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Increasing urbanization is bringing greater attention to the super-community, or metropolis, as a locale for the delivery of mental health services. Social scientists have for some time been describing the unique alienating and dehumanizing aspects of life in the metropolis, so that it is becoming increasingly evident that large urban areas of high population density differ qualitatively as well as quantitatively from smaller communities. With an increased awareness of the ecological aspects of community living, the stress-producing effects of the community itself are becoming more evident.

The choice that seems to be available in the organization of metropolitan mental health services must inevitably reflect a basic choice in program philosophy: Is the metropolitan mental health program to be organized solely for the purpose of treating large numbers of patients, or is it intended to affect adverse living conditions in the metropolis? A public psychiatry program can be developed to develop and organize a proliferation of local treatment facilities for the mentally ill, or a community mental health program can be designed to make an impact on the psychiatric casualty-producing stresses of the community, as well as to treat and rehabilitate the casualties that do occur. The latter approach implies that the human living

condition in the metropolis requires sufficient study and description so that both its casualty-producing and health-supporting potentials cannot only be identified but usefully employed in the mental health program.

Alternatives for an Organizational Framework

If a program in a metropolis (or any other community for that matter) that limits itself to treatment of the poor alone is desired, its organizational framework is basically uncomplicated. Its characteristics will be those of a line health service delivery organization consisting of a collection of treatment and supervisory personnel, whose number and distribution will vary with the direct versus indirect responsibilities of the mental health program itself for the clinical treatment of identified patients. Its role in the community is essentially as a patient-processing system, dependent on public funding and community support. Its success can be measured in terms of numbers of patients treated, compared with those treated in state hospitals. A developmental end point of such a system is never contemplated in its design: Its role is to recruit psychiatric patients and to restore them to acceptable social functioning. Its sources of referrals can be almost limitless, since distress and emotional symptomatology are experienced by virtually all the social casualties of a community. Indeed, treating emotionally troubled deviant people as patients may be the most humane management available to them if their experiences as welfare cases, probationers, school deviants, and

members of other community care-giving client groups are essentially dehumanizing.

Some metropolitan mental health programs have developed storefront and other similar service outposts in poverty neighborhoods, which attempt to venture beyond psychiatric services. Assistance in securing employment, welfare benefits, and other humane services is rendered directly and indirectly via indigenous aides to local residents, based on the mental health agency's conviction that other public agencies are unresponsive to the needs of their disadvantaged clients.

On the other hand, the organization of metropolitan mental health services that contemplate an impact on the community itself as well as on its casualties is much more complex, as it is necessarily closely articulated with the social framework of the community itself. In order to be effective, it must be intertwined with the network of stress-relieving social institutions in such a way as to nurture their effectiveness while standing ready to drain off the casualties that they are unable to effectively manage. Rather than serving as a connecting link between other social, health, and welfare agencies and their clients, assistance is rendered to personnel of these agencies to help them respond more effectively to their clients' needs.

Assuming that the choice of a broad community-oriented program is

made, there are several key considerations in the organization of public mental health services in a metropolis. These include program ideology, community analysis and planning, program goals and policies, and organizational patterns.

Program Ideology

The ideological orientation of a community mental health system is seldom specified, yet it is always implicit in any program. Sociological perspective informs us that, humanitarian motives aside, mental health programs are sanctioned in the community because they are fundamentally agencies of social control. Their role in the community is supported with the implicit assumption that they will identify those individuals who are peculiarly disruptive to smooth societal functioning and will assign these individuals the role of psychiatric illness. This officially sanctioned social role certification allows them to be relieved of many normative social expectations, either temporarily or permanently, dependent on diagnostic assessments relating to chronicity. As social control agents, mental health agencies are also expected to resocialize deviant people in such a way as to return them to non-disruptive social functioning whenever possible.

Imbedded in the social control function of a mental health program is the expectation that it will reflect and support the prevailing mores and social

and cultural values of the community itself. Yet it is characteristic of large urban communities that efforts at social change, often violently confrontative of the status quo, are rampant. Epidemiological studies have indicated that admission rates to psychiatric inpatient services are highest in areas of socioeconomic distress. If those working for social change wish to ameliorate socioeconomic distress, the socially sensitive mental health organization must obviously articulate itself with these groups as well as with those that certify and support its primary social control function.

An ideological principle of rehumanization can underlie an urban community mental health service that wishes to retain its vital effectiveness in a changing social ecology. Organizational survival can probably be achieved by striking the necessarily fine balance between social control and social change. A humanistically oriented community mental health system can attempt to combat dehumanization by supporting the health-sustaining systems of the community. This may be accomplished by reducing through mental health education, consultation, and immediate clinical response in crises, the adverse effects of those casualty-producing systems that often paradoxically increase rather than reduce the bemused urbanite's experience of alienation and dehumanization. The Los Angeles County metropolitan mental health program is designed with this emphasis, but little formal research has been accomplished to prove the effectiveness of this approach. A relatively minor but possibly significant finding in Los Angeles County has

been that lessened personnel turnover of social caseworkers occurs in neighborhood welfare offices that have received regular community mental health consultation. If a higher level of job satisfaction is experienced by welfare caseworkers, it is probably safe to conclude that their impact on clients may be less dehumanizing.

Community Analysis and Planning

It is difficult to visualize a socially oriented mental health program that is not built on a foundation of basic socioeconomic and cultural data about the urban area to be served. Community analysis requires study and description of the sociopolitical and cultural attitudes of a community toward mental illness and mental health, as well as attitudes toward other public programs serving the less fortunate. Awareness of these aspects of the community's sociocultural climate will allow mental health planners to introduce their programs with the appropriate mixture of traditional public psychiatry and innovative, less conservative community-oriented activity. Geographical factors, such as natural neighborhood and community clustering and patterns of traffic flow, especially between home and work or home and shopping, along with other similar data, are obviously essential to the geographical placement of service delivery facilities. Socioeconomic residential patterns must be understood if a metropolitan mental health planner is to pinpoint areas of de facto segregation and other aspects of ghettoization. Patterns of

mobility must also be understood: Recipients of public services in New York City utilize public transportation, primarily, while in Los Angeles County, the automobile prevails as the major transportation modality, even for the poor. These demographic data must be utilized in the development of geographic service areas, and decisions that determine populations to be served by facilities must reflect natural community groupings. Unfortunately, the federal community mental health centers program has enforced an arbitrary range of population to be served by federally funded comprehensive mental health centers, which, in Los Angeles County, as in several other large urban communities, has forced local mental health planners either to fit their understanding of natural community groupings into a Procrustean catchment area bed, or to decide against optimum use of the federal program in their communities.

Community analysis must also include data on customary methods of dealing with mental and emotional illness not only in traditional local and state facilities but in public social systems, such as the schools, public health and welfare agencies, and law enforcement and correctional systems. These data are essential if the urban mental health program is to relate itself supportively to community caregiver services. Finally, community analysis must include a complete assessment of existing mental health and non-mental health resources, potential as well as actual.

The possibilities for further development and deployment of mental health resources can only be realized through a basically political analysis of the community's mental health constituencies. Among the questions to be explored are: Which groups are pressing for mental health programs and which are opposed? What are the patterns of demand for services? Are community demands primarily outpatient in nature? Which groups are interested in supporting living-working arrangements in the community for chronically mentally ill patients, and can they be mobilized to counteract the inevitable resistances to such a program? What are the attitudes of organized medical and other professional groups? What can be expected of local government executive and legislative officials in terms of willingness to fund mental health services? This type of community analysis must not stop after the initial phases of program planning. In order to guarantee the continued relevance of the mental health program to changing community pressures and needs, it can be maintained in the form of community liaison or advisory groups. These groups can serve as two-way communication channels between the program and appropriate elements of the community including consumers, providers, and other beneficiaries of the program. Such an activity, of course, not only gathers information from the community regarding problems and needs but also serves as a channel for general mental health education, as well as for generation and maintenance of a political constituency for the mental health program itself.

When a community organization and planning function has been established, planning for actual mental health services has already seriously begun. Planning must be collaborative to be effective, with each major constituency of the mental health system—professional, provider, and consumer—actively contributing its perspectives to the total mental health plan. The nature of the interest in mental health services will, of course, vary with the constituency. For example, private sector providers will often seek the fullest possible flow of tax funds into their own programs and may strongly oppose new programs utilizing public agency personnel that they may regard as competitive. Particularly large and influential public agencies, such as public health departments or courts, may wish to divert a maximum of mental health program funding to specialized services that relate to their own primary functions. The task of evolving a program that balances perceived needs with often strident demands while still reflecting a definite program philosophy is often the most difficult one in the organizing of mental health services in a large metropolitan area.

Program Goals

Following the initial stages of community analysis and organization, organization of services can best be built on a statement of program goals. The goals set for the program can be useful in the establishment of program budgeting, particularly as this form of fiscal planning continues to supplant

the older type of line-item budgeting. Also a statement of expressed goals can serve as an acknowledged point' of reference for the evaluation of the entire program. Organizational goals can be developed in relation to prevention, indirect services, and direct services in a metropolitan mental health program. They should be a product of considerable discussion between professional staff people and the major mental health constituencies of the community and should reflect an amalgam of staff philosophy and professional concepts with the input of community constituencies. These in turn are to be juxtaposed with legislative and executive policy mandates within which all public programs must function.

An overall goal for the metropolitan mental health program is difficult to express in terms of mental health or mental illness alone. Given the universality of personal psychopathology, an individual's state of mental health is a relative rather than absolute phenomenon. Experienced clinicians recognize that absolute cure of mental illness is an ideal seldom actually attained. Similarly, absolute and complete mental health as the total absence of psychopathological symptomatology can never be completely attained. Realistically, the goal of any mental health effort, including the activities of individual clinical practitioners, is the reduction of social handicap resulting from psychopathology. Ultimately, the relative state of the individual's mental health or illness is the resultant of a number of factors: Basic personality, including such factors as ego strength and character differences, biological life

strengths and stresses, and supports and stresses arising from the individual's experiences with his social milieu, including family, friends, work associates and other social factors. Since mental health services are sanctioned and supported as social control functions, it is ultimately the phenomenon of social handicap resulting from psychopathology to which they are addressed. Social handicap resulting from psychopathology obviously includes relative freedom from symptomatology. It also includes what is generally understood as successful coping behavior, signifying the individual's ability to live in reasonable equilibrium with his physical and social environment. Freud's definition of mental health—*"lieben und arbeiten"* ("to be able to love and to be able to work")—broadly understood, might be a useful criterion for absence of social handicap. Translating this perspective into the identification of goals for a mental health program, it is convenient to utilize the concept of social handicap as a phenomenon to which the entire mental health program is remedially addressed. Reduction of social handicap, therefore, can be a realistic overall goal for a metropolitan mental health program.

The overall goal of social handicap reduction can then be subdivided into a series of subgoals relating to primary prevention, indirect (community) services, and direct (clinical) services. The array of primary prevention services of a metropolitan mental health program can be designed to meet an overall goal of prevention of social handicap by two types of activities: those

with a goal of development of a healthy society and those with a goal of helping make individuals symptom free. The development of a healthy society requires activities aiming at the elimination of disease, social alienation, crime, and discrimination from the community. Such activities can be carried on by mental health personnel by collaborative and consultative work with other life-supporting agencies and programs, such as health, human relations, probation, schools, and churches.

The subgoal of individual symptom reduction can be the aim of activities designed to increase knowledge among the general population concerning ways to anticipate and prevent personal crisis. This subgoal can also be the motive for promoting acceptance in the community of social and behavioral differences, including acceptance of persons who have had mental treatment and those who differ in life styles and ethnic status. Much of this activity can be carried out through the development of public information and education programs designed to reach the total population.

The reduction of social handicap is an overall goal for indirect or community services as well. A keystone of a metropolitan mental health program's preventive services that can be related to such a goal is the principle of preventing clients in other care-giving agencies, such as schools and health and welfare agencies, from becoming mental patients. Indirect services, chiefly mental health consultation, can be developed as a means of

increasing the competence of other community care-givers to deal with the emotional problems of their clients, problems which produce, or at least aggravate, social handicap. Other related indirect services, such as mental health education, professional graduate and postgraduate training, program stimulation, and community organization can all be planned and evaluated in terms of meeting the goal of reduction of social handicap.

Assuming an optimum development of primarily preventive and indirect services, clinical services in a mental health program can also be related to reduction of the level of social handicap in the community. A focus on the living unit as the prime supportive (or noxious) social matrix for the patient suggests subgoals of clinical programs that displace individuals as little as possible from the living unit, and that indeed view the living unit as the basic unit of clinical intervention. Certain distinct principles of clinical program development logically follow such basic goals. These principles include the early establishment of practical service areas for clinical units equipped to carry full treatment responsibilities for their areas,, with emphasis on broad coverage by utilization, wherever possible, of crisis intervention and brief treatment approaches. Immediate professional attention to, and disposition of, all treatment requests, as well as serious responsibility for continuity of care will assure minimal displacement of the individual from his immediate social matrix. This implies attention to a patient referral tracking system to coordinate and plan patient movement

between service elements within an area, including the provision of humane transportation, where necessary, for patients who must be transferred within the complex of service units.

An important program implication of the overall goal of reduction of social handicap is the avoidance of chronicity. This would imply a narrowing of indicators for hospitalization, an emphasis on alternatives to inpatient treatment, and a minimization of holding functions of inpatient services, including the regrettable practice by some teaching centers of conducting psychiatric museums by holding patients on wards based on their suitability as teaching material for a succession of psychiatric residents and other trainees.

Program Policies

Following agreement on goals, a further definition and basic statement of program-wide policies should be developed to guide the organization of services and to serve as a formal statement of organizational principles that can be discussed, supported, challenged, or modified as needed. Key organizational questions that need to be resolved in such a policy statement include (1) the role of constituency input in the development of programs, (2) the relative role of preventive services, (3) the relationship of the public mental health system to other mental health and generic services, (4) the

outlines of a plan for planning, (5) delineation of the role of central office services versus those carried out in decentralized offices, (6) the principle of districting of services to be followed, (7) the principles to be applied in the assignment of professional staff to various duties, (8) the nature of the working relationship between private and public mental health resources as they develop in the metropolis, and (9) policies on special community problems such as drug abuse, alcoholism, and mental retardation.

In the development of the public mental health program of the Los Angeles County metropolis, a series of policy statements have evolved which are designed to govern mental health department activities related to overall program, planning, the organization and delivery of services, and interagency relationships. All these policy statements are related to the overall goals described earlier.

Policy statements governing new program development begin with the requirement that new programs must derive from identified community needs, resources, and citizen input, that they must provide for the maximum use of existing mental health and other services supportive of healthy social functioning, as well as maximum use of all existing sources of private and federal funds as well as state and county funds. In addition, new programs must maintain a balance among prevention, direct treatment efforts, and innovative approaches, in order to continue to develop a mental health

service delivery pattern that regards community organization, mental health education, and mental health consultation as the foundations on which clinical services are to be provided. New programs are to be so structured as to allow for the use of the original referral of a potential patient as an opportunity for mental health education and consultation activity, wherever appropriate, as a desirable alternative to acceptance of the referred person into the client-hood ranks of the mental health system. Further statements emphasizing flexibility in hours and service response, ready availability of service, such as the absence of waiting lists, and the acknowledgment of responsibility of continuity of care are essential elements of a program development policy.

The matter of continuity of care deserves additional emphasis in the development and administration of community mental health programs in a metropolis. Agency professionals, faced with a multiplicity of demands for direct service, as well as other demands, will often make referrals of patients to other components of the mental health system, or to other care-giving resources, with little or no attempt to confirm the successful completion of their referrals. As a result, many patients fall between the planks of the system and experience exacerbation of their illness, which a responsible completion of the referral might have prevented. In order to obviate such discontinuity, the program must articulate a basic philosophy of responsibility for continuity of care. In Los Angeles County, this philosophy is

only now being adequately developed and expressed. What is evolving is the concept of a human contract with a potential consumer as soon as he becomes a patient. An individual making a clinical contact at any point in the system is regarded as entering into a contract with all of the system, and such a contract binds the system to an agreement of responsibility for his clinical care until such time as he is officially discharged as a patient or formally terminates his contract with the system. In order to implement such a philosophy, a patient tracking system is being designed that will provide up-to-date information on patient careers from the time of entry into the system until the time of discharge.

Policies governing planning activities call for participation by the widest possible range of citizens and special interest groups, utilization of all appropriate existing mental health and allied planning resources, sensitivity to local needs, and application of a variety of sources of knowledge about the community, its needs, and potential remedial programs. A continued planning dialogue between the mental health agency and the citizens of the community is mandated, including the widest feasible dissemination of the evolving annual plan in each major stage of its development. This reflects a legal requirement in California that each local mental health program prepare an annual plan for mental health services, as well as an annually updated five-year plan, which must receive endorsement by the official citizens advisory group as well as approval by the elected local government officials. An

important feature of an official plan is the clearest possible statement of departmental and local government policies that has been evolved, or is being proposed, to achieve clearly stated departmental goals. Furthermore, specific activities and programs designed to implement policies and goals must be included in the plan.

A series of policy statements relating to the organization and delivery of services is also an essential feature of the development of a metropolitan mental health system. In the Los Angeles County program, policies emphasizing the decentralization of mental health services on the basis of mental health service regions have been established. The boundaries of these regions are based on generally recognized communities and neighborhoods. The exact placement of these borders conforms to the requirement that they follow census tract boundaries, so that up-to-date demographic information can be used in both the planning and evaluation of mental health services. In other communities, it may be preferable to use other demographic building blocks, such as postal zones, as basic units for the establishment of service areas. Departmental policies also include a provision that the quantity and type of each service delivered will depend on the characteristics of the patients served and the resources of each region, but that each region shall provide for a basic combination of services, which include community organization, mental health education, other preventive services, and treatment services. Furthermore, the delivery of services is required to be

prompt, definitive, and comprehensive, minimizing impairment of function and displacement from the normal social milieu as well as ensuring continuity of clinical care. A further policy requirement is that all regional service professional staff shall, if possible, become competent to deliver all the services rendered. This provides for the widest exposure of clinicians to the entire spectrum of community mental health activity and tends to encourage the development of a unique community mental health professional identity.

A final series of policy statements concern the matter of interagency relationships. This is essential in view of the fact that the Los Angeles County mental health system attempts as much as possible to avoid the role of primary care-giving system in favor of riding on the shoulders of an enriched generic care-giving network. For this reason, the department is encouraged to take the necessary actions to support and encourage the development of the entire spectrum of personal services outside the mental health system, while integrating mental health services with the other systems. An essential part of such function is the identification of obstacles to the delivery of personal health, welfare, and educational services, the formulation of suggestions for the removal of obstacles, and the adoption of measures aimed at other public and private agencies that would contribute to the overall betterment of personal services of which mental health services are an integral part.

Organizational Pattern

The actual organizational pattern of services must, of course, vary with the community and its possibilities for organizational expression of program goals and policies. In some communities, mental health services may be provided as part of a total public health services system. The advantage of such an approach is that the mental health system can be integrated with a hopefully well-established health services system, complete with community roots and a viable organizational structure. The major disadvantage of developing mental health as part of a health services system is the possibility that mental health services will tend to be too narrowly regarded as a branch of public medicine without sufficient flexibility to attempt innovative programs that, for example, may relate themselves more closely to public welfare, educational, or law enforcement agencies in the community. Also, mental health as a department of general health services may be forced to compete as if it were just another medical specialty, rather than a system for prevention or care of that most widespread form of personal disability which we define as emotional.

A separate public mental health agency can be established, with the advantage of greater visibility, greater potential flexibility, and greater opportunity to compete independently for public support. A separate mental health program is also better able to establish a network of working relationships with public programs outside of the traditional health system. An often-voiced disadvantage of the separate mental health system is an

alleged tendency to divorce itself from other health services. Such a point would be considered debatable by those who consider the medical model in mental health programs more of a useful metaphor than an actual reflection of the existence of disease entities known as mental illness.

Perhaps one of the most important decisions to be made in the organization of mental health services in a metropolis relates to the problem of districting. It is widely acknowledged that workers in public agencies spend most of their hours in the care of multiproblem families. In the average urban community, the alienating and dehumanizing effects of public agency contacts with their clients are most often worsened by the fact that there is little or no communication among caseworkers and other caregivers working with the multiproblem family. Typically, such a family may have a spouse in the caseload of a probation department, another spouse in the caseload of the welfare department, and children in the caseloads of mental health, public health, employment, adoption, and a variety of other agencies. Typically, each of these agencies follows its own form of districting, rendering impossible the cooperative discussion of common caseloads. It would be well for the new mental health system to avoid adding to the existing confusion by setting up its own idiosyncratic districting grid. A better approach would be to examine all existing districting schemes already operative in the community and to attempt to gear itself to that districting scheme best related to its own mission. In the Los Angeles County metropolis, for example, the public mental

health department chose to adopt the districting scheme of the public health department, among more than 100 separate existing districting patterns. Two reasons appeared paramount in this decision: (1) the anticipated close working relationship with public health services (although this is equally true of public welfare services, for example); (2) epidemiological research being facilitated by the fact that health department districting was based on census tracts as basic building blocks.

After deciding such matters as program goals and districting, organization of services is best set up in a metropolitan area with a maximum of decentralization possibilities. This assures flexibility in the program at the local neighborhood level, especially if relative autonomy is given to professional program people and if opportunities are provided for effective constituency input into the planning and development of services.

The actual mix of preventive and clinical services to be developed in each district will reflect perceived needs expressed through community liaison groups, and hopefully monitored by a well-staffed research and evaluation team, and the convictions of professional planners and administrators as to how new services should develop. One alternative in the design of programs is to assume the necessity for a complete range of services for each population group of a certain number or area and, depending on resources available, to go about establishing services on that basis. This is

essentially the organizational principle embodied in the federal comprehensive mental health centers program.

Another approach is to start in a neighborhood with a basic core group of mental health professionals who carry out their services by beginning with community analysis and community organization. This is followed by the establishment of a significant amount of mental health education and consultation to community caregivers backed up by limited crisis-oriented outpatient services. Following these beginnings, and dependent on a continued monitoring of community needs, additional service components can be added so that eventually a comprehensive mental health service network is achieved. One of the advantages of this more gradual approach is that it allows for the maximum reinforcement of community potential to manage emotional problems short of referral to the mental health system itself. It also makes it possible to fully develop alternatives to inpatient care, such as outpatient and partial hospitalization services, when psychiatric beds are in very short supply in the immediate neighborhood.

In view of limited resources, the organization of mental health services in a metropolis must make the fullest possible use of private mental health facilities and personnel, as well as those in the public sector. The relationship of the public to the private sector, however, must be carefully planned and developed. In some urban communities it has been characteristic of the

combined private and public system for certain private facilities with large hospital services to tend to keep their beds filled by the active recruitment of patients in their districts. This may actually reflect a fundamental economic necessity rather than limitations of program philosophy on the part of professional staff in those institutions. Nevertheless, the public agency, for reasons not only of fiscal economy (bed services are the most expensive) but also of humanitarianism (chronicity must be prevented where possible), must bend its efforts to enforce some sort of hierarchical system of services in which inpatient services are utilized only if alternatives to hospitalization are not applicable to a patient's needs. One of the ways in which this can be accomplished is to retain for the public agency the function of gatekeeper for the total system. This implies that the public agency either actually serves as the sole referral resource for patients to be served by contract facilities in the private sector or develops a thorough, but practical means of monitoring and supervising actual clinical services being delivered to public patients in private facilities. This task is extremely difficult to perform since it is often characteristic of private agencies in some metropolitan areas to exert political pressure on the public mental health agency whenever the latter attempts to limit, for whatever reason, the freest possible flow of public funds into the contracting facilities.

Informing Qualities of the System

Last of all, some attention must be paid to what has been referred to as the "informing" qualities of the mental health system. These are the sometimes hazily defined flavoring qualities of the program that distinguish it from other public programs in the community. The community philosophy that "informs" a mental health program may be an important factor in attracting young and idealistic mental health professionals for whose services many other agencies and situations may be competing. Some of these informing ingredients include the reputation of the program for interest in problems of youth, racial tensions, social change experimentation, innovation, and serious evaluation and research. A specific informing ingredient would be the nature and extent of citizen and consumer, as well as provider, participation in critical program decisions. On the other hand, informing qualities of conservatism, limited program goals, and social control emphasis may prevail, in which the mental health program stolidly assumes a community role reinforcing the status quo by implicitly re-acculturating its clients into sociopolitical conformity. A program can also be enriched or deprived by the presence or absence of political sophistication, creativity, and last, but not least, its role as a humanizing or dehumanizing force in the metropolis.

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