REPORT TO THE CONGRESS

The Community Mental Health Centers Program--Improvements Needed In Management B-164031(2)

Health Services and Mental Health Administration
Department of Health, Education, and Welfare

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

B-164031(2)

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

This is our report entitled "The Community Mental Health Centers Program--Improvements Needed in Management." The program is administered by the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare.

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

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Elmer B. Staats

Comptroller General
of the United States

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D I G E S T

WHY THE REVIEW WAS MADE

About $447 million was appropriated for fiscal years 1965 through 1970 for the Community Mental Health Centers Program. The goal of the program is to improve mental health services through Federal grant assistance for building and staffing the centers.

The program was authorized by the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. It is administered by the National Institute of Mental Health.

Because the program is relatively new and expenditures are sizable, the General Accounting Office (GAO) examined into the management of the program.

FINDINGS AND CONCLUSIONS

Of the 1965-70 appropriations, $230 million was for construction and $217 million for staffing. As of June 1970, grants had been made to 420 centers; 245 were in operation.

Each center is required to provide inpatient services, outpatient care, emergency services, partial hospitalization (such as day care), and consultation and educational services. GAO's review covered grants of about $12.6 million to 16 centers in California, Florida, and Pennsylvania.

The review showed that

--in their planning some States used areas with larger populations than specified by regulations;

--the Institute did not have a national goal for the number of centers needed;

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- some construction grants seemed larger than warranted;

- --information furnished by grant applicants was insufficient for evaluation of the proposed size of inpatient facilities, and no criteria were given centers to determine whether their inpatient units would serve their areas adequately;

- --there was a need for a realistic appraisal of an applicant's ability to obtain sufficient non-Federal funds for a center's operation and for monitoring a center's financial status after an award is made; and

- --staffing grant money was used for unauthorized or questionable purposes at several centers.

Areas served

Regulations require that each center serve an area having a population between 75,000 and 200,000. Some States used areas with larger populations in their planning.

The Institute estimated originally that about 2,000 centers would be needed nationwide. It was not using that goal in its planning, however, and had not established another goal. The Institute estimates that--when all States have been divided into the specified population areas--from 1,700 to 1,800 centers will be required. (See p. 12.)

GAO believes that, in the interest of orderly implementation of the program, the Institute should promptly obtain from all States their latest plans setting forth the number of centers needed. On the basis of such plans, the Health Services and Mental Health Administration should establish a national goal of centers to be constructed and funded and establish annual funding goals. (See p. 17.)

Construction grants

When a center is built as part of a medical facility (such as a hospital), Federal funds may be used to help pay a share of the construction costs of building areas that serve patients from both the center and a hospital.

GAO questioned the rates used to allocate the costs of common service areas at two centers built as part of hospital units. GAO believes that the rates were not determined on the basis of sound allocation procedures and that, as a result, grants awarded of about $1.1 million were about $168,000 larger than warranted. (See p. 18.)

Recipients of grants were not required to justify the number of beds proposed for a center. GAO's review of seven construction projects showed no documentary support for the size of any inpatient unit.

Also, the Institute had not established criteria for determining whether a center's inpatient unit would serve its area adequately. Indications are that units

--may be too large, resulting in unnecessary costs to Federal, State or local agencies; or

--may be too small, with adverse effect on the quality of care provided. (See p. 22.)

Grants for staffing of centers

Federal grants are provided for a major share of the staffing costs of a center. A center, however, must obtain sufficient additional funds to pay the balance of staffing costs and all other operating expenses. The size of the Federal grants declines from year to year and grants end in a specified period.

Thus a realistic appraisal is needed of the adequacy of funds available to an applicant from sources other than Federal. (See p. 27.) Also GAO believes that a center's financial status should be reviewed by the Institute periodically after a grant has been awarded.

One grantee, for example, used grant funds of about $220,000 for unauthorized purposes during its first 2 years of operation because its non-Federal funds were inadequate to operate the center. The Institute had not made a realistic appraisal of this grantee's financial ability before awarding the grant and did not monitor its financial status after the award. (See p. 30.) The Institute has proposed to take actions to strengthen its review procedures. (See p. 33.)

Examples of staffing grant funds used for unauthorized or questionable purposes included:

--Three centers used about $278,000 for purposes not authorized in the law, such as building renovation and operating expenses. (See p. 36.)

--One center used about $265,000 for staffing costs in excess of the maximum Federal cost-sharing rate as specified in the law. (See p. 37.)

--Two centers used about $89,000 for expenses which should have been paid from non-Federal funds. (See p. 38.)

Officials of the Institute agreed to review questionable expenditures found by GAO and to seek recovery of any misspent grant funds. They reported that new procedures were being developed to tighten the review of the operations of staffing grant recipients. (See p. 33.)

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RECOMMENDATIONS OR SUGGESTIONS

The Secretary of the Department of Health, Education, and Welfare should require the Health Services and Mental Health Administration, which oversees the work of the Institute, to

--establish a national goal for the number of centers to be built and supported by Federal funds and a time-phased program for meeting the goal (see p. 17);

--issue guidelines for allocating construction costs of service areas used jointly by a center and other components of a medical facility (see p. 24);

--require an applicant for a construction grant to adequately justify the proposed size of inpatient facilities and establish criteria for determining the desirable size (see p. 24);

--put into effect the plan of the Institute to obtain adequate information on the financial needs and resources of recipients of staffing grants;

--improve the administration of the staffing grant program through more comprehensive and timely onsite evaluations of newly established centers, adequate guidance to centers and review staffs on accountability for grant funds, and other means (see p. 34 and pp. 43 to 45); and

--obtain settlements of overpayments made under staffing grants (see p. 46).

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW concurred with GAO's recommendations on program goals, review procedures relating to financial needs and resources, improvement of administration of staffing grants, and obtainment of settlements of overpayments. HEW reported that a number of corrective actions had been or would be taken. (See pp. 17, 35, and 46.)

HEW said that in 1968 a formula had been developed for allocating costs of centers built as part of a larger medical facility. GAO believes that the formula does not take into sufficient account the wide variety of conditions at different centers. (See p. 24.)

HEW said that it would not be prudent to establish criteria for the size of inpatient facilities to be provided because many factors were involved and flexibility was important. All applicants must describe their facilities and the rationale supporting each facility, HEW said. GAO believes that the variety of factors involved and the desire for

flexibility emphasize the need for criteria and for adequate justification by grant applicants. (See pp. 25 and 26.)

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report on shortcomings in the administration of the Community Mental Health Centers Program and HEW's corrective actions and plans may be of assistance to the Congress, particularly in view of changes in the level and duration of Federal support made by 1970 amendments to the authorizing legislation.

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Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HSMHA	Health Services and Mental Health Administration
NIMH	National Institute of Mental Health

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CHAPTER 1

INTRODUCTION

The Community Mental Health Centers Program is administered by the National Institute of Mental Health (NIMH), a constituent bureau of the Health Services and Mental Health Administration (HSMHA), Department of Health, Education, and Welfare (HEW). The purpose of the program is to make the most effective mental health care available to all the people of the Nation. This is to be done through establishing a basic network of mental health services at the community level with the assistance of a Federal program under which grant funds are made available for specified percentages of the cost of constructing and staffing mental health centers.

The program was initiated in 1963 by the enactment of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (42 U.S.C. 2681). It was extended and broadened by amendments to the act in 1965, 1967, and 1970 (Public Laws 89-105, 90-31, and 91-211).

Public Health Service regulations state that, to qualify for Federal construction and/or staffing grants, an applicant, which by law must be a public or private nonprofit agency, must present a plan for a coordinated program of at least five essential mental health services: inpatient services, emergency services, partial hospitalization (such as day care), outpatient care, and consultation and educational services. The Community Mental Health Centers Amendments of 1970 (Public Law 91-211) state that, with respect to centers which will serve an area designated by the Secretary of HEW as an urban or rural poverty area, the requirement to provide the prescribed essential services shall not apply under certain conditions for the first 18-month period of center operations.

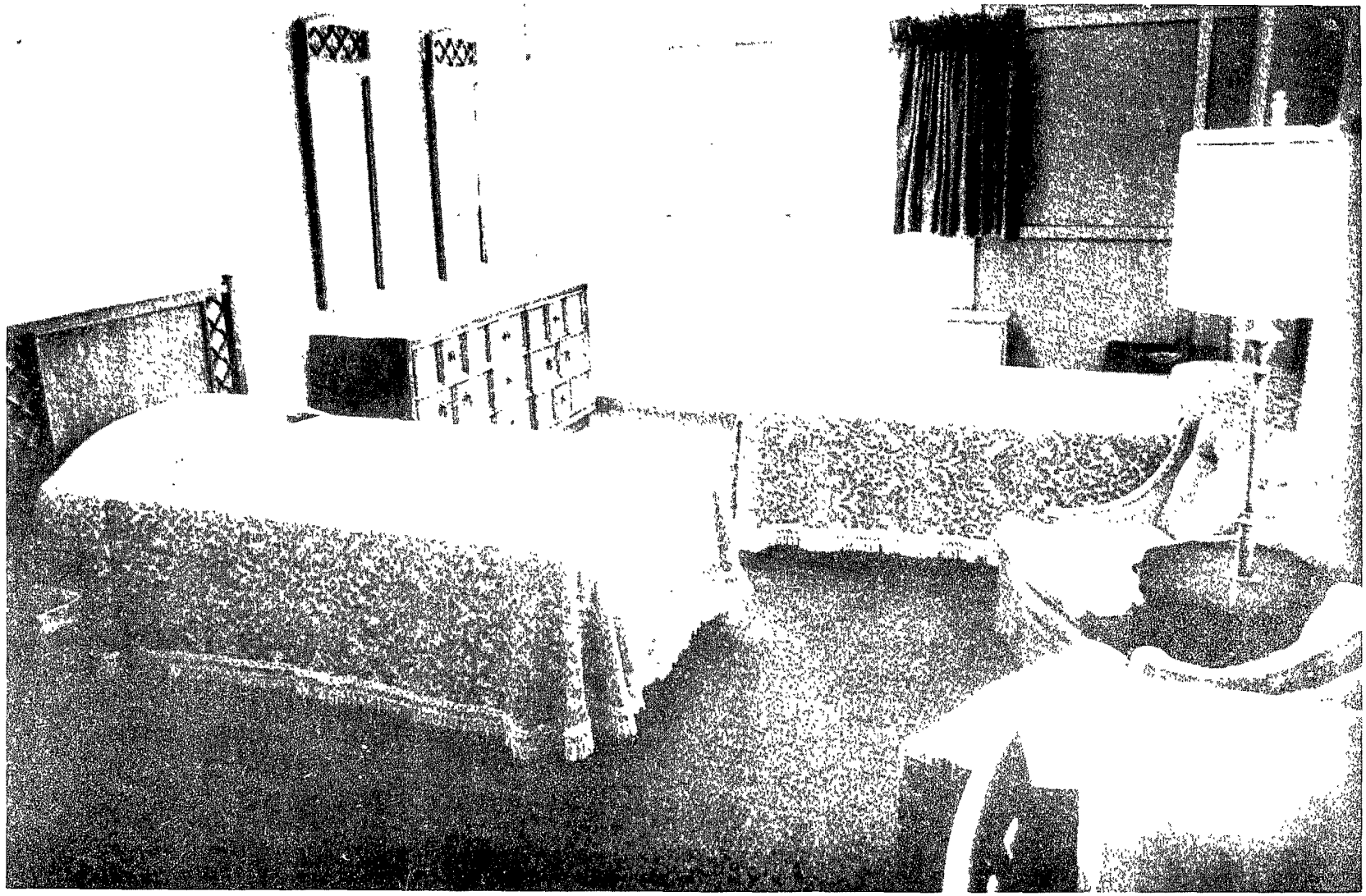
The regulations also provide that each community mental health center receiving Federal financial assistance must serve a specific geographical area (referred to as a catchment area) with a population of between 75,000 and 200,000 persons.

Construction grants are made to help meet the cost of construction, acquisition, or remodeling of facilities for an approved program. (See pictures provided by NIMH of centers built with Federal assistance on pp. 8 and 9.) Construction funds are allocated by HEW to the States under a formula providing for one third of the funds to be allocated on the basis of the relationship of the total population in each State to the total population of the United States and two thirds of the funds to be allocated on the basis of financial need as reflected by relative per capita income.

To participate in the program, a State is required to designate a single State agency to administer the program and to submit a State plan which sets forth, among other things, an orderly program for the construction of centers on the basis of a statewide inventory of existing facilities and a survey of need. The State agency is required to review the plan at least annually and to submit any required modifications to HEW. The rate of Federal participation in the cost of a construction project is established by the State agency each fiscal year. The law provides that it may not be more than 66-2/3 percent of construction costs. Public Law 91-211 provides that, effective with projects approved after June 30, 1970, the Federal share of construction costs for centers serving areas designated as urban or rural poverty areas may be as much as 90 percent.

Staffing grant funds may be used during the periods specified in the law for the cost of compensating eligible professional and technical mental health personnel for the operation of new centers or for new services in existing centers. Compensation includes salaries, fringe benefits, and such other benefits found to be reasonably necessary to secure the services of qualified personnel.

Federal grant funds are to be so used as to supplement and, to the extent practicable, increase the level of State, local, and other non-Federal funds otherwise available for the program but, in no event, are to supplant such non-Federal funds. Until June 30, 1970, staffing grants were authorized for a period of 4 years and 3 months and could not exceed (1) 75 percent of eligible costs for the first 15 months, (2) 60 percent for the first year thereafter,



INTERIOR OF COMMUNITY MENTAL HEALTH
CENTER IN THE STATE OF FLORIDA

COMMUNITY MENTAL HEALTH CENTER

(3) 45 percent for the second year thereafter, and (4) 30 percent for the third year thereafter. Public Law 91-211 extended the grant period to 8 years and provided that grant support not exceed (1) 75 percent of eligible costs for each of the first 2 years, (2) 60 percent for the third year, (3) 45 percent for the fourth year, and (4) 30 percent for each of the next 4 years. In the case of centers serving areas designated as urban or rural poverty areas, Public Law 91-211 provides that grant support not exceed (1) 90 percent of eligible costs for each of the first 2 years, (2) 80 percent for the third year, (3) 75 percent for the fourth and fifth years, and (4) 70 percent for each of the next 3 years.

Public Law 91-211 further authorizes the Secretary of HEW to make staffing grants of up to 100 percent of the costs, but not to exceed $50,000, of projects to initiate and develop community mental health services in rural or urban poverty areas.

The total amounts appropriated for the construction and staffing grant programs through fiscal year 1970 were as follows:

Fiscal year	Construction	Staffing	Total
	(millions)		
1965	$ 35.0	$ -	$ 35.0
1966	50.0	19.5	69.5
1967	50.0	33.8	83.8
1968	45.0	51.1	96.1
1969	15.0	64.3	79.3
1970	35.0	48.3	83.3
Total	$230.0	$217.0	$447.0

Following is a description of the procedures followed in approving grant applications through June 30, 1970.

Applicants for construction grants submitted their applications through the responsible State agencies which determined whether the applications were consistent with the State plans and which established their priorities for

Federal assistance. After the State agency approved an application, it was sent to the responsible HEW regional office where regional NIMH and other HEW staff members reviewed the application and recommended approval or disapproval to NIMH headquarters. The application was also reviewed by the Community Mental Health Centers Program Review Committee, composed of NIMH headquarters and regional personnel. After NIMH approved and awarded a construction grant, the States had the primary responsibility for supervising the construction and for ensuring that construction progressed in accordance with approved plans and specifications.

Applications for staffing grants were submitted to the responsible HEW regional office for review. Regional NIMH staff recommended approval or disapproval to NIMH headquarters. Staffing grant applications were also reviewed by the review committee mentioned in the preceding paragraph. After award of a staffing grant, the regional office had responsibility for monitoring the center's operation and ensuring that adequate services were provided by the center.

Effective July 1, 1970, the approval of grant applications was transferred from NIMH headquarters to the regional health directors. Also, Public Law 91-211 provided that grant applications be approved only upon recommendation of the National Advisory Mental Health Council, which is composed of 12 members, appointed by the Secretary of HEW, who are leaders in the fields of fundamental sciences, medical sciences, or public affairs. The Council also has three ex officio members--the Surgeon General, the Chief Medical Officer of the Veterans Administration, and a medical officer designated by the Secretary of Defense.

CHAPTER 2

STATUS OF THE PROGRAM

NEED FOR ESTABLISHING AN OVERALL PROGRAM GOAL

NIMH had originally estimated that about 2,000 community mental health centers would be required, using the catchment area concept, to adequately serve the needs of the Nation's population. As of September 1970, some of the States had not fully adopted the catchment area concept in their State plans submitted to NIMH, and NIMH was not using a specific goal of 2,000 centers in its planning.

Some of the State plans submitted to NIMH had not divided the States into catchment areas serving populations of between 75,000 and 200,000 persons as specified in HEW regulations. Information available in then current State plans showed that there was a total of about 1,300 catchment areas nationwide because several States used areas with larger populations than that specified by HEW regulations. NIMH informed us that those States which exceeded the specified maximum catchment area population were in the process of revising their plans and that, when all States were divided into areas of the specified population, there would be a total estimated requirement of between 1,700 and 1,800 centers nationwide.

As of June 30, 1970, 420 centers had been awarded staffing and/or construction grants by NIMH. Although the total number of centers funded during fiscal years 1965 through 1970 amounted to 21 percent of the original goal of 2,000 centers, NIMH estimated that the catchment areas served by these funded centers included 28 percent of the total population of the United States (including Puerto Rico). As of June 30, 1970, NIMH had obligated about $176 million for construction grants and about $185 million for staffing grants. The distribution of these grants by State is shown in appendix I. Of the 420 centers which had been funded at June 30, 1970, 245 were in operation at that date.

Our review covered centers in three States--California, Florida, and Pennsylvania--which had been provided substantial amounts of grant funds under both the construction and staffing grant programs. The total grants awarded as of June 30, 1970, to centers in these States were as follows:

	Construction	Staffing	Total
	(000 omitted)		
California	$16,053	$22,758	$38,811
Florida	6,376	6,363	12,739
Pennsylvania	11,011	24,710	35,721
Total	$33,440	$53,831	$87,271
Percent of national total of grants awarded	19.0	29.1	24.1

The progress of the program in the three States and nationwide, in terms of the numbers of centers funded and in operation in relation to the number of catchment areas, is shown in the following table.

	California	Florida	Pennsylvania	National
Total number of catchment areas	148	43	59	1,700
Centers awarded grant funds at 6-30-70:				
Number	40	12	34	420
Percent of total	27.0	27.9	57.6	24.7
Centers in operation at 6-30-70:				
Number	29	8	17	245
Percent of total	19.6	18.6	28.8	14.4

Although these States have made progress in getting centers into operation, we noted that, in California and Florida, many of the centers were not being constructed in those areas where the need was greatest. This matter is discussed in the following section.

CENTERS NOT BEING CONSTRUCTED IN AREAS WITH GREATEST NEED

California's State plan assigned priority positions, for the purpose of ranking areas by need, to the 148 catchment areas within the State on the basis of socioeconomic and demographic factors and existing mental health resources. The socioeconomic and demographic factors considered included the percent of dependent population, median family income, admissions to State hospitals, and alcoholism rate. The range of priority positions for the 23 construction projects which had been approved as of April 22, 1969, was as follows:

Catchment area priority positions	Number approved
1 to 25	6
26 to 50	1
51 to 75	3
76 to 100	-
101 to 125	4
126 to 148	9
Total	23

An official of the California State Department of Public Health informed us that most of the high-priority areas were also the most depressed areas in the State and did not have the community interest, money, or technical skills necessary to start a center. He told us that most of the centers which received grants either were existing organizations or were county-affiliated centers which had no real problems in supplying their matching share of the funds. He told us also that, whereas centers might not have been constructed in areas with the highest need, the centers were being constructed in communities which wanted them and which had sufficient resources to build them.

The State of Florida contains 43 catchment areas which were assigned priority rankings on the basis of such factors as admissions to State mental hospitals, suicide rates, ability to purchase services (relative economic status), admissions to child training schools, and number of acceptable

psychiatric beds. The 12 construction projects which had been approved in the State as of April 30, 1969, were distributed among the areas by priority position as follows:

Priority positions	Number approved
1 to 5	1
6 to 10	4
11 to 15	2
16 to 20	1
21 to 25	2
26 to 30	2
31 to 43	-
Total	12

The reasons for this situation, as explained to us by Florida mental health officials, were similar to those cited in the case of California. The Florida officials stated that communities in the areas with the greatest need have not applied for funds because of a lack of (1) available matching funds, (2) leadership ability to organize a program, (3) interest within the community, and (4) coordination between counties where a catchment area includes more than one county. They also said that they were working with the communities in an effort to find solutions to these problems.

NIMH officials told us in 1969 that they tried to encourage high-priority areas to submit applications for construction grants but that they could not assist communities which did not have the required matching funds. They pointed out that obtaining matching funds for centers in high-priority areas was a function of the States. We were also told that NIMH was trying to help local agencies devise means of channeling non-Federal funds into high-priority areas, such as by working with local mental health associations in seeking funds from the States and looking into the possibility of expanding health insurance coverage to include mental illness. The NIMH officials also pointed out that an amendment to the law was needed to increase the amount of Federal participation for the highest priority areas.

The problems involved in constructing centers in high-priority areas may be alleviated to some extent by Public Law 91-211, which provides for increased Federal assistance for centers serving rural and urban poverty areas. Under this law, the Federal share of construction costs for centers serving such areas may be as much as 90 percent. Also the law increased the Federal share and extended the grant period from 4 years and 3 months to 8 years for staffing grants awarded after June 30, 1970. (See p. 10.)

CONCLUSION

We believe that, in the interest of an orderly implementation of the program, NIMH should promptly obtain from all States their latest plans setting forth the number of centers needed in accordance with HEW criteria. On the basis of such plans, HSMHA should establish an adjusted national goal of centers to be constructed and funded and, in cooperation with State and local agencies, establish annual funding goals, considering the availability of Federal and non-Federal funds.

A time-phased plan of implementation, even though subject to adjustment, would be of assistance to the executive branch and to the Congress in evaluating the funding needs of the program from year to year and the impact of any changes that may be required because of budgetary reasons.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that HSMHA establish, on the basis of the latest State plans, a national goal of centers to be constructed and funded by grants and a time-phased program for meeting the national goal.

In its comments dated December 29, 1970 (see app. II), on a draft of this report, HEW stated that it concurred with our recommendation. HEW also stated that updated State plans, which delineated the catchment areas, were due in the regional offices by September 30, 1970, and that the total number of catchment areas for the immediate future was being updated. HEW further informed us that its planning goal for fiscal year 1971 was an addition of 34 community mental health centers.

CHAPTER 3

ADMINISTRATION OF CONSTRUCTION GRANTS

Our review of selected grants totaling about $3.9 million that were awarded for the construction of 10 centers in the States of California, Florida, and Pennsylvania showed opportunities for NIMH to strengthen the administration of the construction grant program in two respects.

1. By providing adequate guidance to grantees and NIMH regional program staff for the allocation of the cost of constructing a medical facility to a center that is to be included in the facility. Our review showed that grants for two centers were about $168,000 larger than warranted because they were based on construction costs which, in our opinion, were not allocated on the basis of sound procedures.

2. By requiring grantees to justify in their applications for construction grants the size of a proposed center's inpatient facilities and by establishing criteria for determining the adequacy of such facilities to serve the needs of the population of the catchment area. Our review of construction grant files showed that they did not contain any documentation in support of the size of inpatient facilities being constructed or sufficient information for an evaluation as to whether the facilities would be adequate to serve the population of the catchment area.

NEED FOR GUIDELINES ON ALLOCATIONS OF CONSTRUCTION COSTS

When a center is constructed as part of a medical facility, NIMH will participate in the cost of constructing the center and in a share of the cost of constructing building areas which serve both center and other hospital patients. Although the considerations to be taken into account in allocating construction costs for common service areas can be quite complex and different methods of allocation can be used, NIMH had not issued adequate guidelines for allocating such costs.

Our review of the computation of grants totaling about $1.1 million for the construction of two centers that had

been built as part of hospital units showed that, for both grants, the rates used to allocate the costs of common service areas were not determined on the basis of sound allocation procedures and that, as a result, the grants were about $168,000 larger than warranted.

The total estimated construction cost of grantee A's center was about $1.1 million, of which $654,000 was covered by an NIMH grant. We believe that the use of inappropriate cost-allocation procedures resulted in an increase in the grant of about $90,000, of which $33,000 was attributable to improper allocation of the costs of common service areas such as the hospital's business office and the automatic data processing room, and $57,000 was attributable to improper allocation of the cost of recreational facilities.

The HEW regional program staff determined that, of the total cost of constructing the common service areas in grantee A's new hospital addition, 12 percent was chargeable to the center, but no support for this rate was contained in the regional grant project files. Considering the relative benefits obtained by general hospital patients and by center patients from the several service facilities being constructed, we believe that different allocation rates should have been used. Some of the common service areas in the new hospital addition, such as the areas for mechanical equipment, were of benefit only to patients in the new addition. Other common service areas, however, such as the data processing area, were of benefit to patients in the entire hospital. We computed cost-allocation rates for each of the areas by using the ratio of center beds to beds in the new hospital addition and of center beds to total hospital beds as appropriate and arrived at a composite weighted allocation rate of 5.6 percent.

Use of the 5.6-percent rate in lieu of the 12-percent rate would have reduced the cost of the common service areas allocated to the center by about $55,000 and would have reduced the Federal share of the costs (60 percent) by about $33,000.

The new hospital unit constructed by grantee A also included recreational facilities and a corridor leading thereto. The total cost of constructing these facilities

of about $101,000 was allocated to the center even though the grant application showed that the facilities would be available for use by other patients of the hospital. Therefore we believe that it would have been more appropriate to allocate the cost of constructing these facilities on the basis of the ratio of center beds to total hospital beds (5.3 percent) instead of charging all costs to the center. Use of this allocation rate would have reduced the costs charged to the center by about $96,000 and would have reduced the Federal share of the costs (60 percent) by about $57,000.

In the case of the grant of $479,000 to grantee B for the construction of a center, we do not believe that the use of patient-bed ratios to allocate the costs of the hospital's common service areas to the center was appropriate because of the special nature of several of these areas.

The cost of constructing most common service areas, considered by NIMH to benefit both the center and the hospital, was allocated to the center on the basis of the ratio of patient beds in the center to total patient beds in the hospital and resulted in the allocation of 7 percent of the costs to the center. Our review, however, showed that several of these service areas, such as the operating room and the inhalation therapy room, would be used very little, or not at all, by mental health patients. Since these areas would be of benefit mostly to other hospital patients, the costs allocated to the center appeared to be overstated.

During our visit to grantee B's hospital, we obtained information prepared by the hospital which indicated that center patients accounted for less than 1 percent of the total use of these areas. On the basis of such use, we estimated that the costs allocated to the center would have been about $1,000 instead of the $121,000 that was allocated and that the Federal share of the costs (65 percent) would have been reduced from about $79,000 to less than $1,000.

Officials at NIMH headquarters and at the HEW regional office, which had processed the grants for the two centers, agreed that HEW might have participated in construction costs that were not properly applicable to the centers and that there was a need for issuing guidelines to grantees on

the allocation of construction costs of common service areas. A regional official also agreed that the expected use of common service areas by center as well as by hospital patients was a factor necessary for consideration in allocating the costs of such areas.

NEED FOR REQUIRING JUSTIFICATION OF SIZE OF INPATIENT FACILITIES

NIMH has not required grantees to justify the number of inpatient beds to be provided in a proposed center and has not established criteria for determining whether the center would adequately serve the needs of the center's catchment area. We reviewed data on inpatient facilities for all approved construction projects in three States under the jurisdiction of one HEW regional office and compared the number of inpatient beds approved--including beds approved under construction grants and psychiatric beds available in existing facilities--with the total population served by the catchment areas.

For the three States, we found that there were wide variations among the different catchment areas in the number of inpatient beds being planned per 10,000 persons. This is illustrated by the following table.

Estimated population in catchment area	Number of inpatient beds: Approved for center	Existing psychiatric beds	Total planned beds	Total per 10,000 persons
229,100	70	41	111	4.8
157,000	12	-	12	0.8
219,200	22	22	44	2.0
199,474	54	85	139	7.0
80,103	26	-	26	3.2
164,600	27	-	27	1.6

Although we recognize that the size of a center to be built may be affected by several factors, such as the quality of existing facilities and the methods of treatment to be used at the center, we believe that wide variations among centers in the number of beds being provided for each person may be an indication that the size of inpatient units in some areas (1) may be excessive with resultant unnecessary costs being borne by the Federal Government and State or local agencies, or (2) inadequate for the needs of the area with adverse effect on the quality of care provided to persons in need of treatment.

Our review of the project files for seven construction projects in five States under the jurisdiction of an HEW regional office showed that they did not contain any documentary support for the size of the inpatient units requested by the applicants. One applicant, for example, originally requested an 80-bed inpatient unit which was approved by NIMH. The applicant later submitted a revised application for a 58-bed unit. The applicant did not furnish and NIMH made no request for the factors which had been considered in determining the size of the unit requested in either the original or the revised application.

Another applicant requested a grant for the construction of a 50-bed inpatient unit which was awarded by NIMH. Information compiled by the grantee after the first 7 months of operation showed that the average daily bed occupancy was only 25. Subsequent to the start of construction of an eight-story addition to its hospital, the grantee decided to convert two floors of the addition into a community mental health center. The administrator of the grantee hospital told us that the size of the inpatient unit in the center was determined primarily by the size of the space to be converted into the center.

The grant applications we reviewed did not contain sufficient information to permit an adequate evaluation of the need for, or adequacy of, the proposed size of inpatient units. In our opinion, applicants should be required to fully justify the number of inpatient beds requested and to fully disclose all factors which were considered in determining the number of beds requested. We also believe that it would be desirable for HSMHA to establish criteria relating to size of inpatient units to provide guidance to applicants in determining the size of inpatient units to be requested. Such criteria would also be useful to HEW regional reviewers in evaluating the size of inpatient units requested.

Regional program officials stated that they relied upon an applicant's medical staff when reviewing the size of an inpatient unit requested by the applicant because of the staff's knowledge about the needs of the catchment area and the treatment methods to be followed at the proposed center.

RECOMMENDATIONS TO THE SECRETARY OF HEW

To strengthen the management of the construction grant program, we recommend that HSMHA

--issue guidelines for the allocation of the cost of constructing common service areas of a facility to a community mental health center that is to be included in the facility;

--require applicants for grants to justify, in their applications, the size of inpatient facilities to be constructed in a center; and

--establish criteria for determining the size of inpatient facilities that will adequately serve the needs of the population of the catchment area.

HEW COMMENTS AND OUR EVALUATION

In its comments (see app. II), HEW stated that a formula for prorating the costs of centers which are part of a larger medical facility was developed and distributed to the regional offices in June 1968. HEW stated also that this formula and its utilization would merit additional study unless the problems noted by us arose prior to the development of the formula.

Although the construction grants to grantees A and B were awarded prior to development of the formula, we still believe that there is a need for HSMHA to issue adequate guidelines on the allocation of construction costs of common service areas. Although the June 1968 formula might be of some help in determining the costs properly allocable to a center, we do not believe that the formula in itself provides sufficient guidance. The formula contains no instructions as to how it should be applied or as to what should be done in the case of conditions which are not provided for in the formula. The formula is based on average use rates for a number of common service areas and does not give adequate consideration to the wide variety of conditions which may exist at a center.

For example, at grantee A's new hospital unit the cost of constructing common service areas should have been allocated to the center on the ratio of the number of beds in the center (1) to the number of beds in the entire hospital in some cases and (2) to the number of beds in the new unit in other cases. The formula does not provide for such variable ratios. Also the formula does not cover certain types of areas, such as the recreational facilities included in grantee A's new hospital unit.

With respect to our recommendation relating to the size of inpatient facilities, HEW stated that it believed that it would not be prudent to attempt to establish national criteria for the number of inpatient beds to be provided. HEW noted that the sizes of inpatient facilities would vary depending on such factors as the cultural patterns of the persons served, the treatment goals and methods of the center and its professional staff, geographic factors, and available facilities in the community. HEW stated that the essential issue was flexibility and that center facilities should be so constructed that the areas within the center could be changed to meet changing program needs. HEW stated also that applicants were required to describe all facilities to be utilized in the program and to describe the rationale behind the arrangement and designation of space for particular uses.

As stated earlier in this chapter, we found that, at a selected regional office, project files did not contain documentary support for the sizes of inpatient units requested by applicants and did not contain sufficient information to permit an adequate evaluation of the proposed size of inpatient units. We believe that the need for adequate justifications by applicants for grants is emphasized by the fact that the factors to be considered do vary from center to center and that such justification should be included in each grant application.

Because there are many variable factors to be considered in determining the size of inpatient units to be included in a center, a certain degree of flexibility may be desirable. We believe, however, that criteria relating to the size of

inpatient units should be established to provide guidance to applicants for determining the size of inpatient units and to HEW regional reviewers for evaluating the size of the units requested.

CHAPTER 4

DETERMINATION OF APPLICANTS' FINANCIAL ABILITY TO OPERATE CENTERS

Under the Federal grant assistance program for the operation of community mental health centers, grants are awarded for a major part of the staffing costs and the grantees are required to obtain sufficient non-Federal funds to finance the remaining staffing costs and all other operating expenses, such as rent, utilities, supplies, and equipment. The Federal grant assistance is provided for a center on a declining basis for a specified period of years, and, at the end of the specified period, the center is expected to operate without Federal aid. (See p. 7.)

Our review of two centers which were not receiving State or local support showed that these centers used grant funds for unauthorized purposes. One center, for example, claimed that its non-Federal sources of funds were inadequate. NIMH had not made a realistic appraisal of this center's financial ability before awarding a grant and did not monitor its financial status after award.

We believe that NIMH, before awarding a staffing grant, should make a realistic appraisal of an applicant's ability to obtain sufficient non-Federal funds to initially operate a center and to finance its operations after the level of Federal support is reduced and eventually terminated. We believe also that NIMH should periodically review a center's financial status after a grant has been awarded to determine the use made of grant funds and the adequacy and availability of funds from other sources.

INSUFFICIENT NON-FEDERAL FINANCIAL SUPPORT OF CERTAIN CENTERS

The problems encountered by centers which are awarded staffing grants without adequate assurances that non-Federal funding sources will be available are demonstrated, in our opinion, by our finding with respect to two centers located in Los Angeles County, California. These centers

were awarded NIMH grants but were not receiving any State or local support.

The State of California reimburses approved local mental health programs for a portion of their operating costs not covered by Federal grants and funds from private sources. Up to July 1, 1968, the State's share of local program costs was 50 percent for existing services and 75 percent for new services. The State's share was increased to 75 percent of costs for all services effective July 1, 1968, and to 90 percent effective July 1, 1969.

In Los Angeles County, California, 11 centers were awarded NIMH staffing and/or construction grants of about $16.4 million at the time of our field review. The county, however, which determines a center's inclusion in the State's assistance program, was opposed to NIMH's plan of establishing these centers in the Los Angeles area. Only three of the 11 federally assisted centers were included in the program administered by the county and were eligible to receive State funds. The other eight centers were not included in the county program and did not receive State assistance. County officials told us in September 1970 that these eight centers would receive some State and local support for a variety of services provided under contracts with the county but that their costs would not be covered in full under the State's program of assistance.

The county's major criticism of the Federal program, as expressed in a letter by the County Department of Mental Health to the State Department of Mental Hygiene, related to the rigidity of the program and the regulations which require a specified size of catchment area to be served by each center. The county took the position that these regulations were appropriate for the average community in the average state in 1965 (when the legislation authorizing staffing grants was enacted) but not for those communities which had developed their own mental health program.

The county's opposition to NIMH's catchment area concept was based on the following beliefs: (1) Los Angeles County is too large for the catchment area concept since the Federal program would require 53 catchment areas in the county compared with 11 mental health regions projected in

the county's planning; (2) the Federal program has ignored the advance planning carried out by the county, under which the county seeks to develop its services on a step-by-step basis from small beginnings to larger programs as needed; and (3) the catchment area concept will result in the creation of segregated mental health service areas. Los Angeles County's Department of Mental Health estimated that the proposed Federal program would require local funds of $18 million in 1970 as compared with $4.6 million under the county's program.

In September 1966 the Director of Los Angeles County's Department of Mental Health notified the Director of NIMH that he was opposed to the method of awarding Federal staffing grants for centers in the county and that the county could not be held responsible for providing funds for the local share of the centers' costs or for subsequent financial support after Federal grants are discontinued.

As an example of problems which can arise when local support is lacking, the actions taken by NIMH in awarding a grant for grantee C, notwithstanding the objections raised by Los Angeles County, and the financial difficulties experienced by this grantee are described below. Similar difficulties were encountered by grantee D.

INADEQUATE REVIEW OF GRANTEE'S FINANCIAL STATUS

Grantee C was conditionally awarded a staffing grant for its center in June 1966 subject to three programmatic and financial conditions. The grantee was awarded a Federal grant of about $486,000 for the first 2 years of the center's operations which ended in January 1969. We found that a substantial amount of the grant funds was expended for purposes not authorized by law, such as operating costs other than staff compensation and the cost of building renovations. The director of grantee C's center told us that Federal funds had been used for these expenditures because non-Federal sources of funds were inadequate and the center could not have operated without using Federal funds in this manner.

We notified HEW regional officials of this situation, and, as a result, NIMH made a review of the center's use of grant funds. NIMH determined that, of the total grant funds of about $486,000 provided for the center's first 2 years of operation, February 1, 1967, through January 31, 1969, the center had used about $220,000 for unauthorized purposes. NIMH and the center agreed on a repayment plan under which the center would repay the $220,000, with interest, over a 3-year period, starting September 1, 1969. Under the agreement, $50,000 was to be repaid the first year, $100,000 the second year, and the balance the third year. The center made an initial repayment of $5,000 in September 1969 but had not made any further repayments as of December 29, 1970.

Our inquires at the HEW regional office responsible for the review of the grant application and for recommending approval or disapproval by NIMH headquarters showed that regional program officials had questioned grantee C's ability to obtain necessary non-Federal funds for either the period of Federal assistance or after termination of that assistance. They commented, in a memorandum to NIMH headquarters, on the center's location in a catchment area with a highly indigent population and questioned the advisability of establishing the center because it could not count on any solid local support to supplement an NIMH grant.

In view of the questions raised by the regional office, NIMH made its grant subject to three conditions to be met by the grantee. Two of the conditions required service agreements with other medical facilities in the same area. One agreement was to be entered into with a local hospital to provide needed psychiatric treatment services for patients of the center. The other agreement was to be entered into with a nearby county-operated clinic delineating the respective service responsibilities of the center and the clinic.

The third condition required the grantee to present acceptable financial information showing how the operating expenses of the center would be met. The grantee was to show that its income would be sufficient to meet not only its share of the center's professional and technical staff costs but also all other costs, such as rent, renovation, and maintenance of the building; salaries of personnel not funded by the Federal grant; medical and office supplies; and utilities.

After the grantee submitted information for the purpose of clearing these conditions, the NIMH regional staff decided in January 1967 to lift the conditions, and the award was made final in February 1967. The information submitted by the grantee regarding the proposed financing of the center's operations consisted of a statement that the grantee's share of expense would be met from patient fees, insurance payments, and reimbursements for patient services from State and local agencies. The information, however, did not include any firm budget data. Therefore NIMH's regional staff stipulated that it would make quarterly fiscal and program reviews of the center's operations and expected in this way to keep informed of any problems that might be encountered.

We found that the NIMH regional staff did not make the stipulated reviews of the center's operations and had not kept informed of the center's financial condition. Regional program officials and representatives of the HEW Audit Agency visited the center in May 1967 to evaluate the adequacy of the center's accounting system for determining costs chargeable to the Federal grant. HEW officials found the accounting system to be satisfactory for this purpose but did not make a review of the center's costs incurred because it was still in an initial stage of operation.

Regional office personnel made no review of the center's finances during the next 17 months.

NIMH officials were not aware that the center was using Federal grant funds for other than authorized purposes until we notified them. NIMH regional officials told us that regional personnel had made a number of visits to the center but that they did not review the center's financial records or expenditures and had not been informed by center officials of any financial difficulties.

Our discussions with NIMH headquarters and regional office personnel indicated that their respective responsibilities for review of operations at a grantee's center had not been clearly defined and that this factor might have contributed to the failure to make the quarterly reviews of the center's operations stipulated at the time of lifting the conditions that had been imposed on the award of the grant.

NEED FOR IMPROVED REVIEW PROCEDURES

In view of the problems at grantee C's center and similar problems at one other center in Los Angeles County, we inquired of the Director of NIMH as to the adequacy of procedures used in determining whether grantees are able to raise the requisite non-Federal funds and whether NIMH staffing grant funds are used only for authorized purposes.

The Director informed us that NIMH had followed its standard procedures in reviewing the grant applications for support of the centers in Los Angeles County. He stated that the centers provided fiscal projections which seemed reasonable enough for NIMH's staff to make favorable judgmental determinations but that NIMH could not obtain absolute assurances of continuing fiscal viability. He pointed out that NIMH had recognized that grantee C's center might encounter some financial difficulties, but, unfortunately, NIMH had not made the quarterly fiscal reviews stipulated at the time the grant was awarded.

The Director informed us that NIMH was taking or planning to take the following actions to strengthen its review procedures.

> "In view of knowledge obtained recently on the nature of fiscal and management problems in the staffing grant program, we have assigned responsibility to the grants management staff of the Institute for active involvement in the review of grant applications prior to award and for providing a continuing review and evaluation of management aspects of active grants. A concerted effort is now being made to develop more comprehensive review procedures to focus particular emphasis on the management and fiscal plans in the case of active grants. In addition we are considering the need for a more detailed and/or more frequent report of expenditure. The grants management staff will participate in periodic center grant review visits, and will employ an expanded format for these reviews designed to gather information on the actual use of grant funds and the adequacy and availability of funds from other sources.

These revised management efforts will be implemented in the immediate future."

The Director emphasized the innovative approach of the staffing grant program, which provided seed money for one of the most expensive aspects of initial center operating costs and seeks to stimulate additional funding sources to help support these specialized community services.

The actions being taken by NIMH, if fully implemented, should serve to keep NIMH informed of the financial plans of grant applicants and to monitor the use of Federal grant funds awarded. We believe, however, that it would also be desirable for NIMH to (1) provide specific guidelines to grant applicants on the information to be furnished on the financial resources and needs of proposed centers and (2) instruct its review staff on the extent of the verification to be made of such information. The respective functions of NIMH headquarters and regional office staffs should be clearly delineated to remove uncertainties--indicated at the time of our fieldwork--about their respective responsibilities.

In June 1970 we inquired at the cognizant HEW regional office regarding the financial status of the centers in Los Angeles County. The regional office informed us that it had no financial information relating to the centers. We also asked an official at NIMH headquarters whether reviews had been made to determine whether the six Los Angeles County centers not included in the county program, other than the two discussed in this chapter, were encountering financial difficulties. He told us that such a review had been made at only one of the six centers.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that NIMH implement its proposed review procedures, which should include the issuance of adequate guidelines to grant applicants and for use of the HEW review staff in making reviews, that will provide information on the financial needs and resources of recipients of staffing grants before an award is made as well as after an award is made.

In its comments (see app. II), HEW stated that it concurred with our recommendation. HEW stated also that NIMH had issued a policy statement in October 1969 which covered such areas as grant applications and awards, funding of grants, grantee responsibilities, accounting, records, and audit. HEW noted that amending legislation had been enacted since the issuance of the policy statement and that NIMH had developed an updated policy manual which was expected to be issued in January 1971. (An official of NIMH informed us on February 25, 1971, that the manual had not been issued.) According to HEW, this manual will provide applicants, grantees, and review staffs with extensive guidance on the staffing grant program, covering such areas as programming for centers, eligibility requirements for applicants, the application process, financing, accounting, records, and audit. HEW stated that the manual would define the responsibilities of applicants in the fiscal area, would clearly identify eligible grant costs, and would contain a special section on the financing of center programs.

HEW also noted that the administration of the Community Mental Health Centers Program had been decentralized effective July 1, 1970, and that extensive effort had been devoted by the NIMH regional and central office staffs to the development of modified review and approval procedures and policies which have been incorporated into an operating handbook. HEW stated that the section of the handbook on grant application review and approval procedures had been issued in July 1970 and had been discussed in a training program conducted for all regional office program and grants management staff. HEW stated also that the procedures and policies had been applied in each region and that they appeared to be effective on the basis of the limited experience to date.

Although we recognize that NIMH has begun to take corrective action in this area, we believe that emphasis should be placed on the issuance and implementation of the updated policy manual to provide for adequate review procedures.

CHAPTER 5

ADMINISTRATION OF STAFFING GRANTS

We believe that NIMH management controls over the staffing grant program need to be strengthened to help ensure that Federal grant funds are used in accordance with the terms of the grants. Our review of grants awarded for the initial operations of 14 selected centers showed that three of these centers used grant funds for purposes not authorized in the law and that five centers used grant funds for questionable purposes. NIMH was not aware of these unauthorized or questionable expenditures until we brought them to the attention of its program officials.

Improvements in administrative procedures which we believe are needed include (1) additional guidelines to grantees and HEW review staffs regarding the accountability for grant funds, (2) more informative expenditure reports by grantees to assist NIMH in determining how grantees are using grant funds, and (3) more extensive and timely onsite reviews by the NIMH staff of newly established center operations.

UNAUTHORIZED OR QUESTIONABLE GRANT EXPENDITURES

Our review revealed the following unauthorized or questionable expenditures of grant funds.

Grant funds used for unauthorized purposes

The Community Mental Health Centers Act authorizes the use of Federal grant funds for a specified portion of a community mental health center's cost of compensation of its professional and technical personnel but for no other operating expenses. Three centers had used grant funds for other than staffing costs as follows:

Grantee	Amount	Expenditure
C	$220,000	Building renovation and operating expenses
D	53,000	Utilities, rent, and office supplies
E	5,000	Contract services
Total	$278,000	

The director of grantee C's center told us that the center had used Federal funds for other than staffing costs because it was not able to obtain sufficient non-Federal funds for the operation of the center. The financial difficulties of this center and steps taken by NIMH to recover the unauthorized payments are described in chapter 4. A similar situation existed with respect to grantee D.

Grant funds used in excess of authorized Federal percentage of staffing costs

The Community Mental Health Centers Act limited staffing grant support through June 30, 1970, to 75 percent of eligible salary costs during the initial grant period. Grantee E expected to meet its share of costs from a State grant which was not received during the first grant year. An official of grantee E told us that, in order to alleviate a shortage of funds, grantee E obtained oral permission from NIMH to use NIMH staffing grant funds for payment of 100 percent of all center salaries. About 4 months after the first grant year ended, grantee E received its State grant, at which time it had used Federal grant funds totaling about $265,000 in excess of the authorized 75 percent Federal share of salary costs. A grantee official informed us that arrangements would be made with NIMH to repay this money. We informed NIMH officials of what we had found.

NIMH has followed the practice of permitting other grantees to use grant funds for payment of salaries and other expenses in excess of the authorized Federal share of eligible costs to tide them over periods of temporary shortage of non-Federal funds. NIMH generally has concerned itself with whether the Federal share of eligible costs was reduced to the authorized level by the end of a grant year.

In our opinion, the NIMH practice of allowing grantees to use Federal grant funds in the manner described is not a good administrative practice because it results in larger advances of Federal funds to grantees than otherwise would be necessary and in increased interest costs to the Government. Under this practice, there is also a risk that a grantee may not be able later to obtain sufficient non-Federal funds to reduce the Federal share of costs to the authorized level.

Grant funds used in lieu of non-Federal funds

The Community Mental Health Centers Act provides that Federal funds made available under staffing grants be used to supplement and, to the extent practical, increase the level of funds available for the centers' programs. To comply with this "maintenance of effort" provision, staffing grant applicants are required to show in their applications and provide satisfactory assurance that the staffing costs for which they requested Federal assistance represent increased expenditures over the average total cost of community health services for the preceding 2 years. According to instructions issued to grantees, the maximum amount of a Federal grant is to be based on the lesser of (1) the proposed estimated increase in the total cost of the center's mental health program or (2) the total estimated salaries and related costs of professional and technical personnel for furnishing the new services.

In the case of the two centers operated by grantees F and G, we found that NIMH had not reduced the amounts of the Federal grants to amounts based on the increases in total center costs which were less than the costs for new services. Federal grant funds totaling $89,000 were used, as a result, for expenditures which we believe should have been borne by non-Federal funds.

For example, during the first grant year, grantee F expended grant funds of about $323,000, representing 75 percent of the staffing costs for new services. In our opinion, however, application of the maintenance of effort requirement would have limited the amount of grant funds allowable to about $246,000, representing 75 percent of the

actual increase in total program costs. Therefore we believe that the grantee used grant funds of about $77,000 more than allowable under the grant.

To determine whether Federal funds have been used to supplant non-Federal support, we believe that NIMH should consider the grantees' prior levels of expenditures when reviewing their annual expenditure reports.

After we brought this matter to the attention of NIMH officials, they informed us that NIMH had adopted procedures for determining levels of expenditures before and during a grant year in compliance with the maintenance-of-effort requirement.

Center employees' salaries not adequately supported by time records

Three centers did not maintain adequate time and attendance records for their nonprofessional employees and, as a result, charged their salaries on the basis of estimates rather than on the basis of a record of time worked. The Federal share of these costs amounted to about $46,000. We were not able to determine whether this amount was properly chargeable to the Federal grants.

According to NIMH procedures, a staffing grant application must show the portion of a center employee's salary that is expected to be reimbursed under a Federal grant. For employees performing both center work and noncenter work, the applicant must show the expected percentage of time that the employees will be assigned to functions which are eligible for grant reimbursement and those which are not. Although the application is the basis for the award of a grant, actual reimbursements under the grant should be based on documented expenditures made by the center during the grant period.

The HEW Grants Administration Manual requires that direct charges for salaries and wages of nonprofessional employees be supported by time and attendance and payroll distribution records. NIMH had not issued instructions to grantees about the maintenance of time and attendance records. We found that these three centers did not maintain

such records but based their reimbursement claims for partially reimbursable salaries on the estimates in the grant application rather than on time worked and that NIMH was not in a position to verify the propriety of the claimed costs.

We believe that NIMH should issue guidelines to grantees for maintaining time and attendance records to support claimed costs of nonprofessional personnel as required by HEW policy.

Use of grant funds to pay employees not qualifying as technical personnel

Under the Community Mental Health Centers Act, Federal staffing grants are made to meet a portion of the compensation of eligible professional and technical personnel, but the act, prior to the 1970 amendments, did not define the positions eligible for grant support. According to HEW guidelines, the technical personnel category includes mental health aides, pharmacist's assistants, and a variety of other subprofessionals. The guidelines provided that the salaries of these personnel would be eligible for payment under a staffing grant if they had previous mental health training or experience or if they were receiving appropriately supervised training during the grant period. NIMH, however, had made a broad interpretation of the category of subprofessionals and, as a result, had included gardeners, janitors, maids, porters, or any individual providing a therapeutic patient relationship.

We found that three centers had used grant funds of about $37,000 for payment of salaries of subprofessional employees who were not performing duties or were not being trained in accordance with the HEW and NIMH criteria.

For example, grantee F's center used grant funds for the salaries of employees in seven clerical and janitorial positions who did not work with center patients. The center used grant funds of about $16,000 for these positions during the period September 1, 1967, through August 31, 1968.

NIMH regional officials told us that, during their onsite visits to the three centers, they had not inquired into the mental health training given to, or the work performed

by, the subprofessional personnel because they were not sufficiently familiar with all aspects of this new program.

The Community Mental Health Centers Amendments of 1970 added section 265 to the act which provides a definition of technical personnel eligible for staffing grant support.

> "*** the term 'technical personnel' includes accountants, financial counselors, medical transcribers, allied health professions personnel, dietary and culinary personnel, and any other personnel whose background and education would indicate that they are to perform technical functions in the operation of centers or facilities for which assistance is provided ***; but such term does not include minor clerical personnel or maintenance or housekeeping personnel."

The subprofessional employees supported under the Federal grants at the three centers would not qualify for grant support under the provisions of the 1970 amendments and did not meet the criteria for positions eligible for grant support as previously established by HEW. We believe that NIMH in its future reviews of grant applications and onsite visits to newly established centers should assure itself that all positions to be funded by grants are eligible for such support.

Revenue generated by grant-supported activities made available for nonmental health activities

Community mental health centers receive, in addition to NIMH staffing grants, revenues from non-Federal sources, such as donations; patients' fees; and State, city, or county funds. We noted that two centers had combined revenues from Federal and non-Federal sources that exceeded operating expenses during their first grant years by about $283,000.

The grantees, which operated general hospitals, in addition to the mental health centers, deposited the surplus funds into the hospitals' general operating accounts that were available for nonmental health activities. NIMH had

not issued instructions to its grantees on the use of revenues generated from grant-supported activities and had not implemented HEW's March 1969 policy on disposition of such revenues.

In March 1969 HEW issued guidelines in its Grants Administration Manual for the disposition of income generated by grant-related activities. HEW's general policy provides that:

> "The grantee is accountable to the awarding agency for the Federal share of any grant related income. *** that accountability may be satisfied by disposition in accordance with one or a combination of the following alternatives:
>
> "1. Returning the funds to the Federal Government by (a) reducing the level of expenditures from grant funds by an amount equal to the Federal share of the grant related income (b) treating the funds as a partial payment to the award of a succeeding (continuation) grant, or (c) payment to miscellaneous receipts of the Treasury.
>
> "2. Using the funds to further the purposes of the grant program from which the award was made.
>
> "Although grant related income may be used to reimburse costs which have previously been treated as non-reimbursable, it may not be used to reimburse unallowable costs."

NIMH informed us at the time of our review in October 1969 that neither HSMHA nor NIMH had issued instructions for implementing this policy.

IMPROVED PROCEDURES NEEDED TO STRENGTHEN MANAGEMENT OF STAFFING GRANT PROGRAM

We believe that the findings discussed in this chapter demonstrate a need for NIMH to strengthen its management of the staffing grant program, particularly by (1) obtaining more informative grantee expenditure reports, (2) making more extensive and timely onsite evaluations of newly established center operations, and (3) issuing additional guidelines to grantees and the HEW review staff on the accountability for grant funds.

Grantee expenditure reports

Applicants for staffing grants are required to submit detailed budgets of center operations including proposed staff positions and salary rates for which Federal support is sought. After the award of a grant, the grantee is not required to report any details of expenditures corresponding to the budgets submitted; the reporting requirements are limited to brief summary fiscal status reports.

Federal grant funds are advanced to grantees on the basis of monthly reports of total anticipated expenditures. Grantees are required to submit quarterly summary reports of expenditures and reconciliations of grant funds received and remaining on hand. Within a specified period after the end of the grant year, an annual expenditure report is required to be submitted to NIMH showing the status of the Federal grant funds and the grantee's matching expenditures. HEW's general policy is to require grantees to submit only brief summary expenditure reports and to maintain supporting detailed data subject to HEW examination and audit. HEW's policy does not require detailed or supplementary data except when a specific demonstrable need exists.

The several instances of unauthorized or questionable expenditures by centers of grant funds noted in our review, which had not come to the attention of NIMH, suggest the need for more informative program expenditure reporting by grantees. Pertinent information in such reports on a center should include details on its personnel, their functions and compensation, and on other operating expenses and on the sources of their funding. We believe that the circumstances

found by us at newly established centers, where adequate accountability procedures for grant funds have not been established, justify an exception to HEW's general policy of minimizing reporting by grantees.

Onsite visits

NIMH procedures require its regional staffs to make onsite evaluations of a center's operations as soon as possible after it has been active for 90 days. At the time of our fieldwork, these required evaluations had not been made at several centers.

For example, the eight centers in operation in the Commonwealth of Pennsylvania for more than 90 days at June 30, 1968, were not visited by NIMH regional personnel until 7 to 23 months after the centers officially began operating. The evaluations made during the visits covered the centers' mental health service programs but did not include an evaluation of the adequacy of the financial records and procedures. Regional officials told us that the scope and timing of their visits were limited by the lack of available personnel.

In the State of Florida, one of the centers that was awarded a Federal staffing grant was visited by NIMH regional personnel in the first month of its operations. This visit, however, was premature because the program was not fully under way. Also there was no record that a follow-up visit had been made, even though NIMH regional personnel had planned such a visit.

We were informed by NIMH that regional staff responsible for center operations in the State of California had visited selected centers needing attention but that reports on these visits had not been prepared. We were also told that the regional office staff did not have the competency to review the financial operations of the centers.

We believe that prompt onsite evaluations of newly established centers should be carried out as required by NIMH procedures and that such evaluations should be expanded to cover not only the adequacy of the centers' mental health services programs but also the adequacy of their financial records and procedures.

We discussed with a representative of the HEW Audit Agency the extent of the agency's audits of community mental health centers. We were told that HEW audits of the centers had not been made at the time of our review and that, because of the agency's work load and staff limitations, the audits had been deferred. We were also advised that the Audit Agency had started to make audits in fiscal year 1970 and that by June 1970 audits had been made of 27 centers.

Guidelines to grantees and review staff

We believe that NIMH should review the adequacy of its guidelines issued to recipients of Federal staffing grants and for use of its own review staff so that an accurate and timely accounting for the use of grant funds can be obtained. As previously discussed, additional guidelines are needed regarding grantees' (1) compliance with the maintenance of effort requirement of the law, (2) maintenance of adequate time and attendance reports for nonprofessional center employees, and (3) disposition of income generated by Federal grant-supported activities, such as revenues from patients, so that the Federal share of such revenues can be either paid to the Federal Government or otherwise used only for the purposes of the grant program.

- - - -

NIMH officials expressed general agreement with our suggestions for strengthening the administration of the staffing grant program. They informed us that they were considering the need for centers to submit more detailed expenditure reports and the possibility of requiring the centers to submit annual financial statements certified by certified public accountants.

Also NIMH officials, to whom we referred the unauthorized or questionable expenditures of grant funds, agreed to examine into the circumstances in each case and seek recovery of any grant funds that were not used strictly in accordance with the terms of the grants.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that HSMHA strengthen the administration of the Federal staffing grant program by such means as

--requiring grantees to submit more informative reports on center expenditures,

--expanding the scope of and making more timely evaluations at newly established centers,

--providing adequate guidance to grantees and NIMH review staffs on the accountability for grant funds, and

--obtaining settlements of all overpayments or improper expenditures of grant funds.

In its comments (see app. II), HEW stated that it concurred with our recommendations and would direct NIMH to carry them out. HEW advised us that

--the expenditure report form was being reviewed to determine the changes that would make it more useful;

--the HEW Audit Agency in fiscal year 1970 initiated an audit program of the Community Mental Health Centers Program;

--a community mental health center operating handbook would be issued to grantees and regional office staff; and

--full settlement would be made with each of the grantees for the unauthorized use of grant funds, as noted in our report, consistent with the public interest.

Although we recognize that NIMH has begun to take corrective action in this area, we believe that continued emphasis should be placed on the timely issuance and implementation of adequate guidance to grantees and HEW review staffs. We recognize also that some settlements have been made of the overpayments or questionable payments from grant funds, as discussed in this report; however, we believe that timely settlements should be made of all such overpayments, including any disclosed as a result of the implementation of the improved reporting and review procedures. In our opinion, settlements of overpayments and questionable payments would result in determinations that Federal funds have

been properly expended and that collections have been made of amounts which represent unauthorized expenditures of grant funds.

APPENDIXES

DISTRIBUTION OF COMMUNITY MENTAL HEALTH CENTER

GRANTS BY STATE AS OF JUNE 30, 1970

State	Number of centers				Amounts obligated		
	Construction only	Staffing only	Construction and staffing	Total	Construction	Staffing	Total
					(000 omitted)		
Alabama	6	1	-	7	$ 3,244	$ 267	$ 3,511
Alaska	-	2	-	2	-	181	181
Arizona	1	2	2	5	1,817	2,850	4,667
Arkansas	1	3	3	7	2,443	2,998	5,441
California	11	13	16	40	16,053	22,758	38,811
Colorado	-	4	5	9	2,271	6,806	9,077
Connecticut	2	2	-	4	2,314	1,941	4,255
Delaware	-	1	1	2	507	741	1,248
District of Columbia	-	2	1	3	327	4,841	5,168
Florida	3	-	9	12	6,376	6,363	12,739
Georgia	9	2	-	11	5,249	798	6,047
Hawaii	1	1	1	3	677	353	1,030
Idaho	-	2	2	4	602	1,011	1,613
Illinois	6	3	1	10	8,073	7,256	15,329
Indiana	7	-	1	8	4,983	1,168	6,151
Iowa	2	-	1	3	3,368	434	3,802
Kansas	2	1	3	6	1,606	1,501	3,107
Kentucky	-	13	9	22	3,279	11,519	14,798
Louisiana	9	1	2	12	4,445	2,972	7,417
Maine	1	2	2	5	613	1,668	2,281
Maryland	4	1	2	7	3,251	1,813	5,064
Massachusetts	4	5	3	12	4,688	6,078	10,766
Michigan	4	6	3	13	6,378	4,720	11,098
Minnesota	-	1	5	6	2,571	2,286	4,857
Mississippi	2	4	-	6	1,364	902	2,266
Missouri	5	1	3	9	4,274	5,318	9,592
Montana	1	2	-	3	231	362	593
Nebraska	2	-	2	4	1,220	294	1,514
Nevada	1	-	-	1	505	-	505
New Hampshire	2	-	-	2	833	-	833
New Jersey	8	-	3	11	5,119	3,097	8,216
New Mexico	-	1	1	2	700	2,513	3,213
New York	9	2	10	21	15,261	20,151	35,412
North Carolina	11	3	2	16	5,009	1,102	6,111
North Dakota	-	3	2	5	330	1,790	2,120
Ohio	8	1	3	12	9,032	2,845	11,877
Oklahoma	1	1	2	4	2,523	2,461	4,984
Oregon	1	-	1	2	801	537	1,338
Pennsylvania	17	7	10	34	11,011	24,710	35,721
Rhode Island	1	-	-	1	515	-	515
South Carolina	1	-	5	6	3,585	2,618	6,203
South Dakota	1	-	-	1	267	-	267
Tennessee	2	-	6	8	4,325	1,888	6,213
Texas	3	10	4	17	6,533	11,327	17,860
Utah	-	2	1	3	254	1,326	1,580
Vermont	-	-	2	2	542	709	1,251
Virginia	3	-	2	5	4,307	452	4,759
Washington	2	3	2	7	2,700	3,330	6,030
West Virginia	3	1	1	5	2,102	1,106	3,208
Wisconsin	8	2	1	11	4,058	657	4,715
Wyoming	-	1	-	1	-	291	291
Puerto Rico	-	5	3	8	3,800	1,996	5,796
Total	165	117	138	420	$176,336	$185,105	$361,441

APPENDIX II

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

OFFICE OF THE SECRETARY

DEC 29 1970

Mr. Dean K. Crowther
Assistant Director, Civil Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Crowther:

The Secretary has asked that I reply to the draft report of the General Accounting Office on needed improvements in the administration of the Community Mental Health Centers Program. As requested, we are enclosing the Department's comments on the findings and recommendations in your report, together with those of the responsible State and county agencies.

We appreciate the opportunity to review and comment on your draft report.

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

Enclosure

COMMENTS ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT ENTITLED: NEEDED IMPROVEMENTS IN THE ADMINISTRATION OF THE COMMUNITY MENTAL HEALTH CENTERS PROGRAM, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION, DHEW

GAO Recommendation: That the Secretary direct NIMH to establish a national goal of centers to be constructed and funded, based on updated State plans, and proposed annual program goals for meeting the national objective.

HEW Comment: We concur in this recommendation. The original goal of 2000 community mental health centers was based upon the total population prior to the development of the first set of State plans. NIMH no longer uses that figure. Each State plan must now delineate the State's catchment areas. These updated State plans were due in the regional offices by September 30, 1970. The total number of catchment areas for the immediate future is now being updated. The annual planning goal for FY '71 is 34 community mental health centers, bringing the total to 454.

It should also be noted that Public Law 91-211 will assist the higher priority areas to develop community mental health centers by the increased time and percentages allowed for staffing grants, the higher rates of Federal participation in construction and staffing in designated urban and rural poverty areas, and initiation and development grants for poverty areas.

GAO Recommendation: To strengthen the management of the construction grant program, we recommend that the Secretary direct NIMH to (1) issue guidelines for the allocation of construction costs of common service areas which are properly chargeable to the grant for a community mental health center being built as part of a larger hospital facility and (2) require that grant applicants adequately justify the size of inpatient facilities to be constructed in a center and establish criteria for evaluating the size of such facilities which will adequately serve the needs of the catchment area.

HEW Comments: We recognize that during the initial stage of the Community Mental Health Centers Construction Program the allocation of costs of common service areas was often a problem. In June of 1968 a formula for pro-rating the costs of community mental health center facilities, which are part of a larger medical facility, was developed and distributed to the regional offices. This formula is utilized by regional office staff in their work with State agencies and applicants on a project by project basis. It would appear from the recommendation that this formula and its utilization merit additional study unless the problems noted arose prior to the development of the formula.

The size of an inpatient facility will vary from center to center depending upon many factors. These factors include the cultural patterns of the persons served, the treatment goals and methods of the center and of its professional staff, geographic factors, and available facilities in the community. The essential issue is flexibility. Center facilities, including inpatient units, should be so constructed that the areas can be changed to meet changing program needs. Provided that the space constructed is utilized to carry out a center program that is responsive to the needs of the people served, it can be expected that the number of beds needed may change with program experience. In addition, it is required of construction grant applicants that they describe all facilities to be utilized in the program, not just those to be constructed, and to describe the rationale behind the arrangement and designation of space for particular uses, including inpatient space. While these factors are not established as national program criteria, they definitely are a part of the evaluative data in each construction application and are judged during the review and approval procedure. We feel that it would not be prudent to attempt to establish national criteria for the number of inpatient beds to be provided by a community mental health centers program.

GAO Recommendation: That the Secretary provide for implementation of the improved review procedures proposed by NIMH, including issuance of adequate guidelines to grant applicants and HEW review staff, to keep NIMH adequately informed of the financial needs and resources of recipients of staffing grants under the Community Mental Health Centers Program.

HEW Comments: We concur with the recommendation to implement improved review procedures proposed by the NIMH, which would contain guidance to applicants and review staff for informing NIMH about the financial needs and resources of grant recipients.

In October 1969, the NIMH issued a brochure entitled -- Community Mental Health Centers Staffing Grants -- Policy Statement. This policy statement was made available to applicants, grantees and NIMH review staff and covers such areas as: grant applications and awards, funding of staffing grants, grantee responsibilities, accounting, records, and audit. Since the issuance of the policy statement, however, new legislation has been enacted which amended the Community Mental Health Centers Program to the extent that the policy statement must be amended. In that regard, the NIMH has developed an updated policy manual which is expected to be issued in January 1971. The policy manual is entitled -- Manual of Policies for the Community Mental Health Centers Program. It will provide all applicants, grantees and review staff with extensive guidance on the NIMH staffing grant program and covers such areas as: programming for community mental health centers, eligibility requirements for applicants for community mental health center staffing and/or construction grants, application process, financing, accounting, records, and audit. The manual defines the responsibilities of the applicant in the fiscal area, clearly identifies eligible grant costs, and contains a special section on the financing of

community mental health centers programs.

Administration of the Community Mental Health Centers Program was decentralized to the regional offices of HEW effective July 1, 1970. In that connection, extensive effort was devoted by both regional and central office NIMH staff to the development of modified review and approval procedures and policies. This material was incorporated with a larger document entitled -- Community Mental Health Center Grants Operating Handbook. The section on review and approval procedures was issued in final form in July 1970 and was the subject of considerable discussion in a training program conducted for all regional office program and grants management staff. Since that time, the procedures and policies have been applied in each region and appear to be effective, based on the limited experience to date. This document identifies the responsibility of the regional grants management office in the monitoring of active grants, With particular interest on the financial aspects of the program and of the grantee operation.

GAO Recommendation: That the Secretary direct NIMH to strengthen the administration of the staffing grant program by such means as requiring more informative expenditure reporting by grantees, expanding the scope of and making more timely on-site evaluations at newly established centers, and providing adequate guidance to grantees and HEW review staffs for the purpose of obtaining an accurate accounting for grant funds used. Also, that the Secretary direct NIMH to make timely settlements of all staffing grants which involve overpayments resulting from the unauthorized expenditure of grant funds.

HEW Comments: We concur with the recommendation and will direct NIMH to carry it out.

The expenditure report form currently used on NIMH staffing grants is being reviewed by NIMH with the expectation of recommending changes that would make it more informative and administratively useful in monitoring the grant. It would also make it possible for grantees to control and report expenditures by types of service, similar to the application requirement, rather than just in total amount.

In July 1969 the NIMH requested the HEW Audit Agency to initiate an audit program for the Community Mental Health Centers Program for determining, in part, the management effectiveness of the program, particularly in the area of fiscal management and reporting. Pilot audits have been performed on 27 centers (three in each region) and draft audit reports have been issued on all but a few of these centers. These reports are under review by NIMH for the purpose of determining which facets of grant management need to be strengthened.

The soon to be issued Community Mental Health Center Grants Operating Handbook will include a policy manual which incorporates specific guidance to grantees and regional office staff concerning the importance of obtaining accurate fiscal information both as part of the review of applications and in terms of monitoring on-going grant programs. The review and approval procedures section of the handbook, which has already been disseminated to regional office staff, emphasizes the importance both to reviewers and to operating staff of obtaining clear information concerning the fiscal liability of applicants and/or grantees. The concern for grantee fiscal liability extends beyond that of accounting for grant funds used, since the broader information and knowledge is necessary to forestall the inappropriate use of grant funds.

The GAO report covers the Community Mental Health Centers Program through fiscal year 1969. Developments in the program in the subsequent year and a half have been profound in terms of the extension of the program authorization by the Congress in March of 1970, together with the extensive modification contained in that authorization concerning the percentage of Federal support and the period of the Federal support from 51 months to eight years, the introduction of special provisions for more favorable funding of centers located in poverty areas, and provision for waiver of some of the five essential services in poverty areas during the initial period of operation. These rather extensive changes in the program authorization have made it necessary to introduce considerable revisions in our policies and procedures, a development which is still underway. We are attempting at the same time to introduce management improvements learned from the earlier program experience, including those difficulties enumerated in and indentified by the GAO report. We are grateful to the GAO for the many frank discussions with our staff about the management and program aspects of the Community Mental Health Centers Program. We believe the benefits and the insight derived from these discussions will be very useful in introducing and refining changes in program management.

With regard to the repayment by grantees for unauthorized use of grant funds, it should be noted that: full collection and settlement has been made with grantee B;[1] that a repayment schedule has been established with grantee F[2] ($5,000 collected to date); that a repayment schedule has been established with grantee G[3] ($27,500 collected to date). Adjustments are pending on the other grantees noted in your report. We anticipate full settlement with each of these grantees consistent with the public interest.

Comments of Responsible State and County Agencies on the Draft Report

As requested by GAO, comments were solicited from the responsible State and county agencies. They are enclosed. We find that some of the comments in these letters are inaccurate, or do not reflect an adequate understanding of the Community Health Centers Program; we plan to clarify these points with the grantees involved. One of the comments critical of the NIMH catchment center concept states that there should be gradual improvement in services .

GAO notes:

1. Grantee B is designated as grantee E in final report.
2. Grantee F is designated as grantee C in final report.
3. Grantee G is designated as grantee D in final report.

throughout the county without any singling out of subareas. This approach, however, gives no preference to areas of greatest need, a concept which NIMH has advocated and to which the GAO report seems in agreement. We believe that many of the communities that have received Community Mental Health Center grant support initiated their applications because they were not being adequately served by the State and/or county system; frequently, in areas of demonstrated great need.

Comment is also made that patients, potential patients, and concerned citizens, in general, are totaly left out of the planning in Federal mental health programs. This is incorrect. Existing procedures provide for routine involvement of State and county officials in the submission and review of Community Mental Health Center grant applications. A mechanism has existed through the NIMH regional staff for including both county and State analysis and recommendations with regard to these applications. Similarly, the NIMH has advocated maximum citizen participation in the development and submission of Community Mental Health Center grant applications.

We would also like to point out that the comments made on the role of the National Advisory Mental Health Council are inaccurate. They suggest that the "financial decision with regard to the awarding of the staffing grant" is carried out by the Council. The amendments to the Community Mental Health Center Act-(PL 91-211) include a requirement that all applications be submitted to the National Advisory Mental Health Council for recommendation before an award can be made. In practice, the Regional Health Director forwards his recommendation to the Council, which in turn makes a recommendation to the Regional Health Director for approval or disapproval of the application. Subsequently, the Regional Health Director is responsible for determining which, if any, of the applications recommended for approval by the Council are to receive a grant award. This authority and responsibility is clearly and entirely that of the Regional Health Director within available funds. The decision process, therefore, does take place at the regional level.

APPENDIX III

STATE OF CALIFORNIA—HUMAN RELATIONS AGENCY RONALD REAGAN, Governor

DEPARTMENT OF MENTAL HYGIENE
744 P STREET
SACRAMENTO 95814

October 28, 1970

Mrs. Ruth Morley
Associate Regional Health Director
National Institute of Mental Health
Regional Office IX
Federal Office Building
50 Fulton Street
San Francisco, CA 94102

Dear Mrs. Morley:

You will find enclosed a copy of my letter to Mr. Clavelli, Regional Manager, United States General Accounting Office, He was kind enough to send to me for review a draft of the complete report. Since you sent only chapters 1, 4, and 6, some of my comments to him may not appear relevant.

Best regards,

James V. Lowry, M.D.
Director of Mental Hygiene

Enclosure

STATE OF CALIFORNIA HUMAN RELATIONS AGENCY RONALD REAGAN, Governor

DEPARTMENT OF MENTAL HYGIENE
744 P STREET
SACRAMENTO 95814

October 28, 1970

Mr. A. M. Clavelli, Regional Manager
United States General Accounting Office
143 Federal Office Building
50 Fulton Street
San Francisco, California 94102

Dear Mr. Clavelli:

On October 23, 1970, you sent to me a copy of the draft of your report of your review of the community mental health center program. I appreciate very much your courtesy in allowing me the opportunity to see this draft of your report.

I found the report interesting, educational and, as near as I can determine, accurate in its presentation. You might wish to add one small item in that section that has to do with the review of applications for staffing grants. The Regional Office staff of the National Institute of Mental Health in San Francisco cooperated completely with this department in the review of the applications for the grants. Although there is no legal requirement for them to do so, they have forwarded a copy of the staffing grant application to this department in every instance so far as I know. The staff of this department obtains information from the director of the county mental health program or programs that would be affected by the staffing grant being made to the applying center. This information is then given to the Regional Office staff for their use.

There has been a continuing awareness of the financial ability problem which you have discussed so succinctly in your report. I would endorse strongly your recommendation that the future financial support determination be made prior to the granting of the staffing grant.

Perhaps it is not appropriate for your review but, nevertheless, I would like to repeat my comments that the catchment center concept may be a useful theoretical device but is not suitable for application everywhere in the United States and, particularly, in California. The studies that were done in California prior to the establishment of the program for the support of local mental health services showed that because of geographical, political, ethnic, economic, and other reasons, the service area for a mental health program should be a county or combination of

counties. As you know, California has had considerable experience in local mental health program operation. The funds expended in local mental health programs in California are now about equal to the appropriation for the entire United States for the staffing grants for community mental health centers. This fiscal year the state appropriated funds total $72.4 million and the local funds total $6.9 million.

I would like to comment on one other item and that is the requirement that the National Advisory Mental Health Council make the financial decision with regard to the awarding of a staffing grant. This seems to be incompatible with the concept that decisions should be made as close to the site of operation as possible. One one hand authority is allegedly delegated to the Regional Office but at the same time the authority is removed to an even greater distance by placing it within the National Advisory Mental Health Council.

Perhaps it isn't within the purview of your review but I think it is time to re-examine the concept of federal grants being made to local agencies since there is no mechanism to assure that these grants are compatible with local health planning or state health planning. Instead of making individual center grants the funds available for this purpose could be added to the 314(d) funds for mental health services. This would dispense with considerable administrative expense and would permit the design of a mental health delivery system that is appropriate for the particular state and local community.

Again, I thank you for allowing me to review the draft of your report.

Sincerely yours,

James V. Lowry M.D.

James V. Lowry, M.D.
Director of Mental Hygiene

cc: Mrs. Ruth Morley
Regional Office

STATE OF CALIFORNIA HUMAN RELATIONS AGENCY
DEPARTMENT OF PUBLIC HEALTH
744 P STREET
SACRAMENTO 95814

RONALD REAGAN Governor

October 26, 1970

Mrs. Ruth Simonson Morely
Associate Regional Health Director
for Mental Health
Department of Health, Education, and Welfare
Regional Office
50 Fulton Street
San Francisco, California 94102

Dear Mrs. Morely:

Subject: Needed Improvements in the Administration of the Community Mental Health Center Program - GAO Draft Report

A review has been made of Chapters 1, 2, and 6 of the GAO draft report on Needed Improvements in the Administration of the Community Mental Health Center Program, as requested in your letter of October 15, 1970, and the following comments are submitted:

1. Chapter 1 is a historical summary of the construction and staffing grant program and requires no comment.

2. Chapter 2, page 6, indicates that some of the State Plans submitted have not divided the State into catchment areas as specified, and a logical question to follow is "why has this been allowed". It was my understanding that catchment areas of specified population limits were required in order to receive financial assistance under the construction and staffing grant provisions of the Act. There has been in California disatisfaction with the population limitation of the catchment area requirement; however, it has been adhered to, and it seems rather unwise and unfair to allow other States to submit State Plans without complying with basic requirements.

3. The problem of constructing centers in areas having the greatest need and the highest priority has been stated correctly, and I would assume this is the situation throughout the county. It is correct that NIMH cannot assist communities which do not have required matching funds; however, it is also difficult for the State Agency to perform such a function as such responsibility is ultimately a decision of the applicant.

Those chapters of the draft report available are essentially correct, and I find no areas of conflict with the program as administered by the State Agency in California.

Very truly yours,

Robert C. Kimball

Robert C. Kimball, Chief
Bureau of Health Facilities
Planning and Construction

RCK:bs

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
1106 SOUTH CRENSHAW BOULEVARD
LOS ANGELES CALIFORNIA 90019
937-2380

HARRY R BRICKMAN, M D
DIRECTOR

MARVIN KARNO, M D
CHIEF DEPUTY DIRECTOR

October 22, 1970

Mrs. Ruth S. Morley
Associate Regional Health Director
for Mental Health
Department of Health, Education and Welfare
50 Fulton Street
San Francisco, California 94102

Dear Mrs. Morley:

I want you to know how grateful we are to have received drafts of chapters of the General Accounting Office audit of Community Mental Health Centers. We originally were given these drafts for review about a month ago by Mr. Sheldon of the General Accounting Office, and we sent him a letter (a copy of which is enclosed), as well as the draft copies with our corrections noted in them. You should not underestimate the importance of the break-through in communication among our various departments that this exchange of information represents, and we sincerely hope that it will continue to grow in future years.

Although few of our suggestions have been included in this draft, we are withholding comments pending the receipt of the next draft which is due to arrive soon. If you or your staff have a chance to read this material, I will welcome your comments.

Sincerely,

Harry R. Brickman, M.D.
Director

GM/ebr

enclosure

APPENDIX V

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
1906 SOUTH CRENSHAW BOULEVARD
LOS ANGELES, CALIFORNIA 90019
937-2380

HARRY R. BRICKMAN, M.D.
DIRECTOR

MARVIN KARNO, M.D.
CHIEF DEPUTY DIRECTOR

September 11, 1970

Richard A. Sheldon, C.P.A.
General Accounting Office
50 Fulton Street
San Francisco, California 94102

Dear Mr. Sheldon:

It was a pleasure meeting with you and Mr. Jack Birkholze last Friday to discuss issues of mutual concern in community mental health, and specifically your draft report on problems in the development of the Federal program. A few of us have made some minor notes and corrections in the draft which is being returned to you with this letter.

Your description of some of the objections raised by our Department going back to 1965 and 1966 is accurate enough, but simply does not describe this history in sufficient detail. As we noted in the meeting, the County of Los Angeles made three applications to the National Institute of Mental Health for staffing grants. Along with the applications we requested that the Surgeon General of the the United States Public Health Service grant exceptions to the Federal catchment area population limitations. In Los Angeles County, catchment areas as geographic units serve us poorly because they are too small. Our request for waiver was based on planning for populations of over 600,000, while the Federal regulations limited us to a maximum of 200,000. The applications were moved from desk to desk back at Health, Education and Welfare and were rejected. The County proceeded to develop these services notwithstanding our failure to obtain these badly needed Federal funds.

Your draft report does not reflect some of the discussions we initiated with Dr. Brown, Dr. Feldman, Dr. Sirotkin and others in NIMH in our efforts to initiate some kind of coordination between the Federal program and the public program in Los Angeles. These discussions got nowhere even though we raised such cogent

points as our request for involvement and participation in the planning process and our concern for where applicants would obtain increasing amounts of operating money in the face of declining Federal assistance. We also pointed out then, as we did again last week, that there is an assumption in the Federal program that a particular size of geographic unit and a particular style of staffing is the unquestioned ideal model for building community mental health programs throughout the country. We have been complaining about being left out of the planning and reviewing processes but at the same time must point out that patients, potential patients and concerned citizens in general are totally left out of the planning in the Federal program. Whereas both the regional medical program legislation and comprehensive health planning legislation have included devices to assure citizen participation in planning, the mental health program has not. We have a serious question about the philosophy of richly saturating a relatively small area with scarce mental health resources as a way of solving community mental health problems. Limitations of time, manpower and money make that style of program development unrealistic apart from the question of its basic validity. The philosophy of Los Angeles County has been to reach the same goals by very different means. We have tried to create some minimal mental health service to cover the entire county as rapidly as possible. From minimal coverage we aim eventually to locate mental health services that would be literally in and for a particular community. Some of our regional services have already established satellites and a couple of our original mental health regions have deliberately been split to enable us to get a better grasp of the local and unique problems in certain areas. In a certain sense we are saying that local mental health programming needs to be custom tailored to the needs of the locale and not imposed by formula.

I hope these comments are useful to you in editing your draft report, and want you to know that we greatly appreciate our being included in these discussions.

Sincerely,

Harry R. Brickman, M.D.
Director

GM:pd

Enclosure

APPENDIX VI

PRINCIPAL OFFICIALS

OF

THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

RESPONSIBLE FOR THE ACTIVITIES

DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
Anthony J. Celebrezze	July 1962	Aug. 1965
ASSISTANT SECRETARY (HEALTH AND SCIENTIFIC AFFAIRS):		
Roger O. Egeberg	July 1969	Present
Philip R. Lee	Nov. 1965	Feb. 1969
SURGEON GENERAL, PUBLIC HEALTH SERVICE:		
Jesse L. Steinfeld	Dec. 1969	Present
William H. Stewart	Oct. 1965	July 1969
Luther L. Terry	Mar. 1961	Oct. 1965
ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (note a):		
Vernon Wilson	May 1970	Present
Joseph T. English	Jan. 1969	May 1970
Irving Lewis (acting)	Sept. 1968	Jan. 1969
Robert Q. Marston	Apr. 1968	Aug. 1968

	Tenure of office	
	From	To
DIRECTOR, NATIONAL INSTITUTES OF HEALTH:		
Robert Q. Marston	Sept. 1968	Present
James A. Shannon	Aug. 1955	Aug. 1968
DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH:		
Bertram S. Brown	June 1970	Present
Stanley F. Yolles	Dec. 1964	June 1970

[a]The Health Services and Mental Health Administration was established in April 1968 and the National Institute of Mental Health was made one of its constituent bureaus. The National Institute of Mental Health had been made an independent bureau within the Public Health Service in January 1967 when it was transferred out of the National Institutes of Health.

U.S. GAO, Wash., D.C.