American Handbook of Psychiatry

Human Services at State and Local Levels

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e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 2* edited by Silvano Arieti, Gerald Caplan

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Definition of Human Services

Many recent developments indicate a trend toward comprehensiveness and coordination of the many services traditionally supplied by separate disciplines or agencies. One of these is the growth of such organizations as community mental health centers, multiservice centers, neighborhood service centers, youth opportunity centers, neighborhood health centers, and health maintenance organizations, all of which offer two or more services customarily given independently of one another. Comprehensiveness is the goal. Using this very basic definition, the secretary of the Department of Health, Education and Welfare could say in January 1971 that there were more than 2,000 such units in the United States.

There has also been a very clear but less formal trend on the part of various professions to become more comprehensive within their own disciplinary boundaries. Previously separate free-standing public health clinics are now being integrated into broader medical care networks. The solo practice of medicine is almost completely linked to hospital inpatient and outpatient services, emergency wards, laboratories, and third-party payers. General hospitals are increasingly associated with extended care facilities, skilled nursing homes, and home care programs. Rehabilitation facilities are

being designed as integral components of general hospitals and at the same time are enlarging their scope of concern to include nonmedical rehabilitation programs linked to community-based workshops, vocational training, and job placement. And, of course, the expansion of the psychiatric system to include both a variety of nonmedical care-giving agents and indirect services is a further extension of the premise.

Michael March supported the observation that many of the new programs, such as those cited above as well as manpower centers and employment offices, "strive individually to become more comprehensive as they try to meet the complex needs of their clientele."

The trend toward integration of services is also being fostered at the federal level. Among the recommendations of the Task Force on the Organization of Social Services is that new funds be concentrated on comprehensive services. This task force defined social services as including, but not being limited to, the following: (1) information, advice, and referral services, (2) advocacy and legal services, (3) personal counseling, rehabilitative, and therapeutic services (including clinical psychotherapy, family casework, and vocational counseling), (4) personal and home aides, especially to serve the aged, handicapped, ill, and families that need help at home, (5) homemaker services, (6) meals on wheels to meet the temporary needs of aged and ill, or the continuous needs of the aged living alone, (7) day

schools for young children that offer child development programs involving parents, (8) rural campus and urban community centers for young people, (9) education programs for basic education, cultural knowledge, or formal education, (10) community social and recreation centers, (11) family planning services, (12) job placement and training services, (13) volunteer placement and opportunity services, (14) protective and foster care services for children and the aged, (15) home care services for persons recently hospitalized or institutionalized or for ill or handicapped persons who can remain at home with comprehensive assistance from the community.

The trend toward comprehensiveness and coordination is also apparent in the efforts of many state governments to combine several separate health and social service programs within one new department. At the moment, approximately twenty states have combined several services, and many others are seriously considering similar reorganizations. As most of these state-level modernizations occurred during the last decade, it is likely that a structural trend of sorts is at work.

As is often the case, changes occur first followed by conceptual efforts. Public administrators and social scientists have only recently attempted to extract theoretical constructs from this reality, and even these are still primarily descriptive definitions. Further complicating the task of defining human services is the lack of clear-cut direction in the trend.

In their discussion of intersystem relations in human service organizations, Baker and O'Brien implied that the latter may be defined by reference to "the complex array of physical health, mental health, and social organizations as an intersystem field." Harshbarger made the most elaborate effort to define human services.

> In terms of their systemic properties, human service organizations might generally be described as based upon public resources, relatively structured, normative based and morally involving, social or socio-technical service oriented, and aimed at clients, residents, or members as primary beneficiaries and staff members as secondary beneficiaries. Organizationally, the nature of their efforts is to deal with those bio-social problems which arise from the vagaries and complexities of being human.

An analysis of the various state-level human service arrangements yields an operational definition. Each human service agency, whether already in existence or proposed, usually includes the public health, mental health, and social welfare programs of the state, and thus these programs might be seen as the three essential human services. Other services that appear to be an optional part of the definition include vocational rehabilitation, employment, corrections, parole, youth services, legal services, and industrial relations. It is interesting to note that formal education, which is certainly a human service, is consistently excluded from the new state organizational integration. This omission is usually justified on the basis that it has traditionally been administered separately. Since most of the merged services have also traditionally been independent entities and have used this same

reason to argue for continued autonomy, it is clear that other factors must be at work. One factor of particular significance is the reluctance to place such a massive proportion of the state budget under the control of any one agency. In Massachusetts, for example, the new Executive Office of Human Services consumed approximately 70 percent of the state's proposed operating budget during fiscal year 1972, the first full fiscal year of its operation. Adding state-supported educational programs would mean that the new Secretary of Human Services would control more than 80 percent of the state's total expenditures. An equally important factor might be that state departments of education are related to extensive local counterpart systems whose policymaking bodies are usually locally elected and are often politically powerful. To enforce cooperation on the part of each of these local units would be an overwhelming, if not impossible, task.

In contradiction to this formal statewide tendency to exclude education, however, there are some signs of an opposite local trend. Adult education and continuing education have been traditional components of many human service agencies. Also, the community school concept has been greatly expanded since it was originally advanced by the Mott Foundation about forty years ago. Although it was first intended to promote the use of school property for year-round community recreation, many social, health, welfare, recreation, and adult education activities are now included in this arrangement, making some schools major community centers. These

programs may be administered singly or under multiple auspices, but in any case community school directors working with citizen advisory groups are often producing their own versions of a human service center.

Rationale for Human Services

Inefficiency, compartmentalization, specialization, bureaucracy, program barriers, and service gaps are among the many shorthand terms used to criticize the existing public, governmental service system and to justify the move toward alternative human service models. The thrust of many of the new proposals clearly appears to be a reaction to these deficiencies. This can be seen, for example, in Michael March's summary of the direction of the current movement:

> It is toward *comprehensiveness* of services, toward *decentralization* of services into the ghetto, toward *concerting* of resources from different programs, toward *co-location* of service components, and toward operational *integration* of services so that they can be geared together in a *continuum* ordered in proper sequence and effectively administered without the present duplication and time-wasting which goes on for clients and for employees.

Economic factors have been significant in fostering this new movement. In addition to the alleged inefficiency, time-wasting, and duplication that contribute to unnecessary expenditures in providing services, the costs of human services are rising. In economic terms, the health industry alone will

soon be the major industry in this country, and as such it is becoming a target for those interested in controlling its expenditures and a source of income for those interested in exploiting its potential. A typical comment about the health industry is that of Becker:

> Economic factors, quality of care concepts, and automation are just a few of the forces creating new pressures for a coordinated community-wide organizational pattern for the provision of health care. The inevitable result is to bring into a functional relationship all the segments of community health care without regard to whether the unit is public or private.

President Nixon, in his 1971 health message, after briefly noting much progress, went on to describe a lengthy service of organizational ills, stating that "60 percent of the growth in medical expenditures in the last ten years has gone not for additional services but merely to meet price inflation." He also noted that "even those who can afford most care may find themselves impoverished by a catastrophic medical expenditure." In many areas of the nation, especially rural and inner city, "care is simply not available." "The quality of medicine varies unduly with geography and income. . . . most of our people have trouble obtaining medical attention on short notice." The President also criticized the focus on treatment to the detriment of prevention and early case finding.

Although economic factors in the sense of profit-making motives may help to account for increasing interest in a given subsystem, it is the concern

with cost benefits that presses the individual fields, organizations, and disciplines to examine their interorganizational boundaries and concerns, thus fostering the move toward cooperation.

The current trend to reject specialization, combined with a long-standing antagonism toward complex organizations and their bureaucracies, makes it almost faddish to criticize the existing service delivery systems, and the effects of these criticisms are being felt. Agency boards are broadening their composition, community control is advocated, consumer participation is required, and job descriptions are being rewritten to admit nonprofessionals.

Not of significant influence in bringing about the growth of the human services concept, but important nevertheless for the rationalists among us, research findings generally support the major criticisms of existing service delivery systems. The quality and quantity of service delivery is not adequate, and comparative morbidity and mortality statistics indicate that the United States is behind many other Western nations in health care delivery. It is also clear that we are not doing as well as many European countries in providing such services as nursing home care, home care, financial assistance to the aged, and day care for young children.

The defender of the status quo need only follow a few clients through the present system in order for him to realize clearly that the care-giving

network is poorly designed to meet the needs of those it purports to serve. A complex inter- and intraorganizational and policy arrangement surfaces, with boundaries that are often artificial and hamper the delivery of needed assistance. Such terms as “fragmentation,” “overlapping,” “duplication,” “gaps in services,” and “lack of coordination” take on concrete meaning for individuals who need services. For example, a working mother may enroll her four-year-old in Head Start but have no place for her two-year-old; a pregnant woman may receive health care at one clinic and take her children to another clinic, while there are no facilities for the father; screening and eligibility requirements may exclude those who most need rehabilitative services because they are poor risks; an individual or family with several problems may receive help for only one of them because the first agency to which it goes does not diagnose the other problems or does not refer the client on to other appropriate agencies; lack of aggressive and imaginative outreach may prevent certain people (for example, non-English speaking people, the aged) from being aware of the services available.

This situation was tolerated by the poor (out of necessity) and by others (out of lack of knowledge or indifference) so long as it was widely viewed as a problem only for the poor. But now the middle class is also finding that the costs of health care can destroy a family financially, that finding adequate and reasonably priced nursing home care for the elderly may be impossible, and that creative, professional day care for the children of many middle-class

working mothers is not available. As the middle class begins to add its voice to that of the lower class, the pressure for change will become overwhelming. Subsidies, coverage for catastrophes, charges based on ability to pay, and free care are widely discussed alternatives.

Models

Just as the definitions are deduced from many and varying experiences so are the models. In two cases of neighborhood centers (service and health) they bear the imprint of the national organization which stimulated them, the Office of Economic Opportunity. Similarly, the many proposals reviewed by the Department of Health, Education and Welfare resemble the sponsors or disciplines that initiated them. Most will have a core service, but it in turn will share the common traits of the proposal writers (whether from public health, mental health, law, rehabilitation, or social welfare).

Focusing exclusively on the neighborhood or community level there are a number of alternatives that will be described and analyzed: (1) the advice and referral center; (2) the diagnostic center; (3) the one-stop multipurpose center; and (4) a linked comprehensive network.

Information and Referral

The advice (or information and referral) service is a simple concept

based on more than forty years of experience. A small group of generalists, knowledgeable about available services, make appropriate referrals and follow up.

A typical big city health and welfare council would expect its noncategorical information and referral service to make between 5,000 to 10,000 referrals each year, itself coping with those problems lending themselves to immediate generic intervention. The added component in the contemporary model would be small information and referral centers distributed throughout the various neighborhoods. Whatever the final shape, the capacity to advise, refer, and follow up is integral to each model.

Advantages of the information and referral model, and of the diagnostic center discussed in the next subsection, are: (1) both programs are relatively inexpensive; (2) if the agencies cooperate referral is likely to be enhanced and simplified; and (3) since minimal organizational change is required, cooperation is enhanced.

Problems inherent in or precipitated by expansion of the information and referral model are: (1) by itself it can be counterproductive if adequate services are not available; (2) the service gaps, eligibility requirements, and other defects in the existing system are not necessarily affected; and (3) it requires a level of sophistication at both the interpersonal and

interorganization level seldom appreciated by even its most vigorous advocates.

The Diagnostic Center

In this more medically oriented model the information and referral apparatus would be supplemented by skilled diagnostic staff. Thus referrals could be more specific, comprehensive service plans individually devised, and more extensive follow-up undertaken.

Although it suffers from many of the same disadvantages as the information and referral service, some of its advocates are urging that all clients be required to enter all organized care-giving mechanisms via the diagnostic center. As with some other proposals this suffers in its inapplicability to the real world. If the problem is identified and services are available, most patients prefer to go directly to the treatment program. Each time additional layers are introduced into the clinical system some slippage occurs. If all patients are required to go through a central service, the end result could be fewer services delivered to those in need.

One-Stop Multiservice Centers

This arrangement of services contains all of the program elements found in the preceding models and in addition has the internal capacity to

follow through on selected problems. There are now approximately 200 health and service centers posited on this premise.

For most, the specific program stimulus is clearly identifiable. Federal funds were made available to develop a new center along the lines of a nationally designed model or against a set of guidelines. As long as funds are available, the development of comprehensive centers occurred at a rapid rate. With the drying up of federal funds, the reverse has occurred. It is unlikely that a nationwide spread of such centers will be further encouraged by the federal government, for not only did cost analyses fail to justify their repetition on a large scale, but their continued promotion in the poorer neighborhoods of urban areas would simply further the development of improved, but still segregated, ghetto programs.

In spite of these limitations, the comprehensive service center model may have substantial long-range effects. Some professions formally cooperated for the first time. Quality services were offered in the inner city. Community control was given a substantial opportunity. The potential integration of direct services and client advocacy was tested.

Even a so-called one-stop multipurpose center could not contain all needed services and be truly comprehensive, and would therefore still encounter some of the problems of the information and referral center or

diagnostic center in having to relate to other service agencies to assure clients the full range of services.

Network

The Organization for Social and Technical Innovation (OSTI) and March suggested the possibility of forming an urban network of centers that could control one or more major one-stop centers and several intake diagnostic and information referral components.

The network principle includes other options as well. Neither dependent on nor exclusive of large comprehensive programs this model would focus on building linkages between organizations to facilitate services to the client. Generic information and referral organizations and specialized services agencies would continue to coexist. The federal funds formerly used to stimulate the development of new nonreplicable organizations would instead be used to facilitate availability, access, continuity of care, and organizations more responsive to client needs. The organization first receiving the client would either assume the follow-up responsibility or refer to the information and referral service, would be compensated for this responsibility, and would have the capacity to purchase services as needed.

As an alternative to the comprehensive service procedure, Perlman and Jones suggested three alternatives depending on the nature of the

community's service arrangement. Where services are generally adequate, they suggested a primary focus on information and referral. Where gaps exist one organization could take the leadership by developing necessary gap-filling services, possibly bartering with other organizations to take them over eventually. Finally they suggested that where services are totally inadequate a comprehensive center might be developed to offer a range of services.

The multiple models of Perlman and Jones permit pluralism and marketplace decisions. A model that fails to acknowledge these realities can survive only as long as some outside ministering organization pumps funds into its veins.

Whatever the model, the services have to be available and the client has to be able to secure them.

Where gaps and barriers are individual in nature, the referring agent should be supported in his efforts to modify the individual constraining behavior. Where the problems are systemic, the aggregation of many individual experiences will give guidance to administrators and planners as they attempt to modify the structure.

Organizational Issues

A series of other issues integrally related to the effort to develop more

comprehensive services should also be identified: (1) auspice, (2) control, (3) center or program, and (4) core services.

Program Auspice

The long-standing public versus private role dilemma seems to be taking a new form. The government has clearly assumed the ultimate responsibility for providing a human service floor. Public welfare, Medicaid and Medicare, and many governmentally sponsored categorical services illustrate the stability of this development. The issue now is how the services can best be delivered. The alternatives are not very complex: The government can (1) own and operate its own service system (for example, mental hospitals, city hospitals, public welfare social services); (2) provide for a series of client advocates, counselors, and referral agents who can purchase for the client those needed services (for example, vocational rehabilitation); (3) give the client the capacity to purchase what he needs within certain guidelines (for example, Medicare); (4) contract with organizations to provide services to eligible clients (for example, some chronic disease, mental health and day care); or (5) employ some combination of the four.

It seems clear that the multiple roles required of the public administrator are extraordinarily demanding and often quite unrewarding. Thus, we are beginning to see a countermove in public administration

designed to give the public administrator more flexibility in responding to policy changes. Grants in aid, contracts, and purchasing-power type arrangements are being used experimentally. Private nonprofit and private profit organizations may both see a health and welfare renaissance. Competition may be encouraged, and the effort to develop service oligopolies (for example, community mental health centers) may be reduced.

Illustrative of this changing public administration principle[2] are the recommendations of the Services for People Task Force of the social and rehabilitation services of the Department of Health, Education and Welfare. One of the recommendations is to "strengthen government and non-profit providers of social services by additional funds and by placing them in competition with providers that will operate social services for profit." Certain unspecified social services would be operated only by the government. Another recommendation is that

The Federal Government should encourage agencies receiving Federal grants to develop, for major use, systems by which prescribed recipients may purchase social services from private agencies when appropriate. Such types of social services as day care for children and vocational training and retraining, including counselling, should be considered particularly appropriate for use in such systems.

It should be noted that not only does this type of recommendation violate certain cherished beliefs about the appropriate roles of governmental and nongovernmental organizations but it ignores the drive toward coordination, also a firmly held principle. Its effort to coordinate is, at best, indirect. By encouraging competition it permits marketplace decisions about coordination and duplication.

Program Control

Underlying many debates is the issue of control of the program. At present four identifiable but overlapping groupings are contestants in the struggle: (1) human service professions and their affiliated categorical program supporters; (2) active upper-middle-class volunteers, long invested in the voluntary health and welfare system; (3) community control and; (4) consumer control. Although used interchangeably, community and consumer control are not necessarily identical. For a small neighborhood-based organization the community and consumers could overlap substantially, but for organizations serving a metropolitan or larger area or a highly specialized purpose, consumers and community could differ substantially. Community control is territorially based. Consumer control is designed to assign ultimate authority to the users of the product or service.

Since each of the four alternatives suffers from its own unique

limitations it is likely that mixed control mechanisms will become increasingly common. Modal types influencing the appropriate compromises will be neighborhood based, community wide and metropolitan or larger, all in turn influenced by the generic specialized nature of the organization.

In any case it is clear that both the community and consumer control movements, merely on the basis of their newness, have upset the always tenuous balance between the many existing forces.

Center or Program Emphasis

Particularly highlighted by the community mental health center movement but integrally related to most recent human service developments is the latent conflict between the center (or facility) and program advocates. In mental health the unfortunate congressional timing, which made construction funds available a year before state plans were completed, tended to give the community mental health movement a building (center) focus. Associated with this facility orientation was the pressure toward single ownership and management of all the mental health resources in a given catchment area. The goal was unrealizable, of course, but the investment of new financial resources in this center tended to reinforce already existing organizational strains. Furthermore, interorganizational difficulties were enhanced since neither the additional funds nor sanctions were adequate

either to buy or to coerce the rest of the system out of existence. The pragmatic network approach, also permitted by the law and the guidelines, focused instead on the use and coordination of a variety of existing resources and the assigning of certain functions, such as linkage and client advocacy, to the center but not necessarily requiring a superordinate role for a center as such.

Core Service

The core service, in one form or another, is an essential part of most proposed models. The ABT consulting firm described it thus: "Core services are so called because they consist of a nucleus of supportive activities which can be applied to any kind or number of programs." The core service's functions can be described differently depending on the organization's focus: intake, outreach, diagnosis, referral, follow up, client advocacy, and case coordination are all used, sometimes interchangeably.

Demone and Long listed a series of considerations that need to be included in the development of any type of core service: (1) well-trained core staff are indispensable; (2) properly selected, trained, and supervised volunteers can play a significant role in association with the trained professional staff; (3) storefront programs, despite their emotional appeal, lack staying power and are too small to be economically feasible; (4) the

processes of receiving, counseling, diagnosing and referring, separately or collectively, are highly complex and must be done well and at considerable cost in some cases; (5) evaluation and monitoring are critical; (6) for effective referral an up-to-date resource file is necessary; start up time for a metropolitan area will be from three to six months; (7) the service experiences should be reported at least annually; facts, criticisms, opinions, and suggestions should be documented and made available to the public and appropriate organizations; (8) the information and referral component should be able to serve as a barometer of the incidence and distribution of community problems as well as the community's readiness and capacity to cope with them; (9) since an objective should be to place as few intermediaries as possible between caregiver and client the service should train the staff of individual agencies to serve as their own core staff; (10) directories of community services should be compiled and distributed; and (11) as a central source for suggestions and complaints about community services and agencies the service should be an aggressive advocate for its clients.

The core service, information and referral center, and information, referral, and diagnostic center obviously build on one another, overlapping in certain of the basic services but clearly the core service is the most complex of the mechanisms.

Alternatives to Direct Services

Rather than require services for the disabled, handicapped, aged, and the poor, an alternative solution is gaining popularity. It is suggested that everyone should be guaranteed an adequate income. The assumption is that many of the felt needs and service requirements will disappear if income is adequate. Then "we will not have to plan for two kinds of Americans, the average American and the deprived American, as we do now."

Social Action

A variety of social change procedures can be subsumed under social action; from conflict to compromise, from a focus on process and democratic skills to the development of self-help competencies. In common is a goal, vague or specific. For direct service organizations increasing interest in social change is apparent. Mental health centers might include this role under consultation; others might speak of community organization or advocacy.

Although aggressive advocacy for the individual client is increasingly sanctioned for service organizations, the larger systems-oriented change role often creates counterproductive reactions. In his study of six social action programs Grosser found that "it is not easy to negotiate with an agency for a client on a *quid pro quo* basis and at the same time attempt to change its policies or personnel." Furthermore, "The experience of the projects

illustrates that dispensers of public agency services are congenitally and organizationally unable to distinguish between the protest and service function when practiced by the same organization. Thus the public agency sees social action against itself as a breach of faith. . . ," Essentially, Grosser suggested that organizations respond as people; they are unlikely to work harmoniously with other organizations when under attack by those same organizations.

Despite the naturalness of this defensive organizational posture, the literature is ambivalent on this matter. The consultation firm OSTI, for example, although acknowledging that the dual roles of service and social action can be incompatible, still suggested that the neighborhood service center must take a real leadership role in community action. OSTI suggested that if they fail to act they will lose credibility with their consumers and will be seen as agreeing with the establishment. They concluded: "Sometimes a center has to risk antagonizing its funding sources, and gamble that it will find support elsewhere. Sometimes this may be a wise gamble, for after all a center is designed to serve people and without their trust and support, it cannot long survive." However, the trust and support of the center's clients is a complex and volatile entity which must be carefully handled. The disastrous experiences of the New York Lincoln Hospital's mental health services in coping with local citizens exemplifies the lingering dilemmas confronting the human services administrator who seeks to combine social action and clinical

care.

Here again human service organizations are faced with existential choices. The customary solution is for direct service organizations to limit social action activities to those that will not impair securing services for their clients. Major social action programs are mobilized by non-direct service organizations, but even for the latter the degree to which an agency follows a major conflict model may influence the life span of the organization. Short-term ad hoc organizations are better prepared to do battle "to the end."

Perlman and Jones, in their excellent analysis of twenty neighborhood service centers in five different cities, found that "Social action has shown a disconcerting tendency to direct its strongest fire at the allies and benevolent neutrals close at hand, rather than at the more distant enemy."

Service Areas

The Federal Community Services Act of 1966, in referring to efforts designed to overcome duplication and fragmentation, described the new experiments in community-based programs as offering a wider variety of services than previously. Community mental health centers, neighborhood service programs for the aged and poor, and welfare community centers were cited as examples. Each moved in its own direction, in essentially comparable catchment areas, and focused on roughly the same client population. The

conclusion: Comprehensive centers, coordinated programs, and planning focused on the whole man are needed.

Clearly two trends are at work simultaneously. (1) Each field is enlarging the definition of its role and function and necessarily conflicting with others similarly engaged in expansion. Comprehensiveness is perceived by competitors as empire building. (2) The other trend is regionalization. Although definitions of catchment areas, responsibilities, and extent of coverage may vary, the thrust toward a geographic coverage principle is essential to all models.

Experiments at regionalization are not new. In 1889 the Metropolitan District Commission was established in Massachusetts to deal with water, sewerage, and transportation problems in metropolitan Boston. Since that time countless other overlapping efforts have occurred. Recent federal guidelines from the Department of Health, Education and Welfare, Housing and Urban Development, and the Bureau of Management and Budget have all provided impetus for relating services on a territorial basis (the mental health catchment area concept is typical).

What is needed is a common philosophical base. A geographic building block solution offers the most flexibility, neighborhoods serving as the basic unit. A community of solution will vary according to needs and resources. If

kidney transplant centers or air pollution control programs are desired, their territorial base can be constructed by combining several smaller areas into a larger region. Several mental health catchment areas could be combined as a watershed region. Whatever the human service, certain essential characteristics must be considered (geography, population density, political jurisdictions, economic and marketing areas, population trends and composition, transportation, existing and predicted service needs, and utilization and financial considerations).

Given these concurrent trends toward regionalization and coordination of services and continuity of care, a logical conclusion is that the existing linkages by function (settlement house to settlement house, general hospital to general hospital, or mental health center to mental health center) may compete with catchment area relationships, especially if the latter are reinforced by special federal funding encouraging formal linkages at the delivery level.

A caution should be inserted here: For all its advantages, the service area model has a tendency to lock organizations into territory and constituents and reduce competition. Parochialism and ethnocentrism are dysfunctional, whether based on category or geography.

Mental Health and Psychiatry as a Human Service

As each new comprehensive model is developed, tested, and modified, questions are raised about how various professions and fields will be integrated into or linked to it. Naturally enough, these concerns are expressed by the various disciplines, less so by the program designers.

A careful review of the literature suggests that the issue of discipline integration is not considered a significant problem by the program managers. Extensive manuals developed for the Bureau of the Budget and the Office of Economic Opportunity speak only briefly to personnel matters, not at all to the integration of disciplines. They focus on task analysis as a way to factor jobs into their component parts in order to facilitate the assumption of many responsibilities by paraprofessionals. Professionals are described as tending toward bureaucratization, inflexibility, and predetermined standards. Some tasks, it is recognized, will require certain technical skills, although it is also noted that the major societal problems are not responsive to an individual approach. Some professionals, it is suggested, may be able to learn how to relate to larger community problems. The one to one relation is encouraged only as it enhances community change and development. It can only be assumed that the means by which the professional can effectively be integrated into the new developments is not significant.

Ignoring these issues may have serious consequences, however, for these groups have established identities and statuses. Some may be

dysfunctional, but unless careful thought is given to the modified role and status of professionals, programs may be blocked or seriously delayed.

Mental health could contribute to this role analysis in two ways, one focusing on how each discipline (psychiatry, nursing, social work, and so on) would be related to the human service network and the other on how the field of mental health itself would be integrated. Not that introspection is new to mental health. The 1960s saw endless prose directed to both issues as mental health made its latest effort to escape from its institutional base. All the arguments and concerns about community mental health are potentially extrapolatable to the larger, more complex field of human services.

Organizational Problems in Mental Health

Intraorganizational problems have evolved around a series of issues; a sampling includes concern about the dominant role of the clinical medical model, the struggle by the nonmedical professions for more status and influence, the conflict between the institutional and community oriented, the strain between treatment and consultation, and the competition resulting from sharply delineated catchment areas. Interorganizationally, the struggle to separate retardation from the mental health umbrella is perhaps the most vivid illustration of conflict.

The special linkage problem of state mental health, retardation,

correctional, delinquency, and chronic disease systems is that approximately 90 percent of their annual operating budgets are institutionally based. Locked into physical sites, buildings, and civil service, their ability to transform themselves into community-based programs, categorically or comprehensively, is seriously handicapped.

To move mental health into a formal relation with the other direct personal services may either escalate such organizational problems at an exponential rate or allow the more open-minded leaders of the professions and fields a new opportunity to serve consumers more efficiently. It may permit a confrontation with or an alternative to the heavy institutional investment.

The Mental Health Profession and Human Services

Except for its identification as an integral component of organized medicine, psychiatry should have neither more nor fewer problems in working within the larger human service network than any other discipline. The essentially autonomous and omnipotent anti-organizational stance of organized medicine and its assorted specialities has always handicapped cooperative efforts. Nevertheless, the fundamental problems are the same for all disciplines and organizations. They soon find themselves structured for the convenience of the providers rather than the users. The differences

between professions are principally a matter of degree.

The integration of mental health services in general will suffer the same problems as the efforts to link other services together: The specialization and domain fixation will continue to reinforce fragmentation even if the various specialists report to a single administrator.

The Goal of Mental Health Integration

Two goals, not necessarily compatible, should be distinguished. Either the mental health disciplines can be integrated with other care-giving disciplines so that they relate to each other maximally or the mental health disciplines can be integrated to modify the delivery system to the benefit of the consumer. Since we do not need smooth running organizations for their own sake, the latter goal must become superordinate. Necessary components of effective service delivery of particular relevance to mental health, and which it can stimulate, include: (1) the humanization of services; (2) insight into factors that enhance various forms of discrimination (age, sex, race, social class, income, and diagnosis); and

considerations of consumer input in decision-making. Thus, the specialized knowledge in the field of mental health could contribute to system improvement and not merely to system maintenance. There are also significant structural-functional (social and physical) issues with mental

health components.

The Individual or Systems Approach

Since by definition the human services model is designed to deliver services to individuals, it contains the latent assumption that people have problems that can be treated. In part at least the assumption is that the individual is at least partly at fault. If the client could only be adequately motivated to correct these faults, his situation would improve.

Among the problems in the present health and welfare system that Thomas Walz saw as contributing to the growth of new service models is the fact that the system has generally been based on a "social theory regarding the causation of social problems which has produced strategies incapable of dealing with the nature of the problems experienced by the majority of the poor in this country."

Several problematic issues concerning the role a mental health program should play have yet to be resolved within the profession, to say nothing of whether they are resolved in the minds of the larger community with which the program is required to cope. Typical is how broadly mental health (and mental illness) is to be defined. Should a comprehensive mental health center be concerned also with those who are "well," but who need help through especially difficult situations which could conceivably precipitate mental

illness?

It is possible, however, that these definitional problems might not engage the mental health field in continuous intensive dialogue if it were more closely allied with other services. Under these circumstances, for example, the man who was unemployed would ideally be given not only assistance in finding a job and/or receive job training but would also have any additional personal problems diagnosed and would be referred to the proper place(s) to help him cope with these.

Walz said that traditionally

> The preferred methods for dealing with social ills have largely been those based on the psychological sciences in which the focus has been on curing or rehabilitating the individual within the context of his family. As long as individual deficiencies rather than the deficiencies of the social system were the principal target, large-scale measures of social reform were not emphasized. The resistance of the hard-core poor to traditional methods of service intervention appears to be sufficient proof of the invalidity of the social theory upon which the social welfare system has been based.

Many of the new comprehensive centers that have arisen in the past decade were in fact a direct and conscious attempt to apply a new theory about the causes of social ills, such as juvenile delinquency. The emphasis, according to the guidelines of the Juvenile Delinquency and Control Act of 1961, was on community organization and experimentation with new service delivery arrangements.

Despite these conscious public policy decisions about the nature of society, the etiology of social problems, and the validity of various intervention procedures, the various comprehensive service organizations eventually found themselves dealing primarily with individuals and their families rather than system and organization change. Perhaps in reaction to these larger unachievable claims the current human service movement appears to be viewed primarily as a better clinical instrument and not as a complex, multi-organization capable of solving all problems for all people.

From this perspective the mental health model has actually been substantially integrated into the larger social welfare network for some time. Schools of social work and graduate programs in vocational rehabilitation have long been psychoanalytically oriented. In-service training programs for public welfare workers have been based on the verbal insight method. Middle-class theories of motivation, treatability, socialization, and future orientation dominate.

The human service movement offers an important alternative to the mental health community. Most recently mental health has opted for organizational separatism with sanctioned links to the medical care and social welfare systems. The comprehensive human service program allows for a joining of all three, and other subsystems as well, without forcing choices among incompatible alternatives.

The community mental health center could serve as an integral or initial component of a larger linked system. Mental health specialists, in addition to their treatment and remedial responsibilities, can serve as consultants, collaborators, and educators. Most important is the leadership role they can play in reinforcing the concepts of the whole man from a whole family living in a whole community. This is an important vantage point for the press toward primary and secondary prevention aimed at the host, agent, and community.

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Notes

1 The assistance of Mrs. Janet Bouton in library research and editing is gratefully acknowledged.

2 The traditional practice has been to purchase goods and nonrecurring services. If the service was a continuing governmental responsibility, the procedure was for the government to develop its own capacity.