but they have not been entirely successful in reducing unnecessary admissions to mental hospitals or providing services to persons released from such hospitals.[14/] For one thing, GAO maintained that the residential treatment population had been declining before many centers even became operational. In addition, the study charges that comprehensive community-based mental health services that could prevent unnecessary admissions to public mental hospitals and provide a full range of mental health services to persons released from hospitals did not exist in many communities.[15/] For example, the study cited a case where only five of Oregon's 30 county mental health programs offered a complete range of alternatives to State hospitalization.[16/] In addition, GAO claimed that in some cases in this country, psychotrophic drugs and other Federal programs, such as Medicaid and other public assistance programs, have had more of a direct impact on the reduction of mental hospital populations than the CMHC program.[17/]

It is evident that CMHC's have provided some kind of alternative to hospitalization or at least emphasized the availability of some type of community care even if evidence is inconsistent as to how exactly much effect centers have had. For example, 6.9 million patients were treated in mental health facilities in 1975 as compared to 1.7 million in 1955. The outpatient load accounted for 70 percent of the 1975 figure. Community-based services represented most of that outpatient care. However, in 1955, only 23 percent of the patient load were outpatients.[18/] One final caution must be made in review of this particular evidence. Although the emphasis

has been placed on community care, it can not necessarily be considered the best or most appropriate in all cases.

3. Responsiveness of Services to Needs

It is evident that some efforts are being made to respond to needs simply by looking at the 1975 legislation where the number of required services was increased.

Another study supports this contention. ABT Associates' study[19/] of the general public in six center's catchment areas revealed drug abuse and alcoholism most often identified as the most serious mental health problem. Evidence, including 1972 and 1975 legislation requiring services to alcoholic and drug abusers if the need existed in their catchment area, indicates that most CMHC's have increased attention to both these problem areas.

One other indication that some progress has been made in responding to needs is the emergence of poverty areas. In 1970, P.L. 91-211 designated that certain disadvantaged areas would be classified as poverty areas and receive additional support in order to insure the development of CMHC's in such areas. Of the 650 centers funded at the time of passage of P.L. 95-83, 347 or 53 percent were located in urban or rural poverty areas.[20/]

The concept of a catchment area alone also gives the indication of at least trying to respond to needs because it focuses CMHC responsibility and concern on the mental health needs of the population. In the original 1963 regulations, catchment areas are defined according to such factors as population distribution, natural geographic boundaries and transportation accessibility.[21/] A catchment area may be a community, a single city or several counties in a rural area with a population of not less than 75,000 nor more

than 200,000. Only one center may be funded per catchment area. That center then has the franchise to provide mental health services in that area or at least see that those services are provided. Approximately 1500 catchment areas have been designated in the U.S. with about 650 currently being served by a CMHC.

In accessing the viability of the catchment area concept, A. D. Little, Inc.[22/] found it useful in promoting objectives of the centers programs. However, they determined that centers may not have utilized it as fully as possible in trying to match services to needs or in encouraging sharing of available services.

In their 1974 report, GAO claims some problems have been caused by strict adherence to Federal regulations concerning catchment areas. For example, program performance has been hindered by dividing existing planning areas and political jurisdictions.[23/] In addition, GAO also reported that this led to services and facilities being duplicated in some areas. They also found that some mental health services were unevenly distributed within a political jurisdiction. Although responsiveness to needs had been improved somewhat, GAO commented that a better job needed to be done in identifying local mental health needs.[24/] Of course, needs must be identified before they before they can be met. GAO reported that most centers surveyed had not made studies of their catchment areas which would allow them to set priorities and compare services provided against these priorities. The report found that program emphasis was often determined by the availability of funds to match Federal grants and the interests of the center's professional staff.[25/]

4. Accessibility of Services

According to the 1974 GAO report, centers have increased accessibility to their services. Again, this is evident simply by looking at the increase of 312 percent between 1970 and 1975 in the number of people seeking care at CMHC's. However, a study of eight CMHC's and their catchment areas by ABT Associates,[26/] indicated that centers and other mental health service delivery facilities were not well known by the public or community caregivers. If centers are not known, obviously individuals will not take advantage of their services.

According to the ABT Study, approximately one-third of the general public seemed to be aware of the existence of some mental health service in the communities surveyed. However, CMHC's did appear to be the best known among those centers of which the public was aware. The study also looked at certain barriers to seeking care for a mental health problem. ABT determined that psychological factors outweighed physical reasons in preventing individuals from visiting some types of facilities. Psychological factors refer to an individual's awareness of and attitudes toward services. For example, this might include the stigma of mental illness or wanting a personal caregiver. Physical factors refer to such items as center cost, location, hours or other operational characteristics of services. When put into a hypothectical situation of having a mental health problem, only three percent in the community chose their center as a source of help. In fact, the study revealed that few selected any mental health professionals as the first place other than family and friends to go for aid.

5. Equity

Equity refers to how well the centers have developed a single system of care which is equally available to those with and without the ability to pay. After studying the records at 11 of the 12 centers reviewed in their study and census data for the catchment areas, the 1974 GAO study found that those in low-income categories were represented in patient records in numbers well above their proportion in the catchment areas. In addition, it found that, with only two exceptions, centers were serving a mix of patients reasonably representative of the ethnic makeup of the catchment areas. Lack of public transportation and outreach services caused a minority group to be underserved in one area. The study also found that higher income groups tend to seek private care.[27/]

Although the actual study was not completed for NIMH, one interim report by Public Sector[28/] of only two CMHC's determined that inequities existed at the entry and service delivery stages of mental health operations at both centers. Inequity in offering services was most characteristic of one. Inequity in treatment planning was most characteristic of the other. At both, Black patients were treated most inequitably compared to other ethnic groups.

A study by Zeckhauser calls for the Government to be aware of the fact that it controls a number of financial and non-financial levers that can substantially influence the performance of the mental health system including who it serves. The study cites an example where licensing and certification regulations or provisions affecting eligibility for reimbursement from the Federal Government may play an important part. Such regulations

or provisions may influence the mix of patients entering the mental health care system and encouraging or inhibiting the growth of various types of services despite the fact that they may have been inspired to promote the delivery of quality care.

6. Increasing Participation in Providing Services

NIMH guidelines call for community involvement in developing and operating the centers' programs to insure that they will respond to the community mental health needs and have a public base of support. Increased participation in providing services refers not only to consumer participation but to participation by other service agencies as well.

One study by Tufts[30/] concentrated on six CMHC's in four States which were near or overlapped neighborhood health centers and served poverty area populations. Two centers were found to have virtually no relationship to other local health and social service agencies. Of the two, one was just beginning. One center worked closely with the county mental health program but had no relationship to the neighborhood health center. Close relationships were enjoyed by one center with several local government and private agencies. The center even handled a small number of formal referrals to and from the neighborhood health center. Another center operated an active day treatment program in the neighborhood health center building and worked cooperatively with the health center and with the city alcoholism program. The sixth center evolved out of mental health services in a neighborhood health center. In addition, the center maintained structural relations to the model cities agency, the public hospital, a school of social work and a county health department.

Health-PAC[31/] studied a sample of six rural and urban centers. The study determined that centers did not meet community needs or give community members a voice in center affairs. Little evidence was found of meaningful community participation in CMHC policy-making, planning or activities. In only two of six centers reviewed could Health-PAC find that direct community involvement existed. In both situations, peer group activity constituted the community involvement.

The 1974 GAO report criticized that in early years of the program, NIMH placed more emphasis on getting centers operational and making services available than on learning from the community what services it considered most important. They went on to say that the situation had improved somewhat.[32/] P.L. 94-63 addressed this problem of increasing participation in providing services. It required that governing bodies of all new CMHC's under the new law be composed of individuals who reside in the center's catchment area. At least half of that body must be made up of individuals who are not providers of health care.

7. Organize for Continuity and Efficiency of Services

When the CMHC program was established, NIMH developed guidelines aimed at developing a system from the coordinated delivery of services by the centers, State hospitals and other organizations. However, the 1974 GAO study found that the guidelines were not being met because (1) working relationships between the centers and State mental hospitals needed to be improved; (2) effective procedures had not been developed for referring persons requiring mental health services from other community organizations to centers, and (3) some centers were not following up on patients referred

to other organizations to see that services are provided.[33/] According to that report, emphasis on developing a coordinated system of mental health services has varied widely among centers. For example, one center might be well aware of other organizations activities through getting together periodically to mention mutual concerns. However, in other areas, organization officials might not even know about what a center might have to offer. The same problems correspond to relationships between centers and State mental hospitals.[34/]

FOOTNOTES

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27/ Need For More Effective Management of the Community Mental Health Centers Program, op. cit., p. 11.

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