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# REPORT TO THE CONGRESS



## Need For More Effective Management Of Community Mental Health Centers Program

B-164031(5)

National Institute of Mental Health  
Department of Health,  
Education, and Welfare

**BY THE COMPTROLLER GENERAL  
OF THE UNITED STATES**

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AUG. 27, 1974



COMPTROLLER GENERAL OF THE UNITED STATES  
WASHINGTON, D.C. 20548

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To the Speaker of the House of Representatives  
and the President pro tempore of the Senate

This is our report on the need for more effective management of the Community Mental Health Centers program administered by the Department of Health, Education, and Welfare.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

A handwritten signature in cursive script, reading "Thomas P. Abate".

Comptroller General  
of the United States

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#### ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
NIMH	National Institute of Mental Health
CMHC	Community Mental Health Centers

D I G E S T

WHY THE REVIEW WAS MADE

To assist the Congress in its deliberations on extending or modifying the Community Mental Health Centers program, GAO reviewed:

- The administration of the program by the National Institute of Mental Health, Department of Health, Education, and Welfare (HEW).
- Management activities of 12 centers in 7 States.
- Use of construction grants by 9 centers in 6 States.

GAO did not assess the effect of services on persons assisted by the centers. Observations were made, however, on the quantity and type of services provided by the centers reviewed.

FINDINGS AND CONCLUSIONS

The purpose of the Community Mental Health Centers program, representing a new approach to the care of the mentally ill, was to make it possible for most of them to be treated in their own communities.

The Community Mental Health Centers Act provides Federal grant assistance for construction and for

staffing during the early periods of centers' operations.

Through August 1973, 392 centers had become operational and another 148 were being developed. During this period \$793 million of Federal funds were obligated for this program. (See p. 3.)

The centers have increased the accessibility, quantity, and type of community services available and have enhanced the responsiveness of mental health services to individual needs. Some success also has been realized in mobilizing State and local resources to further program objectives.

Also the 12 centers reviewed have established the five services the National Institute considers essential: inpatient, outpatient, partial hospitalization, emergency, and consultation and education.

The National Institute, the States, and the centers, however, need to improve performance in some program areas substantially for continued progress toward program objectives.

These areas include planning related to the area to be served (catchment area) and services provided, centers' ability to operate without continued Federal assistance, monitoring and evaluation, coordination of center activities, and use of construction resources.

According to HEW the magnitude and range of problems identified in this report are not out of the ordinary for newly developing programs. Administering complex service delivery organizations is difficult, particularly when emphasis is placed on initiating services. The need to continue activity that will bring about management improvements in the areas identified is clearly recognized.

### Improved planning

Federal regulations limit the size of a catchment area to no less than 75,000 and no more than 200,000 persons. The National Institute may authorize exceptions.

However, strict adherence to these regulations has in some instances (1) impeded program performance by dividing existing planning areas and political jurisdictions, (2) caused services and facilities to be duplicated in some areas, and (3) caused spending for mental health services to be unevenly distributed within a political jurisdiction. (See p. 5.)

A better job needs to be done in identifying local mental health needs. State plans usually contain general data, such as suicide rates, admissions to State mental hospitals, number of welfare cases, and per capita income, which may be sufficient to justify initiating a program in a catchment area but not to justify continuing the same services year after year without assessing them in relation to community needs.

In addition, data in State plans is not always current or of value to

individual centers in planning programs. (See p. 8.)

Most centers reviewed had not made specific studies of their catchment areas which would enable them to set priorities and compare services provided against these priorities.

The availability of funds to match Federal grants and the interests of the professional staffs of the centers were often important influences in establishing program emphasis within a center.

Although needs met by programs established in this manner are probably valid, there is no assurance that they are the only needs or the highest priority needs of the catchment areas. Also, once programs are established, they tend to dominate center activities in subsequent years.

Citizen participation and community involvement in center programs has varied widely, ranging from minimal to active. Community representatives and advisory groups have often had little voice in setting program priorities and direction or in determining how center funds are to be used. (See p. 12.)

### Centers' capability to operate without continued Federal assistance

Without continued Federal assistance, some services, especially those which provide little or no revenue, will probably be curtailed or eliminated at many centers. The alternative financial sources available cannot realistically replace Federal funds in total.

Insurance coverage for outpatient services--provided to most patients--is usually quite limited; most patients served come from lower income groups and thus have limited ability to pay for services.

The States have been a significant source of support for many of the centers reviewed, but their commitment to center programs has varied considerably. Local communities in most instances have not provided significant financial support.

Some centers can increase revenues by improving their billing and collection systems, but the increase overall would probably not be substantial because of low income and limited insurance coverage. (See p. 18.)

#### Monitoring and evaluation

Program evaluation efforts at most of the 12 centers reviewed were almost nonexistent because the centers placed little emphasis on this activity as did the National Institute during the early years of the program.

In addition, the National Institute's plan to monitor center activities by site visits has not always been effective because procedures for carrying out visits have not always been followed and centers have not always acted on the National Institute's recommendations.

Evaluations made by private contractors for the National Institute have been of limited value because of problems of timeliness and quality of the work. (See p. 32.)

#### Coordinating mental health services

A system for the coordinated delivery of mental health services has not been fully developed because:

- Working relationships between centers and State mental hospitals need to be improved.
- Effective procedures have not been developed for referring persons requiring mental health services from other community organizations to centers.
- Some centers are not following up on patients referred to other organizations to see that the services are provided. (See p. 44.)

#### Constructing centers

GAO's review of funds provided for constructing community mental health centers showed that more than \$23 million was tied up in 32 stalled projects. Many of these projects appeared to have incurred serious delays in starting construction because the National Institute did not require the applicants to furnish, before grant approval, adequate data concerning ability to begin construction within a reasonable time. (See p. 56.)

Five completed projects which had received Federal funds of about \$3.5 million were experiencing delays in beginning operation or were operating on a minimal basis because operating funds from non-Federal sources were not available. (See p. 56.)

In a few instances the National Institute transferred or was contemplating the transfer of construction grants from one grantee



to another after the obligational period provided in the act had elapsed. GAO believes that this is improper. (See p. 64.)

#### RECOMMENDATIONS

The Secretary, HEW, should direct the National Institute of Mental Health to improve program administration by:

##### Improved planning

- Assuring itself, before awarding a construction or staffing grant, that the catchment area is appropriate for effectively delivering mental health services.
- Requiring centers to perform community need studies which would enable them to set priorities and periodically update such studies to permit a comparison of services with the priorities. (See p. 16.)

##### Financing

- Providing technical assistance to the centers in developing self-sufficiency financial plans and in improving their billing and collection systems.
- Considering and, if deemed appropriate, working toward expansion of coverage provided by third-party payment programs for mental health outpatient services and services provided by nonphysicians. (See p. 30.)

##### Monitoring and evaluation

- Insuring that program evaluation contracts are effectively monitored and that evaluation results are made available to centers.

--Developing a more effective site visit program that would improve program management and be of greater assistance to centers.

--Insuring that the site visit program which is developed is made standard for the 10 HEW regional offices so as to promote more effective and accurate analysis of program status and performance. (See p. 41.)

##### Coordination of services

--Requiring centers to establish more formal arrangements for patient referral between the centers and other community agencies. (See p. 54.)

##### Construction of centers

- Obtaining from grantees firmer assurances that facilities can be completed within a reasonable time and that funds will be available to adequately operate and maintain the facilities after construction.
- Identifying, on a case-by-case basis, the factors which have (1) stalled construction projects and (2) prevented the operation of completed facilities and helping grantees to remedy the situation.
- Stopping the practice of changing grantees under the construction program after the 2-year obligational period provided in the act has elapsed. (See p. 66.)

#### AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW agreed that the report identified a number of problems in managing the Community Mental Health Centers program. According to HEW, though such problems are not

atypical of developing service delivery programs, they do point directions in which improvement can and should be made. As discussed in the HEW comments (see app. I), a number of efforts have already been undertaken; others will be initiated.

HEW did not agree that the practice of changing grantees under the construction program after elapse of the availability period provided in the act should be stopped. However, HEW's General Counsel had been requested to review this situation. (See p. 67.)

The State mental health agencies and the individual centers reviewed were given an opportunity to comment on GAO's findings. Their comments have been considered in this report.

MATTERS FOR CONSIDERATION  
BY THE CONGRESS

This report should assist the Congress in its consideration of several bills introduced in the 93d Congress to extend and modify the Community Mental Health Centers program which

expired on June 30, 1974. GAO testified before the Subcommittee on Public Health and Environment, House Committee on Interstate and Foreign Commerce, on February 19, 1974, and discussed the matters presented in this report.

Program modifications being proposed should assist in solving the following problems:

- Need to establish more appropriate catchment areas. (See p. 14.)
- Need to improve the centers' capability to operate without continued Federal financial assistance. (See p. 29.)
- Need to improve program monitoring and evaluation. (See p. 40.)
- Need to coordinate center activities with those of other mental health and social service agencies and to involve the community in establishing center objectives. (See p. 53.)
- Need to improve use of construction funds. (See p. 65.)

## CHAPTER 1

### INTRODUCTION

The first significant legislation dealing with mental illness was the National Mental Health Act (42 U.S.C. 201), enacted in July 1946. The act created the National Institute of Mental Health (NIMH). During the 10 years after it was founded, NIMH was the source of much that was innovative in American mental health training, research, and practice. The Mental Health Study Act of 1955 (42 U.S.C. 242b) authorized, among other things, a nationwide analysis and reevaluation of the human and economic problems of mental illness. A Joint Commission on Mental Illness and Health was formed to carry out this study.

Recommendations based on a report by this Commission were included in the 1963 Presidential message that set the stage for introducing legislation to authorize Federal financial assistance to establish community mental health centers. Such a program began with the Community Mental Health Centers (CMHC) Act of 1963 (42 U.S.C. 2681) which authorized grants for constructing centers. In 1965 the act was amended (42 U.S.C. 2688) to authorize grants to help pay for professional and technical personnel to staff the centers for 51 months.

Subsequent amendments authorized construction and staffing grants to provide services for alcoholics, narcotic addicts, and children. In 1970 the duration of all staffing grants was extended from 51 months to 8 years. The legislative authority for new grants under the CMHC program expired on June 30, 1974.

#### CMHC PROGRAM

The purpose of the program is to make it possible for most mentally ill persons to be treated in their own communities.

The program is administered by NIMH which is now a part of the Alcohol, Drug Abuse, and Mental Health Administration of the Department of Health, Education, and Welfare (HEW). In 1962 NIMH estimated that about 2,300 centers would be needed nationwide to provide services at the community level

for all Americans. NIMH later revised the estimate downward to about 1,500. The program's major objectives are to:

- Improve the organization and delivery of community mental health services by developing a coordinated system.
- Increase the accessibility of mental health services to all in need.
- Increase the quantity and range of available community mental health services.
- Enhance the responsiveness of mental health services to community and individual needs.
- Provide a single high-quality standard of community mental health care.
- Decrease use of State mental hospitals.
- Increase the participation and support of State and local groups in the program.

Federal grants are awarded to public agencies and nonprofit private organizations for constructing and staffing centers. Construction grants are awarded to help meet the cost of constructing (excluding acquisition of land), acquiring, or remodeling facilities. For each fiscal year, the Secretary of HEW allocates funds to the States under a formula which considers the States' populations, the extent of need for centers, and the States' financial need. The Federal share of constructing a project may not exceed 66-2/3 percent if it is in a nonpoverty area or 90 percent if it is in a poverty area.

Federal staffing funds provided under the CHMC act are considered "seed money" for the establishment of centers, and, after a certain operating period (now 8 years), States and local communities are expected to meet the total costs of operating the centers. According to the act, in making such grants, the Secretary of HEW shall consider the States' needs for CMHC programs, their financial needs, and their populations.

Staffing grants to centers serving nonpoverty areas may not exceed 75 percent of total staffing costs for the first 2 years of operation, 60 percent for the third year, 45 percent for the fourth year, and 30 percent for the next 4 years. The maximum percentage for centers serving poverty areas is 90 percent for the first 2 years, 80 percent for the third year, 75 percent for the fourth and fifth years, and 70 percent for the next 3 years.

In the 10 years since CMHC legislation was enacted, 392 centers have become operational and another 148 are being developed. Centers are required to furnish five services--inpatient, outpatient, partial hospitalization, emergency, and consultation and education.

From the program's inception in 1963 through September 1973, Federal funds totaling \$793 million have been obligated for construction (\$216.8 million) and staffing (\$576.2 million) grants. The number and status of funded projects follow.

	<u>Funded</u>	<u>Opera- tional</u>	<u>Percent operational</u>
Centers receiving:			
Construction grants only	108	34	31
Staffing grants only	154	117	76
Construction and staffing grants	<u>278</u>	<u>241</u>	86
Total	<u>540</u>	<u>392</u>	73
Centers in:			
Poverty areas	287	222	77
Nonpoverty areas	<u>253</u>	<u>170</u>	67
Total	<u>540</u>	<u>392</u>	73

Several bills have been introduced to the 93d Congress to extend and modify the program. The Subcommittee on Public Health and Environment, House Committee on Interstate and Foreign Commerce, held hearings and on April 11, 1974, referred House bill 14214 to the full Committee. As of that date, Senate bills 1998 and 3280 were being considered by the Senate Committee on Labor and Public Welfare. Proposed modifications (see chs. 2, 3, 4, 5, and 6), if enacted and properly implemented, should assist in solving many problems we identified.

This is our second report to the Congress on the CMHC program. On July 8, 1971, we issued a report entitled "The Community Mental Health Centers Program--Improvements Needed in Management (B-164031(2))." This second report refers to previous recommendations on which corrective action was promised. Some of the same problems still exist, and more action is needed to solve them. (See pp. 38 and 63.)

## CHAPTER 2

### IMPROVED PLANNING NEEDED

#### TO ACHIEVE PROGRAM OBJECTIVES

The centers have increased the accessibility, quantity, and type of community services available and have enhanced the responsiveness of mental health services to individual needs. Some success also has been realized in mobilizing State and local resources to further program objectives.

Also the 12 centers reviewed established the five services NIMH considers essential: inpatient, outpatient, partial hospitalization, emergency, and consultation and education.

However, program performance could be improved by (1) establishing more appropriate service areas, (2) improving planning to identify the mental health needs of the service areas and to set priorities to meet those needs, and (3) involving the community more in developing and operating centers' programs.

#### ESTABLISHING SERVICE AREAS

NIMH guidelines refer to the catchment area concept as the cornerstone of the CMHC program in that the concept focuses CMHC responsibility and concern on the mental health needs of the total population. Catchment area boundaries are determined and drawn by the responsible State agency. The boundaries are based on such factors as existing neighborhoods, planning areas, physical environment, and available resources. Federal regulations limit the size of a catchment area to no less than 75,000 and no more than 200,000 persons. Exceptions to this requirement may be authorized by NIMH, and 13 percent of all funded centers have been granted exceptions.

However, strict adherence to these regulations has (1) impeded program performance by dividing some existing planning areas and political jurisdictions, (2) caused services and facilities to be duplicated in some areas, and (3) caused spending for mental health services to be unevenly distributed within some political jurisdictions. Examples follow.

--Florida established a 3-county area (Highlands, Polk, and Hardee) as a mental health district with an estimated population of about 301,000, of which 255,000 resided in Polk County. Because it did not conform to catchment area size limits, the district was divided into two catchment areas and Polk County was split between the two areas. One center was established in Winter Haven to serve half of Polk and all of Highlands County. Polk County continued to operate a 32-bed psychiatric unit for indigent persons in that part of the county outside the Winter Haven center's catchment area.

Polk County has provided no financial support for the center, and the center director said that he expected no support because the county was planning to improve mental health services in the other catchment area using existing county facilities and could not assist the Winter Haven center. Winter Haven center officials believed the 3-county area was a natural unit that could have been adequately served by the Winter Haven center and this would have thereby provided greater use of the center facilities and staff. The center director said establishing a center to serve the other part of Polk County would be more costly and inefficient than expanding the Winter Haven center to include all of Polk County.

The Director of the State Division of Mental Health advised us in March 1974 that, in his opinion, the 3-county area with a population exceeding 295,000 was too large for the Winter Haven center to serve adequately.

--Denver was divided into four catchment areas to conform to catchment area size limits. Centers were set up in two of these areas. One of the centers is operated by Denver General Hospital which serves the entire city. We were advised that expenditures for mental health services in the catchment area where the center was located were about \$25 per capita; in the other catchment areas, expenditures were about \$5 per capita. We were also advised by the director of the Denver General center that this difference has resulted in complaints from



organizations that provide mental health services in other parts of the city.

--Orange County, Florida, and the city of Orlando, were divided into three catchment areas to conform to catchment area size limits. The southeast part of the county along with Osceola County was designated as the catchment area to be served by the Orange Memorial Hospital center. Before the center was established, Orange County had established clinics to take care of patients discharged from mental institutions to the county and to handle referrals from local psychiatrists and other mental health facilities in the county. Also available was a 50-bed psychiatric ward in a general hospital in North Orlando.

The Director, Orange County Department of Social Services, said that many people served by county clinics preferred those facilities because they were more familiar with them and services were free. She also said the county preferred working with the hospital in North Orlando, rather than the center, because it had a locked and secure ward. The center's inpatient unit was operating at about 50 percent of capacity during calendar year 1972, and we were told that since July 1972 the State mental hospital serving the area had made no referrals to the center.

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The Chief of the Division of Mental Health in one State agency advised us that, when an existing catchment area's population approaches or exceeds 200,000, there is pressure from HEW to create one or more new catchment areas, each with its own administrative unit. According to this State official, this often results in increased administrative costs and the breaking up of natural population groupings.

#### IDENTIFYING MENTAL HEALTH NEEDS

A better job needs to be done in identifying local mental health needs. State plans usually contain general demographic data, such as suicide rates, admissions to State mental hospitals, number of welfare cases, and per capita income, which may be sufficient to justify initiating a program in a catchment area but not to justify continuing

the same services year after year without assessing them in relation to community needs.

Most centers reviewed had not made studies of their catchment areas which would enable them to set priorities and compare services provided against these priorities. The availability of funds to match Federal grants and the interests of the centers' professional staffs were often important influences in establishing program emphasis within a center. Although needs met by programs established in this manner are probably valid, there is no assurance that they are the only needs or the highest priority needs of the catchment areas. Also, once programs are established, they tend to dominate center activities in subsequent years.

#### State identification of mental health needs

NIMH guidelines urge grant applicants to seek the assistance of State authorities in developing a program of mental health services that will respond to needs of the population to be served. These guidelines also require that State plans be updated annually.

Data in the State plans was not kept current and was of limited value in planning local programs.

In Colorado, for example, the first State mental health plan was prepared in 1965. The plan remained largely unchanged until 1969 when it was rewritten and updated. In 1973 the plan was again rewritten, and a section on area programs was added which described the general characteristics of each area within the State.

In addition to not being updated annually, the plan did not specifically address the needs of any of the State's catchment areas. Though the need for centers was expressed in terms of available facilities, mental health personnel, and the economic condition of the area, the plan provided little or no guidance on the types of local programs needed.

The Acting Coordinator, Community Mental Health Programs, Colorado Division of Mental Health, advised us in July 1972 that the State's construction plan could become a useful operating document if it were updated. He stated

that the current plan is basically a carbon copy of past plans.

Community identification of  
mental health needs

Most centers reviewed had not studied community mental health needs to support their initial staffing grant applications and, in applying for Federal assistance to expand programs, had cited their prior experience to justify the expansions. Demographic data similar to that included in State plans was generally used to support the need for the initial staffing grant. In addition, as discussed on page 12, mechanisms were not always established to involve citizens or community organizations in identifying needed mental health services. The following examples illustrate the necessity of making such studies and establishing programs to meet high-priority needs.

--The Concord, Massachusetts, center, in applying for a grant in 1969, cited alcoholism as a problem in the catchment area; 30 percent of the State hospital admissions were diagnosed as alcoholics. The annual report for 1972 stated that alcoholism was by all accounts the problem for which services were least well organized and effective in the area. In April 1973 we were told that a great need for more services existed, but the center at that time had no formal alcoholism program. In March 1974 the center director informed us that, although a separate alcohol unit had not been established, the staff was aware of the problem and many patients received care on a decentralized basis.

--A study of mental health needs in Albuquerque, New Mexico, in 1965 showed that only limited mental health services were available for children. NIMH awarded the Bernalillo County center five staffing grants, totaling about \$1.2 million, between February 1967 and August 1969. But in April 1973 there was a 2- to 3-month waiting list for emotionally disturbed children needing treatment. The center director said that this service had not been expanded because the program planner had no expertise and little interest in the area. This service now has top priority, but NIMH funds are not available for expansion. The

center director advised us that programs for children accounted for 25 percent of all center expenditures as of March 1974 but that the problem of providing services to children was greater than any single center could satisfy. The director agreed that sufficient emphasis may not have been placed on children's programs in the early development stages of the center.

--The Adams County, Colorado, center received four staffing grants, totaling about \$543,000, between January 1968 and July 1971. No formal study of community mental health needs was made to support the need for any of these grants. The largest grant, \$277,000, was awarded in August 1969 to provide services for children enrolled in four school districts within the county. The center professional staff said the application was justified on the basis of a large youth population in the area, patient referrals from schools, availability of matching funds, and staff knowledge of the catchment area. According to one staff member, this county's needs for a school program were probably no greater than the needs of any other county in the State, but, since the school districts provided the funds to match the Federal grant, a mental health program was initiated in the school districts and 60 mental health workers were involved in it.

In citing the above examples, we are not questioning the desirability of those services provided by centers. We cite them only to indicate the necessity to study needs in order to set priorities and compare services with them. This would enable program changes that would better match resources with priorities. A position paper adopted by the American Psychological Association in 1966 pointed out that, when a center is established, provision should be made for periodic review of center programs to insure that community needs are being met.

An NIMH official told us in March 1974 that greater attention to needs assessment in the review of continuation grant applications by regional offices may be an appropriate step in this direction.

Further evidence that the centers should direct greater effort to determining whether service programs are properly aligned to meet community needs is provided by our analysis of records at 11 of the 12 centers reviewed and census data for the catchment areas. Appendix III gives detailed results of our analysis. In summary, we found that:

- Children under age 5 and persons age 65 and over were underserved in proportion to their numbers in the catchment areas.
- Persons age 20 to 44 and those in low-income categories are represented on patient records in numbers well above their proportion in the catchment areas.
- With only two exceptions, centers were serving a mix of patients reasonably representative of the ethnic makeup of the catchment areas.

Center officials commented that:

- Children and elderly persons are less desirable to work with because a highly specialized staff is needed to provide children's services and it is difficult to show success in treating elderly patients.
- Some services are provided to children through consultation and education or are recorded in parents' case files and as such are not shown in patient statistics.
- Nursing homes and geriatric programs provide services to the elderly; in addition, the elderly often consider themselves self sufficient and hesitate to request services.
- Higher income groups seek private care.
- Lack of public transportation and outreach services caused a minority group to be underserved in one area.

Officials at one center advised us in March 1974 that there was a question on whether the incidence of mental disturbance in children under age 5 was as high as among adults. On the other hand, they indicated that adolescents

and young adults are often in periods of high stress, which might account for their being "overserved" in proportion to their numbers in the general population.

An official at another center felt parents frequently believe children will grow out of a problem, an idea which he believes is reinforced by family physicians. Consequently, referral is not made to a center until another agency, such as the school system, also notes that there is a problem and encourages the parents to seek assistance for the child.

### Community involvement in establishing centers

NIMH guidelines call for community involvement in developing and operating the centers' programs to insure that they will respond to the community mental health needs and have a public base of support. Community involvement was significant in establishing only 2 of the 12 centers reviewed. In some instances center officials, in the early years of the program, placed little emphasis on obtaining community participation in determining what services were necessary and how they would be delivered. It appears that NIMH placed more emphasis on getting the centers operational and making services available than on learning from the community what services it considered most important.

This situation seems to have improved considerably, except that many community advisory boards still are not influencing decisions on program priorities and fund allocations. Most center officials seem reluctant to involve community advisory boards in decisionmaking.

Several examples of the extent of community involvement in center activities follow.

- Three NIMH reports on site visits to the Denver General center indicate that community involvement has been lacking in program planning since the center began. NIMH site visit reports describe the center's citizen council as impotent and unresponsive to community needs.
- The Director of the Illinois Mental Health Institutes Community Mental Health Program informed us that mental health professionals did the bulk of the initial planning for the program in Chicago.

Community involvement, according to the Director, was minimal because of a lack of interest. Through interviews with representatives of community organizations in the Chicago area, we confirmed that there had been little or no involvement in establishing center programs. We were advised, however, that community participation in this center's activities had increased significantly since the center was created.

--An NIMH site visit to the Maine Medical Center Community Mental Health Program disclosed that, during the center's planning phase, the area mental health advisory board attempted to become involved in developing the application for Federal assistance. According to the report, the board's actions were constantly frustrated by the actions of the individual acting as board coordinator. When the center became operational, the board was nonfunctional.

--In contrast, the application for Federal assistance from the Concord Area Comprehensive Community Mental Health Center in Massachusetts contained much evidence of community input in determining community mental health needs and suggesting programs to meet them. In 1964 all the social agencies providing services in the catchment area formed a planning group to determine the area's mental health needs. An NIMH report on a site visit to this center acknowledged the significant degree of citizen input into this center's program.

An official at one center advised us in March 1974 that he did not feel that our above observations accurately showed the difficulty in making community involvement a reality. Citizen councils are more than willing to discuss an issue and provide input, but they usually disliked making decisions or expressing demands to agencies.

The Chief of the Division of Mental Health of the State Department of Institutions in Denver advised in March 1974 that:

- His division knew some center boards were ineffective and that there was little community participation in program planning in some cases.
- The State had implemented and was enforcing standards requiring the governing boards of centers to assume responsibility for center operations.
- Some Colorado centers are governed by boards elected by catchment area residents who shape the service programs and have veto power regarding program decisions.

### CONCLUSION

For statewide planning purposes, it may be necessary to establish catchment areas using criteria similar to those required by NIMH. (See p. 5.) However, before awarding a grant for constructing or staffing a center, NIMH and the State should consider whether the established area is the most appropriate for delivering mental health services, considering political, geographical, or other planning and service area boundaries and existing mental health facilities. Also NIMH should require centers to study community needs in order to set priorities and analyze services against them. This would allow program changes that would better match use of resources with priorities.

We recognize the technological difficulties in performing valid need studies and even defining need as a prelude to priority setting. Despite these difficulties we believe greater attention should be paid to the priority-setting process to better match limited resources with community needs.

### LEGISLATION BEING CONSIDERED BY THE CONGRESS

Legislation being considered by the House of Representatives (H.R. 14214) would require that States periodically review their catchment areas to insure that (1) their sizes are such that the services to be provided through the centers (including their satellites) are readily available and accessible to residents, (2) the areas' boundaries conform, to the extent possible, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and



(3) the areas' boundaries eliminate, to the extent possible, barriers to access to the centers' services, including barriers resulting from areas' physical characteristics, residential patterns, economic and social groupings, and transportation.

To get the community involved in a center's program, House bill 14214 would require a center to have a governing body of individuals who live in the catchment area and who are representative of the area's residents, taking into consideration their employment, ages, sexes, and places of residence. At least one-half the members would be individuals who do not provide health care services.

House bill 14214 would also authorize the Secretary, HEW, to make grants to public and nonprofit private entities to carry out projects to develop community mental health center programs. In connection with a project for a center program, the bill provides that the grant recipient (1) assess the needs of the area for mental health services, (2) design a community mental health center program for the area based on such assessment, (3) obtain within the area financial and professional assistance and support for the program, and (4) initiate and encourage continuing community involvement in developing and operating the program.

One of the bills being considered by the Senate (S. 3280) would require centers receiving operating grants to periodically review their catchment areas to insure that the size of the area is such that the services provided are available and accessible promptly and appropriately and that the area's boundaries eliminate barriers to access to services.

With regard to improving community involvement, Senate bill 3280 would require each center to establish a governing board composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center, considering the same factors discussed in House bill 14214. Senate bill 3280 would require that the board meet at least once a month and set forth the functions to be performed by the board, including establishing center policy, approving the center's annual budget, and selecting a director for the center. In addition, Senate bill 3280 would require each center to establish a professional advisory board, made up of members of the center's professional staff, to advise the governing

board in establishing policies governing medical and other services provided by the center.

Senate bill 3280 would also authorize the Secretary, HEW, to make planning grants to nonprofit agencies, organizations, and institutions which have demonstrated the capacity to prepare a satisfactory plan for providing comprehensive mental health services through a community mental health center. The grants would be to help meet the costs of evaluating the need for a center and developing a plan for providing comprehensive mental health services through such a center.

#### RECOMMENDATIONS TO THE SECRETARY OF HEW

Periodic review of catchment areas as described in the proposed legislation should insure that the catchment areas are appropriate for effectively delivering mental health services. Also greater community involvement in center activities should help to insure that services respond to community needs.

To further improve the planning and insure that services are provided in the areas of greatest need, we recommend that the Secretary direct NIMH, before awarding a construction or staffing grant, to assure itself that an appropriate and timely review has been made of the catchment area. We also recommend that NIMH be directed to require centers to study community needs, which would enable them to set priorities, and periodically update such studies to permit a comparison of services with the priorities.

#### AGENCY COMMENTS AND OUR EVALUATION

HEW concurred (see app. I) with the thrust of our recommendations and found them consistent with the aims of the CMHC program. We were advised that more effective planning for community mental health services, to reduce the fragmentation and duplication of services at the local level, is both necessary and desirable.

HEW advised us that the setting of priorities has been difficult for centers, considering their mandate to provide a broad range of services responsive to the needs of all catchment area residents. HEW agreed, however, that services should be clearly related to community needs as identified in both initial and continuation applications reviewed by HEW's regional offices. Also HEW efforts will

be expanded to develop solutions to the technological problems in performing valid assessments of community needs and the importance of assessing community needs on an ongoing basis would be reaffirmed for both applicants for CMHC grants and for HEW staff in reviewing initial and continuation applications.

In commenting on the problems caused by the establishment of certain catchment areas, HEW stated:

"\* \* \*we do not believe, as indicated in the GAO report, that the catchment area requirement has generally served as an impediment to more effective planning."

We believe that the catchment area concept can help in planning for and coordinating the many services necessary to provide an adequate mental health program in a geographic area if adequate recognition is given to such matters as the service area boundaries of other care-giving organizations and the political boundaries of those entities which will be expected to help finance centers' operations.

In addition, though catchment area boundaries are drawn by the States, the criteria by which the catchment area boundaries are established are promulgated by NIMH, which makes it the responsibility of NIMH to insure that the boundaries established are the most appropriate for the area to be served.

HEW agreed with our observations on the variability of community participation in planning and developing community mental health services. The extent to which citizens can make a meaningful contribution depends, in large part, on their knowledge, experience, training, and working relationships with center administrators. To enhance citizen involvement in center activities, HEW established a Center for Citizen Participation that will plan and initiate actions designed to upgrade the quality of citizen participation.

### CHAPTER 3

#### CENTERS' CAPABILITY TO OPERATE

##### WITHOUT CONTINUED FEDERAL ASSISTANCE

The Congress, in response to an increasing awareness at the local and State level of a critical need for improved mental health services, considered it the Federal Government's proper role to provide financial assistance for operations while the States and local communities worked out new patterns of responsibility for mental health.

The Congress intended, however, that Federal assistance be "seed money" to help the centers during their early periods of operation and that Federal assistance be gradually reduced and replaced by three principal sources, as follows:

- Communities, through taxes and voluntary funds, were expected to provide much of the support.
- States were expected to expand their support of community services.
- Patient fees and expanded insurance coverage for mental illness were expected to cover an increasing portion of the costs.

Some States reviewed are assuming an increasing share of center costs. However, communities in most instances have not provided significant financial support to the centers.

One factor limiting the centers' ability to become self sufficient is the number of low-income patients served. At eight centers 55 to 95 percent of the patients reported earning less than \$8,000 annually. The centers use a sliding fee scale to reduce fees for persons with low incomes, and this limits the revenue available from patient services.

An additional factor affecting centers' ability to become self sufficient is that the centers, for the most

part, receive little or no revenue from their consultation and education service--a required service--provided to community organizations.

As a result, many centers' capability to provide the full range of mental health services considered necessary for comprehensive care without continued Federal assistance is questionable. Officials in 9 of the 12 centers reviewed expressed a need for Federal funding to continue beyond the 8-year grant period if services are to be maintained at their present levels. They voiced concern that the expiration of Federal staffing support would cause program deterioration and a curtailment of or an end to certain services which are not revenue producing. Two centers were already experiencing financial difficulties and had initiated cutbacks and realigned services.

Also insurance coverage for outpatient mental health services is generally limited. Outpatient service is provided to most patients. In 1963 the President directed HEW to explore steps for expanding private voluntary health insurance to include coverage of mental health care. HEW efforts in this area have not produced significant changes in coverage.

#### SOURCES OF REVENUE

As shown in the table on page 20, the majority of financial support for the centers has come from Federal and State sources.

For the centers reviewed, Federal support ranged from 18 to 81 percent in 1970 and from 19 to 86 percent in 1972; State support ranged from 2 to 51 percent in 1970 and from 8 to 70 percent in 1972. The remaining revenues came from local sources, fees, and fund raising.

#### States

Although the States have been a significant source of support for many of the centers reviewed, their commitment to center programs varied considerably, as shown below.

SOURCES OF FUNDS RECEIVED BY CENTERS

Name and location of center and date of establishment:	Year ended	Total revenue	Federal staffing	Federal other	State funds	Percent of total revenue						Fund- raising
						Local funds	Fees	Insurance	Services Medicare	Medicaid	Other	
Nationwide average	1969	\$173,622,000	24	10	32	13	7	6	1	2	4	1
	1971	301,522,000	27	7	29	10	6	9	2	5	3	2
Maine Medical Center, Portland, Maine, Sept. 1969	1970	547,931	50	-	2	-	2	39	2	5	-	-
	1972	1,299,493	24	9	9	-	7	30	14	7	-	-
Emerson Hospital, Concord, Mass., Feb. 1969	1970	416,449	43	-	14	5	<sup>a</sup> 34	-	-	-	1	3
	1972	842,265	37	-	15	4	1	34	2	3	1	3
Orange Memorial Hospital, Orlando, Fla., June 1966	1970	588,232	29	-	9	-	13	43	3	1	2	-
	1972	532,087	19	-	16	-	14	38	4	4	5	-
Winter Haven Hospital, Winter Haven, Fla., Oct. 1965	1970	667,403	39	-	23	-	<sup>a</sup> 38	-	-	(c)	(c)	-
	<sup>b</sup> 1972	1,205,857	49	-	19	-	6	13	-	(c)	(c)	-
Illinois Mental Health In- stitutes Community Mental Health Program Chicago, Ill., Oct. 1967	1970	1,620,930	49	-	51	-	(d)	(d)	(d)	(d)	-	-
	1972	1,812,256	30	-	70	-	(d)	(d)	(d)	(d)	-	-
Ravenswood Hospital, Chicago, Ill., June 1972	1970	-	-	-	-	-	-	-	-	-	-	-
	1973	1,218,470	43	-	9	-	8	21	4	15	-	-
Bernalillo County Center, Albuquerque, N. Mex., Mar. 1967	1970	1,107,188	51	-	33	1	<sup>a</sup> 6	-	-	-	9	-
	1972	1,613,689	49	-	32	1	2	3	2	3	8	-
Denver General Hospital, Denver, Colo., Aug. 1966	1970	1,175,053	54	23	17	6	(d)	(d)	(d)	(d)	-	-
	1972	2,500,840	50	36	12	2	(d)	(d)	(d)	(d)	-	-
Adams County Center, Commerce City, Colo., Jan. 1968	1970	654,900	56	-	23	8	<sup>a</sup> 8	-	-	-	5	-
	1972	1,253,250	44	-	25	22	2	1	-	2	4	-
Bethesda Psychiatric Hospital, Denver, Colo., Aug. 1969	1970	309,296	77	-	13	-	5	4	-	1	-	-
	1972	693,719	43	-	28	-	8	15	1	2	3	-
Memorial Center, Mandan, N. Dak., July 1966	1970	205,248	18	-	27	28	25	-	-	-	2	-
	1972	429,367	37	8	19	22	13	(e)	-	-	1	-
South Central Center, Jamestown, N. Dak., Aug. 1968	1970	399,000	81	-	10	-	9	(d)	(d)	(d)	-	-
	1972	460,000	81	-	8	-	11	(d)	(d)	(d)	-	-

<sup>a</sup>Includes revenue from fees, insurance, Medicare, and Medicaid. No data was available on the amounts collected from each source.

<sup>b</sup>1972 percentages do not total to 100 percent because the total revenues shown represent the value of services provided, whereas the receipts from fees, insurance, Medicare, and Medicaid represent cash collected at the time of our review.

<sup>c</sup>Medicare and Medicaid provided a total of 5 percent.

<sup>d</sup>Information not available.

<sup>e</sup>Less than 1.

- Colorado provided up to 85 cents for each catchment area resident. Additional amounts may be appropriated depending on the merits of budget requests. A State official advised us in March 1974 that Federal staffing grants have begun to reach the end of their eighth year and that the State's General Assembly has not committed itself to continuing all expiring staffing grants at the existing level.
- Florida provided up to 65 percent of eligible center costs, excluding the Federal share, but reserved the option to reduce this amount.
- Illinois made grants-in-aid available to centers offering specific services, but the State legislature does not make commitments beyond 1 year.
- Maine's policy is to provide block grants to catchment areas by appropriating \$1 per person per year on the basis of the catchment area population.
- Massachusetts will fund up to 60 percent of eligible center costs.
- New Mexico has no legislation requiring financial assistance to centers, but assistance has been provided.
- North Dakota limits assistance to 40 percent of total center operating costs.

### Communities

Local support for centers reviewed varied. Of the 12 centers reviewed, 7 received no local support.

Only three were receiving city support. In one case the center actively solicited this support, and the center expects to eventually obtain 10 percent of its revenue from the city.

Some county governments were providing support but it was minimal, except for two centers. The counties served by one center initiated a mill levy to provide support. The revenue from the levy, however, will not be sufficient to offset the declining Federal assistance. The other center receives county funds appropriated to support a school mental health program.

### Third-party programs and patient fees

Support from third parties (i.e., private carriers, Medicaid, and Medicare) at five of nine centers was less than 20 percent of the total center revenue. Third-party payments have been mainly for inpatient treatment. Insurance coverage for outpatient services, which comprise the majority of center services, has provided only a small percentage of center revenues. An expansion of insurance benefits for outpatient services would greatly increase center revenues.

Financial support from patient fees in 1972 was less than 15 percent of total revenues at 9 centers. Patient fees have provided only small amounts of revenues because large numbers of patients have low incomes and cannot pay for services. Federal grant terms provide that the centers serve all persons regardless of ability to pay.

Although improved billing and collection procedures could increase revenues at some centers, the increase overall will probably not be substantial because of the low income and the limited insurance coverage.

### Third-party payment programs

Records selected at random at each of nine centers showed that between 13 and 67 percent of the patients had some type of insurance (private or Federal under Medicaid or Medicare). Insurance data in the records did not show whether the patients had inpatient, outpatient, or both kinds of coverage, but billing data indicated that coverage was mainly for inpatient services. This, of course, is important to the centers because inpatient care is a high-cost service. However, the apparent lack of outpatient coverage is significant because this service is by far the



predominant service provided to patients. Therefore, even though the cost of this service is less than the cost of inpatient service, the volume of service would make it an important revenue source to centers.

To a large extent, it appears that more outpatient revenue is not being obtained because of limitations on reimbursement provided by insurers--private and Federal. For example:

- An outpatient clinic not affiliated with a general hospital is generally disqualified for reimbursement.
- Outpatient services provided by mental health workers in individual and group sessions without direct supervision by a physician or psychiatrist are generally not eligible for reimbursement.

Other factors limiting revenue from third-party payment programs are the deductible and coinsurance clauses. Deductibles must be paid by the patient, and coinsurance provisions require the patient to share in the cost of services. Deductibles in policies offered by several major insurers range from \$50 to \$150, and coinsurance clauses provide that patients pay from 20 to 50 percent of additional costs. A large percentage of the centers' patients have low incomes and probably could not pay the required deductible and coinsurance amounts.

The President, in a message to the Congress in 1963, stated that HEW had been directed to explore steps for encouraging and stimulating the expansion of private voluntary health insurance to include mental health care. NIMH officials could not point out any real accomplishments resulting from this direction. Efforts were limited to working informally with several labor unions and the HEW Social and Rehabilitation Service to encourage inclusion of mental health service insurance coverage in contract negotiations with employers and under Medicaid. No effort has been made to work directly with private insurers.

Private insurance coverage for mental health care varies widely. Of seven plans we examined, those available to Federal employees appeared to contain the most extensive

coverage for outpatient care. But even these plans generally exclude services not provided under the direct supervision of a psychiatrist as well as marital, family, and other counseling. A Blue Cross and Blue Shield official said this is also true of mental health coverage provided in most of the basic plans offered by Blue Cross and Blue Shield.

Under the Social Security Act, Federal and State aid (Medicaid) is available in most States to indigent persons in need of medical care.

States administer Medicaid and establish eligibility criteria for persons needing medical care and for the clinics providing it. Eligibility criteria vary by State and, as a result, the amounts of revenue the centers receive from Medicaid vary.

Medicare, the Federal insurance program generally for persons aged 65 and over, provides for psychiatric coverage but contains restrictions generally based on the type of facility in which service is provided. Under part A of Medicare:

- Insurance for inpatient services in a psychiatric hospital is limited to 190 days in a lifetime.
- Insurance for inpatient services in the psychiatric wing of a general hospital is subject to the same limitations as medical-surgical services; i.e., up to 90 benefit days may be used for each spell of illness.

Physicians' services are reimbursable under the optional part B of Medicare, but services to mentally ill patients are subject to limitations. Essentially, reimbursement for physicians' services rendered to outpatients is limited to 50 percent of the charge or \$250 a year, whichever is less. This also applies to physicians' charges incurred for inpatient care in a freestanding center. Other physicians' fees for hospital inpatient treatment of mental illness are reimbursable according to Medicare payments for general illnesses.

### Patient fees

As required by NIMH, all centers receiving Federal funds must serve all persons regardless of ability to pay. Consequently, most centers have developed a sliding scale, based on family income, to determine what fees patients should pay for treatment.

Poverty is a major constraint on collecting patients' fees in many catchment areas because 222 of the 392 operational centers are in designated poverty areas as determined by the Secretary, HEW. Also, at eight centers visited, the proportion of patients served who reported incomes of less than \$8,000 ranged from 55 to 95 percent. It is unrealistic to expect much revenue from such patients.

### Inadequate billing and collection systems

Adequate accounting systems are necessary for a center to bill and collect charges for services. Most centers visited had inadequate accounting systems and lacked procedures or had poor procedures for billing and collecting charges.

Billing and collection problems varied by center; examples follow.

--At the Adams County, Colorado, center, insurance data was not transferred to the billing statements; thus private insurance companies were not always billed. Patient records were not appropriately noted to enable proper billing and thus caused loss of revenue.

--At the Denver General center no one was responsible for monitoring the submission of forms for billing. Consequently, 6 of 15 service units, providing almost half of the services, were not forwarding data needed to bill patients. The billing department was over 90 days behind in sending out bills for the other units, and charges had not been established for various psychiatric services. We estimated that this center may be losing about \$290,000 annually by failing to bill Medicaid. Billing delays resulted in a loss of

Medicaid revenues because bills for services to eligible Medicaid patients will not be honored in Colorado if they are submitted more than 90 days after services are provided.

- At the Winter Haven, Florida, center, there were no written billing and collection procedures for outpatient services. The hospital had not billed Medicare for outpatient services since October 1971; outpatients were billed at less than 100 percent of the normal cost of the services and bills were sent directly to patients even though the patients were insured; and insurance claims were disallowed because of inadequate documentation.
- At the Illinois Mental Health Institutes Community Mental Health Program, under the control of the Illinois Department of Mental Health, collection procedures for inpatient care were centralized in the State offices while charges for outpatient care were billed and collected by the outpatient clinic. The State offices did not receive adequate data and inpatient services were not always billed. The outpatient clinic billed patients directly even though they had insurance. Furthermore, the outpatient department could not bill insurance companies because of inadequate records.

The incentive for two centers to maximize collection of patient fees and third-party payments was limited because the centers did not directly benefit from these collections. In one instance, collections were transferred directly to the local general fund. In the other, all collections other than Medicaid were deposited in the State mental health fund; Medicaid collections were deposited in the State general revenue fund. In these instances the State and local governments are assisting the centers financially.

#### IMPACT OF REDUCED FEDERAL ASSISTANCE ON CENTER PROGRAMS

Services which generate the least revenue are most likely to be curtailed or realigned if the centers cannot offset the loss of Federal assistance from other revenue

sources. Invariably, consultation and education services to the community were mentioned as most likely to be affected by a decrease in Federal assistance. These services are most frequently provided free to community agencies and, therefore, will become a financial burden to centers when Federal assistance ends.

Other changes likely to be made if the loss of Federal assistance cannot be offset are:

- Inpatient care may be emphasized because the cost of this service, as contrasted with that for outpatient service, is reimbursable under third-party payment programs.
- Outreach activities in the community will be reduced.
- Evaluations, in the few centers where they are being made, will probably be curtailed or stopped.

RESULTS OF PRIOR STUDIES ON  
CENTERS' CAPABILITY TO OPERATE  
WITHOUT FEDERAL ASSISTANCE

NIMH in 1969 contracted with the Stanford Research Institute to study the sources of funds for community mental health centers. The study objectives were to determine

- the present and probable sources of funds for centers when Federal assistance ends,
- implications of variations in funding patterns for the services provided, and
- the present and probable center and State actions needed to maintain and increase funding levels.

A report on the study, accepted by NIMH in 1970, showed that

- few centers had made long-range plans to replace Federal funds;
- in general, accounting systems were inadequate; and

--financial support patterns for centers were extremely variable and sources of funds were Federal grants, State and local governments, fees, third-party payments, and philanthropic contributions.

NIMH, in commenting on the report, said that the report listed some observations about present and probable funding patterns but did not suggest specific policy alternatives or make recommendations on action needed to replace center funds. Although NIMH considered the findings less than definitive or not applicable to all centers, NIMH comments stated that efforts were being increased to assist centers in financial management and resource development.

In December 1972 NIMH contracted with Macro Systems, Inc., to study trends in sources of funds for community mental health centers. The study's objective was to determine whether the conclusions reached in the Stanford Research Institute study were still valid. The final report made in May 1973 stated that it was apparent that the financial situations of most centers had not changed significantly since the Stanford study.

The report stated that few centers had developed realistic plans in anticipation of the end of Federal assistance partly because of optimism that Federal support would continue and because other sources of funds usually cannot or will not make firm commitments of assistance. Implications of the loss of Federal revenue were considered to be far reaching and would probably include

- altered service delivery patterns and
- centers' increased need for technical assistance in preparing for the end of Federal assistance.

The report suggested that NIMH could soften the impact on centers when Federal assistance ends by:

- Beginning a program to convince center administrators that Federal support will end and that they should begin planning for that development.

- Assisting centers to identify alternative sources of funds; plan programs to secure additional revenues from those sources; and maximize income from third-party sources, particularly Medicare and Medicaid.
- Assisting the centers in planning resource allocation so that inevitable restrictions in service programs will have the least impact on the overall quantity and quality of mental health services.

During our review we were told by NIMH headquarters officials that efforts to assist the centers in maximizing income from third-party sources have generally been informal and, because of limited staff, assistance to the centers in planning for the end of Federal support has not been effective.

### CONCLUSION

Despite the eventual end of Federal assistance, most centers will likely continue to operate. However, the concern voiced by the center officials that the end of Federal support would result in curtailment of center programs is real. It appears unlikely that the alternatives available to decrease centers' dependence on Federal assistance can realistically replace Federal funds in total, but insurance coverage for outpatient services and improved financial management practices would go a long way toward achieving this goal.

### LEGISLATION BEING CONSIDERED BY THE CONGRESS

Legislation being considered by the House of Representatives (H.R. 14214) recognizes that the centers are providing free consultation and education services to community residents and agencies. To assist in providing these services, annual grants would be available to centers to cover the costs of these services under certain conditions.

To prevent a significant reduction in the types or quality of services, House bill 14214 would:

- Provide for financial distress grants to be made when centers cannot continue to provide services or when the quality of services would be impaired without continued Federal assistance.
- Require centers to develop plans for the eventual end of Federal financial support under the CMHC act and to make adequate arrangements to secure all available payments for services.

Senate bill 1998 being considered by the Senate would authorize grants for an indefinite period for consultation and education services beginning in the ninth year after the first year that a grant for operating costs has been made.

Senate bill 3280 would authorize grants for an indefinite period to help a grantee meet reasonable costs of operation. The bill provides that grants be approved only if the applicant has made and will continue to make every reasonable effort to collect appropriate reimbursements for services to individuals covered under Medicare, Medicaid, or any other public assistance program or private health insurance program and from individual patients according to their ability to pay.

Senate bill 3280 would also authorize the Secretary, HEW, to provide technical assistance to organizations eligible to receive planning, development, or operating grants authorized by the bill. This would, in part, help these organizations to collect reimbursements from third-party carriers and from recipients of care having no insurance.

#### RECOMMENDATIONS TO THE SECRETARY OF HEW

If enacted, the proposed legislation would improve centers' financial situations and the capability of centers to collect payments from third-party carriers and individual patients. To assist in this matter we recommend that the Secretary of HEW direct NIMH to:

- Provide technical assistance to the centers in developing self-sufficiency financial plans and in improving their billing and collection systems.



--Consider and, if deemed appropriate, work toward expanding coverage provided by third-party payment programs for mental health outpatient services and services provided by nonphysicians.

#### AGENCY COMMENTS AND OUR EVALUATION

According to HEW, action was being taken to improve the centers' capability to operate without Federal assistance. (See app. I.) Specifically, new regulations are being developed which will require centers to prepare financial plans and third-party payment goals as a preaward condition for a grant. In addition, a series of workshops on financing systems has been conducted for centers on a region-by-region basis and a variety of materials and manuals have been and are continuing to be developed to assist centers with their fiscal management operations. Also a training program is being conducted on using and teaching cost-finding and rate-setting techniques to analyze and evaluate centers.

These actions, if properly implemented, should help improve the financial situations of centers. We believe that the requirement for centers to prepare financial plans and third-party payment goals as a condition for receiving a grant should impress upon centers the importance of developing funding sources and provide a useful mechanism for HEW to assess a center's likelihood to develop adequate financing for its operations.

HEW considers it appropriate to work toward the expansion of coverage provided by third-party payment programs as we suggested. HEW indicated that the absence of mental health care coverage equal to general medical care coverage is a serious economic barrier to the purchasing power of the population at risk and to the maintenance and growth of available, accessible, and appropriate treatment resources. The Administration's national health insurance proposal includes benefits for mental health coverage of inpatient, outpatient, and partial hospitalization care, with organized care settings, such as community mental health centers, given preferential benefits for outpatient care.

## CHAPTER 4

### MONITORING AND EVALUATION OF THE CMHC PROGRAM

NIMH has had little success in developing an effective program for measuring the accomplishments of the CMHC program. Evaluations at most of the 12 centers reviewed were almost nonexistent because the centers have placed little emphasis on this activity as did NIMH during the early years of the program. NIMH officials said that results of contracted evaluations were of little value in decisionmaking because of the time-consuming review required to evaluate the plans, the long time frames needed to complete evaluation studies, and the quality of such studies. Moreover, NIMH's plan to monitor center programs by site visits has not always been effective because NIMH personnel have not always followed procedures for carrying out such visits and centers have not always acted on NIMH recommendations.

The Secretary, HEW, is authorized to make funds available for program evaluation either directly or by grants and contracts, in amounts not to exceed 1 percent of the appropriations made under the act. NIMH encourages centers to evaluate their programs and has made funds available to hire professional and technical personnel. NIMH guidelines indicate that an evaluation program should provide objective information on centers' progress in delivering mental health service.

#### EVALUATION BY NIMH

Evaluation by NIMH has been carried out, in part, through private organizations working under contract. From July 1969 through December 1973, NIMH contracted for 29 evaluations at a total cost of about \$2.9 million. As of March 1974, reports on 20 had been completed.

When program evaluation by NIMH began in 1969, funding and monitoring of evaluation contracts was the responsibility of the division administering the CMHC program. A project officer from this division was assigned to monitor each contract. According to an NIMH official, these project officers were assigned this responsibility in

addition to their regular responsibilities and often found little time for monitoring. In addition, project officers and the contractors had little experience in evaluating mental health activities.

Some of the problems arising from this situation can be seen in the results obtained on certain contracts. For example:

- A contract was awarded for \$356,650 to develop a program for evaluating patient care. After almost 3 years of work and expenditures of over \$330,000, the contractor did not succeed in developing a manual useful for conducting patient care reviews. NIMH said that the contractor did not set a goal of developing a specific product useful to NIMH but rather was inclined to treat the project as a grant for basic research.
- A contract was awarded for \$192,810 to perform a study on the accessibility of community mental health centers; completion was to be in June 1972. NIMH found that the contractor had inadequate knowledge of the complexity of the centers' programs. In its critique of the contractor's report, NIMH stated that the study was hampered by the lack of a clear concept of "accessibility" and nearly all the findings were subject to serious methodological and interpretive questions.

NIMH criticized some additional contracted studies for using too limited a sample or not including centers representative of the entire program. An example of this is a \$52,000 contract to study the relationships between the community mental health centers and other care-giving organizations. The contractor's final report was accepted in December 1971, and NIMH stated that the case studies in the report illustrated a wide range of strategies for developing contracts with other care-giving organizations. However, NIMH also said that the small sample size would not allow it to apply the findings to centers in general.

An NIMH headquarters official advised us that, though NIMH has sent copies of some reports to the centers, NIMH

does not regularly distribute reports on these contracted studies to the centers. Instead, it has sent to all centers a list of reports with instructions on how to obtain them.

In October 1971 the Director of the Office of Program Planning and Evaluation in NIMH announced that the evaluation program was being modified. One change was that project officers from the program planning and evaluation staff were assigned contracts so that the Director would be regularly informed of contract problems and progress.

NIMH conducted an internal study during 1972 to determine the reasons for criticism of the evaluations. The results of the study showed that the level of monitoring and the level of NIMH collaboration in a study were significant factors in the success or failure of a study. The most useful products came from contracts in which there was a close or collaborative monitoring relationship between NIMH and the contractors.

Evaluation plans for fiscal year 1973 indicated that an effort would be made to recommend for funding only those studies on which a member of the evaluation staff could spend at least 30 percent of his time. More widespread dissemination of reports to interested personnel or professionals was also planned.

Although it was too early for us to look into the effect of these 1973 changes on NIMH evaluation efforts, the Director, Office of Program Planning and Evaluation, has expressed concern about NIMH's ability to monitor evaluation done under contract because HEW will not allow funds available for evaluation to be used to pay travel costs of the staff. He has also expressed concern about using contracts for evaluations because of the time-consuming administrative requirements and the long time frame needed to complete evaluations. In addition, staff shortages and the increasing number of evaluation contracts which have been let make it difficult to maintain the desirable level of monitoring.

Effective use of evaluation funds will require that NIMH provide the staff necessary to monitor evaluation efforts.

#### EVALUATION BY CENTERS

Program evaluation at most of the 12 centers reviewed was minimal or nonexistent. The reasons given for the lack of emphasis on this activity vary; the need for staff to provide direct services predominates. We found that:

--At the center operated by the Illinois Mental Health Institutes in Chicago, evaluation positions had been funded in each of its 6 grant years. One full-time and one part-time position were never used for evaluation (the part-time position was used to provide services such as babysitting at the center and for staffing a center youth program). Another part-time position was used to gather program statistics, but no evaluation was performed. One full-time and one part-time position had been vacant more than 1 year. In March 1971 NIMH recommended that the positions be used for the purpose intended, but this recommendation was not implemented. NIMH made no followup to secure implementation.

In March 1974 the program director advised us that the Illinois Mental Health Institutes has made some attempts at evaluating its programs but has found this task very difficult and complex. He believed techniques for evaluating mental health programs are needed.

--At the Ravenswood Hospital in Chicago, one half-time and two full-time positions for program evaluation were included in the initial staffing grant application. The positions were not filled in the first grant year ending in June 1973 because of emphasis on delivering services, the uncertainty of continued Federal assistance, and lack of personnel.

--At the Maine Medical Center in Portland, no funding had been requested for program evaluation staff during 4 years of operation because evaluation was not considered a priority activity and matching funds

were not available. Maine, with NIMH assistance, is expected to develop a system to evaluate center programs using uniform procedures at all centers, but the center director doubted whether the project would succeed, because of the extreme difficulty in assessing the quality of mental health services. NIMH has held a conference on evaluation for all centers in HEW region I to impress on them the importance of developing this activity.

- At the South Central Mental Health and Retardation Center in Jamestown, North Dakota, one position had been funded, in part, to perform program evaluation but much of this staff member's time was devoted to providing clinical services. In response to NIMH criticism of certain aspects of the center's operations, NIMH was advised in April 1973 that more program evaluation would be done.
- At the Adams County Mental Health Center in Commerce City, Colorado, the original staffing grant application did not include a program evaluation position because priority was placed on delivering services. A decision was made in April 1971 to employ a full-time research psychologist. At the time of our review, a system was being developed to integrate the collection of clinical and financial data. NIMH has provided financial assistance to determine the feasibility of establishing the system nationwide.
- At the Denver General Center, three staff positions for program evaluation were funded in 1967 and 12 positions were added in 1969. The center also added eight more positions for program evaluation with funds from an NIMH research grant in May 1971. NIMH criticized the center's evaluation and in June 1971 threatened to suspend funding partially because of concern that evaluation was not being done as described in the grant application. In August 1972, an NIMH site visit report showed that some very sophisticated evaluation work was being done but nothing of use was being provided for local program management purposes and no significant program change could be attributed to the evaluation. At the time of our

review, three studies had been completed, but only one contained a recommendation for improving center operations. The center director accepted and acted on the recommendation.

Although a few centers achieved some progress in developing evaluation systems, the ineffectiveness of such programs in most centers visited indicates a strong possibility that NIMH expectations for information on center progress will not be realized. Also the fact that centers have not used some funds provided for this activity indicates that NIMH needs to monitor use of evaluation funds. If centers are to focus their efforts on the most urgent mental health problems in their areas, NIMH should emphasize evaluations.

#### SITE VISIT PROGRAM

The site visit program was designed to annually review and evaluate the CMHC program for compliance with the grant terms and to assist the grantee in the continuing development of the centers' programs. The site visit program had the following problems:

- Site visits in some regions are not being made annually, though required. For example, as of March 1973, a center in Orlando had not had an NIMH site visit since March 1969. Vacancies amounting to 32 percent of the authorized staff had resulted in delays of 2 to 4 weeks in treating new patients at this center. NIMH officials were not aware of this situation because sites were not visited annually.
- Problems and deficiencies noted in site visits have not been followed up for correction. For example, following a site visit to the Milwaukee County, Wisconsin, mental health center in March 1970, NIMH made 12 recommendations for improving operations. The center did not provide a written response to these recommendations, and, at the time of our fieldwork, NIMH had not visited the center to see if the recommendations had been implemented. We visited the center in August 1973, and, though some progress had been made, some of the problems (including the need

for center advisory committees and an increase in consultation and education services) that brought about NIMH recommendations in March 1970 were still in evidence. An HEW region V official said that sites were not visited annually because of a staff shortage.

- Site visit staffs often do not include persons having financial expertise. For example, at three centers in the Denver region, the grantees were having problems in obtaining funds to replace declining Federal assistance and were concerned that, without continued Federal assistance, the programs would deteriorate. Site visit reports showed the financial resources of these centers to be adequate. A State official advised us in March 1974 that the Colorado Division of Mental Health had agreed with the HEW regional office to assume the primary responsibility for scheduling and planning site visits.

In addition, the center at Winter Haven, Florida, improperly claimed about \$160,000 of Federal staffing funds for personnel who were not bona fide center employees and for personnel whose salaries were not eligible for staffing grant support.

HEW regional officials told us action would be taken to recover any ineligible payments.

Although this problem was noted at only one center visited, similar situations may exist elsewhere among the 358 operational centers which have received staffing grants. This further illustrates the importance of improving the site visit program.

During the development of our report to the Congress on "The Community Mental Health Centers Program--Improvements Needed in Management" (B-164031(2)) issued on July 8, 1971, the Director, NIMH advised us that:

"A concerted effort is now being made to develop more comprehensive review procedures to focus particular emphasis on the management and fiscal plans in the case of active grants. \* \* \* The



grants management staff will participate in periodic center grant review visits, and will employ an expanded format for these reviews designed to gather information on the actual use of grant funds and the adequacy and availability of funds from other sources. These revised management efforts will be implemented in the immediate future."

HEW regional offices are responsible for carrying out the site visit program. Authority for implementing action to suspend or terminate grants is the joint responsibility of the regional offices and NIMH. Although the NIMH policy manual prescribes the procedures to be followed for site visits and reporting, there appears to be little regional adherence to these procedures. NIMH headquarters staff reported to us knowledge of 130 formal site visits and additional informal visits to centers by regional office staff in 1973. Since 392 centers had received Federal funds and were operational as of September 1973, it is clear that not every center was visited.

NIMH headquarters officials responsible for managing the mental health centers program advised us that, although they have policymaking responsibility, they do not have supervisory authority over regional personnel and cannot enforce agency policy. This situation resulted from a recent organizational change which requires that regional personnel report to the Office of the Assistant Secretary for Health and not to NIMH.

A NIMH headquarters official said there were an insufficient number of professional staff to adequately monitor regional office activity relating to conducting the site visit program. A regional official stated that the region had insufficient staff to perform annual site visits. Furthermore, we noted that there was little participation by the grants management staff in the site visit program which is necessary for an effective program.

The limited number of site visits, the lack of followup on deficiencies noted during site visits, and the lack of personnel able to deal with problems impedes NIMH from more effectively fulfilling its role of managing the CMHC

program. Responsible headquarters and regional office personnel need to be more active in implementing the site visit program. Personnel should be made available to assist the grantee in developing the center program and to review the grant for compliance with NIMH requirements. Implementation of the management efforts promised in response to our previous report (see p. 38) would improve the site visit program. An NIMH headquarters official stated that more uniform standards for site visits among the HEW regional offices would promote more accurate analysis of program status.

### CONCLUSION

NIMH needs to substantially improve its evaluation efforts to determine if the CMHC program objectives are being accomplished. NIMH also needs to improve its site visit program and place increased emphasis on monitoring program evaluation contracts. In addition, the centers need to continually evaluate the impact of their programs on the mental health of catchment area residents.

### LEGISLATION BEING CONSIDERED BY THE CONGRESS

Legislation being considered by the House of Representatives (H.R. 14214) contains several provisions which would require more extensive evaluation of the CMHC program. Specifically, recipients of grants for the initial operation of centers and for consultation and education services would be required to compile, evaluate, and report certain statistics and other information to HEW on (1) the cost of the center's operation, (2) the patterns of use of services, (3) the availability, accessibility, and acceptability of services, and (4) the impact of services upon the mental health of catchment area residents.

Under House bill 14214, recipients of such grants would, in consultation with the residents of their catchment areas, be required to review their program of services and the statistics and other information gathered, to insure that their services respond the needs of these residents. All centers would be required to establish an ongoing quality assurance program, including utilization and peer review systems.

House bill 14214 would also require grant recipients to obligate funds annually to continually evaluate the effectiveness of their programs in serving the needs of their catchment areas and to review the quality of the services provided by the center. Such funds would be not less than 2 percent of the amount obligated by the center in the preceding fiscal year for operating expenses.

One Senate bill (S. 1998) would require a center to spend no less than 1 percent of any operating grant which it receives for evaluating its programs' effectiveness in serving the needs of its catchment area and for reviewing the center's services.

The other Senate bill (S. 3280) would require centers applying for operating grants to have an effective procedure for developing, compiling, evaluating, and reporting to HEW data on the (1) costs of their operations, (2) patterns of use of their services, and (3) impact of their services upon the health of those individuals which they serve. Senate bill 3280 would also require, similar to House bill 14214, that such centers use an amount equal to 2 percent of their prior year's obligations for operating costs for a program of continuing evaluation.

#### RECOMMENDATIONS TO THE SECRETARY OF HEW

The legislative proposals cited above should, if enacted and properly implemented, improve the evaluation process and produce valuable data for determining the effectiveness of the CMHC program.

To further improve program evaluation efforts, the Secretary of HEW should direct NIMH to:

- Insure that program evaluation contracts are effectively monitored and that evaluation results are made available to centers.
- Develop, with the assistance of the HEW regional offices, a more effective site visit program that would improve program management and be of greater assistance to centers.

--Insure that the site visit program which is developed is made standard for the 10 HEW regional offices so as to promote more effective and accurate analysis of program status and performance.

#### AGENCY COMMENTS AND OUR EVALUATION

HEW concurred with our recommendations. (See app. I.) HEW took exception, however, to our observations on the effectiveness of the site visit program, stating:

"\*\*\*While we recognize that there is need for improvement, we have found the site visit approach to be a meaningful and generally successful approach to monitoring. While there have been problems precluding visits to every center on an annual basis, in individual cases, site visits have served to identify deficiencies for follow-up action. It should be noted that a more effective site visit program should be possible because of the decentralization of community mental health center grant authorities to the Regional Offices."

\* \* \* \* \*

"\*\*\*In some regions, there has been a problem visiting every center on a strict annual basis. This highlights the need to develop additional techniques that will strengthen this developing facet of Regional Office function \*\*\*."

We agree that techniques need to be developed to improve the HEW regional office administration of the site visits. However, the development of these techniques must correspond with an increased effort to visit the centers regularly consistent with stated policy and with a site visit team which includes sufficiently varied disciplines to evaluate both programmatic and management functions of a center. Information provided by one HEW regional office indicates that current manpower levels and organizational structure will not enable the regional office to maintain even the current level of site visits.

Regarding our recommendation on developing site visit standards, HEW stated that a site visit protocol for use in all 10 HEW regions is being developed. We believe that a standardized approach to the site visit program among the HEW regions, when coupled with the assignment of adequate resources, will greatly facilitate center evaluation which is essential to insure most efficient and effective use of limited Federal resources.

Concerning program evaluation being carried out by individual centers, HEW commented that our report did not reflect two current activities to improve this aspect of center operations. According to HEW, two contractors are addressing the problems caused by both a lack of qualified staff and general sophistication about project evaluation within individual centers. One contractor is preparing a series of workshops to which centers will be invited to send staff for the purpose of presenting and sharing information on how to evaluate various aspects of center operations. The first of these workshops, was held in November 1973 and another was held in March 1974.

In addition, a consortium of mental health centers and grant-in-aid clinics in Florida has been funded to test various program evaluation methodologies to see how they work in real settings. According to HEW, a public demonstration of findings was held for many centers in May and a final report is due on this activity in August 1974.

## CHAPTER 5

### COORDINATING MENTAL HEALTH SERVICES

In establishing the CMHC program, NIMH set up guidelines aimed at developing a system for the coordinated delivery of services by the centers, State hospitals, and other organizations.

The expectations of these guidelines are not being fully realized because:

1. Working relationships between the centers and State mental hospitals need to be improved.
2. Effective procedures have not been developed for referring persons requiring mental health services from other community organizations to centers.
3. Some centers are not following up on patients referred to other organizations to see that services are provided.

The emphasis on developing a coordinated system of mental health services has varied widely among centers. Some developed good relationships with other organizations and were holding periodic meetings with them to discuss cases of mutual interest. In one area where services needed to be coordinated with those of other organizations, officials of these organizations were sometimes totally unaware of the services available from the center. Relationships with the State hospitals followed the same pattern. Some centers screened patients being admitted to State hospitals and consulted about the problems of patients being discharged by the hospital into the catchment areas; other centers did not always screen patients admitted to State hospitals and patients were released into catchment areas without notice to centers.

#### WORKING RELATIONSHIPS BETWEEN CENTERS AND STATE HOSPITALS NEED TO BE IMPROVED

The Congress intended that the newly created centers and the existing State mental hospitals should cooperate

with one another in serving the mentally ill. When the CMHC act was passed in 1963, it was anticipated that the centers would build on and be a part of the existing community resources--both public and private--and provide a wide range of community services to the mentally ill. Emphasis was to be placed on prevention, treatment, and rehabilitation at the local level instead of confining patients in an institution.

#### Roles not clearly defined

The roles of State mental hospitals and centers have not been defined or clearly understood.

According to State hospital and center officials in Colorado, their roles in providing mental health services have not been well defined. As a result, there has been competition for patients; duplication of services; and in some cases, a lack of services. Also little cooperation existed in planning aftercare for patients in some instances.

State hospital officials in Colorado, North Dakota, and New Mexico all appeared to agree that their future role was to provide specialized services and long-term care to the more difficult cases and to chronic patients while the centers' role was to serve the less severely disturbed patient requiring short-term care. On the other hand, State hospital officials in Colorado and New Mexico criticized centers for wanting to treat only the easier patients while sending the more difficult cases to the State hospitals. They also criticized centers for not providing adequate services in areas involving the elderly, persons with alcohol problems, and children.

#### Extent to which centers are screening patients for State hospitals and providing care to ex-patients

The extent to which centers screened patients before admission to State hospitals varied considerably from area to area as did the number of patients the State hospitals referred to the centers for additional services. Mental health professionals commented that mental patients should

be given aftercare for a period of time after discharge from a hospital.

To determine the extent of cooperation between centers and State hospitals, we randomly selected some fiscal year 1972 hospital case files for patients released to a specific catchment area to determine whether patients were screened by the centers before admission to the hospital and whether they were referred to the center after release. The results of this work are summarized below.

### Colorado

- Adams County Center--Of 17 patients released by Fort Logan State Hospital, only 2 were referred to the center for aftercare and the center contacted 1 of the 2. A need for more effective referral was shown because 3 of the 15 patients not referred sought services at the center after discharge from the hospital. The center had seen 9 of the 17 patients before admission to Fort Logan Hospital.
  
- Of seven patients released by Colorado State Hospital, six were referred to the center and the center contacted five of the six.
  
- Bethesda Center--Of 16 patients released by Fort Logan Hospital, only 1 was referred to the center for aftercare. Of 20 patients entering the State hospital from the catchment area, 1 was screened before admission.
  
- Denver General Center--Of 22 patients released by Fort Logan Hospital, only 7 were referred to the center for aftercare. The center contacted only three of the seven referred. Of 16 patients released by Colorado State Hospital, 14 were referred for aftercare and the center contacted 9 of the 14 referred.

### New Mexico

- Bernalillo County Center--Of 25 patients released by New Mexico State Hospital, 19 were referred to the



center for aftercare and the center contacted 18 of the 19 referred. Two of the patients were referred to other agencies and followup on the other four was not recommended. The Director of Psychiatry at the hospital told us admissions to the hospital from Bernalillo County had decreased since the center was established. He said that, although there is no State requirement that patients be screened before admission, he would like to see such a policy implemented. He also said that many patients now bypass the center because the police and the courts refer patients directly to the State hospital. After his review of 11 patient records of Bernalillo County residents admitted to the State hospital in 1972, he believed 8 of these patients could have been adequately treated at the center.

#### North Dakota

- Memorial Center--All seven patients released by North Dakota State Hospital were referred to the center for aftercare and the center contacted them all.
- South Central Center--All 10 patients released by the hospital were referred to the center for aftercare and the center contacted 8.

#### Massachusetts

- Concord Center--Of 30 patients released by Metropolitan State Hospital, 15 were referred to area agencies for aftercare. Available information indicated that the center provided aftercare to at least 5 of the 30 patients discharged. State hospital officials said that only 8 of 69 admissions from this catchment area during the year ended January 31, 1973, were screened at the center before admission.

#### Maine

- Portland Center--All 15 patients released by Augusta State Hospital were referred to the center for aftercare. The center contacted 13 of the 15, 1 failed to keep an appointment, and the center had no record of

the remaining patient. Hospital records showed that, for the first 3 months of 1973, the center referred 55 of 72 admissions from the catchment area.

### Illinois

--Illinois Mental Health Institutes Community Mental Health Program--Of 99 patients admitted to the State and county hospitals in calendar year 1972, the center screened only 14 before admission. We attempted to obtain, but were refused, information from the State hospital to determine the number of patients released and referred to the center. The director of this program informed us in March 1974 that most persons admitted to the State hospital without screening went there by themselves or were taken there directly by the police or relatives, thus giving the center no opportunity to screen them.

### Florida

--Orange Memorial Center--In May 1973 a Northeast Florida State Mental Hospital official advised us that the Orange Memorial center had been ruled out as an effective facility to provide aftercare services to patients released from the State hospital. At that time patients were being referred to a county mental health clinic with a copy of the written notification going to the Orange Memorial Center. The center had been the agency responsible for aftercare since August 1970 and, although notified of 117 discharges to its catchment area, the center had treated only 5 and 36 had returned to the hospital.

The foregoing examples indicate a need for more effective coordination of services by center and State hospitals.

Reasons given by State hospital personnel for not making more referrals to centers were:

--Centers do not provide the frequent aftercare services considered necessary.

- Centers are reluctant to go into the patients' homes but instead would rather provide services in a clinic.
- Centers provide limited services in specialty areas.
- Centers do not want to deal with hard chronic cases.

In addition, some centers provided limited aftercare to former State hospital patients. One center, for example, was not contacting patients released from the State hospital in the catchment area, but many of these patients were receiving services from a county mental health clinic.

At another center, the services provided to former State hospital patients generally involved visits to nursing and boarding homes to consult with staff on patient cases and to provide staff training. The catchment area served by this center had approximately 1,200 nursing home beds, of which an estimated 50 to 60 percent were occupied by either ex-State mental hospital patients or persons with histories of mental illness. Personnel at one nursing home told us they needed more help to care for these patients. Personnel in another nursing home said they were caring for ex-mental patients who could benefit from sheltered workshops and halfway houses.

Contrary to the views of personnel in these nursing homes, center staff said that operators of these homes are reluctant to have them provide services other than medication or recreation. Activities in some of these homes were very limited, and one center staff member believed that ex-mental patients were better off in the State hospital because the State hospital had activities for them. The program director of another center stated that, after a patient spends a long period in a State hospital, chances of rehabilitation are less. He stated that, as a result, he has not stressed treatment of patients with chronic illnesses.

#### COORDINATION BETWEEN CENTERS AND OTHER COMMUNITY ORGANIZATIONS

Although few community organizations had a major role in establishing centers or in setting up their initial

programs (see p. 12), most centers reviewed had established relationships with such organizations and agencies. Center patients are being referred for services to other organizations and vice versa, and coordination between centers and other organizations, although informal, is being strengthened.

But cooperation can be improved. Cooperative agreements have not been worked out in some instances with community organizations, such as police departments and churches, and few centers had adequate followup systems to determine whether those organizations saw or assisted patients referred to them.

Community organizations that come in contact with persons needing mental health services or that provide services which may assist these persons are numerous. They include law enforcement groups, churches, courts, schools, welfare agencies, and alcoholism and narcotic treatment organizations. Because the number of organizations is large, the problems involved in coordinating activities become very complex.

For example, center professionals in the children's services program at the Denver General Center said that the task of coordinating activities with outside agencies providing mental health services to children was overwhelming. They said that the Division of Youth Services of the Colorado Department of Institutions attempts to coordinate city and State services but the only way to effectively coordinate program activities is through neighborhood teams that are closer to the problems.

Some centers indicated the need for better coordination with community organizations. In some areas this was indicated by a lack of communication on the part of centers with organizations providing mental health services. In others, the need for coordination was manifested in the organizations' lack of knowledge about centers' activities and the dissatisfaction with the services provided by centers. For example:

- During our interview with a police official in Mandan, North Dakota, he received a call from someone contemplating suicide. He was unaware that the center could handle such cases.
  
- Staff members of county organizations, such as the Mental Health Association, the Department of Social Services, circuit court, and public schools in Orlando, indicated some dissatisfaction with the center's services. We were told that there was a lack of communication between the center and the Department of Social Services; that there was a long waiting period for children's services at the center; and that the court complained the center was directly transferring patients, committed to the center for care, to the State hospital. In March 1974 the center director advised us that, though some agencies and individuals might be dissatisfied with center services, he did not believe they represented the majority--with whom communications had been established. He also said that, although there was a period when a 4-week delay for services existed, corrective action was taken and walk-in services were initiated.
  
- The Director of the Council of Churches in Albuquerque said there was a need for improved coordination between the center and the local Council of Churches, even though the council offered marriage and family counseling. The council director said the center provided the council with no consultation service and has not solicited its input for establishing center programs.

Patient referrals between centers  
and other organizations

For the most part, agreements between centers and other organizations were informal. Formal agreements were usually limited to those instances when another organization was providing one of the five required services for a center. In many instances these arrangements appeared satisfactory. On the other hand, some centers expected patients to make their own arrangements for services and schedule their own

appointments with the organizations to which they had been referred, and few of the centers visited had developed procedures for following up on referrals. As a result, some patients considered to be in need of services had not received them.

NIMH regulations require that centers establish adequate referral systems, including followup when referrals to organizations are routine or fairly frequent. However, in some centers there were no procedures for referral or followup. Examples of problems follow.

- The Illinois Mental Health Institutes Community Mental Health Program had no central control of patient referrals. Staff members agreed that the referral process needed improvement. The Institutes director expressed concern about this situation and planned to discuss possible corrective action with the program director.
- The Concord, Massachusetts, center had no system for tracing referrals to other organizations. Center personnel did not contact organizations to check on referrals, and the center maintained no record of patients referred.
- The Orlando center had formal agreements for referral of patients between an alcohol treatment unit and a State vocational rehabilitation unit; 15 to 20 patients were referred to the latter unit each month. Center officials said that personal and telephone contacts on patient referrals were made. But, because no record of referrals was maintained, we could not evaluate the effectiveness of the system.
- A Denver center had no formal system for insuring that patients referred to community organizations reached the organizations. Patient records for 32 referrals made in January 1973 showed that 7 of the 32 did not contact the organizations to which they were referred.

The director of one center advised us in March 1974 that he agreed there is a problem in "tracking" patients. He stated that no one seems to have a solution for this problem because many patients change residences frequently or don't keep appointments.

## CONCLUSIONS

Greater emphasis should be placed on establishing more effective relationships between centers and other community organizations. Without such emphasis, the congressional expectation of cooperation between the centers and State hospitals and making the centers a part of community resources will not be fully achieved. Action should be taken by NIMH, in cooperation with State mental health authorities, to more clearly define the role of the centers and State hospitals.

If effective coordination of community resources is to be achieved and patients are to be handled in the most effective manner, centers must initiate more formal systems of referral. The present informal systems are easily subject to breakdown and provide no performance record to enable centers to assess the effectiveness of referral systems.

States must also take more concerted action in requiring their agencies, including public mental health institutions, to coordinate activities with community mental health centers and other community resources. Effective referral and followup systems require coordination and collaboration from all levels.

## LEGISLATION BEING CONSIDERED BY THE CONGRESS

Legislation being considered by the House of Representatives (H.R.14214) provides that:

- A center coordinate its services with those of other health and social service agencies in the catchment area to insure that the center's patients have access to all health and social services they may require.
- A center help the courts and other public agencies to screen catchment area residents being considered for referral to a State mental facility to determine if they should be referred or treated in the community.

--A center provide followup care for catchment area residents who have been discharged from a State mental health facility.

One of the bills being considered by the Senate (S. 3280) specifies that the comprehensive mental health services which shall be provided by a center shall include (1) assistance to courts and other public agencies in screening individuals being considered for referral to a mental health facility for treatment to determine whether they should be referred and (2) followup services to individuals who have been discharged from a mental health facility.

#### RECOMMENDATIONS TO THE SECRETARY OF HEW

Program modifications similar to those above should result in more effective coordination of services between centers and State and community organizations. To make coordination of community resources more effective and to insure that patients receive needed services, we recommend that the Secretary of HEW direct NIMH to require centers to establish more formal arrangements for patient referral with other community organizations.

#### AGENCY COMMENTS AND OUR EVALUATION

HEW concurred (see app. I) with our recommendation and stated that soon to be promulgated regulations will require centers to coordinate their services with other human services within the catchment area. HEW advised us, however, that NIMH cannot require State hospitals, or other service providers, to coordinate their services with community mental health centers. Nonetheless, HEW indicated that increased attention to the State plan for mental health services and the assignment of greater priority to such issues in the monitoring of centers should result in substantial improvements.

We realize the difficulty involved in coordinating mental health services at the local level, especially in those areas where numerous agencies and organizations provide services essential to the well-being of the mentally ill. By requiring centers to enter into formal agreements



with other service providers in an area, however, we believe coordinating can be improved. In addition, formal agreements can be used to clearly define the responsibilities and roles of various agencies, delineate referral and followup procedures, and eliminate unnecessary duplication of services.

## CHAPTER 6

### NEED FOR MORE EFFECTIVE USE

#### OF CONSTRUCTION RESOURCES

Funds provided for constructing centers have not been used in the most effective manner. At the time our fieldwork was completed, construction funds totaling about \$23 million were tied up in 32 stalled projects. Many of these projects appeared to be seriously delayed in starting construction because NIMH did not require the applicants to furnish, before grant approval, adequate data concerning ability to begin construction within a reasonable time.

Also five completed projects which had received Federal funds of about \$3.5 million were experiencing delays in beginning operation or were operating on a minimal basis because non-Federal operating funds were not available.

In a few instances NIMH had transferred or was contemplating the transfer of construction grants from one grantee to another after the obligational period provided in the CMHC act had elapsed. In our opinion, this is improper.

#### CONSTRUCTION GRANT AWARD PROCESS

Federal funds for constructing centers are made available to the Secretary, HEW, for allocation to the States. The funds are allocated to the States for a fixed period only, usually the year of appropriation and the next fiscal year. States may request the Secretary's approval to transfer unused funds to other States for the purpose of constructing mental health centers or for use within the State for constructing facilities for the mentally retarded.

To participate in the construction grant program, a State must designate a single State agency to administer the program and to prepare a State plan which sets forth, among other things, an orderly program for constructing centers on the basis of a statewide inventory of existing facilities and a survey of need. The State agency must review the plan at least annually and submit any required modifications to HEW.

Grants are awarded to applicants for a specified share of construction costs, and the grantees must obtain matching funds. They must also provide NIMH with assurances that construction will begin within a reasonable time after the grant award and that funds will be available to adequately operate and maintain the facility after construction.

Applications for grants under the CMHC construction program are in four parts:

1. Initial estimate of cost.
2. Source and location of applicant's funding.
3. Land description.
4. Revised application after construction bids have been received and actual costs are known.

NIMH obligates funds upon the approval of part 1, which is often before completion of the steps necessary to obtain matching funds and acquire the project site. When problems with these matters cause a delay, the catchment area is deprived of mental health services. Examples are described below. The amount of NIMH funds awarded for construction grants and the number of projects funded and operational are on page 3.

GRANT RECIPIENTS UNABLE TO BEGIN CONSTRUCTION  
AND GRANT IMPROPERLY TRANSFERRED

Lutheran South Hospital, Matteson, Illinois, was conditionally awarded a construction grant in June 1967 even though an NIMH trip report of December 1966 noted that the grantee had raised only half the matching funds and it was not clear where the remainder would be obtained. Also, on two occasions just before approval of the application, HEW region V personnel expressed concern about the catchment area because it divided communities and cut off some prime financial resources. Although potential financial problems had been identified, the conditions included in the approval of the application concerned only design of the facility and availability of services to persons unable to pay. In June

1968 the grantee received additional Federal funds, bringing the total award to \$873,147 for constructing the facility.

In April 1970 NIMH noted that the grantee was still having financial problems and was considering merging with another hospital and constructing the proposed facility in an adjacent catchment area. The hospitals merged and in January 1971 the Illinois Department of Mental Health requested a change in grantee and project location. In July 1971 NIMH advised the grantee that a complete revision of the application was required, and in January 1972, the Illinois Department of Mental Health advised NIMH that a consultant was doing a feasibility study of the project. In November 1972, NIMH had not received a revised application and, according to the records, no official change had been made in grantees. In February 1974 NIMH advised us that the project was at a standstill and there was no projected date for starting construction. As of that date more than 6 years had passed since NIMH initially approved the construction award.

The Dallas Neuropsychiatric Institute was awarded a construction grant of \$2 million in June 1968 subject to four conditions, two of which related to developing an appropriate design for the facility. In June 1969 the design was approved, but later the same month a cost analysis of the architect's presentation indicated that the facility could not be constructed within the proposed budget. In August 1971 the Governor of Texas requested that NIMH hold the project open because he believed the legislature would give favorable consideration to a request for matching funds.

In January 1973 the Dallas Board for Mental Health and Mental Retardation wanted to pick up the grant, and NIMH notified the grantee that the grant would be terminated June 30, 1973, if no action was taken toward construction. On August 8, 1973, more than 5 years after approval of the initial grant application, NIMH notified us that a new grantee would take over the grant and was seeking approval of a site from the Dallas County Commissioners. In March 1974 an NIMH official said the grant had been withdrawn from the Dallas Neuropsychiatric Institute.

As stated previously, Federal funds appropriated for constructing centers are available for a fixed period only. During this period, grants may be made for either constructing new facilities or acquiring, expanding, remodeling, and altering existing buildings.

In a few instances, similar to those described above, NIMH transferred or was contemplating the transfer of construction funds after the obligational period expired. This is, in our opinion, contrary to the express language of the act (42 U.S.C. 2682 (a)) as well as the general rules governing availability of appropriations.

ASSURANCE OF FINANCING FOR OPERATION AND  
MAINTENANCE COSTS NOT ADEQUATELY FULFILLED

One of the five completed centers which were experiencing delays in beginning operations or were operating on a minimal basis (see p. 56.) was the Cherokee-Etowah-DeKalb Mental Health Center in Gadsden, Alabama, which was awarded a construction grant of \$650,000 in June 1969. The grantee assured NIMH that sufficient non-Federal funds would be made available to operate and maintain the facility for the purpose for which it was constructed. However, in identifying its source of operating funds, the grantee indicated in the construction grant application that a Federal staffing grant of \$329,000 was needed to provide 52 percent of all center revenues during the first year of operation. Federal staffing assistance was not made available and operating problems were encountered as described below.

Construction of the facility, a 2-story building with a 32-bed inpatient section on the second floor, was completed in March 1972, formally opened in June 1972, and officially accepted by the architect in January 1973. In February 1973, much of the facility, including the inpatient unit, was not in use because of financial problems. In addition, in March 1973, the HEW Associate Regional Health Director for Mental Health advised the Chairman of the center's governing board that there was no inpatient, emergency or partial hospitalization service--three of the five required services. Moreover, there appears to be little hope of fully using the inpatient facility because the center lacks

the accreditation needed to qualify for third-party reimbursement. To compound the financial problem, one of the counties in the catchment area withdrew its financial support and asked to be assigned to another area. Because of these financial problems, the center entered into an agreement with an adjacent facility, Baptist Memorial Hospital, to provide inpatient services.

NIMH could have requested a refund of the construction grant because the grantee could not provide the five essential services, but, because there was no other provider of mental health services in the area, it awarded the grantee a staffing grant of \$455,000 in September 1973 for the period of operations beginning November 1, 1973. The amount of the grant award was less than the amount requested by the applicant. Concern was expressed by the project reviewer that the community might not be able to support a center program at the level of funding proposed by the applicant. The grant was awarded on the condition that the grantee provide financial and staffing plans and appoint a full-time director.

One of the mental health problems cited in justifying the need for this center was raised by law enforcement officials in Cherokee and Dekalb Counties. They stated in 1968 that a center was needed because disturbed men and women had to be held in jail while awaiting commitment to the State hospital. They said that one patient had been held in jail for several weeks under these circumstances. The center director told us that during May 1973, the only month for which statistics were readily available, 28 people were jailed in the 2 counties under lunacy warrants and, during a jail visit on June 25, 1973, he contacted 4 such persons, including 1 who had been jailed 9 days.

The center inpatient facility which will not be used contains four secure rooms which presumably could be used as an alternative to the jails if additional resources were available.

In March 1974 the center director informed us that:

--Plans for use of center inpatient facilities had not been officially proposed to HEW; however, informal

plans provide for use of the facilities for an expanded outpatient program and for office space.

- The adjacent hospital will continue to provide in-patient services.
- The lack of anticipated Federal funds, not the lack of local funds, has delayed implementation of services.

ASSURANCE THAT GRANTEE WOULD PROVIDE  
ALL REQUIRED SERVICES NOT ADEQUATELY FULFILLED

To be eligible for a construction grant, a grantee must agree to provide at least the following services: emergency, outpatient, partial hospitalization, inpatient, and consultation and education. NIMH considers these services essential and they must be available to all catchment area residents.

NIMH, in October 1967, awarded the Richmond County Hospital Authority a construction grant of \$821,104 to build a psychiatric inpatient facility at University Hospital in Augusta, Georgia. University Hospital was to provide inpatient and emergency care, and two affiliates, the Medical College of Georgia and the Richmond County Health Department, were to provide the three remaining services.

The facility at University Hospital opened in January 1971. An NIMH site visit made in December 1971 showed that problems at the center warranted the grantee's attention. Among the problems were:

- A comprehensive center as described in the grant application was not in operation.
- There was little, if any, indication that anyone associated with University Hospital was familiar with the grant application or was committed to the CMHC concept.

The grantee replied to the report in June 1972, agreeing that a comprehensive center was not in operation but disclaiming responsibility for providing all five

essential services. NIMH replied that, as the grantee for the construction project, the authority gave assurance that such service would be provided. Since NIMH had no contract with the affiliate agencies, it must look to the authority as the accountable agency.

In January 1973 NIHM Headquarters and regional office personnel discussed the problem and agreed to conduct a site visit to document the situation and make recommendations. The site visit was made in February 1973, and it was reported that no semblance of a CMHC program was in operation. The grantee was given 30 days to provide a plan and timetable to correct the deficiencies noted, and, if the plan was not forthcoming, legal action would be initiated to recover Federal funds involved.

Following this notice additional correspondence was exchanged. In June 1973 the authority again agreed that the essential services were not being provided but said that it had no way of forcing the affiliates to live up to the agreements. We were told that the affiliates did not honor the agreements because their plans had been contingent on receiving a Federal staffing grant.

On August 7, 1973, the HEW Interim Regional Health Director informed the Richmond County Hospital Authority Chairman that he had determined the authority was not operating a community mental health center as called for by the NIMH construction grant agreement and that he was calling upon the authority to refund the Federal Government its share of participation in the project facilities. We had previously advised HEW regional officials that we concurred that there were legitimate reasons for taking this action.

The authority responded to the HEW letter by offering to meet with HEW and discuss the authority's position. During the next several months a number of formal and informal meetings were held between HEW and authority officials to attempt to resolve the problems surrounding this grant.

On November 19, 1973, the authority provided the HEW Associate Regional Health Director for Mental Health a



summary of progress being made to overcome eight major areas of deficiency identified by HEW. In responding to this letter, the Associate Regional Health Administrator for Mental Health stated that (1) he believed that real progress was being made toward meeting the CMHC requirements associated with the construction grant and (2) he was pleased that communication problems had been overcome so that HEW and the Hospital Authority could work together to insure comprehensive mental health services for Augusta area residents.

The vice-chairman of the authority advised us on March 7, 1974, that he had been informed that all center services were expected to be operational by March 15, 1974. He stated that, although a staffing grant application had not been submitted, funding for center operations would be available.

Although it now appears that progress is being made toward establishing a comprehensive community mental health program in Augusta, a number of issues were raised but not resolved when the grant application was approved. For example, NIMH stated that the review of the grant application in 1967 showed it did not provide for coordination with affiliate agencies, did not consider community resources, and would not meet the area's needs. In addition, it appears that NIMH had identified but had not resolved the need for (1) Federal staffing grant assistance for affiliate agencies, (2) making the grantee aware of its responsibility for establishing the community mental health center, and (3) coordinating mental health services. These factors, which NIMH apparently knew at an early date, have contributed to the delay in establishing a community mental health center providing comprehensive services to the Augusta area.

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In response to our July 1971 report, HEW said it was taking action to strengthen the preaward grant review and monitoring procedures. HEW stated that:

"\* \* \*we have assigned responsibility to the grants management staff of the Institute for

active involvement in the review of grant applications prior to award and for providing a continuing review and evaluation of management aspects of active grants."

In view of the continuing problems identified in the construction and initial operation of some centers, we believe more effective action is necessary to provide the solutions promised by HEW. Since these problems tend to reduce the centers' effectiveness in providing needed mental health services and delay the establishment of needed centers, immediate action is necessary to identify the factors causing these problems and to remedy the situation on a case-by-case basis.

### CONCLUSION

Awarding construction grants without adequate assurance that the grantee will be able to meet the grant terms does a disservice to both the grantee and the entire CMHC program. The grantee thus spends time and money in attempting to initiate mental health services, which unnecessarily ties up program funds that could have been used in other locations.

HEW believes CMHC construction grants have the expressed purpose of serving a designated population within a given catchment area and, so long as the purpose of the grant remains the same and the same population is to be served, it is not necessary to deobligate or reobligate funds.

Generally, when an appropriation is made available until a specified date or for a specified period, its availability relates to the authority to obligate the appropriation. An appropriation is obligated when a definite commitment is made or a legal liability incurred to pay funds from such appropriation. To justify charging an appropriation after its period of availability for obligating purposes has expired, some action creating a definite liability against the appropriation must have been taken while it was available for incurring obligations.

Approved applications for Federal assistance may be amended after the availability period expires. However, the practice of changing grantees after the availability period

expires, in our opinion, involves more than just an amendment of the approved application. The consequences that could result from substituting one grantee for another after the period of availability are of genuine concern to the Government.

We believe the CMHC act reflects the Congress determination to respond to mounting evidence that the mentally ill will often recover sooner and more fully when they have a comprehensive treatment program in the home community. To organize and fully develop quality services on a community-wide basis within a reasonable time after funds are appropriated, it is critical that HEW obligate its funds expeditiously in a particular community or make such funds available to other communities. If HEW is permitted to substitute one grantee for another after the availability period, the realization of this objective would be severely hindered and the funds could lie idle for unnecessarily long periods.

Moreover, permitting the deobligation and reobligation of CMHC funds beyond the period of availability would, in essence, be interpreting the act as being open ended for obligation purposes. Such an interpretation would be contrary to the express language of the act as well as the general rules governing the availability of appropriations.

Thus, it is our opinion that, if mental health funds made available under the act are deobligated, they must be reobligated during the period in which such funds are made available for obligation by the appropriation act under consideration. Reobligation after such period has expired is improper.

#### LEGISLATION BEING CONSIDERED BY THE CONGRESS

One of the bills being considered by the Senate (S. 3280) authorizes the Secretary, HEW, to require that any grantee return to the Secretary any funds obligated for construction but remaining unexpended after a reasonable time and that the returned funds be used to make other grants for construction of centers during the fiscal year in

which the funds are returned and the next fiscal year. The provision in the bill would, if enacted, appear to provide a reasonable solution to this problem.

#### RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary require NIMH to:

- Obtain from grantees firmer assurances that the facility can be completed within a reasonable time and that funds will be available to adequately operate and maintain the facility after construction.
- Identify, on a case-by-case basis, the factors which have (1) caused construction projects to become stalled and (2) prevented the operation of completed facilities and assist grantees to remedy the situation.
- Stop changing grantees under the construction program after elapse of the 2-year obligational period provided in the CMHC act.

#### AGENCY COMMENTS AND OUR EVALUATION

HEW concurred (see app. I) with the intent of our first two recommendations and said it had taken corrective action.

We were advised that, to insure that construction is related as closely as possible to program needs, priority for awarding fiscal year 1974 funds will be given to applicants which already have operational mental health programs. In addition, a financial plan supported by documentation is now required in lieu of written assurances by the applicant that funds will be available.

We were advised that a case by case analysis of the 32 "delinquent" construction projects was made; 15 of these had changed status (3 had initiated construction, 2 had changed grantees, 2 had withdrawn their applications, and 8 had shown varying degrees of progress in moving toward construction) and 17 still remained delinquent. HEW did not supply us with sufficient details to enable us to evaluate the extent of progress made to initiate construction on the 8 projects.

HEW will continue to give technical assistance to mobilize the resources of the catchment areas having "delinquent" projects so that, where possible, community mental health programs could be initiated.

HEW did not agree that the practice of changing grantees after elapse of the obligational period provided by the CMHC act was improper or that the practice should be stopped. However, the HEW General Counsel was asked to review this situation.

## CHAPTER 7

### SCOPE OF REVIEW

Our review concerned the progress made by NIMH and local agencies in establishing and operating community centers providing mental health services.

We did not assess the effect of services on patients. However, observations were made on the quantity and types of mental health services provided.

We reviewed:

1. The program's authorizing legislation.
2. Funding available to NIMH.
3. Procedures being followed by centers in involving the community in identifying needs and delivering of services, funding available to carry out the program, and coordination of mental health services with State and community agencies.
4. Centers' capability to become financially self-sufficient.
5. The program evaluations being made by NIMH and 12 centers reviewed.
6. Progress toward opening and/or constructing centers that received construction grants.

We examined instructions and guidelines relating to grant awards and centers' operations and reviewed center records to determine the extent to which patients were being referred to the centers by other organizations capable of identifying persons with mental problems or by centers to other organizations providing services not available at centers.

Our review was made at NIMH headquarters in Rockville, Maryland; the regional offices of HEW in Chicago, Boston,

Denver, Dallas, and Atlanta; and at the 21 centers listed in appendix II. We made a comprehensive review of 12 centers and gathered information on the use of construction grants by 9 other centers.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C. 20201

APR 25 1974

Mr. Gregory J. Ahart  
Director  
Manpower and Welfare Division  
United States General Accounting Office  
Washington, D. C. 20540

Dear Mr. Ahart:

The Secretary has asked that I respond to your request for comments on your draft report to the Congress entitled "Need for More Effective Management of Community Mental Health Centers Program." They are enclosed.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

A handwritten signature in cursive script that reads "John D. Young".

John D. Young  
Assistant Secretary, Comptroller

Enclosure



## APPENDIX I

### DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE COMMENTS ON GENERAL ACCOUNTING OFFICE REPORT ENTITLED: NEED FOR MORE EFFECTIVE MANAGEMENT OF COMMUNITY MENTAL HEALTH CENTERS PROGRAM

#### Introduction

In brief, the GAO review of 12 community mental health centers was undertaken to assist the Congress of the United States in its consideration of the extension and/or modification of the CMHC Act. GAO's purpose was not to provide an extensive analysis of the CMHC Program or its contribution to and impact on the mental health service delivery system. Rather, GAO focused on identifying problems in the management and administration of CMHCs which, if corrected, would lead to increased program effectiveness. Thus, while the review disclosed that "the operational centers have increased the accessibility, quantity and type of service available at the community level, and have enhanced the responsiveness of mental health services to individual needs," such findings were not central to the core of the study.

It should also be pointed out that the magnitude and range of problems identified by the GAO are not out of the ordinary for newly developing programs. The administration of complex service delivery organizations is difficult, particularly when an emphasis is on initiating services. The need to continue activity that will bring about management improvements in the areas identified is clearly recognized.

For purposes of clarity, we shall focus our response on the recommendations in each of the chapters. Inasmuch as the recommendations are often general, however, and do not reflect some of the major issues raised in the body of the report, we shall also provide some substantive comments as appropriate.

#### Major Issues

##### (1) IMPROVED PLANNING NEEDED FOR CMHCs

GAO Recommendations. Periodic review of catchment areas as described in the proposed legislation should provide assurance that the area to be served by a CMHC is appropriate for the effective delivery of mental health services. Also, greater community involvement in center activities should help to ensure that services are responsive to community needs.

To further improve the planning process and ensure that services are provided in the areas of greatest need, we recommend that the Secretary of HEW direct NIMH, prior to the award of a construction or staffing grant, to assure itself that an appropriate and timely review has been made of the area to be served by the center. We also recommend that NIMH be directed to require centers to perform community need studies which would enable them to set relative priorities and periodically update such studies to permit an analysis of services against the priorities.

DHEW Comments. We concur with the thrust of the above recommendations and find them to be consistent with the aims of the CMHC Program. More effective planning for community mental health services, with the aim of reducing the fragmentation and duplication of services at the local level, is both necessary and desirable. Broad assessment of community needs based on demographic data is expected to be an integral part of each community mental health center grant application, along with a discussion of how these needs are to be met. The setting of relative priorities, however, has been a difficult process for CMHCs in light of their mandate to provide a broad range of services responsive to the needs of all residents of the catchment area. We agree, however, that services should be clearly related to community needs as identified in both initial and continuation applications reviewed by Regional Offices.

In brief, we do not believe, as indicated in the GAO report, that the catchment area requirement has generally served as an impediment to more effective planning. While it is true that in some cases, catchment area boundaries have not been congruent with other service areas, in most instances, the catchment area has resulted in more effective and coordinated service delivery. This has been demonstrated in both federally and non-federally sponsored studies\*.

Basically, the 75,000 to 200,000 population limit established for catchment areas by regulation ensure that CMHCs will mount sufficiently broad programs to meet a variety of needs without becoming so large as to run the risk of mirroring large public mental institutions. Despite these limits, however, it is clear that there are cases where CMHCs may reasonably serve larger or smaller populations. In fact, some 13 percent of all CMHCs have been granted exceptions to these requirements. When there is evidence that exceptions to these limits will enhance service delivery, such exceptions have been readily granted.

It is further important to stress that catchment area lines are determined and drawn by the States and not by the NIMH. Each State is required to take into account a variety of factors designed to assure, to the maximum extent possible, that coordinated service will result. Regulations require, for example, that "cognizance be taken of other health planning

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\*See: Tischler, G. et al., The impact of catchmenting, Administration in Mental Health, Winter 1972

Contract #HSM-42-72-96, Viability of the Catchment Area Concept in the Community Mental Health Centers Program, Arthur D. Little, Inc., Cambridge, Mass.

Wolford, J. et al., The effect on hospitalization of a community mental health/mental retardation center, American Journal of Psychiatry, Aug. 1972

## APPENDIX I

efforts and planning in such areas as urban development, welfare services and related facilities."

The problems of coordinating service delivery are real and complex and the drawing of boundaries will often highlight the existing duplication and fragmentation of service. Unlike other agencies, CMHCs are charged with the responsibility for addressing such problems. Catchment areas crystallize difficulties in coordination; the bulk of available evidence, however, strongly suggests that catchment areas facilitate effective coordination.

With regard to the performance of need studies, it is clear that the identification of needs at the State and local level is an important step in more effective planning. In recognition of this fact, the CMHC Amendments of 1970 (P.L. 91-211) authorized initiation and development grants for the assessment of community needs in poverty areas. To date, these grants - limited to a maximum of \$50,000 for one year -- have been awarded in 26 poverty catchment areas, enabling more effective planning. Such planning grants, however, are limited by legislation to designated poverty areas and are not available for non-poverty areas. Increased attention to the needs assessment process in the review of initial and continuation applications will help ensure that services are relevant and appropriate in all areas. Further, we will expand our efforts to develop solutions to the technological problems in performing valid assessments of community need.

Our experience verifies the variability of community participation in the planning and development of community mental health services. Although regulations require every community mental health center to have some form of community representation, the mechanisms utilized to accomplish this vary. While center advisory boards are the most common means of promoting citizen involvement, in some instances, members of center advisory boards are elected, selected by the State or local mental health authority, or chosen by an already existing board as replacements for members whose terms are expiring.

While we agree that citizen involvement should be promoted and reflected in center programming, the extent to which such citizens can make a meaningful contribution depends, in large part, on their knowledge, experience, training and working relationships with CMHC administrators. To enhance this process, we believe the training of board members and other citizen participants should be actively promoted. In recognition of the need for more effective planning for citizen involvement in community mental health center programs, a Center for Citizen Participation has been established within the Community Mental Health Services Support Branch, Division of Mental Health Service Programs. Within the context of the CMHC Program, this Center will plan and initiate actions designed to upgrade the quality of citizen participation.

We shall continue to explore and implement the most effective ways of bringing about needed improvements. These range from updating guidelines for the development and review of State plans to implementing, effective July 1, 1974, a simplified State plan procedure. In addition, we shall reaffirm the importance of assessing community need on an ongoing basis, both by applicants for CMHC grants and by DHEW staff in the review of initial and continuation applications.

(2) CAPABILITY OF CENTERS TO OPERATE WITHOUT FEDERAL ASSISTANCE

GAO Recommends that the Secretary of HEW direct NIMH to:

- provide technical assistance to the centers to assist them in developing self-sufficiency financial plans and to improve their billing and collection systems,
- consider, and if deemed appropriate, work toward expansion of coverage provided by third-party payment programs for mental health outpatient services provided by non-physicians.

DHEW Comments. The NIMH concurs with these recommendations and has, in fact, already devoted considerable resources to address these areas.

Specifically, the GAO report indicated that most of the centers visited had inadequate accounting systems and poor procedures for billing and collecting charges. New regulations as presented in 45 CFR Part 74, recent amendments to the CMHC regulations, and health services funding regulations requiring improved management of program income will address this area. These new regulations will require the preparation of individual financial plans and third party reimbursement goals as a pre-award condition for each grant. Further, as part of our technical assistance efforts, we are in the process of continuing our development of materials that may be used by CMHCs to upgrade their financial systems. During the past year, for example, a series of workshops on financing systems has been conducted for community mental health centers on a region by region basis. In addition, a variety of materials and manuals have been, and continue to be, developed to assist centers with their fiscal management operations.\* Also, the Institute has developed through contract a procedure for identifying fiscal management needs of CMHCs. As a result of contract #HSM-42-72-181, we are conducting a training program on using and teaching cost-finding and rate-setting to analyze and evaluate community mental health centers.

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\*E.g., NIMH Management Methodology Reports, Series C, No. 5, No. 6, No. 7, No. 8, on Accounting Guidelines, Cost Finding and Rate Setting, Statistical and Accounting Systems, and Definition of Terms, respectively.

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Briefly, the GAO report identifies a number of issues related to the financing of community mental health centers. Regarding the 8 year duration of staffing grant support, we agree with the judgment that most community mental health centers will not cease operations at the end of the 8th year. This is, we believe, a reflection of the validity of the seed money approach. Currently, Federal staffing grants provide only some 31 percent of average CMHC revenues. 31 percent is provided by State governments with local governments accounting for roughly 10 percent. Receipts from service, including third-party payments (insurance, Medicare, Medicaid) and patient fees account for nearly a quarter of CMHC revenues.

At a second level, the GAO report addresses the issue of mental health coverage in insurance plans. We do consider it appropriate to work toward the expansion of coverages in the direction noted by the GAO. It is clear that the extent and nature of such coverage will have a marked impact on the shape of the mental health delivery system.

Although mental health coverage is generally less extensive when compared to coverage for general medical care, the differential between mental health and medical insurance coverage is greatest for ambulatory care -- the prime focus of the community mental health center. Mental health insurance benefits include a higher percentage of co-insurance or higher fixed co-payments, lower dollar limits for maximum reimbursable charges, low annual dollar limit for reimbursable charges and often disproportionately lower lifetime dollar limits.

Furthermore, there are 20 commercial insurance companies which will write individual coverage for psychiatric hospitalization, but only two which will provide some outpatient psychiatric benefits within major medical policies.

Our principal concern is that the coverage of ambulatory mental health care be expanded at least as dramatically as general medical ambulatory care in all major medical insurance programs. The absence of such equitable coverage is a serious economic barrier to the purchasing power of the population at risk, and to the maintenance and growth of available accessible and appropriate treatment resources, such as community mental health centers. Current Administration proposals for national health insurance (CHIP) include benefits for mental health coverage of inpatient, outpatient and partial hospitalization care, with organized care settings, such as CMHCs, given preferential benefits for outpatient care.

(3) MONITORING AND EVALUATION OF CMHCs

GAO Recommendations. To further improve program evaluation efforts, the Secretary of HEW should direct NIMH to:

- ensure that program evaluation contracts are effectively monitored and that results of such evaluations are made available to operating centers;
- develop, with the assistance of the HEW regional offices, a more effective site visit program that would improve program management and be of greater assistance to operating centers,
- ensure that the site visit program which is developed is made standard for the 10 HEW Regional Offices so as to promote more effective and accurate analysis of program status.

DHEW Comments. We concur with the above recommendations, although it is important to point out that the NIMH has undertaken important steps in the areas of program evaluation contracts, improving the capacity of centers to perform self-evaluation, and monitoring site visiting community mental health centers. It is particularly essential to note these efforts in light of the fact that they are not pointed to in the GAO report.\*

It is true that a number of contract studies are open to criticism on the basis of too small a sample or lack of representativeness in general. Because of the great variation in catchment area size and population and the program variations which are directed at varying community needs, it is difficult to select a sample of CMHCs which can truly be called a national sample. We note that GAO had this same problem in reviewing only a sample of 12 centers in relation to individual center evaluation capability. NIMH surveyed all operating centers concerning evaluation capability and found a great variation in capability throughout the country.

The comments made by GAO regarding self evaluation by community mental health centers do not reflect current activities to improve this aspect of CMHC operations. Two contracts currently funded from evaluation set aside resources are addressing the problems caused by both a lack of qualified staff and general sophistication about project evaluation within CMHCs. The first is a contract shared by the Langley-Porter Neuropsychiatric Institute, of the University of California in San Francisco, and by James Sorensen of the University of Denver. This team is involved with Regional Office staff in preparing a series of workshops to which all Centers in a

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\* A list of evaluation studies is available from the Office of Program Planning and Evaluation, NIMH. Copies of evaluation reports are available from the US Commerce Department, National Technical Information Service, 5285 Port Royal Rd. Springfield, Va. 22151

## APPENDIX I

given Region are invited to send a program director, clinical director and research director for the purpose of presenting and sharing the best available information on how to evaluate various aspects of Center operations. The first of these workshops took place in Berkeley, California in November. Another was held in Manchester, New Hampshire in March, 1974. Others are scheduled for Regions II, III, VII, and X prior to the end of this fiscal year. These workshops are not self-contained activities but rather are part of Regional strategies to promote self evaluation capabilities in CMHCs, and more generally, to other Federally sponsored organized care settings. In addition, a Consortium of Mental Health Centers and grant-in-aid clinics in the State of Florida has been funded over the past year to test out various existing NIMH developed local program evaluation methodologies to see how they work in real settings rather than on paper. A public demonstration of findings will be held for many centers in Region IV in May, and a final report is due on this activity in June.

With regard to the monitoring of community mental health centers through site visits, we must take exception to the GAO's initial conclusion that this effort has been ineffective. While we recognize that there is need for improvement, we have found the site visit approach to be a meaningful and generally successful approach to monitoring. While there have been problems precluding visits to every center on an annual basis, in individual cases, site visits have served to identify deficiencies for follow-up action. It should be noted that a more effective site visit program should be possible because of the decentralization of community mental health center grant authorities to the Regional Offices.

The site visit team generally consists of Regional Office staff, representatives of State and local mental health departments, outside consultants and increasingly, representatives of citizens' groups. The center's operations come under extensive review and where problems are identified, the center is required to submit a plan for corrective action. Subsequent site visits are made to ascertain whether the plan has been satisfactorily implemented. We will make efforts to improve the timeliness to provide technical assistance.

Strictly speaking, it is true, as pointed out in the GAO report, that NIMH is less directly involved in making site visits. The Regional Offices of DHEW, however, though not under the organizational jurisdiction of the NIMH, do make a substantial number of site visits per year. In some regions, there has been a problem visiting every center on a strict annual basis. This highlights the need to develop additional techniques that will strengthen this developing facet of Regional Office function, to ensure that centers are operating in

compliance with the terms of the grant and that centers receive appropriate technical assistance in both programmatic and management areas to enhance their capacity for delivering adequate mental health services. With regard to the third GAO recommendation, we are, for example, developing a uniform site visit protocol for use in all ten regions and are prepared to field test the instrument. We share the concern of the GAO in this matter, and with Regional Office coordination, are currently addressing the problem.

#### (4) COORDINATING MENTAL HEALTH SERVICES

##### GAO Recommendations.

To make coordination of community resources more effective and to ensure that patients in need of services receive them, we recommend that the Secretary of HEW direct NIMH to require centers to establish more formal arrangements for patient referral between a center and other community organizations.

DHEW Comments. We concur with this recommendation. Soon to be promulgated regulations require CMHCs to coordinate their services with other human services within the catchment area, reflecting our strong concern with this issue.

As indicated in the discussion on planning the coordination of diverse organizations and services is a highly complex task. Nonetheless, community mental health centers have made important strides in effecting such coordination. Some 92 percent of CMHCs are the result of the affiliation of two or more already existing community agencies. In some instances, as many as 18 different agencies have come together to provide a comprehensive program for the area. Further, a recent study\* has indicated that 53 percent of CMHCs have formal affiliations with public mental institutions. In addition, many CMHCs maintain a variety of informal working relationships. Center staff, for example, have participated in pre-discharge planning for one-third of all patients discharged from State hospitals to the catchment areas in which centers are operating. However, it is important to note that NIMH cannot require State hospitals, or other service providers, to coordinate their services with community mental health centers. To maximize effective coordination and continuity of care, it is important that service providers under State and local jurisdiction, as well as CMHCs be required to coordinate services. Nonetheless, we believe through regulation, increased attention to the State plan for mental health services, and a reexamination toward assignment of greater

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\*Contract #HSM-42-70-107, Study of the relationship between community mental health centers and state mental hospitals, Socio-Technical Systems Associates, Boston, Mass.



## APPENDIX I

priority on such issues in the monitoring of CMHCs will result in substantial improvements.

### (5) NEED FOR MORE EFFECTIVE USE OF CONSTRUCTION RESOURCES

GAO Recommendations. We recommend that the Secretary require NIMH to:

- obtain from grantees firmer assurances that the construction of a facility can be completed within a reasonable period of time and that funds will be available to adequately operate and maintain the facility after construction.
- identify, on a case by case basis, the factors which have (1) caused construction projects to become stalled and (2) prevented the operation of completed facilities and assist grantees to remedy the situation.
- stop the practice of changing grantees under the construction program after elapse of the two year obligational period provided in the CMHC Act.

DHEW Comments. We concur with the intent of the first two of these recommendations, and have, in fact, taken several steps in the directions pointed to by the GAO. We do not agree with the third recommendation and believe the GAO to be in error in its interpretation. However, as discussed further, we have asked the General Counsel, HEW to review this situation.

A basic thrust of the Community Mental Health Centers Program has been to increase the volume of mental health services at the local level. Our experience has verified the finding of the GAO that in many instances, the complexities of constructing new facilities for the delivery of mental health services has led to inordinate delays in the initiation of such services. Thus, while we recognize the continued need for new construction in certain areas, we have increasingly stressed the priority of renovating already existing facilities rather than constructing new ones. In addition, to ensure that construction is related as closely as possible to program needs, priority for the award of fiscal year 1974 funds will be given to applicants who already have operational mental health service programs.

Assurances that a facility constructed with CMHC funds will have adequate sources of funds available to launch and maintain a program have been required as part of the application process. Given the length of time necessary to construct facilities, however, in some instances, sufficient funds did not materialize when the center was ready to begin operations. As a result, we have communicated (April 1973) more stringent requirements to the Regional Offices of HEW; a financial plan supported by documentation is now required in lieu of written assurances by the applicant that funds will be available.

With regard to the recommendation that a case by case analysis of

"delinquent" construction projects be made, that too, has been done. It may be noted that while 32 construction projects were delayed at one point last year, 15 of these have had a change in status (3 have initiated construction, 2 have changed grantees, 2 have withdrawn their applications and 8 have shown varying degrees of progress in moving toward construction). While 17 still remain "delinquent," we will continue our technical assistance efforts so that the resources of these catchment areas can be mobilized and where possible, programs can be initiated.

As indicated above, we do not agree with the interpretation of the GAO regarding the transfer of construction grantees. CMHC construction grants have the expressed purpose of serving a designated population within a given catchment area. So long as the purpose of the grant remains the same, with the same population to be served, it is not necessary to de-obligate or re-obligate funds. While we take exception to the interpretation of the GAO in this regard, we have requested the General Counsel, HEW, to consider the issue raised by the GAO and to render an authoritative legal opinion.

It is our understanding that the GAO recommendation does not apply to grants transferred under circumstances described in the DHEW Office of General Counsel opinion dated October 23, 1968 (copy attached). Until an affirmative legal opinion is rendered, transfers will not be made of construction grants not consistent with the 1968 opinion.

#### Overview and Assessment

In summary, the GAO draft report has identified a number of problem areas relevant to the management of the community mental health centers program. While such problems are not atypical of developing service delivery programs, they do point directions in which improvements can and should be made. As discussed in the body of this response, a number of important efforts have already been undertaken and are ongoing; others will be initiated.

APPENDIX I

Dr. Richard G. Ryricker  
Acting Chief, Mental Health Facilities Branch  
Division of Mental Health Service Programs, NMH  
Division of Public Health Grants and Services  
Office of the General Counsel

DATE: October 23, 1968

Mental health facility construction--Assurances--Joint applicants

You have requested our advice as to a situation arising in New Jersey where the State legislature apparently intends to transfer State funds available for the construction of a community mental health center in Morristown from the approved applicant for a Federal grant (the State Department of Institutions and Agencies) to another institution (New Jersey College of Medicine and Dentistry),<sup>1/</sup> which institution would contemplate some change in the design and a shift of the site location a short distance to a site which it owns. The facility, however, would serve the same "catchment area" as originally planned. The Federal funds obligated for this project were from FY 1965 and 1966 allotments to the State, and you inquire whether the proposed assumption of authority by the College for construction and operation of the facility would require termination of the grant and reversion of the obligated funds to the Treasury. You also ask whether the original applicant could continue as the Federal grantee since it would no longer own the site or operate the facility.

Subject to the considerations indicated below, we believe you might reasonably find that the proposed arrangement could be effected without loss of the Federal funds committed to the project.

As you know, Federal funds obligated for one project may not, subsequent to the expiration of their fiscal year availability, be transferred to a new project.<sup>2/</sup> Apparently you do not, however, regard this as a new project. Although there will be some change with respect to responsibility for construction and operation of the project, and some change as to design and location, it appears that there will be no basic change in the type of facility to be constructed or in the area to be served by such facility. We understand that it is not unusual to modify the design and change the location of the project subsequent to approval of Part 1 of the application. Since the Federal

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<sup>1/</sup> Although not entirely clear from the material submitted, we assume that both parties are State agencies but that they operate as separate entities.

<sup>2/</sup> E.g., see our memo re the Hospital Construction Program, G.C. (Gardner to PHS (Graning), February 9, 1968.



- 2 -

obligation remains the same, <sup>3/</sup> and since modification of facility design and site location within limits is permissible, <sup>4/</sup> we think that if the necessary assurances can be obtained with respect to both construction and operation of the facility you would not legally be precluded from finding that the project is still eligible for Federal assistance on the basis of the original award.

It would seem that the necessary assurances in this case could be most effectively obtained by permitting the New Jersey College of Medicine and Dentistry, subject to the approval of the Secretary, to be added as a joint applicant. In view of the substantial involvement of both the Department of Institutions and the New Jersey College of Medicine, it would appear to us that such a joint application would be the most satisfactory means of satisfying legal and administrative requirements. Alternatively, however, you might be able to find that the necessary assurances can be obtained by means of contractual arrangements between the parties whereby the Federal government could look to the parties, individually or jointly, for carrying out all Federal requirements.

Our Regional Attorney in New York, to whom we are sending a copy of this memorandum, has studied the issues raised in this case and is prepared to consider any particular arrangements which you and the parties may wish to adopt.

*Joan M. Fulton*  
 ✓ Joan M. Fulton

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3/ Cf. 39 Comp. Gen. 296 holding that a Federal grant made in one fiscal year based on specific objectives and estimates of project costs gives rise to definite and maximum obligation of U.S. and the enlargement of the grant beyond the original scope creates additional obligation and must be regarded as a new grant. See also section 403 (b) of P.L.88- specifically authorizing the use of subsequent allotments where estimate of cost of approved project is revised upward.

4/ See 42 CFR § 54.209 (d) (e). The crucial issue in such cases is whether the proposed change is of such a substantial or essential nature that it must be considered a "new" project, or whether the proposed revisions are within the scope of the original application. See, e.g., memo, GC (Rourke) to GC:RAVI (Stafford), July 1, 1968; memo, GC (Rohner) to G. C. Files, June 11, 1965; memo, GC (Rourke) to NIH-DRG (Scudder), Feb. 14, 1957.

## APPENDIX II

COMMUNITY MENTAL HEALTH CENTERS REVIEWED

	<u>City and State</u>	<u>HEW region</u>
Reviewed in detail:		
Maine Medical Center	Portland, Maine	I
Emerson Hospital	Concord, Mass.	I
Orange Memorial Hospital	Orlando, Fla.	IV
Winter Haven Hospital	Winter Haven, Fla.	IV
Illinois Mental Health Institutes	Chicago, Ill.	V
Community Mental Health Center	Chicago, Ill.	V
Ravenswood Hospital	Chicago, Ill.	V
Bernalillo County Center	Albuquerque, N. Mex.	VI
Denver General Hospital	Denver, Colo.	IV
Adams County Center	Commerce City, Colo.	VIII
Bethesda Psychiatric Hospital	Denver, Colo.	VIII
Memorial Center	Mandan, N. Dak.	VIII
South Central Center	Jamestown, N. Dak.	VIII
Reviewed construction grants only:		
The Greater Bridgeport Center	Bridgeport, Conn.	I
Erich Lindemann Center	Boston, Mass.	I
John C. Corrigan Center	Fall River, Mass.	I
Cherokee-Etowah-DeKalb Center	Gadsden, Ala.	IV
Northside Hospital Center	Atlanta, Ga.	IV
Central DeKalb Center	Decatur, Ga.	IV
St. Joseph's Hospital Center	Tampa, Fla.	IV
University Hospital Center	Augusta, Ga.	IV
Milwaukee County Center	Milwaukee, Wis.	V

## COMPARISON OF CATCHMENT AREA CHARACTERISTICS

WITH THOSE OF PATIENTS SERVED

## Ethnic Groups

	<u>Percent in catchment area</u>				<u>Percent served by center</u>			
	<u>White</u>	<u>Black</u>	<u>Spanish</u>	<u>Other</u>	<u>White</u>	<u>Black</u>	<u>Spanish</u>	<u>Other</u>
Maine Medical Center, Portland, Maine	99.4	0.3	-	0.3	99.4	-	-	0.6
Emerson Hospital, Concord, Mass.	97.2	2.0	-	.8	99.3	0.7	-	-
Orange Memorial Hospital, Orlando, Fla.	96.9	2.7	-	.4	97.6	1.8	-	.6
Winter Haven Hospital, Winter Haven, Fla.	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
The Medical Center, Chicago, Ill. (note b)	26.6	20.9	49.4	3.1	28.5	32.6	22.9	13.2
Ravenswood Hospital, Chicago, Ill.	98.1	.2	-	1.7	96.2	.8	-	3.0
Bernalillo County Center, Albuquerque, N. Mex.	38.9	3.0	55.0	3.1	50.3	3.3	45.3	1.1
Denver General Hospital, Denver, Colo.	59.3	9.6	28.2	2.9	58.6	16.7	22.5	2.2
Adams County Center, Commerce City, Colo.	83.5	.7	14.2	1.6	93.3	1.2	4.9	.6
Bethesda Psychiatric Hospital, Denver, Colo.	95.3	.4	3.3	1.0	97.2	1.4	.7	.7
Memorial Center, Mandan, N. Dak.	97.0	-	-	3.0	98.2	-	-	1.8
South Central Center, Jamestown, N. Dak.	99.7	-	-	.3	98.9	-	-	1.1

<sup>a</sup>Comparable information not obtained from this center.<sup>b</sup>Information on ethnic group not available on 2.8 percent of records sampled.

APPENDIX III

Income Groups

	Percent in catchment area				Percent served by center			
	0 to \$3,999	\$4,000 to \$7,999	\$8,000 to \$11,999	\$12,000 and over	0 to \$3,999	\$4,000 to \$7,999	\$8,000 to \$11,999	\$12,000 and over
Maine Medical Center, Portland, Maine (note a)	11.7	26.2	31.6	30.5	36.6	26.2	7.6	2.9
Emerson Hospital, Concord, Mass.	4.0	13.6	23.3	59.1	18.4	14.9	24.1	42.6
Orange Memorial Hospital, Orlando, Fla. (note b)	16.0	28.3	27.0	28.7	29.5	38.0	10.8	7.8
Winter Haven Hospital, Winter Haven, Fla.	(c)	(c)	(c)	(c)	(c)	(c)	(c)	(c)
The Medical Center, Chicago, Ill.	(c)	(c)	(c)	(c)	(c)	(c)	(c)	(c)
Ravenswood Hospital, Chicago, Ill.	[ 29.3 ]	[ 70.7 ]	[ 54.9 ]	[ 45.1 ]				
Bernalillo County Center, Albuquerque, N. Mex.	(f)	(f)	(f)	(f)	(f)	(f)	(f)	(f)
Denver General Hospital, Denver, Colo.	23.3	31.7	25.2	19.8	72.1	23.0	3.6	1.3
Adams County Center, Commerce City, Colo.	7.9	20.4	36.0	35.7	25.2	38.0	25.2	11.6
Bethesda Psychiatric Hospital, Denver, Colo.	8.7	19.4	26.2	45.7	38.2	28.4	16.7	16.7
Memorial Center, Mandan, N. Dak.	21.2	30.1	26.4	22.3	40.5	30.1	20.9	8.6
South Central Center, Jamestown, N. Dak.	20.8	33.6	22.5	23.1	48.0	33.0	12.3	6.7

<sup>a</sup>Incomes of 26.7 percent of patients served were not shown.

<sup>b</sup>Incomes of 13.9 percent of patients served were not shown.

<sup>c</sup>Comparable information not obtained.

<sup>d</sup>Income category was 0 to \$7,799.

<sup>e</sup>Income category was \$7,800 and above.

<sup>f</sup>Not available.

## APPENDIX III

Age Groups

	<u>Percent in catchment area</u>					<u>Percent served by center</u>				
	<u>Under 5</u>	<u>5 to 19</u>	<u>20 to 44</u>	<u>45 to 64</u>	<u>65 and over</u>	<u>Under 5</u>	<u>5 to 19</u>	<u>20 to 44</u>	<u>45 to 64</u>	<u>65 and over</u>
Maine Medical Center, Portland, Maine	8.1	28.7	29.2	21.1	12.9	1.2	23.8	55.8	17.4	1.8
Emerson Hospital, Concord, Mass.	9.2	32.4	36.7	15.5	6.2	5.3	54.7	32.7	7.3	-
Orange Memorial Hospital, Orlando, Fla.	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
Winter Haven Hospital, Winter Haven, Fla.	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)	(a)
The Medical Center, Chicago, Ill. (note b)	10.6	32.8	30.7	18.3	7.6	1.4	20.1	54.8	16.7	4.2
Ravenswood Hospital, Chicago, Ill.	6.9	22.1	29.2	25.9	15.9	2.3	19.5	47.4	27.8	3.0
Bernalillo County Center, Albuquerque, N. Mex.	(c)	(c)	(c)	(c)	(c)	(c)	(c)	(c)	(c)	(c)
Denver General Hospital, Denver, Colo.	8.4	24.1	32.5	20.6	14.4	.4	15.8	62.2	18.0	3.6
Adams County Center, Commerce City, Colo.	10.0	35.7	36.4	14.3	3.6	-	22.7	63.2	12.9	1.2
Bethesda Psychiatric Hospital, Denver, Colo.	6.9	24.5	34.9	21.0	12.7	-	11.8	61.8	26.4	-
Memorial Center, Mandan, N. Dak.	9.0	33.6	27.7	20.5	9.2	3.1	47.2	38.7	9.8	1.2
South Central Center, Jamestown, N. Dak.	7.2	31.1	25.4	22.8	13.5	1.1	19.5	55.3	20.7	3.5

<sup>a</sup>Comparable information not obtained from these centers.

<sup>b</sup>Information not available on 28 percent of records sampled.

<sup>c</sup>Statistical sample of patients served not valid.



APPENDIX IV

PRINCIPAL HEW OFFICIALS  
 RESPONSIBLE FOR ACTIVITIES  
 DISCUSSED IN THIS REPORT

	Tenure of office	
	<u>From</u>	<u>To</u>
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Caspar W. Weinberger	Feb. 1973	Present
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
Anthony J. Celebrezze	July 1962	Aug. 1965
ASSISTANT SECRETARY (HEALTH AND SCIENTIFIC AFFAIRS):		
Charles C. Edwards	Mar. 1973	Present
Richard L. Seggel (acting)	Dec. 1972	Mar. 1973
Merlin K. DuVal, Jr.	July 1971	Dec. 1972
Roger O. Egeberg	July 1969	June 1971
Philip R. Lee	Nov. 1965	Jan. 1969
SURGEON GENERAL, PUBLIC HEALTH SERVICE:		
Paul S. Ehrlich Jr. (acting)	Jan. 1973	Present
Jesse L. Steinfeld	Dec. 1969	Jan. 1973
William H. Stewart	Oct. 1965	July 1969
Luther L. Terry	Mar. 1961	Oct. 1965
ADMINISTRATOR, HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION (note a):		
Harold O. Buzzell	May 1973	June 1973
David J. Sencer (acting)	Jan. 1973	May 1973
Vernon E. Wilson	May 1970	Dec. 1972
Joseph T. English	Jan. 1969	May 1970
Irving Lewis (acting)	Sept. 1968	Jan. 1969
Robert Q. Marston	Apr. 1968	Sept. 1968

	<u>Tenure of office</u>	
	<u>From</u>	<u>To</u>
ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION (note a): Roger O. Egeberg (interim)	Oct. 1973	Present
DIRECTOR, NATIONAL INSTITUTES OF HEALTH (note a):		
Robert S. Stone	May 1973	Present
John F. Sherman (acting)	Jan. 1973	May 1973
Robert Q. Marston	Sept. 1968	Jan. 1973
James A. Shannon	Aug. 1955	Aug. 1968
DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH (note a):		
Bertram S. Brown	June 1970	Present
Stanley F. Yolles	Dec. 1964	June 1970

<sup>a</sup>Effective July 1, 1973, the Health Services and Mental Health Administration was abolished and the Public Health Service was reorganized into six health agencies under the direction and control of the Assistant Secretary for Health. Most Health Services and Mental Health Administration functions were transferred to four new agencies: the Center for Disease Control; the Health Resources Administration; the Health Services Administration; and the Alcohol, Drug Abuse, and Mental Health Administration.

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