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WHATEVER HAPPENED TO COMMUNITY MENTAL HEALTH?

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Editor's Note: **In the commentary below, Steven S. Sharfstein, M.D., discusses the article on page 611, reprinted from the September 1966 issue of *Hospital and Community Psychiatry*. In the 1966 article, Walter E. Barton, M.D., described trends in community mental health care driven in part by the Kennedy-Johnson legislation establishing community mental health centers. Dr. Sharfstein points out Dr. Barton's farsightedness in understanding the implications of the federal government's involvement in the care of persons with severe and persistent mental illness, the need for new types of treatment for this population, and even the current controversy over confidentiality in an era of computerized records. Dr. Sharfstein also discusses some trends that Dr. Barton could not have foreseen. (*Psychiatric Services* 51: 616–620, 2000)**

In the cost-driven medical marketplace, psychiatry and, more broadly, mental health have suffered more than the rest of medicine. Private health insurance benefits have been cut significantly, and the public mental health system is in a state of collapse that varies only by degree from state to state.

Two sectors of care in particular have been under attack in the managed care revolution: hospitals and physicians. Managed care has taken on many of the rhetorical flourishes but none of the substance of the community mental health revolution of the 1960s and 1970s. Managed care emphasizes lower levels of care and lower-cost professionals as a way of saving money and enhancing stockholder value, which has led to an increasingly consolidated behavioral health industry. But in the face of cost cutting, what about access and quality?

The social philosophy underlying community mental health, on the other hand, emphasizes better access to high-quality care for all Americans and allocation of more resources to community treatment. The increasing scarcity of these resources and the overall crisis in access to health care have led us to an interesting crossroads in the history of the community mental health movement. In this paper I make an assessment of the movement in light of history and the realities we face at the new millennium.

The 1960s was a time of great social ferment, idealism, and hope. Dr. Jeffrey Geller (1) comprehensively reviewed the past half-century of psychiatric services in the January issue of this journal. His review of the major changes, which included changes in the title of this journal, emphasized dehospitalization (a better term than deinstitutionalization), community care and treatment, economics, and other important policy issues as they have affected patient care over the decades. His emphasis on clinical treatment in the context of sociology, politics, and economics of the latter half of the 20th century is where I begin my review of the past and future of community mental health centers (CMHCs).

President John F. Kennedy (2) expressed great optimism in his special message to Congress on February 5, 1963, in which he proposed a national mental health program to inaugurate "a wholly new emphasis and approach to care for the mentally ill." The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164) was signed just a few weeks before President Kennedy's assassination.

President Johnson picked up where Kennedy left off, with amendments in 1965 that provided staffing grants. By September 1966, when Walter Barton's article "Trends in Community Mental Health Programs" (3) was published, the first federal grants for construction and staffing of CMHCs had already been made. Barton was a visionary and giant of American psychiatry in the 20th century, serving as medical director of the American Psychiatric Association at the time of the passage of the Kennedy-Johnson legislation in the 1960s.

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The 1960s were marked by social ferment due to the civil rights movement and the Vietnam War. The war had begun to consume more and more of the national agenda and the nation's resources when Barton wrote his article. Kennedy's vision was beginning to be compromised by the fiscal realities of the war and a changing national will to provide every American with access to a CMHC.

This paper comments and reflects on Barton's article—one article among hundreds on community mental health—in light of subsequent developments in psychiatry, public policy, and community mental health. To what extent did Barton anticipate the true trends? What has happened to community mental health in light of major changes in the federal role supporting this concept, changes in state support and policy toward mentally ill persons, and changes in approaches to care and treatment driven by private-sector managed care?

The federal government: "the great almoner"

Barton was a conscientious, ethical, and brilliant architect of what was a new federal leadership role in the development of alternative approaches and sites of care for treatment of mental illness and addictions. He realized that in order to overcome more than 100 years of state-based approaches emphasizing long-term institutional care, large hospitals, and custody rather than treatment, the federal government had to step into what had been the province of states to promote community-based approaches.

Public Law 88-164, signed by President Kennedy in 1963, reversed 109 years of federal noninvolvement in state services for the mentally ill as expressed in President Franklin Pierce's veto message of the Indigent Insane Bill in 1854. This mid-19th century bill, written and promoted by Dorothea Dix, would have provided a grant of land for "the relief and support of indigent, curable and incurable insane." Its passage by Congress was the culmination of more than six years of intense work by Dix and her allies in trying to provide asylums that would emphasize "moral treatment" approaches to mental illness (4). Dix's asylum movement emphasized the need for more humane treatment based on compassion and care rather than assigning mentally ill persons to jails, poorhouses, or a life on the streets as was common in 19th century America. The movement argued that orderly routine that incorporated social contact, exercise, and work could cure insanity much more humanely and effectively than efforts to rid the body of demonic possession and other extreme measures of corporal punishment (4).

President Pierce (2), in his veto message, said, "If Congress has the power to make provisions for the indigent insane, the whole field of public beneficence is thrown open to the care and culture of the federal government. I readily acknowledge the duty incumbent on us all to provide for those who, in the mysterious order of providence, are subject to want and to disease of body or mind, but I cannot find any authority in the Constitution that makes the federal government the great almoner of public charity throughout the United States."

Pierce's veto led to a resumption of Dix's campaign, state by state, for the establishment of public asylums supported by state tax dollars. Over three decades, her advocacy led to the founding of 32 hospitals in 18 states. With waves of immigration to the United States in the second half of the 19th century and the opportunity for local communities and families to shift the cost of care of the mentally ill to state-supported facilities, these asylums changed from small therapeutic programs into large custodial public hospitals. Concepts of "curability" were replaced by concepts of incurability and chronicity leading to long, if not lifetime, institutional stays.

Many factors led to the movement called deinstitutionalization: journalistic exposés; the introduction of chlorpromazine into U.S. practice, which initiated the psychopharmacologic revolution; Blue Cross–Blue Shield's decision to cover inpatient psychiatry in general hospitals; and President Eisenhower's major study of the care of the mentally ill population.

One hundred years later, Pierce's veto was reversed ever so slightly by an increasing federal presence in the areas of health and disability. In 1954 Congress passed Title II of the Social Security Act, the Disability Income Program, and it was signed by President Eisenhower. The federal government began to become "the great almoner of public charity," as Title II of the Social Security Act anticipated the important future titles, Title XVIII, Medicare; Title XIX, Medicaid; and Title XVI, the Supplemental Security Income Program. These three acts were passed in the 1960s and 1970s (5).

By the mid-1950s, we had reached the peak of public-asylum psychiatry in the United States with more than 500,000 Americans residing in state-supported institutions (6). The average length of stay was measured in years; many patients expected to spend their entire lifetime in such institutional communities. Many factors led to the movement called deinstitutionalization: journalistic exposés; the introduction of chlorpromazine into the United States, which initiated the psychopharmacologic revolution; Blue Cross–Blue Shield's decision to cover inpatient psychiatry in general hospitals; and President

Eisenhower's major study of the care of the mentally ill population (7).

In his article about trends in community mental health programs, Barton underscored the great significance of this support by the federal government in the delivery of mental health services. He emphasized what is probably the most important point in health and mental health policy, that "service follows the dollar." He already knew that the Medicare and Medicaid programs would be critical to the success or failure of the idealistic notions of community mental health and would dominate mental health policy for the next 30 years.

Throughout the 1970s, the CMHC program competed with many urgent domestic programs, both health-related and non-health-related. Richard Nixon tried to discontinue the program but was rebuffed by the Democratic Congress.

The federal CMHC program was based on a seed-money concept. Local communities applied for federal funds that declined over several years (initially five years and then eight). Alternative funds, especially third-party payments, were expected to replace the declining federal grant. These programs were intended to serve catchment areas of between 75,000 and 200,000 individuals and provide five essential services: inpatient services, outpatient services, day treatment, emergency services, and consultation and education services. The country was divided into 3,000 catchment areas, and the hope in the 1960s was that the entire country would be covered by the mid-1970s. That did not come to pass.

Throughout the 1970s, the CMHC program competed with many urgent domestic programs, both health-related and non-health-related. Richard Nixon tried to discontinue the program but was rebuffed by the Democratic Congress. Congress passed amendments that added more requirements for the mental health centers but did not appropriate the funds necessary either to pay for the newly required services or to cover even half of the country in the time frame initially envisioned. Required services included those for children, the elderly population, and chemically dependent persons as well as rehabilitation, housing, and preventive services.

In 1977 a reassessment of the CMHC program took place in the context of the Presidential Commission on Mental Health, chaired by First Lady Rosalyn Carter. The decision was made to reinvigorate the program with additional dollars and redirect the program toward the tens of thousands of individuals who had been dehospitalized during the 1970s. The Mental Health Systems Act of 1980 (Public Law 96-398) was an effort to find new meaning in the original Kennedy legislation, and it was signed just one month before the election of 1980.

What Barton could not anticipate was the Reagan revolution of the 1980s and the reemergence of Franklin Pierce's concepts of the federal government's more limited role in service delivery. What had been a federal categorical grant program to local communities became block grants to states. Reagan's repeal of the Mental Health Systems Act of 1980 greatly limited a federal leadership role and left it up to states to reprogram institutional budgets as dehospitalization took place and patients were treated in community mental health programs.

At the end of the 20th century, we remain deeply ambivalent about the federal versus the state role in the support of community mental health services. The example set for all public and private health insurance programs by the federal government's recent decision to require parity in health insurance coverage for federal employees (an initiative of the Clinton Administration) is just one recent instance of the resurgence of federal leadership in the community mental health movement. Another is the current debate on a patients' bill of rights for managed care (8).

Community mental health practice

Barton pointed to several critical factors in clinical practice that continue to have a major influence on the success or failure of services provided in the community:

- The need for active aftercare and aggressive placement of patients discharged from acute care hospitals
- The need for long-term administration of antipsychotic medications for persons with serious and persistent mental illness
- The need for additional acute care hospital beds to treat short-term episodes
- The inadequate prescribing patterns of family physicians and the need for more clinicians to work in the community.

These issues continue today to bedevil practice as the availability or lack of insurance benefits to pay for outpatient services remains a critical element in community mental health. Barton anticipated the assertive community treatment approaches of the 1980s (9). Because "service follows the dollar," and discriminatory insurance coverage was and continues to be a major obstacle to the success of community-based approaches, outpatient care remains fiscally problematic. The difficulty in finding alternative sources of support to declining federal grant dollars exposed the most dangerous flaw in the original design of the federal community mental health centers pro-

gram. As several knowledgeable observers emphasized, the expectation that CMHCs would treat patients discharged from mental hospitals even though these persons often arrived at the centers with no ability to pay proved to be overly idealistic (10).

Yet despite the funding shortfall, the clinical and programmatic ideas expressed in Barton's 1966 paper remain relevant to practice today. Let me mention just a few: day hospitals as an alternative to 24-hour inpatient care; the need for rapidly accessible emergency psychiatric services; the availability of alternative residential care, both crisis oriented and longer term; and treatment that is culturally informed and relevant to age-specific needs. Barton wrote, "Within each community, the goals must be the same: individual treatment and rehabilitation for all patients of all ages and with all types of illness. The assistance must be continued from the moment the need is recognized until the problem is acceptably resolved. Anybody eligible for any service must be eligible for every service he needs. Ideally the therapist who is responsible for giving care during one phase of the treatment will continue to work with the patient in all other phases of illness." What could be a better statement of the challenge to provide high-quality services in today's managed medical marketplace?

Setting priorities

Barton, being the consummate administrator, recognized the need for a process to allocate scarce resources and to set priorities. He felt that community mental health centers had to give priority to caring for discharged patients from public facilities and the needs of seriously and persistently mentally ill persons. However, this concept was rather idealistic because local citizen advisory boards gave priority to services for less seriously ill people (11). Barton was rather wishful when he stated, "The public expects us to use most of our scarce psychiatric resources for the seriously mentally ill, who cause the community distress and who may endanger themselves or others. The public is concerned, too, about those who, because of mental illness, cannot work. Lower in its priorities is help for people who are troubled personally but who can still function. Lowest of all comes the public desire for preventive treatment for those who, under stress, may be susceptible to mental and emotional illness."

Barton was clearly skeptical of the trend that already had begun to emerge in the 1960s of social engineering and prevention as the best approach to spending community mental health dollars. He stated, "If, however, the weight of evidence offered by the behavioral and medical sciences can demonstrate that manipulation of social systems will reduce the incidence of mental illness, then more of our resources will be shifted to this type of prevention." But many psychiatrists were restless in the 1960s, were social-action-oriented, and felt that rent strikes and other social protests to relieve poverty and empower people in their local communities were "mental health" services. They felt that the elimination of racism would have a more profound effect on mental health and the prevention of mental illness than any specific treatment program. Again, as Barton brilliantly put it, "We would like to see dependency prevented, poverty eliminated, the aged cared for, and delinquency controlled. The trick is how to do these things. If they were done, would mental disorder disappear?"

At first, mental health centers were all directed by psychiatrist leaders, as was the overall federal policy toward community mental health. Very rapidly, however, a political ideology combined with fiscal realities reinforced the demedicalization of community mental health centers.

However, Barton was exquisitely sensitive to inequities of his time and place. The small percentage of women in medicine and psychiatry, the long-standing prejudice against minority physicians, and the lack of culturally competent treatment approaches were areas that he felt the leadership in medicine and psychiatry had to address very aggressively if community mental health had any hope of survival.

The role of psychiatrists

As access to community-based care grew dramatically with federal support and the parallel support for the training of many nonmedical mental health professionals, especially psychologists, social workers, and nurses, the place and role of psychiatrists in these community mental health centers changed. This trend was not anticipated by Barton in 1966.

At first, mental health centers were all directed by psychiatrist leaders, as was the overall federal policy toward community mental health. Very rapidly, however, a political ideology combined with fiscal realities reinforced the demedicalization of community mental health centers, with the emphasis on prevention and social engineering approaches. Psychiatrists were considered too elitist, too expensive, and too removed from the realities of social change (12). Those who were employed by community mental health centers were relegated to the role of medication management, which foreshadowed the managed care future for many psychiatrists in the world at large.

Information systems and confidentiality

Barton understood the potential of the information revolution in 1966, before the era of personal computers. He realized that as more information was collected and stored in community-based programs, there would be a need to safeguard it. He saw the challenge that information systems posed to the confidentiality patients expect when they go to mental health clinicians with the most personal of problems. At the American Psychiatric Association, he launched a four-year study with support from the National Institute of Mental Health on how protecting patient confidentiality might be accomplished.

Barton anticipated the electronic age and privacy issues with the following statement: "Insurance carriers need [information]; personnel departments in industry need it; patients and clients themselves have the right to certain information about their illness. We must develop new standards of confidentiality that will enable us to share the information that is essential to fulfill an assigned mission and at the same time not violate the patient's right to have certain aspects of his illness kept confidential." As we intensively debate the privacy of medical records at the dawn of the 21st century, this particular issue has reemerged as a major priority for the field and for community mental health.

Conclusions

Community mental health battles for survival in the rapidly changing public and private marketplace. Many of the old federally initiated community mental health centers are now called community behavioral health care organizations, or CBHOs, with a principal function of coordinating and integrating aspects of mental health treatment, addiction treatment, and primary care.

The success of psychosocial rehabilitation approaches coupled with supervised housing stands in contrast to the continuing public health disaster of seriously mentally ill persons who are homeless or in prison. Dorothea Dix would be shocked if she revisited America today. As Geller (1) understates, "We remain entrenched in our concerns about locus of care, confusing it with the humaneness, effectiveness, and quality of care." Because most care will take place in the outpatient arena, a great challenge for community mental health in the 21st century is to address the issue of people who are not in treatment, who resist treatment, and who become marginalized and destitute.

Without reinventing asylums or discovering a magic bullet or cure for schizophrenia and other serious mental illnesses, we must rely on mental health policies and services with adequate financial support for community care. Barton's "service follows the dollar" maxim is important if managed care is a temporary aberration in mental health policy, as I believe it to be. We still must find a way to set priorities, allocate resources, and ensure delivery of high-quality scientific and humane care to people in need. ♦

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