DOCUMENT RESUME

ED 153 145 CG 012 494

TITLE	The Mental Health Aspects of Health Planning.
INSTITUTION	Southern Regional Education Board, Atlanta, Ga.
SPONS AGENCY	National Inst. of Mental Health (DHEW), Bethesda, Md. Continuing Education Branch.
PUB DATE	77
GRANT	1-T1S-MH14703
NOTE	63p.
EDRS PRICE	MF-$0.83 HC-$3.50 Plus Postage.
DESCRIPTORS	Alcoholism; Clinics; Community Services; Drug Abuse; *Federal Legislation; *Health Programs; *Mental Health Programs; Mental Retardation; *Planning; Professional Personnel; *Program Coordination; State of the Art Reviews; *State Programs

ABSTRACT

This publication provides an overview of the mental health system as it relates to the general health system and especially as it relates to overall health planning under the National Health Planning and Resources Development Act. There is a need for the staff persons of the health planning agencies and the staff persons of local and state mental health agencies to have a clearer notion of the mental health aspects of health planning so that they can incorporate these aspects into their planning as effectively as possible. This publication explains some of the differences in perspectives between general and mental health, in organization, in definition and in service delivery. (Author/FC)

THE MENTAL HEALTH ASPECTS OF HEALTH PLANNING

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Southern Regional Education Board
130 Sixth Street, N.W.
Atlanta, Georgia 30313
1977
$1.50

FOREWORD

When Congress passed the National Health Planning and Resources Development Act (PL 93-641), it established a new structure of local health planning agencies (Health Systems Agencies) which were given the responsibility for planning for all health programs -- both general physical health and mental health. In the past the structures for physical health and mental health have been quite separate in local and state jurisdiction and even within the federal government. Now the planning for both of these health domains is being brought together. When the new Health Systems Agencies have established acceptable local health services plans and have been fully designated, they will assume the responsibility not only for planning for both areas of health, but also for approval or disapproval of applications for funds under a wide range of federal support programs.

The Mental Health and Human Services program of the Southern Regional Education Board (SREB) has a grant from the Continuing Education Branch of the National Institute of Mental Health (Grant No. 1-T15-MH14703) to assist the staff persons and governing body members of both the new health planning agencies at local and state levels and the staff persons and board members of local mental health centers and state mental health agencies to understand more of the issues involved in strengthening the mental health aspects of health planning under PL 93-641. This publication is one activity of that project.

We are grateful to the NIMH for their support and to the Regional Office staff persons from both Health Planning and Mental Health units of the Public Health Service in Atlanta, Dallas and Philadelphia who offered a great deal of assistance. We are also grateful to the directors of the three Health Resources Planning Centers in the South for their help.

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INTRODUCTION

The fields of physical health and mental health, while linked in many ways and employing some of the same kinds of workers, have evolved remarkably separate systems for the planning and delivery of services. Each has developed its own vocabulary, its own terms for defining health and illness, its own systems of treatment, and its own bureaucracy of agencies at local, state and national levels. There have even been substantially separate systems for planning; in fact, the mental health system has had four separate systems for planning -- one for mental health, one for alcoholism, one for drug abuse and one for developmental disabilities.

When Congress passed the National Health Planning and Resources Development Act (PL 93-641) in 1974, it mandated that the new health planning structure would have the overall responsibility for all health planning -- especially at the local level. The local Health Systems Agencies, once they have their Health Service Plans prepared and accepted, and once they have been fully designated, will have the authority to approve or disapprove federal grant funds under several programs that are primarily in the mental health area. At the same time Congress still expects each state to prepare an annual plan for mental health, alcoholism, drug abuse and developmental disabilities. In most cases these plans will be prepared by agencies that are not closely linked to the general health planning system.

Obviously there is need for both the staff persons and governing body members of the health planning agencies and the staff persons and board members of local and state mental health agencies to have a clearer notion of the mental health aspects of health planning so that this aspect can be as effective as possible. This publication explains some of the differences in perspectives between general health and mental health, some of the organizational differences, some differences in definitions, and some of the differences in service delivery.

Chapter I

PLANNING RELATIONSHIPS BETWEEN MENTAL HEALTH AND GENERAL HEALTH SYSTEMS

In the past the mental health system has been looked at as a system quite separate from the general health system. In most states the mental hospitals are operated either by separate departments of mental health or by mental health divisions of departments of welfare or institutions. In only three or four states are the mental health programs part of an overall health department, and even then they are separate divisions. At the national level the mental health system has its own set of bureaucracies -- The National Institute of Mental Health (NIMH), the National Institute of Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Drug Abuse (NIDA), and the Developmental Disabilities Administration. Each state and federal mental health agency has its own appropriations which are almost always separate from those for general health.

Unfortunately this organizational and financial separation of the mental health and general health programs has influenced the attitudes of a number of the leaders and planners from both parts of the system who act as if they would prefer for each to go their own way as they often have done in the past. Modifying these attitudes will require special sensitivity and flexibility on both sides since they have been reinforced by different terminology,

criteria and procedures in many cases. There are surely many aspects of mental health and general health services that are common to both, but there also are some unique aspects of each that must be respected and maintained. It will be a mistake to force these into a common mold, or worse yet, to set them up in opposition to each other.

In spite of this separate funding at state and federal levels and the "isolationism" of the mental health system, a substantial part of the mental health system is definitely a part of the health care system. The acute care of the mentally ill and emotionally disturbed is ordinarily undertaken in hospitals (general hospitals or private or state mental hospitals) or clinics. The individuals are called "patients" and the treatment programs tend to follow the medical model.

An issue arises regarding certain other parts of the mental health system which provide services that are regarded more as social-rehabilitation than as medical treatment. This includes the support in community living arrangements of the chronically mentally ill and mentally retarded as well as counseling for some of the lesser mental disturbances, such as marriage counseling and counseling for personal adjustment problems. This situation has some parallels in the rehabilitation and long-term care of the physically disabled and care of the aged and chronically ill. Such individuals require both health care and social-rehabilitative care.

With the coming of the Health Systems Agencies, which are to be the primary building blocks for local health planning, it will be essential for

leaders in both health planning and mental health planning to recognize the presence of each other and to begin to think and plan together. Mental health and general health planning must be considered together because of the impact they both have on the overall system of health, and yet there will continue to be some separateness because of the separate funding, organizations and services.

NEED AND POTENTIAL FOR COORDINATION

The National Health Planning and Resources Development Act of 1974 (PL 93-641) is expected to have a major effect on the planning of both mental and general health services by bringing all health planning together at local, state and national levels. The purpose is to plan for more effective delivery of health services and to contain the rising costs of health care. It is important for both groups to understand the necessity for joint planning. This planning should hasten the development of a partnership between mental and physical health services. Expected benefits of joint planning are:

- avoidance of duplication of facilities and programs;
- use of a common planning format;
- inclusion of mental health in overall health policy making and programming;
- creation of a better data base for overall decision making and internal management;
- better coordination of all health service programs, regardless of their source of funding.

The Act establishes a coordinated health planning network at the regional, state and national levels. The cornerstone of the network is the Health Systems Agency (HSA), a regional health planning unit run by a governing body with a consumer majority and a professional staff of at least five. Each HSA will assess the existing health services programs in its area, prescribe short- and long-range plans for the s[illegible]mprovement, and use its authority, development funds and technical assistance to bring its plans to fruition. Included in the HSA authority is the power to approve or disapprove federal grant proposals under several general health, mental health, mental retardation, and alcohol and drug abuse programs. To be approved, proposals will have to be in harmony with the established HSA plan. While this authority applies only to federal grants, it is hoped that the plans will also influence expenditures of state, local and private funds for health programs and facilities.

The local Health Systems Agency is the fundamental authority for all health planning under the Act. Each Health Systems Agency must prepare an overall Health System Plan and an Annual Implementation Plan for its Health Service Area. Future grant proposals will then be judged on the basis of whether they are consistent with these plans.

The next level in the structure of the health planning system is the State Health Planning and Development Agency (SHPDA) and its related Statewide Health Coordinating Council (SHCC). The state agency is responsible for compiling the individual plans (including mental health plans) from the local HSAs into an overall State Health Plan. The SHPDA's

responsibilities also include planning for certain statewide resources (e.g., professional health manpower) and transmitting of grant proposals with comments to federal agencies. The state level components do not have any authority to approve or disapprove of proposals.

Planning of the mental health agencies is generally in a somewhat reverse pattern. In the case of community mental health, alcohol and drug abuse programs, federal law requires that the designated single state agency for each of these program areas develop an annual plan. Local plans for individual community mental health centers, alcohol treatment programs, drug abuse programs, etc. are then developed in harmony with the appropriate state plans. The mental health planning system will have to assure that both the state mental health plans and the local mental health plans are coordinated with the Health Service Plans of the HSAs and with the State Health Plan developed by the SHPDA and approved by the SHCC. This merger of planning interests is spelled out in the guidelines from the March 26, 1976 Federal Register, "Moreover the Department (of HEW) particularly wants to call attention to the need to integrate the roles of mental health, drug abuse and alcohol abuse services with the interests and concerns of the general health care system."

DIFFERENCES BETWEEN MENTAL HEALTH PLANNING AND GENERAL HEALTH PLANNING

In many ways it is easier to plan for physical health than for mental health. Many of the physical illnesses have very specific causes and physical findings so that the statistics regarding the prevalence, incidence, morbidity, mortality, etc. are easy to measure. These are tangibles that

are rather easily addressed for purposes of planning. Mental health planning is more difficult because there are few concrete guidelines. The symptoms of mental disorders are often variable, and there are few tangible physical signs or tests that are specific to mental illness. In addition there are no universally accepted treatment procedures for many mental conditions.

There are at least nine major areas of planning concern in the charge to the Health Systems Agencies. One of these is the area of health statistics. As already noted, the output of the mental health system cannot be readily equated with the statistical outputs of the physical health area because mental disorders do not lend themselves to the same kind of precision as physical illnesses.

Since there is no mandatory reporting of mental illness, it is difficult to come up with specific incidence and prevalence rates for the mental disorders beyond the data on the utilization of mental health resources. There may be many other persons with mental disorders in nursing homes, in boarding homes or in the general population who never come to the attention of the formal mental health system and thus are not reported in the available mental health statistics.

In a few communities it will be possible to make some estimates of the persons needing mental health care from the statistics on juvenile delinquency, crime, divorce, and problem behaviors such as truancy in schools. A certain portion of these problems are likely to have emotional

factors which underlie the behavior. Thus they indicate a need for mental health services.

Two major areas of planning concern are those of the health status and health problems of the population and demographic data about the population. For planning to be effective, there must be indicators and data related to the population. The National Institute of Mental Health has developed the Mental Health Demographic Profile System (MHDPS) for the planning of community mental health services. This system provides 130 indicators computed from the population data based on the 1970 census. These indicators are useful in identifying areas with high or low risk and special needs for both health and mental health services for each of the proposed 1,500 community mental health catchment areas. Data have been tabulated for each Health Service Area (HSA) in the United States and for each of the counties within each HSA and can now be used as an aid in planning both general health and mental health services under PL 93-641.

This profile system provides information and data on the following aspects of the population:

- socio-economic status;
- ethnic composition;
- household composition;
- family history (structure);
- style of life;
- condition of housing;
- community instability.

Perhaps the most common use of this system is to calculate the potential utilization rates for the population. These rates are usually defined as the number of admissions or episodes of care during the year in mental health facilities among residents of the catchment area for each 100,000 population of that area. The planner can use the profile system to develop a list of problem categories by examining which social groups are likely to have special mental health problems.

The following characteristics may help in identifying groups who may have special problems:

- age;
- sex;
- location of residence in the community;
- race or ethnicity;
- institutional status (inpatient, etc.);
- social class;
- families of disabled person;
- marital status.

After a comprehensive list of mental health problem categories has been developed, it would be helpful to rate each separate category according to the best information regarding its importance in the community in terms of whether it is critical, serious, etc. An additional approach might be to list specific problem categories together with statements of possible solutions and objectives. These methods of analysis will allow one to make

some statements about how the resources of the community mental health system could be allocated to best fit with the priorities and objectives that have been established.

Two other sets of data which are needed for planning relate to health care facilities and the utilization of these resources. It is usually an easy matter to identify the mental hospitals, community mental health centers and psychiatric clinics and services within the specific area. It is also important, however, to assure that the planners are aware of other facilities, such as state mental hospitals and Veterans' Administration hospitals, that lie outside of the area but still serve the residents of the area. In the case of mental health it is also important to learn of day programs and other variant programs that serve the mentally ill and retarded but are not traditional inpatient or outpatient facilities. These include half-way houses, sheltered workshops, social rehabilitation programs, hot-lines, day hospitals and special education programs for the emotionally disturbed or mentally retarded. These facilities and nursing homes serve large numbers of mentally disabled persons outside of the traditional hospitals and clinics.

The traditional measures of utilization of hospitals and clinics are:

Inpatient Admission -- Admission to a service for a period of inpatient care regardless of whether the individual had been a patient of that service earlier in the year.

Outpatient Admission -- Admission to a series of one or more visits either for the first time or after having been previously considered terminated from outpatient care.

The number of admissions to the total set of psychiatric facilities may include a duplicate counting of certain individuals. While this measure is rather crude, it does provide some indication of the extent to which the system of mental health services is used. Daily census data gives the best indication of utilization for other kinds of mental health facilities.

Another area of planning data is that of health care programs, such as Medicaid, utilization review, etc. The major health financing programs that serve physical health generally serve mental health also except there are likely to be severe limitations in the coverage of mental disorders. These may be limits of time, total dollars or conditions which can be included under the coverage of the programs. All of the major mental health facilities that serve Medicaid patients have active utilization review mechanisms. Mental health programs are generally served by local area Professional Standards Review Organizations (PSRO) but a few state hospitals have their own PSRO.

The major mental health programs are those which will be discussed under the section on the mental health systems. These are the community mental health centers, the alcohol abuse and alcoholism programs, the drug abuse programs and the developmental disabilities programs for the mentally retarded and certain other developmental conditions, such as cerebral palsy and infantile autism. Each has its own federal and state legislation, funding, organizational structure, and policies and procedures.

Another planning item that must be considered by the HSAs is health economics. Mental disability tends to have high costs because it is so

often socially disabling and long-term. This is especially true of the major mental illnesses and mental retardation. Persons are often unemployable except in sheltered situations. This reduces income to poverty levels or below and leads to many of the victims being on welfare. In many places more than half of the persons receiving disability income payments are the mentally disabled.

Expenditures for mental health come disproportionately from public funds since the major illnesses are so disabling and chronic. The funding for the mental health system has several unique aspects. The funding for local mental health services comes from one or another of four separate federal agencies plus one or more state agencies. Other funds come from private fees, third party payments and contracts. It should be noted that many health insurance plans either exclude or drastically limit mental health benefits. Often programs with multiple sources of funding, and with accountability to each of the several sources from which the monies originated, are housed in one facility.

Another aspect of planning data required by HSAs is that of manpower data. The mental health system uses physicians (psychiatrists) and nurses and certain other allied health personnel, but it also uses large numbers of professionals, such as psychologists and social workers, who are less common in the general health system. The mental health manpower system also uses a variety of alcohol and drug counselors and mental health technicians who are unique to these program areas. They are described in greater detail in the section on the scope of mental health care.

The final major area of data required by the HSAs for health planning is that of environmental and occupational health. The mental health system also has its counterpart of environmental stresses, such as overcrowding, poor housing, unemployment, and poverty, which are largely psychological or sociological rather than physical. Other more specific stresses, such as overt prejudices and practices of certain groups or agencies, may put groups of individuals (e.g., the aged, minorities or the disabled) under special mental stress. These problems are dealt with through public education, consultation, change of agency policies and practices, etc. These programs of prevention can and should be planned for, along with diagnostic and treatment services. The data of need for such programs is often hard to obtain and document just as in the case of environmental pollution of air and water, but it is nonetheless important.

LINKAGES BETWEEN MENTAL HEALTH AND HEALTH PLANNING IN THE CONTEXT OF PL 93-641

In developing both mental health and general health plans, joint thinking will be imperative because the HSAs must now look at all facilities, at all sources and levels of funding and at all proposed functions, and assist with the planning and assessing of all these arrangements. This means that the health planners must have knowledge about all the public and private mental health facilities in the service area plus some indication of each facility's contribution to the overall mental health service needs of the community. The needs and resources for each community area must then be weighted, combined and ranked. This is a difficult role for planning agencies that have not been accustomed to thinking of mental and physical

health plans together. The local mental health centers and state mental health agencies must also redirect their thinking because specific goals must be planned and funding arranged to assure that they are consistent with the overall local Health Systems Plans Mental retardation programs are mainly related to health planning through the requirement for a certificate of need for new facilities to serve the mentally retarded.

While federal legislation requires that the state mental health agency, the state alcohol agency and the state drug abuse agency each prepare an annual plan for the entire state in these program areas, it also calls for community mental health centers to be the legal entities to do the local planning, coordinate the services and deliver many of the mental health services to the persons who live in local catchment areas. Catchment areas are geographic areas serving between 75,000 to 200,000 persons (although there are exceptions based on waivers). The catchment areas do not necessarily correspond with the larger Health Service Areas which include several community mental health catchment areas. An additional complication lies in the fact that the community mental health centers program is not yet fully funded; consequently, there are still 860 catchment areas without community mental health centers to do this local planning.

The complications of planning for the mental health aspects of health planning become immediately apparent in the face of all of these overlapping plans and planning jurisdictions -- especially if each adheres to its own definitions and values regarding the scope of the task to be done. It would seem especially desirable for the responsible staff persons in both the

Health Systems Agencies and in the state and local mental health programs to get together with each other to learn more about each other's needs and operations. A telephone call can initiate such a relationship if it does not already exist. A working relationship should not have to depend on formal representation of mental health interests on the governing bodies of the HSAs, but it should involve some kind of formal contracts or letters of agreement between the HSAs and the local and state mental health agencies. Ideally there will be structured staff relationships between specific individuals on the staffs of the HSA and the local community mental health centers so that questions and potential conflicts can be ironed out long before things come to the point of formal action. The state planners in mental health, alcoholism, drug abuse and mental retardation must also be systematically related to the Health Systems Agencies' planning to assure that all phases are consistent and complete.

Chapter II

THE MENTAL HEALTH DELIVERY SYSTEM

THE PRESENT MENTAL HEALTH DELIVERY SYSTEM

The present mental health delivery system is a complex amalgamation of public and private programs and facilities with a considerably larger commitment to public services than the general health system. There are private mental hospitals and private practitioners in the major urban centers, but the greater portion of the mental health delivery system lies in the public sector. The private sector cares for acute mental disorders that can be reimbursed by private fees and by third party payments, but these are largely limited to either affluent families or short periods of intensive treatment. Thus the major responsibility for long-term care of both the mentally ill and the mentally retarded and for the care of the poor and indigent falls to the public sector. Because much mental illness is either long-term or economically disabling, these persons make up a disproportionate share of the total population of persons requiring services from the public sector. The public sector carries the major responsibility for the preventive aspects of mental health programming and for the overall planning and coordination of services.

The major organizational level for the mental health delivery system is at the level of state government. The mental health systems originated with

the state mental institutions, and while there has been considerable local development through the community mental health centers where they exist, the major responsibility for planning, coordinating and even supporting mental health services still lies with the state mental health agency or corresponding state developmental disabilities agencies or state alcoholism or drug abuse agencies. In many states these four state program offices are all combined in a single division or department, but there are several states in which one or more of these programs is administered separately from the others. It is these state program offices (called "single state agencies" in the federal alcoholism and drug abuse legislation) that are charged by the federal laws and guidelines with preparing each state's plan for that program area.

In most cases these state agencies also operate some facilities themselves (e.g., state mental hospitals, state schools for the mentally retarded, state alcoholsim clinics, etc.). They also offer major program assistance (e.g., data processing for patient data systems, program consultation, staff training) to local programs, but they also generally provide additional financial support to local public programs. This may be done under legislative authorizations or administrative procedures for matching formulas or it may be under contract programs. This funding is in addition to any funding that may be received from the federal government for direct program operation of local programs.

Local mental health, mental retardation, alcoholism and drug abuse programs are organized under a wide variety of authorizations and auspices.

Many states have some kind of community mental health legislation that spells out the structure, functions and funding for these programs. Some states require that these local programs be part of local governments or at least heavily influenced by local public officials while others provide for voluntary, non-profit organizations. In some states the local mental health centers are private, but then still have contracts to serve the public needs. The local mental health programs are usually responsible for the planning and coordination of services in the local area within the overall guidelines of the state plan. In many cases the local programs will contract for many of the needed services through private psychiatric hospitals, local general hospitals, nursing homes, halfway houses or private practitioners in addition to the services that they provide directly.

In recent years the federal government has become greatly involved in programs to help develop and support local mental health, mental retardation, alcohol and drug abuse programs under a variety of acts of Congress. These are all administered by the Department of Health, Education, and Welfare usually through the three Institutes in the Alcohol, Drug Abuse and Mental Health Administration although the Developmental Disabilities (mental retardation) programs are administered by the Office of Human Development. Local programs that meet the qualifications for receiving the federal program monies have this source of funding in addition to state monies, local monies, private fees, contract fees, third party payments, etc.

At the local level the mental health centers may provide for all four program areas (e.g., mental health, mental retardation, alcoholism, and drug

abuse) or some of the program areas may be separate. The local pattern tends to follow the state pattern. In the case of community mental health centers that serve several program areas, there is a truly astonishing array of regulations, funding and evaluation procedures that must be administered.

The major federal programs that affect one or another of the local mental health program areas are the community mental health centers program, the developmental disabilities program and the alcoholism and drug abuse programs.

COMMUNITY MENTAL HEALTH

Community care and control of mental disorder is the primary emphasis of the community mental health center. According to the Community Mental Health Centers Amendments of 1975 (PL 94-63) the Congress of the United States finds that:

- Community mental health care is the most effective and humane form of care for a majority of mentally ill individuals.
- The federally funded community mental health centers have had a major impact on the improvement of mental health care by:
  - fostering coordination and cooperation among various agencies responsible for mental health care which in turn has resulted in a decrease in overlapping services and more efficient utilization of available resources;

- bringing comprehensive community mental health care to all in need within a specific geographic area regardless of ability to pay;

- developing a system of care which insures continuity of care for all patients.

- There is currently a shortage and maldistrubtion of quality community mental health care resources in the United States with 860 of the proposed community mental health centers still to be developed.

The Congress further declares that federal funds should continue to be made available for the purposes of initiating new and continuing existing community mental health centers and initiating new services within existing centers and for the monitoring of the performance of all federally funded centers to insure their responsiveness to community needs and national goals relating to mental health care.

What is meant by a community mental health center? According to section 201 of the Community Mental Health Centers Amendment, the term community mental health center means a legal entity through which comprehensive mental health services are provided:

- principally to individuals residing in a defined geographic area, referred to as a catchment area;

- within the limits of its capacity to any individual residing or employed in such area, regardless of his ability to pay for such services, his current or past health condition.

The comprehensive mental health services which shall be provided through community mental health centers shall include:

- inpatient services, outpatient services, day care, and other partial hospitalization services and emergency services;
- a program of specialized services for the mental health of children, including a full range of diagnostic liaison and follow-up services;
- a program of specialized services for the mental health of the elderly, including a full range of diagnostic treatment, liaison and follow-up services;
- consultation and education regarding mental health for a wide range of individuals and entities, such as health professionals, schools, courts, state and local law enforcement and correctional agencies, members of the clergy, public welfare agencies, health services delivery agencies;
- a wide range of activities (other than the provision of direct clinical services) which are designed to develop effective mental health programs in the center's catchment area such as:

- promoting the coordination of the provision of mental health services among various entities serving the center's catchment area,

- promoting the prevention and control of rape and the proper treatment of the victims of rape,

- assisting courts and other public agencies in screening residents of the center's catchment area who are being considered for referral to a state mental health facility for inpatient treatment to determine if they should be so referred or where appropriate treatment for such persons might be provided as an alternative,

- developing programs of transitional half-way house services for mentally ill individuals who are residents of its catchment area and who have been discharged from a mental health facility or would without such services require inpatient care in such a facility.

In summary, consultation and developmental services of a community mental health center should be available to a wide range of individuals and agencies. They should also include a wide range of activities designed to develop effective mental health programs in the center's catchment areas. This is the public health aspect of mental health.

Diagnostic and treatment services for the acutely ill and maintenance and support services for the long-term mentally ill are special services that should be available through community mental health center programs. Additionally, rehabilitation services should be available for the center's patients/clients. These are services operated for the primary purposes of assisting in the rehabilitation of disabled persons through an integrated program of: a) medical evaluation and services; and b) psychological, social and vocational evaluation and services.

All of the above services must be under competent professional supervision in cases whether furnished within the mental health center or in connection with a hospital.

SERVICES FOR THE MENTALLY RETARDED (DEVELOPMENTALLY DISABLED)

Mental retardation is recognized by the Developmental Disabilities Act as a public health problem affecting the general welfare and economics of individual states and the federal government. Mental retardation means a "state of sub-average general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior." The mentally retarded individual is recognized as one who may be improved physically, mentally and socially through care, treatment, special education and counseling. Adequate facilities and programs, including specialized services to meet the retarded person's needs for normalization are declared to be in the best interests of the society's health and welfare.

At the federal level the leadership responsibility for programs for the mentally retarded was originally established in the National Institute of Mental Health. However, in the mid-1960's this responsibility was separated from the National Institute of Mental Health, and ultimately from the Public Health Service, into the Office of Human Development where it is presently lodged. The formal name of the program at the federal level is the Developmental Disabilities Administration and its concern includes cerebral palsy, epilepsy, and childhood autism as well as mental retardation. In most states and at the local levels, however, the programs for mental health are closely related to those for mental retardation although there are some readily apparent differences both in the conditions and in their management.

On the federal level, the government allocates monies for research programs and construction of facilities for the mentally retarded. Additionally, federal monies are sent to the states to support the delivery of services to the developmentally disabled.

The growing trend in the country is in the direction of normalization of the mentally retarded in their communities to the greatest extent possible. The states have a variety of service programs for the mentally retarded. The primary purpose of these support programs is to provide community alternatives to institutional care so that mentally retarded individuals can continue to live in their home communities. When one speaks of "community services" it means all services deemed reasonably necessary to provide for education, training, rehabilitation and care of mentally retarded individuals and

includes diagnostic and evaluation services, day care and training services, work activity services, community residential services, such as group family care homes, transportation services incidental to educational, training and rehabilitation services, social services, medical services and other specified home services.

The community services programs for the mentally retarded may be administered at the local level by the community mental health authority or by a separate mental retardation or developmental disabilities agency. This agency has the responsibility for information and referral work, for providing advice and guidance for the families or guardians of retarded persons and for developing new community resources that are felt to be needed.

The state developmental disabilities (mental retardation) agency has overall responsibility for planning, developing, and monitoring of standards and providing technical assistance to local community developments.

SERVICES IN ALCOHOLISM AND DRUG ABUSE

At the state and local levels the programs for alcohol and drug abuse are often included in the overall mental health programs, but they are sometimes separate. All receive combinations of federal, state and often local public tax dollars as well as receiving private fees. Each of the national institutes (NIAAA and NIDA) requires a separate state plan from each state's single state agency for alcohol and drug abuse. These are in addition to the state mental health plan.

FEDERAL ACTIVITIES IN MENTAL HEALTH

Despite the extensive activities of the Department of Health, Education, and Welfare, not all federal mental health services are under its jurisdiction. The Department of Defense and the United States Bureau of Prisons care for their own clientele.

Of even greater significance for health planners is the Veterans' Administration which operates a number of mental hospitals and clinics, as well as psychiatric units in virtually all of its general hospitals. While a large part of the annual mental health expenditures of the Veterans' Administration has been for disability pensions, approximately half has been for the operation of mental hospitals and outpatient clinics. As far back as 1965 the budget for mental health hospitals and clinics was $300 million; 38 of the then 168 VA hospitals were classified as psychiatric, and of a total of 118,896 operating beds, 58,746 were for psychiatric patients. A retrospective glance gives us some idea of the impact of mental illness and the cost factors involved even twelve years ago.

The Veterans' Administration also undertakes extensive research on various aspects of mental illness. It is generally conceded that the Veterans' Administration mental health program is the best funded and staffed in the nation. It spends considerably more per patient per day than do most states, but it also competes for scarce manpower with state and local programs. The Veterans' Administration is the nation's largest single employer of professional mental health workers.

COSTS AND SOURCES OF FUNDING

The origin of much of the money for community mental health services is the federal government. There are grant monies that come directly from the federal government; other monies go through the states from the federal government; and still other monies come through vendor payments under specific titles of the Social Security Act, such as Titles XVIII (Medicare), XIX (Medicaid), and XX (Social Services).

Listed below are the projected federal monies that are clearly earmarked for mental health programs for the year 1977.

National Institute of Mental Health (NIMH):

- Community mental health centers -- $232 million;
- Research, training and technical assistance for community mental health centers -- $454 million.

National Institute of Drug Abuse (NIDA):

- Overall expenditures -- $260 million.

National Institute of Alcohol Abuse and Alcoholism (NIAAA):

- Overall expenditures -- $153 million.

Developmental Disabilities Administration:

- Overall expenditures -- $30 million;
- Protection and Advocacy Formula -- $3 million;
- Special projects: Section 145 -- $19.5 million;
- University affiliated facilities -- $5.5 million.

In addition other federal funds are available through such programs as Medicaid, Medicare, Title XX (Social Services), the Bureau of Education for the Handicapped and the Rehabilitation Services Administration.

Most states have some kind of matching program under a statutory community mental health services act or some similar administrative program. The matching ratios vary from 33 percent to almost 90 percent but generally range between 50 and 70 percent. The states also vary in which kinds of mental health services are eligible for matching funds under these mechanisms.

(In addition to support for community mental health, the states still support the state mental hospitals and state schools for the mentally retarded. While the populations of these institutions has declined, the costs have generally risen partly as a result of inflation and partly because of court orders that have required higher ratios of staffing and services to assure the patients their "right to treatment.")

Chapter III

SCOPE AND HISTORICAL DEVELOPMENT OF MENTAL HEALTH

SCOPE.

Physical illness has been with mankind since the beginning of civilization. Physical illness and health have many facets and dimensions ranging from programs to improve health through better nutrition and health practices to treatment of major illnesses that are frequently fatal. Hospitals and public health programs all originally came into being to control the ravages of epidemics of contagious diseases. Now that these diseases have been largely contained, the health system is concerned with a wide range of other physical illnesses, such as cancer, heart disease, metabolic diseases and arthritis.

Similarly the mental health system sprang from a single major scourge, insanity, as it once was called, but has now expanded into a wide range of community mental health programs that have to do with the prevention of anxiety and depression as well as the treatment of a wide range of conditions that were not even recognized a hundred years ago. Just as the contagious diseases have been largely controlled but not eliminated in this country, so the major mental illnesses are coming under control, and other conditions, such as the neuroses, personality disorders and lesser emotional disturbances, are receiving more attention.

Mental illness and the mentally ill have always existed and societies have reacted to mental illness in strange ways. Some prehistoric cavemen punched holes in the skull to release demons supposedly causing mental aberrations. Other societies put unfortunate victims to the stake or drowned them. In other places the mentally ill were incarcerated in asylums and hospitals, out of the reach of society. Through the years, methods of caring for the mentally ill have not followed a consistent developmental pattern; rather they have been characterized by stops and starts, by advances and setbacks.

The mental health system in the United States formally began with the establishment of state asylums for the mentally ill in the mid-1800's. Dorothea Dix, distressed at the sight of the mentally ill being incarcerated in jails and prisons, began a campaign to petition the legislatures of the individual states to establish asylums for these unfortunate people. She was remarkably successful in her appeals to the states, but singularly unsuccessful in her petitions to the U. S. Congress. As a result, the mental health systems have grown largely as state supported systems. The state hospitals for the mentally ill and the state institutions for the mentally retarded still require a large portion of the individual state budgets -- in most cases the state tax dollars spent for the mental institutions alone make up 60 percent of all of the state dollars spent for health. In addition most states invest a considerable number of state dollars in community programs for mental health, alcoholism, drug abuse and mental retardation.

Mental health is a major American industry. In one way or another mental health programs are being developed by a wide range of governmental agencies, private voluntary groups, schools and universities, commercial and industrial enterprises and even religious organizations. Along with state government the federal government invests vast resources in mental health care, research and education. One can gain some conception of the growing involvement of the federal government in mental health simply by comparing the budgets of the National Institute of Mental Health in 1950, $9 million and the projected expenditures for 1977, $453.4 million. Such agencies as the National Institute of Mental Health, the National Institute of Alcohol Abuse and Alcoholism, the National Institute of Drug Abuse, the Developmental Disabilities Administration, the Veterans' Administration and the Armed Forces have initiated and developed a great variety of demonstration programs, research efforts and construction programs in mental health. From a quick survey of programs and involvements, it is clear that mental health is everybody's business. The cost of direct state expenditures for the mentally ill and mentally retarded in institutions is estimated to be $4.28 billion each year. The total cost of mental health services is calculated to be $17 billion of the total $104 billion spent on health services in the United States. Of this total 31 percent comes from state and local funds, 21 percent from federal funds, 11 percent from insurance, and the remainder from private fees and other sources.

The need for mental health efforts and programs must be measured not only in terms of monetary expenditures for services, but also in regard to

the suffering and disabilities that characterize mental illness. These disabilities extend well beyond the mentally ill themselves, affecting work relationships, families and community life in general. The fact that mental illness is so socially disabling is a major reason that the care of the mentally ill became a public responsibility in the first place.

There is no way to precisely measure the number of persons who are affected by mental health problems, because the boundaries of what is considered to be mental disability keep changing. Studies in recent years have shown that approximately 85 percent of the population are afflicted with some kind of emotional or mental problem. Of course, most of these problems are not the major mental illnesses that so long filled the state institutions. However, in 1975 there were still 219,000 persons residing in state hospitals for the mentally ill and 168,300 persons living in institutions for the mentally retarded. Countless thousands of other mentally ill and retarded persons are living in nursing homes, group homes or intermediate care facilities. At the latest count there were three times as many mentally ill or retarded persons residing in nursing homes as in all of the mental institutions combined.

In 1973, there were 3,425,296 outpatient visits to mental health facilities; 1,679,608 persons were admitted for inpatient mental hospital treatment. These are the persons known to have been seen in public and private facilities. In addition many more have been treated by private psychiatrists and in private clinics, for which the data are much less certain.

These are the persons who have been sick enough with major mental disorders, psychoneuroses, and personality disorders to require specific professional diagnosis or treatment. However, there are several other groups of persons whose problems are not severe enough to require specific services or whose problems have not yet been fully recognized as mental health problems. Among these are:

- Many emotionally disturbed children whose problems remain unrecognized because they are often perceived by the schools as having behavior problems rather than mental health problems, just as schools sometimes regard children with intestinal parasites to be lazy and stupid.

- Many persons with physical illnesses have underlying emotional causes. Most physicians feel that 30 to 50 percent of their patients have emotional problems that either aggravate their physical conditions or provide the sole basis for the patient's visit. These persons are seldom sent for mental health consultation or treatment.

- Many individuals have emotional problems that end up in divorce, crime, delinquency, etc. where they are handled by the justice system. Over the past 25 years there has been a remarkable tendency for our society to recognize the emotional basis to behavior and to redefine problems as mental health oriented rather than as criminal justice problems. This has happened

with alcoholism, drug abuse and more recently with child abuse and wife beating.

DEFINITION

To give a firm definition of exactly what mental illness is would be admirable but almost impossible, just as it is almost impossible to define the exact boundaries of physical illness. Much of the disagreement stems from the lack of consensus as to how broad or how narrow the conception of mental disorder should be. Some psychiatrists restrict the definition to a limited set of major psychotic disorders while others include a wide variety of problems in the emotional sphere.

Traditionally, psychiatrists have developed diagnostic labels to describe the categories of psychiatric problems they see. They recognize and define psychiatric problems through the appearance of particular patterns of behavior, thought or feeling states. There are relatively few mental disorders that can be diagnosed by specific physical or laboratory findings. In occasional instances the person does not have an awareness of his illness, but is eventually defined as being mentally ill when a crisis develops because of his unusual thoughts or behavior in relation to his family or some community agency.

Mental disorders may be broadly classified into two major groups: 1) those conditions caused by or associated with impairment of brain tissue or physiology (organic brain disorders); 2) disorders without clearly defined physical cause (functional disorders).

Organic Brain Disorders.

The major organic brain disorder is mental deficiency, or mental retardation as it is more commonly called. Mental deficiency is the condition of impaired intellectual functioning that results from injury to the brain in its developmental stages before birth, at birth, or in infancy or childhood. It may result in relatively mild intellectual impairment or very severe impairment so that the individual is unable to care for even personal needs. These individuals are not mentally ill, but they require special training and support to help them function at the highest possible social level of which they are capable.

There is also a range of other organic mental illnesses which are caused by injury to the brain in later life. These injuries may result from toxic substances, such as alcohol or drugs, or from brain damage caused by infections, tumors, trauma, or chemical imbalances. Many of these conditions are reversible if the damaging agent is removed, but many are not -- especially if the damage has continued over a rather long period of time. These illnesses range from mild to very severe.

Functional Disorders.

The great bulk of conditions that are considered to be mental disorders to be treated by the mental health system are the functional disorders. These are conditions which seem to be caused by psychological stresses and strains although they frequently respond to physical treatments, such as tranquilizers or antidepressant drugs. The functional disorders also range from very

disabling to only mildly disturbing. The commonly described categories of functional disorders are:

Psychoses.

These are the major disorders of thought or mood in which the individual loses contact with reality in rather major ways. They may have some as yet undetermined physiological causes. There are two major classes of psychoses:

- Thought disorders, such as schizophrenia and paranoia, in which thinking is often bizarre and inappropriate, with delusions, hallucinations and disturbed behavior.

- Mood disorders, such as the depressions and manic illnesses, in which the feelings are either "blue" and slowed down or overly active and excited. These conditions may lead to suicide or exhaustion.

Neuroses (psychoneuroses).

These are disorders in which the individual is disabled by anxiety symptoms in certain areas of life, but does not lose overall contact with reality. They include conditions in which there are obsessions, compulsions, hysteria, phobias, or just disabling fear and anxiety.

Character and Personality Disorders.

These are conditions in which the individual has developed habitual personality or character problems that interfere with functioning. Included are extreme passivity, or aggressiveness, extremely withdrawn personalities, antisocial personalities, alcoholism, drug addiction and sexual deviations.

Psychosomatic Disorders.

These are the conditions in which anxiety and psychological stresses produce or aggravate physical illness. Examples are found in many cases of ulcers, high blood pressure, asthma, colitis, and skin eruptions, to name a few.

Trait and Behavior Disorders.

These are most often disorders of childhood and include such things as thumb sucking, temper tantrums, bed wetting and fire setting.

From the point of view of lay definitions the two most common perspectives on mental disorder are those based on the health-illness and the goodness-badness dimensions. The public tends to equate all mental disorder with the major psychoses characterizing the whole person rather than just certain parts of functioning. The implication is that because the mental disorder marks the entire person and because it sometimes causes deviations of behavior, the individual cannot be trusted to understand a situation or to make decisions concerning his welfare. Since this assumption is most often untrue, it is not difficult to understand why people undergoing mental health treatment resist being viewed in this way.

In the past, mental health professionals interpreted mental disorder according to the idea that individual people were sick inside and needed treatment for their mental disorder, just as when they were physically ill. This is often true, but much may be overlooked by using only this concept of illness. Many situational stresses have an impact on emotion and behavior -- unemployment, inadequate education, housing, poor nutrition, the effects of racial and sex discrimination. The problem in these instances lies in the community stresses and not in the individual patient. The community agencies must look to each other to help deal with those stresses. Citizens must rethink their relationships to service providers; rather than being told that their problems lie within themselves, they need to be able to resolve community stresses when these are the causes of anxiety and strain. These community mental health stresses are comparable to the environmental health problems of air and water pollution which affect individuals but which must be dealt with at the broader community level.

HISTORY OF THE MENTAL HEALTH SYSTEM

The historical development of mental health programs in the United States explains in large part the present system.

During the Colonial period the mentally ill and mentally retarded were either kept at home or were confined to local jails. The major political events since then have been:

1756 The Pennsylvania Hospital in Philadelphia was the first general hospital to establish a unit for treatment and care of the mentally ill.

1773 Virginia opened the first public asylum for the mentally ill at Williamsburg. It was followed by Kentucky (1824) and South Carolina (1828).

1841-1881 Dorothea Dix traveled the country advocating humane treatment for the mentally ill. Twenty states responded by establishing asylums.

1909 National Committee for Mental Hygiene, established by Clifford Beers (A Mind that Found Itself), emphasized research into the causes of mental illness, treatment and the development of preventive measures. The child guidance movement grew from this thrust.

1917 The Selective Service Act established screening of recruits for psychiatric disorders and treatment of mentally ill military personnel. This was the first federal recognition of mental disorder which had previously been considered to be the full responsibility of the states.

1930 The Division of Mental Hygiene was established in the U. S. Public Health Service to treat drug addicts, federal prisoners and to provide psychiatric diagnostic services to federal courts.

1946 The National Mental Health Act established the National Institute of Mental Health to give attention to research and training in mental health and to provide technical assistance and modest grant-in-aid support to the states.

1950 The National Association for Mental Health was founded by the merger of three voluntary groups -- The National Committee for Mental Hygiene, The National Mental Health Foundation and The Psychiatric Foundation. The National Association for Mental Health is an active citizen support group. The National Association for Retarded Citizens (then called Children) was also established at this time to develop support and programs for the mentally retarded.

1963 The Mental Retardation Facilities and Community Mental Health Centers Construction Act provided support for the development of community programs for the mentally ill and retarded. In 1965 the Staffing Amendments were added to provide staffing grants. These acts followed the report of the Joint Commission on Mental Health and Illness in 1961 and the commitment of the Kennedy administration.

1970 The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act established the National Institute of Alcohol Abuse and Alcoholism.

1975 The Community Mental Health Centers Admendment (PL 94-63) expanded the services that community mental health centers must provide and established requirements for program evaluation and other administrative procedures that would help the centers become independent of federal support.

These major political events created the mental health system. In the meantime there were vast changes in the technology for the treatment of mental disorders.

TECHNOLOGY IN THE TREATMENT OF MENTAL DISORDERS

At the time of the creation of the first state hospitals there was a conviction that the "moral treatment" of the time would restore the mentally ill to their homes and families. The treatment record of those early pioneer physicians was generally good. (An association of superintendents of hospitals for the insane in 1851 was the first nationwide medical society in the United States; it was the forerunner of the American Psychiatric Association.)

However, it soon became apparent that not all patients recovered so quickly, and so the states began to build "asylums" in the rural areas where persons who did not respond to short-term care could find peace and protection. These asylums became badly overcrowded in the 1890's, and then underfinanced as well. The early psychiatrists were called "alienists". They had few effective therapies and found themselves carrying out mainly diagnostic work so that patients could be committed to the asylums.

In the late 1930's there began to be research breakthroughs in the treatment of some of the major mental illnesses It became possible to treat syphilis of the brain and pellagra and to reverse the agitation and depression of the functional psychoses with sedatives, insulin and convulsive therapies.

Meantime psychological therapies were emerging largely from the leadership work of Dr. Sigmund Freud in Vienna, but followed by a host of other medical and non-medical therapists. As a result the specialty of psychiatry emerged as a blend of neurology and psychology. World War II gave a tremendous boost to the newly emerging specialty and to the knowledge of the treatment of a wide range of lesser psychiatric disorders in addition to the major psychoses.

In the early 1950's there was a great national concern about the thousands of persons confined to the large state mental institutions, as the old asylums had now been renamed. Books, such as The Shame of the States and Snake Pit, brought public attention to their plight. About this time (1955) the major tranquilizer medications were discovered; these drugs were a major help in controlling the extremely disturbing behaviors that had plagued the mentally ill in state hospitals.

Soon the combination of the newer drugs and the increases in staffing with qualified professionals began to transform the hospitals to treatment hospitals, and the patient census in several states began to level off and then decline, despite ever-increasing number of admissions.

Since the late 1950's there has been a great drop in the numbers of persons confined to state mental hospitals -- from more than 750,000 in 1955 to less than 225,000 in 1975. With the increases in community mental health programs and private practitioners and facilities, the thrust of care for the mentally ill has clearly moved to the community. At the same

time it has greatly expanded to include treatment of large numbers of individuals with lesser psychiatric disorders that may be treated with a combination of medication and a range of psychological therapies -- supportive and group psychotherapy, behavior shaping, reality and insight therapy, psychoanalysis, etc.

PROGRAMS FOR THE MENTALLY RETARDED

Meanwhile the mentally retarded were recognized as having different problems and needs from the mentally ill. Several states established separate institutions for the mentally retarded during the first half of the 1900's. These came to emphasize special education techniques for both the trainable and educable mentally retarded together with a range of programs designed to enable them to function in their communities to the best of their ability.

During the late 1950's and 1960's there were great expansions of special education programs in public schools, sheltered workshops, day care and activity programs for the retarded, etc. Finally the populations of the state institutions for the mentally retarded also began to be reduced as the community programs made their impact. Now most of the mentally retarded are managed entirely in the community. Only the most seriously disabled are cared for in institutions. This process has been called "normalization."

ALCOHOL AND DRUG ABUSE PROGRAMS

While persons suffering from alcoholism and drug abuse had long been treated in psychiatric hospitals, little separate attention was given to

persons with these addiction problems, except in the U. S. Public Health Service Hospitals in Fort Worth, Texas and Lexington, Kentucky, until the late 1960's and early 1970's when an epidemic of drug abuse swept the nation. These led to the establishment in the early 1970's of separate federal institutes and legislation for alcohol (National Institute of Alcohol Abuse and Alcoholism and the National Institute of Drug Abuse).

Local treatment programs consist of programs to overcome the acute toxic effects of these drugs (detoxification programs), programs to counsel and rehabilitate alcohol and drug users, and programs of prevention.

MENTAL HEALTH PERSONNEL AND SERVICES

Traditionally the mental health personnel system was made up of four major professions -- psychiatry (M.D.), psychiatric nurses, clinical psychologists (Ph.D.) and social workers (M.S.W.). Their work was primarily oriented to direct clinical work with patients and their families -- diagnosing, testing, counseling, treating, teaching and researching. In recent years there has been a considerable expansion of workers in the field. These include special education teachers, vocational rehabilitation counselors, activity therapists, pastoral, alcohol and drug abuse counselors, and mental health technicians.

The role of the traditional professionals has changed from that of direct patient therapist to a combination of teacher-consultant-administrator. Professionals are expected to be in the forefront of policy formulation, program planning and administration, while much of the direct service is

rendered by the newer kinds of worker. Even those professionals who carry direct clinical duties also have some supervisory or administrative responsibilities for a few other personnel or for a sub-unit of the overall mental health program.

Part of the clinical services in mental health are the primary responsibility of medical-nursing personnel, for example, establishing diagnoses for the major psychoses, prescribing and administering medications and other physical treatment procedures, diagnosing and treating concomitant physical illnesses. These are particularly common in the acute, inpatient units which are usually located in psychiatric units of general hospitals or in special private or public mental hospitals. Such hospitals also employ laboratory and x-ray personnel, occupational and physical therapists, etc. who are common to the rest of the general health field. The lead professional in this area is the psychiatrist -- a physician who has specialized in the diagnosis and treatment of mental illness and emotional disturbance.

Another part of the clinical services of mental health programs, however, is the responsibility of workers who deal primarily with the psychosocial adjustment of the patient/client. Psychologists have a particular stake in the mental health field because of their central concern with the behavioral and emotional development and functioning of human beings. From a general base, they have developed a variety of specializations in areas such as personality and intelligence testing, behavioral therapy, counseling and psychotherapy. Psychologists specialize in areas such as child,

community and educational psychology and research. They are human relations specialists who often serve as consultants to schools, courts, jails and prisons. Clinical psychologists are psychologists who have specialized in the treatment of abnormal behavior; counseling psychologists deal with the resolution of problems of adjustment.

The social worker is critical in this psychosocial area of patient treatment since many patient problems are the results of family or social situations which must be modified to reduce the stresses or the patient must be counseled to better adjust to the social stresses. Social workers may have a Master's degree from a graduate school of social work or a Bachelor's degree from an undergraduate social work program. Social workers make up a large proportion of the staff of most mental health programs -- especially of the staff who do outreach consultation and education to community agencies and caregivers as required of community mental health centers.

The manpower pool has recently been expanded by the addition of pastoral counselors and a range of alcohol and drug abuse counselors. Many of the addiction counselors have been chosen because they have had a personal experience with alcohol or drug abuse which enables them to better establish rapport with the clients they serve. In addition, the past ten years have seen the addition of a range of new mental health workers or technicians. Some of these were trained on the job in New Careers programs and others in two-year associate degree programs in community colleges. They are employed in all parts of the mental health system but especially in community

outreach and aftercare programs for patients returning from state hospitals and institutions for the mentally retarded. In many cases the patient does not need a high level of professional skill but rather a sympathetic relationship with a person whom he can trust to help with many aspects of everyday adjustment and problems of living. Mental health technicians are excellent for this kind of relationship. Mental health programs also make considerable use of volunteers -- college students, housewives or retired persons who can establish continuing relationships with patients as in the foster grandparent program for the mentally retarded.

One of the special difficulties experienced by many mental health services is in overcoming the social and cultural gap between the middle class professionals, most of whom are white, and the lower social class patients who may come from minorities, isolated rural areas or other national or cultural groups. This becomes especially critical in mental health care in which so much of the process of treatment is linked to language and culture. The professionals must be made aware of these problems and trained to overcome them. Many of the mental health workers in the paraprofessional programs (New Careers and Mental Health Technicians) are recruited from these minority and local cultural groups so they can more easily establish relationships and understand the problems and needs of the clients. They can then turn to the professionals for consultation in establishing the diagnosis and setting a treatment plan which can be carried out with the patient. In this way they use their cultural knowledge and life experience to extend the expertise of the professionals to the patients to whom they are better

able to relate than are the professionals. This relationship between the professionals and the paraprofessionals must be carefully delineated and developed among all the staff so that there will not be conflicts over someone else taking over a responsibility which a staff member feels is his.

SUMMARY

In this publication we have attempted to provide an overview of the mental health system as it relates to the general health system and especially as it relates to overall health planning under the National Health Planning and Resources Development Act (PL 93-641). There are some substantial commonalities -- especially in the acute treatment of major mental illness, but there are also some considerable differences in the system of care for the chronically mentally ill and the mentally retarded and in the diagnosis and treatment of some of the behavioral disorders which are not primarily organic or subject to the usual medical treatments. The general health and mental health systems are certainly compatible with each other, but to build a realistic plan for all health services in the community, a special understanding of the uniqueness of the basic problems, the separate funding and organizational requirements is needed. The information is provided to give basic background to be used by all parties in developing the mental health aspects of health planning at both local and state levels.

GLOSSARY OF TERMS

The following definitions have been given by Public Law 93-641 (The National Health Planning and Resources Development Act);

Hospital.

A facility providing inpatient care for diagnosis, treatment and care of acute illness. It includes general, tuberculosis and other type of hospitals and related facilities such as laboratories, nursing homes, outpatient departments, extended care facilities, self care units and central service facilities. Many general hospitals have psychiatric units. There are also separate private and public psychiatric hospitals.

Long-term facility.

A facility (including a skilled nursing or intermediate care facility) providing inpatient care for chronic or convalescent care. There are many mentally ill and retarded persons residing in long-term facilities.

Outpatient clinic.

A medical facility located in or apart from a hospital for the diagnosis and treatment of ambulatory patients (including ambulatory inpatients): a) which is operated in connection with a

hospital; b) in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the state; c) which offers to patients not requiring hospitalization the services of licensed physicians in various medical specialties and which provides to its patients a reasonably full-range of diagnostic and treatment services. There are many psychiatric outpatient clinics.

Community. (Not defined by PL 93-641)

A group of people who have something in common. This implies people living in the same district, city or general environment and sharing common interests.

Short-stay hospital.

A facility that would include in most instances the minimal requirements as defined under the term hospital. The provisions in the facility would be dependent upon the specialization of that hospital. There are many short-stay private psychiatric hospitals.

Intermediate care facility.

A facility providing inpatient care for convalescent or chronic disease patients who require skilled nursing, intermediate care and/or related medical services. This care or medical service is performed under the general direction of persons licensed to practice medicine or surgery in the state.

Rehabilitation facility.

Social rehabilitation programs are undertaken in most instances in a rehabilitation facility. This means a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical, psychological, social and vocational evaluation services under competent professional supervision and in the case of which the major portion of the required evaluation and services is furnished within the facility, and either the facility is operated in connection with a hospital or all medical and related health services are prescribed by, or are under the general direction of, persons licensed to practice medicine or surgery in the state.

Community mental health center.

Community mental health care is the most effective and humane form of care for a majority of mentally ill individuals. A community mental health center means a legal entity through which comprehensive mental health services are provided. These services shall include: inpatient services, outpatient services, day care and other partial hospitalization services and emergency services. Additionally they include programs of specialized services for the mental health of children and the elderly, including a full range of diagnostic treatment, liaison and follow-up services.

Consultation and education.

These are services for a wide range of individuals and entities involved with mental health services, including health professionals, schools, courts, state and local law enforcement and correctional agencies, members of the clergy, public welfare agencies and health services delivery agencies. Additionally these services include a wide range of activities designed to develop effective mental health programs in the center's catchment area, and increase the awareness of the residents of the center's catchment area of the nature of mental health problems and the types of mental health services available. The provision of comprehensive mental health services through a center shall be coordinated with the provision of services by other health and social agencies serving residents of the center's catchment area to insure that persons receiving services through the centers have access to all such health and social services as they may require.

Certificate of need.

Mandatory review process whereby proposals to alter institutional health services or the health facility must be justified on the basis of expenditure and community need.

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