

**The Role of Community
Mental Health Centers as
Rural Safety Net Providers**

Working Paper #30 November 2002



UNIVERSITY OF
SOUTHERN MAINE

The Role of Community Mental Health Centers

As Rural Safety Net Providers

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Working Paper #30

November, 2002

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This study was funded by a grant from the federal Office of Rural Health Policy, Health Resources and Services Administration, US Department of Health and Human Services (Grant #CSUR00003-03). The opinions and conclusions expressed in the paper are the authors'. No endorsement by the University of Southern Maine or the funding source is intended or should be inferred.

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ACKNOWLEDGEMENTS

We greatly appreciate the efforts of the individuals who assisted us with completion of this paper, whether by providing background information, participating in interviews, or reviewing and commenting on drafts. The names of staff at the three Community Mental Health Centers that were visited are not provided here for reasons of privacy.

Executive Director and Program Director, Tri-County Mental Health Services, Lewiston, ME.

Executive Director; Chief of Children's Services; Chief of Adult Services; and Clinical Director, Northwest Mental Health Center, Crookston, MN.

Executive Director, Lane County Mental Health Center, Eugene, OR
Clinic Director and clinical staff members, at South Lane Mental Health Clinic, Cottage Grove, OR.

Leslie H. Nicoll, PhD, MBA, RN for her assistance with the preparation of this working paper.

EXECUTIVE SUMMARY

Community Mental Health Centers (CMHCs) have long played an important role in providing mental health services to a broad range of people. When they were originally created by Congress in 1963, federal funding enabled CHMCs to serve all members of the community, regardless of their ability to pay, creating a “mental health safety net.” While CMHCs were by no means exclusively rural, centers in rural areas were typically the primary source of specialty mental health services and were usually the only providers offering sliding fee payment scales.

Changes in funding as well as deinstitutionalization forced many CMHCs to devote an increasing proportion of their resources to individuals defined as members of priority populations. Typically, these priority populations include adults with severe, persistent mental illness (SPMI) and severely emotionally disturbed (SED) children.

Using a comparative case study approach with site visits and interviews with key personnel, this study sought to understand the experiences of three CMHCs serving rural populations in three states: Maine, Minnesota an Oregon. These states represent differences in managed care penetration and county government involvement.

We found that all three CMHCs continued to believe that it was within their mission to act as a mental health safety net, but all three also acknowledged that their priority population is now SPMI adults and SED children. Their ability to serve indigent clients who do not fall into these categories depends on their ability to cross-subsidize such services with funds designated for their priority populations. These providers were also able to fund some safety net services with grant funds made available through federal and regional programs, often targeted to outreach and prevention. In Minnesota and Oregon, county government and county funded social services also supplemented the safety net in meaningful ways. Lacking such county involvement, the Maine CMHC was forced to use waiting lists to manage the demand for free

care. We conclude that county funding and grant writing are two ways that CMHCs have been able to plug the otherwise widening hole in the rural mental health safety net.

RECOMMENDATIONS:

- An explicit discussion on the mental health safety net, both urban and rural, is needed. The Institute of Medicine's report on America's Health Care Safety Net might be a model for such an effort. This discussion must acknowledge how the view of "safety net" held by mental health professionals differs from primary care-oriented definitions.
- Outreach programs that identify individuals in rural communities who are experiencing mental health problems such as stress, depression and anxiety, and refer them to appropriate services should be considered part of the safety net. These programs have proven effective in those communities fortunate enough to have them, but they are typically grant-funded and available in far too few communities.
- The dominance of diagnosis-specific funding in current mental health policy is a barrier to effective intervention with at-risk families. To be effective, the safety net must be funded so as to allow the use of a family systems model when individuals are referred through outreach programs.

Key Words: community mental health services, rural health, mental health safety net, health policy, health care organization and financing

INTRODUCTION

The 1963 Community Mental Health Centers Construction Act (PL 88-164) and its subsequent amendments required grantees to provide five core elements of service: outpatient, inpatient, consultation/education, partial hospitalization, and emergency/crisis intervention (Wagenfeld, Murray, Mohatt, & DeBruyn, 1994). Categorical grant funding enabled community mental health centers (CHMCs) to serve all members of the community, regardless of their ability to pay, effectively creating a mental health safety net.¹ While CMHCs were by no means exclusively rural, centers serving rural areas were typically the primary source of specialty mental health services in these communities and were almost always the only providers offering sliding fee payment scales.

In part as a consequence of the deinstitutionalization movement that began in earnest in the 1960s, many CMHCs abandoned their roles as multiple service agencies to devote an increasing proportion of their resources to the needs of individuals defined by their state mental health agencies as members of priority populations. As evidence of the persistence of this trend, a recent article about the public mental health safety net listed six principles for effective mental health services, all of which were specifically targeted to persons with serious and persistent mental illness (Schnapp, Bayles, Raffoul, & Schnee, 1999). Most state mental health agencies identify these priority populations as:

¹ Our working definition of “safety net” in this paper is derived from the Institute of Medicine’s definition “Those providers that organize and deliver a significant level of health care...to uninsured ...populations....they maintain an ‘open door,’ offering access to services for patients regardless of their ability to pay.” (IOM 2000, pp. 3-4) Since mental health providers often use a slightly different definition of the safety net, we took pains in our methodology to clarify our definition. Our approach is described further in the methods section.

- Children and adolescents under the age of 18 with a diagnosis of mental illness who exhibit severe emotional or social disabilities which are life threatening or require prolonged intervention; and
- Adults who have severe and persistent mental illness such as schizophrenia, major depression, manic depressive disorder, or other severely disabling mental disorders which require crisis resolution or ongoing support and treatment (Diamond, Warner, & Wong, 1998).

By consolidating federal mental health funding into block grants administered by the state mental health agencies, the Omnibus Budget Reconciliation Act of 1981 (PL 97-35) hastened the transition of CMHCs away from their safety net roles. Since 1981, CMHCs have received no direct federal operating grants, and indeed, the title “community mental health center” is no longer an official federal designation, although many mental health clinics continue to use it. Experts in rural mental health have argued that the inadequacy of the CMHCs’ response to the farm crisis of the 1980s and other comparable community traumas was the result of this shift away from meeting the mental health needs of the whole community and toward meeting the needs of priority populations (Beeson, Johnson, & Ortega, 1991; Cecil, 1988).

A recent trend may be bringing rural CMHCs in some states back to their earlier role of providing a broad array of services to the community. In Utah, Oregon and Colorado, for example, CMHCs have become the hubs of Medicaid managed behavioral health care programs (Lambert, Hartley, Bird, Ralph, & Saucier, 1998). Such arrangements may increase the need for communication and formal linkages between CMHCs and other community providers such as community health centers or rural health clinics. While these arrangements do not provide funds to serve the uninsured or

the underinsured, it is possible that they have broadened the focus of rural CMHCs beyond the priority populations that have been their chief concern for the past two decades.

Beyond the immediate cost savings derived from keeping people with serious mental illness out of inpatient settings and in community-based settings, managed care has the potential to create incentives for CMHCs to provide more preventive mental health services than have been typical in recent years. In addition, in states with a strong county government involvement in the financing and delivery of mental health services, the local focus provided by the county combined with the financing mechanisms of managed care may enable CMHCs to resume the role of safety net provider.

This paper reports findings from comparative case studies of three CMHCs that serve rural communities. We selected CMHCs in states with which we were already familiar due to prior work in Medicaid managed behavioral health care (see, for example, (Hartley, 1998; Lambert, Gale, Bird, & Hartley, 2001; Lambert et al., 1998). From this group, we chose states in which county involvement in mental health financing and delivery and penetration of Medicaid managed behavioral health care varied from weak to strong. Using a combination of telephone and in-person interviews with CMHC administrative and clinical staff as well as other community members, we sought answers to the following questions:

- To what extent do those organizations formerly designated as community mental health centers currently act as a rural mental health safety net, e.g., provide mental health services for free or at reduced charges to rural populations not covered by public or private insurance or grants?

- Where do uninsured rural residents not covered by priority-population-targeted funds receive mental health services?
- Do rural CMHC staff perceive their mission to include a commitment to provide mental health services to all in the rural community who cannot afford to obtain them from mental health professionals in private practice?
- How much do CMHCs that serve rural populations vary in terms of the services they provide and the population groups they serve?
- To what extent is this variation explained by the role of county involvement in mental health financing and delivery? To what extent is this variation explained by Medicaid managed care penetration?

BACKGROUND: THE EVOLVING ROLE OF CMHCS

Mental Health Services and Policy in the U.S. Prior to the 1963 CMHC Act

The National Mental Health Act of 1946 (PL 79-487) established the National Institute of Mental Health (NIMH) and charged the organization with three broad functions:

- Aid to states in developing programs to address mental illness and thus reduce the need for institutional care;
- Development and promotion of training for mental health professionals; and
- Promotion and conduct of mental health research (Buck, 1984).

In order to fulfil the first of these functions, Congress authorized NIMH to administer block grants to the states to develop and expand mental health services, including outpatient care, screening for inpatient care and community based prevention (Buck, 1984). The NIMH block grant program exercised a dramatic effect on the development of outpatient mental health clinics. Between 1947 and 1964, the number of clinics more than doubled, increasing from 850 to 1,930 (Buck, 1984). While little clinic

development occurred in rural areas during this period, it is reasonable to surmise that some urban clinics offered services to residents of nearby rural communities (Buck, 1984).

Although federal support for these clinics increased during the late 1950s and early 1960s, the program came to represent a decreasing share of total NIMH grants and of federal funds spent on community-based mental health services. On the other hand, from 1950 to 1960, state spending for community-based mental health services increased more than tenfold from \$5.1 to \$60.3 million (Buck, 1984). In part, this was a response to mounting concerns about the growth of the inpatient population in state hospitals and a recognized need to shift to more humane community-based models of care.

The national movement to provide community-based mental health services to a broad segment of the U.S. population began at a 1953 conference on mental health cosponsored by the American Medical Association (AMA) and the American Psychiatric Association (APA). Out of this conference came a recommendation for a study to develop national standards for treatment of the mentally ill. In 1955, the World Health Organization published a study indicating the need for community-based treatment of the mentally ill. Several European countries were ahead of the U.S. in their development of community-based residential care and outpatient services for persons with mental illness (Chu & Trotter, 1974). In this climate of concern, Congress agreed to sponsor the study recommended by the AMA/APA conference, passing the Mental Health Study Act (PL 84-182) on July 28, 1955.

The study was conducted by a nonprofit corporation, the Joint Commission on Mental Illness and Health, which had been formed by the AMA and APA with partial financing from a major pharmaceutical manufacturer (Dorwart & Epstein, 1993). In

1960, at about the time John F. Kennedy assumed office as President of the United States, the Joint Commission released its report, *Action for Mental Health*. The report recommended building on the structure already developed by state governments using the NIMH-funded community clinic model. This approach was intended to bolster the state hospital system and maintain state control over the clinics (Buck, 1984).

The *Action for Mental Health* findings influenced an address President Kennedy made before Congress on February 5, 1963. In this address, Kennedy emphasized poverty as a causal factor in mental illness and called for community prevention efforts specifically directed toward low-income people. Kennedy also proposed a fifty-percent reduction in state hospital populations across the country over the next ten years (Dorwart & Epstein, 1993). In response to the report, President Kennedy also formed an interagency task force on mental health headed by his Secretary of Health, Education and Welfare, Anthony Celebrezze. The task force included representatives from the Veteran's Administration, Department of Labor, Bureau of the Budget and the Council of Economic Advisors (Chu & Trotter, 1974). Professionals from NIMH staffed the group.

The Celebrezze Task Force released its findings in December 1962, proposing a federal categorical grant program that would create a national network of community mental health centers. During the subsequent hearings regarding the proposed Community Mental Health Centers Act, both the Kennedy Administration and Congress elected to follow the Task Force recommendations rather than those from the *Action for Mental Health* study (Buck, 1984; Grob, 1991). The moral values of the era, asserting the primacy of civil and human rights, coupled with intensely negative criticism of state governments as providers of care, influenced these choices.

During the period prior to the adoption of the CMHC Act, members of the psychiatric profession were divided into two camps regarding the preferred model for

organizing and delivering mental health services. One supported the public health model of mental illness, which focused on prevention, education and community care. The tenets of so-called community psychiatry had much in common with the emerging anti-poverty movement, so these groups tended toward a natural alliance (Rochefort, 1984). The other camp took a more traditional, “medical model” stance that focused on expansion of the state hospital system and state government control of community-based services (Chu & Trotter, 1974). While the second group, in combination with the AMA, influenced the development of the Joint Commission report, the first group influenced the Celebrezze Task Force and the Kennedy Administration.

Likening community care to “socialized medicine,” the AMA also allied itself with state government administrators in opposition to the CMHC Act (Rochefort, 1984). The latter vigorously opposed the Act due to the proposed shift in the locus of control and funding away from states (Chu & Trotter, 1974). In their defense, most state government leaders supported deinstitutionalization for both humanitarian reasons and as a means of controlling rising institutional care costs. Supporters of the public health model blamed state governments for the failings of the institutional mental health system and its well-publicized abuse and neglect of psychiatric patients. The alliance of community psychiatrists and community mental health activists successfully characterized state government leaders as personally responsible for the persistent evils of custodial care. The lingering resentment of state mental health program directors toward the psychiatrists who ran many of the new CMHCs established a persistent barrier to coordination between the two sectors of the public mental health system.

Expansion of Community Mental Health Center Facilities and Roles, 1963-1981

President Kennedy signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act (PL 88-164)---commonly known as the CMHC Act---into law on October 31, 1963. It represented a deliberate shift of control over the community mental health system from the states to the federal government (Bloche & Cournos, 1990). More critically, the Act created a split in authority and responsibility between the state hospital system of institutional care and the system of community-based mental health care intended to serve as a means of controlling admissions to the state hospital system (Bloche & Cournos, 1990; Levine, 1981). Over the next 15 years, the census of state and county mental hospitals declined by about two-thirds, while federal funds supported the establishment of more than 500 community mental health centers (Rocheftort, 1984). In testimony presented to Congress in 1980, NIMH staff reported that 37% of the CMHCs served rural areas [Foley & Sharfstein, 1983]

Due to the push to pass comprehensive social legislation in a volatile political climate, the CMHC role described in the Act was broad and open to interpretation. To be eligible for federal funds, centers had to provide the following:

- *Inpatient services*, either directly or through referral by screening patients for hospitalization;
- *Outpatient services*, although neither target populations nor specific services were defined;
- *Partial hospitalization services*, the precursor to day treatment programs for discharged hospital patients;
- *24-hour emergency services*, available as part of at least one of the other three services; and
- *Consultation and education services*, for professionals and community agencies.

The law also encouraged provision of an additional five services (*rehabilitation, diagnosis, pre- and aftercare, research /evaluation and training*), which entitled a CMHC to use the “comprehensive” designation. In part because the Act failed to define priority service populations, many CMHCs did not assume responsibility for the aftercare of patients discharged from the state hospitals. While the population of these facilities dropped rapidly during the 1960s in accordance with the goals of the Kennedy Administration and many state legislatures, many people with serious and persistent mental illness were discharged into community settings with little or no follow-up care (Chu & Trotter, 1974; Grob, 1991).

Although the CMHC Act required centers to serve a defined geographic catchment area, the law also included minimal requirements regarding services to low-income people, suggesting merely that centers provide “...a reasonable volume of services to the indigent” (Chu & Trotter, 1974). This is surprising given the deliberate linking of mental illness to poverty expressed by both the Kennedy Administration and the community mental health movement. This lack of specificity regarding the CMHC role in serving low-income populations allowed for considerable latitude in CMHC policies and practices. Provision of services to low-income people varied significantly from center to center, depending on the extent to which center leadership viewed such activity as mission-critical.

With the expectation that the facilities would eventually become self-sufficient, Congress built time-limited and declining federal support into the CMHC Act (Dorwart & Epstein, 1993). In addition, the initial grants supported construction but not staffing (Connery et al., 1968). As a consequence, operating funds were an issue from the inception of the program. Many CMHCs developed serious financial difficulties within a few years of opening. This dilemma prompted them to market services to individuals

covered by health insurance at the expense of other, more needy, populations (Grob, 1991). Some critics argued that the centers under-performed in serving both low-income people and people with serious and persistent mental illness (Chu & Trotter, 1974; Dorwart & Epstein, 1993). A more charitable view is that CMHCs were simply overwhelmed with the demands for service and the range of needs of the diverse groups that comprised the very loose definition of those with mental illness and could not respond adequately given their considerable resource limitations (Dowell & Ciarlo, 1983).

A series of amendments to the original Act attempted to address some of these shortcomings. For example, following the 1964 Democratic landslide, Congress overcame resistance to the use of federal funds to cover CMHC staffing and increased the number of mandated services to twelve (Levine, 1981). The additions included services to children and the elderly as well as substance abuse treatment services and aftercare for deinstitutionalized people (Schnapp et al., 1999). Other amendments changed the language of some of the service definitions to reflect the growing pressure to provide case management and care coordination to people discharged from state hospitals (Grob, 1991; National Institute of Mental Health, 1978).

Reliance on the federal government to address problems of poverty, disease and disability continued with the enactment of the sweeping policies associated with the Great Society. From the viewpoint of the CMHCs, the most important of these were Medicaid, Supplemental Security Income, (SSI) and Social Security Disability Insurance (SSDI). Particularly in its early years, the Medicaid program encouraged states to prefer nursing homes and psychiatric wards in acute care hospitals as sites of care for people with serious and persistent mental illness (Gronfein, 1985).

Community-based mental health services expanded throughout the 1960s and 1970s, in part as a consequence of the growing number of clinicians setting up private practices (Mechanic, 1994). Nevertheless, the lack of community-based services for people with serious mental illness coming out of state hospitals remained an apparently intractable problem. Its urgency was amplified in many states by highly publicized class action suits and resulting consent decrees that required state mental health agencies to assume responsibility for redressing the consequences of years of neglect (U.S. General Accounting Office, 2000).

In response to these and other concerns, in 1977, President Carter appointed a Commission on Mental Health to study the need for further changes in the nation's mental health system. The Commission's recommendations, released in 1978, focused on increased funding of mental health services, particularly for people with serious and persistent mental illness and other priority population groups (Foley and Sharfstein, 1983). These recommendations were codified in the Mental Health Systems Act (PL 96-398), which President Carter signed into law on October 8, 1980, a month before he lost the election to Ronald Reagan.

OBRA 1981- The Return of Authority to the States

Ronald Reagan won the 1980 election with promises to reduce government waste and regulation and to return responsibility for many social programs to the states. This platform was known as the New Federalism. One of the keystones of the New Federalism was the Omnibus Budget Reconciliation Act of 1981 (PL 97-35, also known as OBRA 1981). OBRA 1981 and its resulting administrative rules included several provisions directly affecting the status, mission and viability of CMHCs (Dorwart & Epstein, 1993; Mechanic, 1994), such as:

- Repealing the Mental Health Systems Act;

- Withdrawing direct federal categorical grant support from the CMHCs and replacing that funding with Alcohol, Drug Abuse and Mental Health Block Grants to the states;
- Through the block grant mechanism, returning to the states the primary authority for deciding how and to whom mental health services should be provided;
- Reducing overall federal funding for mental health service delivery and reallocating funds to substance abuse treatment services;
- Eliminating the federal requirements regarding CMHC utilization reporting; and
- Ceasing to make official use of the term “community mental health center” to describe a unique entity.

Both the CMHCs and the state mental health agencies were compelled to adapt to these dramatic changes in the policy and funding environment. As we have already noted, the states were already under considerable pressure to move people with serious and persistent mental illness out of state institutions and into the community. Many states took advantage of the shift in control mandated by OBRA 1981 to contract with CMHCs to provide services to de-institutionalized or other priority populations (Bachman, 1996).

With federal support for community mental health services declining by over 20% from 1981 to 1983, fears of financial insolvency resurfaced among CMHCs (Hadley & Culhane, 1993; Sorensen, 1985). However, very few CMHCs closed or merged as a result of these changes. As of 1991, 672 (88.3%) of the 761 CMHCs in operation in 1981 were still providing services (Hadley & Culhane, 1993). Reductions in staff and increased efforts to shift services toward paying clientele were common strategies adopted by centers in an effort to assure survival (Drolen, 1990).

By the early 1990s, the picture was starting to get brighter. From 1987 to 1997, state spending on mental health services increased by over 2%. Federal spending during the same period increased by over 6 percent, in large part as a consequence of increased reliance on Medicaid funding for these services (U.S. General Accounting Office, 2000). The Alcohol, Drug Abuse and Mental Health Administration Reorganization Act of 1992 (PL 102-321) established a community mental health services block grant specifically aimed at supporting services for children with serious emotional disturbances and adults with serious and persistent mental illness (Friedman, Katz-Levy, Manderscheid, & Sondheimer, 1996).

Community Mental Health Centers Enter the 21st Century

While many CMHCs have survived, their service priorities and the locus of control over these priorities have changed substantially. A common practice among CMHCs and other health care providers has been to use revenues produced by paying patients combined with support from federal, state and local government to cover the costs of caring for low income uninsured people. However, a number of forces have combined to change the practices of insurers, providers and government agencies, leaving each less willing to pick up a share of the costs of these so-called safety net populations (Dorwart & Epstein, 1993). For example, some states that have adopted managed behavioral health in their Medicaid programs have contracted with CMHCs to provide mental health services to all Medicaid clients, although the emphasis may continue to be on Medicaid's SSI population, and the nature of these contracts may make it more difficult to subsidize services to the uninsured.

The intent of the 1963 CMHC Act was twofold. Economically disadvantaged groups were considered at greatest risk for development and exacerbation of a wide

variety of mental health problems, so the law sought to make mental health services available to all who needed them regardless of financial means (Foley and Sharfstein, 1983). The legislation also sought to coordinate and integrate services for people with serious and persistent mental illness returning to the community from the state hospital system. While the federal designation of CMHCs has changed, these two goals remain the most consistent basis for measuring the performance of the publicly funded mental health system in the United States.

Community mental health centers remain the only real option for mental health treatment for low income uninsured people, yet the availability of services for this population have steadily decreased in the last twenty years. These individuals often sit on CMHC waiting lists for extended periods or are turned away due to a lack of funds for services other than those targeted to priority populations. While Medicaid provides financial access to mental health services for people poor enough to qualify, CMHCs still are caught between state priorities and local need with limited staff and resources.

Understanding this background and context, this study was undertaken to learn more about the role that CMHCs are playing in serving as a rural safety net. We decided to use interviews and a comparative case study approach to provide an in depth look at services and populations served by three rural CMHCs.

METHODS

Sample

CMHCs in three states were selected for the case study. Rationale for CMHC selection included:

- Serves a substantial rural population as part of its catchment area;
- Has a well established history of providing mental health services;

- Key leadership personnel in the organization were willing to participate and host a site visit.

CMHCs were differentiated on two key variables: amount of managed care penetration in rural mental health services delivery within the state and level of county government involvement in the funding or delivery of mental health services to the general population. Potential CMHCs were identified through referral and networking. After preliminary contact with several CMHCs, three were selected for inclusion in this study:

- Tri-County Mental Health Services (TCMHS) , Lewiston, Maine (representing limited managed care penetration and no county government involvement in funding);
- Northwestern Mental Health Center (NWMHS) , Crookston, Minnesota (representing limited managed care penetration and strong county government involvement in funding);
- Lane County Mental Health Center (LaneCare), Eugene, Oregon (representing total penetration of managed care and strong county government involvement in funding).

We had originally hoped to have a fourth site, representing strong managed care penetration and limited county government involvement (such as is found in Colorado) but we were unable to secure the necessary permission for participation.

Data Collection

Data were collected using face-to-face interviews during site visits, and follow up interviews by telephone. Additional questions were answered by email. Additional data were collected by reviewing printed materials provided by the CMHC, such as financial and clinical data. The site visits to each CMHC lasted one and one-half days. Interviews were held with the administrator, healthcare and social services providers, and

consumers in each selected community. In order that consistent information be collected from each site, an interview protocol guided the conversation (see Appendix A). The protocol was used as a guide; the site visitor could probe more deeply on any question to obtain information relevant to the purpose of this study. General questions addressed by the protocol were:

1. The range of services provided;
2. New services offered;
3. Service populations (Medicare, Medicaid, privately insured, uninsured, special populations);
4. Other mental health providers in the community;
5. Integration of services with primary care (or with social services); and
6. Existence of formal linkages or network affiliations.

To assure that our informants attention was directed to the safety net population as we have defined it, we provided several of our informants with brief vignettes describing typical patients who might seek services. CMHC clinicians often see their SPMI clients as “safety net” because those clients are so dependent on the CMHC for services. However, by virtue of their disability, these consumers almost invariably qualify for Medicaid coverage, and the services provided to them are well-funded. The vignettes describe clients whose symptoms and history are not likely to qualify them as disabled, and who, therefore, must pay out of pocket since they are described as uninsured. (See appendix A for the vignettes.)

Our analysis took the form of comparative case studies, using the catchment area served by the community mental health center as the unit of analysis. We hypothesized that CMHCs that have contracted to provide services to the general Medicaid population (e.g., TANF beneficiaries) under a Medicaid managed behavioral

health care program will serve a broader population than those operating in the fee-for-service environment. Similarly, in states where county governments control a significant portion of mental health spending, county mental health officials may be interested in serving the needs of the entire population, rather than limiting services to those with serious and persistent mental illness. Thus, we believed that CMHCs in such states are also likely to serve a broader population. To serve this broader population, a wider array of services is likely to be offered.

FINDINGS

The Centers: A Snapshot

All three centers had similarities but were decidedly different from each other. All three have been in existence for at least three decades. Tri-County Mental Health Services (TCMHS) in Lewiston, Maine, was established in 1951 and is the oldest continuously operating CMHC in the state. Northwestern Mental Health Center (NWMHC), in Minnesota, started providing services in 1958 and has been a designated CMHC since 1962. Lane County Mental Health Center, in Oregon, was established in 1969.

All three centers are located in designated metropolitan areas, but serve rural populations. TCMHS is located in Lewiston, which is part of the Lewiston-Auburn metropolitan area. Rural residents are served through satellite offices located in non-metropolitan Franklin and Oxford counties as well as western Cumberland county. These are contiguous counties in central and western Maine and cover an area of approximately 4246 square miles.

The population of the three county area is approximately 189,095 (U.S. Census Bureau, 2002) which is 14% of the total population in the state. The population is 97.5% white. Population change in Franklin and Androscoggin counties was negligible between 1990 and 2000, while Oxford county had 4.1% growth. Approximately 12.5% of the population lives below the federal poverty level and approximately 17% of the adults over 25 have less than a high school education. Persons over 65 make up 15% of the population while children under 18 make up 24%. The 2000 annual average unemployment rate for Androscoggin County was 3.5%, identical to the statewide average for this period. Rates for Franklin and Oxford Counties were 6.6% and 5.4%, respectively. The most recent state-level estimates from the Current Population Survey suggest that, as of 1999, the overall rate of uninsured in Maine was 11.8%, about four points lower than the national rate.

NWMHC is located in Crookston, Minnesota, which is designated as urban by the federal Office of Management and Budget, due to its adjacency to Grand Forks, North Dakota. However, throughout most of NWMHC's history it has been designated rural and its six county catchment area includes 4 rural counties (Mahnomen, Norman, Polk, Red Lake) and two frontier counties (Kittson and Marshall). The six counties cover an area of approximately 6703 square miles.

The population of the six county area is approximately 98,658 (U.S. Census Bureau, 2002), which is 1.9% of the total population in the state. In five of the six counties, the population is 96.4% white. The exception is Mahnomen County, with 28.6% of the population being of American Indian descent, primarily members of the White Earth Band of Ojibwa. Mahnomen County is also the only county that increased its population since the 1990 census (2.9%). Approximately 11.5% of the population lives below the federal poverty level and approximately 20% of the adults over 25 have less

than a high school education. Persons over 65 make up 19% of the population while children under 18 make up 26.1%. The unemployment rate in 1999 was 3.1%. According to the Minnesota Rural Health Association, the most recent state statistics indicate that northwestern Minnesota has an uninsured rate of approximately 14%.

Lane County Mental Health Center is located in Eugene, Oregon which is part of the Eugene/Springfield metropolitan area. Lane County is the second most populous and fourth largest county in Oregon and covers an area approximately the size of Connecticut (4554 square miles). It extends west from Eugene to the Pacific coast, east to the Cascade Mountains, and south to the town of Cottage Grove. Satellite facilities serve the rural areas of Lane County in Florence (Options Counseling Services) and Cottage Grove (South Lane Mental Health Clinic).

The population of Lane County is approximately 324,316 (U.S. Census Bureau, 2002), which represents 9.3% of the total population in the state. The population is 90.6% white. Approximately 14.4% of the population lives below the federal poverty level and 12.5% of the adults over 25 have less than a high school education. Persons over 65 make up 13.3% of the population while children under 18 make up 22.9%.

Center Histories and Current Status

All three centers reflect the ebb and flow of funding that changed with federal and state law as well as health and social policy, as noted in the background presented earlier. In Maine, TCMHC has been in continuous operation since 1951, when it was established as the Catholic Bureau of Social Services. In 1966, it merged with the Androscoggin Mental Health Clinic, a satellite of the Augusta Mental Health Institute. That same year, TCMHC received a CMHC construction grant for the facility in Lewiston. In 1967 it was renamed the Child and Family Mental Health Center and was the first CMHC in the state to receive a staffing grant from the National Institute of Mental Health.

The board adopted the name Tri-County Mental Health Center in 1972, following mergers with Oxford County Mental Health Association and Franklin Area Mental Health. The organization assumed corporate responsibility for Western Maine Counseling Services in Bridgton in 1993.

At the present time, TCMHC maintains administrative offices and a primary service location in Lewiston. Outpatient mental health and substance abuse treatment services are also available at satellite offices in Livermore Falls, Farmington, Kingfield, Bethel, Rumford, South Paris and Bridgton. The annual report in 1998 listed 347 part-time and full-time clinical and administrative staff. TCMHC provides a wide range of services, including:

- Outpatient services;
- Substance abuse counseling;
- Specialized children's services;
- Geriatric services;
- Intensive case management;
- Community support services;
- Residential care (group homes);
- Short term respite care/crisis stabilization;
- Emergency services;
- Day treatment; and
- Referral to inpatient services.

Inpatient mental health services for residents of this region are primarily centered at St. Mary's Hospital in Lewiston. Hospitals in Farmington, Norway and Rumford are able to provide crisis stabilization and emergency overnight psychiatric care.

In Minnesota, NWMHC has been a CMHC since 1962, but was providing services without the CMHC designation since 1958. Its early mission was to provide a broad range of services, from prevention to tertiary, to a wide range of populations. Its mission has changed along with changes in the state system. While emphasis is now on two special populations, adults with serious and persistent mental illness (SPMI) and seriously emotionally disturbed children (SED), prevention, family services and an array of other services are also offered. There has been a dramatic growth in children's services, especially following the 1989 community mental health act for children.

NWMCH has a total of 65 FTEs, including 26 in adult services, 14 in children's services, 6 in outpatient services and various support staff. The staff includes a part-time child psychiatrist, a locum tenens psychiatrist, and one state hospital psychiatrist who visits once a week. During the site visit, it was noted that plans were underway to hire a full-time psychiatrist within the next six months.

NWMHC provides a wide variety of services, including:

Counseling for Children, Families, and Adults:

- Counseling and therapy for personal, marriage, and family problems.
- Medication for certain psychiatric problems.
- Psychological testing of intelligence, personality, school abilities, and other needs.
- Help for mental health problems related to drug or alcohol abuse, including coordination of mental health services with other agencies that specialize in drug and alcohol treatment.
- Specific ways for handling stress, depression, and anxiety.

Family Based Services:

- In-Home Services: Early Intervention, Family Community Support Services (Family Ties), and Professional Home-Based Family Therapy aimed at providing necessary supports to families with children who are at risk of out-of-home placement. This support is provided through: in-home skills-building, outreach support services, family therapy, and coordination with schools and/or other agencies that impact the lives of children and families.
- Crisis services including: respite provider network, mobile crisis outreach services, and in-home skills-building aimed at crisis prevention and crisis management.
- Therapy for children who are victims of physical, emotional, or sexual abuse.
- Support services for the families of abuse victims.

Services for Adults with Long-term Mental Health Needs:

- Northwestern Apartments — a residential center for intensive treatment and skills training; treatment includes follow — up services after people are discharged.
- Community Support Program — personal support services and home visits to help adults who suffer from severe psychiatric disorders remain in the community and improve their level of functioning.
- Day Treatment — a program to teach vital skills, and provide support in the local community.
- Psychiatric Consultation — provides medication management.

Additional Services:

- Mental health services for homeless adults and families.
- Psychological evaluations: intellectual and academic ability; personality assessment; competency; child custody disputes; civil commitment hearings; peace officer evaluations

- Employee Assistance Programs for State employees and people employed with several other organizations.
- Intensive treatment program for sex offenders who have sexually abused children or adults.
- Therapy for adults who were sexually abused as children or teens.
- Domestic Abuse Treatment Program for offenders including therapy for adults who are now in relationships (or have recently been in relationships) where hitting or other physical abuse occurred.
- Emergency crisis intervention, and supportive therapy for victims of "Post-Traumatic Stress" resulting from violence or other trauma

Many of these services are provided at the Crookston facility, although some outpatient services are provided at satellites in East Grand Forks and Mahanomen. Some residential and day treatment services are at separate locations in Crookston. However, services to the two special populations (SPMI adults and SED children) are primarily delivered by outreach staff in the home, school or community. These staff live and work throughout the six counties. They do some day treatment in church basements, and children's services are delivered in the schools. "The car is the office, or sometimes they have an office in the school." Clinical supervision is by telephone, with staff meetings in Crookston every two weeks. Some thought has been given to cross-training staff from SPMI services to deliver outpatient services (to populations other than SPMI) in outlying areas. Currently, "people within 25 miles are getting much more access...than others in those very small communities."

Lane County MHC was established in 1969. Like many community mental health centers, it has developed its approach to management and delivery of mental health services by responding to categorical funding. Currently, it is a program within the Lane

County Department of Health and Human Services. The program operates two separate clinics, one for adults and a second for families and children, in Eugene. It subcontracts to 14 other agencies throughout the county, including satellite clinics in Florence and Cottage Grove. Lane County also operates its own psychiatric hospital. In the late 1980s, funding for mental health services was in a flux and a levy was passed for the county to build its own inpatient psychiatric facility. Lane was the only county in Oregon to have done this and receives about \$500,000 a year from state funds to run the hospital.

Lane County MHC provides the following services:

- Adult mental health
- Adult residential mental health
- Child and adolescent mental health
- Civil commitment
- Crisis assessment and intervention
- Inpatient care at the Lane County Psychiatric Hospital

The priority populations for Lane County MHC are adults with severe, persistent mental illness and severely emotionally disturbed children who are at risk of hospitalization and whose illness severely impacts their day-to-day functioning. Lane County MHC, through its subcontracts to 14 community based agencies provides a wide range of services for “softer” mental health problems.

Staffing for Lane County MHC Adult Clinic is approximately 23 FTEs and includes administrative staff (director, manager, office support) and clinicians (supervisors, MSW, psychiatrist, psychologists, nurse practitioner RNs). There are 9 FTEs for the Family and Child clinic including administrative staff, MSW and LCSW

clinicians, psychiatrist, and psychiatric nurse practitioner. The satellite clinics in Florence and Cottage Grove have 4-5 FTEs each.

Funding

As noted earlier, TCMHC in Maine was selected to represent a state with low managed care penetration. Funding for TCMHC comes primarily from Medicaid, approximately 80% of its \$12.5 million budget. So important is Medicaid as a source of revenue for the Center that it employs dedicated staff to determine the Medicaid eligibility of new clients. The budget has increased from \$2 million in 1980; there has also been a concomitant increase in staff.

The annual budget for NWMCH is approximately \$3.2 million. About half of the operating revenue comes from state block grant funds. An additional 13% comes from county funds, 13% from Medicaid and nearly 20% from a mixture of federal and foundation grant funds. It is these grant funds that have enabled NWMHC to offer safety net and prevention services. Self-pay and insured clients account for only 3% of total revenue.

In Minnesota, the Community Social Services Act of 1980 turned all mental health dollars over to the county. In response, the counties developed a sliding fee scale for the uninsured. Under this arrangement, the county paid NWMHC for some safety net services, then collected from the patient on the sliding fee scale. Over the ensuing decade the counties were given less discretion each year because the state observed inconsistencies in county priorities that it (the state) found unacceptable. The 1987 Community Mental Health Act for Adults and the 1989 Community Mental Health Act for children have changed the funding stream, and targeted specific services to specific populations. Counties now receive block grant funds from the state Department of Mental Health to provide services for specified populations (adults with serious or

persistent mental illness, and seriously emotionally disturbed children). The counties then contract with providers in the area for needed services. The counties have little discretion as to how much will be spent, or what kinds of services will be provided, but the choice of vendor is theirs. CMHCs have had to change from seeing the county as a "parent" to seeing the county as a "primary stock holder."

In this region of the state, NWCMHC is the only vendor with which counties can realistically contract. One informant had worked in an area where the county had a choice of vendors, and found it to be very politically charged, to the detriment of continuity of services.

Lane County MHC in Oregon operates within a relatively stable annual budget of \$14 million that covers mental health services provided by LCMHC and all other provider agencies serving the LaneCare population. Lane County MHC establishes its own rates for services, some of which are higher than reimbursed under the Oregon Health Plan. Current sources of income include the state general fund; third party reimbursement, which includes the Oregon Health Plan and Oregon Medical Assistance Program (Medicaid) and a sliding fee scale for clients. Substance abuse is completely separate. Lane County MHC does not provide these services, nor are they reimbursed for them. The state is trying to find a way to establish payment for dual diagnosis clients.

Oregon has a Medicaid managed behavioral health plan. This was done under the auspices of and within the context of the Oregon Health Plan (OHP). The OHP was developed to expand health coverage to low income persons and to control the steady increase in healthcare costs. In designing the behavioral health component of the OHP, the state mental health agency had four major goals: increase health coverage for the poor; impose budgetary discipline and predictability; improve the array of services offered; and increase flexibility in the administration of services. The state mental health

agency was guided by two principles in trying to achieve these goals: change should be incremental and the mental health safety net must be maintained (Kast & Goetz, 2000). Eligibility and expansion under the OHP was intended, in part, to ease the increasing burden on the mental health safety net, particularly as Oregon continued to reduce inpatient psychiatric beds. However, Oregon mental health policymakers recognized that there would still be uninsured persons needing mental health services or insured persons in the community who could not access the mental health services they need. Mental health agencies that have traditionally been safety net providers might find that role more difficult to perform under the financial constraints of managed care.

Under the OHP, counties—either individually or in multi-county collaboratives—would have their mental health services delivered through a managed care organization (MCO). The state’s preference was for MCOs to be national managed behavioral health organizations with significant managed care experience and administrative and financial infrastructure (Lambert et al., 2001). Counties—either singly or in collaboration—were also eligible to be MCOs. Lane County MHC chose to be its own MCO. It is named LaneCare and operates under a capitated risk arrangement. It was a fight for LaneCare to become an MCO. The state preferred national MBHOs to get the contracts. Lane County MHC believed it had a great system and did not want it “messed up” by an outsider. They fought for and became the MCO for Lane County MHC.

The Rural Safety Net

In Maine, staff at TCMHC responded to our vignettes by acknowledging that none of the clients described therein were part of their priority population. The case involving substance abuse could be referred to an existing substance abuse treatment provider, funded through a different state department. They indicated that there would

be an effort to serve the other cases described in the vignette, simply absorbing the cost of providing such services in the annual budget. They also acknowledged that this budget is unable to meet all such needs, and that their primary means of managing indigent care when the budget cannot accommodate it is to place clients on a waiting list. Anecdotally, it should be mentioned that these waiting lists exist in both urban and rural areas, and are widely acknowledged as evidence of provider shortages and unmet needs. With no county infrastructure or human services budget, the county is not involved in addressing these needs.

The staff at NWMHC in Minnesota was familiar with the concept of the safety net, although they tended to re-define the population in their terms: services to adults who are not seriously mentally ill are referred to as “outpatient” services. The other category of safety net services is prevention, such as prevention of suicide and domestic violence. These often involve providing therapy to individuals who are rarely insured for mental health services. These services—outpatient and prevention—NWMHC is struggling to maintain. Changing funding priorities has placed these services in jeopardy.

One informant noted that the county is responsible for children and adults who are at risk, but has never had a mission to serve the general population. When NWMHC offered services to the safety net population, the county saw this as “irrelevant” and asked, “Why don’t you get to the real mental health issues?” When funding was controlled primarily by the county in the early 1980s, NWMHC was on the brink of going out of business. Although the state stated that prevention was important, it was not funded.

At NWMHC, there has been no growth in outpatient staff or reimbursement rates since the mid-1980s although the therapists are reportedly delivering twice as many

units of service. They are seeing more patients per day in shorter sessions. The course of therapy is brief, averaging 3.3 visits per client served.

Despite the fact that the two special populations (SPMI adults and SED children) seem to dominate the funding mix, the staff believe that the funding for these populations has sustained the agency and created opportunities to serve the safety net population. The county offers small subsidies (\$160,000 – \$200,000 year) for outpatient services, primarily to the parents of children served by other county programs. Even so, outpatient services operate at break even levels or have lost money. Additional funding to provide services to uninsured adults and to cover prevention programs comes from grants. For example, the Safe Schools program is funded by the Department of Justice with additional funding from DHHS and the Department of Education to address violence in the schools. There is also a grant funded, 16 week domestic abuse program in which participants pay a \$10 copay per session. A \$60,000 grant from a regional bank is being used to help farm crisis victims.

Despite the changing relationship between NWMHC and the county, and despite staff claims that the county does not see the safety net as a priority, the county continues to be a partner in supporting safety net services, as evidenced by its contribution to adult outpatient services.

The NWMHC appears to be committed to serving the safety net population and is managing to do so through grant funding and collaboration. Some of these funds have become available because of the series of disasters that have shaken this community, including the ongoing farm crisis and the flood of 1997. Other funds have become available due to the ability of NWMHC to respond to new federal and state initiatives directed at domestic violence and safe schools. Partnering with the county, the school system, the local branch of the University of Minnesota, Rural Life Outreach and other

local and state agencies has helped to secure grant funding and to keep NWMHC in touch with its community.

In Oregon, Lane County MHC sees its primary mission as service to the most seriously mentally ill, those with serious and persistent mental illness and severely emotionally disturbed children. Services provided by LCMHC in Eugene are almost exclusively provided to these populations, although 10 -15% of their clients do not have sufficiently serious symptoms to qualify as disabled, and are therefore indigent. Lane County MHC identifies its priority population as adults and children at risk of hospitalization or those whose illness severely impacts their day-to-day functioning. Others not meeting this threshold are referred to other agencies. LaneCare, the MCO, covers most of these other mental health needs under the Oregon Health Plan. Clients who do not qualify for Medicaid or the Oregon Health Plan, and whose needs are not severe, are usually able to find services at one of the 14 human service agencies in the county. It should be noted here that Eugene and the surrounding area are rich in human services, and benefit from a strong, progressive county government. The University of Oregon produces professional graduates and contributes to Eugene being a desirable place for mental health professionals to live and work. This service rich environment, backed by county funding, allows Lane County MHC to limit its service to the more severe populations in the Eugene area.

Lane County MHC has done well under managed care by limiting its service focus and staffing. The role as a safety net for children is growing because of grants that the Center has pursued. Indigent persons with “softer” mental health problems can be referred to other agencies that have the support to treat them. The story we heard from the satellite clinic in Cottage Grove is somewhat different. Although this clinic is considered part of Lane County MHC, it sees its mission as somewhat broader. Cottage

Grove has few alternate resources, and the clinic staff feel that the population may not understand being told that their problems are not serious enough to qualify for services at the clinic. As the clinic director told us, “We would lose credibility in the community if we turned people down.” Thus, the satellite clinic provides some services to the uninsured with less serious emotional problems. Staff at both the parent clinic in Eugene and the satellite in Cottage Grove acknowledge that persons with mental problems who live in more remote parts of the county, including those residing just a few miles inland from Florence and Cottage Grove, have considerably less access to services.

CONCLUSION

We found that staff at each of these three rural mental health centers, formerly designated as CMHCs, continued to believe that it was part of their mission to act as a mental health safety net as we defined it. We found that the extent to which they were able to do this was determined by their ability to subsidize outpatient services to the indigent with block grant funds that were designated for those with more serious mental illness, their ability to successfully seek funding from foundations or state and federal grant programs, and the existence of direct county subsidies or county-funded services. We found that the outpatient services provided were somewhat more limited at the managed care contracting center in Oregon than the other two CMHCs, despite the fact that this was the only site with an inpatient capacity. This limitation on services was made possible by the existence of alternative safety net providers. While all sites acknowledged that indigent county residents in more remote areas had access problems, one center addressed this issue with an extensive satellite system, while another addressed it with extensive home-based care. We regret that we were not able

to visit a CMHC in a state with strong managed care presence and a weak county system. The ability of Lane County MHC to meet the demands of its managed care role appears to depend on the existence of county funded services and a generally resource rich environment. The long waiting lists experienced by sub-acute indigent patients in the Tri-County area of Maine also suggest that the absence of county funding leaves a hole in the mental health safety net. If Tri-County MHC faced financial pressure to further limit its services to the indigent under a managed care contract, it appears likely that the hole would be larger.

We conclude that rural CMHCs continue to have the will to serve as a rural mental health safety net, and their ability to do so may be enhanced by their county's ability to provide funds for indigent care, or to support alternative service providers who can share the safety net role.

DISCUSSION

One could conclude from this study that the rural mental health safety net is alive, if not well, at least in areas where progressive county government or entrepreneurial administrators have marshaled the resources. To put the rural mental health safety net into a broader, national policy context, however, at least two key issues must be addressed that are not explicitly related to funding.

First, the mental health safety net must go through a somewhat more thoughtful process of explicit definition. In the case of primary care, the IOM report approached the definition issue by reference to mandates and missions that create an "open door," that is, a policy of offering treatment to any client who walks in the door (IOM 2000). Despite this approach, the IOM definition is interpreted by many to exclude private physicians who may provide a substantial amount of free care. In its policy position on the safety

net, the National Rural Health Association has endorsed the IOM definition, but has pointed out that the language of that definition should be more explicitly interpreted to include rural private physicians who provide such charity care (NRHA 2002).

The mental health safety net has not had the benefit of this kind of policy dialog. Most of the staff with whom we spoke at rural CMHCs continued to think of their SPMI and SED clients as a “safety net population.” We created vignettes to describe the kinds of clients that do not qualify for categorical funding, or for the significant benefits available to Medicaid beneficiaries. While such clients were known to these staff, it was clear to us that we were talking about a different definition of “safety net.” Any policy discussion at the national level must acknowledge these differing orientations explicitly to avoid misunderstanding, and to assure that the mental health needs of those less acutely ill do not continue to be trumped by those more seriously ill, but well-funded.

The second issue that must be acknowledged and addressed is the implicit assumption that an “open door” assures access. Rural clients experiencing stress, depression, anxiety, or other non-urgent mental health problems do not find it easy to seek help (Hoyt 1997). A number of rural outreach programs have acknowledged this problem, and created new models that identify mental health problems at the work site, in the community, or in non-mental health settings such as primary care offices, county social services, and agricultural extension (Lambert et al. forthcoming 2003). These programs are not typically staffed by CMHC-based providers, but often must refer some of the individuals they identify to CMHCs. To be effective, the rural mental health safety net must explicitly consist of outreach programs linked to CMHCs or other mental health providers.

Rural providers with whom we spoke in the process of gathering data for this report noted that often the individual who is identified by such outreach efforts is a

member of an at-risk family, with multiple behavioral and physical problems, often low-income and uninsured. Clearly, what is needed for such families is not a diagnosis that qualifies an individual as disabled, and therefore categorically eligible for CMHC services. Rather, what is needed is a well-integrated, interdisciplinary treatment plan that helps the whole family, based on cooperation among social service agencies and mental health providers. By linking service eligibility to diagnosis and focusing on individuals, our current mental health policy environment has created barriers to that approach.

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APPENDIX A. INTERVIEW PROTOCOL

- When was this CMHC established? How long have you worked here? (This is important in terms of respondent's knowledge of transitions.)
- How many full-time equivalent staff does your facility currently employ? How has this changed over the time you have worked here? (For this question, we would certainly like to see clinical and administrative staff FTEs listed separately. Ideally, we would like a fairly detailed breakdown of clinical staff, especially noting FTEs by professional type.)
- What services does this facility currently provide? (You can probe from the list of required CMHC services.) How has this changed over the time you have worked here?
- What geographic area does this facility currently serve? How many sites does it operate? How has this changed over the time you have worked here?
- How has the annual budget for this facility changed over the time you have worked here? (Has it gotten larger or smaller or stayed pretty much the same?)
- What are the current sources of funding for this facility? How has this revenue mix changed over the time you have worked here? (Ideally, what we are looking for here is percent of revenues from each source at different points in time.)
- How has this facility adapted to important changes in federal and state policy? (You can probe by mentioning the transition from categorical to block grants---federal---and any consent decrees---state. It would probably be helpful to have fairly specific knowledge of these for your respective state.)
- Please describe the client population your facility currently serves. How has this changed over the time you have worked here? (You can probe in terms of adults with serious mental illness, children with serious emotional disturbance, other Medicaid recipients, individuals with private health insurance, people without any insurance.)
- One of the major purposes of this study is to look at the groups that were identified as service priorities in the original federal legislation and compare those priorities with the current contracting requirements of state governments under the block grant program. The purpose of this is to understand how CMHCs are coping with the service demands of low-income uninsured or Medicaid recipients with "less than" chronic mental illness yet still in need of ongoing treatment. How are Centers responding to diminished or eliminated state funds for this population?
- What other sources of outpatient mental health care are available to people residing in your service area? (Probe to elicit any information you can get about location, relationship to CMHC, acceptability to different population groups.) Where do people who live in your service area have to go when they need acute inpatient mental health services?

Sample Vignette Descriptions:

A 26-year-old unemployed female seeking treatment with a three-month history of depressed mood following a marital separation. She is uninsured, has somatic disturbance but no suicidal ideation and no prior psychiatric history. She is not currently receiving medical care and is otherwise healthy.

A 19-year-old indigent male seeking service through referral by probation and parole and is identified as needing assistance with “anger management”. History of assaults and domestic abuse- on probation for a fight he instigated while intoxicated. States that he has an explosive temper and is worried that he could hurt somebody. Also wondering if he could get joint counseling with his girlfriend on how not to “provoke” him.

A 36-year-old female Medicaid recipient seeking service for anxiety and difficulty “coping”. Part of a well-known “multi-problem” family with a history of child protective involvement. Very limited intellectual and social skills, has been in and out of mental health treatment service for years starting as an adolescent when she was psychiatrically hospitalized after a suicidal gesture involving superficial lacerations to the wrists.

A 22-year-old indigent male seeking service for phobias and OCD style ritualistic compulsive behaviors yet no evidence of psychotic thought or apparent risk of harm to self or others. Wants “help” but isn’t sure what he would accept- very fearful of medications “taking control of me”. No prior psychiatric history, very poor employment history apparently related to the disorder.

Questions for Case Descriptions:

Would this case be screened out? Triaged? Placed on a waiting list? Given short-term treatment? How would services be paid for? Does the Center have general policies or practices on services to indigent clients?

If short-term or solution focused treatment is used what is the wait-time for these cases? If there are continuing treatment needs after short-term treatment contract is completed is there another wait for longer-term services?

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