
Task Force Reports

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Manifestly, the findings, opinions, and conclusions of Task Force Reports do not necessarily represent the views of the officers trustees, or all members of the Association. Each report, however, does represent the thoughtful judgment and consensus of the task force of experts who formulated it and it is considered by the trustees a useful and substantive contribution to the ongoing analysis and evaluation of problems, programs, issues, and practices in a given area of concern.

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COMMUNITY MENTAL HEALTH CENTERS

A Report of the APA Task Force To Develop a Position Statement on
Community Mental Health Centers

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Table of Contents

I INTRODUCTION

 Perspective in Regard to Time 1

 Implications of a Defined Population Base 4

II COMMUNITY MENTAL HEALTH CENTER RELATIONSHIPS

 To State Hospitals 6

 To General Health Programs 8

 To the Communities Served 10

 To Private Psychiatric Practitioners 14

 To Funding Sources 15

 To Evaluation 16

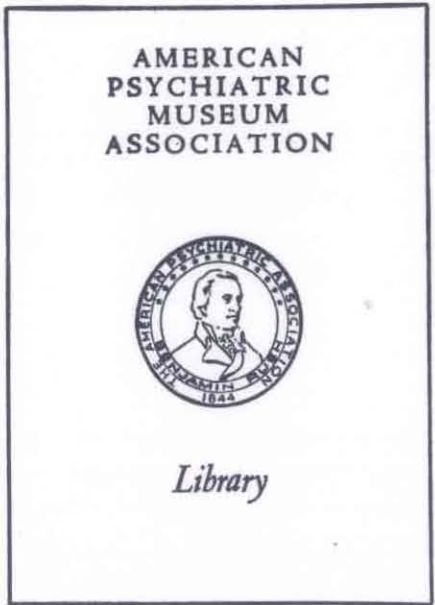
III RELATIONSHIPS OF THE PSYCHIATRIST IN THE COMMUNITY MENTAL HEALTH CENTER

 To Other Human Service Personnel and Other Disciplines 18

 To Nonprofessionals 20

IV ISSUES REGARDING MEDICAL STUDENT TEACHING AND RESIDENCY TRAINING 24

V A POSITION STATEMENT RECOMMENDED 27



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I. INTRODUCTION

Perspective in Regard to Time

The community mental health center is one of psychiatry's major responses to the numerous indications of the need for change in medical practice during what might be called a "third epoch," in which there has been increasing awareness of the necessity to deliver effective, appropriate services to the entire population and to move forward and intensify effort to reduce the incidence of illness. The "first epoch" may be seen as beginning with the Flexner Report of 1910, an indictment of medical training that led to the modern era of professionalism. The second, beginning after World War II, focused on the rapid growth of basic scientific knowledge and the development of techniques to apply this knowledge to medicine — an effort that continues into the present.

This "third epoch" is part of a world-wide revolution affecting all social institutions. The deficits in medical service may be seen in the discrepancy between the high level of medical competence that can be bought by the well-to-do and the lesser competence, or absolute lack of service, for the poor. By now the nation has largely accepted the basic principle of equality of medical care for all Americans, without having yet realized the vast problems that must be solved in order to put this principle into practice. To accomplish this goal will require major federal intervention, together with the support of state and local government, professional organizations, private insurance firms, voluntary health facilities, and associated consumer groups. A climate concerning health care, that until recently was characterized by the dominance of health professionals with whom state and local health departments, insurance carriers, and private hospital boards collaborated, has substantially changed in the face of many new and powerful forces that have become active advocates of change.

Unless this historical perspective is appreciated and weighed, the involvement of the profession of psychiatry in the community mental health centers cannot be managed constructively. This report must therefore be seen as an effort to assess a continuing process of change that will require the most careful thinking of our Association in the years ahead.

Psychiatry, because of the social nature of many of the problems it undertakes to remedy, and because of its comparatively long and close association with government, has already had both the privilege and the burden of attempting to pioneer comprehensive health services through the vehicle of the community mental health center. General medicine is only now beginning to struggle with problems of defined catchment areas, comprehensive state and local planning, continuity of care, and other issues that were confronted some years earlier by psychiatry. Federal comprehensive health planning legislation, OEO health centers, and Model Cities health components signal the same development for much of the remainder of public medicine.

Affecting both psychiatry and medicine in general is the increased pressure for a national health insurance program with a major emphasis on early detection and other preventive efforts. The question of quality control of the services paid for through a national insurance system is at issue, as well as who will evaluate the quality. Added to these conceptual developments are the concrete realities of: a) scientific developments in medicine and psychiatry, which do not stand still while the nation debates the political and economic issues of distributing care; b) an expanding technology for handling information through automatic data processing, ready to be used in solving many of these problems; and c) a growing cadre of nonmedical health professionals and paraprofessionals, offering solutions to problems and seeking roles of increasing importance in such national efforts.

In summary, some of the problems of community mental health centers are related to much broader social, economic, and political issues. They would be inherent in any pioneering effort. Many of these problems will be solved only as certain of the larger medical, social, and economic problems of our nation are attacked.

To sharpen this focus, let us consider some of the social movements and concerns which have an impact on mental health centers as health delivery systems and on psychiatry as a profession.

One movement is toward decentralization. This is seen in the present Administration's emphasis on "creative federalism" and in the increasing responsibility which the Department of Health, Education and Welfare is placing on its regional offices. In some states (e.g. California), much authority and fiscal resources for human services have been passed to local government and citizen bodies. To the extent that the community mental health centers represent local efforts to take over a responsibility previously almost totally vested in the state, it is congruent with this broader national trend. A corollary of more decentralization is more local control; and in mental health, patterns for the delivery of services may vary greatly from place to place and be less subject to influence by centralized govern-

mental and professional constraints.

Another movement is "participatory democracy," seen in the desire of college students for "dialogue" with college administration, in the desire of parents for local control of public schools, in "maximal feasible participation" of residents in OEO and Model Cities programs, and in organizations for consumer protection and control. This movement may have great effect on the planning process, policy setting, and administration of community mental health centers.

A related trend is an increasing skepticism about professional competence, posing questions about the wisdom, motivation, and judgment of the professional. Few psychiatrists who deal with adolescents and young adults escape such questions and numerous mental health centers have already felt its impact in areas of patient care, community relationships, and personnel training and supervision.

The role of the professional and the balance of power between the server and the served are under pressure to change rather drastically. We have seen this in general medical services in some metropolitan areas under the Title XIX Program (Medicaid) where welfare and recipient indigents are free to choose their own medical agents and have rejected the traditional public "charity" general hospital. A national health insurance program obviously has special implications here as the consumers, including those who can currently receive services only from state hospitals and mental health centers, gain the economic resources whereby they can have access to other agencies and services.

There is also increasing pressure for accountability, broadened beyond informal monitoring by one's peers. Both the consumer and the government are increasingly concerned with what is being received for the dollars invested, with whether the health and mental health services are relevant to the perceived needs of the people being served and with whether quantitative goals are being attained. The days of unquestioning public support for professional education, research, and demonstration projects seem about at an end. Future support may be much more closely tied to attainment of goals.

It is clear, and we acknowledge without qualification, that community mental health centers cannot be either the "property" or the responsibility solely of psychiatry. Improving their effectiveness and clarifying their goals require the sharing of efforts with psychology, social work, nursing, and education, as well as with federal, state, and local governments and consumer constituencies. Certainly one of psychiatry's greatest challenges now is to define our special expertise and to provide leadership accordingly, while learning to work cooperatively with the other mental health workers and with the consumers of services, each in his own area of greatest competence.

The Implications of a Defined Population Base

The most crucial element differentiating a comprehensive community mental health center from most other local psychiatric facilities is that it is assigned responsibility for the mental health of all residents of a defined geographic area. The implications are profound and revolutionary. Traditionally, the status of being a patient is self-assigned or is assigned by family, friends, police, or physicians other than psychiatrists; the role of the psychiatrist has been essentially to legitimize this status. The psychiatrist in a community mental health center must view all residents in his community as patients or potential patients. While the community may in the past have accepted deviant behavior, or defined it in other terms than illness (e.g. as badness or criminality), now the responsibility of the community mental health center psychiatrist is to make appropriate help available in the community.

4 In playing this new role, it is fair to say that the psychiatrist has not yet, by and large, proven himself adequately imaginative or innovative. The psychiatrist tends to remain content in doing what he has learned how to do, to teach medical students and residents what he knows how to do, and to focus his research and experimental efforts on doing better what he already knows how to do. So long as psychiatrists allowed patients to be defined for them, they felt justified, though regretful, in asking those whom they could not help at once to wait their turn; but if the psychiatrist himself defines the need for help and is responsible for providing service to the entire community in need, a waiting list becomes insupportable. Traditionally, when patients did not respond to the techniques available to the psychiatrist, they were thought to be poorly motivated, or too beset with reality problems to participate in psychotherapy, or as incapable of interpretation, restraining impulses, and utilizing insights. The community mental health center psychiatrist must remain responsible for such patients and invent new services and techniques.

The "catchment area" concept thus forces a confrontation between the community mental health center staff and the mental health problems of the community. The psychiatrist in the community mental health center must develop services for larger numbers of people than he has been accustomed to, develop continuities between service elements where formerly there were none, and plan for population groups and for behavior disorders he has rarely had to deal with before.

Perhaps an even greater challenge is the demand for primary preventive approaches and for a role for the psychiatrist in health enhancement and maintenance. At the level of secondary prevention,

it must be recognized that most people with emotional problems do not initially define themselves as psychiatric patients, and as a consequence, much of the work of a community mental health program must be invested in casefinding or outreach efforts.

Even in the face of tightening of finances there has been a relatively broad acceptance of the mental health professional's increasing concern with the "quality of life," not just with the prevention and treatment of flagrant illness. Such concern can be so broad as to lead mental health into areas where it has neither the license, the knowledge, the public support, nor the resources to effect change. On the other hand, if we conceptualize persons with behavioral difficulties and emotional dysfunctions as being "adaptational casualties," then we must be concerned with human ecology.

The concern with the "quality of life" and with environmental stress raises immediate issues as to the applicability of the "disease model." In turn, the common conceptualizations of "doctor," "patient," the "contracts" between the parties involved in treatment, and their mutual "responsibilities," both ethical and legal, must be called up for reappraisal. These are among the most pressing challenges facing mental health workers in general and American psychiatry in particular. The community mental health center did not produce them, but it does offer a beginning framework in which to experiment with solutions to some of them and a locus for seeking solutions both to new problems and to old problems recast in a new light.

As the goals of community mental health programs broaden to embrace such areas as marital harmony and vocational effectiveness, the relevance of psychiatry becomes increasingly uncertain. The psychiatrist in a multiservice storefront center, a city planning commission, or a public housing or employment agency is likely to hear from both his more traditional psychiatric colleagues on the one hand, and from the lay and professional members of these agencies on the other, the question which has become the apotheosis of the shift in focus from mental illness to mental health, "What has this to do with psychiatry?". Frequently the question is followed, again both by psychiatrists and by agency staff and consumers, with the accusation that psychiatrists have no special expertise for such work in the mental health area. But in fact, the psychiatrist, through his clinical training and experience, may be especially well qualified to identify those sources of stress which represent important threats to emotional well-being. In any case, the potential of the psychiatrist to contribute in such areas ought to be determined by the quality of his performance. Until further experience provides better guidelines, the role of a psychiatrist in a program for improving mental health cannot be rigidly defined.

II. COMMUNITY MENTAL HEALTH CENTER RELATIONSHIPS

To State Hospitals

6 The community mental health movement emerged as an effort to provide comprehensive and accessible local alternatives to a system of public mental hospital care. That system had been largely mis-conceived as centered around a highly exaggerated and outdated image of huge mental hospitals, geographically remote from the communities whose residents they served, security minded, and custodial in orientation. In fact, state mental hospitals had begun to change some time prior to the publication in 1960 of *Action for Mental Health*, the report of the Joint Commission on Mental Illness and Health. These hospitals had begun to unlock wards, active treatment was replacing custodial care, partial hospitalization programs were appearing, aftercare teams were going into the community, and the average daily census of state hospitals had been declining for five consecutive years. The Joint Commission's report accelerated these trends, strengthened the public mental hospitals, and rendered them more relevant to patient treatment.

The boundary between community mental health centers and state hospitals remains undefined. The distinction suggested by the Community Mental Health Center Act of 1963, which implies responsibility for long-term care to the hospitals and for short- and medium-term care to the centers, does not mean a great deal in the light of the sharp decline in the duration of stay of patients in *all* psychiatric hospitals. What is of great concern is the possibility that mental hospitals, as they become ringed by community mental health centers, will become repositories for the most chronic patients and for those unresponsive to current treatment techniques. The centers are likely to enjoy better financing and to have more opportunities for promotion, and thus to attract more dynamic staff members. Most important, the community-based mental health centers will have first contact with patients, and are likely to transfer to the state hospitals the chronic schizophrenic patients in their fifth or tenth psychotic episode, the geriatric patients with chronic brain syndrome, the alcoholics, and the neurologically damaged patients.

There is the danger that thousands of patients will be condemned

to chronicity by this very structure of mental health services. A more rational relationship between community mental health centers and state mental hospitals must be evolved.

A separate set of considerations points in the same direction. There are, in effect, in some areas of the country, two parallel, separate, and competing mental health systems. The state mental hospital system concentrates its efforts on the more disabled end of the spectrum of severity of illness and the community mental health center on the less disabled end, with considerable overlapping in the middle. The discontinuity between the two systems is marked, and the transition from either one to the other is too often sharp and abrupt. This can foster a destructive competitiveness in which the members of each system experience the transfer of a patient to the other as a surrender or defeat. The effect on patients may be still more disastrous. The administrative structure of some state departments of mental health, with separate deputy commissioners for mental hospitals and for community programs, is almost calculated to promote the separation of hospitals from community mental health centers.

7 Because many state hospitals are already divided into units serving particular geographic areas, and because about half of the country's population lives within an hour's drive of a state mental hospital, more of these hospitals might accept responsibility for the catchment area in which they are located. Adolf Meyer's recommendation 60 years ago that state hospital staffs provide outpatient treatment and aftercare should be more fully implemented than is the present case.

Staff sharing, compatible record systems, and joint participation in regional mental health planning would promote liaison between mental hospitals and mental health centers. To accomplish all this will require many hospitals to make a greater effort to develop cordial, cooperative relationships with, and support from, their own localities.

Programs that in the past were assigned to the state hospital for lack of other alternatives — to inpatient treatment of children, the mentally retarded, the deteriorated aged, and the legally incompetent criminal — should be re-evaluated in terms of present needs, alternative resources, and availability of funds. When such patients can be most appropriately served by the state hospital, programs for them should be adequately funded and staffed. Where they are inappropriate, they should be eliminated as burdens on the hospital staff's treatment responsibilities. Determining boundaries between hospital and mental health center will be difficult precisely because the decision-making authority will have been vested in a state agency that developed around the operation of hospitals, which may see any

contract for services to community agencies as diminishing its own scope and budget.

For all these reasons, a range of models for effecting liaison between community mental health centers and state mental hospitals should be established and tried out. There can be no single pattern, because of differences in the nature of the population served, the urban or rural setting of community mental health center or hospital, the distance between the two, and so on.

To General Health Programs

Mental health services should be closely coordinated with other health programs in a community. When the community mental health center serves a very poor neighborhood, where the level of general health is very low and the need for general health services is abundantly clear, such coordination is particularly important.

Various mechanisms have been used to tie community mental health centers to other health and medical programs in the community. One has been the placement of the community mental health service in a general hospital. Since the general hospital typically serves as one of the sponsoring agencies of the center, it provides a link between the mental health program and the rest of the health service system. A second mechanism has been the involvement of local physicians, including nonpsychiatrist physicians, in the program of the community mental health center. A third approach has evolved through the development of specific ties between community mental health centers and neighborhood health centers. Some poor communities are now served by both a community mental health center and a neighborhood health center, and the two have common program development and joint program operation.

The general hospital, whether public or voluntary, is clearly one suitable locus for the community mental health center. In the case of voluntary hospitals, the entire hospital may wish to consider switching to a designated catchment area rather than continuing to attempt to serve whatever patients apply from an unspecified area. The public general hospital, on the other hand, can overcome traditional restrictions on providing services for those in the community who are able to pay for needed care. General hospitals have been able to capitalize on their orientation to community-based acute treatment services, while at the same time they have been able to develop extramural outreach services in addition to their traditional inpatient oriented treatment programs.

As a side issue, it would be well for the Department of Health, Education and Welfare to reconsider the regulations relating to con-

struction of psychiatric facilities in general hospitals. Such services for many years were eligible for funding under the Hill-Harris (formerly Hill-Burton) Act. With the enactment of the federal community mental health center act, Hill-Harris funds became unavailable for constructing psychiatric units in general hospitals until such time, in each fiscal year, as all community mental health center construction funds were exhausted. This meant that any such applicants could be approved only if they submitted a plan to provide all five of the "essential" services required by the community mental health center program. Thus, various hospitals that might have found themselves able to mount an inpatient and partial hospitalization program, for example, found themselves unable to obtain federal construction support for anything at all, because they were unable to finance their portion of a five-service facility. There is some evidence that the community mental health center program therefore actually eventuated in a reduction in the rate of growth of general hospital psychiatric units. It would seem reasonable for Hill-Harris funds to be made freely available once more for psychiatric services, just as they are freely available for many other kinds of specialty sections of general hospitals.

Each community mental health center is also expected to encourage participation in its program by local physicians who are not psychiatrists. This participation makes it possible for referring physicians to take part in the care of their own patients who are receiving services at the center. Many severely ill mental patients are identified by medical practitioners and referred by them. Moreover, within the setting of the general hospital, psychiatric complications of medical and surgical illness are so common as to require that the psychiatrist be readily available to provide consultation for his medical and surgical colleagues. Conversely, many patients suffering from mild mental disorders can be referred to general physicians for care in an outpatient setting. Services for emotionally disturbed and mentally retarded children, in particular, require intensive collaboration between psychiatrists and general practitioners, family physicians, pediatricians, and pediatric neurologists. Family practitioners are also frequently in the best position to provide aftercare and follow-up services for aged patients and for former mental hospital patients, especially when psychotropic drugs constitute a major component of the long-term treatment. The alcoholic patient may also require medical management in addition to psychiatric services. Moreover, the prevention of suicide and the identification and management of depression are problems not only for the psychiatrist but also for family physicians and specialists of all kinds.

It is most unfortunate that many mental health centers have

failed to enlist significant participation by general physicians. This is partially the result of the reluctance of many general physicians to involve themselves in dealing with the emotional problems of their patients. At the same time, however, it may be presumed that many physicians are willing to undertake the management of mentally ill patients when adequate psychiatric consultation and support are available.

As for relating community mental health centers and neighborhood health centers, one must take into account that the latter typically serves 10,000 to 30,000 people, while the former serves a population of at least 75,000, ranging up to 200,000. Thus, some special arrangements must be worked out to assure integrated programs. The community mental health center may establish a neighborhood satellite unit at the neighborhood health center, which then becomes the primary mental health resource for the neighborhood health center. Commonly the neighborhood satellite unit offers emergency services in conjunction with the neighborhood health center's emergency services, and the satellite also provides outpatient and community consultation and education services, and may provide limited day hospital services. Inpatient services are provided at the community mental health center itself, where there are also additional outpatient, emergency, day hospital, and consultation services.

10

While it is important for community mental health centers to develop and maintain liaison with general health services, at the same time it is important for community mental health centers to be allowed to maintain autonomy when to do so contributes to effective program development. Autonomy may enhance the opportunity for experimentation in administrative design. Moreover, the general health care system is itself in a state of flux and crisis, and it seems ill advised to tie community mental health centers to organizational structures that may soon be obsolete. Finally, the community mental health center should be sufficiently autonomous to be able to involve and utilize nonmedical elements both in program and staff.

In the meantime it would be desirable to study, comparatively, a group of autonomous centers and a group of centers that are administrative units of larger health services, in the interest of developing information upon which it may be decided which is the locus of greatest effectiveness.

To The Communities Served

The affluent and the sophisticated significantly control their health and mental health resources. This has not been true for poor people and many middle class people. It is widely believed that con-

trol of one's circumstances and of one's community enhances the sense of identity of a group, its cohesion, competence, and mental health. This striving for control can have very useful effects on the development of community mental health centers and on other health programs by contributing to the ordering of priorities that are meaningful to and supportable by the consumers of services. Community development and community organization that lead to community control are often justified as preventive efforts in mental health. If a community is not organized and its residents are not familiar with the social structure, power groups, and life styles of community members, chaos is likely to exist, interfering with the development of an effective community identity and the delivery of appropriate services. Where community development has not played its facilitating role, only the most vocal and the most aggressive are rewarded. Where logical and necessary efforts have been successfully undertaken, the sense of community life and power can be enhanced.

Community control and community ownership of mental health resources can present problems to professional staffs that are far different from the problems of clinical practice. The complex network of accountability, not only to peers and professional supervisors, but to community representatives as well, may be an unsettling experience for the psychiatrist. The view of the patient and former patient should also be considered in establishing goals and creating new methods of delivery. The priorities set by the consumers may require psychiatrists to learn new skills, such as developing preventive services to children or working with addicts. Some target populations will require the invention of new skills. Even our historic concern for standards in service delivery will require critical re-evaluation. If our efforts are to be meaningful to the community we serve, we must be willing to assess standards in the context of many other factors, including the enhancement of community identity and of community participation. We can no longer retreat to the definition that good psychiatry is what a good psychiatrist does.

Many of the confrontations which mental health centers have faced in the recent past are a result of their pioneering entry into unserved communities. Many of the centers offer the first view deprived communities have had of the medical "establishment" and the first available target at which to direct years of frustration over poor services. We cannot retreat from a community that does not treat us graciously; rather, we must redouble our commitments to serve the unserved, learn from our failures, and encourage our medical colleagues to join us in devising new and more effective delivery systems. We urge increased emphasis on locating and funding centers in high-risk areas of our inner-city and deprived rural communities. It

may be necessary to pay premium salaries in order to attract effective staff. The development of basic medical and social services where they do not exist is, of course, essential.

The delivery of effective psychiatric services requires that the therapist and the treatment team study and serve the patient in the context of his functioning within a family and work group, as well as his individual clinical condition. Whether the outcome in psychiatric disorders is to be successful may, in some cases, be influenced by the availability of a wide range of services other than those usually identified as psychiatric, including money to live on, foster care, vocational training, job placement, and basic medical services. Several states and many communities are now initiating attempts to ease access to and improve continuity of such services by developing multiservice centers concerned with a broad range of human services which share the goal of maintaining social functioning in people who are at high risk of becoming psychiatric casualties. The need for contracts with such centers to insure continuity of care should be studied. An important consideration in such an arrangement would be provision for a foolproof system of confidentiality for psychiatric patients. The concern that the confidentiality of their patient status will not be maintained is an important reason why some persons needing psychiatric attention will not apply for it. Furthermore, the ethical system on which psychiatry is based demands at the outset that confidentiality must prevail. Research and cost-benefit analyses should be applied to alternative models of service delivery.

The effectiveness of services for given individuals must be distinguished from the effectiveness of the total service as a system. The routing of patients for services, the length of wait, the number of service modalities available, the length of dysfunction or impaired function can provide data for evaluating the effectiveness of the system and for designing improvements.

Three areas of specialized services merit special mention because of the high priority which communities give to them, although they are relatively slighted in many psychiatric centers — mental health services for children and adolescents, consultation and education services, and services dealing with chronically ill patients.

Mental health services for children and adolescents. Community mental health centers should offer clinical services for all age groups. This is increasingly important as treatment moves toward recognizing the family as a most important unit of pathology and as a focus for remedial efforts. In lower class socioeconomic areas, the proportion of population under 21 may exceed 50%. With the presumed loosening of family ties, as well as ties with church and school, the rates of

mental illness, suicide and delinquency strongly indicate that the ghetto child, adolescent, and young adult constitute a high risk population. It appears that thus far, community mental health centers have not filled the void in providing services for disturbed children and youth in ghetto areas and that doing so remains a major challenge for the mental health centers and child psychiatry as well. There has been a poor fit to date between child guidance and child psychiatry clinics and community mental health centers, even allowing for a small number of locales that are brilliant exceptions. The poor fit has been at both a philosophical and an operational level. Correcting this situation needs to be given high priority by those responsible for leadership in both child psychiatry and community mental health.

Consultation-education services. Of the five "essential services" required under federal mental health center regulations, the broad range of indirect activities, almost all of which are exceedingly difficult to evaluate, attracts the most open criticism both from certain quarters within the mental health professions and from outside groups. Yet it is within this cluster of indirect services that the community mental health center attempts to take a public health-oriented, preventive stance. Mental health has been criticized from all sides for dealing with the "casualties," rather than the causes of emotional and behavioral disruption. In part, consultation and educational services are a response to this criticism. Additionally, they are also a response to many decades of experience by clinicians that the environment has a major influence on mental illness and health and that much of what we are doing clinically is of limited effect if we are unable to influence patients' surroundings.

To have funds and other resources with which to begin even a limited effort in the field of prevention, through various consultation and public educational efforts, is to many a welcome challenge. Often these activities within a mental health center fall to nonpsychiatric personnel, but certainly conducting such activities can be a legitimate psychiatric role, much as are general public health efforts by a medically trained public health officer. What is needed is imagination, fortitude, a willingness to innovate, and a sense of balance between clinical needs and nontreatment efforts. Certainly, such efforts must be evaluated.

Services dealing with more chronic problems. Some community mental health centers do not appear to be taking much interest in the chronic psychotic patient and the elderly person suffering from organic brain impairments, or to be developing those particular serv-

ices needed by many such patients, including rehabilitation programs, nursing home consultation, and particularly aftercare/medication efforts. Often, these patients appear to be referred or transferred to the state hospital. While the expectation held by some that centers would ultimately replace state hospitals may have been overly optimistic, it is clear that the mental health center should take a heavy responsibility for care of chronic patients. The centers' fears that they will "silt up" with the chronic patients, or go bankrupt because of the costs of aftercare medication must be answered by an adequate partnership with the large state hospitals. The maintenance of chronic patients in the community through adequate follow-up services, including the prescription of appropriate psychoactive medication, may not be a very exciting challenge to a psychiatrist. On the other hand, it is clear that most chronic psychotics and severe neurotics can be maintained in the community, often performing effectively as family members and workers, if they are given adequate supervision with medication and other services. Aggressive follow-up of dropouts from such programs is a necessity if unnecessary readmissions to inpatient services are to be avoided. Too few community mental health centers are going outside their walls on such necessary follow-up missions, or maintaining liaison with public health nurses essential to performing this function.

14

To Private Practitioners

In some mental health centers the staff, including psychiatrists, appear to be isolated from psychiatrists in private practice. This is undesirable from the standpoint of both patient care and professional development of psychiatrists. It can only be remedied as psychiatrists in both private and public work are able to come together socially and professionally. Certainly the District Branches of APA are admirably positioned to serve this purpose and have an obligation to further the efforts of mental health centers in their areas.

Private psychiatrists should be encouraged to spend time in supervising clinical activities and in training and other educational efforts with the full-time staff in mental health centers in their community. Some psychiatrists in private practice have specialized skills lacking in the psychiatric staff of the center. While donation of time for such clinical and educational efforts is to be encouraged, it is unrealistic to expect the private practitioner to contribute any significant amount of free time to a publicly supported community mental health effort. The budget should include funds for private practitioners interested in spending some of their time with the mental health center.

To Funding Sources

Most community mental health centers must rely on a variety of public and private sources of funds. Public funds must be derived from all levels of government—federal, state, and local. Moreover, there may be several agencies providing a portion of the funds at each of these levels of government. For example, federal funds for community mental health services have been available through the National Institute of Mental Health, the Social and Rehabilitation Service, and the Office of Economic Opportunity, among others. In addition, funds may be derived from both fees and third-party payments (such as insurance benefits). Moreover, within the private sector, centers should be encouraged to participate in prepaid comprehensive health care programs and other experimental payment mechanisms.

Federal funds have already played a vital role in stimulating the development of community mental health centers. Initially it was anticipated the federal "seed money" would be needed for only approximately four years. Now it has been realized that in many cases the development of a community mental health center requires a longer period of federal support. Accordingly, the period of federal support has been extended to eight years. During this limited period of federal support, obviously the centers should be developing alternate sources of public and private funding to supplant the federal funds as they decrease and then terminate. Several mechanisms are available for providing this support. State governments, for example, can provide direct grants-in-aid to community mental health centers. Local governments can contract with community mental health centers to provide services for medically indigent persons. Both state and local governments can support consultation programs designed to assist other public agencies operating in the fields of health, education, corrections, and social service. Both state and local support is critical for the successful operation of a community mental health center, and this support must extend not only to diagnostic and treatment services but also to preventive services.

Private fees and insurance payments also represent important potential sources of income for community mental health centers. Centers should be able to collect fees in a proportion to each patient's ability to pay. This requires that the center develop a sliding scale of charges. Moreover, the center should be in a position to collect fees and insurance payments for all direct services that it renders. If centers can be reimbursed for only certain services and not for others, then decisions regarding patient care will be made on the basis of the availability of reimbursement rather than on the basis of clinical

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judgment. For example, if insurance carriers reimburse a center for inpatient care but do not reimburse the same center for day hospital care, then many patients will needlessly be admitted to the inpatient unit even though they could be cared for just as well or better in the partial hospitalization unit.

It is also important that community mental health centers have access to both public and private support for their community consultation and education program. One of the goals of the community mental health center is to develop preventive programs that will reduce the incidence of mental illness and thus the need for treatment. This goal cannot be attained so long as funds are unavailable for the support of prevention-oriented consultation programs. The lack of support for such programs is now particularly evident in the reimbursement patterns established by health insurance carriers. Health insurance benefits, generally inadequate for mental health services, are typically limited to fees for psychiatric treatment. Few efforts have been made to develop prepayment approaches oriented to total mental health programs. It is clear, however, that the effective development of community mental health centers will require the development of new types of prepayment mechanisms that can support services that are oriented to prevention as well as those that are designed for treatment.

16

Finally, it should be noted that in many centers, funds collected for mental health services are simply deposited in the general account of the state or local government that sponsors the center. The income is not reflected in the operating budget of the center. As a result, there is not incentive either for maximum output of services or for accurate cost accounting. It is desirable that community mental health centers be able to make full use of funds collected from patient fees, insurance benefits, and public contracts in the interest of furthering sound budget planning and financial management.

To Evaluation

There have been relatively few efforts to evaluate community mental health centers. Much of the problem has been the deficiency in evaluative technology and the lack of financial support for such efforts. Currently, however, technology is markedly improved, due in part to evaluative programs in other behavioral sciences upon which we can draw and apply in part to psychiatric record systems and the methodology of mental health epidemiological studies. Additionally, new interest at the federal level in program evaluation has developed.

The efforts of Ernest Gruenberg, in studying the impact of psychiatric programs on specific populations, the systematic evaluation

of a specific psychiatric program itself, such as exemplified by the work of Paul Binner and others at Fort Logan Mental Health Center, and the development of automated psychiatric record systems, of which the multistate effort located at Rockland State Hospital is an example, point to the type of technology that has developed within our own field. Add to this the efforts evaluating other types of federal programs in the behavioral area, and it becomes apparent there is a very considerable available technology which is quite applicable to evaluation of specific mental health centers. All centers should build evaluation mechanisms into their operations and a sizeable number of centers able to do so, and representative of different types of programs, should conduct extensive sophisticated evaluation studies. Their findings should be made available to all centers for such application as they may have for their own program efforts. At a time when cost-effectiveness is a vital concern, high priority must be given to evaluation.

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III. RELATIONSHIPS OF THE PSYCHIATRIST IN THE COMMUNITY MENTAL HEALTH CENTER

To Other Human Service Personnel and Other Disciplines

The psychiatrist's ultimate responsibility is the diagnosis and treatment of mental disorder. Psychiatry's pioneering in the utilization of other professionals and nonprofessionals to improve capacities and extend manpower and to take advantage of the particular skills of staff members has been most effective in the community mental health center and in the newer drug abuse programs. Triage, evaluation, diagnostic formulation, and assignment to appropriate therapeutic modalities should be the task of the psychiatrist and only of the most expert and experienced practitioners. The training of other professionals in family therapy, group therapy, and case supervision, and the monitoring and supervision of their efforts offers another role the psychiatrist can share with others on the basis of specific training and skill. Consultation with collaborating agencies, the courts, the police, and the schools will require the broadest clinical judgment and administrative sensitivity of senior professional staff, including but not limited to psychiatrists. Center administration and program design, staff recruiting, the development of information systems and evaluation systems will require the input of psychiatrists, and also of other mental health and management professionals. Many who seek services from a community mental health center are not mentally disordered and need not be managed by therapists. Services such as prevocational training, job finding, and legal assistance, do not require medical legitimization. Experience has shown that what is to be considered medical or nonmedical in any given center cannot realistically be prescribed by regulation but is in actual fact defined operationally by the load and kind of problems people present, the available staff resources, and how people define their problems and will use help.

It is clearly time for American psychiatry to re-examine the issues of medical responsibility. The alternative of training new psychiatrists in sufficient numbers and in sufficient depth to provide medical service exclusively to all those with emotional disorder does

not appear to be feasible. Rather, it is necessary to reassess in just what circumstances it is advisable for the physician to assume responsibility. Psychiatric therapy, along with many other psychosocial therapies, has moved far away from the medical tradition of the "doctor assuming responsibility to protect the helpless patient." Most treatment approaches now attempt to stimulate the patient to serve as the agent of his own recovery. Even in major mental illness, including suicidal emergencies, we increasingly seek to preserve the patient's responsibility to change himself. As therapists or counsellors we provide the opportunity for change, but the responsibility for change remains with the patients. It may well be that we are reaching the point where, with well chosen exceptions we, as well as other helping professionals, will increasingly decline to accept exclusive and ultimate responsibility for all psychotic and suicidal patients in public systems of care where the authority and control are vested in a multiprofessional service group. Perhaps one creative effort might be to define "parsimoniously" those clinical activities that only psychiatrists or physicians can perform adequately (e.g. medical, neurological, and certain initial diagnostic efforts; drug and other somatic therapies; etc.). In collaboration with other professions, we might define those clinical situations in which direct or periodic psychiatric review or supervision of the therapist is indicated (for example, certain psychotic or suicidal patients). We might further define, in collaboration with other professions, those clinical areas that can be carried out with or without psychiatric consultation (for example, certain group or individual therapies, remedial, rehabilitative, and emotional re-education, and other interventions).

Our redefinitions of responsibility must go beyond direct clinical services to consider administration, consultation and preventive work, and program development, where other professionals must be involved in a major way, including taking the ultimate responsibility for directing some areas of activity (for example, school consultation, mental health education, daycare programs, expatient clubs, transitional residencies, sheltered workshops, etc.).

Utilizing such an approach, the job-specific roles of the psychiatrist would thus be defined by the needs of those to be served and by the staff team in each work situation. In terms of personal capabilities and what other disciplines and competencies are available on the staff, the psychiatrist will contribute three kinds of competencies:

1. He will contribute his knowledge of the interaction of physical and psychological processes, his array of diagnostic skills and tools, his understanding of disease processes and psychopathology, his

training in medical, pharmacological, and psychotherapeutics to the team.

2. He will also blend his competencies as a behavioral scientist and therapist with the other behaviorally trained professionals present on the staff and share in the planning and execution of psychological and social interventions for the benefit of individuals or groups.
3. His functioning in consultation training and administrative roles will, in the future, not be based on status but on merit, experience, and specific training in these areas, whether the psychiatrist be a full-time center staff member or a private practitioner serving part time.

But at least for the time being, it is urgent to realize that in almost all jurisdictions and under almost all statutes, it is the psychiatrist who remains legally answerable for all the clinical activities of the program. However much he may delegate authority, "flatten hierarchies," or even report to a nonmedical program director, it is almost invariably the psychiatrist who carries the responsibility for any charge of malpractice.

To Nonprofessionals

20

Community mental health centers have highlighted the shortage of mental health professionals. Largely in response to the pressure of these staff shortages, a variety of programs for the training and utilization of nonprofessionals was developed, initially intended to relieve the burdens of the professional staff. It rapidly became evident, however, that a spectrum of functional roles was emerging, of far greater significance than the mere freeing up of professional time. These range from nonclinical assignments as ombudsmen or expeditors through receptionist interviewers to roles as co-therapists in individual, family, and group therapy programs; for each of these assignments considerable sophistication and skill are required. The nonprofessionals range from uneducated slum residents—the "indigenous mental health workers"—to middle-class women who, having raised their families, seek careers in the mental health field. Training programs vary from casual supervision to intensive year-long full-time schedules of seminars and conferences.

The nonprofessional who functions solely as an assistant to or an extension of the professional—the case aide and the nursing aide are the most familiar traditional examples—does not add a new job area to the work of the clinic or hospital; rather, some of the work which is the job of a professional is separated from the work which only the professional is qualified to do and is made to constitute the job of the nonprofessional. Little training is required for these jobs,

and there are rarely disputes about which tasks belong to the professional and which to the nonprofessional.

At least two sets of forces can be identified as factors leading to the emergence of a quite different category of nonprofessional, semi-skilled therapeutic agents in community mental health centers: first, the need to relieve professional staff members from purely mechanical and regulatory chores; second, the necessity of treating substantially larger numbers of applicants for service than could be handled by the professional staff. It was readily demonstrable that such partially trained staff members could function in treatment programs, and attention has rapidly shifted from questions concerning their effectiveness to questions about training. It should be noted that the "mental health counselor" or "assistant therapist" remains an assistant to the traditional therapist, doing essentially the things which a therapist traditionally does, but doing only some, rather than all, of them. A second factor, likely to be of more significance to the future of psychiatry derives from the mandate of a community mental health center to accept responsibility for all persons with emotional disturbance or mental illness in their catchment area. Substantial numbers of patients whom professionals traditionally avoided because of the high risk of treatment failure—addicts, alcoholics, sociopaths, and poor people—now confront us with the necessity of adding new dimensions to our treatment efforts. One product has been the "indigenous mental health worker."

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In some regards, the indigenous worker continues to be an assistant to or an extension of the professional, but in several dimensions he adds to and even changes the functioning of the professional therapist. In his most characteristic role, he functions as a bridge, articulating between the culture of the therapist and the culture of the patient. The boundaries separating the two are largely, but not exclusively, class lines. The indigenous nonprofessional, living within the class and community boundaries of the patients, knows the culture of the patients and can communicate more effectively than can the professional. He has often had to cope with the same problems as those which beset the patients and has been successful, and can thus add to a supportive program of therapy concrete help which is outside the knowledge and skill of the therapist. He can identify the import of behavior which can be expected to elude the therapist—it is, for example, a rare psychiatrist who can spot the return of an addict to the use of drugs as rapidly and as reliably as can an ex-addict, and every experienced group therapist has encountered situations in which members of the patient group could see the issues in a patient's productions more quickly than the therapist. The psychiatrist has traditionally placed favorable prognostic values on the

capacity for "psychologizing" or introspection on the part of the patient; this is, of course, only a reflection of the psychiatrist's own characteristic pattern of behavior and of the pattern demanded by most psychotherapeutic approaches. When parameters of activity are introduced—e.g. when it is felt necessary to see the entire family of an identified patient—the psychiatrist is less likely than is the indigenous mental health worker to think of a home visit instead of an office interview (to observe behaviors in the home, to save the multiple fares a clinic visit could cost the family, to demonstrate concretely to the patient and his family the importance of the session); if a home visit is made, he is less likely to differentiate accurately appropriate culture-bound behaviors from neurotic reactions. The psychiatrist is likely to make inappropriate assumptions concerning knowledge by the patient of the nature of the psychotherapeutic process (e.g. that intimate topics will be discussed, that absolute confidentiality is maintained, that the professional relationship is impaired by the intrusion of a personal relationship) which the indigenous mental health worker can pick up and correct. The psychiatrist in particular may assume mistakenly that the organizational structure of his center will be as plainly evident to his patient as it is to himself and will refer a patient to a vocational or social rehabilitation program with no expectation that the patient will respond to the referral as a rejection.

22

The range of activities suggested implies a quite high level of mental health expertise, and this in turn underscores the critical role of training. Experience has demonstrated the advantages of training indigenous workers with a brief period of preservice didactics, a pattern quite unlike that experienced by the medical student or doctoral candidate in psychology. Most frequently, as a result, the indigenous workers start with the most menial tasks, requiring the least preparatory training, and too often the most talented candidates drop out before their highest potential begins to be actualized. For those who are able to remain in training programs, sophisticated roles as co-therapists prove quite feasible and extremely valuable.

The relationship between the psychiatrist and the nonprofessional indigenous worker in a community mental health center, in the light of what has been described, has two points of stress. On the one hand, there are unfortunate consequences of the failure of the psychiatrist to encourage the development of the highest levels of competence of which the nonprofessional is capable. As a result, the turnover rate of the nonprofessional staff may be high; the extent to which professionals will be relieved of their responsibilities may be minimal; and saddest of all, the unique expertise of an indigenous population to bridge the gap between the professional and the lower-class patient may not be available as a therapeutic resource of the

center. On the other hand, the opposite danger must also be taken into account. A number of experiences prompt quite serious attention to the problems that grow out of the over-evaluation of the work of nonprofessional staff members. There is a tendency on the part of the community mental health center professional staff to continue to avoid the risk of treatment failure by assigning poor patients entirely to the care of indigenous mental health workers. This places an unmanageable burden upon these workers, and offers the most difficult patients the services of the least trained staff. Encouragement by the professional staff of the efforts of nonprofessional workers to undertake challenges beyond their capabilities sometime leads constructively to the nonprofessional entering a formal training program in one of the mental health disciplines; but more often it leads to resentment against the professionals and to leaving the field entirely. The most serious danger of over-valuing the work of the nonprofessional staff is that the latter staff may come to feel that they can operate the facility without any professional staff. "Strikes" and "sit-ins" by nonprofessionals have occurred, sometimes with the cooperation of some members of the professional staff. It is not here proposed that complaints by nonprofessional staff members of incompetency by professionals, or of inadequacies in program design, are to be dismissed out of hand. They are not, however, likely to be resolved constructively by the elimination of professionals.

23

IV. ISSUES REGARDING MEDICAL STUDENT TEACHING AND RESIDENCY TRAINING

24 Full expression of the issues involved in medical student teaching and residency training programs for psychiatry would require separate consideration. The implementation of community mental health center programs requires a commitment to the operational success of these programs on the part of psychiatric training centers. The crowded medical school and residency curricula must be restudied and restructured, if time is to be found for additional skill training. As new medical curricula evolve permitting elective training in the third and fourth years, a strenuous effort needs to be made to provide more medical students with electives as well as clinical clerkships in psychiatry that include tours of duty in mental health centers. Hopefully, this will prepare more physicians to work in mental health centers and ultimately lead some of them to engage in further psychiatric training to prepare to become psychiatric clinicians or administrators in mental health centers. In addition, as psychiatric internships evolve and as more psychiatric residents come directly to specialty training without internships, curriculum planning for these trainees should include experiences in the mental health center and allied systems of health care. The components of a training program include not only content, but also role models that are provided the trainee and on which he bases his own career expectations. In the past ten years, the careers of the psychiatrist who teaches students and trains residents and of the psychiatrist who operates and manages community programs have diverged, a trend that should be reversed. One method for supporting the development of creative service programs and providing the evaluative sophistication to which new delivery systems should be subjected could be to have training centers take responsibility for services to a defined population. The creation of combined university-community mental health center training programs would help to coordinate service and training, and provide training staff with constant feedback on the application of the training they offer. Such a responsibility would, of itself, tend to orient the training program toward preventive programs and

toward the evaluation of outcome and effectiveness rather than to focus exclusively on diagnosis and treatment technique. Of equal importance is the increasing necessity for the psychiatrist to see himself as a medical specialist, a major portion of whose practice is conducted in a general hospital setting as therapist, program director, trainer of other professionals, and consultant to other physicians. Many leaders of psychiatry have noted the inadequate preparation of psychiatrists to function in a community role as a medical specialist. It must be the responsibility of the training center to prepare a resident for locations of practice which may be new and stressful.

In addition to the orientation to the field of psychiatry offered in medical school and residency training, the more holistic use of interagency, interdisciplinary, and multiple interventions in community mental health centers calls for supplementary education and role-specific training. Field surveys of psychiatrists serving in community mental health centers report their need for more extensive and specific preparation in some of the following areas, whether they have assumed only a clinical or also an administrative responsibility:

- (a) The development and operation of interagency and interdisciplinary contractual consultation relationships designed to strengthen and extend relevant mental health competencies of the consultee.
 - (b) More thorough knowledge of the relevant mental health competencies, training backgrounds, limits, and operational patterns of the other helping professions in the community to serve as a framework for consultee consultation, disposition and referral of cases, and the development of alternative patterns of care.
 - (c) More thorough briefing on the relevant mental health services, as well as prevention and educational programs of the agencies normally allied to a community mental health center.
 - (d) The utilization of practical, economical need-assessment methods to guide planning, deployment of resources, and program evaluation.
 - (e) Skills, knowledge, and experience in developing interagency relationships, and working with community planning, citizen participation, and nonprofessional groups (unions) as well as professional societies.
 - (f) Knowledge and skill in using nonacademic methods of staff development; i.e. supervision, apprenticeships, career ladders, etc., in order to enrich and hold staff.
 - (g) Knowledge and skill in using educational and rehabilitation methods in clinical programs; i.e. day hospitals, emotional
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re-education, aftercare, and family care as well as for inservice training to staffs of allied agencies, and public information programs.

- (h) Specific training on the expectable group process phenomena within hierarchical organizations (wards or whole centers).
- (i) Knowledge of leadership and/or administrative roles in recruiting and developing staff, planning, maintenance of operations, translating needs into plans with factually justified budget requests as well as monitoring, presenting and coping with staff conflicts and dissatisfactions.

Ideally, such training should be individualized to the specific psychiatrist's experience, educational background, and job responsibility. He should have a major role in diagnosing his own "learner needs" by study of the mental health needs of the area he serves, the particular role responsibilities expected of him, his own degree of preparedness, and his own professional goals. Through interaction with his trainers, an individualized curriculum can be formulated in which he has shared in defining the goals, content, method, and evaluation of his own training. Such training can be delivered in part or in whole on the job, in supervised field experiences or in special training centers using both didactic and experiential inputs.

The competencies required of the psychiatrist to project his clinical knowledge and skills effectively into the more comprehensive service delivery systems of a center appear at the present time to be essential in the training of all psychiatrists. It may be timely to discuss the merits of recognizing community psychiatry as a justifiable subspecialty of psychiatry. The need for well-prepared psychiatrists in key positions in centers necessitates the support of the profession for training programs to develop such manpower. Training in community psychiatry should be integrated into medical school and psychiatric residency curriculum. The complex nature of this new service delivery system merits advanced fellowship training to prepare psychiatrists for leadership roles in community mental health centers as well as continuous job-specific training for all psychiatrists accepting responsibilities to serve in such centers.

V. A POSITION STATEMENT RECOMMENDED*

In the light of the foregoing, the task force recommends to the Council on Mental Health Services and to the Trustees of the Association adoption of the following position statement on community mental health centers:

1. Psychiatry, because of the social aspects of many of the problems it undertakes to remedy, and because of its comparatively long and close association with government, has already had both the privilege and the burden of attempting to pioneer comprehensive health services through the vehicle of the community mental health center. The American Psychiatric Association strongly supports the purposes of community mental health centers: to provide ready access to mental health services and related medical and psychosocial care to all persons within a given population who need such services; to offer a model to build upon in the evolutionary process of constructing a more effective national health system.

The centers are flexible, evolving modalities adaptive to cooperative arrangements with comprehensive health centers and broader human services. They operate on a "catchment area" principle which dictates that they shall assume responsibility for meeting the mental health needs of a defined population without discrimination of any kind and with emphasis on preventive and health maintenance services as well as treatment and rehabilitation of illness. This obligates them to render direct and indirect services for a far greater number of persons than was formerly possible, to develop new treatment strategies for categories of patients formerly considered "poor candidates" for therapy, to eliminate long waiting lists, and to develop continuity among service elements.

2. The integration of services as among the community mental health centers and public and private psychiatric hospitals must be planned with great care so that the network of mental health serv-

* This statement was approved by the Board of Trustees of the American Psychiatric Association in April 1972 and by the Assembly of District Branch in November, 1972.

ices in a catchment area shall be organized rationally as a continuum. A key responsibility of the centers is to assist in the development of active treatment and rehabilitation programs in psychiatric hospitals, to obviate the need for hospitalization whenever possible, and to assume immediate responsibility for services to patients who have been hospitalized and have returned to the community. This purpose would be ill served if the centers were to cope only with the acute or most highly treatable patients, and to transfer the least treatable to public mental hospitals, for this would tend to concentrate a treatment-oriented staff in the former and a custodially-oriented staff in the latter. Instead, both the centers and the hospitals need to be treatment oriented, with a choice between them, for any given patient, based on differential diagnosis and differing clinical needs. A range of models for effecting liaison between the centers and public mental hospitals should be established.

3. Because of the disproportionately high incidence of unmet needs for medical care of physical illness in psychiatric patients, because of the greater acceptability of psychiatric care under a "medical" rather than a "mental" aegis, and because of the inseparability of various forms of mental from physical medicine in large numbers of patients, it is necessary to establish close working relationships with the medical community generally and, when present, with comprehensive medical centers specifically. Various types of relationships between the two centers need to be tested, one of which can be through the integration of community mental health centers into comprehensive medical programs. The mental health centers should be encouraged to strengthen their ties to primary care physicians and to psychiatrists in private practice far beyond what has evolved up to this time.
4. Since social service programs deal inevitably with psychosocial problems in the individuals and families they serve, and since health care is inseparable from other basic human needs of the clients, community mental health centers should explore and establish effective patterns for close functional relationships with human service delivery centers. Again, one method of procedure may be an amalgamation of the two programs into an agency approach in comprehensive psychosocial care giving.
5. Consumers, and representatives of the consumers being served, must share in the decision-making processes governing the development of new organizations for the delivery of health care and in determining priorities to be assigned to services offered. In the

case of community mental health centers, this presupposes that these consumers and local representatives will be cognizant of the boundaries and capabilities of the mental health field. The principle of such participation marks a drastic departure from tradition and poses a host of new challenges to leaders. Nevertheless, if it is not accepted, the organization cannot succeed for lack of local confidence and support, and this is most particularly true of community mental health centers in inner city areas.

6. Substantial federal support is presently needed if the community mental health center movement is to survive. Funds should also be forthcoming from other public sectors of government—states, counties, and cities. In addition, fees from patients and third parties must continue to support a significant portion of direct treatment services, and there is some prospect, much to be encouraged, that in time they will also support some preventive and consultation services. But basically, new centers cannot now be established, nor can they offer a full range of services without federal support for construction, staffing, and training of personnel.
7. The medical, including psychiatric, treatment program offered by a community mental health center must be the responsibility of a physician, preferably a psychiatrist, and directed by him. The center's total program, however, may be under the administrative direction of any health professional with adequate training in administration and experience in mental health services.
8. The development of paraprofessional workers on the staffs of community mental health centers should be encouraged. They have facilitated communication and rapport between service providers and patients, their families, and the community. Many, through training and experience, have successfully undertaken varied therapeutic roles in the centers. It is important, however, if high standards are to be achieved in the quality of care rendered, to avoid operating on the false principle that "anybody can do anything." The limits of the roles, responsibilities and skills of both professionals and paraprofessionals should be delineated. An effective in-service training program for paraprofessionals should be provided as well as regular supervision by appropriate professional staff members.
9. Education programs for psychiatrists, including residency and continuing education programs, should be immediately strengthened and rendered more relevant to the unfolding of community psychiatry, and most particularly to the services that will be rendered by the community mental health centers.