Expectations for the Comprehensive Mental Health Center: The Community

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ABSTRACT: The process of developing community support for a comprehensive mental health center in a rural and an urban setting is described. The more limited the community in existing services, manpower and economic potential, the more radical the realignment of such resources must be before a center can emerge. In his efforts to obtain community commitment, the mental health professional must be aware that idiosyncratic expectancies of what the center will accomplish are held by the sponsoring agencies. Shaping such diverse aspirations into a realistic program of services is a hazard and a strength of the community mental health movement.

The aim of the community-based comprehensive mental health center focuses upon providing a variety of treatment and preventive services to all citizens residing within the catchment area (PHS 1964). The sheer enormity of such an aim dictates in many instances a major reshuffling of public and private resources, as well as realignment of funding patterns of local, state, and Federal agencies. The more limited the community is in existing services, available manpower, and economic potential, the more radical the realignment must be before a comprehensive mental health center can be contemplated.

A large metropolitan general hospital over a period of years provided some inpatient, outpatient, emergency services, and limited consultation to the courts. Such a hospital experienced minimal difficulty in adding partial hospitalization services and becoming a comprehensive mental health center within two months. Contrast this to a rural county of 80,000 population whose existing mental health resources consisted of an outpatient clinic operating on a $42,000 annual budget, $21,000 coming from local sources, and the remainder from state grant-in-aid funds. Staffing of the clinic consisted

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of a half-time psychiatrist-director who commuted to the area by plane, one psychologist, and two social workers, along with a secretary-receptionist residing in the community served. With the exception of a college in the county employing several guidance counselors and teaching psychologists, no other mental health personnel resided within 30 miles. Approximately eight months were spent in exploring the possibilities of increasing local funds to acquire additional state funds, thereby making the community eligible for Federal grants to establish the required five elements of a comprehensive mental health center. The college, the public school system, the county welfare unit, as well as civic and fraternal organizations were contacted. In appearances before such groups, the thinly veiled question inevitably was posed, "What's the payoff of this center idea, and will it help me or my agency?"

Simultaneously, while trying to explore the possibility of more local financial support (to become eligible for more state support and Federal funding), the clinic staff approached the county general hospital through its administrator. The need for inpatient psychiatric beds in a center is mandatory; and if the county general hospital would not cooperate, then no center could exist. The hospital administrator's reaction was forthright, "What will the hospital gain from such a venture? How much will it cost, and who will pay for it?" After three months of collective bargaining, the hospital board finally agreed that ten beds would be set aside for psychiatric care provided the center staff assume total staffing responsibility and serve as consultant staff to any and all departments within the hospital. After approximately 18 months of meetings, collective bargaining sessions, and drafting of tentative agreements, the rural county mental health center could be committed to formalization.

COMMUNITY ASPIRATIONS AND EXPECTATIONS FOR THE CENTERS

Returning to the large metropolitan general hospital center, since only the mayor, the hospital administrator, and the board of health were involved in the final decision to establish a center, almost all commitments, aspirations, and expectations resided within this group. The problems of crime, alcoholism, hippies, drug addiction, and drug abuse are current concerns of the city administration. The hopes and expectations of the sponsors of the metropolitan center focus on the center's effectiveness in intervening in civic disorder, reduction of social deviancy, and increasing the productivity of its citizen taxpayers. Two years after the establishment of this center, the man on the street as well as heads of other city agencies are not aware that the general psychiatric program has shifted to a comprehensive community mental health center approach. Since historically the general hospital has served indigent patients and minority groups, this expectancy role persists and sooner or later will come into conflict with the comprehen-