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**The graduation of consultation and education units of
Massachusetts CMHCs from NIMH funding : implications for the
prevention mission of the community mental health center.**

David J. Armstrong
University of Massachusetts Amherst

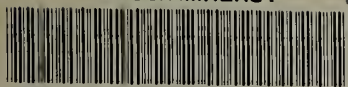
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THE GRADUATION OF CONSULTATION AND EDUCATION UNITS OF
MASSACHUSETTS CMHCs FROM NIMH FUNDING: IMPLICATIONS
FOR THE PREVENTION MISSION OF THE
COMMUNITY MENTAL HEALTH CENTER

A Dissertation Presented

By

DAVID J. ARMSTRONG, JR.

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

February 1985

Psychology

DAVID J. ARMSTRONG, JR.



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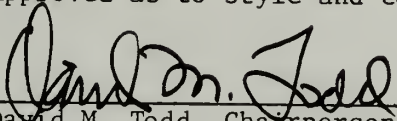
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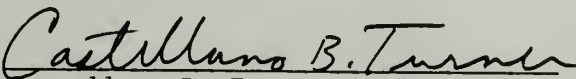
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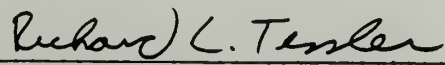
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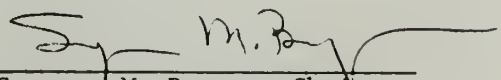
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ABSTRACT

The Graduation of Consultation and Education Units of Massachusetts
CMHCs from NIMH Funding: Implications for the Prevention
Mission of the Community Mental Health Center

February, 1985

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Primary prevention was frequently understood to be a central goal of the Community Mental Health Center (CMHC) movement. Consultation and education (C&E), as one of the mandated services of federally funded CMHCs, was frequently taken to be the vehicle of this goal. C&E services suffered, however, from a lack of clear guidelines and a marginal role in agencies whose chief tasks were those of direct clinical service delivery. With the elimination of CMHC grants from the National Institute of Mental Health (NIMH) in 1980, CMHCs were faced with the challenge of having to restructure services in line with available funding sources.

This research examines the fate of C&E services in the state of Massachusetts since the elimination of NIMH funding. A history is presented of prevention, consultation and education starting with the mental hygiene movement and reviewing CMHC legislation, developments in

NIMH and research on the nature of C&E services and their funding.

The recent fate of C&E services in Massachusetts was studied through the use of NIMH grant records and a survey of CMHCs. A structured interview was conducted with thirty-three respondents in twenty of the twenty-five former CMHCs in the state. Case studies of C&E grant programs are presented and compared with survey results for C&E services across the state. Block grants and state funding for CMHCs and C&E is reviewed.

Results compare pre-1981 services with 1984 services and indicate that C&E is less frequently offered and has shifted in goal orientations, activities and target populations toward sources of funding in the private sector and direct service functions within the CMHCs. The preventive mission of CMHCs was found to have been minimal. Changes in funding patterns, do, however, threaten the direct service mission of CMHCs in restricting funds for services to the working poor. The future of C&E is mixed, with limited opportunities for work in specialist areas of training and consultation. The future of prevention may be less tied to CMHCs, and more dependent on the possibility of organizing citizen constituencies which will effectively lobby state legislatures to fund discrete prevention programs.

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CHAPTER I

A HISTORY OF CONSULTATION AND EDUCATION IN MENTAL HEALTH PROGRAMS

Prevention and the Mental Hygiene and Child Guidance Clinic Movements

How one feels about the current status of consultation and education services in mental health depends on how one interprets history. And, feelings ranging from optimism to bitterness run strong among the small cadre of mental health professionals who have specialized in consultation and education.

The Community Mental Health Centers Act (Title II of the Mental Retardation Facilities and Community Mental Health Centers Construction Act, P.L. 88-164, 1963) gave birth to Consultation and Education (C&E) as one of five mandated services to be delivered by federally funded mental health centers. In his address to congress, President Kennedy introduced the legislation with a speech which continues to echo in the writings of consultation, education and prevention professionals 20 years later. The Community Mental Health Center (CMHC) Act was to introduce a new era in mental health services where treatment would be available to all in their communities. Services would be progressive in offering a range of alternatives to state hospitals and would be delivered by a new mix of workers, integrating specialist professionals with para-professionals drawn from the communities served. Most strikingly to C&E specialists, the CMHCs were to be a vanguard of prevention in the community, attacking the incidence of disorder at its root.

If one takes President Kennedy's words on prevention as the definitive key note of CMHCs, then the history of C&E is one of a betrayal of the mission of the community mental health movement. If, however, as Snow and Newton (1976) suggest, the CMHC Act is seen more as an Eisenhower-era attempt at fairness in the rights of all to see the doctor, then the history of C&E is one of an entrepreneurial spirit within CMHCs which served to keep experimentation in service innovation alive in the centers, link the centers to the outside world, and build collaborative service networks which integrated a variety of resources and teachings. Heirs of the mental hygiene and child guidance movement, born in the era of civil rights activism and social upheaval, C&E incorporated the contradictions of a value-based commitment to community change, delivered from a mental health treatment facility, and measured against public health models of prevention.

Consultation and education services may be seen as the most recent episode in the cycling history of prevention in mental health. As prevention, C&E is a movement "whose time has come not once, but many times," as Saul Cooper (1980) punned with the title of NIMH's hopefully titled book, Primary Prevention: An Idea Whose Time Has Come (Klein and Goldston, 1977). Spaulding and Balch (1983) provide striking examples of similar goals, concerns and even phrases cycling through the twentieth century, linking C&E to earlier mental hygiene and child guidance movements.

Founded in the outcry following the publication of Clifford Beer's 1908 autobiography of life in state institutions for the insane, the

National Committee for Mental Hygiene represented professional and citizen reforms concerned with the promotion of mental health. The founding Connecticut chapter stated in its 1908 proclamation:

The chief purpose of this Society shall be to work for conservation of mental health: to prevent nervous and mental defects: to secure and disseminate reliable information on these subjects... (Winslow, 1934, cited in Spaulding & Balch, 1983, p. 61).

The proclamation of a movement since discredited (its national committee changed its name to "Mental Health" in the mid-1950's to avoid association with its past) carries a strong similarity to the goal statements of many C&E units.

Child guidance clinics, based on Dr. Douglas Thom's Boston "habit clinics," were promoted in the early 1920's by the U.S. Children's Bureau as a preventive mental health program. Adopted by the Mental Hygiene movement as a "favorite son" (Spaulding and Balch, 1983), the child guidance clinic was to intervene with parents, teachers and children in teaching the proper method of child rearing designed to promote mental health (much as one might promote good moral character). Indeed, much of the early child guidance work incorporated the concerns of John Watson and other pragmatic American behaviorists with "bad habits," their consequences and prevention in infants.

The early 1900's were years of great power for the sciences of behavior and American society turned to its scientists for instruction in rational child rearing. Lomax, Kagan and Rosenkrantz (1978) offer a fascinating history of the relationship between science and society in their Science

and Patterns of Child Care. In summarizing "Watson and the American Tradition," they offer an example of the early health promotion ideal that framed the mental hygiene movement:

Watson's message could be summarized succinctly to an American parent in a single one-hour lecture: reward the behavior that you want your child to maintain and punish him for the behavior that you do not want him to maintain; apply that principle consistently for 10 years and you will have produced your "dream child." (Lomax, et al., 1978)

Science offered society the rational and proven means of being able to "produce" a child's fate. Aside from the obvious flavor of capitalist industrialization, highlighted by the writers, the message was a strong one: society, through its parents, could produce criminals and juvenile delinquents or it could produce upstanding magnates of industry. Given the choice, citizen movements could not help but proclaim their support for mental health promotion, a cause somewhat broader than the contemporary prevention of discrete disorders.

While originally reflecting the behaviorist optimism, child guidance clinics also spearheaded the introduction of analytic theory, with much of the same fate as that of many prevention efforts in soliciting an increased demand for direct intervention or treatment. Peaking in popularity in 1932 with 674 clinics in 34 states, the number had dropped to 260 by 1946 (Spaulding and Balch, 1983) and by that time much of their emphasis had shifted to treatment:

Early clinics set as their goals the prevention of juvenile delinquency and of mental illness. Present day standards are more modest... 'outpatient psychiatric help' is shown not be an insurance against future ill health, but an aide to currently

better functioning. (Lindt, 1950, cited in Spaulding and Balch, 1983, p. 63.)

It is interesting to note that in Massachusetts the child guidance clinics were the first non-inpatient settings to receive direct state support for treatment staff. State professionals were placed in local clinics at the behest of community parent and mental hygiene associations, creating the state's "partnership clinic" system. This "partnership clinic" system, in the wake of the repeal of CMHC legislation, remains the dominant publically-supported outpatient resource in the state (Note 1).

General health promotion or education was supported by many means in addition to child guidance clinics. "Scientific" advice has been offered to parents in the country for at least the past 80 years, often in popular magazines and best sellers. The Children's Bureau instituted a series of pamphlets entitled, Infant Care (1914 through 1945, as cited in Lomax et al., 1978). Mrs. Max West, author of the first edition, emphasizes the vital importance of early education:

It must not be forgotten that the period of infancy is a period of education often of greater consequence than any other two years of life. Not only are all the organs and functions given their primary education, but the faculties of the mind as well receive those initial impulses that determine very largely their direction and efficiency through life. The first nervous impulses which pass through the baby's eyes, ears, fingers, or mouth to the tender brain makes a pathway for itself; the next time another impulse travels over the same path, it deepens the impression of the first. (Child Care, 1914, cited in Lomax et al., 1978.)

It is tempting to hear echoes of this same concern for promotion/prevention for infants in Pierre the Pelican, a periodic parent guide to early childhood development distributed currently by C&E units and pediatric branches of hospitals. The same fervent respect for the possibilities of infancy have certainly continued to dominate prevention and developmental screening efforts, albeit in a much more refined and focused manner.

The mental hygiene movement supported in principle the usefulness of education and training, targeting populations later favored by C&E such as parents, school children, and teachers. Topics discussed at the First International Mental Hygiene Congress (Washington, DC, 1930) included: "organization of community facilities for prevention, care and treatment;" "parent and teacher training;" and "marital relationships" (Spaulding and Balch, 1983). By the early 1950's the movement had promoted mental health via education in mental hygiene and sex education classes for school children, parent and teacher training, human relations classes, mothers' classes for pregnant women, and marriage clinics (Spaulding and Balch, 1983).

Early Federal Involvement in Mental Health

The rise of the role of the federal government in mental health care led eventually to the demise of the mental hygiene movement in the mid-1950's and plants the seeds of the CMHC legislation, the major federal action to date in mental health service delivery. The early precursors to the National Institute of Mental Health offer

some interesting, if speculative, hints as to the concerns of the federal government. The Children's Bureau, publisher of *Infant Care*, and promoter of child guidance clinics, was actually a division of the U.S. Department of Labor. Could it be possible that the Children's Bureau at the turn of the century predates corporate human resource departments by 70 years in its concern with promoting a productive workforce? Certainly the Children's Bureau, like many federal offices, took on a life of its own separate from its host, and industry of character has long been viewed as a strength of American mental health. NIMH, for its part, may be traced to a blend of the Departments of Labor, Treasury and the Public Health Service. The Narcotics Division of the Treasury Department changed its name in 1930 to the Division of Mental Hygiene in an explicit attempt to attack criminal behavior at its root (a tradition which has continued to the present with some C&E units receiving prevention grants from the Law Enforcement Administration Assistance program).

The Public Health Service, with the Surgeon General as its spokesperson, had long been a federal branch on the forefront of the war on disease. Of all the traditions in prevention, perhaps that of public health has enjoyed the greatest tangible success, hence prestige and legitimacy. A service branch designed to administer to the public welfare at large, the Public Health Service implemented the findings of medical breakthroughs in nutrition and infectious diseases made in the late 1800's and early 1900's. The advances were startling as epidemic diseases were controlled through simple sanitation and dietary interven-

tions even before the discovery of antibiotics in the 1940's. The model of prevention was straightforward. "Pure" scientific research identified the metabolic or cellular cause of a disease and then an intervention was designed targeted on the most accessible point in the cycle of the illness. A highly scientific medical model, the Public Health Service, benefited from the early wave of optimism where a single specific treatable cause could be expected to be discovered for an illness, given time. This ideal of "proven" scientific causality continues to weight on psychiatry and mental illness prevention, embodied in the breakthrough in the treatment of neurosyphilis made by Kraft-Ebing and others at the turn of the century. Medical prevention, itself, has long since evolved beyond the single proven credo of causality to far more complex models where certain conditions are understood to place populations "at risk" regardless of the specific, as yet undiscovered, etiological mechanism. The early public health model remains a yardstick, however, against which mental illness prevention has often been measured and found wanting (Bloom, 1979).

The science of public health provided mental health with its definition of prevention. In public health, primary prevention is a reduction in the incidence of a disease or condition (it occurs less often). Secondary prevention is the identification of diseased people for early treatment before much, if any, harm occurs. Tertiary prevention is the curtailing of damage done and rehabilitation of a person. In mental health, primary prevention is often simply called prevention, secondary prevention is often called early identification, and tertiary prevention may be called treatment, direct service, therapy, or

rehabilitation. The range of prevention reflects the success, for instance, of community clinics, early identification and specialty hospitals in lowering the incidence of tuberculosis. Early identification and treatment in mental health have yet to be shown to lower the incidence of other people going crazy, so primary prevention is often argued to be the only prevention in mental health (President's Commission on Mental Health, 1978).

Wars have frequently emphasized to society its own moral and psychological failings, much to the professional benefit of psychiatry and psychology. Freud's discovery of the repetition compulsion in shell-shocked soldiers of World War I is even now being reassessed in research on Vietnam veterans and post-traumatic stress disorders (Van der Koke and others, suggesting a possible addiction cycle to endogenous opiates, Note 2). Of greater concern to society at large was the 12.5% rejection rate on psychiatric grounds of inductees for the American armed forces during World War II. This concern led to the passage in 1946 of the National Mental Health Act, amending the Public Health Act of 1944, and creating the National Institute of Mental Health (Snow and Newton, 1976). Testimony by representatives of the Division of Mental Hygiene, Children's Bureau and the Office of the Surgeon General before Senate subcommittees made it clear that the pressing national needs were ones of research and prevention in mental illness (Spaulding and Balch, 1983). Placed under the National Institutes of Health, a branch of the Public Health Service, NIMH became the new focus of national initiatives in mental health. The Division of Mental Hygiene was disbanded by 1949.

Research and public interest in the causes of emotional disorder continued to exert considerable influence during the 1950's on prevention and social policy. Following the Coconut Grove tragedy of the late 1940's (where hundreds of patrons died in a dance club fire), research by Erich Lindeman on grief and adjustment led to his crises theory of adjustment and disorder. He founded the Wellesly Human Relations Service as a community mental health program for his prevention services. (Thirty years later the Erich Lindeman Center in Boston is one of the largest state-owned mental health facilities, devoted mostly to the remedial treatment of the poor and chronic populations.) Research on social structure and causes of mental disorder (such as Hollingshead and Redlich's Social Class and Mental Diseases, 1958 and Scole, Langer, Michael, Opler and Rennie's 1962 Midtown Manhattan Study reflected an increasingly more sophisticated appreciation of "the effects of poverty, racism, and increasing urbanization and the relationships between social class and other social factors and mental illness (Snow and Newton, 1976, p. 585)." Research on the psychological effects of racism was taken into consideration in the Supreme Court's 1954 ruling on desegregation.

Perhaps the Supreme Court decision and the civil rights movement in general framed the later C&E endeavor more than is generally acknowledged. Here a major national movement pursued fundamental societal change on an ethical, principled basis. The movement provided galvanizing images of tragedy, confrontation and victory and drew on the methods of community organization and development to build the coalitions which could act on society. There was the conviction that society had to change

for the betterment of its individual members and that such change would be brought about not by medical specialists using public health techniques, but by citizens and community leaders organizing for legal and political power. It is perhaps this movement more than any other that contributed to the value conflicts of C&E professionals, subtly shaping their sense of mission with an invisible heritage quite different from that of their professional roles and the treatment facilities in which they worked.

The Joint Commission on Mental Health

The National Institute of Mental Health, created with a public health mandate (Snow and Newton, 1976), served chiefly to coordinate the expansion of research and training during the early 1950's. The Veteran's Administration greatly expanded its psychiatric facilities and with the major increases in funding made available by NIMH and the VA, graduate and medical students moved in large numbers into clinical training, swelling the national ranks of clinical-treatment oriented professionals. When Congress mandated in 1955 that a national study of mental health be undertaken (Mental Health Study Act), NIMH was given the responsibility of designating a nongovernmental, interdisciplinary study group. NIMH chose the Joint Commission on Mental Health, a study group formed earlier that year by the American Medical and American Psychiatric Associations. Comprised at it was of 25 M.D.s (out of 45 members), the Commission's findings were largely treatment-oriented.

Submitted to President Kennedy in 1961 (Action for Mental Health),

the Commission's report states:

A national mental health program should recognize that major mental illness is the core problem and unfinished business of the mental health movement, and that intensive treatment of patients with critical and prolonged mental breakdowns should have first call on fully-trained members of the mental health professions. (p. xiv)

The conclusions were clearly not a mandate for the prevention of mental illness. In fact, the report was highly critical of the mental hygiene movement as having been premature, unscientific and ineffectual. In support of this view, the Commission cited Robert Hunt, from his 1956 presentation to the Milbank Memorial Fund: "Our hopes of preventing mental illness by mental health education and child guidance clinics have been disappointed and there is no convincing evidence that anyone has ever been kept out of the state hospital by such measures" (p. 9).

The Commission's own research (Americans View their Mental Health, Gurin, Veroff and Feld, 1960), had indicated that the vast majority of citizens turn to neighbors, family, clergy and family doctors for help, rather than to mental health professionals. As Snow and Newton (1976) note, however, these results did little to shape the Commission's recommendations:

Yet in the Commission's final report, little emphasis was placed on secondary preventive approaches. There was scant discussion of the need for educational and consultative approaches to community service agents as a response to the manpower problem and as a means of developing a service network for people in need. (p. 587)

The report was met by an outcry of protest by prevention advocates, not the least of which was Gerald Caplan. Soon to publish his seminal work, Principles of Preventive Psychiatry (1964), Caplan had specialized in the late 1950's in the study of the process of consultation to parents, teachers, and service providers. Spaulding and Balch (1983) note that Caplan, himself, had been critical of child guidance clinics for their drift toward direct service and away from prevention (Caplan, 1961). For his part, Caplan was reportedly assured that prevention was again placed in the spotlight by President Kennedy's address to Congress in February, 1963, calling for legislation (Caplan, 1965; Spaulding and Balch, 1983). Historical analysis suggests, however, that what changes were made were due less to popular opinion and more to internal political maneuvers within the Executive Branch (Chu and Trotter, 1974; Musto, 1975; Snow and Newton, 1976).

The Joint Commission was not the only agency to submit a report with recommendations to the President in 1961. A power struggle had developed between the Public Health Service (responsible for service delivery) and the National Institutes of Health (previously responsible in large part for research). The Surgeon General, representing the PHS, submitted a plan which would chiefly have served to strengthen the state mental hospital system. A planning group of NIMH, representing NIH, submitted an opposing viewpoint, arguing that monies should go directly to localities and not to state departments of mental health (and by extension, state hospitals). The President appointed a Cabinet level committee, chaired by HEW Secretary, Anthony Celebrezze, to study the

plans and make recommendations. The committee chose, as its working staff, professionals from NIMH. The subsequent legislation passed by Congress in 1963 authorized monies to go directly to localities and appointed NIMH to administer the grants. It is something of an irony that many of the former NIMH staff who administered the CMHC service program during the 1970's may not be found under the employ of PHS regional offices, as NIMH returns more to a research role after 20 years. This was a power struggle that was won only for the moment.

The CMHC Act: Did It Promise Prevention in C&E?

In 1963, Congress passed Public Law 88-164, the Mental Retardation Facilities and Community Mental Health Centers Construction Act. Title II, the Community Mental Health Centers Act, provided federal monies to qualifying applicants for the construction of Community Mental Health Centers. Applicants were to be local private nonprofit agencies or collaboratives serving populations of 75,000 to 200,000 residents as designated by a state approved geographical "catchment area" service plan. Applicants also had to provide five mandated services, which included: (1) emergency services; (2) outpatient services; (3) partial hospitalization; (4) inpatient services; and (5) consultation and education.

What exactly was meant by consultation and education services and what the concrete task of C&E was to be has never been clear. Many writers agree that prevention was to be inferred as a goal of the CMHC movement in general and of C&E services in particular:

Primary prevention per se was not listed as one of the five essential services (perhaps in partial response to the attitude of the Joint Commission), but preventive interests were to be served to some degree under the requirement to include consultation and education services and later under the added services of research and evaluation (Spaulding and Balch, 1983, p. 71).

Saul Cooper comments that, "the federal mandate for consultation and education was meant to assure prevention programming" (1980, p. 253) and Backer, Levine and Erchul, in their NIMH-funded evaluation of C&E activities (1983) conclude that, "C&E services from the beginning have been seen as largely preventive in nature" (p. 3).

This role was, however, clearly a "challenge" both to the C&E unit (Raber, 1983) and to the center as a whole (Steve Goldston, former Director of Prevention at NIMH, 1969; cited by Raber, 1983). As the only indirect service of the five, C&E could be assumed to have a wide range of responsibilities for those tasks left unaddressed by the other four direct services. Gabbert (1980) suggests four tasks of C&E: (1) responsibility for continuity of client care through systems consultation with other area providers (often termed "networking"); (2) training of caregivers to help shift personnel to community-based descriptions, increase the use of local paraprofessionals reflective of community norms and values, and increase dissemination of innovation; (3) early identification or secondary prevention through case consultation to non-mental health providers; and (4) primary prevention in education and community development projects for high risk populations. This list of tasks suggests that primary prevention was in fact only one of four

C&E tasks and stands in contrast to the characterization of C&E units offered in the Backer, Levine and Erchul evaluation of C&E activities (1983). Their report suggests that primary prevention was central:

Starting from the basic definition of C&E given in the 1963 enabling legislation for community mental health centers, several basic orientations of these services became clear: first, that C&E is an outreach function more likely to be community-based than CMHC-based. Second, that prevention of mental illness is the major emphasis of these programs. Third, that both educational efforts and consultation with programs that provide direct or indirect mental health services are included under this rubric -- services that ideally have a "ripple effect" [in spreading impacts to numerous people not directly seen by C&E professionals] (p. 5).

This suggests a fairly clearly defined legislated role for C&E and prevention in the CMHC movement. Retrospective research indicates, however, that C&E units typically represented only 4% of the work force and 2% to 5% of the total staff hours of CMHCs (Bass and Rosenstein, 1978; Ketterer & Bader, 1977; Hassler, 1979; Backer et al., 1983). C&E directors often occupied lower positions organizationally than other program directors (Ketterer & Bader, 1977). In fact, it seems from writings in the field and the history of C&E in Massachusetts compiled in this research that C&E units were not in many cases even created until 1976, 13 years after the passage of the CMHC Act.

A central contributor to the confusion is to be found in the vague and ambiguous guidelines for C&E promulgated by NIMH. Published first in 1966 (NIMH, 1966) and later revised in the 1971 Policy and Standards Manual, CMHC Program Handbook, Part I (NIMH, 1971), the guidelines assigned the following two tasks:

(1) Consultation with key community caregivers to enhance their skills in addressing the mental health problems of their clients and in developing mental health programs within their own community organizations and (2) the provision of educational programs to make the CMHC more accessible for all residents of the catchment area and to promote mental health and prevent emotional disturbance through dissemination of relevant mental health knowledge (NIMH, 1977, p 23).

While clear enough as paragraphs go, this particular paragraph was assumedly meant to be the basis for evaluating one-fifth of the performance of a multi-million dollar mental health center, part of a movement with prevention as a core goal. Snow and Newton (1976) characterize the first task as, "a rather conservative mandate, and one that is basically clinical in nature" (p. 589). They point out that the second task is the only mention in the entire manual of "a beginning of a discussion on primary prevention" (p. 589). As a basis of evaluation, notes from the 1966 manual are even more clearly ambiguous:

What proportion of the mental health staff should be concerned with consultation? How much time should be devoted to it? Where should it take place? No absolute guidelines apply to these questions. (NIMH, 1966, p. 25)

And no absolute guidelines were applied. Seven years after his first review, David Snow returned to summarize the guidelines in an article written with Thomas Wolff (1983). They conclude that the guidelines never adequately represented the assumed promise of prevention contained in the CMHC Act:

Fairly traditional views of C&E were contained in these documents and little attention was given to prevention, even though prevention was presumedly to be a major thrust of community mental health centers. (p. 40)

While the spirit of the CMHC Act was taken by many as a significant programmatic commitment to prevention in the form of C&E services, NIMH regulations which defined the letter of the law failed to reflect such a spirit.

The issue of NIMH regulations is central to the history of C&E services in several respects. A discrete service entity commonly referred to as "consultation and education" had not existed before the legislation. Now it did and, conceptually at least, as one of five mandated services it could be assumed to represent one-fifth of a center's resources (Snow and Newton, 1976; Backer et al., 1983). Apparently the concept was a compromise mixture of indirect services, integrating mental health education with consultive services which could involve individual education, clinical training, case outreach and identification and direct clinical interventions mediated through a third party. Caplan's work in preventive psychiatry and consultation (Theory and Practice of Consultation, 1970), while influential, was certainly not definitive or accepted widely enough to assume that it represented C&E. Without a formal, external definition, C&E as a service unit lacked any practical unity. D'Augelli (1980) characterized C&E as a "service in search of a technology, an ideological stance in search of a professional identity" (p. 5). This dilemma was one that C&E shared with its parent movement, prevention:

Primary prevention must overcome conceptual organizational and professional threats to its existence. This is equally true of C&E as the prime operationalization of primary prevention in mental health (D'Augelli, 1980, p. 17).

Prevention and C&E were, perhaps, more of a cause than a profession or an agreed upon technique at the time of the CMHC Act.

As a service unit without definition placed in an organization which faced pressing demands for service, C&E staff activities could be expected to be pulled into more clearly defined administrative or clinical roles. Even as late as 1977, Ketterer and Bader found that C&E staff spent less than half their time delivering consultive or educational services to the community. As a consequence of the lack of definition, C&E took on many identities ranging from public relations for the CMHC, to grant development for other center programs, to implementation of community and social change efforts (Snow and Wolff, 1983, p. 39). The press for direct service and the daily administrative business of delivering that service exerted a powerful distorting influence on C&E from the beginning, at least as far as primary prevention was concerned.

Along with current controversies of prevention, the C&E mandate inherited an organizational contradiction of need and demand. While all CMHC activities were to be based on local and state-wide needs assessments, the centers responded most naturally to service demand. In contemporary American society there has rarely been a demand for prevention services. For C&E this was often, in fact, a contradiction. Many of the at-risk constituencies identified by C&E needs assessments were unorganized, disempowered minorities who frequently were not organized or coherent enough to demand direct or indirect services. School children at risk of incest, acquaintance rape or alcohol related deaths

are not likely to come to the executive director of a center and demand a preventive program. At times their parents or teachers would, but more often, once sensitized by C&E services to the issues at hand, such representatives would request direct clinical services for those people (or cases from the service perspective) that they were worried about. The complaint that prevention had never demonstrated a reduction in demand for state hospital beds cited by the Joint Commission would haunt C&E. C&E services by their nature tended to mix early identification with primary prevention, increasing demand for the direct clinical services they were not mandated to provide (Gottlich and Hall, 1980). Clinically-oriented case consultation is often a useful and necessary step in establishing credibility and gaining entry to a community or agency, permitting later program consultation or system change. Unfortunately, the generalist model of C&E, when placed in the context of a major direct service agency, was easily pressed into the reactive case-consultation end of this spectrum. As one executive director put it, "We can't give prevention away. The teachers want us to take a look at the kid!" (Note 3). Fifteen years after the legislation, and well into the first wave of "graduate-CMHCs" (those centers who have graduated from federal funding), Ketterer and Bader (1977) would note that C&E had long suffered under the "press for direct services." They predicted C&E would be the first units to disappear because of such a press. Snow and Newton conclude:

It is in the nature of the clinical case task that it tends to overwhelm and heavily subordinate all other tasks unless strenuous efforts are made to protect the others (p. 588).

Snow and Newton introduce the concepts of social task, structure and process (Newton, 1973; Levinson, 1973) to explain the popular misunderstandings surrounding the CMHC Act and its prevention mission. The social task is that endeavor which is superordinate over all others in an organization's mission, its reason for existence. Structure within the organization reflects this primary task. Social process is the process of fantasy, ideology or imagery which surrounds the organization. Snow and Newton argue that social process, arising from desegregation and anti-Vietnam war era protests, characterized the CMHC movement as a radical task of social change. C&E and prevention services were taken as the structural representatives of such a mission. The fantasies of a radical mission were further augmented by writings in the field of academic community psychology which characterized the CMHC legislation as a movement. The primary task as reflected by the enacted structure of CMHCs was not one of prevention, however, but that of the extension of direct service:

It is clear that to an overwhelming extent, the primary task (of CMHCs) was to extend direct clinical service and that the task of indirect service ran well behind. (Snow and Newton, 1976, p. 589)

They note that in its primary task the CMHC Act may be judged as something of a success, in contrast to the reactions of disillusionment and loss concerning the failure-to-thrive syndrome of its C&E component.

While the passage of the CMHC Act was greeted by many as a new commitment to prevention, it was the ideology of prevention more than the work of prevention which gained the greatest strength.

In their history of prevention, Spaulding and Balch suggest that as a prevention movement, the CMHC structure, like that of the earlier child guidance clinic, precluded the success of prevention activity:

Our reading of this literature suggest that two of the major preventive movements (i.e., the child guidance clinic movement and the comprehensive mental health center movement) have been ill-fated as they have found themselves too entrenched in service delivery issues and settings. (1983, p. 76).

Much of the consequent history of prevention and C&E (abbreviated in recent writings as P, C&E) is that of advances in technology and sophistication of delivery, surprising in light of the barriers faced by this service.

Legislative History of the CMHC Act and Subsequent Bills

The legislative history of the CMHC Act is one of frequent amendments, a continuous expansion of required services and repeated crises over the expiration deadlines for federal funding. The consequences of this history include ever-increasing red tape in reporting procedures, expansion of clinical service staff and programs, largely dependent on direct federal funds, and an enduring barrier to long-term fiscal planning by the centers. Histories of this legislation may be found in Chu and Trotter, 1974; Morrison, 1977; Sharfstein and Wolfe, 1979; Gabbert, 1980; NIMH, 1981; and Backer et al., 1983).

The 1963 Community Mental Health Centers Act (P.L. 88-164) originally authorized money only for the construction of physical plants. The Act was ammended in 1965 (P.L. 89-105) to provide funds for personnel

in the form of staffing grants. Centers were to be eligible for staffing grants for 51 months on a decreasing scale from 75% to 30% of the staff costs for the center overall. This declining scale was known as the seed funding concept and carried in it the seeds of contradiction. Seed funding was designed to help create local treatment centers which would reflect the mission of comprehensive services expressed in the federal legislation. The service design of comprehensive services would offer a balance to state mental health services which were mostly oriented toward chronic, inpatient mental health and retardation populations. After independent creation by the federal government, however, the centers were expected to successfully solicit state, local and private funds, thereby eventually "graduating" to self-sufficiency. The legislation, in part, represented an attempt to influence public priorities for service funding on the state level through creating a lobby of agencies and a public expectation of services on the local level. In reality, the centers remained largely dependent on federal funds. As Gabbert states, "once begun, no one expected Congress to abandon CMHCs if they ran into trouble" (1980, p. 25).

The legislation was amended 13 times between 1963 and 1980, when it was replaced by the Mental Health Systems Act. Following the creation of staffing grants in 1965, the Act was amended in 1967 (P.L. 90-31) to extend funding to 1970. The Act was amended in 1968 (P.L. 90-574) to extend services to substance abusers. Amendments in 1970 (P.L. 91-211, 91-513, 91-515 and 91-616) extended funding until 1973. Staff grants were extended in duration to eight years for each

center and the scale was modified for poverty areas. Additional staffing monies were made available for consultation and new categorical grants for children's services were added. Funds were extended for drug treatment and prevention and treatment of alcoholism. Additional drug service provisions were added in 1972 (P.L. 92-225) and in 1973 funding for staffing, construction, children's and substance abuse grants were extended one year, to 1974.

The short extensions of funding and the frequent amendments in the early 70's reflect the change in attitude of the President. President Nixon impounded funds in 1970, leading to staff reductions in centers and at NIMH. Battles for renewal of funding met stiff resistance in Congress, leading to the single year extension of funding in 1973. NIMH was placed under a newly created Alcohol, Drug Abuse, and Mental Health Administration. (The bureaucratic chain of command now ran from the Department of Health, Education and Welfare, to the Public Health Service, to ADAMHA, to NIMH, to the Division of Mental Health Service Programs, a division of an institute of an administration of a service of a department.) The National Council of Community Mental Health Centers was formed in 1974 during a bitter struggle for funding in which Congress met two presidential vetoes before finally passing amendment P.L. 94-63 in 1975.

The struggle to overcome presidential vetoes entailed a considerable amount of pork barrelling in Congress with a number of changes added to the CMHC Act as a result. The five mandated services were expanded to twelve, with the addition of children, elders, screening, follow-up

care, transitional living, alcohol, and drug abuse services. In Massachusetts, it is interesting to note that this legislation led several general hospitals to surrender fiscal authority over their CMHC grants. The earlier grants could easily be used to construct and staff inpatient units, while subcontracting some funds to area vendors of outpatient services. The additional services and reporting requirements apparently made under this arrangement less feasible. In some ways, this amendment created a second wave of CMHCs which were younger, more outpatient-oriented, and yet, middle-aged in terms of their CMHC funding cycle. A number of grant changes were included in the amendment to facilitate transitions. Staffing grants were changed to operation grants to permit support of administrative personnel. Conversion grants were instituted to help start up new mandated services and distress grants were added to assist those early CMHCs which were now completing their eight-year cycle and facing a graduation crisis. A new sliding scale was created and planning grants were added to help communities organize for a full CMHC application, thereby encouraging an expansion in new centers. And, of course, funding for the CMHC Act was extended three years. In all, the 1975 amendment represented a forceful, if complex, reaffirmation of federal involvement in service delivery, with increased "monitoring of the performance of all federally funded centers to insure their responsiveness to community needs and national goals relating to community mental health care" (NIMH, 1981).

Perhaps of greatest import to C&E, the 1975 amendments created a new categorical grant for C&E services. The funding was placed on a

three-year declining scale, but would bottom-out at a base rate which would then continue. Centers receiving both C&E and operations grants were required to have a full-time C&E director with direct line access to the executive director of the center. This legislation was designed to address the previous neglect of C&E services, placing a financial and organizational floor beneath the C&E service mandate (Snow and Newton, 1976; Gabbert, 1980).

Public Law 95-83 (1977) allowed for a three year phase-in of the new services. In 1978, P.L. 95-622 extended distress grants and allowed centers to retain up to five percent of their grant funds from one year to another. This, for the first time, allowed centers to accumulate a cash reserve, allowing for longer range planning and alleviating the cash-flow crisis which plagued many centers (Gabbert, 1980). Funding was again extended for the Act, this time until 1980, when new, comprehensive legislation was expected. A final amendment in 1979, P.L. 96-32, changed accounting procedures.

In all, funding provisions were amended 12 times, in the end allowing a center to receive one planning grant, eight operation grants and three distress grants, for a total of 12 continuous years of funding. Children's substance abuse and C&E grants could be received over many of these same years. By September, 1980, 789 CMHCs had received 2.659 billion dollars and served catchment areas representing 55% of the national population (NIMH, 1982; Backer et al., 1983). C&E grants totaled 40.9 million dollars or approximately 1.5% of all CMHC grant monies.

The Community Mental Health Centers Act was rescinded in 1980 with the passage of P.L. 96-398, the Mental Health Systems Act. President

Carter had appointed a President's Commission on Mental Health in 1977 to study mental health needs and make recommendations for change. The Committee issues its report in 1978, which included a report from the Task Panel on Prevention. The Commission identified four areas where change was needed, including the following: (1) failure to serve the neediest populations, including children, elders and chronically disabled; (2) failure to adequately involve states in funding or planning; (3) failure to connect with medical settings; and (4) a need to expand prevention activities. Critics of the report complained that it downplayed CMHCs and the comprehensive service model in favor of increased state control and emphasis on priority populations like the deinstitutionalized (Gabbert, 1980). Research with graduate centers had already indicated that increased reliance on state funding led to an elimination of the comprehensive service profile and of indirect services such as prevention (Naierman et al., 1978).

The Mental Health Systems Act increased the authority of states to coordinate the priorities and distribution of funds. At the same time, the Act continued funding of C&E, planning, financial distress and initial operations grants to CMHCs for one more year. A non-revenue producing services grant was to provide additional funding for services that could not be billed as direct clinical costs, including case management, evaluation research and, to some extent, C&E. Prevention was separated from C&E in the legislation, "undoubtedly contributing to further confusion in actually implementing (C&E) services" (Raber, 1983, p. 32). A prevention center was to be created under NIMH with \$6 million to

fund prevention activities. It was felt that, with the expiration of C&E grants in 1981, indirect services grants, prevention grants, and possibly even special population treatment grants could be applied for by existing C&E units (Wolff, Note 4).

The Mental Health Systems Act is not studied widely as a legislative entity because it lasted less than a year. Without the benefit of a national study commission, the Reagan administration effectively introduced into Congress, lobbied for and signed into law P.L. 97-35, the Omnibus Budget Reconciliation Act of 1982, known more simply as "Block Grants." The block grants did three things: (1) cut total funding; (2) collapsed ten categorical grants under AMAHMA into a single block grant; and (3) awarded these grants directly to state governments (GAO, 1984).

The precise amount of reduction varies according to the reporting service. General estimates by the Massachusetts Department of Mental Health (DMH, 1984) and anecdotal reports by CMHC directors in the state, place the cut in mental health dollars to around 25%. Federal figures from GAO obscure the impact somewhat by combining all ADAMHA funds together and frequently reporting them incompletely within the combined federal, state, and private funds, which have risen. According to GAO figures, total federal dollars for alcohol, drug abuse, and mental health services were cut 21% between 1981 and 1982. They note that many of these cuts were not felt at the service level immediately because categorical grants awarded under the old system continued well into 1982. (In Massachusetts, 84% of all federal funds in 1982 were still in

the form of categorical grants.) The trend is clear, however. Total federal dollars for ADAMHA services between 1980 and 1984 were cut 26%, at least 37% when adjusted for inflation, which is the common budgetary practice (GAO, 1984).

The ten categorical grants combined in the Alcohol, Drug Abuse and Mental Health (ADM) block grants were taken from the categorical grant programs of NIMH, NIAAA (National Institute of Alcohol Abuse and Addiction) and NIDA (National Institute for Drug Abuse). The three institutes had previously awarded grants in various ways. NIDA had been issuing state contracts (block grants) since the mid-70's. NIAAA awarded some grants to states and some to agencies and individuals. NIMH had, of course, awarded monies directly to agencies, preferring private non-profit corporations.

The stated goals of P.L. 97-35 provided for comprehensive and preventive services for substance abuse, but placed greatest importance in mental health on the chronically mentally ill, already a traditional priority to states. The provisions of the law required, first, that 20% of federal substance abuse funds go to prevention. Second, all CMHCs were to continue funding for those years they would have been eligible for CMHC funding (at reduced rates, according to a state formula). In Massachusetts, 9 of 25 CMHCs funded by NIMH in 1981 received sole source block grant awards in 1984. Finally, all CMHCs receiving sole source awards had to maintain the five original services (at what level and by what definition was unspecified).

The original legal, financial and organizational mandate for C&E units ended with the termination of C&E and operations grants from NIMH. In Massachusetts, most, if not all, of these grants ended in September, 1982. On a national level, the NIMH Center for Prevention Research (now the Prevention Research Branch) survived miraculously with its \$6 million annual budget, funding only research, mostly university or medical school based. NIMH, itself, shrank enormously as it returned to a research mandate, withdrawing from its roles in community services and training almost entirely.

Seed Funding and CMHC

While the original CMHC legislation is now gone, the CMHCs and many C&E units are not. To understand the present environment in which C&E services may (or may not) continue, it is necessary to examine the effects of "graduation" of CMHCs from federal funding. As is clear from the above history of legislation, the end result of graduation was always an anticipated (if ambivalently) goal of the legislation. The process and consequences of graduation were studied for at least ten years before the repeal of the CMHC Act. Issues of graduation are reviewed in detail by a number of writers (Morrison, 1977; Naierman et al., 1978; Sharfstein and Wolfe, 1978; Wasserman et al., 1980; Gabbert, 1980; Woy and Mazade, 1982). A brief review of these reports in chronological order provides a progressively detailed description of the consequences of graduation even as the CMHCs were graduating in increasing numbers.

The Stanford Research Institutes reported in 1970 (Harvey, 1970) that less than half of CMHCs received greater than 20% of their funding from states. While individual profiles varied greatly, fees and insurance rarely covered more than 20% of the budget. Other sources were negligible. The Stanford study, like those that followed, focused on sources of funding because in large part the nature and sources of funding determined what services the CMHC would deliver. A study by Macro Systems, Inc. (MSI, 1973) confirmed the Stanford study results, noting a wide variability in centers' success in getting funds other than CMHC grants and noted a general lack of long term planning in the management of CMHCs.

The General Accounting Office (GAO) (GAO, 1974) surveyed the financial status of CMHCs and reported that third-party payments were too limited in availability and rates to offer a viable replacement of federal funds. Fee-for-service was noted as inappropriate for many of the lower income and poor populations that were to be reached by CMHCs. It also commented on the poor quality of CMHC management and accounting procedures. In 1975, the National Council of Community Mental Health Centers (NCCMHC) reported that 60% of centers graduating from staffing grants were forced to reduce staff significantly and realign their service priorities with the goal of acquiring funds. They noted a shift away from CMHC comprehensiveness and towards more medical model/inpatient emphasis. Landsberg and Hammer (1977) express similar concerns that graduate CMHCs might be turned into outpatient and intake screening branches of state hospitals.

Naierman, Haskins and Robinson reported one of the most thorough studies to date in their book, Community Mental Health Centers: A Decade Later (1977). They surveyed all centers which had graduated at that time (99) and categorized them by their age. Centers between 5 and 8 years old evidenced some ability to replace declining federal dollars with fee-for-service and third-party sources. By the 10th year, however, these sources had reached a maximum plateau of utility. State and local dollars were either unavailable or carried new restrictions and priorities in service population (such as emphasis on chronic inpatient and deinstitutionalized clients). In general, graduate centers evidenced some tendency to "retrench" their services, moving away from C&E, prevention and even outpatient programs in favor of service for the more severely disabled. They note that fiscal viability for these centers stands almost at odds with the CMHC ideology.

NIMH entered the scene in 1979, when some form of massive graduation could be expected from upcoming legislation, with a series of studies. Weiner, Woy, Sharfstein and Bass (1979) noted that graduate centers could be divided into "true" and "quasi" graduates. True graduates were those centers that did not take advantage of distress grants and conversion grants to delay the inevitable, but rather assumed total independence from federal funding. Quasi graduates did extend federal funding as long as possible. True graduates were found to be more assertive in seeking funding, but also had moved further away from the CMHC mission of comprehensive services for all. Quasi graduates retained more of this mission. The authors challenged the seed funding concept and

concluded that some floor-level funding was necessary to continue the CMHC-like center.

Wasserman, Woy, and Weiner-Pomerantz (1980) confirm these findings, noting a wide variability in center profile, but a general shift along the lines described earlier. They argued in their summary for continued funding, especially for non-reimbursable services such as C&E.

Reporting on a NIMH-sponsored "National Conference on Graduate Mental Health Centers" held in 1980, Woy and Mazade (1982) summarize the conclusions of executive directors of CMHCs and state, local and federal experts assembled by the Conference as a working task force. Participants saw the "original CMHC ideology and template of mandated services as disappearing" (p. 214). Indirect services declined as a "high clinical," "medical" orientation prevailed. Participants reported pressures from state departments of mental health to focus more on chronic populations and state officials saw services declining overall, with little prospect of increased state funding. Attention was focused on management, planning, reimbursement and private practice models for survival. The authors conclude with four core recommendations, the second of which called for "ongoing 'floor funding' by the federal government for CMHC service not readily reimbursable from other funding sources" (p.222).

To say that the seed funding approach failed would be simplistic. Clearly the approach allowed for the creation of a number of mental health centers and probably exerted an enduring impact on the profile of available mental health services in America. The full impact of the CMHC

movement has yet to be evaluated and it may be many years before an objective assessment can be made. The research reviewed documents, however, that state, local and third-party funds failed to support the service profile or "mission" of CMHCs as conceived by federal legislation. The precise cause of this failure is unclear and involves far too many variables for this review. Overall, it can be concluded that the seed-funding concept entailed an inherent contradiction, that of expecting centers to successfully market not only their clinical products, but also their ideological basis. Naierman and others in 1978 had observed that fiscal viability and continued CMHC-like structure often appeared to be at odds. Backer and others (1983), in evaluating C&E services for NIMH concluded that centers which failed to solicit new funding sources often suffered from the mixed message of the seed funding concept:

Thus, CMHCs were not remiss in going after payments for services, but rather were following the ideology of the movement along with the unresolved issues of the reality of seed money funding." (p. 4)

Reviewers such as Gabbert (1980) and Sodano (1982) point out a number of barriers to self-sufficiency inherent in the CMHC legislation and its enactment by NIMH. The failure to involve state departments of mental health in the development of a CMHC philosophy is central to understanding the current situations of CMHCs, and by extension, of C&E. As reviewed earlier, the original CMHC Act represented a victory of sorts by NIMH in its attempt to prevent monies from being used for the state hospital systems. In rejecting the state hospital system (the

dominant force in many state departments of mental health), the legislation paved the road for the later dilemma of CMHCs. States were given merely a "tangential" role by NIMH (Sodano, 1982). While there was great variability in state's relationships with CMHCs, in many cases the structure and priorities of service delivery by state governments were unaffected by the CMHC movement (Naierman et al., 1978; Gabbert, 1980).

Exceptions were noted in which decentralized state departments of mental health (DMHs) designated CMHCs as their service representatives and continue to this day to reflect much of the CMHC orientation (Naierman et al., 1978). In many cases, however, NIMH and CMHCs maintained antagonistic or neutral relations with state DMHs (Gabbert, 1980). The subsequent budget crises of many state and local governments has served to exacerbate the resistance of states to underwrite CMHCs. Robert Okin, then Commissioner of Mental Health in Massachusetts, described a variety of barriers to the development of a comprehensive service profile in the state (Okin, 1978). The largest portion of DMH resources were devoted to inpatient services, despite an ongoing process of deinstitutionalization which lowered the average daily inpatient census from more than 20,000 in 1960 to approximately 1,800 in 1983 (DMH, 1984). Okin noted that the first patients to leave state hospitals actually represented a hospital work force which had to be replaced by hired staff. Increasing demands for treatment over custodial services also contributed to escalating costs with a decreasing census. Okin noted also the conservative resistance of public employee

unions and local communities which relied on the hospitals for employment. In all, the priorities of a focus on the neediest, chronic population, the increasing costs of inpatient care, and the neutral or antagonistic relationships established with NIMH all contributed to resistance by many state DMHs to adopting the CMHC program wholesale.

As noted by several researchers above, the graduation of CMHCs typically placed indirect services in jeopardy first. As non-reimbursable services, much of program evaluation, C&E and staff training functions were not covered by highly restrictive medicaid or insurance plans. A variety of "survival" plans were offered to CMHCs during the forced graduation of 1981 (conference participants often termed it "abandonment" [Woy and Mazade, 1982]), plans which frequently recommended the reassessment and possible elimination of non-fund producing programs. Illustrative of such advice are the "77 Action Strategies for Survival" published by the Council of Management of the NCCMHC (Goplerud et al., 1983). The second strategy recommends that directors "reduce or eliminate services that do not produce revenues" (p. 65). Other suggestions included the following: "allow the government to support its own priorities"; "focus on core mental health services"; "cultivate middle and upper class clientele"; and "prioritize non-billable services for cutbacks by their contributions to securing revenue." The author's conclusions predict significant elimination and replacement of programs based chiefly on the income value of the service, suggesting that executive directors:

...review organizational missions and priorities. To remain viable, centers may have to leave their traditional core services and acquire different staff and programs. To make these changes, centers may have to lay off staff in old programs at the same time new programs are being developed. (p. 72)

Needless to say, staff morale in many CMHCs suffered during the early 1980s, with severe cutbacks in staff, elimination of entire programs, the introduction of production quotas and a preference for fee-for-service staff positions. The contradictions inherent in the seed funding concept left C&E the most vulnerable of the five mandated services. Frequently producing a minimum of monies (an average of 1% of CMHC revenue in 1975 [Bass and Rosenstein, 1978]), C&E was often defined as administrative overhead, an overhead which had to be cut for survival in the 1980s.

Developments in Prevention, Consultation and Education
Technology, 1960-1980: A Struggle of Paradigms

The practice and theory of consultation, education and prevention had continued to develop during the 1960s and 1970s, benefiting from popular ideology of community mental health. Something of a history of developments is suggested in the series of titles published by Gerald Caplan and Ruth Caplan during this time: Principles of Preventive Psychiatry (G. Caplan, 1964); The Theory and Practice of Consultation (G. Caplan, 1970); Helping the Helpers to Help (R. Caplan, 1972); Support Systems and Community Mental Health (G. Caplan, 1974); and Support Systems and Mutual Help (G. Caplan and M. Killilea, 1976).

The consultee target population evolved from case consultation with professionals to an ever widening range of formal and informal caregivers, including clergy, teachers, police and active neighbors or community "gatekeepers." D'Augelli (1980) sketches a useful history of developments in consultation and education, noting the increasing emphasis placed on reaching the consultee closest to the case in the day to day life of the community. Natural helpers and qualitatively different styles of informal caregiving and social networks were more fully explored. (Collins and Pancoast, 1976; Froland et al., 1980). The psychological basis of community was reviewed by community psychologists such as Seymour Sarason in his, The Psychological Sense of Community (1977a).

With the shift in populations came a shift in target activity, with consultation goals moving from individual client improvement to general systems change in organizations or communities. As such, consultation began to include more education and group training (D'Augelli, 1980), and to include community development activities such as coalition building and linking between resource groups. Theories of social networks and social support gained credibility with research results correlating psychological well-being and even raw mortality rates with structure and frequency of personal social contact (Berkman and Syme, 1979). Mutual help and self help increasingly were favored as goals of community interventions (Caplan and Killilea, 1976). Network consultation frequently integrated case-oriented consultation with natural caregivers with community development, linking education and the promotion of mutual help networks or organizations. As such, issues such as individual change

as opposed to systems change and primary prevention as opposed to early identification and treatment gradually began to blur in a somewhat fluid community practice. It is perhaps this generalist quality which most characterized much of C&E activity.

Mental health education ranged in development from center public relations and inservice trainings for CMHC staff, to workshops and conferences for a wide range of formal helpers, to seminars in self-help, health promotion and wellness for the general public. Mass media was enlisted as a direct vehicle for primary prevention, most notably in the field of alcoholism, spearheaded by NIAAA and National Highway Safety adds. Despite criticisms that mental health educators had "little or nothing specific and practical to tell the public" (Davis, 1965), national interest had continued to grow (D'Augelli, 1980). The National Committee of Mental Health Education published guidelines in 1977 which provided a concrete definition of mental health education targeted at three populations: the general public; "non-client", "non-patient" populations at risk; and clients, patients and significant others (NCMHE, 1977). D'Augelli cites the last two NCMHE objectives under the third target population as examples of how consultation and education practices had begin to "intertwine":

4. Education to those in the community who are in a key position to effect the lives of others.
5. Education of those who are in a position of influencing and effecting public policy.

(NCMHE, 1977, p. 3)

Not all consultation and education was prevention and not all prevention was C&E, but the boundaries were quite overlapped by the later 1970s.

The scientific legitimacy of mental illness prevention had also gained somewhat in stature, furthered considerably by the annual Vermont Conference on Primary Prevention organized by George Albee and others, starting in 1975. The conference published an annual book of proceedings and papers organized around yearly topics such as psychopathology, children and socio-political interventions. Reviewers of literature noted the growing evidence of the efficacy of primary prevention (Munoz, 1976) despite difficulties in evaluation research design (Bloom, 1979).

NIMH entered the fields on a major level in 1976 with a Pilot Conference in Primary Prevention. Editions of the published proceedings, Primary Prevention: An Idea Whose Time Has Come, (Klein and Goldstein, 1977), advocated the importance of preventive interventions while criticizing the methodological inadequacies of many prevention projects, particularly in the specification and measurement of effects or outcomes. C&E activities were criticized specifically by the authors as being vague and imprecise to the point of not actually practicing prevention:

...consultation and education, although a required service, has become a term without precise meaning used to encompass and legitimize a variety of activities usually regarded to be of minor significance among CMHC top leadership. The term 'prevention' is used frequently in the same vague way to gain acceptance for a range of popular activities having little or no demonstrably significant preventive impact. (pgs. vi-vii)

This sharp criticism reflected both the nebulous definition of C&E services and the perspective of a particular group within the prevention movement which adhered to the public health model of medical research. Prevention

from this perspective could only be justified as rigorous experimental field research using precise measurement techniques to test hypothesis. Unfortunately, debates over the nature of true prevention frequently seemed to be more of a foil for time-honored debates over what is true science, and true research technique. C&E units, representing the small portion of CMHC resources that they did and based in service delivery settings, were not ideal sponsors of prevention research.

As with the Joint Commission in the 1950s, the histories of prevention science and mental health legislation again overlapped in a national study, The President's Commission on Mental Health (1978). The Commission's Task Panel on Prevention assembled a configuration of professionals different from that of the earlier Joint Commission. The task panel membership included: six Ph.D. psychologists, two M.D.s (one with a specialty in public health), an M.S.W., a lawyer, and an executive director of a CMHC. National advocates of the prevention movement were represented, including Emory Cowen, Bernard Bloom and George Albee.

The report of the Task Panel on Prevention (President's Commission on Mental Health, 1978) represented a forceful reaffirmation of the legitimacy and need for prevention in mental health services. Prevention was characterized as the fourth "revolution" in mental health service (following Pinel, Freud and CMHCs). Arguments offered in support of prevention maintained that there would never be "enough" direct clinical service available, that no disorders had yet been reduced in incidence by direct treatment alone, and that, in light of the proven efficacy of prevention technology, society was forced by economic, moral and ethical

imperatives to move toward a preventive practice in mental health services. Barrington Moore is cited in support of this view: "Human society ought to be organized in such a way as to eliminate useless suffering" (President's Commission, 1978, p. 1828).

The Task Panel took clear and definitive stands on a number of issues, not the least of which was the definition of primary prevention, in which they linked lowered incidence of illness with health promotion:

Primary prevention means lowering the incidence of emotional disorder (1) by reducing stress and (2) by promoting conditions that increase competence and coping skills. It is proactive -- it often seeks to build adaptive strengths through education and reduce stress through social engineering (p. 1825).

This definition was illustrated by Albee (1981) as a formula:

$$\begin{array}{lcl} \text{incidence of} & & \\ \text{emotional distress} & = & \frac{\text{organic factors and stress}}{\text{Competence(skills) + Self-esteem + Social-support}} \end{array}$$

Interventions diagnosed to "prevent" the numerator or to "promote" the denominator would both lower the incidence rate.

The Panel observed in its summary that models of prevention in public health had made an important shift in paradigm, favoring high risk concepts of etiology rather than, "the futility of searching for a unique cause for every emotional disorder" (p. 1826). As such, in response to the academic debate on true science and prevention, they argued for the moderate-left position that "successful efforts at the prevention of a wide variety of disorders can occur without a theory of disorder-specific positive causal mechanisms" (p. 1826).

As part of their mandate, the panel identified barriers to the development of prevention, barriers which take on added significance in light of the subsequent repeal of the legislation this report supported. Barriers included the following: (1) a crises orientation in society which deprived prevention of any "constituency or political clout"; (2) a history of motivation, training and identity in mental health professionals which valued direct clinical service; (3) the sensitive and "threatening" nature of prevention as "social and environmental change"; and (4) the competition with clinical service demand for scarce resource dollars.

A final list of "Catch 22" barriers reflected in many cases the limits and failings of CMHCs and C&E units. Many of the conditions listed below may be taken as direct references to the plight of C&E units as agents of prevention:

- (a) Fiscal allocations for primary prevention dollars rarely exist, or at best are pitifully small.
- (b) We lack appropriate administrative structures charged with the responsibility of promoting the development of primary prevention.
- (c) Personnel trained in the ways of primary prevention are in extremely short supply. Moreover, they tend to be the last hired and the first fired.
- (d) Few professionals are assigned to primary mental health activities on a sustained full-time basis.
- (e) Activities that are labelled primary prevention often, in fact, are not that at all.

(p. 1836)

While not restricted to C&E services alone, the Panel's remarks did appear to refer directly to the financial, organizational; personnel,

and programming difficulties encountered by C&E units within their host CMHCs.

A power struggle in the Commission developed subsequently over the Panel's positions and recommendations, a struggle which reflected many of the barriers listed above (Albee, 1981; Spaulding and Balch, 1983). The Commission's report did, however, in the end include a strong recommendation for prevention services. In turn, this recommendation encountered resistance from an HEW Task Force charged with proposing specific legislation (HEW Task Force, 1978). The concerns of the Task Force seemed "well worn" at this point, echoing concerns that seemed to recycle "in many guises over the decades" (Spaulding and Balch, 1983). Critics noted that a specific cause of mental illness had yet to be proven and that without such proof, no prevention program could be shown to actually "innoculate" a specific individual (HEW Task Panel, 1978).

The perseverative quality of scientific criticisms of prevention services deserves comment. Spaulding and Balch (1983) note the similarities in language and argument of the HEW Task Panel's report to those of critics of the mental hygiene movement. The criticisms and reservations concerning prevention in mental health mirror those of tobacco industry experts concerning lung cancer. While the Surgeon General laments that smoking has yet to be banned, considerable investments have been made in prevention messages on cigarette packages. These investments were made before the precise biological mechanism of lung cancer has been discovered and even before strong proof

existed that messages on the cigarette package would be an effective prevention intervention. A similar federal and legislative attitude has not existed in mental health prevention. If anything, the perseverative quality of the stock arguments pro and con (already phrased with great accuracy by Munoz in 1976) reflects a conflict of fundamental "paradigms" in society and the professional sciences of service technology. As such, the history of prevention and C&E is not so much one of developing technology or scientific research, as it is a professional guild issue of ideology, legitimization and world view (Kuhn, 1978; Habermas, 1973; Fay, 1975; Jacoby, 1975).

It is perhaps a dawning appreciation of this fact, in the context of historical frustration, which led to a trend in the writings of prevention advocates during the later 1970s toward social commentary. This trend combined a new social realism with an impatience with the traditional approaches and goals of prevention technology. Snow and Newton (1976), reviewed above, pointed out with stark clarity that the source of disillusionment felt with the CMHC movement was fed by fantasies of a new prevention mandate which was never really encoded in the actual legislation. Albee, in his "Politics, Power, Prevention and Social Change" (1979) and "Preventing Prevention in CMHCs" (1981) continued this realism by pointing out the failings of CMHCs and emphasizing political power and social changes as keys to the fate of prevention services in this society. Others, such as Seymour Sarason ("Community Psychology and the Anarchist Insight," 1977b), and Julian Rappaport ("In Praise of Paradox: Social Policy of Empowerment Over Prevention," 1981) pointed out the contradiction of seeking social

change through the sponsorship of government agencies (CMHCs). Indeed, social change itself was now suggested as the most appropriate goal of prevention. The Fifth Annual Vermont Conference on Primary Prevention (1979) had as its theme prevention through political and social change. The growth of this perspective reflected both the realities of the struggle for survival faced by C&E in the CMHC legislation as well as a growing realization that the argument of legitimization for prevention was one that had to be made to society at large, outside of the rules and practices of "normal" science (Kuhn, 1978).

Realities of Time, Structure and Practice
in C&E Units

Concerns about the lack of definition for C&E services in the CMHC Act and NIMH guidelines (reviewed above) were reinforced in the early 1970s by indications that C&E services were not being delivered in any consistent form by CMHCs. Legislation amending the CMHC Act in 1975 sought to provide "floor" funding for C&E services in acknowledgement of "the fact that a significant portion of such efforts constitute a public service for which reimbursement was not readily available" (Backer et al., 1983, p. 7 and Pomerantz and Stockdill, 1983, p. 23). New regulations for both CMHC operation grants and C&E grants required that an identifiable C&E unit be headed by a full-time director with direct line access to the center's executive director (that is, on a par with other service heads). In all, the legislation was designed to provide special support for the "often misunderstood and neglected

C&E service" (Gabbert, 1980, p. 13). The legislation was successful to some degree in creating more specialists and specialized C&E programs during the second half of the 1970s (Schelkin et al., 1980).

Little data had been collected up to this time concerning what C&E services were and how they functioned within centers. Rough measures had suggested that C&E hours had peaked in 1973 at 4.8% to 5.5% of total staff hours in CMHCs, dropping by 1977 to 3% of total staff hours (Bloom, 1977; Hassler, 1979). Backer and others (1983) cite NIMH records which indicate an average in the mid 1970s of C&E hours at 4.1%. Bass and Rosenstein (NIMH, 1978) offer a detailed analysis of 1975 government figures in which C&E is combined with "public information" and "public education" functions (suggesting an enduring confusion over the definition of C&E, which supposedly already included the latter functions). Out of an average of 94 full-time staff equivalent positions (FTE's) in CMHCs, 3 FTEs were devoted to C&E and one FTE was devoted to PE/PI, for an average of 4% of total staff hours. It was noted that children, as a target population, received about half of C&E service time and that C&E staff hours were divided overall in approximately one-half case consultation, one-third program consultation, and one-fifth staff development or continuing education activities.

The authors examined C&E time by age of the center and found a trend in decreasing C&E hours as a fraction of total staff hours, a decrease which reflected the diminishing federal support in seed funding as CMHCs approached graduation.

Ketterer and Bader (1977) noted slightly different trends in activity time using a more detailed case analysis of four C&E units in Michigan. They noted that C&E staff devoted only 49.6% of their time to actual community activities, with 22% of C&E time devoted to administrative and training services within the host CMHC and 28.5% of time committed to C&E planning and maintenance. In fact, C&E staff typically spent a fair amount of time attempting to legitimize and justify their own existence to the host center (D'Augelli, 1980). These concerns were reflected in C&E goal statements which frequently targeted the host center itself for education in an attempt to increase the C&E unit's standing (Ketterer and Bader, 1977). The overall decline over time of staff hours devoted to C&E was understood to reflect the low priority of C&E services as federal monies decreased and centers placed a greater emphasis on reimbursable services (Backer et al., 1983).

The actual organization of C&E units within CMHCs took several different forms. Ketterer and Bader (1977) proposed a list of three types of C&E units, including: the specialist unit; the generalist model; and the mixed type. The specialist unit consisted of staff designated for more than 50% of their time as C&E specialists. They typically worked together as a team. Bergner (1981) notes that specialist units tended to have higher levels of expertise in P, C&E activities, tended to protect C&E projects from encroachment by demands for direct service, and often became well known to the community as a discrete entity having a reputation of its own. Specialist units were also more isolated from the rest of the center, contributing to a limited appreciation of the value of C&E by other center staff. Specialist C&E units were easier targets than generalist models for lay-

offs during times of fiscal crises in the centers (Backet et al., 1983). Specialist units probably also produced the most prevention-like activities of the three C&E unit types.

Generalist models coordinated C&E activities as a small fraction (5% to 30%) of direct service staff positions. As such, generalist models tended to integrate C&E as one technique or orientation within clinical programs. Generalist C&E activities reflected the concerns of these programs, often without a unified center goal or philosophy concerning C&E. While generalist models promoted a greater appreciation of the value of C&E throughout the center, the model had distinct weaknesses. Cherniss (1977) portrayed these vulnerabilities most clearly in his case study of a generalist model C&E unit in one CMHC. C&E projects, carried out as a fraction of clinicians' time, were wiped out at a crucial point of development when a service "crunch" occurred which demanded all of the clinicians' time. Integrated generalist models had little visibility as discrete services in the community, and low priority under treatment pressures, allowing poorly defined projects to "erode" and disappear (Schelkin et al., 1980).

Mixed models incorporated the strengths and weaknesses of both structures with a core specialist team responsible for coordinating some percentage of generalist staff time scattered throughout the center. Anecdotal reports suggest that mixed types frequently did not integrate specialist and generalist models so much as allow them to exist side by side, with specialist staff pursuing C&E projects and clinical staff doing case management, case conferences with other

agencies and schools and service networking on a case by case basis as permitted by program directors. Although few, if any, measures are available, it could be argued that most clinical staff did some form of C&E of the case management variety.

Mixed and generalist models both depended to a greater extent than specialist units on institutional support to protect and define C&E activities. As such, C&E activities within these models frequently reflected the philosophy of the center's executive director and his or her investment in prevention, consultation and education goals. Bergner (1981) recommends that centers without a P, C&E "ideology" create specialist units to protect the integrity of the service. She also usefully notes that generalist models actually enjoyed some success in smaller centers (with greater staff cohesion around a unified center identity) and in rural centers where generalist roles in mental health often proved more effective across programs.

Innovations in structure and monitoring were proposed during the later years of 1970, due in part to the need to protect C&E services and make them cost-effective during center graduation from federal funds. A "matrix" model of management created C&E project teams which integrated specialist and generalist staff and rotated leadership of project teams based on the task at hand and the strengths of the team members (Schelkin et al., 1980). Of particular interest were MIS systems which allowed C&E directors to contract for and track the delivery of generalist C&E service time scattered throughout the center staff (Kaghey, 1981). It was hoped that such systems would allow C&E units

to document their value and take financial credit for work and income produced by generalist C&E activity.

The frequency of the three C&E unit types has not been measured. It appears that specialist units were more common in those CMHCs which received categorical C&E grants (149 of 789 or 19% of CMHCs). The actual formation of a C&E unit was frequently, however, a fiction of record-keeping designed to protect the center's eligibility for operation grants. This condition is mentioned by Backer and others in their 1983 evaluation of C&E activities:

Most CMHCs have tended to develop "separate C&E units" in name only, because of previous federal funding requirements, and in actuality have conducted C&E activities with part-time personnel in conjunction with direct service and administrative programs of the agency." (p. 8)

They comment that this arrangement worked well in many cases, "since many successful C&E activities include a direct service component" (Backer et al., 1983, p. 8). A "successful C&E activity" in Backer's study meant that it had continued to survive, at least to the time of their survey in January of 1983. It may be concluded that while generalist model, clinically oriented C&E activity probably survived fiscal crises more easily than the other models, such activities represented C&E more in name than otherwise and accounted in part for the frequent criticism that C&E activities were not prevention.

The nature of C&E goals and activities varied greatly and probably to some degree in relation to the type of organizational structure. Specialist units were more likely than other types to have written

goals, distinct C&E projects and a range of daily activities different from that of the clinical staff. The case research by Ketterer and Bader offered one of the few summaries of C&E goals and activities. They found that there were typically three groups of goals (Table 1) including service goals for the community (82% of all goals), service goals toward the host CMHC (4%) and C&E survival/maintenance goals (14%). Major service goals for the community included general mental health education, promotion of program development in the community, increasing the skills of community caregivers and responding to "grass roots" needs (representing a combined total of 66% of all goals). Less frequent service goals included coordinating mental health programs in the community, providing program/administrative consultation, increasing the skills of high-risk and normal populations, identifying high-risk populations for prevention action and promoting system change through social action (representing 16% of the total goals). The goals emphasize a mission of both prevention and more efficient identification and treatment on natural and formal levels of service delivery. C&E based on such goals represents a general commitment to indirect service as a favored mechanism in the pursuit of CMHC objectives of treatment, early identification, and prevention.

Ketterer and Bader also categorized the kinds of daily activities performed by C&E staff, organized by goal type. Table 2 lists the "services to community" activities in descending order of average time devoted to each. Mental health education and training and

Table 1
Stated and Unstated C&E Goals

Goal Category	Total Stated and Unstated	
	Number	Percent
A. Service goals directed toward the community		
1. To disseminate information about CMHC services and to educate community groups about general mental health issues.	22	22.9
2. To promote the development of formal and informal social and mental health programs.	16	16.7
3. To increase the skills of community care-givers through consultation and training	15	15.6
4. To take grass roots community needs into account in developing C&E programs	11	11.5
5. To coordinate social and mental health programs in the community	5	5.2
6. To provide program and administrative consultation	4	4.2
7. To increase the knowledge and skills of high-risk and normal populations through in-depth educational programs	3	3.1
8. To identify high-risk individuals and groups for prevention and treatment programming	2	2.1
9. To promote systems change through social action programming	1	1.0
	<u>79</u>	<u>82.3</u>
B. Service goals directed toward the CMHC		
1. To provide services to larger CMHC systems	<u>4</u>	<u>4.2</u>
	5	4.2

Table 1 (continued)

Goal Category	Total Stated and Unstated	
	Number	Percent
C. <u>C&E survival/maintenance goals</u>		
1. To insure survival of C&E through adherence to federal guidelines	5	5.2
2. To improve C&E's functioning through documentation and self-evaluation	4	4.2
3. To improve C&E's relative status/resources within the CMHC through clarification of C&E's role	2	2.1
4. To enhance C&E's position vis-a-vis a variety of external groups through educational strategies	1	1.0
5. To improve C&E staff knowledge and skills through inservice training	1	1.0
	<u>13</u>	<u>13.5</u>
	<u>96</u>	<u>100.0</u>

Note: From Issues in the Development of Consultation and Education Services in Community Mental Health Centers by R.F. Ketterer and B.C. Bader. Final Report of the Detroit-Wayne County Consultation and Education Project. Submitted to the Michigan Department of Mental Health, Planning and Evaluation Unit, December, 1977.

Table 2

Service Activities of C&E Staff, listed in
descending order of staff time

Service Activity
1. Public mental health education
2. Caregiver consultation training
3. Network/coalition building
4. Program and administrative consultation
5. Competence training
6. Grass roots consultation
7. Community crises intervention
8. Client advocacy
9. Case consultation

Note: From Issues in the Development of Consultation and Education Services in Community Mental Health Centers by R.F. Ketterer and B.C. Bader. Final Report of the Detroit-Wayne County Consultation and Education Project. Submitted to the Michigan Department of Mental Health, Planning and Education Unit, December, 1977.

systems-oriented consultation activities are favored much more than case consultation. This suggests a greater frequency of prevention-like activity than of direct treatment-like activity.

As mentioned above, Ketterer and Bader documented the significant amount of time in daily activity devoted by C&E staff to the CMHC (22%). They reported that at least half of all C&E staff surveyed were involved in the following five services during the preceeding year: "(1) information dissemination to CMHC; (2) CMHC staff development; (3) needs assessment; (4) miscellaneous tasks with CMHC (such as grant writing for other programs); and (5) CMHC board consultation" (p. 25). They note the discrepancy between the low frequency of CMHC goals (only 4.2% of all goals) and the moderate frequency of CMHC-oriented activity. Ketterer and Bader suggest that most of the C&E units performed similar chores for their host centers, but under-represented these activities in their goals because they were not considered to be "legitimate" C&E services. As such, this discrepancy illustrates the degree to which C&E staff performed activities outside of their own preferred definition of what C&E "should be."

It is possible that C&E, as described by Ketterer and Bader, represented a more developed ideal of diversity as found in some specialist units and did not represent C&E as it was found in many centers, particularly those CMHCs that did not receive C&E grants. Backer and his associates (1983) have suggested not only that many C&E units existed "in name only," but also that most C&E units did not reach special or unusual populations using exotic prevention techniques:

Most C&E programs continue to serve a fairly limited range of clients, mostly human service agencies and schools, providing case consultation on mental health issues. (p. 8)

It is likely that a majority of what was labelled C&E across the 789 CMHCs was case consultation and some training and program networking performed with schools and human service agencies with whom the center shared clients, delivered by clinicians as a part-time second role pursued when the opportunity arose and time permitted. While, as Backer and others suggest, this activity is useful and important to comprehensive client care, it is suggested here that such activity does not represent C&E as a service technology, nor does it capture more than a glimmer of the C&E philosophy.

Ah, and was there a C&E philosophy, a C&E code? Surprisingly there seems to have been a strong and distinct value base shared by staff who specialized in C&E. Ketterer and Bader identified an ideological consensus among C&E specialists expressed in a commitment to five values: (1) citizen involvement in CMHC activities; (2) development of community resources and social supports; (3) prevention; (4) a view of problems as arising from individual-environment interaction; and (5) an active (seeking) mode of delivery" (p. 18). A similar ideological consensus was noted also by D'Augelli (1980) and by Raber (1981) in his dissertation on the essential skills and qualities of C&E specialists. These values, perhaps more than anything else, offer a definition of the "ideal" C&E role. The values also place emphasis on community empowerment as one of the preferred orientations to prevention.

If the history of prevention as opposed to direct service is a history of struggles in conflicting ideologies or paradigms, then the role

of values in C&E staff may have been central to the fate of C&E units. Bergner (1981) notes a number of issues of staff "resistance" to prevention activities, resistances which highlight the differences in professional identity and values between clinicians and prevention-oriented C&E staff. While not necessarily contradictory, the values of the two are in different dialects. Bergner notes as an example that both share the value of "helping people," but clinicians frequently experience an indirect service role as depriving the client of service. C&E prevention staff maintain a sense that their community interventions promote health and helping resources even though they may have to wait several years and take quiet credit for far removed "ripple" effects (Todd and Armstrong, 1984). As different ideologies it is easy to imagine the barriers which existed to a full acceptance or even understanding of the C&E approach by direct treatment-oriented CMHCs.

Late Developments in C&E: 1978-1983

Even as C&E was the youngest child of the CMHC services, frequently born after the 1974 amendments, host CMHCs were rapidly aging in their seed funding cycles: many graduated before 1981 and most could read the writing on the wall. C&E itself developed rapidly and appeared to reach for a new level of sophistication just as the CMHC Act itself was being repealed. The Staff College of NIMH initiated technical assistance workshops for C&E development, offered in cities around the nation starting in 1978. The technical assistance was designed to offer training and sharing of resources to executive directors and C&E directors and staff. NIMH had begun to exert a more thorough

influence through its annual site visits to the recipients of C&E grants (illustrated in the data of this work). A Prevention Council (now the Executive Council of the Prevention Section) was formed in the National Council of Community Mental Health Centers (NCCMHC), fostering further self-improvement and innovation by C&E staff in prevention activities. In 1979, NIMH convened the first National C&E Conference, allowing C&E staff to "network" with, train and empower themselves. The field had developed a distinct professional identity which, while diverse, was maturing rapidly.

Despite the developing sophistication of C&E units, agreed upon definitions or guidelines for C&E within service agencies remained vague at best. The NIMH guidelines offered little basis for evaluation of C&E activities, nor could a center's commitment to C&E services be judged with any consistency. The Joint Commission on Accreditation of Hospitals issued its "Principles for Accreditation of Community Mental Health Service Programs" in 1973 (later revised, 1981). The JCAH accreditation was considered useful in qualifying for some third-party payment plans and included C&E-like activities under its Service Function Area (i.e., prevention) and its Citizen Participation and Research and Evaluation Areas. Scrutiny of the actual conditions of accreditation, however, revealed extremely minimal or optional standards which would be met in almost any catchment area (JCAH, 1981). As David Snow and Tom Wolff suggested, these guidelines once again indicated that prevention was not the task of mental health service providers:

These patterns seem to stem from continuing ambivalence about whether programs of mental health consultation and primary prevention are to be defined as essential components of mental health services. (Snow and Wolff, 1983, p. 39)

Negotiations were being conducted at that time with NIMH by C&E directors who sought new C&E guidelines and a definition of C&E within the upcoming Mental Health Systems Act of 1980 (Snow and Wolff, 1983). Tom Wolff, then Chair of the Council on Prevention, directed a Task Force and Subcommittee in the development of NCCMHC guidelines for C&E services in CMHCs. The effort represented an attempt by C&E specialists to define themselves in the absence of appropriate action by NIMH. The process of drafting the guidelines in itself illustrated the maturing professional identity in the field. Published first under separate cover in 1982 (Snow and Swift, 1981) and later in the NIMH-funded journal, Consultation (Snow and Wolff, 1983), the "Recommended Policies and Procedures for C&E Services" provided definition along five dimensions: (1) mission, goals and service domain; (2) organization; (3) program planning; (4) fiscal and contract management; and (5) ethical principles.

The primary mission and goal of C&E services is identified by the authors as "primary prevention and the promotion of individual and system development" (Snow and Swift, 1981, p. 3). Service dimensions are organized in three categories: (1) training and education; (2) consultation; and (3) community network development.

Organizationally the C&E unit is to have a budget (or fiscal cost center within the center budget). Staff structure can be specialist or generalist, but is to be specified in designated portions of FTEs within the center's budget. The director is to be a specialist (and full time if possible) with equal organizational standing to that of other program directors. The C&E cost center should document billing and accounting procedures which protect C&E fees and grant dollars from being diverted to other programs (a standing problem with some of the ghost budgets submitted by centers to NIMH). Perhaps most prophetically the "Policies" recommends a permanent subsidy by the center for C&E services, to permit a stable core of C&E staff to offer some minimum of services regardless of the ability of clients to pay fees.

This final provision is most illuminating in "Policies" which were published the same year that all remaining C&E grants were expiring. It suggests that the authors believed that a C&E philosophy of service could not exist on a strict fee-for-service basis. It remains to be seen what kind of enduring influence the "Policies" may have on the course of C&E.

It has already been observed that C&E was often one of the first services to be reduced or cut with the graduation of the center from federal funding (Naierman et al., 1978). In their article, "Leadership Strategies and Values in Times of Scarcity " (1982), Kraft and Kraft note that values shift with necessity. In times of relative prosperity organizational leaders manage on the basis of questions such as, "Why are we doing this? and Ought we to be doing this?" (p. 179). During

times of scarcity and shrinking resources, however, the questions change to, "How can we survive? and What can we afford (in dollars)?" (p. 178). While such a shift in concern was true for centers overall, it was particularly true for the question of C&E, its mission, and its survival. In many cases the C&E activity which survived the graduation of CMHCs from federal dollars revealed an orientation or goal structure more attuned to survival than to previous C&E values. Perhaps what is most surprising is the degree to which C&E services preserved significant vestiges of the previous ideology.

The plight of C&E was predicted to be a dire one. In their review of conference participants in the NIMH Graduation Conference, Woy and Mazade (1982) cite the prediction of federal experts that, "there will be an immediate cessation of indirect services such as consultation/education" (p.357). The exceptional vulnerability of C&E to cuts is explained in part by the observation that indirect services were never the central task of CMHCs (Snow and Newton, 1976). Retrospectively, Backer and his associates (1983) suggest three particular vulnerabilities of C&E. First, they note that C&E was tied closely to the field of prevention and shared in "the numerous peaks and valleys of the prevention movement." Despite the Task Panel on Prevention and its conclusions in 1978, there was no more of an observable national mandate then for prevention services than in 1963). Second, the long range, indirect goals of C&E made it difficult to evaluate, measure or document its impact. It was hard to see its worth in the same light as a therapy session with a troubled family. Third, they observed that C&E was largely action

oriented, failing to develop much of a body of literature, especially in the establishment of scientific press. As Tom Wolff observed, "community consultants don't write" (Armstrong, 1981).

Bergner (1981) suggested that one of the sources of vulnerability for C&E was that center directors did not know how to manage the C&E function in such a way as to preserve it. She notes additional vulnerabilities including: (1) lack of definition in the original legislation; (2) the moral press and practical imperative of demand for direct service; and (3) a lack of competent C&E specialists. Bergner suggests that the four most common reasons for C&E "failure" (elimination) were financial instability, lack of community support, lack of program evaluation, and a lack of institutional protection. She concludes that "the most common reason for the collapse of consultation programs is their reliance on federal monies" (p. 244). While pragmatically true, such observations fail to note that "C&E" was created by federal monies and that its original mission frequently reflected its role as a public service.

Many survival tips were offered to C&E directors. The NCCMHC study on "Action Strategies for Survival" (Goplerud et al., 1983) suggested that C&E units teach other people in the community to do their own C&E. Centers might "transfer" C&E that didn't make money to other agencies and examine any C&E given away for free strictly on the basis of its dollar worth as advertising. C&E that survived was going to have to change its techniques and target populations in "directing

services toward paying markets" such as employee assistance plans (EAPs) with companies. Health promotion, organizational consulting and behavioral courses such as stress management and parent training were to be targeted at those with the money and interest to pay for the services. "Needs assessment" changed to "marketing." Survival could be enhanced through the separation of C&E from the mental health center, which was now increasingly associated with the chronic, deinstitutionalized patient, a group with which many of the potential C&E clients would not want to be associated. In establishing separate and more plush professional offices, the C&E unit could become the marketing arm of the mental health center to business, industry, and middle and upper class clientele. Raber (1983) offers the successful marketing of his "Growth Associates" in Kansas as a model for survival of C&E as "a department of personal and professional growth services." He notes that "traditional C&E" represents only a small part of the overall unit activities, which range from management training and organizational development to inpatient hospitalization under the auspices of their EAP.

EAPs were widely touted early on as one of the keys to C&E survival. Sodano and Woy surveyed a number of centers and C&E directors to examine the role of EAPs in supporting and altering C&E activities. They note that the new initiatives with industry were not likely to replace lost federal revenues and threatened to divert dollars and attention from "the values of educating and developing the community at large" (Sodano and Woy, 1983, p. 82).

These concerns reflect the terrible dilemma faced by C&E directors and staff. While many saw the situation as an exciting challenge, the propensity of C&E staff toward optimism verging on denial had been observed (Backer et al., 1983). D'Augelli (1980) noted that survival would force a change in some of the defining techniques and target populations and goals of C&E. He predicted that C&E would become an increasingly more center-based service to the "YAVIS" population that had money. Poor or hard-to-reach populations, as well as favored C&E activities such as community organizing, social action or consultation to natural caregivers, would all disappear. He summarized the dilemma as this: "How to maintain a focus on the underserved while seeking third-party payments?" (p. 19). Key informants in the survey on EAP's by Sodano and Woy (1983) spoke of serving "two cultures" and "selling our souls." There was considerable angst in the C&E movement. Survival and even prosperity could be had, but only at the price of change.

As perhaps its last service to C&E, NIMH conducted a national evaluation of consultation and education services in mental health programs through the Human Interaction Research Institute in Los Angeles (Backer et al., 1983). The survey was conducted in January of 1983, approximately five months after the last of the C&E grants had expired. The "Final Report," issued in August of 1983, focuses on survival strategies for C&E. The report offers the most thorough information to date on the state of C&E services after graduation from federal monies.

The subject pool consisted of the cream of the crop of CMHCs with regard to C&E. Recipients of C&E grants (149), which could be expected to have more developed C&E services than other CMHCs, were surveyed along with centers recommended to the researchers for their exceptional C&E units. A response rate of 51% provided 91 useable questionnaires. The data indicated only a 4% "failure" rate among C&E units, although the fate of the other half of surveyed units that never responded left this figure open to considerable debate. As Tom Wolff comments in an editorial, it's a bit like mailing out a questionnaire that asks if you are homeless (1984).

Among those centers that continued to offer C&E services, 24% no longer had separate C&E units. Backer and his associates comment that this may not represent a significant change:

...since there is considerable anecdotal evidence to suggest that many local agencies from the beginning did not really consider their C&E projects to be a separate part of the agency but had to report them that way because of federal funding requirements, which now have been eliminated" (p. 80-81).

Perhaps more revealing was the fact that 41% of surviving C&E units anticipated changing their name in the near future, assumedly to reflect more accurately their altered roles based on new sources of income.

The data describes the parameters of C&E services in those centers where it continued to be offered. Organizationally, 21% of the centers had specialist units, 26% used a generalist model and 56% reported mixed structures. Approximately 60% had full-time C&E directors, with only 20% reporting quarter-time or less for the director's position.

Most C&E services had considerable overlap with clinical programs and showed some influence of marketing pressures, as evidenced in Table 3, reported C&E activities. Almost 90% of the centers reported some form of C&E goals, listed in Table 4. While similar to earlier reported goals, it is notable that two out of the six goals are concerned exclusively with C&E survival.

Income was a central concern for obvious reasons. The report listed as one of its chief tasks a number of successful innovations in fee production by C&E projects. The authors note, however, "that most of the innovations reported in this study are generating income, if at all, just sufficient to offset costs" (p. 81). The average C&E budget was \$133,440 with a lower median of \$92,000. Almost one-fifth of centers reported a drop in budget size from the previous year.

Examining the impact of funding changes, 79% of the centers surveyed reported changes as a result of shifts in funding and program priorities -- and more cuts were expected. The cause and consequences of these changes were strongly supported by surveyed experts on the state and county level.

The results were surprising if only in the high survival rate of reported C&E services. While raw survival appeared to be possible, the researchers note a change in the mission or ideology of continuing services, as C&E staff:

...reconceptualize their roles in the mental health service process, in order to redefine new areas of impact that also provide long-term funding viability and gain community support (p. 82).

Table 3
C&E Staff Activities

	N	% of respondents who answered item (N=76)
Providing consultation & support to other professionals and social service agencies.	47	62.0
Providing information and educational programs regarding selected populations.	47	62.0
Providing information and educational programs to the general public.	35	46.0
Providing technical assistance to and education programs for private industry and business.	19	25.0
Serving in a public relations capacity.	19	25.0
Providing in-service training for staff.	13	17.0
Serving as a community resource and referral center	12	16.0
Developing and disseminating printed and audio visual materials	10	13.0
Conducting research	1	1.0
Agencies not responding	11	---

Note: From Final Report: National Survey of Consultation and Education Programs by T.E. Backer, I. Levine and W.P. Erchul. Los Angeles: Consultation Research Program, Human Interaction Research Institute, 1983.

Table 4
Typical C&E Goals

-
1. To increase the visibility and acceptance of mental health services in the community.
 2. To educate the general public regarding mental health concepts.
 3. To increase knowledge and skill level of staff members and community health service practitioners through continuing education programs.
 4. To encourage and facilitate the establishment of effective linkages among agencies/organizations and individuals for the betterment of community mental health.
 5. To continue to offer existing C&E programs and to establish new ones.
 6. To increase revenues by developing fee-for-service programs, conducting fund-raising activities, and discovering new sources of funding.
-

Note: From: Final Report: National Survey of Consultation and Education Programs by T.E. Backer, I. Levine and W.P. Erchul. Los Angeles: Consultation Research Program, Human Interactions Research Institute, 1983.

This reconceptualization required a redefinition of the mission of C&E services which, at times, directly contradicts previous C&E values. Backer and his associates report the distress expressed by many respondents:

There is some movement today, alarming to many of the observers who contributed to this study, toward keeping only those services that produce service, clearly at variance with some of the original philosophies of community mental health, prevention and C&E (p. 83).

Without public funding, the finer points of CMHC philosophy were expendable as centers hustled to maintain their central task of delivery of direct clinical services.

The prospects appeared sobering and particularly emotionally disturbing for C&E staff who developed a professional identity in the previous environment of federal funding. As Backer and his associates state, many of the responses were frustrated and depressed in tone:

The emotional tone of a substantial number of respondents is bleak: there are fears that C&E simply won't survive the present set of problems, and that without increased funding, good ideas and even exploitable client opportunities simply can't be realized (p. 81).

Part of the difficulty seemed to be a lack of experience and continued ambivalence on the part of center administrations about moving wholeheartedly into the entrepreneurial market of indirect services. Many directors were understandably hesitant to take the risk of investing the significant amounts of dollars and time required for product development and marketing in the private sector. Public mental health service systems were not structured for or experienced in risk-taking for

profit enterprises, regardless of ideological conflicts.

The report concludes with a list of promising possibilities for generating revenue (making money). Although the authors warn against supposedly low-risk "gold mine" innovations in the tradition of no free lunches, they suggest six areas of opportunity, including: (1) EAPs; (2) health promotion and wellness programs; (3) work with the deinstitutionalized chronic populations; (4) private industry; (5) consultation to psychosocial rehabilitation programs; and (6) collaborative enterprises with health maintenance organizations (HMOs), hospitals and nursing homes. Despite the promising nature of these areas of opportunity, the authors conclude with the observation that the fate of C&E remains closely tied to that of prevention as a service paradigm still struggling for legitimacy in society:

...there is a recognition that many traditional C&E efforts are simply not likely to survive without funding that comes on the basis of a general priority in the prevention area... (p. 83).

The report of Backer and his associates generated considerable comment among C&E professionals, some of which is usefully captured in the editorials which followed a synopsis of the findings published in the journal, Consultation (Backer et al., 1983). The survey was also taken as a basis for this present research. Many of the comments about the HIRI study refer as well to the findings of this current research and as such, are taken as a starting-point for the discussion of results in this present work.

CHAPTER II

METHODOLOGY

The purpose of this research is to document the current status of consultation and education services in CMHCs. This research follows that of Backer and his associates (1983) described above and attempts to address some limitations in the methodology of that study. The low response rate of that survey (51%) and the elite qualifications of the subject pool left two questions unanswered: (1) What happened in the 49% of centers that didn't respond? and (2) How did the status of C&E services differ in those CMHCs which did not receive categorical C&E grants and, therefore, did not qualify for the subject pool? More than 81% of all CMHCs never received a C&E grant, yet were required to provide C&E as a mandated service. The focus of this research differs from that of the HIRI study. Instead of seeking to identify survival strategies as the HIRI study did somewhat successfully, this research is primarily concerned with documenting the changes in mission and activities of C&E services along with the changes in size and funding. The goal of this study is more descriptive in its attempt to examine both the raw survival rate and the qualitative differences over time of C&E services and the causes of such changes. Finally, this research serves as a follow-up to the HIRI study, with data collected 1½ years after the previous survey and almost 2 years after the expiration of all C&E grant funds from NIMH. It is hoped that this time difference will allow some examination of trends hinted at in the HIRI study.

This research is historical as well as current. In an attempt to examine changes over time, a history of C&E services was compiled for each participating center. The research also examines historical variables such as the C&E unit structure and size in an attempt to identify those dimensions which might have predicted the present survival of C&E services in that center. Analysis was not expected to reveal statistically significant causal relationships. Rather, it was hoped that certain descriptive trends might be suggested in the findings.

The methodology was selected in an attempt to promote descriptively detailed data, while allowing for generalizations to be made concerning a group of centers representative of the CMHC system. As such, a combined case study/survey methodology was developed. A C&E unit with which the researcher had extensive familiarity was selected for a detailed historical case study. The case study examines the unit along several dimensions, including:

1. goals and objectives
2. organizational structure
3. funding patterns
4. project activities
5. staffing
6. impact and outcome of activities

These dimensions were examined along the seven years of the unit's existence from 1976 to 1982. Trends and details of this case were examined both to document the precise nature of C&E activities in one CMHC and to offer some suggestions as to the cause of its demise with the end of its C&E grant.

Relevant variables were then taken from the case study and applied to other centers. It was felt that a high rate of response was needed in the survey to allow conclusions to be made which pertained to the CMHC system as a whole. The size of the CMHC system, however, and the pursuit required for a high response rate necessitated the selection of a small subject pool. Previous research reviewed above had also predicted that state environments would become increasingly central to the development of CMHCs after graduation from federal funding. It was noted that state environments differed widely in the support available for a CMHC model of mental health services. Data from national surveys such as the HIRI study necessarily obscured these differences. In an attempt to limit the subject pool size and in recognition of these state differences, CMHCs in the state of Massachusetts were selected for the survey. The survey pool was defined by the NIMH 1981 "Directory of Federally Funded CMHCs" (NIMH, 1981) which listed all CMHCs in Massachusetts that received federal NIMH grants during the final grant cycle, 1981-82.

A questionnaire was designed based on the HIRI questionnaire and on the findings of the case study (see Appendix A for a copy of the questionnaire). The survey was conducted using the NIMH directory. All 25 Massachusetts CMHCs were contacted. An attempt was made to contact more than one person in each center with preferred respondents being executive directors, C&E directors, or former C&E directors. The survey was administered by telephone or in-person interviews with mail survey forms used as a back-up when requested.

In addition to the survey, several other sources were used to augment the data. An archival review was made of the NIMH grant records of all C&E grants made in Massachusetts (29 grants over six years). State Department of Mental Health documents were reviewed to examine in greater detail the current state environment in which CMHCs operate. Documents reviewed included the DMH "Proposed Budget for Fiscal Year 1986" (July, 1985 to June, 1986), the DMH "1985 Block Grant Proposal" submitted to the federal government, and various DMH memos pertaining to the budgets and services of DMH partnership clinics (a majority of CMHCs in this state also have DMH "partnership" contracts).

Finally, state and federal experts were interviewed where possible to gain further clarification of the data and expert opinions as to trends evident in C&E services. Experts interviewed by phone or in person included:

Dr. Leon Nicks, currently Administrator of Region I (New England) of the Public Health Service and former Director of ADAMHA for Region I, representing ADAMHA and the PHS Institutes, including NIMH, and participant in the drafting of the 1975 NIMH regulations encoded in the 1975 CMHC Act amendments.

Brian Flynn, currently with the NIMH Cuban Refugee Project and formerly a Region I Administrator and C&E Technical Consultant for NIMH

Dr. Richard Woy, currently Clinical Director of the Dorchester Mental Health Program and former NIMH College Staff member and Acting Chief of the Program Analysis Branch, Office of Program Development and Analysis, NIMH (reported on the NIMH Conference for Graduating CMHCs).

Elizabeth Funk, Executive Director of the
Massachusetts Association of Mental Health
Service Providers

John Lichten, Acting Associate Commissioner,
Massachusetts Department of Mental Health

Milton Wolk, Assistant Director of Health
Education, Massachusetts Department of
Public Health

Harry Schulman, President of the Massachusetts
Association of Mental Health Service Providers
and Executive Director of South Shore Mental
Health Center

Dr. Thomas Wolff, former Chair of the Council
on Prevention, National Council of CMHCs and
former C&E Director at Franklin/Hampshire CMHC.

A standardized questionnaire was not used for the interviews of experts listed above. As such, the results are included in the reported case study, survey results and discussion section where relevant to an understanding of the data.

The collected data is reported in four sections. First, the case study of a C&E unit is presented in detail. Second, six case histories are presented of those C&E units in Massachusetts which received NIMH C&E grants. The case histories integrate NIMH archival data with questionnaire data from this survey. The third section reviews the survey data for all 25 CMHCs in the state, including the centers reviewed as case studies. Comparisons are made between centers which received C&E grants (6) and those which did not (19). Finally, the history and current status of mental health services on the state level in Massachusetts are reviewed as an aide to the interpretation of data.

In review, the questions this research seeks to address may be summarized as follows:

1. What were the C&E resources (staff and services) in CMHCs in Massachusetts and what are they currently? How have C&E services fared in this state since graduation from federal funds?
2. How does the current profile of C&E services differ in organization, goal or activity from the pre-1981 profile?
3. Did any pre-1981 variables in C&E structure, funding, or service orientation seem to predict later survival of C&E services in that CMHC?
4. What consequences do the changes observed carry for the prevention mission of CMHCs in this state?

CHAPTER III

RESULTS

Section 1: A Case Study of the Rise and Fall of C&E Services in One CMHC

Introduction

The subject of this case study is the C&E unit of the Franklin/Hampshire Community Mental Health Center (F/H CMHC) located in Northampton, Massachusetts. The catchment area for the center consists of two largely rural counties spanning the upper Connecticut River valley and foothills of the Berkshire mountains in western Massachusetts. The three major towns include the county seats, Northampton and Greenfield, along with Amherst. The area is known academically for its four colleges, including Amherst, Hampshire, Mount Holyoke and Smith, as well as the University of Massachusetts.

This particular unit was chosen because of its unique reputation and because of the researcher's familiarity with the center and the C&E unit, having been employed by the center in various capacities from 1979-1983. The C&E unit was directed by Tom Wolff, former Chair of the NCCMHC Council on Prevention and recipient of the 1984 NCCMHC Award for Distinguished Service in Consultation, Education and Prevention. During its approximately 6½ years of existence, the C&E unit reached 7.5 FTE specialist staff positions at its peak (1979-80), received over \$438,000 in NIMH C&E grants and \$370,000 in federal grants from other sources, and completed three nationally noted model projects in

prevention. C&E staff presented extensively at national and regional conferences, hosted two regional conferences on prevention, and published several papers and technical reports (Wolff and Crisci, 1979; Armstrong, 1981a, 1981b; Peterson and Hutchinson, 1982; Wolff, 1982; Warner, Hutchinson, Shannon and Armstrong, 1982; Armstrong and Warner, 1982; Snow and Wolff, 1983; Wolff, 1984; Todd and Armstrong, 1984).

The case study is based in large part on an unpublished history of the unit, "The Rise and Fall of a C&E Unit" written in draft form in 1983 by Tom Wolff. The researcher assisted Dr. Wolff in compilation of data for the history. This case study represents an edit of Dr. Wolff's manuscript combined with data from extensive interviews with Dr. Wolff and review of F/H CMHC documents and NIMH C&E Grant Proposals submitted by F/H CMHC.

In 1970, NIMH staffing and construction grants were awarded to a consortium of mental health agencies representing Franklin and Hampshire counties. The fiscal conduit or designated recipient was a general hospital. Funds were used to support the services provided by the agencies, as well as to build and staff an inpatient psychiatric unit at the hospital. With the increase in mandated services required by legislation in 1975, the hospital management decided that the funds were too costly to administer and withdrew from the consortium.

The remaining agencies, joined by a few others to round out the list of required services, decided to create an independent administrative office which would function simply as a fiscal conduit for the grants. A new CMHC board was formed in 1975 representing the consortium of

approximately 7 agencies. Board members conducted a needs assessment which identified three populations in need of services, including the elderly, children, and victims of sexual assault and domestic violence. Board members wrote and submitted to NIMH grant proposals for operations and C&E grants in the name of the newly-formed nonprofit corporation, the Franklin/Hampshire CMHC.

Notices of awards for these grants arrived in October, 1976. An executive director was hired in December, 1976 to administer the funds. The only service function to be delivered directly by F/H CMHC was the new C&E services. A director of C&E, Tom Wolff, was hired in April, 1977 with four C&E staff (representing 3 FTEs), hired by May, 1977. The executive director, assistant and secretary all shared the same basement offices with the C&E unit. The C&E unit actually shared the same room, making intra-unit communication rather unavoidable -- everyone knew what everyone else was doing.

One may note that the C&E and administration functions began after monies were awarded. The executive director used the unspent funds from the operations grant to hire additional administrative staff. This was the beginning of a steady expansion which marked F/H CMHC as an "empire builder" among area service providers. The executive director steadily brought more and more of the service functions inhouse with the support of NIMH, which favored a strong administrative structure with line authority over funded staff positions (permitting greater direct accountability to NIMH). By 1983, F/H CMHC had approximately 10 service

programs and four subcontractors. Services included outpatient clinics, half-way houses, emergency services, day-treatment, MR and MH case management, alcohol counseling and early childhood developmental screening programs.

The C&E staff consisted of one man, the director and a clinical psychologist, and four women, MSWs and master's level human service workers. Staff were hired based on their expertise with and interest in working with the three at-risk populations identified by the Board's needs assessment. These populations remained a focus of C&E throughout the unit's existence, guiding the specialization of staff and their development of contacts and reputation. The three major federal grants awarded later for prevention projects were all within these areas.

The C&E director, Tom Wolff, identifies three phases which describe the history of the unit, including:

Start-Up Phase:	June, 1977 to March, 1979
Big Boom Phase:	April, 1979 to June, 1981
Collapse:	July, 1981 to September, 1982

The dates are rough approximations of periods of change, often marked by the award or expiration of major grants. The curve of these three phases is evidenced in Figures 1 and 2, which chart the C&E total income and FTE staff positions by year. It should be noted, as suggested by the names, that the phases reflected staff spirits and feelings, as well as raw dollar and staff hour figures. With the seed funding process the staff was hired on what amounts to a race against the clock to become self-sufficient. As such, the Unit was painfully future-conscious and the changes in feelings, plans and even roles during each

FIG. 1: Full-Time Equivalent Staff Positions in Specialized Consultation and Education Services at Franklin/Hampshire Community Mental Health Center.

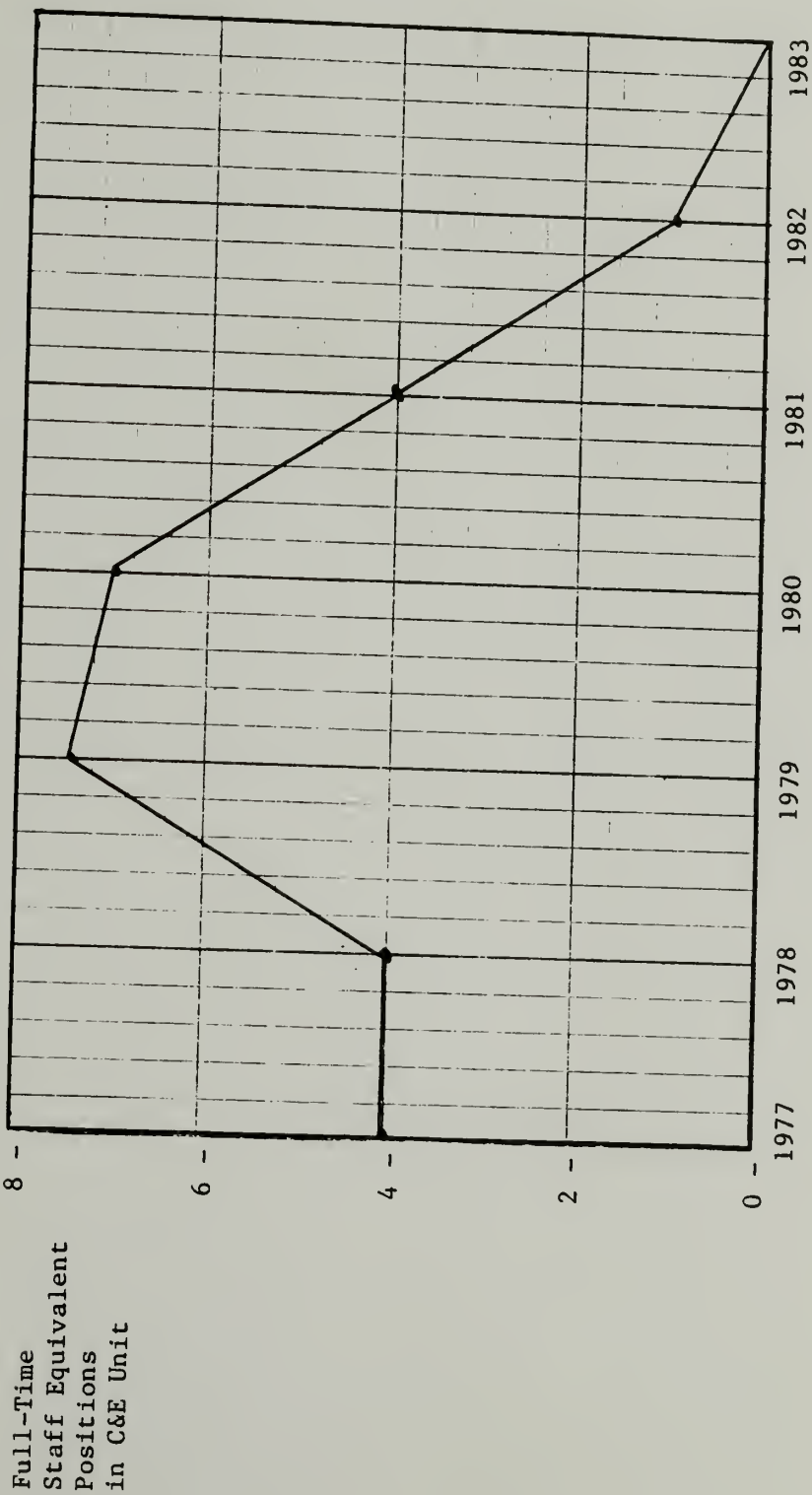


Figure 1

FIG. 2: Yearly Budget and Sources of Income for the Consultation and Education Unit of Franklin/Hampshire Community Mental Health Center.

Key

- NIMH - National Institute of Mental Health C&E Grant
- AoA - Agency on Aging Model Projects Grant
- LEAA - Law Enforcement Assistance Administration Grant
- NCAAN - National Child Abuse and Neglect Model
Projects Grant
- Other - Fees and Smaller Contracts

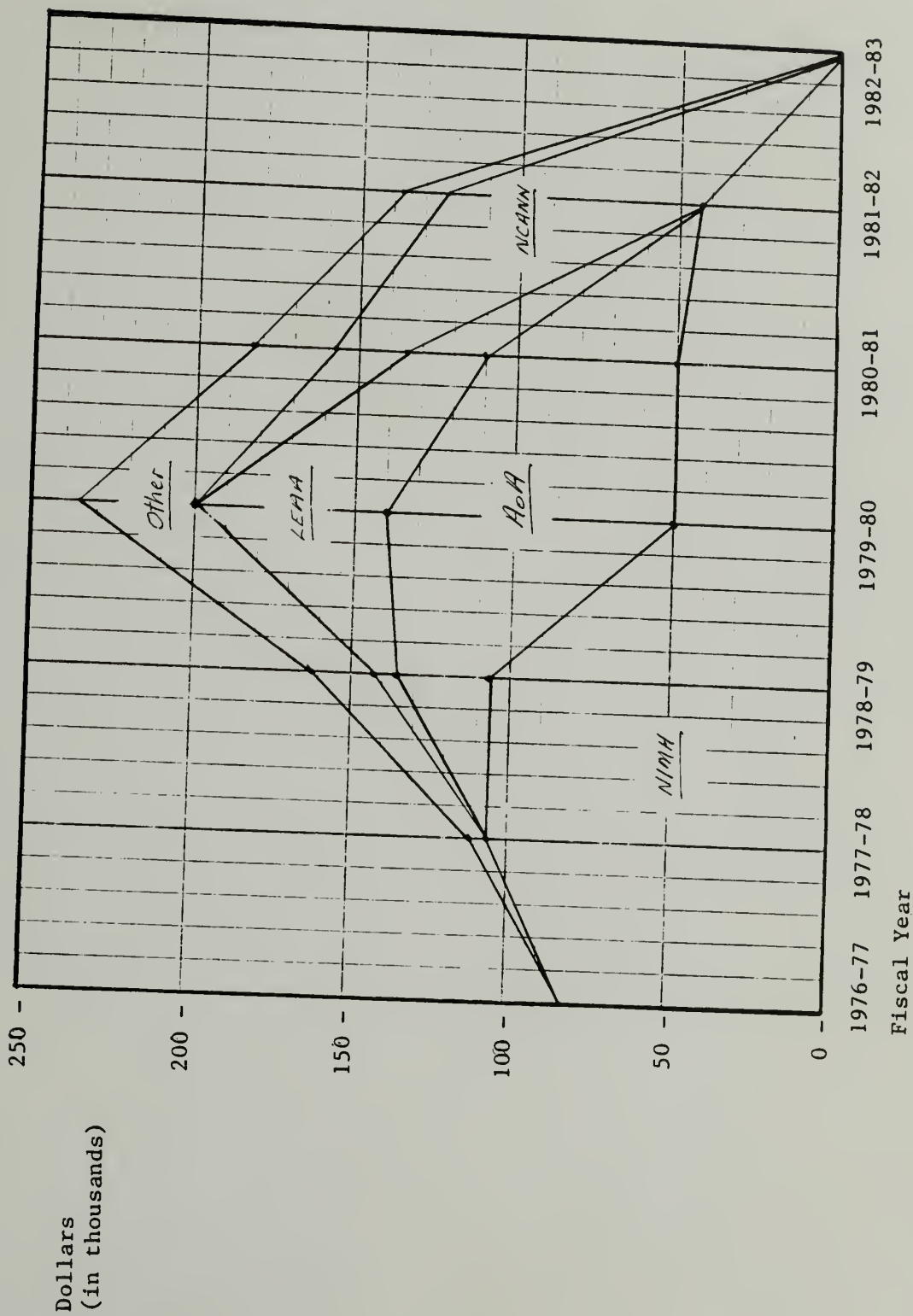


Figure 2

of the three phases typically occurred some weeks or months before the actual changes in funding or staff positions. As such, the dates chosen represent a rough compromise between these variables.

Start-Up Phase: June, 1977 to March, 1979

The Start-Up Phase is remembered fondly by staff members as a time of excitement and close staff unity. This unity was evidenced in the development of an explicit mission statement which remained essentially unchanged throughout the unit's history. It can be argued that it was this unity around mission which both led to the unit's success (by focusing resources) and to the unit's later demise (by limiting flexibility). The mission was expressed in four principles and six goals (see Table 5, F/H CMHC C&E Goals and Objectives). The four principles of service delivery included:

1. Prevention and health promotion
2. Development of individual and community competence
3. Reliance on individuals and groups in the community to be the agents of service delivery and change in their own communities
4. Promotion of collaboration among area service agencies

The organization of the C&E unit was to be that of a specialist unit which pursued its prevention goals as one service of the center. The C&E director had direct access to the executive director (indeed, he was half of the administration at first). While apparently well defined, issues of boundary definition with administration developed quickly. Throughout the three phases there were pressures placed on C&E

Table 5

Franklin/Hampshire Community Mental Health Center
C&E Goals and Objectives

I. Promote Individual Family and Community Competence

A. Objectives

1. To encourage individual and family competence to cope with developmental and transitional periods and stress
2. To support community strengths by fostering social support networks and self-help groups, and aiding natural helpers

II. Broaden the Scope of Caregivers

A. Objectives

1. To educate caregivers (service delivers, teachers, para-professionals) to more effectively learn people's needs and to identify and use resources to meet them
2. To increase caregiver's emphasis on preventive programming

III. Impact Organizational Practices

A. Objectives

1. To help organizations find new ways to solve problems
2. To optimize staff performance

IV. Foster Coalitions of Community Resources

A. Objectives

1. To promote collaborative problem-solving among community groups
2. To exchange needs and resources within the community

V. Influence Social Policy

A. Objectives

1. To increase awareness of and information about the impact of social policy on people, with special attention to policies with a preventive focus

Table 5 (continued)

-
- VI. Increase Community Understanding of Mental Health and Knowledge of Resources
- A. Objectives
1. Create and disseminate information about mental health resources
 2. Increase knowledge and change attitudes about mental illness
 3. Increase accessibility and availability of mental health services
- VII. Assess the Needs of Citizens in the Franklin/Hampshire Area and Plan Consultation and Education Activities Based on these Needs.
-

to perform center-wide tasks such as public relations (advertising) and grant writing. These tasks were performed to greater and lesser extents throughout the three phases, resisted strongly during the first two, then relied on during the third phase in an attempt to maintain support for C&E staff positions. Perhaps the one line that was drawn more absolutely was around case consultation. A request from the executive director was made in the first year to send one of the C&E elder specialists to a nursing home to do reimbursable case consultation. The C&E director supported the elder specialist's refusal, pointing out that it did not fit the prevention mandate. While staff trainings were later conducted with nursing home staff, case consultation was not.

An Aside on the Limits of NIMH Data

Boundary definitions were most clearly violated in financial records and budget figures. C&E never had an identifiable budget or cost center accounting of income and expenses. One could never tell much about the C&E budget from the NIMH C&E grant proposals submitted, despite the extensive reporting requirements (see Table 6, F/H CMHC C&E Budgets in Grant Proposals).

This was the case across centers and is due to problems with the application process. The budgets submitted were projections of the future, not statements of current or past budgets. In the case of F/H CMHC and many other centers, they were estimations because C&E was not a distinct budget line in center accounting. As applications for funds, the proposals tended to be rather optimistic, especially about future income. This is due in part to the NIMH allocation formula used

Table 6

Franklin/Hampshire Community Mental Health Center
C&E Grant Proposal Budgets (in dollars)

Year	Source					TOTAL
	Federal	State	Applicant	Local	Other	
1976	81,866					81,866
1977	106,500					106,500
1978	106,500	20,000	14,000		12,000	153,000
1979	50,000	64,000	18,000	15,000	163,000	310,000
1980	50,000	46,000	12,000	5,000	216,000	329,000
1981	43,170	40,000	23,000	175,000		281,170
TOTAL:	438,036	170,000	67,000	195,000	391,000	1,261,036

to set the amount of the awards. The formula was based on the population size in the catchment area combined with some fraction of population or income, whichever was lower. Centers regularly over-estimated C&E income to qualify for a larger award and penalties were not as a rule exercised over such estimations. NIMH was concerned that C&E become self-sufficient and liked to see increasing C&E funds in the C&E budget columns for "Applicant," "State," "Local," and "Other." This assumedly meant that C&E was producing income above and beyond the NIMH grant and that the center was devoting additional resources to C&E.

In the case of F/H CMHC, these factors combined to create optimistic or ghost accounting in the grant proposals. A more accurate measure of the C&E unit could generally be had from the list of personnel salaries paid for by the grant. In the case of F/H CMHC there was regularly some padding, but less so than with the budgets. An administrative assistant was partially supported for many years as a part-time C&E research and evaluation specialist. This padding reflected a general plight of administration in CMHCs. Various funding sources, such as DMH contracts, fee-for-service and insurance were extremely limited in their use and administration turned frequently to grants, including the C&E grant, to cover administrative overhead.

Padding was also evident in the grant proposals in the list of auxilliary C&E staff positions paid for by other sources. This list was meant to be a back-up for the high projected income figures submitted.

At one point in the third year (1979-80), the C&E staff consisted on paper of 22 people representing 11 FTE positions. In fact, the core specialist unit was up to 7.5 FTE with some additional funds going to staff in a prevention agency C&E was supporting, so the figures weren't so far off. One could never figure out, however, the actual size and structure of the C&E unit from the NIMH records alone.

Internal organization of the C&E unit during the first phase was rather flexible. Communication between staff was high, due in part to their all sharing one office. The clarity of the unit's mission also contributed to a strong sense of team spirit and support. A regular weekly meeting based on the case conference model was used to keep staff informed of individual projects. This allowed for group supervision and a sharing of resources and contacts. It also permitted a certain flexibility in role as consultants were able to fill-in for each other based on familiarity with the people and projects. The dense internal organization and clear mission no doubt contributed to the rapid development of a positive reputation in the community.

Staff activities during the Start-Up Phase were characterized by diversity and extensive contacts. The C&E unit, during this phase, was most able to respond quickly to requests for service from diverse groups and agencies. A needs assessment was conducted in which over 100 groups and agencies were interviewed and familiarized with C&E services ("dog and pony shows"). Films were distributed, program consultation was developed, community forums were joined or created and relationships built. Service could be offered for free and quickly

with an education process developing which oriented the area agencies increasingly toward prevention. Excess funds from the first year were used to present a regional conference on social networks and network interventions. The conference featured national and regional speakers at low cost to the community and served to further public awareness of the unit and its goals. The C&E director observed later that this phase effectively introduced prevention as a valuable form of activity to the community:

It was clear that the community understood the concept of prevention and was very willing to engage us in project development in that area, although they could not provide the resources to fund those activities (Wolf, 1983, Note 5).

The rural, scattered population and relative small agency size did not readily offer fee-for-service funding large enough to support C&E as it was being practiced at F/H CMHC. As the staff noted frequently in strategy meetings and retreats through the three phases, the demand for fee-paying or reimbursable services was not prevention-oriented, but rather clinically-oriented. The C&E staff maintained the perception that without public funding, the prevention focus and target populations would have to be changed in order to generate funds. Negotiations with the Area Office of the Massachusetts DMH had not yielded any state monies for C&E and the staff could anticipate their NIMH funding declining. Grant writing was turned to as a temporary solution to carry on the growth of C&E services until such time as state and local dollars were more available. Grant topics were chosen in line with the target populations. In March, 1979 a two-year, \$180,000 Model Projects

prevention grant was awarded by the federal Agency on Aging (AoA). In September, 1979 an 18-month \$90,000 grant from the federal Law Enforcement Administrative Assistance (LEAA) program was awarded to support ongoing work with rape and domestic violence. And so began the Big Boom Phase.

Big Boom Phase: April, 1979 to June, 1981

Activities during this phase were expanded in volume, but narrowed in scope due to the grant project funding. The expanded but increasingly specialized staff grew to 7.5 FTE in 1979-80 and "contact hours" in 1980-81 totalled more than 24,000 hours reaching more than 9,600 people. The estimated budget peaked in 1979-80 at around \$235,000. Despite these increases, staff were unable to continue ongoing needs assessment interviews and were able to respond to local requests for service only when paid and when time allowed.

The AoA project involved 3.5 FTE and was focused on the support systems of elders in three rural townships. Middle-generation key support relatives and local natural caregivers were targeted for consultation and support. Elder forums were held to conduct needs assessment and community organizing. Education and program consultation was provided to elder clubs and agencies and community education, including mass media, was co-sponsored with these groups. Workshops for the public were provided and mutual help programs, including a support group for key support relatives, were developed. In all, the project reached a number of individuals and groups with support and information. Elder housing was successfully lobbied for and attained by citizen participants.

An Elder Service Task Group of county service providers was formed. Information concerning the model project was disseminated in a regional conference on prevention and elders, featuring Maggie Kuhn of the Grey Panthers. Numerous conference presentations, publications and manuals were produced (see list above).

The LEAA grant supported ongoing work with a network of agencies concerned with rape and domestic violence. Protocols for rape crises were developed with the police, district attorney's office, local hospitals and social service agencies. Rape prevention education was developed for school children, featuring films and materials on such topics as acquaintance rape. Program consultation was provided to a women's shelter for domestic violence and a women's counseling program. Research on domestic violence was conducted and published in local papers.

Despite the restriction of the grants, or perhaps because of their focus, several other projects developed. A mutual help directory for two counties was developed, printed and widely distributed using other agencies and donations of in-kind services from a printer, a newspaper and an insurance company. Training and program consultation contracts were developed with local and state agencies based on the unit's expertise. There were increasing solid partnerships established with local agencies and groups, both through the contracts and through the grant projects (which permitted extensive free service within the project guidelines). The unit was increasingly represented

on community boards and committees (some of its own creation) with access to area decision makers. While local funds were restricted, during 1980-81, 42 local funding sources made up almost one-sixth of the estimated C&E budget.

The prevention activities evidenced in C&E services during the Big Boom Phase offer a useful insight into the debate over whether C&E was ever truly prevention. This unit was explicitly prevention-oriented in its goals and mission. Despite that fact, the prevention practiced evidenced a typical C&E style of integrating many modes of intervention. Community interventions, unlike academic experiments, are not simply dropped on a captive audience. Access to populations is negotiated along personal contacts and interests. One rural town involved in the AoA grant project took a human service worker (whose time had been donated by the county) and put him to work painting the fire house. That's what they felt they needed and that's what they wanted. In some cases the diversity of activities which characterized the C&E services were not pure primary prevention. This diversity reflected the realities of community work. Consultants started with groups or agencies where they were (much as clinicians do with clients) and attempted through the course of the relationship to foster a shared definition of the problems. In this case, C&E consultants encouraged a preventive perspective and sought to empower individuals and groups through education, training and organizing, based on a systemic outlook. The complexity of this process was difficult to document or evaluate

given both the subtleness of the interactions and the long-term, indirect effects. The C&E staff frequently remarked with humor on newspaper articles that had been developed originally through C&E consultations. The model suggested that credit be taken only at a distance. As such, the C&E style of prevention was not conducive either to academic research style projects or to hard sell marketing.

A second observation should be made concerning prevention and the reduction in demand for direct service. The services of the C&E unit frequently increased demand for clinical service on the center. In educating populations about the nature of mental health and illness, C&E services promoted the identification of persons in need of treatment. As an outreach service, C&E also provided many of the residents with their only personal contact with someone from the center. Consultants were often advised by well meaning residents that they shouldn't even mention that they were from a mental health center. The C&E services and staff provided hard to reach populations with a link to direct services. The generalist role that many of the consultants adopted, while typical of rural mental health (Flynn, 1978), also reflected the fact that they were often the only folks getting out of the office. As a result of C&E prevention projects, the center eventually hired an elder mental health clinician and an incest/rape counselor. Clearly, prevention, C&E style, did not reduce demand for clinical services.

Despite the relative prosperity of the Big Boom Phase, pressure to find future funding sources continued to build. The Unit was heavily dependent on time-limited grants for funding. NIMH site visitors also expressed concerns. The 1978 site visit notes in NIMH files expressed cautions that the unit was not integrated enough with the "overall service pattern" of the center. No specific suggestions for change were made, however, possibly because "one of the most exciting programs of the center" owed much of its reputation to its specialized team structure (NIMH C&E Grant Proposal 374-03, Region 1, 1978-1979).

The following year, 1979, NIMH site visitors elaborated on their concerns and noted the strengths and weaknesses of the unit. In particular they recommended a greater emphasis be placed on fee-for-service case consultation using a mixed model structure to integrate other CMHC staff time:

This C&E program also differs from others in funding strategy. Rather than seeking contracts for individual case or school programs, this group uses a university type grant seeking approach. While this may develop a much more in-depth project type approach with a concomitant development of staff expertise in specialized subject areas, it is vulnerable since the funding is soft and time-limited. The unanswered question is whether the center could benefit even more from an equal emphasis on case and program consultation on a contract or fee-for-service basis utilizing other staff members in a coordinated, center-wide balanced C&E service system. This approach should emphasize not only prevention, but selected, reimbursable consultation activities (Site Visit Report, NIMH C&E Grant Proposal 374-04, 1979-1980).

It is significant that NIMH officers felt compelled to suggest changes in the goals, mission and structure of what the report itself characterized as, "one of the country's most notable prevention programs." Prevention did not appear to be a fiscally viable service for CMHCs.

Attempts to respond to these recommendations produced little change. The child expert on the C&E staff was not tied at this time to a grant project and was able, as a result, to develop a number of service contracts with many schools. Despite this work, and other existing state and local contracts for program consultation and training, a saturation point seemed to exist. Locally-generated income reached its plateau and began to drop. A marketing survey commissioned by the center indicated that the general public in the area would only support workshop services at about \$2 per hour, far below cost. An attempt to offer a series of training workshops for the public produced extremely low attendance ("workshops for empty chairs"). A significant gap still existed with the state DMH, which would not fund C&E.

Internal organizational issues began to arise. The C&E unit was simultaneously very busy (with ongoing projects) and very worried. Consultants were hired and staff retreats were arranged to facilitate team building and planning around survival strategies. Despite these efforts, the director and staff began to show signs of "burn out." Staff evidenced an increasing ability to aggressively seek fees and negotiate contracts, but reported considerable conflict over their mixed roles in refusing service to former clients, and being forced

into more case consultation. Staff were rightly concerned about job security and began to look elsewhere for employment. The unit took on an embattled feeling with regard to the center at large. Programs throughout the center were facing the threat of severe cutbacks as the NIMH funds began to diminish. Financial crises occurred regularly as the center administration struggled with little success to develop a long range plan. The experience within the C&E unit reflected on a small scale the stress within the center at large.

As the Big Boom Phase approached an end, the unit learned that it had been awarded a grant from the National Center for Child Abuse and Neglect (NCCAN) to develop and disseminate a prevention curriculum to be used in elementary and junior high school classes. The grant was for \$100,000 for a period of about one and one-half years. While the money would support the child expert and an assistant, much of the award would go towards purchasing the materials and expertise needed to develop and produce the curriculum, and to part-time auxiliary staff in the field used to disseminate the material and train school teachers. The grant in itself would certainly not support the C&E unit.

Funding sources dried up quickly. The AoA and LEAA grants expired in the spring of 1981 and the last NIMH C&E award was made on a diminished scale (\$43,170, down from a peak of \$106,500). The NIMH Prevention Center, created by the Mental Health Systems Act of 1980 and spared by the block grants of 1981, was being approached for grants, but looked like it was going to be more research than service

oriented. On the state level, Title XX training funds had been so mismanaged in the central office that the government froze the account in 1981, curtailing the only hopes by C&E staff of developing more contracts. Other state funding sources were feeling budget crunches as well. The Department of Elder Affairs, which had awarded the unit contracts worth \$20,000, and thought highly of the work done, expressed reservations that the services should more properly be funded by the state DMH.

Collapse Phase: July, 1981 to June, 1983

The clear impetus for the crises faced by the C&E unit was not just the decline in the NIMH C&E grant, but a much more pervasive assault on all levels of prevention funding in mental health (Wolff, 1983, Note 6).

Within six months of President Reagan taking office, the C&E unit received four refusals of grant applications from major federal agencies which had funded prevention. These results were surprising and disappointing, considering the previous high rate of success the unit had enjoyed with similar applications. The NIMH Prevention Center "went research," with little apparent opportunity for prevention service funding at that time. The Omnibus Budget Reconciliation Act of 1981 sent all ADAMHA funds (reduced by 25%) to the state. The Massachusetts DMH refused to fund C&E despite some desperate lobbying made by C&E directors (through the Massachusetts Coalition on Consultation, Education and Prevention) in an attempt to have an Office for Prevention created. Cuts in federal dollars were felt widely on the local level by agencies which had previously contracted

for C&E work. Proposition 2½, passed by the state legislature, cut the funding base of cities and towns, effecting school and agency budgets. The state also committed some of its budget towards supporting essential town services. In general, state funding became central and in great demand in the wake of federal and local cuts in revenues. The money for C&E dried up faster than spit on a griddle.

The NCAAN project supported some C&E staff during 1981-82. A prevention curriculum was developed and eventually disseminated, often with teacher training, to 40 sites in schools and organization. The funding was limited, however, and C&E staff FTEs dropped to four in the summer of 1981 and down to one by the summer of 1982.

A variety of strategies were used in an attempt to keep C&E staff, with their resources of knowledge and community contacts, in the employ of the center. The C&E director became the adult outpatient clinic director, and C&E was merged with the clinic. C&E staff worked with case managers to develop resources for the chronic client and perform community education about deinstitutionalization. Public relations for the center was performed under the auspices of the administration budget. C&E staff provided consultation and direct clinical supervision to clinic staff. An EAP was attempted but developed far too late and with no long-term backing, with little success. Eventually, the few remaining C&E staff were placed in clinic positions as fee-for-service or salaried staff. From September, 1982 until June, 1983 there was a quarter-time C&E coordinator position. By June of 1983, all previous C&E staff had left the center and there was no service designated as "C&E."

Center-wide the CMHC had experienced a 20% reduction in staff, necessitated by budget crises. The executive director, who had been there five years and was generally supportive of C&E and the CMHC philosophy, quit and went into retail sales. New programs were started and old ones given up or lost to other agencies as DMH pressed for a consolidation of services in the area. Most changes were toward the development of services for the chronic, deinstitutionalized client. Staff morale plummeted and a unionization campaign was successfully organized. The new executive director promised improved management and planning functions that would streamline the services and marshal the resources of F/H CMHC.

Current Status of C&E at F/H CMHC

A follow-up interview was conducted in the fall of 1984 with Mike Murphy, a newly hired director of training for the center. He reported that there was "no C&E." Historically, he reported that the agency had "scrambled," cut back on non-chargeable services and revamped its pricing and fee collection process. The center's budget was stable at over three million dollars, with a staff of 108 FTE positions. Many of the previous services remained, including outpatient clinics, developmental screening, family services, and daycare run-away shelters for adolescents. Emergency services (screening state hospital admissions), deinstitutionalized client case management, and protective services had all grown. A forensic team had been added for court consultations.

While no C&E unit existed, some C&E-like functions continued. The forensic team and child clinic staff did case consultations. Mr. Murphy performs inhouse training and develops manpower through volunteer and

student programs. Some public speaking is performed by staff and administration when requested.

There was no immediate interest expressed in redeveloping C&E services, unless DMH was interested in funding something like public relations. There was no plan or apparent resources to develop prevention programming.

Discussion of Implications of the Case

A number of variables contributed to the rise and fall of C&E at F/H CMHC. This unit was unique in its focus on discrete prevention projects and the associated grant funding mechanism. It is possible, however, that the case reveals issues and themes common to the history of other C&E units.

Tom Wolff (1983, Note 7) points to society-wide and systemic issues of prevention. The problem, he suggests, rests in the failure of "main-stream" society to place a lasting and durable emphasis on prevention, as opposed to remediation. This failure in priority filters down through the agencies of government and is evident in the meager support for prevention units when placed in a remediation/treatment service agency. Local communities can be educated and convinced as to the usefulness of prevention, but often do not have the resources to support such a service (much as they don't have the resources to support outpatient services without state funding). Dr. Wolff also notes a frustrating split between academic and mental health professionals on the one hand and prevention practitioners on the other. Closely involved

in the national and state lobbying efforts around the Mental Health Systems and Omnibus Budget Reconciliation Acts, he expressed frustration with the silence by academics and the American Psychological Association in the face of dismantling of the CMHC Act. Their concerns seemed to be more with research and training dollars than with service.

Funding is clearly a central, if not the central issue. Dr. Wolff suggested that without public protection and funding, C&E can continue but prevention will not. In the case of this C&E unit, the role of their perceived prevention mission was central. The mission guided the staff and director in their pursuit of funding. Fee-for-service consultation and contracts were pursued half-heartedly and too late in large part because it was seen as violating the goals and mission of C&E. Basically, it would have been a different job with a different philosophy. The mission did not seem very conducive to survival. While a variety of events contributed to the lack of funding, in large part the C&E unit depended on federal grants because no one else wanted or could afford to pay for major prevention programs to disempowered or unorganized constituencies. Most of the services were proactive and sought to create demand where there was none. Often the communities resisted focusing attention on topics such as isolated elders, incest, rape and domestic violence. Certainly from the perspective of this C&E unit, sophisticated mental health promotion and prevention projects targeted at high-risk, needy populations in the community at large could only be supported by state or federal funding.

C&E could continue, but not with the same prevention philosophy. A major shift in populations was needed, moving away from the hard to reach segments of the community who are rarely seen in treatment settings. Instead, a population had to be marketed which was already seen in and preferred by existing clinical services, namely, the employed, insured, and less disabled population.

The organizational structure of the specialized team contributed to the strengths and weaknesses of the unit. The team approach allowed specialized staff to develop expertise with targeted high-risk populations. It greatly facilitated community reputation and the development of contacts. It allowed for group planning and development of resources. The structure protected the prevention projects from encroachment by demand for direct service. It also prohibited the integration of C&E techniques or prevention philosophy into the rest of the center. A currency of exchange was never established by the center which allowed for rotation of staff or services on a formal level, although the C&E staff worked at the center before anyone else and were well known personally throughout the center. The structure left the unit vulnerable to being jettisoned just as it promoted the sophistication of its product.

As a result, the enduring impact of the C&E services may be found more in the community served than in the host center. Themes of social support, organizing and natural helping resources are more commonly addressed in planning and training by area agencies. In the case of the LEAA grant project on rape and domestic violence, the

grant ended, but "all the pieces" continued independently. Rape crises protocols remain in place, a general hospital continues training and runs a batterers group, a shelter exists and public awareness and concern has continued to focus on the issue. Elder service agencies continue to collaborate in a task force and advocate mutual support prevention approaches. A Mayor's Task Force on Deinstitutionalization, facilitated by the C&E director during a town crises over a flood of former state hospital patients, continued long after the C&E unit was dissolved. The sexual abuse curriculum was disseminated to numerous schools and was purchased by at least one child guidance clinic in Springfield, which reported through the survey that it is even now looking for public funding to start up a prevention project based on the curriculum. In all, the impacts of the C&E services endured, but were not to be found in the host CMHC.

A question unanswered by this case study is that of mixed or generalist C&E services. It is possible that prevention and C&E might have survived in the center if it had been more thoroughly integrated. It is possible that the prevention so delivered would have had less of a developed, primary prevention technology, but it might have survived. Whether this would fulfill a "prevention mission" is unclear. For this to have taken place, the center administrator would have had to have more power and control over the C&E unit and would have had to promote the prevention mission himself rather than leaving this up to the specialist team. In general, better management, long-range planning, and control of programs might have helped to control the effect of

budget crises. Whether or not better administration from the executive administrator would have preserved a prevention mission of any noticeable impact is unclear, but doubtful to the researcher.

Section 2: Case Studies of the Other C&E Grant-Funded Units in Massachusetts

The data in this study is organized into three subsets of CMHCs in Massachusetts. As of 1981, there were 25 federally designated CMHCs in the state, receiving different forms of NIMH grant packages. The first subset level was that of the single case study of a C&E unit (F/H CMHC). The second level, reported in this section, is that of brief case studies of the other five C&E grant recipients in the state. The third subset is that of all CMHCs in the state, including those 19 centers that did not receive C&E grants as part of their NIMH funding packages. Data for all three subsets was gathered in the C&E survey conducted for this study. Additional, more detailed data was collected for the case studies based on NIMH records, interviews, and additional reports submitted to the researcher by the centers.

Response Rate and Limits of the Data

While the overall response rate (80%) of the C&E survey will be discussed in the third section of this chapter, some comment is necessary here pertaining to the case studies. Of the six C&E grant recipients, representatives from five of the centers responded to the survey, offering some measure of current functioning. NIMH records

of 29 separate grants over six years (1976-1981) were reviewed, providing some historical data for all six of the case studies. Unfortunately, NIMH records were quite limited for one of the centers, the Solomon Carter Fuller Mental Health Center (SCF). While records suggest that six C&E grants had been awarded, records from only the two most recent years were available. Apparently the four earlier years had been awarded to a different source (a change was frequently made as NIMH encouraged state DMH area offices which received CMHC grants to form private non-profit corporations to administer the grants). Additionally, SCF was unique in using its full operations grant to fund C&E services, creating a huge C&E unit of more than 30 FTEs, only a fraction of which was described in the C&E grant data. Finally, SCF has yet to respond to the survey, although a large C&E unit continues and a response is "in the mail." As a result, data on what may be (historically and currently) the largest C&E unit in the state has been excluded from the case studies and survey data.

A comment is relevant here also on the conditions of access to NIMH grant data. A thorough search was not conducted for the SCF operations grant data and missing C&E files in large part due to the transitional phase of NIMH district office functions. All NIMH district offices have been functionally closed, with some former NIMH personnel continuing in Public Health Service district office positions. NIMH and PHS officials on both the federal and district level were extremely helpful in providing the fullest access possible to data. Unfortunately, all NIMH records were in the process of being packed up and sent to

regional warehouses for storage. The timing wasn't the greatest for a leisurely review of records -- the final C&E grant record to be reviewed by this researcher was placed in a cardboard box and shipped out right then and there.

Other limits to the data have been illustrated above in the F/H CMHC case study. Financial and organizational descriptions of the C&E units contained in NIMH files appeared to suffer the same problems of "ghost data." While roughly reliable, accurate measures of C&E operating budgets were impossible. Review of the grant proposals was often a process of interpretation and detective work, reading lists of specific personnel salaries and attempting to identify the actual C&E staff from descriptions of unit activity. Generally, a fairly accurate measure of specialist C&E FTEs was reflected in the list of personnel. The overall projected budget figures and ascribed sources of funding did not, however, appear to be very reliable.

A final significant difficulty involved the reality of CMHC structure. While this dilemma will be illustrated more clearly in the case studies, in general the problem was that CMHCs were not always discrete, identifiable entities. NIMH preferred to fund private, non-profit corporations. There were generally two structures for these, including: (1) a fiscal conduit office which was basically an office established to administer CMHC funds for six or seven semi-autonomous service agencies; and (2) a non-profit corporation that provided half or more of the services inhouse, with direct line control. This second structure was the one promoted by NIMH. Additionally, however, the

state DMH service structure is and was very dominant in the state. It is also extremely complex.

Originally established to administer inpatient services for the mentally ill and retarded (state hospitals and schools), DMH moved into outpatient services in the 1930s with the birth of partnership contracts with child guidance clinics. Partnership contracts allowed state employees to be placed in private, non-profit clinics, which were supported by local mental health associations. Currently, DMH remains split between being a direct provider of services and a funder of services to be delivered by vendor organizations. DMH is divided organizationally into a central office and 40 area offices. (Regional offices were abolished as unnecessary and replaced the same year, 1978 with district offices, which vary in authority and function.) Funding for direct services comes both from central office and area office accounts, but much of the control is exerted by area offices. As a result, the structure and profile of DMH services varies widely from area to area dependent in large part on the outlook of the area director. This variance in service profile was actually measured in 1984 by DMH in its "Mental Health Resources" survey (DMH, 1985).

At the moment, DMH administers seven operating state hospitals, seven state schools or developmental centers, and two state-wide inpatient specialty units. In addition, the state fully owns and operates ten "CMHCs" of its own which were often related to, but not the same as, federally funded CMHCs. The state administers approximately 50 partnership clinic contracts for child and adult outpatient

services and has innumerable vendor contracts for a wide range of mental health and mental retardation services (especially case management, residences, day-treatment and emergency services) which are paid for on a service-cost, lump-sum, or unit-cost basis.

Returning to the question of the definition of federal CMHCs, the centers can be categorized roughly by their affiliation to DMH.

Of 25 CMHCs: eight recipients were state-owned CMHCs (which included the DMH area office, making the area director also the center's executive director); one was an area office; and 16 were private non-profit corporations of some form.

Currently, looking at the agencies which made up the former federal CMHCs, of the 25 "CMHC groups" in 1984:

- 15 received federal block grant awards
administered and awarded by DMH
- 14 have partnership clinic contracts
(at a minimum)
- 8 are wholly state-owned CMHCs
- 1 is an area office

The numbers total to more than 25 because they overlap. In one case, a federal CMHC also included a wholly state-owned CMHC/area office, two partnership clinics with associated private non-profit corporations and mental health associations, numerous separate agencies, and the department of psychiatry from a city hospital. Such an overlap is not uncommon.

Whatever organizing influence the CMHC grants had in fostering a particular structure has now dissolved as agencies are organized in line with current sources of income, in large part from DMH. As such, the question arises as to how to measure current C&E in a center

that is not now and to some degree never was a discrete entity. Who does one call? An effort was made to identify what specialist C&E units might exist in agencies formerly associated with the CMHC. Given the complexity of the service structures, however, it is very likely that C&E units might have been missed because the researcher did not hear of them. The problem was both one of surveying the homeless and of surveying a population which had moved several times in the past few years. People sometimes remembered that C&E had been around, but weren't quite sure where they had moved to. This situation, in itself, represents a major finding of this research.

NIMH Funding Structure and the C&E Grant Programs

The case studies begin with an examination of the environment which they shared in common, NIMH funding policies. All CMHC grant packages were awarded and monitored by the District I, New England Office of NIMH, located in Boston. CMHC funds were allocated to the district offices in lump sums. It was then left up to district administrators, using federal guidelines and formulas, to approve applications, set dollar amounts for awards and specify any conditions or demands to be made of the recipient center. Annual site visits and grant application reviews were held for each grant. Review boards typically included representatives of federal and state health service planning commissions, the Massachusetts Department of Mental Health (which had "minimal influence," Note 8), and NIMH. Representatives from city planning offices and other key agencies were included as appropriate. Despite the wide representation involved, the central policy decisions and opinions were made

and written by NIMH district office administrators and their designates. As such, the Massachusetts CMHC grant awards (with their conditions of approval) very much represented a compromise between the current realities of the state's mental health system and the NIMH district office's philosophy about how mental health services should be delivered. While involving DMH officials very little in the actual decisions, the NIMH grant system can be seen as a lobbying mechanism designed to bring about enduring changes on the state and local level.

The 25 federally-designated CMHCs in Massachusetts received one of four grant packages in 1980, including: (1) basic support (an operations or staffing grant); (2) specialized support (for centers which had completed their basic grant support cycle and were receiving conversion, children's, financial distress, or C&E grants); (3) construction (for centers that received funds only for construction of physical plants); and (4) no funding (for centers currently qualified but without funding).

There were often not enough funds sent to the district level to fund all centers which had qualified. NIMH ranked centers according to different priorities and low-priority centers might have to wait several years before funds were actually sent to the center. Of the 25 CMHCs, the frequency of grant packages awarded in 1980 were as follows:

- 13 Basic Support
- 7 Specialized Support
- 3 Construction-Only
- 2 Not Currently Funded

Of the seven specialized support recipients, six CMHCs received C&E grants as part of their package. The selection of those centers that were approved for funding of C&E grants was based first on the age of the CMHC in its grant cycle. As described above, C&E grants were considered in part to be specialized support for those centers which had or were close to exhausting their basic grant supports. The C&E categorical grant could provide a base for a service which might be the most endangered by the expiration of general operations or staffing grants. As such, the older CMHCs tended to get the C&E grants and, in this state, the older CMHCs tended to be the state owned CMHC/area offices. Out of six C&E grant recipients, five were state-owned CMHC/area offices and only one was created originally as a private non-profit corporation (F/HCMHC). This means that the C&E grant projects were hosted by generally larger centers that were direct extensions of the DMH area office.

This is particularly relevant when considering the income sources tracked by NIMH for C&E services in the six centers. Total dollar sums are listed below for C&E grants awarded to Massachusetts CMHCs:

Grants received:	29
Awarded over 6 years:	1976-1981
Total dollar sum:	\$2,175,612
Grant award: (ave.)	\$75,021
Total reported C&E budget revenue:	\$6,015,944
Annual C&E budget: (ave.)	\$207,446

The reliability of total budget revenues reported is questionable as discussed above. The identified sources of revenue are divided by categories which probably overlap. Categories of revenue were reported as: (1) federal; (2) state; (3) applicant; (4) local;

and (5) other. How these areas were defined and distinguished is not clear to the researcher and doesn't appear to have been clear to the center administrations, with subtotals switching from one column to another depending on the year of application. Certainly "state" and "applicant" distinctions were a bit theoretical in state-owned and operated CMHC/area offices. "Local" and "other" were also not clear as to definition. Merging these categories to improve reliability, the sources of reported C&E revenues can be compared, with a clear trend of diminishing federal percentages of support over time (see Table 7). According to these figures, C&E grants were almost tripled in size by the addition of matching funds put up by the state, center or other sources. The reality of these resources is challenged somewhat by the case studies which follow and the precipitous disappearance of C&E units which characterized the C&E grant projects.

Massachusetts Mental Health Center/Vinfen Corporation

"Mass Mental" (MMHC) is a state CMHC/area office with a large budget and staff of indeterminate size. While staff and budget are measured, they can be added up ten different ways depending on how one defines the organization and the CMHC part of it. This is true of all state-owned centers. Gustav Baggis, Area Director of the West-Ros-Park CMHC/area office, offered an example. The West-Ros-Park CMHC/area office has a budget line for \$4.6 million with 222 state employees and 80 contract employees. State contracts are not included in this account, although vendors receiving state dollars through the area office

Table 7
Sources of Reported C&E Revenue

	Percentages	
	1976-1981	1981 alone
NIMH C&E Grants	36	29
State/Applicant Sources	41	45
Local/Other Sources	24	26
	101	100

may have been considered part of the West-Ros-Park CMHC. A total of over \$13 million in state budget funds may go to servicing people currently residents of or recently from (as with state hospital inpatients) the W-R-P catchment area. While more will be said of W-R-P in the third section of this chapter, it is mentioned here as an example of how budget and staff measurements posed a bit of a dilemma when looking at NIMH CMHCs. As NIMH reviewers commented on the Mass Mental 1979 C&E grant proposal: "The organizational chart is the one document in an otherwise excellently prepared application that is illegible."

The record of C&E at Mass Mental picks up in 1978 with the award of the third C&E grant. Records for the first two years were not located for review, but the third year grant (#608-03) suggests that C&E was attempting to formalize and strengthen its position in the organization. The unit was structured as a mixed model with a specialist core and some responsibility for generalist C&E conducted throughout the rest of the center. The long range goals, summarized below, offer a good example of a specialist C&E orientation:

1. To sustain and expand community helping networks and provide C&E to informal helpers.
2. To provide continuing education and inservices to promote professional skill levels in areas of high need, including: elder issues, rape crises, domestic violence and systems and families in crises.
3. To provide mental health education to the general public.
4. To move the unit into a more central position within MMHC and promote C&E services to the center.

The last goal highlights the unique role of C&E services in having to make as a goal the organizing of a constituency of support for C&E within their own center. The C&E unit stood somewhat apart, using the same organizing techniques to gain entry and build support in the center as they did in the community. Most of the big specialized C&E units were better at this with the community than they were with their centers. The MMHC C&E unit was unusual in spelling out their objectives for center relations early on and clearly. They are summarized below:

1. To identify and prioritize populations for C&E services in MMHC catchment.
2. To identify the scope, range and type of existing C&E activities within MMHC.
3. To strengthen the organization of C&E activities within MMHC.

These objectives highlight an important point about C&E services in centers. Most centers reported (usually without measurements, but with reasonable evidence) that their staff routinely did C&E-like things as part of the clinical role. This generalist C&E was usually unmonitored and uncoordinated. It was usually controlled by program directors of other services and not the C&E unit. Centers would point this out when they submitted proposals which showed matching state or dollars twice as large as the C&E grant. What they were saying basically was, "Hey, we fund a baseline of C&E throughout the center as part of our daily clinical operations. If you want to fund a specialist unit, great, but consider some rough percentage of our

operating budget to be the in-kind services donated to C&E." The problem was that typically the C&E unit did not have authority over or even an awareness of what "generalist" C&E might be going on. Some centers, such as Mass Mental and Cambridge/Somerville, even conducted major surveys in an attempt to find out how much and what kind of generalist C&E was done. Generalist C&E is discussed more at the end of this section.

The MMHC C&E unit conducted a variety of activities, with a diverse staff and innovative program. They provided bilingual mental health education and networking with minority-language populations. Community organizing and developing was a major orientation, a "helping network philosophy" which was commented on by NIMH reviewers of the 1979 grant proposal. The reviewers were, "impressed with the philosophical base which supported other groups and organizations as the primary providers of C&E."

Mental health courses were provided (including sex education in Catholic schools) and in-services were given with many human service agencies and the police department. Public housing initiations for the elderly were organized, a babysitting collaborative was established and C&E staff helped facilitate school desegregation parent councils (at a time and in a city where mandated racial desegregation of schools was an explosive issue). Mental health fairs were promoted, libraries supported in developing mental health resources, C&E open houses given and a media project organized with the Spanish-speaking community. Also, an EAP was begun with Beth-Israel Hospital, a major contract

and an early success in the state for C&E units moving into EAP.

In all, though, there were difficulties of money and staff similar to that of F/H/CMHC. Table 8 illustrates the specialized FTEs in C&E units funded with NIMH categorical grants. While MMHC enjoyed a large specialist C&E core until the end, it shrank from 9.1 FTEs to 6.1 FTEs in four years, despite their successes with EAP income. NIMH, in its closeout report on this unit in 1982, noted the trend across centers that mixed state and private employees. With an increased tightening in the enforcement and control over the use of state staff positions, the integration of state and private staff in one center was often difficult. A dual salary structure existed between state slots and contracted slots or private non-profit staff. C&E was not a state priority and even in state owned CMHCs, C&E staff were often contract or private positions which could be eliminated or switched to other programs. In the case of MMHC, under NIMH pressure, the center finally formed a private non-profit corporation to administer the CMHC funds. The C&E staff positions were transferred to this corporation, Vinfen, in the last year of the grant, 1981-1982.

The staff reported other difficulties. With the press for survival dollars they noted that they lacked the development time to enter systems and develop and market income-producing services. In a way, the time ran short on them, before they could switch gears to the survivalist C&E service profile. From the perspective of a prevention, needs-assessment oriented service, they noted that with developing projects and reputation a demand developed very quickly. They found themselves

Table 8

Specialized C&E Full-Time Staff Positions for C&E Grant Projects

Year	Harry Solomon	Community Mental Health Center					TOTAL
		Cambridge/ Somerville	Bay Cove	Massachusetts Mental Health	Franklin/ Hampshire	Solomon Carter Fuller*	
1976	8.25	3.0	2.0	N.D. ^a	0.0	N.D.	13.25
1977	9.0	4.4	2.0	N.D.	4.0	N.D.	19.40
1978	10.375	4.5	2.0	9.1	4.0	N.D.	29.275
1979	5.7	4.0	2.0	6.5	7.5	N.D.	25.70
1980	3.0	5.0	2.0	6.1	7.0	6.0(25) ^b	23.10
1981	2.0	4.0	2.0	6.1	4.0	6.0(25) ^b	18.10
<hr/>							
1984	0.2	2.0	0.0	0.0	0.0	N.D.	2.20

*Data from Solomon Carter Fuller CMHC is not included in the Total column because it is so incomplete

^aN.D. = No Data

^bNumbers in parenthesis are suggested, but not clearly confirmed by data

being asked for C&E services and reacting to requests, with little time left to develop contacts with new groups. This experience mirrors that of F/H CMHC in discovering that there is a need and demand for publicly - supported C&E services.

Finally, they reported problems moving into the MMHC system. Clinical staff reported that they had less and less time for C&E, as well as a felt lack of skill, resources or experience. The very extensive and highly reputed psychiatric and psychological training program at MMHC did not include consultation as a topic. There was a general lack of integration into the center.

During the last year of existence, the C&E unit made a striking effort to shift into work with business and industry. The staff positions were reorganized into market and program managers in an attempt to develop new paying markets while not sacrificing ongoing community goals. One community education project, the Fenway Players, became semi-autonomous. The Fenway Players used theatre to perform community education around various issues in a powerful, often moving medium. At least two other C&E units around Boston supported similar "Players" theatres. EAPs continued to be important for income, along with new programs such as an industrial human resource management program.

In the end, it was clear that the C&E unit would be closed. Vinfen had become truly independent, but was largely reliant on state contracts. C&E was not supporting itself. As Dr. Nicks, author of the NIMH grant closeout report, reported in September, 1982:

Of all of the federally funded C&E units in the state, this is the only unit that will not survive beyond the federal grant period. The state has adopted a policy of excluding C&E services from ADM Block Grant Funding, even though such services, which are vital for prevention and health promotion, are least likely to be supported by fees or third-party reimbursements.

In follow-up calls to MMHC and Vinfen Corporation, the researcher was told that there were no longer any identifiable C&E staff and that there were no records to indicate where the staff was now. One person thought the former C&E director might be "still working somewhere in Boston with kids."

The MMHC received a total of \$403,003 from NIMH for four years for C&E services, with a total C&E budget estimated by the center administration (in grant applications) at just under \$1,000,000.

Cambridge/Somerville Community Mental Health Center

The Cambridge/Somerville CMHC is, or was, another one of those CMHCs which defied definition, much to the frustration of both NIMH and the C&E director. A site visitor from NIMH described the center in a March, 1979 report with a mixture of frustration and awe as an:

...indeterminant mixture of a government bureaucracy, a consortium of non-profit agencies, a lead agency model, an employment program, an extended training program, a citizen's advocacy organization, and, to perhaps the smallest degree, a private, non-profit human service delivery business.

The center received numerous refusals for increases in C&E grant size and was placed on conditional status several times, probably suffering

in the end with smaller grants than they might have received. NIMH critics wanted the center services to be more under direct line authority of the executive director. The executive director, as area director, did control some services, but others were delivered by vendor or partnership contracts. Critics also wanted C&E generalist activities to be under direct control of a C&E director. This was another center where considerable specialist C&E energies went into just trying to document and influence generalist C&E. The C&E director, at one point, lamented all of the different boards, directors and program heads she had to negotiate with to develop some overall plan. NIMH critics were probably irritated somewhat by the C/S proposals which were a bit too honest. The proposals indicated "grant" and "non grant" C&E. "Grant" C&E were specialist positions supported by NIMH monies. "Non grant" C&E was a breakdown of the center's overall sources of revenue. The argument was that administration figured roughly 5% of staff time went to C&E-like services. So they multiplied the center resources by .05 and listed those as in-kind center support for C&E, a mathematical exercise which was noted with little humor by grant reviewers.

The C&E unit here was labelled as mixed, with generalist and specialist C&E. A large segment of the specialist core was represented by Community Training Resources (CTR). CTR, begun in 1972, had provided inservice, continuing education, and workshop trainings for area human service professionals in a variety of areas. The

organization was small and efficient, charging fees and tuition from the start which covered a good fraction of operating costs. It had, and still enjoys, a fine reputation for the quality of trainings put on by its "faculty" of experts who work on a per-training basis. The model is equivalent to that of an adult education center designed especially for professional helpers and focused on topical needs and issues. The model is found in several other C&E units across the state and seems to have staying power as one C&E service that survives, if on a shoestring budget.

The C&E director was separate from CTR and faced the issues of generalist C&E in the center. Again, early goals of the unit reflect internal organizational concerns as the director sought to document and organize generalist C&E resources across 17 discrete programs. Perseverance on her part, combined with NIMH pressure, produced some results. Although never given line authority, she was able to successfully organize a C&E committee with 13 members from 9 programs. A C&E plan was written with six C&E goals: (1) agency support (case consultation); (2) networking; (3) service development (training); (4) community education; (5) prevention; and (6) self/mutual help promotion. Target populations and agencies were identified, including: children and adolescents, elders, the retarded, chronic deinstitutionalized, alcohol prevention, and work with school, legal systems and health delivery agencies. In all, this committee offered an excellent example of a mixed model. The specialist C&E director could pursue a variety of community development projects while at the same time facilitating a

team of generalist C&E practitioners. The team met to set goals, review projects, and promote their own levels of skill. The generalist model also reflected the realities of the center's structure and its direct service priorities. The C&E team acted as an influence within system, purposefully promoting an indirect approach and setting a goal of encouraging more diverse C&E activities than just case consultation. Resource surveys conducted by the C&E director indicate some success with an expansion in new kinds of activities reported by clinical staff. Percentages of generalist hours by activity were compared between 1977 and 1981 as listed in Table 9. The results suggest a trend in generalist style toward more training, public education, and interagency coordination.

As with F/H.CMHC and MMHC, the specialist C&E director position did not survive the end of NIMH funds. From a peak of five FTE specialized C&E positions, there are now two, found in the enduring CTR program. The C&E committee no longer exists and no plan coordinating goals or setting target populations exists in a formal way. Generalist C&E has reverted to the programs and seems to be varied and diverse. Along with CTR, C/S agencies include services such as medical liaison consulting, child and adolescent case consulting, a geriatric team for consulting to nursing homes, a court clinic, and education programs for families of inpatients. Alcohol education is supported by an alcohol outpatient clinic and networking continues with many collaborative interagency committees focusing on school children, abuses and neglected children, elders and the mentally retarded. An active inservice

Table 9

Types of Generalist C&E Activity in the Cambridge/
Somerville CMHC, by percentage*

Type of Generalist C&E Activity	Percentages	
	1977	1980
Case consultation	54	43
Program consultation	30	21
Training	16	20
Public education ^a		7
Interagency coordination ^a		10
	100	100

*Data reported in the C&E Grant Proposals of the Cambridge/
Somerville CMHC

^aThese activities were not identified separately as categories when the data was collected in 1977, in part because they were rare

and training programs also links many of the agencies.

As the area director explained, from the center's perspective the C&E coordination and documentation were basically "makework" forced on the center by federal regulations. If C&E was done in an enduring manner, it was only in the context of the ongoing direct service of various agencies and programs. This seems to continue and even prosper. If anything is lacking it would be the influence toward diverse styles of indirect service and a more primary prevention focus encouraged by the former C&E director.

The Cambridge/Somerville area office also felt the impacts of federal cuts for prevention monies. The C&E director collaborated with a nationally recognized alcoholism prevention project, CASPAR, which specialized in educational curriculums and peer training models for school-aged children. NIAAA model project funds were cut and CASPAR was unable to maintain itself on the income from sales of its curriculum, widely praised as it was. CASPAR remains in existence, but at a considerably smaller size than before.

Harry C. Solomon Community Mental Health Center

Based in Lowell, the Harry C. Solomon CMHC is also a state-owned CMHC/area office. It, like the other state-owned CMHCs, serves an urban, ethnically mixed, predominantly working class population. The center received its first C&E grant in 1976 for \$154,930. During the next six years, a specialist C&E unit pursued a variety of activities serving at-risk and target populations. The specialized FTE staff

positions peaked in 1978 at approximately 10.375, dropping quickly thereafter to 2 FTEs in 1981.

Staff were assigned to specific activities and target populations and included the following C&E services:

- Outreach to Hispanic population
- Consultation, training with police
- Consultation, education with elderly
- Consultation and organizing around housing
and resource development for the
deinstitutionalized
- Community education to groups and agencies
- Program development with business/industry
- Support groups (prevention) and volunteer training
- Child consulting
- Client advocacy
- Rape prevention and treatment

In all, the activities reflected a diversity typical of active specialized C&E units, with a wide range of target groups.

The course of development over time was one of direct correlation to the size of the C&E grant. The grant dollars peaked in 1979 at \$117,730 and the C&E FTEs peaked at 10.375. The grant dollars dropped the next year to \$63,322 and the C&E FTEs dropped to 5.7. NIMH comments on applications criticized the center for not allocating shared funds to C&E and the C&E unit for not providing income. Actually, the unit did report income ranging from \$6,000 to \$9,000 a year. The center also did report putting up matching funds, doubling the total federal grant of \$513,531 with a reported total C&E budget of \$1,067,827.

The C&E unit was not integrated into the ongoing task of the center, however, probably did not receive that much in matching funds, and preferred to continue serving the populations it had as long as possible.

Over time, various speciality services were dropped, such as elder services, housing and resources (taken over by case management), police consultation (which may have gone private or at least ended when that C&E staff person left), and the Hispanic liaison service. The rape prevention program was spun-off to a local community group that continued the work based on its commitment to the issues. Near the end there was a C&E director, a part-time educator, a part-time volunteer coordinator, and a part-time trainer as C&E staff.

The last year of the grant there were only two FTEs and the stated goal was to establish an information and referral network that would survive the end of the federal dollars.

A follow-up interview with the current C&E coordinator (a former C&E staff member) indicated that he continues services such as public relations and speaking, volunteer development and staff inservices. Able to devote only 20% of his time to C&E, his chief role involves administrative duties and grant writing. The respondent identified several crucial variables that he felt accounted for the disappearance of C&E. He pointed out the lack of a mandate from DMH for indirect services or prevention. The center, itself, is restricted in its flexibility in the use of staff by rigidly defined and allocated "state" slots.

Cuts in the total DMH staff size statewide had filtered down to the service level, with increased service demand and fewer staff. He felt there were real possibilities in the future for C&E-like work with the Hispanic and Indochinese populations, case management of chronic

deinstitutionalized, and with schools and nursing homes. The opportunities required money, however, and support from the center administration.

Bay Cove/Tufts New England Medical Center Hospital

The C&E unit at Bay Cove was similar to that of Cambridge/Somerville in doing a lot with very limited specialist resources. They received their first grant in 1976 for \$55,284 and over the next six years received the smallest average grant amounts (\$53,000) of any of the six C&E grant projects. The shortfall resulted from their receiving basically even funding across the years, instead of large early grants of over \$100,000 that would then shrink quickly. In all likelihood, this contributed to a more stable condition.

The center received much of the same criticisms from NIMH as did the Cambridge/Somerville CMHC; namely, that it was an organizational blur of DMH area office, partnership clinics, agencies and a hospital/university. NIMH critics also were concerned, as with C/SCMHC, that the C&E director did not have enough authority over generalist activities and did not have a high enough standing in the organization.

The C&E unit was based on a somewhat unique vendor model where a C&E specialist team of two FTEs supervised vendor contracts. For the first three years, C&E funded four vendor agencies outside the CMHC to deliver C&E services. During the last three years, actual funds were not given out, but the C&E director signed detailed contracts with programs within the CMHC for generalist C&E services. It is probable

that this system reflected NIMH's concern with authority over generalist C&E. The system of detailed internally-signed contracts is probably the most sophisticated and formalized coordination of generalist C&E revealed in this survey and offers an ideal for the successful generalist model.

The external vendor agencies represented organizations that already specialized in some form of C&E or prevention and were closely linked to target populations. The agencies received peak funding the first year with \$28,290 going to four agencies to fund prevention in alcoholism, particularly with the fetal alcohol syndrome and C&E services to elderly and Chinese populations. These monies shrank with the C&E budget and were no longer contracted out after the third year.

Simultaneously, however, the C&E specialist team extended control over generalist inhouse C&E resources. A needs assessment and resource identification survey was conducted internally to identify the ongoing generalist activities. A C&E seminar, similar to the C/SCMHC C&E committee, served to coordinate goals and received the praise of NIMH reviewers for promoting effective collaboration between CMHC programs and other agencies. With continued NIMH pressure to increase direct C&E authority, however, the C&E director drew up and signed annual contracts for specific personnel to do specific projects part-time out of 15 different programs. While it seems that this moment was fleeting (1980-1981) with the C&E director soon leaving and the contract system dropped, it offers an ideal of coordinating authority over generalist C&E. The programs each had a representative in the

C&E seminar to represent their concerns and get ongoing group supervision. The C&E director was able, on the other hand, to promote the planned and purposeful use of indirect services center-wide.

In addition to generalist C&E coordination, the specialist team pursued a variety of activities, including community and minority population education, contracted case consultation and training to agencies, outreach and organizing of mutual help groups. A bilingual rape prevention brochure was produced, along with organized educational events and brochures (including a calendar) for the Chinese population. Alcohol education and prevention activities were continued with C&E staff. The unit made money (up to \$15,000 annually) from EAPs, consulting and training contracts, and a series of successful conferences for professionals on topics such as battered children, elder needs and teenage delinquents. Finally, a prevention/education periodical for the parents of newborn children, "Pierre the Pelican," was distributed by C&E through various health clinics.

In the last year, the C&E director noted that survival issues threatened the goals of the unit. While there were some EAP contracts, the C&E director of the past five years had left and taken many connections with her. This happens often, as consultation relationships often take years to build and are as tied to the person as they are to the institution, regardless of whether in business or community consultation. The current director explained that the mission of C&E was to acquaint community caregivers and residents with resources and educate them about

mental health issues through C&E services. She reported that while there was a great local interest in C&E services, there had developed a hesitancy to call on C&E services because agencies had no money and were not used to paying for C&E services. Dr. Nicks, former administrative head of NIMH in New England, commented that C&E in Massachusetts, more than any other state, was given away at no charge with a resultant barrier to survival when pressures to charge increased. In any case, the pressure to charge was perceived as contradictory to the C&E mission when only for-fee services could be offered.

Survival strategies in the last year included interest in prevention funds from the Department of Public Health, along with plans for seminars in stress management, decision making, and time management. EAP and conference projects were also viewed hopefully.

In follow-up attempts, the researcher was unable to locate anyone who could or would comment on C&E. Phone calls weren't returned, nor was the questionnaire, which wasn't surprising because there was no one to address it to. It is possible that C&E continues, certainly probably that C&E-like services exist. Mental Health conferences are still sponsored by Tufts University and the Medical Center. The Medical Center has an occupational health program and is looking into entrepreneurial investments into health promotion/illness prevention services with business and industry. There was no identifiable C&E unit reported, however.

Solomon Carter Fuller Community Mental Health Center

As noted above, data on the Solomon Carter Fuller (SCF) CMHC is extremely limited. It is a large urban, state-owned CMHC/area office. In the past, the center is reported to have used its full operations grant (often ten times larger than average C&E grants) to fund a large specialist C&E team, with FTE positions in excess of 30. The C&E grant was used to fund one C&E project, the Community Programs Against Sexual Assault. With approximately six FTE positions (five full time), the CPASA developed extensive clinical and preventive expertise in issues of sexual assault. Staff conducted community research to document related issues and provided extensive training for clinical staff. Community organizing, networking and education was used to mobilize forces for both prevention and treatment. The full C&E unit also included a clergy project, Hispanic consultation project, and smaller prevention and education projects placed throughout the center's programs. The NIMH reviewers were generally pleased with the center's C&E, though they wanted it to bill more for C&E services. During closeout they comment with pleasure on the center assuming responsibility for continuing their C&E unit and its services. There is currently a full time C&E director and some specialist unit of unreported size.

Brief Summary of Survey Data on Case Studies

A review of the data indicates that of six CMHCs with C&E grant-funded projects, three now have some identifiable person or unit called (or associated with) C&E. This is a raw survival ratio of 50%.

In the past, all six C&E units had full time directors, with four of the six at an organizational level equivalent to other program directors. Currently, of the three C&E units or people, one has a full time position, another devotes 80% of her time to C&E, and the third devotes 10-20% of his time to C&E. The organizational levels are not clear, and are probably not comparable given the complex structures of the CMHCs.

The real change is found in that of specialized FTE staff positions in C&E. The FTEs all peaked between 1978 and 1980. Taking the peak FTE number for the five C&E units where complete data is available, the total number of specialized C&E FTEs was approximately 34. There was an average specialized C&E team of 6.8 FTE positions in five CMHCs.

Currently, for the five CMHCs, the total reported FTEs for specialized C&E is approximately 2.2, for an average of 1.1 FTE positions in two CMHCs.

In the past, there were five C&E units based on a mixed model of a specialist team and some level of authority over generalist activities. One unit appeared to be chiefly specialist, with little reported involvement in generalist resources. Currently, there is little clear data. In one center a specialist team continues as a discrete program, without a mandate to coordinate generalist C&E. In another, one person does part time C&E work. In the third, there is a specialist unit with an indeterminate relationship to the rest of the center.

Discussion of Results of Case Studies

A discussion of the results of the case studies is useful here to highlight some tentative conclusions which can then be examined in light of the full survey data.

The first observation is that the recipients of CMHC grants were often not coherent organizations. It was hard to "find" the CMHC even when they were designated as such and expected to at least try to look like one. In follow-up contacts, the agencies have changed, the collaborative networks have shifted, and the constellations of the programs have realigned along different funding sources, in large part DMH. NIMH tended to encourage discrete, private non-profit corporations which had direct line authority over services. With the larger, older, state-dominated CMHCs which received C&E grants, this was not the case. If anything, the younger centers reviewed in the next section were more likely to fit the NIMH model. It is not surprising that unreliable data was reported to NIMH given the reality of CMHC structures and their priorities. This is especially the case with reported matching revenues.

The C&E grant projects did not assume a very survivable form. Most of the specialist C&E vanished quickly. In general, it seems that the major vulnerability was that specialist C&E services were not considered the chief task of the agency. As a result, C&E specialist teams were largely separate programs, unintegrated in the ongoing work of the other center services. When C&E funding disappeared, the C&E units were unable

to generate survival income. This failure seems to reflect a lack of big money market for the C&E services. Units that did pursue EAPs or training institutes enjoyed modest results at best. No one was going to get rich. Also, the training institute that did survive does so on a cost basis with some modest help from the center. The activity does not fund other C&E activities. Specialist C&E that endures does so in extremely modest form. One can only speculate that if a significant C&E unit remains at Solomon Carter Fuller, it is only through an act of the area director, who had decided that it does represent a task central to the agency.

Generalist C&E, however, poses an intriguing mystery. Many of the centers argued that program staff routinely did C&E-like activities as part of their direct service jobs. Three of the C&E units even tried to measure generalist C&E. The Cambridge/Somerville C&E unit estimated that their center of approximately 435 FTE staff positions produced about 12,630 hours of generalist C&E in 1977. The Bay Cove unit estimated their center (approximately 400 FTE positions) produced 18,000 hours of generalist C&E in 1977. The "Mass Mental" C&E unit reported that in 1977 their center (somewhere between 350 and 400 FTE positions) produced 37,864 hours of generalist C&E. These are significant resources if the measurements are correct.

There are two trends relevant to generalist C&E: type and amount. The survey by both C/S and Bay Cove indicated that 50% or more of these services took the form of case consultation. The survey at C/S seemed to document that active specialist coordination promoted a more diverse range in types of generalist C&E, away from case consultation and toward

training, education and networking with agencies. Many of the specialist C&E units participated in or created coordinating committees for collaborative agencies. These committees seem to continue in many cases. It is possible, though, that without the specialist influence, most generalist C&E is case-oriented.

In terms of amount, though widespread, the Mass Mental C&E unit documented a 77% drop in generalist C&E hours between 1977 and 1978 (from 3,147 hours/sample month to 722 hours/sample month). The figure seemed to then remain stable through 1980 at around 8,700 hours per year. The drop coincides with a time when many financial pressures were increasing on centers in general. By 1982, many centers reported staff cuts and an increased reliance on fee-for-service hourly staff and measured production quotas (factory mental health). It seems likely that generalist C&E activities by clinical staff were significantly reduced by these pressures. It also seems likely that some level of generalist C&E will endure and return when and if time permits. While somewhat of a luxury, some generalist C&E activities appear to be inherently associated with direct service delivery, i.e., unavoidable. Partnership clinics, through their organization, the Massachusetts Association of Mental Health Providers have in fact reported that current funding mechanisms do not cover the cost of unavoidable indirect and non-reimbursable hours provided by clinical staff (Note 9). As such, some indirect service and C&E-like activities appear to maintain a baseline.

A second observation is relevant concerning clinical consultation. While usually pursued by specialist C&E staff least frequently in their activities, case consultation remains a viable and reimburseable service in clinical programs. The birth of many new geriatric, medical liaison, court and child consulting teams or units suggest that case consulting may even be becoming more specialized and formalized. DMH has, in fact, instructed all Area Offices to provide case consultation to nursing homes and courts, in part in response to public and political pressure produced by the increase in chronic deinstitutionalized state patients seen in their systems.

A final area of discussion is that of the nature of services lost. While some generalist C&E service endures in case consultation and clinical programs, many would argue that these services were never the thrust of specialist C&E. Clearly the diverse community development, education and prevention services pursued with at-risk and hard-to-reach populations have largely disappeared. As one interviewee explained, "Now, we just pay lip service to community organizing and prevention."

C&E, as evidenced in the larger specialist units funded by C&E grants, seemed to represent a general commitment to indirect service more than prevention, per se. Activities often focused on promoting a collaboration, coordination and sharing of resources between agencies and community groups. C&E specialists helped to improve professional helper skill levels and generally multiply the resources available in an area through efficiency of coordination.

Specialist C&E services were often devoted to organizing self-help and mutual-help resources in communities. In building the informal resources they may have "prevented" some experiences of distress by promoting a sense of empowerment and community. They could not be expected, however, to reduce service demand. If anything, specialist C&E increased demand by organizing hard to reach constituencies and giving them a link to the formal service system.

As a result, it is probable that specialist C&E helped keep clinical services in touch with minority populations. "Direct service" as defined by fifty minutes in a stranger's office across town is surprisingly uninviting to a number of populations who nonetheless may experience considerable handicaps. As such, specialist outreach C&E activities often translated "direct service" for both the residents and for the professionals in the CMHC. This kind of active community involvement allowed professionals to stay in touch with, be alerted to and trained in issues relevant to the populations. It doesn't seem to be a coincidence that C&E specialists often focused on issues long neglected by clinical services such as alcoholism, sexual assault, domestic violence, and racism issues which are now receiving considerable attention as major causes of psychological disorder and distress.

Many of these efforts were considered explicitly preventive in goal by specialist C&E staff. Few of the projects reached the sophistication of a formal research-oriented prevention program. If anything, C&E represented a kind of practitioner's prevention theory which integrated preventive goals with other goals, such as service coordination, empowerment and the translation of direct service issues between residents

and the community mental health center.

In all, specialist C&E seemed to represent both an invaluable bridge to the community and a force of innovation in mental health services, innovations which included, but weren't restricted to, primary prevention projects. These are the services lost with the demise of specialist C&E as practiced in the case examples.

Section 3: Survey of C&E Services in Former Massachusetts CMHCs

Response Rate

The overall response rate for the survey of C&E services in former CMHCs is 80% (20 of 25), or 83% of those centers that received C&E grants (5 of 6) and 79% of those centers that received only basic operations or construction grants or a "non-funded" status (15 of 19). As Table 10 illustrates, the issue of how to define the respondent CMHC was best resolved by referring to "constellations" rather than centers. (Throughout this text the term "center" refers generally to various agency constellations, as discussed below.) Most, if not all, of the CMHCs acted as a vendor in subcontracting out funds for some of the 12 mandated services to other agencies. Applications to NIMH routinely included a stack of collaborative contracts with those agencies which would fill out the service gaps and comprise the CMHC constellation.

The recipient of the NIMH grants, the designated CMHC, was held responsible for meeting the conditions of the grants and, just as importantly, the reporting of requirements to NIMH. These recipient

centers are divided in the survey into three categories, including: (1) DMH-owned CMHC/area office/vendor constellations; (2) DMH area office/vendor constellations; and (3) private non-profit corporations. As can be seen in Table 10, while private non-profit corporations were the numerically most frequent CMHC form (16 of 25), the DMH-owned CMHC/area offices received categorical C&E grants most frequently. Response rates range from 62.5% of DMH-owned CMHC/area offices, to 87.5% of private non-profit corporations, to 100% of area office constellations (n=1).

The private non-profit corporations could have also been divided into two different models, including: (1) consortium models and (2) key agency models. The consortium model, which was fairly rare, consists of an administrative office or fiscal conduit which simply meets the monitoring requirements of the grants while sending all monies out to subcontracted agencies. The only services likely to be provided by the corporate fiscal conduit were C&E services, all others being delivered by the constellation agencies that formed the consortium umbrella corporation in the first place. In the key agency model, a majority of services would be delivered in-house by a single agency whose corporate administration would receive the NIMH funds. The case history of the Franklin/Hampshire CMHC is that of a transition from a consortium model to a key agency model. The data collected did not permit a reliable identification between these two forms in past CMHC structure, although the key agency seemed to have been the most frequent by far.

Table 10
Response Rates to Survey Questionnaire by Type of Center and Grant

	Number receiving C&E grant	Number responded	Per- cent	Number not receiving C&E grant	Number responded	Per- cent	Total No.	Number Respon- ded
DMH-owned CMHC/Area Office/Vendor agencies con- stellation	5	4	80	3	1	33	8	5
DMH Area Office/ Vendors				1	1	100	1	1
Private non-profit corporation (key agency or consor- tium)/Vendors	1	1	100	15	13	86	16	14
TOTAL:	6	5	83	19	15	79	25	20 (80%)

Source of Data

The issues of current CMHC definition have become more complex with time, as the formal CMHC constellation has changed with funding sources. The block grants that replaced CMHC funding were mandated to continue sole-source grant awards to former CMHCs through their remaining years of eligibility. Only 9 of the former 25 CMHCs are listed by DMH as eligible for sole-source awards past September, 1984 and of these, at least one consortium model is known to have dissolved in July of 1984. Along with the cuts in dollar value and lack of service requirements, the block grant system may be seen as having terminated any generally meaningful previous definition of the CMHC.

The question became one, then, of whom to contact for the survey interview or questionnaire. The interviewer typically contacted the agency listed in the NIMH 1981 Directory of CMHCs and introduced himself as doing a survey on C&E services in that state. The responses were highly diagnostic, rather like a projective test. The person on the phone might immediately recognize the term "C&E" and refer the researcher to the C&E director or related staff. A referral to a clinic director usually meant that the C&E unit had only recently been dissolved and/or merged into an outpatient clinic. An opposite, but equally well-informed, first response was sometimes, "Oh, yes, we used to have a C&E unit but it's gone now!" This may or may not have been entirely true as further questioning often revealed specialized case consulting teams or generalist C&E. A final response was that of, "Oh, what is that?" This was usually followed by a detailed inquiry

into who the researcher was and what agency he represented, along with a referral to administration. In all cases, the responses gave some impression of a system memory of C&E. This memory was found to have completely faded in only four of the systems contacted.

References were accepted through multiple persons and/or agencies until a "system nominated" respondent was identified. In all cases, attempts were made to interview more than one respondent per system, with a 50% success rate. The number of sources used to compile the survey data ranged from one to four, with half of the systems represented by multiple sources. Contacts were made with currently employed staff in all the systems for which data is reported.

Table 11 illustrates the breakdown of survey respondents by role and current employment. As indicated, almost half (48%) of the respondents were current or former C&E directors or coordinators of C&E-like specialities. The use of past employees was necessary to fill in gaps in the system memory where possible. The respondents represented a range of years employed by the agency of one to fifteen years, with an average of 5.3 years of professional history with the agency. In many cases, however, even where there was a current C&E director, there was only a faint memory of what the C&E activities and staff size had been three or four years ago.

The respondents listed do not represent individually completed questionnaires. A completed questionnaire from one source was extremely rare. People answered what they could, estimating many variables. Some variables, such as the number of generalist C&E hours

Table 11
Interviewees by Occupational Position

Position	Currently with CMHC	Formerly with CMHC	Total	Per- cent
Executive Director of center or agency	6	1	7	21
C&E Director or coordinator	10	6	16	48
Business Manager or personnel office staff	5		5	15
Clinic Director	2		2	6
DMH Area Director	2		2	6
DMH Area Office Staff	1		1	3
Total	26	7	33	99

provided by staff, are frequently not measured. Others, such as the CMHC budget and number of FTE positions, were either reported as a definite measure, estimated, or difficult to define given the CMHC constellation.

Four case examples illustrate the barriers to measuring certain variables for former CMHC constellations. One example is that of a DMH-owned CMHC/area office/vendor constellation which includes one agency that specializes in prevention-oriented parent education. If one takes that particular agency as the CMHC, then one gets a very small center that is 100% specialized in C&E. If, on the other hand, one wants to take the full constellation as representative of the CMHC, then a full research project is itself necessary to define and measure the appropriate operating budget and FTE staff size of the constellation.

A second example is that of another DMH-owned CMHC/area office/vendor constellation which does not have C&E, but has a specialist C&E-like unit which is so large it skews the data for the survey. The area director is committed to indirect services as the preferred mode of intervention and a "key to managing resources for the chronic deinstitutionalized client." The community service office of this center maintains a staff of 15 FTE positions, who conduct case management via a variety of C&E-like activities such as training, networking, case and program consultation and organizational and community development. While outstanding, the unit is large enough and unique enough in case management services to skew the

data significantly (this is noted where relevant in the data below).

A third example is that of a private non-profit former CMHC (key agency model) which opted to change its service profile when CMHC funds ended. Rather than sacrifice the center to the unfiltered influence of the DMH area office by signing a partnership contract ("puppetship" was the term used), the administrators decided to rely on fees, third-party payors and more directly defined DMH service contracts (07 monies) which it could choose to compete for or not, as it liked. The DMH area office subsequently set up its own CMHC and sponsors many C&E services such as training of professionals. The former CMHC agency was designated here as the survey respondent even though it represents a smaller proportion of the area services than it once did, including C&E.

A final example is offered by a consortium model private non-profit corporation. The CMHC in this case consisted of an executive director and office staff and a C&E director. After the last sole source block grant award was received in the Spring of 1984, the CMHC office was dissolved. Three out of four former vendor agencies were contacted, along with the former executive director. Interviews revealed that the former specialist C&E services were gone, but one agency has a C&E coordinator who works in a traditional style. The other two agencies have extensive generalist C&E and speciality case consulting teams. One also has a primary prevention program for sexual abuse and incest, temporarily held in limbo while a financial sponsor can be found. The other is launching a specialist, semi-

autonomous EAP program which was cloaked in secrecy because of area competition, impeding a measure of FTE staff positions or activities.

In all, it is very much like comparing apples, oranges and blue birds, some of which are not counted and others of which are recalled with varying degrees of vividness.

Definition of "Specialist C&E"

In the past, the definition of C&E was varied and diverse. If anything, it was handy to have the common label to know what to measure. As might be imagined, the loss of a mandate for something called "C&E" has contributed to a greater blurring of definitional boundaries. The question of how to define "specialist C&E" services in the present and the rules adopted to answer that question represent some of the major findings of the survey.

In a number of systems the C&E label is gone, but staff specialize in C&E-like work under a different label. A "Consulting Center" offers consultation and training to business and industry. "EAP" programs coordinate clinical referral and treatment with supervisor training and health education. A "community services team" provides "C&E-like" case management. Training institutes and prevention programs continue under their own names.

The major roles adopted refer to what specialist C&E is not. Current specialty case consulting teams (i.e., nursing home/geriatric, court clinic and child teams) are considered here to be an extension of developments in direct clinic services. They frequently began before C&E units were dissolved and tend to have a much more restricted,

explicitly clinical mandate. As such, they are not defined as specialist C&E, but are noted as a new and significant development relating to C&E.

Specialist C&E also could not be wholly defined by in-house staff training or research and evaluation activities. A specialty in center public relations was accepted because interviews revealed the use of C&E-like community education techniques.

A specialist in C&E had to devote a discrete and measureable portion of their time (more than 50% in most cases) to indirect activities (other than case consultation) focused in the community. Such specialists typically also performed case consultation, in-house training, public relations, and other activities frequently argued to be outside of the proper definition of C&E. These activities are noted below.

Generalist C&E activities also were found to frequently include similarities to specialist C&E activities. Generalist C&E also reached a diverse range of populations traditionally served by C&E. Generalist C&E is reported here as a separate service, however, from specialist C&E.

Amplification of Changes Over Time

This survey is designed to offer an indication of change over time in C&E services, comparing pre-1981 federally funded services with current, 1984, services. The changes reported in various centers followed similar trends over this time, but had different schedules. While a general shrinkage in specialist C&E staff time

is reported, centers peaked in their specialist C&E FTE positions at different times. C&E activities began shifting in type and target populations as early as 1979 in some centers, although not as frequently as after 1981, with changes following the same general directions. It is the conclusion of the researcher, based on comments solicited during interviews, that C&E services began to reflect emerging issues of center sponsorship and funding before 1981 in many cases. In cases where the reported history allows this change to be discussed, the "before" data reported here reflects the earlier traditional C&E data. This technique serves to amplify to some degree the changes reported in the service of clarifying a trend. While this technique does act somewhat as a preconceived conclusion in shaping the data, a clear and powerful trend would be observed if reported strictly on the basis of two chronological dates. The ideal technique, that of reporting all variables for each of the past ten years, would have been too lengthy and beyond the accuracy of the frequently estimated data which was reported. An appropriate "before" and "after" orientation is used and more detailed changes over time are noted where they seemed particularly powerful or were readily measureable in a reliable fashion.

Data is reported for C&E grant projects and non-C&E grant recipients separately where the data revealed differing trends between these two groups.

Specialized C&E Service

Table 12 illustrates the raw survival rate of some core specialized C&E service (either a unit or a single person) in CMHCs. While the respondent pool is generally limited to 20 centers in this survey, data on this variable was available for 21 out of 25 former CMHCs (84%). The average raw survival rate is 63%, or 50% of the C&E grant projects and 69% of the non-C&E grant recipients.

Organizational Standing of Specialist C&E

Organizational standing was measured by the presence within the center of a full-time director of C&E (see Table 13) and by the organizational standing of the director (see Table 14). The frequency of full-time (80% or more) C&E directors dropped from 100% to 58% in those centers with a specialist staff. The total number dropped from 19 full-time directors to 7 full-time directors. It is also noteworthy that many of the currently measured directors are directors of a unit of one person, making them more of a coordinator or service representative than a director, as changes in title sometimes indicate.

Organizational standing of directors was measured for 16 centers. The variable examined whether or not the specialist director or sole staff person had equal organizational standing with other CMHC program directors and/or direct line access to the center executive director. The data reported indicates a clear slip down the organizational tree by specialist C&E staff (see Table 14). In those centers with specialist C&E staff, 88% of the directors formerly had equal standing, while currently only 45% have equivalency with program directors of other services.

Table 12

Specialist C&E Service in Massachusetts CMHCs

	Offered	Not Offered	N
<u>C&E Grant Projects</u>			
Pre-1981	6	0	6
1984	3	3	6
% Surviving	50%		
<u>Non-C&E Grant Projects</u>			
Pre-1981	13	2	15
1984	9	6	15
% Surviving	69%		
<u>Totals for all CMHCs</u>			
Pre-1981	19	2	21
1984	12	9	21
% Surviving	63%		

Table 13

Full-Time C&E Director Positions in Those CMHCs
with Specialist C&E Services

	Full-Time Director			
	Yes	No	% Yes	N
<u>C&E Grant Projects</u>				
Pre-1981	6	0	100	6
1984	2	1	67	3
<u>Non-C&E Grant Projects</u>				
Pre-1981	13	0	100	13
1984	5	4	55	9
<u>Totals for All CMHCs</u>				
Pre-1981	19	0	100	10
1984	7	5	58	12

Table 14

Organizational Level of C&E Director in CMHCs
with Specialist C&E Service

	C&E Director on level with other program directors and/or has direct access to executive direc- tor			
	Yes	No	% Yes	N
<u>C&E Grant Projects</u>				
Pre-1981	4	1	80	5
1984	1	1	50	2
<u>Non-C&E Grant Projects</u>				
Pre-1981	10	1	91	11
1984	4	5	44	9
<u>Totals for Combined CMHCs</u>				
Pre-1981	14	2	88	16
1984	5	6	45	9

Peak-Year Specialist C&E Staff Positions

The measure of peak-year specialist C&E FTE staff positions is perhaps the most revealing numerical measure of change. Table 15 reports the changes over time separately for C&E grant projects and non-recipients of C&E grants; while Table 16 illustrates the changes for the respondent pool as a whole.

The C&E unit size of C&E grant projects ($n=5$) has collapsed from an average of 6.8 to an average of .4 FTEs, or an average of 1.1 FTEs between the 2 centers that currently report specialist C&E.

Specialist C&E staff time in non-grant recipients was smaller to begin with and shows less change. The average specialist C&E FTE expanded from 3.2 to 3.4 staff positions, although the total number dropped. When averaged across all 15 centers in this category, the average dropped from 2.8 to 2.1 FTE staff positions. The data is also skewed by one center which has recently created a C&E-like team of more than 15 FTE positions. Exclusion of the data from that center amplifies the shrinkage over time and condenses the variance, with the overall average for 14 centers shrinking from 2.8 to 1.1 FTE specialist C&E staff positions.

The total for combined groups (see Table 16) indicates a smaller average C&E unit in centers with specialist staff, dropping from 4.2 to 3.0 FTEs. Taken across all 20 respondents, the total number of specialist staff dropped 56%, with the average specialist FTEs dropping from 3.8 to 1.7. When this data is again corrected by exclusion of the one unique current C&E unit, the drop in average number

Table 15

Highest or "Peak-Year" Number of Full-Time Equivalent (FTE) Staff Positions for Specialist C&E Service

	C&E Grant Project		Non-C&E Grant Project	
	Pre-1981	1984	Pre-1981	1984, n-1 ^a
Number of Centers				
Sum FTE	5.0	2.0	13.0	9.0
Mean FTE per Center	34.0	2.2	41.5	31.0
Standard Deviation	6.8	1.1	3.2	3.4
	3.3	1.3	2.2	4.5
Mean FTE for all Centers contacted (including those without specialist C&E)	(n=5)	6.8	(n=15)	2.8
		0.4		2.1
				1.1

^aOne C&E unit in this group is exceptionally large and represents a unique definition of the service. The figures from this unit are removed from the last column to illustrate the distribution of C&E FTEs in the other centers.

Table 16

Totals for Peak-Year Number of FTE Staff Positions
for Specialist C&E Service

	Pre-1981	1984	1984, n-1 ^a
Number of Centers	18.0	11.0	10.0
Sum FTE	75.5	33.2	18.2
Mean FTE per Center	4.2	3.0	1.8
Standard Deviation	3.0	4.2	1.5
Mean FTE for all Centers contacted (including those without specialist C&E)	3.8 (n=20)	1.7	1.0 (n=19)

of specialist staff across all centers is even greater, showing a decline from 3.8 to 1.0 specialist C&E FTE positions.

The data reveals that there has been a significant decrease in the unit size and frequency of specialist C&E staff throughout the centers. The drop is most significant in former C&E grant projects, which declined from an average unit size of more than twice that of other centers to less than a third the average of specialist staff positions currently found in non-grant recipient centers. It appears that the receipt of a C&E categorical grant was associated with a highly unstable C&E structure or orientation over time and may even have mitigated against survival.

The peak years selected for these comparisons reflect a general growth curve in the number of C&E specialist positions. For 16 systems where accurate data was available, 75% (12) either reached or were at their peak in specialist staff size in the three years between 1978 and 1980. Another 12.5% peaked in 1981, while the remaining centers (12.5%) peaked before 1978.

Organizational Model of Specialist C&E

Three types of specialist C&E units were indicated by the data. The "specialist core with authority over generalist" type represented a specialist team whose director had some level of authority over C&E services center-wide, including the part-time C&E services delivered by clinical staff in other programs (generalist C&E). This authority ranged from written contracts to in-name-only authority. A second type, or "separate specialist core", featured a specialist team with no authority over or responsibility for generalist C&E. A third type,

or "specialist core/vendor" model was comprised of a specialist staff member or team and staff or service funding which was subcontracted out to other agencies for C&E projects. Table 17 reports the standings by organizational model for all 20 respondents. A trend is evident toward a separate specialist core (82% of current specialist C&E units) and away from some authority over generalist C&E services (72% of specialist C&E units in the past).

Goal Orientation

Specific goals of C&E units are too complex and/or poorly recalled to analyze in detail. A general orientation or type of goal structure was suggested, however, by the data. Four types of orientation for specialist C&E services were identified, based on key phrases or words reported. The first type, that of needs assessment/at-risk populations, was based on the goal of delivering services that were most needed to the populations most underserved and/or at risk of developing disorders.

The second type, that of marketing C&E products, seeks to develop C&E-like service products and related target audiences with the primary goal of making money. A third type, the mixed type, incorporates needs assessment and marketing goals in a kind of compromise, often structurally established in different sub-units or projects. Finally, in some systems (different over time), C&E was used primarily as a public relations arm of the center.

Table 17
Organizational Models of Specialist C&E Units

Model	Pre-1981		1984	
	Number	Percent	Number	Percent
Specialist team with authority over generalist C&E activities (mixed)	13	72	2	18
Specialist team with no connection to generalist C&E activities	3	17	9	82
Specialist Core/Vendor	2	11	0	--
TOTAL	18	100	11	100

A growing diversity of goal orientations is apparent in Table 18. Where 83% of specialist units (for which data is available) had a needs assessment/at-risk population orientation in the past, only 27% maintain that goal as a sole orientation. A majority of C&E specialist units (36%) currently have marketing as a primary goal, while 27% have a mixed orientation.

Activities of Specialist C&E Staff: Traditional

Past and current activities were reported in narrative form by respondents. Activity categories were then developed using key words and phrases in the responses. In a majority of cases, responses reflected a common language of activity labels similar to that reported by Ketterer and Bader (1977) and reviewed above. This technique of data collection (narrative) and coding (retrospectively constructed categories) serves to highlight the focus in perceptions by respondents. All data, including NIMH files and reports, were used. The data is often limited, however, by the lack of accurate memory within the respondent system. As such, the results do not offer a completely accurate record of past activities. The results, instead, serve to illustrate general past concerns and activity priorities, as contrasted with current activity priorities.

A trend was apparent in changes in activity over time. A group of activities emerged over time and were typically not present in the first years of the C&E unit's existence. The results have been divided into two activity groups to reflect this trend. Traditional C&E activities (the earlier focus of C&E units) are reported in

Table 18
Goal Orientation of Specialist C&E Units

Goal Orientation	Pre-1981		1984	
	Number	Percent	Number	Percent
Needs assessment/high-risk populations	10	83	3	27
Marketing of C&E products	--	--	4	36
Mixed needs assessment and marketing	1	8	3	27
Center-wide public relations	1	8	1	9
TOTAL	12	99	11	99

Table 19. Contemporary C&E activities are listed in Table 20. In some cases the activities actually overlap and where appropriate are tabulated in both tables.

A difference typically exists, however, in perspective. Mental health education and training serves as a useful illustration. Traditional C&E in Massachusetts included mental health education to the general public and to specific at-risk target populations. Training was offered to area professionals in various topics. Modes of intervention in these areas included pamphlets and publications, newspaper articles, radio, and cable and broadcast television, public speaking, workshops, seminars, film showings, educational fairs and events, to mention a few. One particular form of education/training developed over time, that of health promotion/mental health education workshops. These workshops often focus on behavioral approaches to weight, stress or general lifestyle management, including active planning for predictable life transitions. These workshops were developed as more clearly defined packages than many of the other education/training activities. They represent a developed form of C&E project which integrates prevention education with a marketing strategy. The workshops are typically sold, not given away, and may be marketed to business and industry, human service professionals and agencies, and to segments of the general population. This activity is reported below as a "contemporary" (rather than "traditional") C&E activity because it represents a developing form which has become increasingly more common with time.

Table 19

Traditional Activities of Specialist C&E Staff by
Percent of CMHCs with Specialist Service

Activity	Pre-1981 (n=18)	1984 (n=11)
Mental health education to general public	67%	45%
Community organizing/development	61%	9%
Trainings, inservices, continuing education for mental health workers	50%	55%
Network collaboration with other human service providers	50%	18%
Focused mental health education for high-risk target populations	50%	18%
Case consultation (unspecified)	44%	36%
Program consultation (unspecified)	33%	27%
Sexual assault prevention/early intervention	50%	18%
Substance abuse prevention	39%	18%
Domestic violence prevention/early intervention	11%	0%
Mutual help/support groups	33%	17%
Conferences	28%	9%
Publications	28%	9%
CMHC public relations	11%	45%
Client advocacy	6%	0%
Volunteer coordination for CMHC	6%	9%

Table 20

New Areas of Specialist C&E Activity by Percent of
CMHCs with Specialist Service

Activity	1984 (n=11)
Employee Assistance Plan (EAP)	64%
Health promotion/mental health education workshops and seminars (i.e., stress, weight, habit, or life transition management)	64%
Organizational consulting to business and industry (B/I)	27%
Management training for B/I	27%
CMHC inhouse staff training	36%
Medical liaison with hospitals	18%
CMHC board training	9%
Case management	9%

A review of traditional C&E activities listed in Table 19 reveals a decrease in the frequency of offerings in 13 of the 16 categories reported. Outstanding drops occurred in community organizing and development (61% to 9%), networking (50% to 18%), focused education for at-risk populations (50% to 18%), and in prevention projects. C&E units evidenced a surprising similarity in prevention/early identification projects focused on sexual assault, domestic violence and substance abuse, reflecting common concerns across the state.

Increases were reported in training to human service professionals (50% to 55%) and particularly in public relations activities for the CMHC (11% to 45%).

Developments in contemporary C&E activities have replaced those traditional activities which are seen to have diminished in frequency. In general, contemporary activities reflect a growth in services oriented to the private sector of business, industry and the paying individual as well as services to the host CMHC system. Health promotion/mental health education workshops and employee assistance programs are offered by 64% of those CMHC systems which have surviving specialist C&E services. More than a quarter of the systems with specialist C&E staff offer organizational consulting, development and management training services to business and industry. More than a third function as a component of the internal staff training unit within the host CMHC system. A speciality in liaison consultation to psychiatric and medical hospital settings was

reported infrequently (18%), but may represent a new developing trend.

The tables of activities (Tables 19 and 20) report the percentage of C&E specialist units that routinely participated in each activity. The total number drops with the number of existing C&E specialist staff and units in the state. As such, 102 responses were coded under the "pre-1981" column in Table 19, while only 66 responses are coded in the "current" columns of Tables 19 and 20 combined. The percentages reported serve to illustrate what specialist C&E staff do as a group.

Populations Served

The changes in populations served reflect the same trends apparent in changes in C&E activity. Table 21 lists past and current populations served by three groups of general audiences, target populations and frequent organizations. There is a decrease in the frequency of services to the general public (67% to 45%) and to most target populations. Increases are evident in services to business and industry (6% to 64%), human service agencies and professionals (61% to 73%), and to the host CMHC system (11% to 55%). This latter increase may reflect a greater comfort and honesty with reporting services to the host center, services which were criticized in the past as inappropriate to C&E. It also probably reflects a greater integration of C&E within the CMHC system.

Sources of Financial Support

The change in percentage of free services offered is one of the most powerful measures of change in C&E activities and should have

Table 21

Populations Served by Specialist C&E By Percent
of CMHCs with Specialist Service

	Pre-1981 (n=18)	1984 (n=11)
<u>General Categories</u>		
General public		
Human service agencies and professionals	67%	45%
Business and industry	61%	73%
CMHC internal staff and needs	6%	64%
	11%	55%
<u>Target Populations</u>		
Children		
Elders	44%	27%
Women	39%	18%
Minorities	39%	18%
Clergy	28%	27%
Adolescents	28%	0%
Police	17%	9%
Physicians	17%	9%
Mentally retarded	11%	0%
Chronic deinstitutionalized patients	11%	0%
Unemployed	11%	9%
	0%	9%
<u>Frequent Agencies</u>		
Schools		
Elder service providers	44%	36%
Hospitals	28%	18%
Nursing homes	17%	27%
Housing authority or residence managers	17%	27%
Legal system	11%	9%
	11%	0%

been more explicitly measured by the survey. The change in percent of services delivered at token or no charge has effected the changes in types of services and populations served. Many, if not all, of the changes reflect the pursuit of income and financial stability. Free services offered currently often are done so on a marketing timetable, with the generation of fees or paying clientele for the CMHC system a specific, measured objective.

The major sources of financial support for specialist C&E are difficult to measure because accurate C&E budgets often were not and are not kept. Many respondents and data sources (such as NIMH records) were unable to provide reliable data pertaining to sources of income. The researcher is able to offer some estimates which do, however, possibly suggest a trend, if not a precise measure, of change in sources of financial support.

A majority of CMHC systems with specialist C&E in the past relied on NIMH operations and C&E grants as major sources of support for the activities (at least 83%). In the years prior to 1981, fees were a major source of support for only about 20% of the CMHC systems in funding their specialist C&E.

Currently, NIMH grants are gone. Fees provide a major source of support in around 64% of the CMHC systems for the specialist C&E which is sponsored. Employee Assistance Program (EAP) contracts provide a major source of support of specialist C&E in about 36% of the CMHC systems with such services. Support from the general operating budgets of CMHCs is more apparent now because C&E simply would not exist as a

specialist service in many cases without it. Different forms of DMH support comprise a majority of the income sources for mental health services in general in this state and about 45% of the specialist C&E staff identified in the survey drew indirect support from DMH in the form of state slots or contract monies. Other sources of support include block grants, hospital budget lines, third-party billings, and general operating budgets of the sponsor agency.

Despite a focus on self-supporting fees, specialist C&E services remain significantly dependent on multiple sources of income, including limited amounts of public funding.

Significant Changes

Respondents were asked to identify significant changes which had occurred in specialist C&E services over the past three years. The results reported below (see Table 22) illustrate those changes which caught the respondents' attention. Often, other measures suggest that changes were more frequent than reported in this section.

Examining all CMHC systems which formerly sponsored specialist C&E services (n=21), a total demise of specialist C&E (the most extreme of changes) occurred in 37% of the cases.

Examining the CMHC systems which continue to sponsor specialist C&E (n=11), changes range from shrinkage in staff FTEs (55%) to a temporary demise of specialist services (18%). Frequently reported changes include a change in activities in response to demand on the CMHC to provide direct clinical services (45%), changes in populations served in pursuit of fiscal stability for C&E (36%), and changes in

Table 22

Types of Changes in Specialist C&E Service Between 1981
and 1984, as Reported by Interviewees

Type of Change	Percent
A. By percentage of all former C&E specialist units ^a	
Total demise of service	37%
B. By percentage of CMHCs which continue to offer specialist service ^b	
Shrinkage in FTE positions	55%
Change in activities in response to press of direct service needs of CMHC	45%
Change in population served in pursuit of financial stability for C&E service	36%
Limitations or curtailment of free service	36%
Changes in activities in pursuit of income for C&E	27%
Temporary demise	18%
Loss of organizational standing	18%
Collapse of established human service consulting network	18%
Little or no community development or prevention service offered now (had been before)	18%

^a n=19; ^b n=11

activities in order to generate C&E income (27%). A limitation or curtailment of free service was mentioned in 36% of the CMHC systems still sponsoring specialist C&E.

Crucial Variables Affecting Changes

Respondents were asked to identify those "crucial variables" which caused or significantly affected the changes in specialist C&E. While these responses do not represent causal proof, they do offer a summary of the perceptions and conclusions of persons involved with C&E services. These responses captured some of the more open and revealing statements offered during interviews. The comments are presented, therefore, both numerically (see Table 23) and in selected narrative format.

Categories of identified crucial variables, as listed in Table 23, include a wide range of issues. Responses were taken from multiple sources, but grouped by CMHC system, with 18 respondent systems. Of these systems which formerly sponsored specialist C&E, the loss of NIMH dollars was a reported crucial variable for the fate of C&E in 94% of the cases. The press of the DMH service and funding priorities was identified as a significant force in relation to 61% of the C&E specialist services. Other crucial variables included a general failure in attempts to generate fees for services (44%), the support, or lack thereof, from the executive director (39%), and the timing of cuts in NIMH dollars with cuts on the local level in agency and school budgets (28%). Conflicts with direct service staff impaired the

Table 23

Crucial Variables Effecting Changes in C&E Specialist
Services, as Reported by Interviewees by Percent
of CMHCs Formerly Offering Specialist Service^a

Crucial Variable	Percent
Loss of NIMH dollars	94%
Press of DMH service and funding priorities	61%
General failure of attempts by unit to generate fee-for-service income	44%
Support or lack thereof from executive director of center	39%
Timing of cuts in NIMH dollars with cuts on local level to agencies and schools (including Proposition 2½ and federal cuts)	28%
Conflict with direct service staff	22%
Late entry into market, lack of proper facilities and/or lack of adequate investment of CMHC money and staff time for EAP development	22%
Cuts in center staff as a whole because of block grants or state budget	17%

^a
n=18

smooth integration of specialist C&E services with direct service programs in 22% of respondent systems that had specialist C&E. The conflicts took the form of staff resistance to shared roles and cross referrals based on a lack of experience or training in C&E, feelings of resentment toward C&E as a program that did not pay its way or as a program that had sold-out to commercialism (image problems either way), and general power struggles over limited resources.

Comments are reported below in the belief that the respondents' own words provide the richest source of data the survey produced. Identifying references to the centers or programs have been removed where possible to protect anonymity.

Narrative Comments on Crucial Variables

"There was a balance of power when federal and state officials were both involved. The state didn't have absolute control -- feds encouraged more of a CMHC perspective with emphasis on a full range of services, whereas the state sees itself as concerned with, responsible for chronic care. Speaking wholistically, C&E is not a very high priority. The state is the largest funding source and was required by federal block grant guidelines to give C&E dollars as one of five service categories. I'd be surprised if they give any dollars to C&E. There is no emphasis from the top [DMH central office] and within the centers, it has varied depending on whether you've got someone [a center director] who was enthusiastic about C&E--that's rare! Generally they hire someone to be a provider of

direct service and ask them, incidently, to spend 5% to 10% of their time giving a talk to some community group. It was not the reason they were hired and its not the thing they like to do."

"Dollars from the feds created and ended the first waive of C&E."

"We didn't have the internal extra dollars to support C&E. We were one of the earlier centers to lose our CMHC dollars -- we had to fill the grant-gap earlier...Oh, there was some resentment of the other centers...Yet the other centers all got cut at the same time. Ours was more of a gradual process. We were out of the feds before 2½ [Proposition 2½]. We cut back on the hours of C&E...we found different ways to work C&E into a meaningful financial situation. Our timing was good, we were in an area far enough from Boston not to be too competitive [with other EAPs] and we had an executive director experienced with EAPs who released staff time and worked together with us to develop it...Also, we've had less staff turnover, more consistency within C&E...The consultation is based on our reputation, known staff, people continue with the same consultant."

"The [DMH] area director decided that C&E was a luxury."

"We decided to go on our own [as a center], rather than become a DMH 'puppetship'."

"The state wasn't interested [in C&E]. DMH is half the center now."

"Our role was narrowed with DMH."

"The area director in '68 was very much into C&E. He took positions to other agencies as consultants. We worked to infuse knowledge and expertise with community caregivers, physicians, clergy... The staff did groups, networking, education to the community, training, organizational development...A new director came in '74. With the hiring freeze, cutbacks, people were called in from agencies, community boards...nurses went from doing things like sex ed in catholic schools to staff positions on inpatient units -- back into the hospitals...The community infusion began to wither away...issues of mistrust [of C&E by administration], 'what were they doing out there?' Finally, after more hiring cutbacks, more cuts through attrition, the director resigns.

Now we're climbing out of the pit. The new director sees C&E as fundamental to our work, with some additions. Consultation is the key to resource management, especially with the chronic...If the director himself goes out and says things are going to change, editorials get written about it...But the wounds [in the community] will take years to heal. We left them short -- there's a legacy of abandonment. Now, we're off on a new foot. But you can't say what would have happened if we hadn't cut back [on C&E] in the first place."

"C&E is a focus of conflicts that plague the center in general."

"There was a tension with the direct service staff over demand for service and limited center resources."

"There was a value conflict among center staff, in an atmosphere of limited resources, over the 'center as business'...C&E represented

this new attitude [of the center as a mental health business]."

"There was a mistrust by administration of indirect service and out-of-center work hours."

"Workshops weren't attended as well as we had hoped -- kind of like giving a party and no one comes...Referrals to the outpatient clinic didn't rise [through C&E efforts], so we have to reassess."

"Money from our innovations went to other programs -- like EAP went to the outpatient clinic."

"Prevention changed around the block grants, graduating from operations grants. We were active with the state group of C&E directors. No one would have asked this question in the mid-'70s. By fiscal year '82, there was C&E goal displacement, we were covering our rear ends. NIMH changed its position too. We were conflicted. They wanted C&E to be the marketing arm, to bring in the middle class through clinical ed groups, seduce the affluent into the center and then refer for clinical services to outpatient. It was clinical education, rather than prevention -- there's more to primary prevention than stress management...Also, the federal system kept the state system on its toes -- it influenced the quality and orientation of other [service] vendors. The state-level bureaucracy is not ideologically committed to prevention. This state is gutted with clinically oriented professionals. To be competitive with EAPs you have to compete against private practitioners and clinical programs...The EAPs around here tend to be more clinical,

less preventive...Also, it's easier in this part of the country to compete clinically [because] you have to know what prevention is to sell it. There aren't many professionals sophisticated in prevention."

Generalist C&E and Specialty Case Consulting Teams

A majority of CMHC systems contacted reported generalist C&E activities. It is likely that they occur in most systems, as illustrated in the case studies presented in Sections 1 and 2 of this chapter. There is little accurate knowledge of the frequency or type of generalist C&E activities which occur. Estimates by respondents suggest that at least 60% of generalist C&E is case consultation which is sometimes reimburseable through Medicaid, DMH contracts, and some insurance policies. Other activities include education, program consultation, training, public speaking and lobbying and community organizing for mental health services. Generalist C&E activities may be conducted by a wide variety of staff, including executive directors, program heads, and clinical staff.

Populations targetted by generalist C&E include a wide range of groups. Children and schools seem to be the focus of 50% to 60% of generalist activities. Other groups include police, visiting nurse associations, hospitals, senior centers, nursing homes, physicians, mentally retarded clients, housing managers, courts and the state's Department of Social Service (often around protective services to children). While an estimation of the percentage of frequency in contact is impossible on the basis of this survey, generalist C&E appears to reach many of the same populations as specialist C&E (with

perhaps the exception of business and industry).

While a measure of the frequency of generalist C&E hours was not possible, 4 of 20 systems reported evidence of a decline in the number of C&E hours delivered. Evidence reviewed in the next section illustrates sources of pressure on mental health centers which might be expected to force a decline in generalist indirect service time.

Specialty case consulting units seem to be on the rise. They represent an efficient packaging of direct clinical services for human service organizations that do not specialize in mental health. Services often include psychiatric assessment and diagnosis, treatment plan recommendation and referral, case management consultation, and some training and program consultation. The most common team appears to be the school/child service agency consultation team. These teams often represent ongoing collaborative agency committees as well as specialty case consulting units within a mental health center. Geriatric (or nursing home) teams and court clinics (or consulting teams) appear to be second in frequency. These units have evolved in part as a direct priority from DMH. The discharge from state hospitals of large numbers of chronic patients has contributed to the sharp rise in the number of such patients now found in nursing homes. Geriatric/nursing home consultation units are, in part, an attempt by DMH to maintain services and housing for DMH clients out of state hospitals. Court clinics were mandated by DMH on the requests of legal systems throughout the state for more

assistance in assessing psychiatric issues in criminal cases involving juveniles and adults. There have also been some trainings for police in areas such as suicide risk and prevention for detainees and collaborative management between emergency services and the police of deinstitutionalized, homeless patients living on the street.

A few discrete specialty units provide C&E-like services such as storefront counseling for the unemployed and mental health training for minority indigenous helpers (both funded by federal funds through DMH).

Summary of Results

The results indicate that, on the average, specialist C&E has continued to survive, albeit on a much smaller scale. C&E services were least disrupted in those centers which never received C&E grants and, hence, did not develop large specialist units. C&E specialty staff are much less frequent throughout the systems, with units often comprised of a single specialist. There are fewer full-time C&E directors and C&E usually holds a lower organizational standing than it once did. Specialist C&E has shifted its foci of activities and populations in an attempt to generate greater financial stability. Business and industry, fee-paying service providers, and middle and upper class clientele have been cultivated, along with the host CMHC systems themselves. Services have shifted away from

community development and prevention projects which typically had poorly defined and financially poor constituencies. Services have shifted more toward packages which are attractive as marketable products to the above-mentioned audiences. Crucial variables affecting these changes included the demise of federal funding, service priorities from DMH which overwhelmingly emphasize the chronic deinstitutionalized client, variable success of C&E units in successfully selling their services and the support of center executive directors.

Generalist C&E and speciality case consulting teams continue some similar activities, though largely dominated by clinical concerns for specific cases.

Section 4: Current State Environment of CMHCs and its Affects on C&E

"C&E is a focus of conflicts that plague the center in general."

- Survey respondent

The statement above summarizes the results of this section. Many of the current changes in specialist C&E services reflect changes made in the host centers as they adapted to a changed financial environment. The history of the Massachusetts Department of Mental Health demonstrates that DMH has always had a different mission than that of the CMHCs. DMH is the provider of last resort for the most chronically disabled, destitute and homeless. The Omnibus Budget Reconciliation Act of 1981 cut the amount of federal support available

and placed that money under the direction of DMH. The smaller block grants caused a significant fiscal crisis in a number of centers. Programs were streamlined and, in some cases, staff were laid off in significant numbers. DMH became the overwhelmingly dominant source-of support for mental health services, with a coinciding dominance of its service priorities. Outpatient services to the working poor are threatened with significant cutbacks. Centers have not only had to adapt to DMH priorities on services to the chronic deinstitutionalized, but are under pressure because reimbursement rates by DMH, Medicaid and insurance companies often do not cover the cost of service delivery. Block grant funds are not used significantly for C&E and DMH does not, as a rule, fund C&E. Specialist and generalist C&E services are lucky to have survived at all in a direct service system. They probably do so by making some income and by demonstrating the importance of a base-line of indirect services in supporting the Center, its reputation and connections and its direct services.

The Department of Mental Health Mission and Budget

The history of state-funded mental health services in Massachusetts is relevant to this study, but beyond the scope of this work. Briefly, it enjoyed an illustrious beginning with Dorothea Dix and moral treatment, the first state hospital (Worcester, 1833) and the first inpatient state school for the mentally retarded (Fernald, 1848).

The Department of Mental Health began in 1919 as the Department of Mental Diseases and was created to supervise the 13 state hospitals and 2 state schools then in existence. The sharing of state funds with child guidance clinics began in the 1920s to help diagnose mental retardation. Local-state cooperative clinics were begun in 1939 to provide outpatient services to the poor. Throughout its history, however, the vast majority of the DMH budget has gone to state schools, state hospitals and the community services needed to support former patients of these institutions.

The service profile has shifted significantly toward community services in the past thirty years. The state hospital inpatient census peaked in the 1950s with about 23,000 patients, dropping steadily to the low of about 2,000 in 1981. This trend reflects the impact of anti-psychotic medications; the rising costs of inpatient services; the leadership of DMH Commissioner Robert Okin (1975 to 1979), who believed in normalization and deinstitutionalization; and at least 6 class action suits brought on the behalf of DMH patients, leading to at least two consent decrees (mental retardation cases statewide and mental health clients in District 1). While this is an extremely simplified history, it is reflected in the "DMH Fiscal Year 1986 Budget Narrative" and supported by interviews conducted in this survey.

A variety of factors favorably affected the financial base of CMHCs during this time, not the least of which was the CMHC Act which established a second mental health system in the state. Other events

entailed the inclusion of outpatient services under Title XIX, Medicaid funding, and a state law requiring all health insurance policies to include at least \$500 for outpatient services (both in 1976). Following the cuts in funds with block grants, however, several other events occurred. "Proposition 2½" (1981) was passed, placing a statewide limit on the real estate tax base of local governments. Another state law, M.G.L. 372, the "Hospital Cost Containment Act" (1981) placed a ceiling for all hospitals on the total dollar figure they could bill to insurance companies. This limit forced the elimination or cutback of many auxiliary mental health services. DMH was also targeted by the legislature for mismanagement and level funding was cut or frozen for many DMH accounts. Approximately 1,000 DMH employees were laid off in 1982, including many state slot direct service personnel out of area offices.

At the moment DMH annually serves approximately 8,000 mental health inpatients, 3,700 mentally retarded inpatients, 16,000 residents in community housing and/or day treatment, and 80,000 clients through emergency, outpatient or case management services. It's mission is to act as the provider of last resort for the destitute and the most severely disabled. The budget for fiscal year 1985 was approximately 602 million dollars (the federal block grant, by contrast, was only 9 million dollars). It is extremely difficult to break down the budget by accounts to identify where money goes precisely. With the assistance of expert interviewees, the researcher

suggests that approximately 90 million dollars goes to adult mental health services in the community (that is, excluding inpatient settings). The block grant makes up about 10% of this figure. The budget includes about \$400,000 for "special population" services in 1986 for cultural/linguistic minorities, the sight and hearing impaired and a self-help center for former clients. Most of this money goes to training of service providers. There is no budget line for C&E.

Block Grants Bring Cuts in Service Dollars

The Comptroller General issued a "Report to the Congress" in 1984 (GAO, 1984) which evaluated the implementation by states of the block grants. The amount of the budget cut made by those block grants appears to be debatable. Backer and his associates (1983), along with many others, refer to a 25% cut. The GAO indicates a 21% cut from 1981 to 1982. It also indicates a total cut in federal dollars for mental health and substance abuse services from 1980 to 1984 of 26%, or 37% when corrected for inflation. Interviews with state experts suggest that the funds in Massachusetts dropped from 15 million dollars in categorical grants to a 10 million dollar block grant in mental health. The GAO report notes that few changes in services were caused by block grants, but it also notes that half of all centers surveyed had cut their staff size. John Lichten, Acting Associate Commissioner of DMH, reports that many centers

across the state responded to the federal cuts by laying off staff, increasing the billable hours ("productivity") of staff, and by placing staff in fee-for-service positions. The impact of the cuts is illustrated by the budget of the South Shore Mental Health Center, a former CMHC and current block grant recipient. Federal funding for the center dropped with the block grants from 1.1 million to .66 million dollars. They lost approximately \$430,000, but the operating budget dropped from 4.7 million dollars in fiscal year 1982 (July, 1982 to June, 1982) to 3.9 million dollars in fiscal year 1983. This is because they not only lost the federal funds, but also the additional income which was generated by staff supported by those funds. A 40% cut in federal funds produced a 17% cut in the total operating budget line of the center.

DMH Becomes the Major Funder of Mental Health Services

The GAO report (1984) indicates that the state share of total dollars spent in Massachusetts for mental health and substance abuse services rose from 64% to 75% between 1981 and 1983. The influence of state agencies rose even more in assuming control of the federal block grants (22% of the 1983 total according to GAO).

Surveys of 43 DMH partnership clinics for fiscal year 1982 and 48 partnership clinics for fiscal year 1983 indicate that the DMH share of these clinics' budgets rose from 47% to 61%, even with the block grants (Note 10). A similar trend is reported by survey respondents for those centers which are not partnership clinics.

Block Grant and DMH Missions Differ from CMHC Mission

The DMH service mission, reviewed above, differs from the CMHC mission in placing most of its emphasis on treatment of the chronically ill. The mission of the block grants and Omnibus Budget Reconciliation Act of 1981, as described in the GAP report (1984) is similar to that of DMH. While a provision is made in the legislation that all funded CMHCs must provide five services, including C&E, the mental health goal of the Act focuses first, in all cases, on the "chronically mentally ill." This stands in sharp contrast to the goal for substance abuse monies, which lists prevention as the first service. A provision is made that at least 20% of block grant substance abuse funds go to prevention. No such provision is made for mental health.

Concerns of Mental Health Centers Currently

The trends described above threaten to produce major changes in mental health services. A number of interviewees in this survey expressed concerns regarding the plight of mental health service in general. A major concern is that services for the "working poor" will disappear. The unfunded middle ground appears to be widening between the destitute or chronically disabled and the person who can afford private treatment. (This is the very condition that the CMHC mission addressed.) Competition with health maintenance organizations, along with new limits on insurance coverage and the hospital cost ceilings have hastened a trend in public mental health agencies

to see a more disabled and destitute clientele. This trend has been noted by the Massachusetts Association of Mental Health Service Providers and by DMH employees (Note 11).

A major concern of centers is that funding even for this clientele is too limited. It is argued that services contracted for and provided for by DMH are "undercosted." It is claimed that contracts do not provide enough money, DMH staff slots are cut and rates of reimbursement by the state Rate Setting Commission are too low to cover the actual costs of service delivery. This is due in part to the considerable amount of indirect services and case management required to treat a severely disturbed population.

It is estimated by the Massachusetts Association of Mental Health Service Providers that less than 1% of the population is "tragically disabled" (Note 12). The focus on chronicity drains funds from the previous base services, "tearing apart" the former service profile. It was noted in interviews that the previous baseline of services provided prevention of chronicity through early identification and treatment, as in child and family clinics. Community issues known to be associated with psychological disorders such as alcoholism, drug abuse, incest and rape go unaddressed.

One interviewee concluded:

Chronicity can be defined, measured and documented...Prevention of chronicity can not be defined...The major focus / of DMH / on the chronic patient pours its dollars into a great pit.

This is a conclusion which may be hinted at indirectly by initial DMH findings that increasing the overall service dollars to areas may simply seem to increase demand for more services.

Little Money for C&E in the State

The end result of such concerns is that mental health providers are in little shape to support indirect or prevention services unless a general change in thinking occurs which reframes indirect services as a "key to resource management." This is unlikely.

In the 1984 DMH block grant budget for mental health, 2.6% of the 9.965 million dollars is noted as going to C&E. This C&E total of \$263,284 is divided among only three centers. Interviews with representatives of one of these centers suggest that much of this money goes to general administration.

A 1984 statewide mental health resource inventory, conducted by DMH and reported in the "Block Grant Proposal for Fiscal Year 1985" indicates that there are 52 C&E FTE staff positions statewide receiving \$956,000 from various sources. This represents only .49% of the total dollars listed for mental health services and only .46% of the total mental health FTE positions statewide. Given the current level of data analysis used for this resource survey, there is no available data on what these 52 positions actually represent in the way of services.

The surveys of partnership clinics reported in DMH memos (Note 13) indicate that C&E services represented 2% of the partnership clinic

budgets in fiscal year 1982 (while NIMH CMHC grants were still funded in most cases). The surveys indicate that the C&E budget of 1.258 million dollars for these 43 centers was supported by federal (45%), state (29%), and fee and third-party (12%) sources. Data was not available for C&E for fiscal year 1983 for these centers. The surveys indicated, however, the rise in the state share of funding that next year (47% in 1982 to 61% in 1983) as federal grants to centers disappeared.

The data reviewed, in summary, documents that the block grants in Massachusetts only minimally fund C&E. The resource inventory highlights the low status of C&E in mental health service across the state. The surveys of partnership clinic budgets again illustrate the low status of C&E, even in 1981-82, and explain why that status would have dropped even more given the changes in funding.

CHAPTER IV

DISCUSSION

The fate of C&E services in Massachusetts appears to be quite in keeping with predictions made by researchers of graduating CMHCs during the late 1970s and early 1980s. As a nonreimbursable community service, C&E has diminished enormously as a specialty within CMHCs. While still found in about half of the former CMHC systems, C&E is a barely measureable service, relative to other mental health services. The activities and orientation of surviving C&E specialists has, by necessity, changed significantly from that found during the days of federal sponsorship. This process of change is likely to continue and even accelerate with time as current service and funding forces reshape the structures and missions of the host CMHC systems.

The crucial variables which have affected this change are illustrated with a descriptive vividness by the data. While causality could not be tested within the limits of the data collected, certain issues demonstrate a weight of evidence merely by their constant re-emergence in the data. Well developed specialty C&E teams that delivered prevention and health promotion services to at-risk populations were clearly dependent on public financing. The very process of developing a stable financial base for C&E appears

to, of necessity, redefine that service toward marketing oriented goals.

Within the context of the CMHC systems, the press of demands for direct clinical services is an irresistible force. This is especially true of services, such as C&E, which have lost their categorical funding source. C&E was not the major task of these direct service organizations and certainly became extremely vulnerable the moment funding stopped, placing C&E in the "overhead costs" category. After advising numerous C&E units to diversify in search of income, and after chastizing the C&E units of Massachusetts, in particular, for "giving away services," Dr. Leon Nicks comments, himself, that C&E by definition required public funding. This fact was recognized by NIMH officials as early as 1975 when Dr. Nicks and other administrators drafted NIMH recommendations adopted in the CMHC amendments which created the categorical C&E grants.

In this situation, where specialist C&E services continue, the services either enjoy a rare and unique support by an executive director or the services pay for themselves, either directly or by promoting the clinical services of the center.

Predictive variables such as unit structure, types of activities, or size of the specialized team appear to be generally subservient to variables affecting CMHC systems as a whole. Money is tight and center directors are not in the position to promote a service or a philosophy they are not paid to promote.

The survival of generalist C&E and the growth of specialty consulting teams is not evidence of the success of one type of C&E model over another. Rather, these events point to the dominance of direct clinical services within the clinical model. Services which cling as close as possible, as support functions, to direct clinical service are more likely to survive. The issue of what C&E is and is not becomes central here. While always plagued by a lack of definition, probably as a result of the placement of C&E within a system with a different central task, the claim that generalist C&E was a more serviceable form stretches the issue beyond recognition. Along the continuum of services between indirect prevention and health promotion and direct clinical services, generalist C&E has always tended to be more clinical and less C&E. The few studies conducted by specialist teams in the state suggest that specialist C&E services could influence the type and amount of generalist service, moving it more toward a specialist model of service. The same forces which have diminished specialist C&E services can be assumed to have affected generalist services, diminishing them in quantity and promoting a clinical orientation.

The question of what defined "true" C&E remains central to, yet rather elusive in the findings of this study. The specialty units which developed with C&E and operations grants demonstrated some uniformity of goal orientation and activities, despite a wide diversity of projects. C&E services were based on a goal of identifying at-risk or underserved and needy populations. Activities were

indirect in nature and system oriented, either to agencies, community groups, or the public at large. In the case of training professionals (one of the more enduring activities), C&E activities often introduced both clinical and preventive needs of the underserved populations to the professional service system.

This was true, as well, of the outreach functions of C&E which developed as a natural consequence of C&E specialists gaining entry into communities. When examined as a speciality, C&E services were preventive and more. Arguments that C&E units did not "do primary prevention" miss the unique approach which typified C&E services. Through their role, C&E specialists were more likely than other CMHC staff to be aware of both the needs and the style of living of local residents. As such, C&E intervention technology tended to reflect local patterns of helping and local patterns of concern and interest. If clinical interventions were needed and acceptable, C&E specialists functioned as one of the CMHCs' more efficient outreach referral services, much to the dismay of prevention theorists who argued that prevention should lower service utilization. Just as often, C&E services translated the professional resources of the CMHC system into forms of intervention more acceptable to and in keeping with the lifestyles of hard-to-reach populations. In the translation, many of these resources were delivered in indirect modes, such as education, coalition development, and organizational consulting.

Discrete primary prevention projects were sponsored by specialist C&E units and the traumas addressed by such projects showed a surprising uniformity. Rape, sexual assault, incest, domestic violence, and substance abuse were commonly addressed, both through developed educational curricula and through community organizing and awareness campaigns. While not sophisticated by medical standards of primary prevention research, it seems a bit ironic that these same issues appear to be receiving ever increasing clinical attention as major factors in the cause and treatment of psychopathology. While some of these projects continue to be supported by C&E specialists, many have been either significantly scaled-back in size or transferred to community groups willing and able to continue the work as a personal cause. Such transfers may be a hint as to the future home of some primary prevention in this state.

C&E specialty services also delivered considerable case consulting services. Often these services were offered in keeping with the targeted at-risk populations. Perhaps just as often these services were provided on a request basis to area agencies. Case consulting, as a needed function of C&E services, appears to have dropped off quickly. The general constriction over time of the ability to offer case or program consultation to local agencies reflected, if anything, the potential size of demand for such services and the restricted C&E staff numbers which limited specialist services even at the peak of prosperity. Some of these services continue in specialty case consulting and generalist C&E, but it is arguable

that specialist C&E consulting typically carried a shaping influence which favored more educational and programmatic issues even when focused on specific groups.

Implications for the prevention mission of the CMHC movement suggested by the fate of specialist C&E services are somewhat limited. The prevention mission of CMHCs has been debatable from the start and certainly the modest size of C&E, even at its peak, suggests that prevention really was never much of a mission for CMHCs, at least as far as money and staff resources. Editorial comments on the study of C&E by Backer and his associates, written by such C&E experts as Marshal Swift and NIMH officials James Stockdill and Risa Pomerantz, focus on the shift in goals evidenced by C&E. While by no means absolute, C&E increasingly serves the routine needs of the CMHC system for indirect services such as public relations and in-house training (Swift, 1983). In serving the public, many C&E services have been reoriented away from needy populations and toward better functioning ("worried well") populations either in the general public or in business and industry (Stockdill and Pomerantz, 1983). While arguments that the workplace has been too long ignored as a setting ripe for primary prevention are logically valid and even somewhat consoling, the rationalization is apparent. Services are not being marketed to industry because the science of mental health service delivery (if there is one) has identified work as the major cause of psychopathology or the best intervention point for prevention. In the limited areas where workplace settings are the optimal points of intervention (as in alcoholism), organizations have existed

for some time to service those needs (such as A.L.M.A.C.A.,

This survey of C&E services, if anything, offers some disturbing indications of a shift in the CMHC mission in general, prevention aside. The loss threatened by current changes is not so much the loss of prevention services as it is a loss of comprehensive direct services. The review of NIMH grant commentary, as well as survey interviews, suggest that NIMH officials hoped, through CMHC grants, to promote a particular profile and structure of service delivery. Private, nonprofit corporations were to take responsibility for promoting a coordinated, efficient service network. This network was to offer a comprehensive range of services as defined by the five mandated services (and in contrast to the previous split between state hospitals and expensive private practice). In providing comprehensive service that also reflected local lifestyles, this network was designed to reach populations previously excluded from mental health services, either through their lack of money, their lack of severe chronic disability, or through their being a member of an ethnic or racial minority. The current situation of service priorities and funding sources in Massachusetts runs the risk of redesigning CMHC systems so that these populations will no longer be served. Such an event would historically carry a far more powerful impact on the CMHC mission than would the demise of specialist C&E services (even if C&E represented "the best" of the CMHC mission, as some have argued).

The future of specialist C&E will probably be somewhat different from the future of primary prevention services in mental health. C&E is surviving and will continue to survive as a minimal specialty within direct service agencies. C&E specialists typically have needed skills in community relations and training, and will also continue to weave more "traditional" C&E values into their roles as opportunities permit. (The one exception to this might be found in the high turnover of C&E specialists as C&E staff with more experience and memory of past values leave positions because of the frustrations associated with the forced changes in goal orientations -- "You can only dance so long," one interviewee explained.)

Opportunities exist, first, for C&E specialists to function as marketing and public relations experts for the center ("the face of the CMHC to the community," as it was described). This role will become increasingly more necessary as centers search for referred individuals who have insurance to keep outpatient clinics afloat. Service coordination will also remain a basic foundation of quality service (something still protected as an explicit goal by many administrators interviewed). C&E will remain useful in its networking capacity to the degree that direct service staff don't have the time to assume such responsibilities.

A second avenue appears to be that of entrepreneurial marketing of training and consultative services. C&E specialists are well equipped to provide such services to human service agencies. As long

as such agencies have money to train staff and send staff to conferences, there will be some market for C&E training services. Major competitors exist, however, with large, well-known medical schools, such as Harvard, showing an increasing interest at least in the conference market. Health promotion and life transition training for the well-off general public also remains a staple for C&E income. Interviews suggest that competition is growing in this field also, with adult education and community colleges offering more classes in topics ranging from stress management to parenting to nutrition and exercise.

The business and industry market is, of course, a highly touted target for C&E growth. This potential remains, in large part, to be realized. Employee assistance programs offer this potential to market both direct clinical services (through referrals), as well as training and health promotion/prevention education. Many surviving C&E specialist units in this survey offer EAP services as one product. Research by the National Council of Community Mental Health Centers (1984) suggests that more than a quarter of CMHCs currently offer EAP services. The same research documents that most of these programs do well to cover their costs. In their survey of key informants, Sodano and Woy (1983) came to a similar conclusion and warn of the potential shift in goal orientation associated with such endeavors. EAP services may well become a fairly common, self-supporting program with a discrete standing like that of other programs, such as outpatient clinics or day rehabilitation programs. EAPs will,

as such, support EAPs, not C&E.

Consulting to business and industry around organizational issues and management training is another potential field of growth for C&E. It is likely that the successful C&E units in such a market will increasingly come to resemble other business consulting firms. A master's degree in business administration may well become the most desirable credential for such a C&E expert.

A major problem with C&E moving into most entrepreneurial fields is presented by the lack of experience most mental health administrators have in entrepreneurial projects. Very few directors are experienced in designing and managing such high-risk enterprises. If anything, CMHC systems are woefully unequipped to undertake high-risk investments. Many specialist C&E units suffer, as a consequence, a lack of the investment capital and management support to successfully pull off projects which might well succeed. It is likely, however, that C&E specialists will maintain some role as the marketing entrepreneurs of CMHC systems.

Other possibilities include working with health maintenance organizations to provide education and prevention services on a subcontract basis. This may be a limited market, as many HMOs are developing in-house mental health services and, when subcontracts are brought in, it is usually to provide strictly controlled clinical service. If indirect services are threatened in CMHCs, they are almost antithetical to mental health services as provided by some of the larger HMOs in this state. Alcoholism prevention may be one

exception to this situation, but it is ironic that many C&E specialists have not developed working relationships with the well established alcoholism treatment and prevention network which already exists in this state.

Some interviewees suggested that the competition for clinical cases may force administrators to try to elevate the agencies' reputations by seeking accreditation as a Community Mental Health Service Provider by the Joint Commission on Accreditation of Hospitals (JCAH). The JCAH model for community mental health providers (JCAH, 1981) includes several provisions which might promote C&E specialty services. Prevention (through public information, education, consultation, and somatic intervention and ecological change) is listed as a service required for accreditation, along with citizen participation requirements of community development and planning. While providing one of the more precisely defined models of community mental health, the JCAH guidelines do little or nothing to enforce these particular C&E-like requirements, as noted previously by Snow and Wolff (1983). The cost of meeting these requirements is high in general and interviewees suggest that Medicaid licensing is likely to remain the top priority for most agencies. This is particularly true of DMH facilities, many of which have had their Medicaid accreditations revoked.

The area of medical consulting offers one more potential market for C&E. Some C&E specialists in the state currently provide medical liaison and case consulting services to general medical

hospitals and state psychiatric hospitals. These are likely, again, to be limited fields. DMH area offices have only a few thousand dollars for consulting in the annual budget and much of this money will go to one-time trainings. General hospitals are cutting back enormously on consulting services and psychiatric and social work services in general in the wake of continuing fall out from the hospital cost containment legislation. One C&E specialist interviewed commented that her services had taken on great popularity in a general hospital after all of the other private consultants were terminated. She wondered what would happen when she had to start billing for services herself. The key to medically-related C&E may well be the ability of hospitals to bill such services to third-party payors, such as Medicaid and private insurance companies. If such services do qualify, C&E units may be able to offer inexpensive services, without the cost to hospitals of having to maintain in-house behavioral medicine or psychiatric liaison units.

All of these future possibilities carry clear implications for a continued drift away from traditional C&E goals. It seems likely, also, that with this drift, the fate of primary prevention in mental health will become increasingly separated from that of specialist C&E services and of CMHCs in general. Primary prevention in mental health has long carried the signs of a paradigm without a home. Carolyn Swift, in her comments in the Backer study (C. Swift, 1983) , points out that preventively oriented consultation and education services have long been provided by agencies other than CMHCs. The

question she identifies is not whether such services will continue to exist, "but whether they will continue to exist in CMHC" (C. Swift, 1983, p. 24).

The major barrier to prevention as hosted by CMHCs is that identified by Snow and Newton (1976) and commented on at length here; namely, that the main task of CMHCs has always been that of direct service delivery, not prevention. With the rise in influence of service priorities from DMH, this condition will certainly not change.

Prevention is supported by the state government, but not by DMH. The Massachusetts Department of Public Health funds primary prevention projects in alcoholism, drug abuse and sexual assault, along with a developmental screening and early identification program for infants which delivers significant secondary prevention services to parents and families. These services are notable for their efficient use of funds and expert staff. Alcoholism prevention is a particularly good example. DPH funds eight regional alcoholism prevention centers across the state which host teams of specialist staff who use many C&E-style techniques. It is probable that primary prevention enjoys a more supportive environment in DPH because the department is, by design, prevention oriented. DPH prevention services are often established as discrete offices or projects and thus do not suffer in competition with direct service mandates.

In the mental health field, DMH is an extension of the state government. As such, it reflects the expectations of the governor and the legislature. These individuals respond to the demands of their constituencies. Without an active citizen-based constituency, no amount of agency-based lobbying will produce more dollars for primary prevention. The generation of an energized constituency requires several conditions. A truly alarming event must be shown to be widespread and people must believe that such tragedies can and should have been prevented. John Lichten, Acting Associate Commissioner of Mental Health Services, pointed out the barriers in mental health to achieving these conditions. Taking the example of severe child abuse of incest, he pointed out that people have a strong aversion to either acknowledging that it's common or to accepting that they, or their friends, or even people like them, could even be remotely associated with such actions. He summarizes: "It's hard to get people to come out for something like that" (Note 14). Until C&E specialists, or other advocates in the field are able to use their skills to effectively break down such barriers and generate a citizen-based constituency, primary prevention in mental health will remain a minor paradigm in mental health services.

REFERENCE NOTES

1. Information concerning DMH partnership clinics, their budgets and services was compiled from several sources. The DMH Fiscal Year 1986 Narrative Budget (DMH, 1984) offers some broad information on overall spending. Two DMH memos were particularly useful.

The first memo, dated May 4, 1983, was directed to the "Executive Staff, District Managers and Area Directors" of DMH from Donna Mauch, Assistant Commissioner for Mental Health Services. The memo reviewed summaries of state fiscal years 1982 and 1983 partnership clinic services, staffing and costs.

The second memo was directed to Frank Keefe, Secretary of the Executive Office of Administration and Finance and John Mudd, Acting Secretary of the Executive Office of Human Services from the Commissioner of Mental Health, James J. Callahan, Jr., Ph.D. Dated January 31, 1984, the memo reviewed the data compiled from the attached "Partnership Corporation Revenue Survey" conducted by Elizabeth L. Funk, Executive Director of the Association of Community Mental Health Service Providers, Inc., of Massachusetts.

Personal interviews conducted in the course of this research with Elizabeth Funk and John Lichten, Acting Associate Commissioner for Mental Health Services provided explanatory background for the reading of the DMH memos and budgets.

2. Van der Koke, Bessel. Post-traumatic stress syndrome and endogenous opiates: A psychopharmacological theory of dependence. Department of Psychiatry, Cambridge Hospital, Cambridge, MA: Unpublished paper.
3. Information was gathered from a personal interview conducted in the course of this research with Harry Schulman, President of the Association of Community Mental Health Providers, Inc., of Massachusetts, and Executive Director of the South Shore Mental Health Center, Quincy, MA.
4. Wolff, T. The rise and fall of a C&E Unit. Franklin/Hampshire Community Mental Health Center, Northampton, MA: Unpublished paper.

This paper was prepared in draft form with the assistance of the researcher. Much of the data for the case study presented in Section 1 of the Results Chapter of this work was collected by

Dr. Wolff and the researcher during the preparation of this paper. Every attempt has been made to reference Dr. Wolff's conclusions in the discussion of the case study. The discussion of the case study presented in this work should not be taken as a statement of Dr. Wolff's conclusions, except when indicated. The researcher assumes responsibility for the discussion of implications to be drawn from the case study and any errors which might be contained in this discussion, and in the case study itself.

5. Wolff, T., op cit., unpublished paper.
6. Ibid.
7. Ibid.
8. Information was gathered from a personal interview conducted in the course of this research with John Lichten, Acting Associate Commissioner of Mental Health Services, Department of Mental Health, Commonwealth of Massachusetts.
9. Information was gathered from the DMH memo, dated May 4, 1983 and January 31, 1984. (See Reference Note 1)
10. Ibid.
11. Information was gathered from personal interviews conducted in the course of this research with John Lichten and Elizabeth Funk (see Reference Note 1).
12. Information was gathered from a personal interview with Elizabeth Funk (see Reference Note 1).
13. Information was gathered from the DMH memos, dated May 4, 1983 and January 31, 1984 (see Reference Note 1).
14. Information was gathered from a personal interview with John Lichten (see Reference Note 8).

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APPENDIX A

Survey Questionnaire

Revised 10/84

SURVEY OF CONSULTATION & EDUCATION SERVICES IN MASSACHUSETTS

NOTE: The following list is provided as an example of some staff services or activities commonly grouped under consultation and/or education:

- case consultation to school or other agencies
- program consultation
- mental health education for the general public
- mental health education for target populations (i.e., families of clients, highrisk populations)
- public relations/information on center services
- training, inservices and workshops (internal or external to center)
- primary prevention projects
- community organizing and development
- consultation to business or industry

Respondent: _____

Name & Address of Center: _____

Phone Number: _____

Date: _____

Respondent's position & number of years at center:

I. Current Description of Consultation, Education or Prevention Services:

1. Do center staff engage in any form of consultation, education or prevention services?

(If not, please advance to section II.)

If so, briefly describe those services:

SURVEY OF C&E

IV. Description of Type and Size of Mental Health Center:

1. What (financial/organizational) type of mental health center is this?
(for example, private, non-profit, state partnership, hospital affiliated; note: These categories are not necessarily exclusive. Please describe the type of center in your own words, listing affiliations as relevant.)
2. Please describe the range of services currently offered by your center.
3. What is the full-time equivalent staff size (including state slots under the center's authority)?
4. What is this year's approximate annual operating budget of the center overall (a total dollar figure)?
5. What are the main sources of income for the center overall and the approximate proportion of the budget accounted for by each source? (For example: Mass. DMH, 55%; local governments, 10%; Mass DSS, 10%; fee-for-service, 15%; medicaid/third-party, 10%)
6. What towns are in your catchment and what is the total population of the catchment area?

SURVEY OF C&E

2. What is the approximate number of fulltime equivalent (FTE) staff positions or staff hours devoted to C&E services?
3. Do any staff do C&E activities as (close to) 100% of their work time? If so, what positions are specialized in this way?
4. Is there an organizational unit, coordinator or director responsible for any of these C&E services? If so, please describe briefly the position or unit.
5. If there is a director or coordinator of one of the C&E services, at what level of authority is this position within the center's organization? (i.e., are they on the same level as program directors, do they have direct access to the center director, are they on the management team?)
6. Is there a budget line in the center's budget for any of the C&E services? If so, what is it? (are they?)

SURVEY OF C&E

7. Is there a written goals statement for any of the C&E services?

8. How are C&E services supported financially within the center?
(By what funding source?)

9. Do any of the C&E activities produce income? If so, how much?
(and/or what % of its budget is self-generated?)

II. History of C&E Services in the Center:

1. Briefly describe the history of development of each of the C&E services mentioned above and/or services that were offered at one time. For each of these services, please note the changes (and years of the change) over the past 8 to 10 years of:

- A. Type of service
- B. Approximate FTE staff positions or staff hours involved
- C. Structure of staff (a unit? specialized staff positions?)
- D. Budget line
- E. Goals

C&E Service (If none, please advance to section III.)

1.

2.

SURVEY OF C&E

3.

4.

(Please continue on back as necessary.)

2. Were C&E services in your center ever supported by NIMH or other federal grants? If so, what kind of grants, for which years, at approximately what levels of \$ support?
3. In the past, did any C&E services produce revenue? If so, approximately how much (and/or what % of the budget was self generated?)
4. To your knowledge, what factors or events most influenced the course of C&E services in your center over the past 8 to 10 years?

SURVEY OF C&E

5. Were financial or funding issues among these major factors?

6. If so, please describe any strategies used in response to financial pressures on C&E services (i.e., fee for service contracts, shifts in activity or target audience, shift to more "marketable products", specialization in one field, etc...)

7. How successful were these strategies?

III. Future of C&E in Center:

1. Do you anticipate any changes in the quantity or type of C&E services offered by your center over the next five years? Please describe briefly:

2. What factors do you anticipate effecting the future profile of C&E services offered by your center?

3. How would you describe the possible future of consultation, education and prevention services in mental health centers in this state?

SURVEY OF C&E

7. What Massachusetts Department of Mental Health Area is this center in?
8. Is the area office officially part of the center's organization? (For example, in some centers, an area director may also function as the executive center director.)
9. Please describe the center's financial relationship to Mass DMH. For example, a partnership clinic; private vendor for multiple DMH contracts; vendor for single DMH contract, etc...f

Thankyou very much for your time and attention in completing this questionnaire. Please add any additional information and attach descriptive pamphlets, etc..., as you think appropriate. Please return this questionnaire in the enclosed envelope to:

David Armstrong
South Shore Mental Health Center
460 Quincy Avenue
Quincy, MA 02169

Also, please check to make sure that your name and address are correctly filled in on the first page of this survey so that I can return the summarized results to you.

