

Community Mental Health as Specialty Practice

Elevating and Sustaining High-Complexity Care



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Why This Conversation Matters



WORKFORCE
SHORTAGES IN
CMH



HIGH
TURNOVER
RATES



INCREASING
CLIENT ACUITY



IMPACT ON
VULNERABLE
POPULATIONS

The “Transitional Setting” Narrative

Common career messaging in the field

How CMH is often positioned professionally

Implicit hierarchy within practice sessions

Consequences of this narrative

The Clinical Sophistication of CMH



Community mental health is not entry-level work. It is high-complexity, systems-based clinical practice.

Advanced Risk Assessment and Chronic Crisis Management

- Chronic suicidality vs. acute crisis
 - Longitudinal/pattern-based risk assessment
- Risk documentation under scrutiny
 - Higher incidence of adverse events
 - Greater likelihood of audits
- Balancing safety with autonomy
 - Cycle between stability and crisis
 - Involuntary care is high
 - Over-hospitalization can destabilize housing, relationships, benefits
 - Under-intervention carries real safety risk
 - Rationale for not escalating care

Systems Navigation and Interdisciplinary Collaboration

Medicaid and documentation standards

Court systems, probation, DCS involvement

Schools and medical providers

Housing instability and community resources

Engagement with High Barrier Clients

Involuntary clients

Mandated treatment

Substance use relapse cycles

Ambivalence and resistance

Clinical Decision-Making under Resource Constraints

- Productivity expectations
 - Targets for billable hours
 - Reimbursement requirements
 - Caseload volume
- Limited referral options
 - Inpatient/crisis stabilization units
 - Fragmented SA treatment access
 - Insurance barriers
- Caseload triage
 - Acute risk escalation
 - Recent hospital discharge/crisis stabilization
 - Missed appointments of known high-risk clients
- Ethical decision-making under pressure
 - Hospitalization – protective vs. destabilizing
 - Action vs. capacity
 - What should be done vs. what can be done in the moment with available resources

Case Vignette

- Jordan is a 33-year-old individual receiving CMH services for Bipolar I disorder and borderline personality traits. Jordan has a history of misusing multiple illicit substances and has experienced intermittent homelessness over the past three years, along with a history of multiple psychiatric hospitalizations beginning in late adolescence. Jordan's most recent hospitalization occurred 15 months ago following a suicide attempt during a substance use lapse.
- Jordan reports chronic passive suicidal ideation for the last several years, typically stating, "Sometimes, I really wouldn't care if I didn't wake up." Jordan reports that intensity fluctuates but denies any current intent or plan to harm during routine sessions. Jordan can identify some protective factors, including a desire to maintain housing stability and close relationships with a friend and sibling.

Clinical Presentation

- Highly variable over time
- Periods of interpersonal stress/substance use relapse
 - Increased emotional dysregulation
 - Missed appointments
 - Transient escalation in suicidal ideation
 - Occasionally accompanied by vague preparatory behaviors
- Most recent 90 days
 - Missed multiple sessions but reengaged after outreach
 - Reported increased substance use after a relationship ended
 - Endorsed worsening hopelessness but continually denied active intent
 - Maintained housing with supportive case management involvement

CMH as Systems- based Clinical Unit

- Team has documented ongoing chronic baseline risk with episodic escalation
 - Notes that Jordan's suicidality is persistent but not consistently associated with imminent intent
- Treatment Focus
 - Safety planning and crisis coping strategies
 - Intensive case management support
 - Coordination with medication management providers
 - Harm reduction around substance use
 - Strengthening natural supports and community engagement

Changes in Baseline Risk and Decision-Making Tensions

“Sometimes I think about ending it, but I don’t actually plan anything. It just feels like it would stop everything.”

Clinicians must:

- Determine whether chronic baseline ideation
- Emerging acute risk requiring a higher level of care

Vignette illustrates key CMH practice tensions

- Chronic suicidality vs. acute escalation
- Baseline comparison over time
- Clinical reasoning documentation – not just risk status
- Balancing least restrictive care with safety responsibility
- Role of engagement as a CMH-systems protective intervention



CMH vs. Private Practice Models



Private Practice

Episodic care

Lower acuity

Scheduled engagement

Symptom-focused treatment

Individual-therapy centered



CMH

Continuous care

High-acuity complexity

Outreach and engagement

Systems-based interventions

Risk + stability management over time

Sustainability and Professional Identity

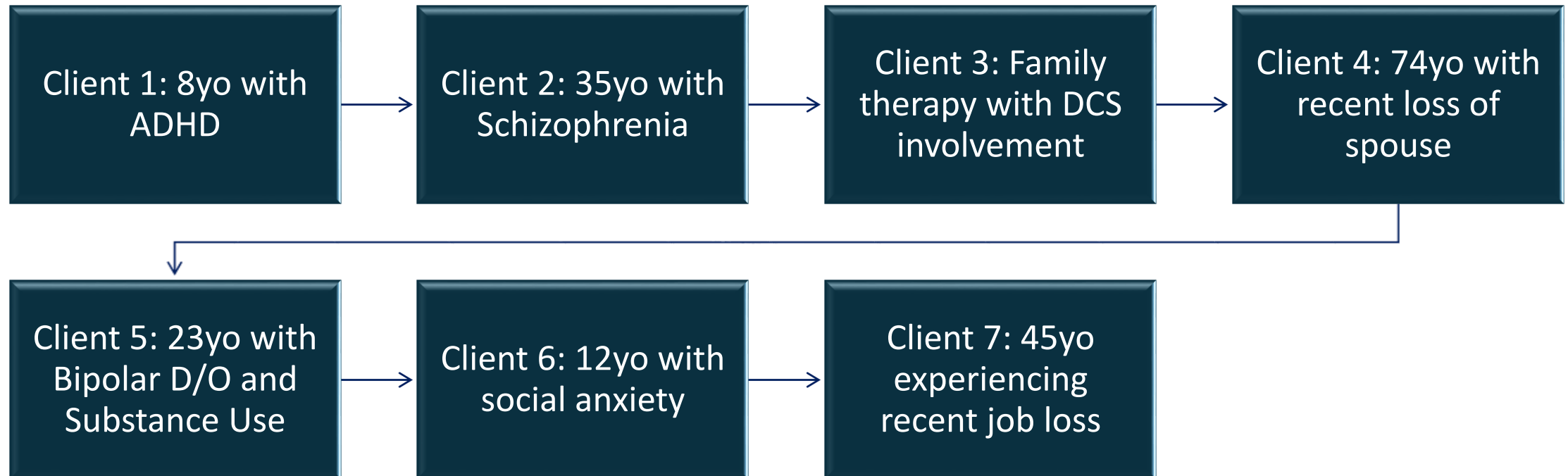
The Hidden Cost: Moral Distress and Secondary Trauma

When systems
conflict with
clinical values

Emotional
containment in
high-acuity
settings

Cumulative
exposure to crisis

CMH: A Day in the Life



Reframing CMH as Specialty Practice

- CMH as high-complexity work
- Clinical sophistication required
- Systems intelligence as a specialty skill
- Population-level impact



Advocacy within Professional Communities



Naming CMH as an advanced practice



Counseling programs encouraging practicum and internship experiences within CMH



Mentorship of early-career clinicians / Peer consultation groups



Shifting language



Leadership roles within agencies



Parity in reimbursement / smaller caseloads

What competencies have you developed in CMH that you would not have developed elsewhere?



Community mental health is not where clinicians begin. It is where advanced clinical skill, systems intelligence, and sustained commitment intersect.



References

- Adams, D. R., Williams, N. J., Becker-Haimes, E. M., Skriner, L., Shaffer, L., DeWitt, K., Neimark, G., Jones, D. T., & Beidas, R. S. (2019). Therapist financial strain and turnover: Interactions with system-level implementation of evidence-based practices. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(6), 713–723. <https://doi.org/10.1007/s10488-019-00949-8>
- Last, B. S., Lehrbach, K., Rawa, E., & Crane, M. E. (2026). Private practice providers' experiences and perceptions of working in public mental health settings: A mixed-methods study. *Psychiatric Services (Washington, D.C.)*, 77(2), 123–129. <https://doi.org/10.1176/appi.ps.20250274>
- Last, B. S., & Zhu, J. M. (2025). State policy strategies to promote the recruitment and retention of the behavioral health workforce. *The Milbank Quarterly*, 103(S1), 50–74. <https://doi.org/10.1111/1468-0009.70013>
- Saunders, H., Guth, M., & Eckart, G. (2025, August 9). *A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs*. KFF. <https://www.kff.org/mental-health/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/>