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MENTAL HEALTH PROGRAMS IN WELFARE SYSTEMS

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MENTAL HEALTH PROGRAMS IN WELFARE SYSTEMS

Poverty and Psychiatry

The disproportionate prevalence of mental health problems and emotional disabilities in the lower socioeconomic segments of society has long been recognized and repeatedly documented. Critical comments by Miller and Mishler notwithstanding, Hollingshead and Redlich's classic study on the relations between social class and mental illness demonstrated clearly that the lowest class almost invariably contributes many more psychiatric patients than its proportion of the population warrants.

By and large, mental health services for the poor have remained grossly inadequate in spite of many well-intended efforts. During recent years some improvements have been achieved as a result of the interest and involvement in community psychiatry. Many professionals lack the knowledge, the skills, and often the interest and the willingness to engage the poor in treatment.

The psychological problems of the disadvantaged are often complicated by difficulties that threaten these people's very survival. It has been justly questioned whether some approaches, helpful to people from the middle and upper income groups, are relevant to the life styles or suited to the needs of the poor.

Responsible psychiatrists must search for effective remedial approaches to psychological distress wherever it is found. Even though “poverty is *not* primarily a mental health problem,” psychiatrists must collaborate in efforts aimed at preventing and treating the psychological misery of the poor. The required expansion of psychiatric knowledge and expertise can be achieved only by thorough study of the problems and by personal exposure to the special conditions of poverty and its complex relation to mental health and illness. The experience with the poor has motivated psychiatrists to reevaluate and restructure their professional roles and to modify concepts, methods, and techniques correspondingly.

Some Aspects of Public Welfare

Between 20 and 25 percent of the total United States population live on submarginal incomes below the level of the poverty income index by which the U.S. Department of Labor and the Office of Economic Opportunity define the poor. According to this index, in December 1969 a nonfarm family of four needed an annual income of $3,600 to meet the expenses of a minimum adequate standard of living. This amounted to about $70 per week.

A little more than one-fourth of the poor, as defined by the index, receive income from public assistance. The rate varies greatly among the states, depending on differences in eligibility requirements, levels of grants,

the community's moral standards, and availability of other resources that keep many poor from applying for public relief. Currently, the number of recipients of public assistance exceeds 13 million people. Their number increases rapidly in periods of economic recession and growing unemployment, but it keeps mounting even during times of economic expansion and relatively full employment. The great majority of welfare recipients are too old, too young, too sick, or too disabled to be self-supporting. Only a small percentage are able bodied and capable of being trained or retrained to be potentially self-supporting.

Families with children comprise the largest group of recipients today. In September 1970, 2,332,000 families with 6,498,000 children, comprising a total of 8,873,000, received public assistance nationwide. Most of these families were eligible for aid owing to the disability or absence of one parent because of death, divorce, or desertion. In twenty-six states a family could not obtain financial assistance as long as the father was living in the home, even if he was unemployed or unemployable. This rule has been blamed for the actual or alleged desertion of many fathers who wanted to render their families eligible for support by leaving the house.

More than 2 million aged over sixty-five years of age, one-half of them seventy-five or older, comprise the second largest group of recipients. Many of this group are also beneficiaries of old age insurance, but continued

inflation has rendered their Social Security payments insufficient.

Almost 1 million recipients are either blind or disabled as certified by medical authorities. About 900,000 persons in urgent need of support fit none of the federal categories. These people, single adults or childless couples, must be aided under a county or a state-county general assistance program, which is usually so low that it barely keeps the recipient from starving.

Public welfare is not limited to the provision of income maintenance and assistance payments. It is an organizing term, which for purposes of administration brings together a variety of supportive services—financial, medical, and social. These services include child welfare and child placement programs, preschool compensatory education, help with the education of children by providing aids for the development of children such as books or camping opportunities, medical assistance programs (Title XIX of the Social Security Act, often referred to as Medicaid), assistance with the procurement of appropriate medical care, rehabilitation services such as work incentive and concentrated employment programs, assistance with the securing of employment; homemaker services, volunteer services, food stamp programs; counseling with family problems and obtaining help for marital problems, family planning, legal services including assistance with a divorce, help with the obtaining of furniture or other household items, arranging for phone services and repairs, and assistance in the preparing of a budget. While the

target population of these services is the very poor, public welfare offers in some areas other community services such as help with adoption and protective services for children as well as for adults. The boundaries and the

focus of public welfare are constantly shifting to reflect legislative changes and reorganizations of service programs. These changes add to the heavy burden of the job of the welfare worker.

When President Lyndon Johnson appointed the Commission on Income Maintenance Programs, in 1968, he described the attitudes toward welfare in his introductory remarks, “The welfare system today pleases no one. It is criticized by liberals and conservatives, by the poor and the wealthy, by social workers and politicians, by whites and by Negroes in every area of the nation.” There are many reasons for this general dissatisfaction. Public assistance programs as they are operated today were originally established by the Social Security Act of 1935 in reaction to the Depression. Federal and state governments assumed responsibilities for the poor that had previously been borne mostly by local voluntary and governmental bodies. The initial intention was for public assistance to be a supplementary and residual program of income security, a temporary measure that would be phased out as soon as a comprehensive network of social insurance programs could take over. This expectation never came true. Because of complex social, economic and technological developments public assistance programs have grown and

expanded, and their steeply rising costs have aroused the apprehension and the resentment of the taxpayers. They have in fact become a significant factor upsetting the fiscal stability of state and county budgets.

The basic objectives of welfare are quite ambiguous because of the widely differing values of various segments of the population. Some people would like to restrict public assistance to the doling out of just enough money to protect the smallest possible number of deserving poor from the consequences of extreme indigence so that the more fortunate citizens can preserve their peace of mind. These people feel that everyone is responsible for his own success or misfortune. Failure to achieve self-support is in most cases ascribed to a lack of initiative and diligence and, therefore, should not be rewarded or encouraged by support. Other people, especially professionals, see public welfare as an instrument of social betterment, which could raise the general quality of life in the community by providing needy recipients with the means for a decent living and with appropriate social services to improve family and social functioning. Some welfare departments clearly state that they see their functions as including "advocacy for the consumer." A considerable number of people expect welfare to aim especially at the reduction of dependency by encouraging any potentially capable recipient to develop toward the greatest possible degree of self-support. In the case of single parents, this position creates all kinds of complications.

The conflicts in values and objectives lead to passionate political controversies, which interfere with all truly constructive major welfare reforms. They also make it very difficult to conduct evaluative research and to assess the effectiveness and the impact of a program or of program components. Furthermore, reflecting the ambivalent attitudes of the public at large, the staff of welfare departments are also confused about their goals. They experience tremendous frustrations in their work, which deprive them of the sense of direction essential for commitment to their difficult tasks.

The present welfare system has many obvious deficiencies and inequities. During the thirty-five years that have passed since the welfare system’s creation, the world has changed dramatically, but public assistance and social insurance titles of the Social Security Act have not been altered correspondingly. The existing welfare mechanisms have been accused of being merely palliatives that institutionalize dependency. As a rule the system provides substandard incomes that keep most recipients in abject poverty. Geiger claimed: “One reason for the continuation of most people on public assistance is simply that the level of public assistance keeps them there struggling for the very essentials of existence.” Hagstrom, describing the “psychology of the powerlessness of the poor,” asserted that the enforced dependency of the recipients “gives them little scope for action under their control” and therefore “dependency relationships become institutionalized and perpetuated.”

There is no part of the welfare system that is not in need of basic overhaul. The brunt of criticism is usually directed at the Aid to Families with Dependent Children (AFDC) program because (1) participation rate and costs are increasing at a particularly fast pace; (2) the program seems to promote family break up; (3) there are unjustifiable discrepancies among the various states and regions of the country; and (4) the current legislation has built-in incentives to quit working.

The Family Assistance Plan (FAP), proposed by President Nixon, is attempting to remedy these deficiencies. The most fundamental departure from present policy is the federalization of AFDC and its extension to the working poor. The proposal is currently under consideration in Congress. Much discussion and delay can be expected before basic reforms of our current welfare legislation are passed, but such changes are inevitable. Anyone involved and interested in the fate of the poor must keep himself constantly informed of the developments and their implications.

After this very condensed introduction to some basic aspects of public welfare, the question could be raised as to why psychiatrists and other mental health professionals should get involved at all with a system that has such glaring shortcomings and that, in addition, is in a state of great flux. Notwithstanding the general lack of satisfaction with public welfare, it would be staggering to contemplate what would happen if this institution would not

exist to reduce widespread human want and suffering until such time that a better approach and solutions have been found for the tremendous problems of contemporary poverty. A sizable proportion of all poor people in America, in fact most of the very poor, are greatly dependent on and affected by the welfare system. In addition to the recipients, the welfare workers represent a sizable army of providers of care in the community. They too are influenced by the structure and the limitations, as well as the opportunities of the system to furnish human services. The immense complexity of the problems will require for their solution lay people as well as a host of various professionals, economists, social planners, research experts, politicians, to name but a few. The victims of the system cannot wait until stabilizing legislation has been passed or until the present institution has been replaced by a better approach. People are suffering now, and the need for appropriate psychiatric expertise is urgent. The welfare system is one of the avenues by which psychiatrists and other mental health professionals can meet the poor and can learn from them about poverty and its problems. They can acquire new expertise, which can be used to humanize the system and assist in the development of a better design to replace it. Even as cautious an endorser as Gruenberg stated in a reply to a paper by Riessman: “We all hope that current efforts to eliminate low living standards and personal indignities associated with extreme poverty will succeed rapidly. I suspect that psychiatrists have a significant, but minor, role to play in this process.”

History and Review of Literature of Mental Health Efforts in Welfare

Adolf Meyer advocated as early as 1909 that coordinated community mental health programs be established in which all care-providing agencies and resources, including the welfare establishment, would cooperate with psychiatric facilities. It took many years before the first steps were taken to translate these suggestions into action.

There are relatively few reports that describe the development of collaborative relations between the staffs of welfare agencies and mental health professionals. Psychiatrists began to associate with social workers when they first noted that "Social work has needed the contributions of the psychiatrist because of the wide prevalence of emotional disturbance among its clients, and psychiatry has needed the assistance of social work in finding and meeting its community responsibilities." The multidisciplinary team consisting of a psychiatrist, a psychologist, and a social worker was introduced during the early 1920s by the child guidance movement, but for a long time each profession maintained a distinct and separate role identity within the collaborative arrangement.

Social Workers Assume Limited Treatment Responsibilities

About the middle 1930s the first reports appeared in which social workers in clinical or social agency settings were described as increasingly

assuming treatment responsibilities with the support of a consultant psychiatrist.

During the Depression private family agencies expanded rapidly by temporarily becoming the disbursing agents for the federal or state government. Eventually public relief departments were set up. Private agencies reverted to their previous smaller caseloads and focused their attention on casework in the modern psychotherapeutic sense. They invited psychiatrists to serve in staff positions or as consultants to diagnose, interpret, and evaluate the behavior of clients and treat them if so indicated. Later psychiatrists participated in agency in-service programs.

The collaboration of the two professions taught psychiatrists to respect their social work colleagues. Even though the workers had less formal instruction, they were able to obtain a great deal of meaningful psychological information and insight, and they managed even cases with psychopathological symptoms surprisingly well. On the other hand, social workers discovered that psychiatric consultants were able to fortify them with "some quality of reassurance" and that their effectiveness with clients increased as their anxiety abated. This kind of help was even more significant than whatever understanding was gained concerning the clients' psychodynamics. These observations are cited independently and repeatedly in many reports of this period.

In 1946 Drake, a welfare agency administrator, discussed the needs for consultants to local welfare departments and the pitfalls in their use. He defined as consultant, “One who gives advice or service the results of which are carried into action by the more responsible line officers of the agency.” Psychologists and psychiatrists are listed last among the six groups of potentially helpful specialists. They should be employed “for mental testing and child guidance clinical service in connection with problem children, family adjustment cases, and children being studied for adoption or foster home placement.” Drake called for a clear definition of the role and the responsibilities of the consultant as distinguished from the functions of a supervisor or administrator. “Consultants should always be consulted by agency executives before taking action involving the particular specialty in question.” The specialist must be acquainted with the structure and the functions of the consultee agency so that he can address his interventions in the right form to the right person. Only in this way can confusion, mutual resentment, and injury to the morale of the agency staff be avoided. Drake made a strong plea for the use of consultants to supplement knowledge and skills of the regular welfare staff and recommended that consultants be taken into conferences on administrative matters to give them a sense of participation. Like in the army, “you can do almost anything to a man in the service except ignore him.”

From the psychiatric consultant’s side, Coleman described in 1947, in a

classic paper, a new method of psychiatric consultation which was “basically worker oriented rather than client oriented.” Since social agencies help to carry a significant share of the neurotic burden of the economically less privileged segment of the population, Coleman felt that psychiatrists had to find a way to enhance the effectiveness of caseworkers. Even though the method of support and influence should be based on psychiatric knowledge and insight, no attempt should be made to change workers into psychiatrists. Social workers are invaluable to many clients in their specific professional role. Coleman stated that “the indication for psychiatric treatment is determined as much by the patient’s ability to make use of it as by his neurotic suffering. Direct treatment is not the only way of relieving such suffering.” He felt that most psychiatrists were quite unfamiliar with the functioning and the goals of social agencies, since during their training period they had been given little or no opportunity to work cooperatively with social workers. Thus they could not develop recognition and acceptance of the professionalism of social workers. Any psychiatrist wishing to function as a consultant must first acquaint himself with the social system of the agency, with the specific needs of the workers and their clients, and with the best way to respond to these needs. The psychiatrist appeared to be most helpful when he accepted the worker’s presentation of the problem in an uncritical stance and when he was able to determine and to reduce the worker’s emotional distress. Coleman admonished psychiatrists to limit their comments strictly

to the professional problems and not to transgress into the workers' personal problems. This new method of consultation was a procedure *sui generis,* which had to be studied and mastered with special care. Coleman's paper has stood the test of time. Most of his recommendations apply to currently practiced forms of consultee-centered consultation without major modifications.

Coleman deplored that many psychiatrists felt their services could be utilized only by sophisticated workers with considerable education and skills. This limited psychiatric consultations mostly to the wealthier private agencies, whereas "public agencies, discharging a social responsibility which may be no less important, often have too few workers, trained or untrained, and rarely have enough psychiatric consultation." This description applied to public welfare agencies. Most welfare workers lacked then, as they still do, graduate education in social work. They had enormous case files, which made it difficult if not impossible to provide individualized case work. Prior to 1962, services were confined primarily to the determination of eligibility and to the provision of money payments, and psychiatrists showed little interest in consulting with psychiatrically unsophisticated low status welfare workers. If consultants worked with public agencies it was usually with organizations that offered service for children, such as child welfare, foster home placement, and adoption.

In 1950, in an early report on consultation to a public welfare agency, Maddux emphasized that even workers with limited training could effectively utilize the Coleman model of worker-oriented consultation. A psychiatrist delegated by a mental hygiene clinic to a local welfare agency for one and one-half days a week conducted conferences with individual workers and their supervisors whenever they requested it. He also interviewed selected clients for diagnostic purposes. Maddux described the enormous stress under which welfare workers must function. They are squeezed in the conflict between the needs of their clients and the demands of the taxpayers. As they respond to dependency needs of their clients, their own conscious and unconscious yearnings for dependency are aroused. Low salary ranges limit the hiring of graduates of social work schools, and most welfare workers have little or no relevant training even though they have usually graduated from college. The resulting rapid staff turnover prevents the building of ongoing relations between a client and the same caseworker. Large caseloads, enormous quantities of paper work, and complex regulations determining eligibility and availability of services restrict the time for constructive casework even further. But Maddux was not deterred from offering consultation by the lack of sophistication of the workers. He, too, confirmed the overriding need of the workers to be put at ease and reassured so that they could do their best under difficult circumstances: “The central aim of the consultant then becomes relief of worker anxiety.” Theory and didactic

instructions were of minor importance. At times the psychiatrist acted as a role model, for example, when demonstrating how he as a professional could remain acceptant of the worker in the face of a hostile assault, a situation that workers often had to face with their clients. Workers requested consultations much more frequently than diagnostic evaluations of their clients, which indicated that they found the consultations more helpful. Sometimes, diagnostic interviews with clients were combined with consultations with the workers. In spite of heavy time commitments to paper work, more than half of the workers in the agency asked for consultations. Those who kept returning for consultations showed “a progressive diminution in anxiousness with emergence of deepening interest in understanding their clients and increased ease in their contacts with clients.” This demonstrated the usefulness of this method for staff development. Workers ranged widely in the degree of their sophistication and in their reactions to the procedure. Whenever a worker could bring himself to an initial interview, he returned one or more times, proving the reassuring effect of the experience with the psychiatrist. Maddux’s paper contains some interesting case illustrations, which reveal that the aim of the consultation was not so much assistance in the specific case that had been presented but improvement of the worker’s overall ability of helping future clients with similar problems. Some staff reacted with indifference, ambivalence, or outright hostility, but on supervisory and higher administrative levels the psychiatric consultant was

enthusiastically accepted. The psychiatrist's position outside the channels of administrative responsibility added to his acceptability by the workers. He was seen by them as a friendly and potentially helpful visitor. An effort to involve some disinterested and even hostile workers was only partially successful. At no time were consultations foisted on unwilling staff.

Although psychiatrists worked in ever-increasing numbers in social agency settings, there were few generally accepted guidelines for their functions and the interprofessional working arrangements varied tremendously in different programs. Bernard made an attempt to abstract more precise and realistic concepts from her own experience in an adoption agency. She considered consultation by individual case conference a core function, although psychiatrists could make many other contributions, such as the interviewing of selected clients for purposes of diagnosis or referral, participating in staff development projects, and involving themselves in discussions of treatment policies and program orientation. Bernard's model of consultation is primarily client centered and relies heavily on the application of psychodynamic interpretations. In all the cases she cited, the client was subsequently referred for psychiatric treatment. The consultant's intervention was not related to the worker's individuality. The support was an unspecified by-product of the consultant's knowledge and availability, "in addition to the dynamic and clinical explanations," which "significantly helped to reduce the worker's own anxieties and thereby enhanced the

capacity for skillfully aiding the precariously maladjusted client." The involvement of several psychiatrists in the management of a single case makes this model uneconomical in terms of professional time and costs and would preclude its large-scale application within the framework of a community program.

The Mid-1950s: A Climate of Exploration

The middle 1950s were a time of stock taking in the mental health field. The Congress of the United States, in the Mental Health Study Act of 1955, directed the Joint Commission on Mental Illness and Health, as chosen by the National Institute of Mental Health (NIMH), to analyze and to evaluate the needs and resources of the mentally ill throughout the nation and to make recommendations for a national mental health program.

In this climate of exploration, Lamson, of the community services branch of NIMH, surveying the state of integration of mental health services in health and welfare community agencies, found two levels of action. (1) On the level of state government, in nearly all states at least one full-time professional person was responsible for the development of statewide community mental health services. This was frequently a psychiatrically sophisticated social worker who established liaison with the administrators and the staff of other human services, including welfare departments. Matters

of common concern would be discussed in formal and informal administrative meetings defining needed resources and planning programs to remedy deficiencies. (2) On the local level, community mental health clinics had become aware that direct services to patients and their families alone could not meet the existing needs. They realized that consulting services and education offered to referring agencies could reduce caseloads and number of referrals by upgrading the mental health skills of agency staffs. The new communication also improved coordination of services between participating agencies and counteracted attempts of some clients to play one agency against another.

About the same time, attention was refocused from individuals on the importance of the family for the mental health of all its members. The concern for the family received new impetus through the 1956 amendments to the Social Service Act which emphasized services, "to strengthen family life and helping needy families and individuals attain the maximum personal independence of which they are capable."80-p-183 The legislation stimulated increased interest in staff development. Within a few years a number of relevant papers appeared which expressed the greater readiness of welfare agencies to utilize the help of psychiatrically sophisticated professionals. Social work schools progressively incorporated knowledge from dynamic psychiatry into their regular curriculum, and since psychiatrists were scarce, social workers were invited to act as mental health consultants.

In fact, social workers had been consultants in public assistance administration as early as 1939. But while they were aware that agencies were made up of “human beings both wanting and resisting controls”4 and while they employed social work principles based on mental health principles, such as respect for the person, confidentiality, self-determination, and individualization, their main attention was directed toward program implementations, personnel policies, and intergovernmental agency cooperation.04 This kind of consultation differed considerably from the types discussed here. They were defined as staff functions with responsibilities of the consultant “clearly defined and placed within the administrative structure of the organization.” Now social workers began to serve as extra-organizational mental health consultants.

Two faculty members of a graduate school of social work, Decker and Itzin, visited at monthly intervals, essentially untrained staff of several county welfare agencies under the sponsorship of a state agency. They hoped to improve the workers’ ability to render more intensive casework to their “most needful” families in the AFDC program. Cases were selected by the workers themselves. The consultations were primarily client centered. The consultants helped the workers to arrive at a diagnosis of the family and to develop a case plan. The results were quite spectacular, especially in cases that had not shown any improvement for a long time prior to the consultation. The effect was ascribed to the increased self-esteem and

interest of the workers. As they gained self-assurance, due to the consultations, they were able to show more interest in their clients who in turn responded to the increase in attention with a gain of self-respect. Where the consultants noted deficiencies in individual line workers, they recommended supervision by the state social work staff.

The discrepancy in the perception of consultations by consultant and consultee respectively was illustrated by two companion papers published in 1957. Both the psychiatric consultant and the administrator of the corresponding consultee social agency described the consultation process and their expectations from their respective vantage points. The psychiatrist listed among the "requirements for consultants" such items as, "he should be well trained in dynamic psychoanalytic therapy," "should have had special training and experience in work with children," "should be paid an adequate fee," and, surprisingly, that "previous experience as a consultant is not essential." The low value assigned to prior consultation experience may account for his numerous references to "agency-consultant friction," "undercover motives" of the workers who select cases to "test" the consultant "to demonstrate the futility of expecting any good to come of casework or of consultation," who "maneuver the consultant into supporting an opinion with which the supervisor disagrees," and who finally cause the consultation to end "only in frustrating disintegration and more or less open antagonism." One gains the impression that this consultant had many unpleasant

experiences, so that his paper, contrary to his expressed opinion, demonstrates how great the need is for a careful preparation of the consultant for his very special role. In the companion paper the administrator of the consulted social agency conceded that “consultations can be gratifying and productive of growth in both consultee and consultant” but only if the relationship is based on mutual respect, if the agency is clear what it wishes to gain from the procedure, if it is stable in its administration, in its staff and in its programs, and if the role of the psychiatrist consultant is precisely defined in advance. The author stressed that much thought must be given to the careful selection of the consultant. Attention must be paid not only to his professional background but equally to his personal fitness and ability to look at the process as a mutual learning experience, especially in its early stages. The psychiatrist must not be permitted to usurp administrative prerogatives, supervisory functions or believe that he is qualified to teach basic social work skills and techniques. Before the psychiatrist is asked to function fully as a consultant, he must be oriented about the agency and about the world of the clients. If several consultants serve an agency, one should be designated as the senior consultant, and he should be invited to help with the orientation of incoming consultants. The author’s agency is never specified, but it was most likely a child welfare agency with a trained staff primarily interested in enhancing their skills in casework therapy and their knowledge in psychodynamics. Among the five listed indications for the use of consultation

the first three refer to lack of knowledge, the fourth to psychiatric emergencies, and only the last relates to “problems in the worker-client relationship.”

An air of authoritarianism pervades the contributions of both the administrator and the psychiatric consultant. It is most clearly expressed in the stated policy of the agency that all workers had to present cases for consultation whether they liked it or not. As a rule, requests for consultation are left up to the individual worker and his supervisor.

It is evident from these two papers that this consultation relationship was fraught with tensions and painful complications. They were most likely caused by two major factors: (1) the consultant’s lack of preparation for his task, and (2) the discrepancy between his conception and the agency’s expectations concerning the consultation procedure and its functions. The administrator remarked that “Social agency staff sometimes complain that the psychiatrist doesn’t listen enough,” a complaint that ought to have been heeded. Both authors agreed that the association of a psychiatrist with a social agency lent authority to the agency’s decisions and facilitated some actions on behalf of their clients with professionals as well as with lay people in the community. The administrator added, however, that employing a consultant in order to borrow his authority was a “debatable” position.

Lifschutz, Stewart, and Harrison, a psychoanalyst, a field social work supervisor, and a public welfare worker, respectively, pointed out in a paper published in 1958 that the psychiatric consultant “an increasingly familiar figure in the social agency” was now beginning to collaborate with public assistance agencies. They saw the consultant chiefly in a didactic and interpretative role. They concurred with Ormsby that “Effective consultation educates and influences rather than takes over and directs.” Two illustrative consultation examples were client centered and dealt with by psychoanalytic interpretations. The outcome of the first case was a referral to a psychiatrist. In the second case, the worker was assisted to help the client to make the decision to relinquish her child born out of wedlock. The consultant acted mainly as interpreter of the probable unconscious meaning of the client’s social breakdown or of the contemplated interventions of the agency. No special attention was paid to the caseworker’s individuality and her contribution to the problem, though the authors seemed aware of the feeling tone in the interplay between caseworker and client. One gains the impression that the consultees benefitted from the consultation mainly by sharing in the experience of looking at human events through the fascinating lens of psychoanalytic interpretation.

Nitzberg and Kahn, a senior social worker and a clinical psychologist, staff members of a rural mental hygiene clinic, compared the method described in the preceding paper with their own consultation model, in which

the aid given by the consultant’s dynamic understanding of a given case was emphasized in contrast. They tried to develop the skills and background of workers “as well as to provide more immediate help on some specific problems.” Over a period of four years, they met separately though concurrently with a group of welfare workers. The psychologist started earlier and discussed cultural values and attitudes, causes of emotional problems and attitudes toward people with disturbing behavior. The workers themselves changed the format by bringing up some of their own cases. As they became increasingly free to air their anxieties, the sessions seemed more effective. Then the social worker initiated monthly group case conferences. The psychologist now returned to semi-didactic sessions covering a wide range of psychological topics. This form of consultations was essentially a prolonged form of in-service training. In a statewide training program, the participants of the consultation program stood out by their ability to learn. The authors felt their greatest contribution consisted in the support they gave to the workers for service activities in which they were already involved. They were amazed at how well these untrained workers functioned in spite of heavy caseloads and extremely difficult working conditions. They were impressed with how much time and effort some workers devoted to individual cases. This is an experience reported by everybody who consults with welfare personnel.

Also in 1958, Eisenberg, concerned with the uneconomic utilization of

scarce psychiatrist manpower, suggested that child psychiatrists could make their greatest contribution to the mental health of the community by functioning as diagnostic consultants to a public agency, leaving the actual treatment to the agency staff. He felt that preoccupation with the individual psychotherapy model, reflecting the social matrix of contemporary psychiatric practice, often resulted in disrespect for the effectiveness of planned social conditioning as a therapeutic instrumentality. To make the best possible use of limited psychiatric time and manpower, he spent half a day each week at the foster-care division of the welfare department. He interviewed children who presented special problems and then met with case workers and supervisors to discuss the diagnoses, to formulate treatment plans, and to lay the foundations for effective casework by helping the workers to gain more insight into the psychodynamics of the case. The case worker was responsible for the development of a sustaining relationship with the children; for the interpretation of the clinic findings to foster parents, school, and court; and for the involvement of children into constructive group relations and activities. The case workers were thus the most important people in the life of these children, who were often severely traumatized by prior abandonment and rejection. Eisenberg reasoned that efforts invested in the case workers helping them to understand the problems they had to deal with would pay off in the long run by saving scarce and expensive psychiatric time. He likened his method of “manipulation of social space” to the use of the

“therapeutic milieu” in inpatient facilities. He felt this approach was neglected by professionals because of the prevailing fashion to expect results only from “inner changes.” With these children, who were in the custody of the welfare department by authority of the juvenile court, the method resulted in substantial and significant improvement. A somewhat superficial follow up revealed that where the consultant’s recommendations had been followed the outcome was just as good as one could have expected if the child had undergone conventional psychotherapy. Furthermore, many of these children would have made very poor candidates for psychotherapy because of their tendency toward antisocial behavior.

In the same year, 1958, Bush and Llewellyn described for the first time a statewide experiment with psychiatric consultation as part of an in-service training program. Several years later a follow up of the same program was published by Llewellyn and Shepherd. The North Carolina State Board of Public Welfare initiated a psychiatric consultation service to foster deeper understanding of human behavior and to strengthen casework skills and agency services in a casework staff, many of whom had only limited training. Any county could request monthly two-hour consultations for three consecutive months with a team consisting of a consulting psychiatrist, the state supervisor of staff development, the area public welfare psychologist, and occasionally other invited consultants. The local agency prepared a summary of the case in advance, listing the chief problems and concerns and

distributing it together with copies of all pertinent reports to all participants of the joint conference. Most of the time, the authors found that the true, more or less hidden, problem was not an “impossible” case but attitudes, expectations, and motivations that interfered with the agency staff’s effective utilization of casework methods.

A planning session of the consulting team preceded each consultation. The written material was reviewed, and specific problems and needs of the particular area, community, or of the agency itself were discussed. In addition to the case worker who presented the case, as many members of the agency as could be spared attended the consultation. At the onset of the consultation the staff development supervisor from the state agency instructed the consultees what to expect from the consultation. The purpose was not to solve a specific problem or to evaluate a specific client psychiatrically but to serve as a springboard for a general discussion, which would hopefully improve the knowledge and skills of all participants. For a good part of the consultation the psychiatrist listened in silence until he gradually joined in the discussion. This gave him an opportunity to observe the group and to define for himself the nature and the probable causes of the workers’ apprehension. Then he would attempt to reduce their tension by providing information, explanations, and interpretations of the client’s behavior. This approach was based on the assumption that “agency-client relations can be enhanced through better understanding of the meaning of the behavior of the

client and of the effect of environmental stress upon the client and his family."

All participants of the consulting team contributed according to their respective areas of expertise. An atmosphere of support was maintained throughout the session. The final period of the consultation was devoted to a discussion of a management plan based on the newly won insight into various aspects of the case. According to the authors, the procedure rallied the workers toward constructive thinking and realistic goals. The warm acceptance of the staff by the conference leaders seemed to contribute greatly toward an improvement in intra-agency relationships.

This particular consultation model was also an integral part of a statewide staff development program with the manifest intent to stimulate desire for more information about human behavior, to increase the self-awareness of the workers, and to stimulate their thinking of the role of casework and of the functions of the agency. A single session appeared to be much less effective than a brief series of three consecutive meetings. Characteristically, the first session was usually about a hard-core case, with the client clearly in the focus. By the time the third session had come around, the presentation frequently involved a relationship problem between a worker and his client. This was quite a contrast to the first meeting. A written summary prepared by the staff development supervisor and distributed to the agency personnel and the consulting team aimed at reinforcing the impact

of the consultation. The local agencies were strongly urged to review the summary of their own staff developmental meetings. The consulting team often inquired about previously presented cases. This demonstrated to the workers their continued interest, but it also gave them a chance to get some feedback on the effectiveness of their efforts. An indirect evidence of the usefulness of this program is the fact that it has been continued now over a period of more than fifteen years with only minor modifications and most of the time under the guidance of the same psychiatric consultant.

The 1960s: Expansion of Mental Health Efforts

Several major developments occurred simultaneously in the 1960s, bringing about a rapid and extensive expansion of mental health efforts in public welfare systems throughout the nation.

1. Community oriented mental health services, established with funds provided by the Health Amendment Act of 1955 for demonstration projects, were beginning to get into operation and offered consultation services to public agencies.

2. Publication of the final report of the Joint Commission on Mental Illness and Health in 1961 stipulated national interest and discussions and prepared the public climate for new mental health legislation and programs.

3. The Community Mental Health Centers Act of 1963 sparked the development of federally funded comprehensive community mental health services, which in several enterprising states had preceded the new federal legislation. One of the obligatory basic services of these new centers was consultation and education for other community agencies and resources.

4. Progressive changes in welfare legislation paralleled the legislative developments in the field of mental health. Amendments to the Social Service Act of 1962 introduced the principle that social services and money payments were companion parts of public agency responsibilities. Many public assistance departments changed their names to departments of public social services to emphasize the new philosophy. These program alterations were not entirely humanitarian. Many legislators hoped that services would motivate recipients toward self-support, which would in turn reduce welfare costs. In order to make better social services possible, federal financial participation was linked to a progressive reduction of caseload per worker and a smaller number of workers per supervisor. In many programs, caseload coverage was restricted to sixty cases per worker. In the guidelines to the 1962 amendments, the welfare workers were presented as providers of services and as agents of change along the lines of traditional casework models.

The amendments failed to fulfill the expectations that welfare costs

could be eventually reduced. Their immediate effect was a need and a demand for many more workers. The numbers of staff of welfare departments rose sharply and with them the welfare budgets. Because workers had fewer clients and because the focus was now clearly on more and better services, agencies intensified their staff development efforts to upgrade the capabilities of the staff. Consultation with sophisticated mental health professionals appeared a promising approach to staff development. The greater availability of mental health services by clinics, mental health centers, and even by contractually employed private practitioners coincided happily with the increased interests of welfare departments.

Simultaneously with these developments, the "other America" was once again rediscovered. Interest in all aspects of poverty increased sharply and culminated in the so-called war on poverty. At the same time, psychiatric professionals developed increasing interests in the community and in its relations to mental illness and health. Psychiatrists began to reexamine their roles and responsibilities. They searched for new concepts and methods that could be helpful to them in their new functions in nonclinical community settings.

Among the many significant contributions to the field of community psychiatry the comprehensive and concise conceptualizations of Gerald Caplan have proved especially helpful to practitioner as well as programmer.

Over a period of twenty years, Caplan refined the basic theory and practice of mental health consultation. He differentiated them from other specialized professional transactions, such as supervision, education, psychotherapy, casework, counseling, and collaboration. In this way, he made a major contribution to rendering consultation a basic clinical modality in community mental health services. His classification of the various types of consultation provided a taxonomy that permitted comparison and evaluation of the many different models of consultation presented in this survey.

Leaning heavily on Caplan's work, Rogawski established a consultee-centered consultation program for the Los Angeles Department of Public Social Services (the former Bureau of Public Assistance), a mammoth agency employing several thousand social service workers. Rogawski did not begin to consult until he had spent several months in thorough orientation. During this time, he familiarized himself with the complex issues of welfare, studied the history and current practices and legislation of welfare, became acquainted with a large number of people working at different levels of the huge agency, sat in with social service workers while they were interviewing clients or accompanied them when they made home visits, learned how to compute a grant within the different aid categories, and finally began to experiment with several models of consultation. Because of the tremendous demands for professional support for the largely minimally trained welfare workers, he decided that group consultations with work units consisting of a

supervisor and his or her five line workers promised to reach the largest number of staff. He referred to the work unit as a “work family,” because relations in the unit resembled relations characteristic of families. At first he consulted alone, under the sponsorship of the local mental health department, but soon he was able to recruit additional psychiatrists from private practice as part-time consultants. They were available to specific districts for a few hours each week. Each new consultant had to go through an orientation phase during which he was familiarized with basic concepts of consultation. Then he became an observer in consultations with an experienced consultant. Finally, he would conduct consultations on his own, at first monitored and supervised by his preceptor, with whom he discussed the dynamics of the procedure following the consultation. The careful preparation paid off. The program enjoyed a favorable acceptance through all levels of the agency, and it has continued for a decade without a single major negative incident. Rogawski also integrated his consultations into a course on mental health consultation techniques for third-year psychiatric residents, many of whom joined the program after their graduation.

An even more ambitious program was described by Liben, who combined psychiatric consultation and mental health education for a local welfare center with the training of psychiatric residents in community psychiatry. Two departments of the School of Public Health and Administrative Medicine and of the College of Physicians and Surgeons of

Columbia University, a teaching hospital, the New York State Psychiatric Institute, the New York City Community Mental Health Board, and the Department of Welfare pooled their resources in the collaborative venture, which at once ran into hostile conflicts and resistance. While the psychiatric faculties wished to restrict the number of workers in contact with consultants in order to provide the most intensive service and the best learning experience for its residents, the agency staff insisted that all workers share equally in all aspects of the program and demanded the traditional models of instruction. A compromise was finally reached by arranging monthly seminars for the staff, with the attendance to be determined by the welfare agency, while the content was selected by the division of social and community psychiatry, and by providing weekly consultations with a limited number of welfare units. The monthly institutes included combined case conferences, videotapes demonstrating interviewing techniques, movie presentations with subsequent discussions, and lectures. As anticipated, these efforts had a limited impact on the welfare staff. But the contacts had a very welcome side effect in reducing the hostility between welfare and mental health personnel, and improving communication and relationships between them. They came to respect each other as they became aware of their respective problems. The consultee-centered case consultations were attended simultaneously by two to three units and their supervisors. The worker who presented a selected case prepared a psychosocial summary in

advance, and after the meeting the respective supervisor summarized the discussion and the recommendations. Progress was reviewed in follow-up consultations.

The consultation approach seemed to be much more effective with regard to staff development. Success might be partly owing to the fact that each consultant prepared himself for the program in advance by reviewing the relevant literature and material that had issued from the experience of his predecessors. The first consultant always spent a "daily block of time for some weeks to develop the necessary data, as well as to make himself 'visible' in a nonthreatening way by interacting informally with various levels of staff." This resembles closely the path pursued by Rogawski.

Common problems of the consultees were difficulties in perceiving both their limitations and their strength. Inexperienced workers tended to over-identify with clients and become overprotective or antagonistic. They reacted with guilt whenever they could not fulfill unrealistically high aspirations on behalf of their clients. Themes interfering with their professional functioning often included conflicts with their supervisors, with their colleagues, or with agency policies. At first, they seemed reluctant to refer clients to psychiatric resources. As they became aware that the psychiatrist consultants were human beings without dangerous and magical powers, they became more inclined to refer clients for psychiatric treatment. Group discussions often

revealed misinformation or lack of information about appropriate referral agencies. The format of meeting in groups had the advantage that fellow workers who in the past had coped with a problem similar to the one presented in the consultation could offer help to the consultee. As a rule a worker was able to follow guidelines proposed by a fellow worker easier than what was introduced by the consultant.

The consultations resulted in a rise of self-esteem in the workers, greater objectivity toward the clients, fewer conflicts with supervisors, and even better understanding of the agency policies.

For the psychiatric residents, the experience was highly educational. They were able to see that they could help staff in their dealings with clients, and they learned to apply their psychiatric insights in the service of the ego functions of the consultees. They reviewed, used, and modified various models of consultation to develop their own conceptual framework for the consultation process. Though the consultations were at first perceived as an opportunity of solving the problems in an individual case, the focus quickly shifted to common problems of the workers and to the improvement of their expertise. A measure of the success of the program could be demonstrated by the agency's request to continue, enlarge, and expand it.

Mental Health Programs in Welfare Systems: Current State

In preparation for this chapter, a search was made by the American Public Welfare Association through an assortment of materials received from state departments of welfare, which described a variety of divisional and specialized programs. The Association serves as a clearing house for the exchange of information and experience in the field of public welfare administration. Nothing pertaining to the administrative and professional arrangements between mental health programs and welfare systems could be located. Also, the Interstate Clearing House on Mental Health of the Council of State Governments could not provide any description of coordination of efforts in welfare and mental health.

In 1961 Llewellyn and Shepherd received replies from the state welfare departments of all fifty states plus the Virgin Islands, Puerto Rico, and the District of Columbia to an inquiry about the utilization of psychiatrists in staff development programs, either locally or on a statewide basis. Three out of four states (73.6 percent) used psychiatrists, half of them only on the state level, one-fourth only on the local level, and one-fourth both on the state and on the local level. The authors suspected that the informality of their survey letter caused some ambiguity among their respondents. Even in states that denied the utilization of psychiatrists, some clients were probably referred at times for diagnostic evaluation. But two states insisted that they never made use of psychiatrists in any form. In 49 percent of the state agencies replying, psychiatrists were actively engaged in the education of welfare personnel by

means of case conferences or other means of teaching. In an additional 24 percent of the sample, psychiatrists were involved in staff development without actively planning for it. In four states, psychiatrists functioned only as lecturers or seminar leaders. Only in two states were psychiatrists involved in a statewide staff development program: In North Carolina, Llewelyn, himself, employed psychiatric consultations as a training device to develop basic interpersonal skills, self-awareness, and mental health knowledge in workers of all programs at both state and county level; in Mississippi, statewide consultation services were used, but only for the education of child welfare workers.

Ten years have passed since this study, and I decided to explore the current state of mental health programs in welfare systems by means of a questionnaire mailed to representatives, most often staff development specialists of welfare departments in all fifty states, the District of Columbia, and U. S. territories. The questionnaire could be completed partly by checks and partly by brief narrative. It inquired into the following areas: cooperation between mental health agencies and welfare staff; use of consultation programs; conditions of employment and types of mental health professionals; methods used by welfare staff to identify, evaluate, and serve emotionally and mentally disturbed clients; in-service training about mental health and illness issues; use of volunteer workers; employment of "new Careerists"; and compensation for services under the provision of Medicaid

(Title XIX). Completed replies were received from forty-three states, the District of Columbia, and Puerto Rico. One state sent alternative information but refused to complete the form.

There were many obstacles interfering with the obtaining of the data. States differ widely in the administration of welfare and mental health programs. More than half of the states have completely separate departments for the two areas. A number of states have omnibus agencies combining under a single administrative official of cabinet rank the departments of health and welfare and other allied bureaus or divisions. While this may sometimes facilitate interprofessional communication, it is not always the case. For economic reasons the inquiry had to be limited primarily to state agencies. Some state officials were well informed about conditions on the local levels. In larger and more populous states staff development specialists were often incompletely acquainted about activities and arrangements by the county agency staff. This was revealed when in some instances replies from state officials were compared with information from local sources. A similar discrepancy became evident when the information from welfare staff was compared with the impressions of the mental health professionals in the same program. Psychiatric staff were always much more optimistic about the effect of their contributions.

Some informants from welfare departments expressed concern that the

questionnaire method would evoke a rosier picture than the actual state of interprofessional cooperation warranted. One state official wrote: “While the above questionnaire would indicate that there is mental health consultation and service available to the Division of Family Services in . . . , it is, in reality, woefully inadequate. The services provided are at best erratic and at worst non-existent. The services are confined to two or three metropolitan counties and practically non-existent in the rural areas.” Expressions of similar sentiments recur throughout the replies from many states. Frustration with the inadequate supply and quality of mental health services may have been one of the reasons why seven states refused to participate in the survey, in spite of repeated correspondence urging them to return the completed questionnaire.

The following data are excerpted from the survey, which will be reported in greater detail at a later date:

Cooperation between mental health agencies and welfare departments varied widely among the respondents. On the state level the focus was primarily on planning, development, and implementation of mental health programs involving welfare clients and staff. The contact was either formalized or on an informal basis, ranging from regularly scheduled weekly or monthly joint conferences to meetings set up for a specific purpose. Some respondents complained that there was no communication whatsoever. In

New York City an office of psychiatry is an integral part of the Department of Social Services, budgeted by the agency, and functions on the basis of a joint agreement with the mental health commissioner, who appoints the director. This office provides evaluation and consultation services to the Bureaus of Child Welfare, Public Assistance, and Special Services, all operating divisions of the Department of Social Services. It also furnishes psychological evaluation and consulting services to the Bureau of Child Welfare, participates in centrally and locally initiated staff development programs, promotes liaison with state, city, and voluntary mental health systems, administers the psychiatric Medicaid program, consults with the executive staff of the welfare agency, and participates in policy decisions, research, and evaluation activities. Such intensive integration of the services seems unique, but movement toward greater communication and collaboration between welfare departments and community mental health agencies was reported from several states. In one state, the continuing education committee of the local branch of the American Public Health Association served as a common platform for welfare and mental health professionals to meet and to air common problems. In other states, communications and agreements were restricted primarily to certain specific issues, such as arrangements concerning persons who were both welfare clients and patients in mental hospitals. Arrangements between local agencies often seem quite independent from relations at the state government level. On the county level

the focus is usually on service-related issues and on ways to upgrade and support the staff.

Five states claimed that they had no mental health consultations whatsoever. This reply may be due to a misunderstanding of the term. A sixth state, which also denied using consultations in general, reported in another section of the form that “consultation is obtained from mental health agencies in disability determination applications when there are symptoms of mental or emotional illnesses.” Obviously, recipients considered to be actual or potential mental patients are referred to psychiatric resources for diagnostic evaluation, although this procedure does not seem to be considered by some an act of professional collaboration.

About three-fourths of the responding state agencies indicated that they had individual or group consultation programs for their staff. Most frequently the consultations seemed client-centered, less often consultee-centered case consultations, and in only one-third of the states psychiatrists were invited to participate in administrative consultations. Five states reported that sensitivity groups were employed to improve staff relations. As indicated before, use of consultation was limited by the availability and accessibility of psychiatric resources. It varied considerably from region to region, even in the same state. Only sixteen state agencies reported the use of consultations as part of a regularly scheduled in-service training program in certain

districts. Programs varied in frequency from once-weekly conferences to occasional meetings once or twice a year or special events scheduled in connection with perceived needs.

The following problems were cited as common indications for the requesting of a mental health consultation: adult or child behavior disorders indicating the presence of a mental illness; acting out behavior; marital conflicts and family disruptions; special problems, such as drug addiction; teenage abortions; illegitimacy; alcoholism; disturbed mothers neglecting or abusing their children; planning for placement of children, mentally disturbed adults, and, especially, aged and helpless persons; determination of eligibility for special programs of financial assistance or vocational rehabilitation; management of families with serious problems, such as a mentally retarded or psychotic youngster; obtaining help in the finding of mental health professionals or other psychiatric resources for the agency's children; learning problems; child-parent problems; emergency problems; pre-care and after care planning; clients in conflict with the community; changes in mental health legislation; and implementation of new treatment modalities.

The mental health consultants (psychiatrists, psychologists, and psychiatric social workers, and very rarely nurses and vocational guidance counselors) were usually furnished by a public health or a mental health agency, funded by the government or by private funds, federally or locally

supported community mental health centers, outpatient clinics, family services and guidance clinics, state hospitals, psychiatric departments of general hospitals, and psychiatric training programs affiliated with a medical school or university. In some instances, welfare agencies employed private psychiatrists either on a part-time basis, on a contractual fee for service, or on a per diem basis. Only in rare instances were consultants directly employed by the welfare department. One funding resource for psychiatric manpower has been the Medicaid program (Title XIX).

The questionnaire permitted us also to gain an impression of the methods used by the welfare staff to identify emotionally and mentally disturbed clients and to serve them after proper evaluation.

Although almost all states seem to have some orientation program preparing the workers to recognize disturbed behavior, to determine the severity of the problem, and to initiate appropriate measures to deal with the problem, the level of orientation and continued in-service training seems to vary widely from state to state. All workers are taught some basic casework methods and learn how to elicit and evaluate historical information, how to review medical reports and recommendations, and how to use interpersonal relationships to stabilize disturbed clients and their families. In some departments much time is spent on teaching service workers how to provide emotional support by counseling as well as by concrete assistance, by group

casework, and by appropriate referral and placement if so indicated. Herrick's study of mental health problems in public assistance clients is an illustration of a high-quality in-service training effort and ought to be read by anyone who plans to consult with welfare workers.

The scarcity of mental health professionals, in general, and some reluctance to work with welfare clients and staff often force welfare workers to rely on their resourcefulness beyond their technical training. One respondent wrote: "Mental Health Professionals are limited in Idaho and consultation is limited both in quality and quantity. Because of the tremendous need, professionals tend to limit their time to the motivated client." One respondent from another state wrote that the staff members tried not to engage themselves in continuous treatment of the seriously disturbed client but time and again found they had to remain available and work with psychotic and even potentially dangerous patients until such time as a psychiatric resource could become involved in the management of the case.

The replies to the survey reflect the great need for support by the psychiatric professions and the frustrations of the welfare staff when relevant collaboration with mental health professionals is lacking. One agency reported that in its state the emphasis in mental health seemed to be on the psychoanalytic model, and "this does not meet the needs of our client population." The director of staff development from another state stated: "It

has been our observation of the approach of psychiatrists and social workers who have been involved in some in-service training that their approach is academically oriented and is not the job-related training that the local welfare department finds helpful, which subsequently leads to a breaking off of this kind of relationship.” Several informants reported on discontinued interprofessional programs even though they politely claimed that the service was “discontinued following the reorganization of our service program.”

Psychiatrists in Public Welfare

In view of the demonstrated need for psychiatric participation and the destructive consequences of disillusionment and discontinuation of interprofessional collaboration, the final section of this chapter will be devoted to a description of the various roles psychiatrists can assume within welfare systems.

The material presented in the foregoing sections of this chapter should make it obvious that any mental health professional wishing to function effectively within any part of a welfare system should prepare himself by expanding his traditional psychiatric expertise in several directions.

He must acquaint himself with the issues and conditions of poverty as they affect the life and the mental health of the poor, individually, in families, in communities, and in our society as a whole. He must learn about the

legislative background and the current practices of welfare, and he would benefit from acquaintance with the history and the values, means, and ends of public welfare.

1. He ought to be thoroughly familiar with the theory and practice of mental health consultation. This should preferably include the rationale and the techniques of conducting the various types of consultation, the strategy of building a relationship with a consultee institution, and the ways of developing a program suited to the specific needs of the agency. Langsley and Harris advocated, more than a decade ago, as most valuable preparation for such work, a supervised field experience in doing consultation with some agency during or after the psychiatric residency.

2. The mental health professional should refrain from plunging at once into activities even though he may be pressed for immediate intervention by some urgent problem of the agency. He should allocate some time for orientation in the agency in which he plans to function as clinician, consultant, or educator to become acquainted with specific conditions in the agency and to build rapport with his future consultees and colleagues. The reports of the experience of predecessors in the field cited in this chapter will prove invaluable as guides through the preparatory period.

3. Success or failure of a consultation program may ultimately be

determined by the care given to the preparation of the consultant.

4. Finally, after learning about the needs of his agency, the psychiatrist should select from the range of possible functions those most fitting to the agency and to his own qualifications. Broad psychiatric knowledge, competence gained in basic psychiatric skills in the intensive one to one relationship, sensitivity for psychodynamic processes, the ability to listen with the "third ear," acuity of observation, and tact in interpersonal relations remain invaluable and essential prerequisites of any psychiatrist in a public agency.

There are several options available to a psychiatrist who wishes to work within a welfare program. He may serve as a (1) clinician, (2) mental health consultant, (3) participant in staff development, (4) mental health educator, (5) clinical researcher and program evaluator, or (6) participant in a new careers program.

Clinicians

A psychiatrist may provide diagnostic services for a welfare agency to assist in the planning of a therapeutic program, in decisions on placement of clients to board and care homes or referral to psychiatric facilities, and in the determination of eligibility for certain financial assistance programs (for example, Aid to

Totally Disabled) or for special medical services. Some psychiatrists are directly employed, on a part-time or full-time basis, to evaluate and to decide on requests for authorization of psychiatric treatment or special supportive services. Diagnosticians are especially important in programs concerned with child welfare to determine the suitability of children and their prospective substitute parents for adoption or placement in foster homes, to evaluate degrees of mental fitness or retardation, and to diagnose possible psychotic conditions.

Under the provisions of Medicaid (Title XIX) a psychiatrist in private practice may be reimbursed for treatment of medically indigent persons with or without special authorization, dependent on local regulations. Legal interpretations of federal regulations depend on state and local conditions and are unfortunately subject to changes in political climate.

Therapists treating welfare recipients ought to be informed about the various medical, social, and supportive services to which their patient is entitled. To gain this knowledge and to obtain services for the patient, the welfare worker should be included in the total management. The problems of the poor can rarely be resolved by psychotherapy alone even if combined with drug therapy. These patients usually need concrete assistance, which a worker acting as a supplemental ego may provide. Many psychiatrists are, unfortunately, not aware how much more can be done for their patient and

his family if time is spent on communicating with the worker in a language free from technical terms and helpful to the worker to understand the client and his needs. In this communication, a psychiatrist's knowledge and experience with consultee-centered consultation are invaluable.

Mental Health Consultants

The various forms of consultations previously described represent the most important contribution a mental health consultant can make to the staff of a welfare agency. As a rule, he will be urged at first to conduct client-centered case consultations to help a caseworker and his supervisor with an immediate problem. If he is sensitive and knowledgeable, the focus will soon shift to the consultees, to the determination of the interference with the workers' objectivity to the clients, and to attempts to remedy this interference with workers' optimal work efficiency. If the consultant follows the recommendations of experts, defines his role carefully in advance, maintains good relations with the executives and administrators who must sanction his presence and with the line workers, supervisors, and middle management who must learn to trust and to accept him, he will most likely be retained by the agency for a long time. The more he is able to learn from and about the welfare personnel, the more helpful he will become, and the more likely that he will be invited to participate in administrative conferences, in program planning, and in discussions of policies. In this way psychiatrists

may be able to contribute toward the humanization of human services.

Participants in Staff Development

The better acquainted the psychiatrist becomes with the welfare system, the more valuable he will be as teacher in orientation and in-service programs. He may begin as a lecturer or seminar leader and progress to course consultant or training program consultant. If he has previously established good working relations with the agency staff as their mental health consultant, he may be given special credit by his audience, and he may overcome resistances in their mind which the uninitiated stranger may not be able to overcome.

In 1964 an intensive staff development effort was mounted, reported, and, subsequently, carefully researched and evaluated by the Los Angeles County Bureau of Public Assistance, which had to recruit large numbers of new social service staff to respond to the 1962 amendments of the Social Service Act. The program consisted of several parts. A nationally known sociologist, a psychoanalyst who was in fact the agency's own mental health consultant, and a highly experienced social work educator addressed almost 600 caseworkers and supervisors of all degrees of experience and sophistication in general sessions on the nature of the "normal family," on the "unique opportunity of workers to help people in crisis," and on the "social

needs of the welfare family, respectively." These lectures were followed by intensive orientation workshops for workshop leaders and resource personnel, and, subsequently, all participants met in weekly intervals in four two-hour small discussion groups. The project was evaluated by a carefully designed research effort that revealed that workers with longer experience at the agency, even if they were formally untrained, were the most receptive to the learning of mental health concepts. They were able to attend to the needs of their clients for service because they were not so distracted by the handling of routine aspects of their assignment as less experienced workers. The presentation of the psychiatrist was the most popular. It was substantially more often designated as "pitched just right" because the workers appreciated "that the psychiatrist recognized the difficulty and the importance of the public assistance jobs and articulated their mental health components." Most likely, the psychiatrist was so well accepted because he had established the image of a supportive helper in his role as a mental health consultant.

Every teacher of welfare workers experiences the tremendous eagerness of the staff to learn. Partly this zeal is based on guilt and on the almost unrealistic hope that more education will enable the workers to help their clients with their enormous and overwhelming problems. Even though it is most questionable that seminars and lectures have a lasting and improving effect on the workers' skills and knowledge, traditional

educational methods are highly popular with agency staff. It seems, however, that well-conducted consultations with small groups, because of their personal immediacy and relevance, are a far more effective means of education.

Mental Health Educators

The psychiatrist who works in a public welfare agency has excellent opportunities to broaden his experience and knowledge on human problems, especially as they concern the disadvantaged. As he absorbs this knowledge and thinks through his experience, he becomes uniquely qualified to bring his understanding to the attention of his colleagues. He can contribute to an improvement in the communication between the psychiatric and the welfare professionals and build respect for the dedicated efforts of the often misunderstood and much maligned agency staff. He may even reduce some of the widespread misinformation and the simplistic thinking concerning welfare policies and welfare practices in the population at large. Even though the physician’s public image may be somewhat tarnished, he commands the respect of the public, and he may do a great deal toward the correction of erroneous impressions by presenting, in fairness, the serious and involved problems of poverty and the efforts toward its relief.

Clinical Researchers and Program Evaluators

Even though large sums of money are spent on public welfare, only insignificant amounts are allotted to research, in spite of its potentially great importance for public policies and programs. The opportunities of studying relations between impoverishment, powerlessness, and mental impairment, the psychodynamics of the helping process and its potentially destructive influence on recipients and their families are endless. Much clinical and social research is necessary to determine the importance of work and activities for the mental health of individuals. Also, we have no answers as to which approaches are best for the stimulation of motivation and independence in a society in which individual fate and life style are increasingly determined by super-systems beyond the control of single persons. New conceptualizations, perhaps supplied by the recent interest in systems theory, are required to permit evaluation of schemes proposed to alleviate poverty and their implications on the quality of life in communities and on the total fabric of our social institutions. In these endeavors, the interests of man ought to be also represented by the psychiatric expert.

Participants in New Career Programs

One of the most promising and innovative developments that has emerged from the war on poverty and that aims at the improvement of mental health services for the disadvantaged is the so-called new careers movement. Essentially, this is the recruitment, training, and employment of

people of disadvantaged background to provide human services for their neighbors or others with similar problems and life experience. The innovative core of the new careers effort is the challenge to traditional mental health professionals to learn from this new source of human service manpower how services can be rendered more relevant and effective by changes in techniques and strategies of service delivery. In this endeavor, help can also be expected from newly formed recipient organizations, such as the Welfare Rights Organization. It would transgress the frame of this chapter to elucidate the many and complex aspects of new careers. One of the exciting realizations issuing from the program was the discovery that the helper is the first to benefit from his being given the opportunity to help others. The new careers program may thus serve simultaneously a number of problems: improvement of human services, rehabilitation of a large number of people of disadvantaged background, employment of unemployed or underemployed people in occupations from which they are unlikely to be phased out by technological progress, opening the door for large segments of population hitherto excluded from education and upward mobility, and initiating new thinking on social and mental health services.

An increasing number of welfare systems are beginning to integrate new careers into their organizations. Progress is slow because it arouses much resistance from administrative and professional quarters by challenging the status quo of service delivery and professional prerogatives.

But the development seems inevitable, and fortunately so. Mental health professionals have been among pioneers and ardent advocates of new careers programs as participants in program planning, educators, collaborators, and providers of back-up services. While psychiatrists have experienced that involvement in innovative and still controversial areas can at times bring them pain and frustration, it is completely in the tradition of the profession to espouse causes in conflict with the established order on behalf of suffering man.

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