Community Mental Health Principles: A 40-Year Case Study

by Paul R. Ahr, PhD, MPA

By the time Congress had passed the Community Mental Health Centers (CMHC) Act of 1963, community-based services for people with serious mental illnesses were in place in several locations around Missouri, and more were planned for the future. Beginning in 1960, the Missouri mental health agency developed detailed plans and budgets for the establishment of comprehensive community-based treatment centers that would shift acute mental healthcare away from state-operated mental hospitals. The availability of these plans thrust Missouri into the forefront of CMHC grant recipients, in both the public and private sectors.

The 40th anniversary of President John F. Kennedy's signing of the CMHC Act provided the backdrop for a review of the principles of the CMHC movement nationwide, and an analysis of the extent to which they still define community mental healthcare in this pioneering state. In early 2003, I interviewed 17 direct observers of the evolution of community mental healthcare in Missouri for their first-person reflections. These interviews were incorporated as a key element of my book *Made in Missouri: The Community Mental Health Movement and Community Mental Health Centers 1963-2003*. The range of their personal experiences spread from 1950 to the present. In addition, the CEOs of Missouri's 22 private not-for-profit CMHCs contributed in-depth descriptions of program development in their service areas, including descriptions of current and planned programs. These interviews provide a unique case study of the viability of eight CMHC principles (listed below).

Responsibility for a specified population. This principle has been sustained in Missouri in large part because the Department of Mental Health (DMH) incorporated it as the first condition for designation of a local mental health center as the exclusive agent (known as *administrative agent*) of DMH funding in its service area. Over four decades, the number of service areas has been reduced and some CMHCs, especially in rural areas, have earned administrative agent status for several service areas.

Focus on prevention and early intervention. Missouri CMHCs were required to include prevention and early intervention in their service array (both hallmarks of the public health approach); it was a strategy to reduce demand for services over time. Unfortunately, federal funding for these services was not available until the CMHC program was well underway. In Missouri, state funding for primary prevention programs was suspended in the early 1980s because of budget cuts. Despite these obstacles, prevention and early intervention are alive and well in CMHCs throughout the state. In some cases, they are ongoing programs; in other cases, the concepts are embodied in immediate large-scale interventions on the scene of natural and man-made disasters.

Treating people with mental illnesses in their home communities. When asked about treating people in their home communities, Dr. Morty Lebedun, retired CEO of Tri-County Mental Health Services in North Kansas City, spoke for all Missouri CMHCs when he described what goes on at Tri-County: "That is what we do." Although driven by an ideology that promotes treatment close to home in the least restrictive environment, Missouri CMHCs are confronted daily with a chronic shortage of available acute mental health beds. The solution to this problem sparks a lively exchange between proponents of more inpatient capacity and those promoting alternatives such as additional community residential slots and home-based supports.

Provision of a continuum of care. While the principle of a continuum of care has remained unchanged since the CMHC movement's earliest days, the continuum's components have changed periodically. Presently, the robustness of a CMHC's continuum of care is marked by two elements. At the base, CMHCs are providing a set of services required by DMH to meet the needs of some consumers in the department's target groups. At the high end, CMHCs continue to provide a full

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range of services for adults with serious mental illnesses and children and youth with serious emotional disturbances, as well as some of the more traditional prevention, early intervention, and mental health counseling services for people not counted among the DMH target groups.

Use of multidisciplinary teams, including paraprofessionals. From the earliest days of public mental hospitals, through the era of mental hygiene and child guidance clinics, the mental health field has enjoyed a long history of team-based treatment. This tradition remains a key component of CMHC care. Today, CMHCs in Missouri use the expertise of consumers of mental health services and parents of children with serious emotional disorders, while other consumers fill important roles in crisis intervention and wraparound services.

Linkages with other community organizations and agencies. CMHCs were always expected to work closely with other human service agencies in their communities. In fact, the intent of mandated consultation services was to improve the mental health case finding and intervention skills of practitioners in such agencies. The practice of linkage has grown, especially as human service agencies have proliferated and as scarce resources have become scarcer. Some agencies were designed to directly access and pay for services from other community practitioners and agencies. The emergence of consumer and family-of-consumer organizations has provided an additional opportunity for CMHC linkages.

Over the past six years, CMHCs have entered into formal linkages with each other to form larger, regional service units. Two examples of this activity are the establishment of regional joint ventures and the consolidation of several smaller mental health agencies. Some observers of Missouri's CMHC system believe that increased economic pressure, especially from state sources, may trigger further consolidations of smaller CMHCs into larger mental health or healthcare systems.

Fiscal and program accountability. As their federal funding began to wane, Missouri's CMHCs promoted a fee-for-service reimbursement arrangement with DMH. This funding mechanism was at the opposite end of the reimbursement continuum from the multiyear, guaranteed federal grants. This approach has dominated DMH-CMHC fiscal accountability arrangements ever since. Whenever centers secure other public

or private funding, these funding sources impose their own typically unique financial and reporting requirements.

Citizen participation. Citizen participation in governance has continued as a hallmark of CMHCs in Missouri. Although they were not at first required by the National Institute of Mental Health, eventually all federally funded centers established boards of directors that included representatives of community and professional stakeholder groups. Even where Missouri's CMHCs were incorporated into larger organizations, the expectation of a broadly representative governing or advisory board has been maintained. Perhaps the greatest boost to high-quality citizen participation, however, has been the steadfast advocacy of the Mental Health Association and the emerging relevance during the past two decades of other powerful advocacy groups, especially the National Alliance for the Mentally Ill and the Missouri Statewide Parent Advisory Network.

The Missouri case study of the orienting principles of the community mental health movement has demonstrated their versatility and viability over more than 40 years of constancy and change. These principles have endured within an environment of evolving priorities and emerging practices. Thus, proponents of community-based care, while facing many fiscal hardships and regulatory barriers, can take pride in knowing that the principles behind their movement remain strong. **BHM**

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