THE COMMUNITY MENTAL HEALTH CENTER
An Analysis of Existing Models

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In our competitive American society, we tend to view our shortcomings as "gaps," i.e., the standard is in relation to what others have accomplished. This in turn leads to the undertaking of "crash" programs to "fight" the problem or condition. For example, an intensified concern about, and wider awareness of, the complex problems of social pathology and injustice have led us to declare a "war on poverty." Such tactics are not entirely undesirable or necessarily doomed to failure, provided we do not seek solutions to very complex issues through unitary, superficial measures.

There are very few public health problems that present so many socio-economic, cultural, and technical complexities as that of coping with the various mental illnesses. We have not been able to arrive at a consensus about defining them, let alone organizing our resources and manpower rationally to cope with the need to treat, alleviate, rehabilitate, and, hopefully, prevent them.

After lagging for some years behind Great Britain, the Netherlands, and some other European countries in the organization and deployment of our psychiatric and social resources for the mentally ill, our states and territories are now in the throes of a federally financed, long-range planning effort toward the better use and expansion of available and potential services, in order to overcome the acknowledged deficits.

The forerunners of our present effort—which is gratifyingly

vigorous, but far from "all-out"—occurred over a period of years. They include the work of the Joint Commission on Mental Illness and Health; the opportunities afforded by the psychotropic drugs combined with other medical and social measures; the pioneering programs of the Milbank Memorial Fund in fostering epidemiological studies and flow of information about European programs; publication of *A Guide to Control Methods in Mental Disorders,* by the American Public Health Association; the work of the National Institute of Mental Health to foster a public-health approach to mental disorders; and, eventually, the historic March 1963 mental health message of President John F. Kennedy, which advocated the development of locally based, comprehensive community mental heath centers and led to the necessary appropriations to aid the states in planning them.

Now we are trying to organize better ways of using our limited resources so as to maximize their effectiveness. We are, in effect, engaged in a "crash" program or, we might observe, a "war" on inefficiency and the maldistribution of knowledge and skills. Yet if we achieve these ends, we shall have made only a beginning. Since the problems of the mentally ill are so intertwined with various aspects of society, we must forge new social tools to help the mental health professions function better in the milieus where their patients live. The comprehensive community mental health program is intended to furnish systems of care that will enhance our efforts and improve their effectiveness. Community mental health centers are "enabling" or expediting devices and are not modalities of treatment. Success in developing badly needed models will not be an end in itself, but rather a bench mark to facilitate the ongoing tasks.

While it is a truism that each center must be "tailored" to meet the particular needs of its own community, it is also true that we cannot rely on most of our mental health professionals to develop such centers out of theoretical concepts. They need concrete models —the more the better. This is so because far too little of the training given to mental health workers specifically equips them to carry through the processes inherent in the successful development of mental health centers. These processes are community organization,

social planning, and administration. Professional training generally has emphasized services to individuals, not to communities, organizations, or related professions.

This is not to maintain that our professional personnel lack the potential for learning or that many do not possess native talent which often works well in the absence of systematized knowledge. But they do require living examples in addition to abstract principles, just as clinical demonstrations are balanced with theory in customary professional training.

This book is an attempt to fill this need—a distinctly successful attempt, considering the limited amount of "clinical" material available in the United States. A team of four investigators—sponsored by leading professional associations, a voluntary mental health agency, a university department, and the government—has provided us with a very interesting and useful report, well organized, rich in significant detail, acute in its observations, and practical in orientation. It will be a valuable resource for all who are concerned with the present and future planning efforts in community mental health. Not the least of its virtues is its timeliness, for it is no secret that, despite financial aid, encouragement, and expert assistance from the National Institute of Mental Health, progress in planning how to "close the gap" has been uneven. Thus while the results of the first two years of organized planning in many states will be sophisticated and creative, elsewhere they may be limited and unimaginative. (In any case, planning should be a continuous process and should not cease with the expiration of the two-year program.)

The team that produced this book describes 11 out of 330 facilities which completed a preliminary check list of service elements submitted to them. The 11 centers vary widely in their characteristics. This variation is evidently the result of selection and constitutes one of the virtues of the survey, for it enables planners in many different kinds of communities to identify with problems similar to their own and, hopefully, will encourage them to emulate the relative success of others. Ten of the centers are scattered from coast to coast in the United States, and one is in Canada. (All but the

Canadian center were visited by the entire team; the Canadian center, by two members.) The centers generously supplied voluminous data through interviews, completed a detailed questionnaire and reviewed the reports made about them. The quality of the final report reflects the value of this process, as well as a sense of real involvement, enthusiasm, and dedication on the part of the participants.

The wide and interesting variation among the centers is indicated by the following summary of their key characteristics:

Penn Foundation, Sellersville, Pennsylvania: A voluntary association, collaborating with a general hospital. Serves a stable population of 110,000 in a relatively well-off, ethnically homogeneous, semirural area. Staffed by full-time, paid personnel. A notable feature is a very active volunteer corps of 150 women, which augments the program. Catchment area embraces the population living within 10½ miles of the center, in two counties.

Division of Mental Health Services, County Department of Public Health and Welfare, San Mateo, California: A division of a department of public health and welfare, serving a rapidly growing county with a population of 500,000 near San Francisco. Despite admitted gaps in service, it has developed a well-founded program which significantly reduced hospitalization. Strong public health emphasis, with stress on prevention and reduction of disability.

Yorkton Psychiatric Centre, Yorkton, Saskatchewan, Canada: Sole psychiatric resource for 93,000 people in a large, thinly populated, rural catchment area. Under auspices of the provincial psychiatric system, it collaborates with a mental hospital and controls all referrals to it. Unusually well-designed physical plant and good continuity of service.

Psychiatric Receiving Center of the Greater Kansas City Mental Health Foundation, Kansas City, Missouri: A nonprofit corporation serving an urban population of 550,000, with patients coming mainly from lower socio-economic levels. Financed by a variety of sources, including a city contract, federal grants, foundations, community chest, etc.

Dutchess County Project, Poughkeepsie, New York: A clinically independent unit within a large state hospital. Serves a semiurban county with a fairly stabilized population of 180,000. Emphasis on comprehensive hospitalization services (including pre-care and after-care) in co-ordination with the community services of the county mental health board. Financed by the hospital, with supplementation by the Milbank Memorial Fund. Strong emphasis on research to find ways of avoiding the "social breakdown syndrome" that has traditionally characterized state hospitals.

Prairie View Hospital, Newton, Kansas: A small voluntary hospital-centered program in contract with a county mental health board, principally serving one county, plus after-care services in a tri-county demonstration project. Population of 65,000, living in small-town and rural settings. Project is gradually extending services into the community.

Fort Logan Mental Health Center, Denver, Colorado: A state mental hospital serving a metropolitan area with a population of 1,000,000. Does not meet many of the federal criteria for comprehensive programs, but is of interest as a small, community-based unit which may be the model for future state hospitals. No emergency services. Has a geriatric service with a limited number of beds and is opening a children's unit. Heavy reliance on group and milieu therapy.

Massachusetts Mental Health Center, Boston: A research and teaching unit of a state hospital system. Serves an entire state, but actually draws 80 to 90 per cent of its patients from metropolitan Boston. Special features include strong orientation to the community, 24-hour emergency walk-in clinic, and good continuity of care. Specialized community facilities supplement the Center's program.

Reiss Mental Health Pavilion, St. Vincent's Hospital, New York, N.Y.: Psychiatric department of a general hospital, serving an urban district with about 125,000 population in a mixed residential, business, and manufacturing area. While other psychiatric programs give some service to the area, and its own in-patient program is not restricted to it, this program is community-oriented and extremely varied, with a good deal of training and increasing

research. A large indigent and marginal population is served. There is a well-developed outpatient children's service as well as consultation service for retarded school children.

Nebraska Psychiatric Institute, Omaha, Nebraska: A major training center with a broad, impressive program that serves the entire state somewhat in the manner of the Massachusetts Mental Health Center. Unusual features include an advanced industrial rehabilitation program in co-operation with the Goodwill Industries, four satellite clinics, transitional units for special groups, and sophisticated use of audio-visual technology for teaching, consultation, and service. Displays interesting potentials for development of consultative programs to serve regional or local mental health centers with more limited facilities.

Albert Einstein Medical Center-Bronx Municipal Hospital, The Bronx, New York: Psychiatric department of a medical school which staffs and operates the program of a municipal general hospital and also operates a division of social and community psychiatry in a district health center. The hospital unit supplies a large volume of varied service, in connection with its training program, to an urban, low- and middle-income population of 782,600 which has few other than state hospital services. Its part-time hospitalization program at Westchester Square Health Center is of special interest, because of indications to date that two out of every three patients randomly accepted for 24-hour hospitalization can be successfully treated in a day-hospital setting.

Because of the report's uniform approach to fact-gathering, the data on the centers are more or less comparable, considering the difficulty inherent in surveying a field for which there have been practically no standards and relatively little uniform reporting. But to compare the centers directly with one another is somewhat risky, since the communities they serve are so varied. The report wisely refrains from overgeneralization about the findings. Nevertheless, so long as the reader does not attempt to apply disparate approaches without relation to the specific problems of his own community, there is a good deal of interest inherent in the comparisons.

The fact that it was possible to compare the data reveals that the 11 centers are quite different in auspices, administration, internal structure, and relationships with "host" or co-operating agencies. At the same time, they are relatively similar in the variety of treatment modalities used by most, and in their success in supplying a range of services. (There are, of course, variations in the amount of each activity, one center limiting the use of drugs, for example, and another stressing group therapy.) There are also a number of similarities, it must be added, among their deficiencies, notably in the serious inadequacy of services for children and the aged, and for alcoholics and narcotics addicts. While some attention is given to problems of chronicity, the focus seems for the most part to be on incipient and "crisis" problems.

As one might expect, problems of staff recruitment loom large in the list of problems encountered and unsolved, although the centers based in urban communities tended to fare better. The universality of the recruiting problem for these relatively well-developed centers, it should be noted, lends ammunition to the contention that vigorous measures and increased federal support are needed to remedy the deficiency. Even if these are legislated soon, a good deal of time must elapse before the required personnel can be developed.

The report notes a "substantial deficiency across the board" in evaluative programs for the purpose of determining the efficacy of their services. Were it not for the fact that in subsequent discussion clear recognition is given to the difficult research and methodological problems involved, this might not be fair criticism. Indeed, while there definitely are gains to be anticipated from the use of evaluation procedures in such programs, one wonders if a good deal of the responsibility for such work does not also lie with outside agencies, such as the state and federal authorities, professional associations, and universities, or perhaps some independent unit organized along the lines of the Medical Research Council of Great Britain. There is a good deal to be said for concurrent, independent evaluation, as opposed to the "built-in" variety.

It might have been interesting if the survey team itself could have

elicited some sort of evaluation data from the communities served by the various centers, for example, from unaffiliated referring agencies and those to which the centers in turn make referrals, as well as key groups like the clergy, the schools, general practitioners, and the police. This might well be considered for a follow-up to the present report. Ideally, there should have been base-line data-gathering to provide a "before-and-after" picture.

In examining the work of these 11 centers, the question inevitably arises: Are they—actually or potentially—"true" comprehensive community mental health centers? Following the precept that such a center should provide a system that serves the total population of a defined geographical area, this would not seem to be the case for most. Granting that all the required services need not be under the same roof, or even under the same direct control, all the centers do not either satisfy this principle or supply the list of essential services specified in the National Institute of Mental Health regulations.

Comparisons with foreign programs are risky, but it must be said that, while the quality of services portrayed in the report appears for the most part to be of a higher order, all the programs do not appear to typify the concepts of comprehensiveness and continuity to the same degree as do some of the better British and Dutch programs, nor do they all seem to be proceeding along those lines. Conspicuous by their absence are indications of easy and natural relationships with the public health programs of their respective communities, except in one or two instances. Adequate services to the chronic, long-term patient are in most centers deficient in quantity and scope. There is relatively little indication of interest in domiciliary services that bring public health nursing, social, or psychiatric service into the home when required; the programs are strongly agency-centered. Even the follow-up work depicted seems to be strongly centered in institutions, with a relative lack of active relationships with families, employers, and other community elements that are crucial to the post-release progress of the patient. Comparatively little attention seems to be given to the critical matter of vocational rehabilitation, or to industrial therapy.

Perhaps, when there has been sufficient experience with the existing programs and the carrying out of present plans, such gaps will be closed. Certainly, this should have great meaning for patients, and may not only increase the effectiveness of the work in progress but be of great teaching value as well to the more desk-bound professions. When such programs are rounded out in these ways, even more progress will have been made by these pioneering groups toward the development of truly comprehensive systems of continuous care.

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