American Psychiatric Association

Task Force Report

Community Mental Health Programs

An American Psychiatric Association Task Force Report

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This report was prepared in April 1981 and the addendum written in September 1981. The entire report was approved by the Assembly at its Oct. 23-25, 1981, meeting and by the Board of Trustees at its Dec. 11-12, 1981, meeting. It was prepared by the Task Force on Community Mental Health Programs of the Council on Psychiatric Services.

THE TASK FORCE on Community Mental Health Programs held seven meetings, including an organizational session in Atlanta during May 1978. The charge, an unusually broad one, was to address problems of community mental health programs, especially as they affect psychiatry. The issues of standards, professional staffing, services, interprofessional relationships, cost-benefit ratios, and future directions were considered. This final report contains the conclusions and recommendations of the task force.

Introductory Statement

Massive industrial, economic, and social changes since World War II have been reflected in the structure of the American family. Postwar patterns of suburban living, in which the two-parent-plus-children family unit often was viewed as the ideal, frequently resulted in the expectation of independence for the individual family. Communities also have sought independence, attempting to contain within each all of the essential health care services. American psychiatry, and the development of community mental health programs especially, demonstrate the emphasis on the proximity of services as one of the two critical features of availability.

The Task Force on Community Mental Health Programs included the following: Ulysses E. Watson, M.D., chairperson; John Bowman, M.D.; William Jepson, M.D.; John Ordway, M.D.; James Osberg, M.D.; and Bertram New, M.D., and consultants Alan Elkins, M.D.; Eric Plaut, M.D.; J.M. Stubblebine, M.D.; Morton Albert, M.D.: and Philip Phillips, M.D.

Technology during this period has provided many effective psychoactive drugs, whose impact on the treatment of mental illness is unmatched by any other single development. In addition, we have developed a technology, exemplified by cerebral tomography and gas and liquid chromatography, that has enhanced diagnostic capability almost beyond belief. Supported by this drug and research technology, mental health practitioners have developed new systems of therapy, revolutionizing our approaches to mental health services and to the supporting legal statutes.

In 1963 Congress acknowledged our changing society's needs by passing the Community Mental Health Centers Act. An affluent American society increasingly perceived health care as a right. Today high-quality mental health services in one's own community, in the least restrictive setting and consisting of effective agents without risk or side effects, are often seen as a right, especially if treatment is involuntary. From this perspective current community mental health care represents the revolutionizing of our basic capability to care for the mentally ill and our acknowledgment of their right to effective treatment as a national and community prerogative.

The movement of great numbers of patients from the state hospitals in the 1960s gave further impetus to the development of community mental health centers. The mental health system then had two very large components sharing resources. Too often it was convenient to glorify the community mental health "child" as the totality of the future and to disparage its parent, the state hospital, as the embodiment of the evils and inadequacies of the older generation of health care. In fact, the state hospital, originally conceived to receive the tired, poor, and hopeless mentally ill, had become itself the form and substance of their hopelessness, a victim of its patients' schizophrenia–autistic, ambivalent, and geographically and spiritually withdrawn. Professionals associated with state hospitals were often forbidden to participate in the planning for centers by federal officials fearful of contamination. Clearly, the community mental health center movement above all symbolized a new hope for the mentally ill.

Community mental health programs today reflect administrative, scientific, economic, and ethical issues that must be resolved if we are to provide the best possible care. This report focuses on these issues.

Services

Community mental health programs have a common goal: to provide high-quality mental health services to a specific population. These services must be geographically and economically accessible and potential recipients must be motivated to use them. The report of the President's Commission on Mental Health in 1978 was a far-reaching blueprint for the future with which this task force agreed. The report delineated the need for an integrated system of mental health care implemented by partnership efforts of public and private purveyors. The need for a community support system providing levels of care that matched the needs of patients was emphasized. Case managers assisting patients to negotiate the various levels and components of care would provide an unprecedented facility for coordination. The Commission's report noted the needs for cultural and economic diversification of care provision and for public attitudes that do not act as barriers to care. The Commission acknowledged the need for serious research to develop more effective treatment technologies; supported the development of more psychiatric, other mental health professional, and paraprofessional personnel; and emphasized the consumer's need for freedom of choice and the safeguarding of human rights.

The task force agrees with the President's Commission and believes that the safeguarding of human rights should be accomplished by means of the careful adherence to guidelines that protect the rights of patients but do not reflect an adversary relationship. The patient should no more be in conflict with his or her psychiatrist or program center than with a surgeon.

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The rendering of high-quality mental health services is often made easier by the ready availability of general medical services. Thus general hospitals and community mental health programs are mutually enhancing. Carefully planned, documented, and coordinated functioning with related state hospitals, general hospitals, and other community institutions will provide an effective delivery system that best serves the needs of the chronically ill and the underserved. The task force applauds the report of the President's Commission on Mental Health and believes that implementation of its recommendations would result in a reasonably responsive mental health services delivery system with the flexibility to keep pace with future scientific achievement. We are pleased that the Mental Health Systems Act has been passed to implement the Commission report.

Philosophy

The availability of high-quality mental health services requires a philosophy and orientation that meet the diverse needs of patients. The task force believes that the first priority of a community mental health program is the treatment of the mentally ill. Prevention, and maintenance of mental health, is the second priority. High-quality general medical care and social services are necessary for the chronic patient in need of rehabilitation. They must be provided concomitantly with psychiatric treatment and will increase its effectiveness.

In an American Medical Association position paper on community mental health centers (1), Donald Langsley, M.D., stated, “A major issue is whether the comprehensive community mental health center is part of a health delivery system with the necessary linkages to social services and other community functions.” He maintained that the community mental health center (CMHC) is first a health care facility, its first priority that of competent medical treatment. The task force agrees with Dr. Langsley and believes that the final responsibility for treatment of mental illness must rest with the physician in charge. When possible, that physician should be a psychiatrist.

Physician responsibility for treatment does not prohibit the use of a treatment team that includes other disciplines and paraprofessionals. The medical model of treating the ill in no way precludes the biopsychosocial model. Psychiatrists today are generally cognizant of the genetic, growth, developmental, familial, economic, and social factors that influence the onset of mental illness and the maintenance of health. The medical and biopsychosocial models in the absence of professional politics are mutually supportive and should operate conjointly within all community mental health programs, as pointed out in the 1978 report of the task force.

The concept of granting practice privileges to each member of the professional staff according to specific qualifications has gained popularity recently. We strongly recommend that community mental health programs have privileges and credentials committees that screen all professional staff, recommending acceptance for specific therapeutic modalities based on those individual qualifications.

Treatment teams composed of personnel from various professional disciplines are often the most effective means of providing comprehensive care. Schizophrenia, a biochemically based disease affecting greatly the psychological and social dynamics of patients' lives, requires both medical treatment and a social support system. The determination to provide these should be reflected in the philosophy, orientation, and subsequent establishment of fully integrated systems of care.

Staffing

High-quality mental health care should be provided by an integrated, diversified clinical staff. Public Law 94-63, passed by Congress in 1975, delineated a dozen services as a part of the spectrum of community mental health programs. The task force strongly supports the maintenance of staff competent in various treatment approaches. A few issues of psychiatric staffing, the subject of our first report, are repeated here.

Since 1973 there has been a steady decline in the average number of psychiatrists in CMHCs. Full-time psychiatrists have declined to an average of 4.1 in 1979 (latest figures available). Overall the number of full- and part-time individual psychiatrists averaged 6.7 per center. (Earlier figures indicating a minimum number of 3.2 were discovered by NIMH to have resulted from an artifact in the production of data.) Nevertheless, the downward trend, characterized as the “flight of psychiatrists from CMHCs,” has been deleterious to the quality of mental health care in such centers.

Psychiatrists who joined the community mental health center movement originally were too often inadequately prepared for the administrative responsibilities. They often lacked experience in working with boards and other community organizations. As federal funding of CMHCs decreased, pressure to replace psychiatrists with less expensive staff whenever possible increased and sometimes led to questionable and occasionally unethical use of psychiatrists. (Some psychiatrists have been pressured to sign blank prescriptions for nurses to fill in.) Jealousy among the professions, often stimulated by obvious economic considerations, has frequently led to an atmosphere that is disparaging of psychiatrists–one where authority has not been commensurate with the responsibility for patient care. Because clinical responsibility is not meaningful in the absence of accountability, patient care in such circumstances deteriorates. In our previous report, we strongly urged psychiatrists in all community mental health programs to carefully avoid prescribing and supervisory arrangements that are not in clear accordance with high ethical standards. We also urge psychiatrists to remain ever mindful of their role as physicians and to consistently educate the public about the significance of that role.

Fewer physicians are choosing the specialty of psychiatry. The resulting decrease in numbers may seriously affect the availability of psychiatrists. Recent federal statutes affecting foreign-trained physicians, who previously were a major source of institutional psychiatric manpower, will exacerbate the problem. Federal support for training psychiatrists is at a record low. Training grants and other supports for the production of psychiatrists are disappearing. The task force believes that a crisis in the availability of psychiatric manpower will occur if we do not take steps to prevent it. We urge the designation of the psychiatrist as a primary care physician. We urge that federal support for training psychiatrists increase, perhaps with a “pay-back” arrangement that specifies a period of service in an underserved area for the trainee. We recommend a strong collaborative effort between the university training programs and the mental health delivery systems. Such an effort should result in the production of greater numbers of psychiatrists, better trained in the diversified treatment approaches necessary to meet the expanding challenges of the delivery system. Other mental health personnel should also increase in numbers and skills. We also recommend that the National Health Corps take steps to facilitate the availability of psychiatrists.

Standards

Standards, the criteria by which an organization measures its effectiveness in meeting its goals, are greatly needed by the mental health care system. Standards for CMHCs developed by the Joint Commission on Accreditation of Hospitals (JCAH) became available in 1977. These standards embodied the concept of the balanced service system and were significantly different from previous JCAH standards.

The task force disagrees strongly with the development of a “cookbook” approach to standards. Programs across the country exist in communities of greatly varying circumstances. What is most important is not whether programs can follow a series of specified steps but whether they can provide high-quality services. This should be reflected in flexible, realistic approaches, all of which cannot be envisioned by young, zealous, and frequently inexperienced standards writers. We disapprove of the absence of mandated medical assessment and treatment planning and control for the mentally ill. We believe that treatment standards for mental illness must have medical input. The 1981 JCAH publication “Consolidated

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Standards for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Programs" (2) again demonstrated a highly specific approach, with many totally unacceptable requirements. Because standard-setting bodies such as JCAH, NIMH, and the Social Security Administration so seriously affect the operations of community mental health programs, we urge that criteria and guidelines for the writing of standards be established. Such guidelines should prohibit the "cookbook" approach, which too often reflects the limited experience and personal biases of their authors. Instead, clear goals, supported by flexible policies, with high-quality patient care the ultimate proof of success, should be intrinsic. Such standards should clearly avoid the implication of a patient/provider adversary relationship. The significant input of experienced, current providers of service is a sine qua non for the fusion of the ideal and the pragmatic in standards writing.

Funding

Competent funding analyses are critical to providing competent care. Too frequently, allegations of higher costs in public or private systems are based on comparisons of dissimilar units.

The majority of CMHCs are at least partially government funded. Many have developed a significant fee-for-service system as well. It has been alleged that program funding diminishes the motivation to economize while producing a system insensitive and poorly responsive to clients whose fees are prepaid. The charge that an hour spent with a master's level social worker may far exceed the cost of an hour with a psychiatrist in private practice cannot be validated. Nevertheless, we believe that a higher cost of the community mental health program service hour may well be justified by the greater spectrum of services needed. The poor and the disabled require complex services, the provision of which imposes an additional financial burden on the community mental health program. Although it is generally accepted that the fee-for-service system of the private sector tends to maintain a high level of motivation to use every hour for the production of income, this fact does not generally make the private practitioner more accessible during nonworking hours.

The catchment area concept, a product of the community mental health movement, means funding for a specific target population. Although generally an excellent concept, it is at times self-defeating. Persons in borderline areas may have difficulty obtaining services unless centers nearby are flexible. We urge community mental health centers and programs wherever possible to make services available to persons living within reasonable distance. Even if unreasonable, specified funding should not be the final arbiter of service provision.

The task force believes that the state is the most effective government level for funding and monitoring community mental health programs. At the state level 1) licenses can be issued. 2) sensitivity to local needs and issues can be maintained, 3) federal, state, and local funding requirements can be merged, 4) standards of safety and service can be enforced, 5) statistical and other monitoring is most reasonably accomplished, and 6) funding can be made at least a significant consequence of productivity.

The general statement "He who holds the purse strings controls the operations" does not accurately reflect the position of NIMH toward CMHCs. Centers with their own nationwide organization, as well as local citizens' boards, often have powerful legislative support from politicians who significantly affect the budget of both centers and NIMH. Consequently, the withholding of funding by NIMH may result in political backlash destructive to itself.

The private system of mental health care has been generally ignored by public officials seemingly determined to exclude its active participation. In light of such a bias, it must be emphasized that mental health care can only be competently provided to all segments of our society by means of a public/private partnership. Innovative approaches to contractual arrangements which will structure that partnership are needed. Quality service will be assured by many mechanisms that are already in place.

The public/private partnership is the only means by which patients can achieve real freedom of choice. We hope that one day needy patients will be authorized to obtain psychiatric services from any qualified provider within a fee range established by the state.

The funding of indirect services remains a difficult issue for community mental health programs. We strongly urge that the federal government continue and perhaps expand the consultation and education grants currently available to centers with effective programs. In addition, a fee-for-service system must be accompanied by basic grants for administration, training, evaluation, and other nonreimbursable functions. A versatile public/private partnership within a sensibly structured fee-for-service system should produce an effective service system with an optimal cost-benefit ratio. We retain the hope that a system can be developed whereby those whose care is publicly financed will have choices similar to those found in the private sector.

Summary

The goals of health care are 1) treating the ill, 2) maintaining the health of those at risk, and 3) primary prevention of disease. Community mental health programs can achieve these goals only by the rigorous application of high-quality standards throughout program activities. We strongly support the 1978 recommendations of the President's Commission on Mental Health.

Critical to the healthy evolution of the community mental health movement is its realignment with general health care. We advocate a return of the CMHC to active collaboration with general hospitals and other medical care institutions. Continuity of care, a primary focus of case management, requires the active collaboration of community mental health care program staff with state hospital, general hospital, and transitional care staffs. Such collaboration must have the highest level of administrative support.

Psychiatrists must be recruited back to community mental health programs. The issue is not whether the psychiatrist has the central role of the center but rather the availability of psychiatric services to the acutely and chronically mentally ill. This goal commands the active effort of APA and NIMH. Liaison between the two organizations should be active, focused, and consistent. APA might consider undertaking a highly visible project whose director, a distinguished leader on sabbatical, would visit a variety of district branches to raise the consciousness of psychiatrists to the needs of the chronically mentally ill.

The establishment of a public/private partnership should involve district branch peer review committees as well as insurance committees in a variety of negotiations. Consistent and effective liaison with the American Hospital Association would enhance general hospital support of community mental health programs.

Welfare components should be extracted from mental health service funding. Funding streams should be based on clear delineation and separation of mental health costs from others.

Monitoring of programs must include PSRO involvement, self-evaluation, quality assurance, and fiscal accountability. The effective provision of a wide spectrum of services clearly mandates an organization with full components of both the medical and social models. The conjoint operation of these models is a goal we must pursue.

Standards should be the result of rational consideration by knowledgeable, experienced professionals and active current providers of care. They should avoid the "cookbook" presentation of the current conventional wisdom. Clear, flexible guidelines without implications of an adversary relationship between patients and providers are most desirable.

The future of community mental health programs will depend on 1) the evolving technology of treatment for mental disease, 2) the national economy, and 3) the integration of the various components of mental health systems.

The task force believes there will be fewer chronic patients, who will be more competently treated within the community mental health program

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and the general hospital. Psychopharmacological treatment will improve and research breakthroughs can be expected. APA should continue to strongly support the funding of research and the implementation of all treatment models that will make possible the better overall care of the mentally ill and the prevention of mental illness by efforts in the community.

ADDENDUM

National developments resulting from the attitudes and approach of the current federal administration promise to have a very significant impact on mental health care systems. The commitment by the federal government to reduce the amount of its expenditures for domestic programs and the scope of its regulatory functions has thus far resulted in the following:

1. Alcohol, drug abuse, and mental health facilities previously funded by categorical grants will now be funded through a block grant to the state. State officials will have some discretionary powers as well as responsibilities for the monitoring of service quality.
2. Beginning in October 1982, the level of continued funding may no longer be anticipated but is subject to actions of the current Congress. Funding levels are anticipated to be no higher than 80% of the current level and perhaps as low as 50%.
3. The Secretary of the Department of Health and Human Resources will have the power to decide if Indian tribes should receive funds directly rather than through the state block grant.
4. Perhaps the most dramatic development is the anticipated closing of regional NIMH offices.
5. The Mental Health Systems Act has been repealed.
6. New community mental health statutes specifically prohibit use of these funds for inpatient services. Care for children, the elderly, and the chronically mentally ill is emphasized.
7. The overall number of stipends for the support of education in the four core disciplines continues to decrease. Current legislation specifies that recipients must pay back these stipends on a year-for-year basis by working in approved areas. Approved areas are those in which there is a public manpower shortage and certain public nonprofit institutions, including public inpatient mental health institutions. The penalty for failure to pay back by working in an approved place is reported to be about three times the cost of the original stipend.

The current ills of the national economy are reflected in the individual economies of many states, where employment is down and state income is drastically reduced. These conditions emphasize the anticipated fatal financial illness of many programs. Community mental health programs, often poorly defended, are particularly vulnerable to the budget ax. Many are already receiving diminished support from the states and are desperately seeking ways of continuing to survive and to serve their clients adequately. It is especially important that community mental health workers at all levels encourage in every appropriate way the continued funding of services within the community.

Although inpatient services (for which community mental health funds may no longer be used) are still available through the welfare mechanism (Medicaid), it is very clear that the current statutes will augment the population of the state hospital, especially since reduction of Medicaid funding will probably occur along with other cutbacks.

The task force believes that much of the future of the community mental health movement could be affected by current research technology, which includes giant leaps forward in brain research. We are deeply concerned that the uncertain national economy will disproportionately endanger significant national mental health research programs. State administrations have too often been short-sighted in eliminating research as a significant budget item. The task force urges APA to give all possible support to the proportional maintenance of research programs, in which our hopes for the future lie.

In summary, the community mental health center program initiated nationally in 1963 is at grave risk. This task force believes that curtailment of this significant national service would be tragic. We urge all who have influence to maintain maximum public pressure on Congress, the federal administration. and state governments to preserve our services for the mentally ill.

REFERENCES

1. Report of the Council on Scientific Affairs to the American Medical Association House of Delegates, Report C. Chicago, AMA, 1979
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