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Perspectives on Delivery of Mental Health Services

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PERSPECTIVES ON DELIVERY OF MENTAL HEALTH SERVICES

The secret of the care of the patient is in caring for the patient [pp. 65-66]

To speak of the future delivery of mental health services at this point in our history is fraught with risks and uncertainties. During the past quarter of a century the face of American psychiatry has changed dramatically—reflecting a heightened awareness and concern for those with emotional problems—from the use of the custodial institution as the primary model to the development of community-based facilities, such as community mental health centers, psychiatric units in general hospitals, consultation and education programs in schools, courts, social agencies, etc., and, where possible, increased emphasis on preventive programs to the extent that our current knowledge permits.

As a result of these developments, it is generally agreed that great strides have been made in the past decade in providing better quality care more quickly and effectively. But these very achievements have brought about an interesting dilemma: because the success of such programming is acknowledged by policy-decision makers, federal support at appropriate levels to ensure continued success is being withdrawn.

Also, during this period of time, innovative new training methods have been developed to equip mental health personnel for the delivery of direct

and indirect services, their planning and evaluation, and new modalities of treatment have been evolved. The impact of the community mental health center movement has been felt in all sectors of the psychiatric profession, both public and private. Yet, as is known to all, federal support for training young psychiatrists and other mental health professionals is being rescinded. This poses another dilemma: the future loss of adequately trained manpower to implement new programs and of research scientists to evaluate and refine programs.

A fact of life, which has been recognized by many of us for some time, is now coming into sharp focus. Decisions regarding health and mental health policies and programs are being made on the political level. There is insufficient input to this process from mental health professionals at all levels, federal, state, or local. The fault lies not only with the policy makers who do not seek out such input, but with the professionals who are reticent to involve themselves at this level. This stems, in part, from their lack of awareness and thus they are unwilling to become involved in the development of policy in health or mental health matters. As will be described in a subsequent section of this chapter, there is an opportunity for professional input to help determine the future patterns of delivery of health and mental health care in this country.

This chapter is divided into three sections. The first deals with the

historical development of health and mental health care in this country, highlighting some of the problems, dilemmas, mistakes, progress, and conflicts. This is done in an effort to make us aware that some of the difficulties we are facing today have their roots in the past, for as George Santayana tells us in *The Life of Reason,* "those who cannot remember the past are condemned to repeat it." The second section deals with current trends in the development of health care delivery systems, emphasizing mental health care; information regarding recent amendments to the Social Security Act, i.e., the development of Professional Standards Review Organization (PSRO) legislation and its implications for comprehensive mental health care delivery. The third section is a futuristic look at the delivery of mental health services. This last section must be viewed in a hypothetical and theoretical framework since, while patterns of delivery of health care will be drastically changed within the next few years, the parameters of such change are as yet not clearly defined. Nevertheless and despite the uncertainties, we must look to the future in a positive way, drawing on past experiences and errors we have made, taking from other disciplines those techniques that will improve the delivery of quality care without sacrificing effectiveness for efficiency, and without abrogating our responsibilities in policy formulation and decision-making to those whose primary orientation is that of fiscal accountability. This statement has implications for changes in the basic training of young physicians to better acquaint them with the broader social and political

elements of health care delivery without in any way interfering with the sound, clinical training that is the bulwark of the effective practice of medicine.

Historical Perspectives

It can be generally agreed today that effective and meaningful delivery of mental health services has as its fundamental aim the successful dealing with mental illness through treatment, rehabilitation, and prevention. The history of our profession is the history of the search for ways in which to do this. This search has taken us from a time, approximately 150 years ago when there was no treatment, to the recent surgency of the community mental health movement. The period between was characterized by important breakthroughs, dramatic changes, periods of progress (some illusory), periods of stagnation, recognition of failures, and renewed attempts to find still other ways of dealing with the problem of mental illness. As we have moved from step to step there have been efforts at assessment, consolidation, and synthesis. During that time we have seen impressive changes in the objectives, philosophy, and methodology for dealing with mental illness. Contributing to these changes have been scientific discoveries, new understandings, pragmatic responses to necessity, but also a change in our national awareness of prevalence and needs, and an evolution toward a national philosophy of social responsibility.

Today, once again, we are becoming aware that our present delivery system is not adequately solving the problems. Rising costs have become an overwhelming concern and there are discernible trends toward a shift in our national philosophy. It becomes imperative that we try to assess our present system; evaluate our successes and our failures; learn from our failures; affirm our successes, and re-chart the course for the future. In doing so, it is useful to examine the events and forces, somewhat parallel, that have played a part in the emergence of our nation and the traits that have shaped it, along with the developments in our ways of caring for the mentally ill.

As our nation developed from early frontier days with a stress on individualism to our present complex urbanized society, there has been a growing recognition of the need for cooperation and coordination as well as an increasingly strong sense of interdependence.

In dealing with the mentally ill, as a nation and as a profession, we have come a long way from the days when the mentally ill were kept in jails or county poorhouses—when the objective was primarily to remove from society those whose behavior was considered troublesome and irresponsible —to our present objective of helping the mental patient return to society as a functioning member. Our philosophy of care has developed from custodial and punitive approaches through moral treatment to our present recognition that the mental patient is a person with rights, a person who can and should

be helped. Along the way new modalities of treatment have evolved—such as concepts of milieu therapy, crisis intervention, discovery of the use of psychotropic drugs as adjuncts to treatment—that have had enormous impact on bringing about these changes.

Important milestones were passed along the way; we learned from pioneering and crusading efforts of those who led the fight for better care, and in some of our national experiences and times of crises we found other guideposts to our present system of service delivery. The efforts of Dorothea Dix focused attention on the plight of the mentally ill and the squalid and inhuman conditions to which they were subjected. She persuaded us that it was the responsibility of the state to care for the mentally ill and this led in large part to the establishment of the state hospital system. But as our population grew and more and more of the mentally ill were consigned to this system, it became apparent that more needed to be done, for we were still adhering to our early objective of putting away and out of sight those among us who were suffering from mental disorders. A significant contribution to our shift in philosophy and objectives for service to the mentally ill was the delineation of basic concepts underlying our present efforts by Adolf Meyer in 1913 when he stated that "the characteristic traits of a clinic for mental diseases should be first, service to the patient rather than to the administrative system; second, elaboration of the study of the diseases rather than the means of wholesale handling of patients; third, possibilities of following up

the studies of nature's experiments beyond the hospital period, and preventive work through extramural efforts outside the hospital." It is of the utmost importance, he believed to ". . . make possible studies of the social situation and of the dynamic factors which lead to the occurrence of mental derangement, which must be attacked for purposes of prevention." In the years that followed there was increasing recognition of social factors as causation in mental disorders and the experiences of the two world wars brought a national awareness of the high incidence of mental illness and psychiatric casualties in our nation. Efforts to deal with this led to the passage of the National Mental Health Act in 1946 and the beginning of federal government involvement in the mental health movement. Lessons learned in World War II were applied during the Korean War when major psychiatric resources were deployed in the field for fast and appropriate treatment, enabling the return of greatly increased numbers to duty and reducing those having to return to general hospitals for ultimate discharge. The proven efficacy of this new modality of treatment began to be widely applied in two types of treatment facilities that began to be widely established in communities throughout the country during the 1940s: outpatient clinics for treatment of the mentally ill and psychiatric units in general hospitals for inpatient and intensive treatment of mental disorders. The concept of community based psychiatry began to take hold and by the early 1950s the idea of community mental health centers was defined. In 1955, Congress

passed the Mental Health Study Act, which directed the setting up of the Joint Commission on Mental Illness and Health to "analyze and evaluate the needs and resources of the mentally ill in the United States and to make recommendations for a national mental health program." The findings of the Joint Commission and its recommendations led in 1963 to the first Presidential message ever on behalf of the mental health movement in which a "new type of health facility" was called for that "would return mental health care to the mainstream of American medicine, and at the same time upgrade mental health services." Enabling legislation was passed in 1963, the Mental Retardation Facilities and Community Mental Health Centers Construction Act authorizing federal matching funds for states to aid in the construction of comprehensive community mental health centers. This new type of facility was to "provide a complete new range of care in the community, with strong emphasis on prevention." Mental health service delivery entered a new era and mental health professionals were infused with high hopes that the 1960s would be the decade in which the fight against mental illness would make significant strides. It was a time of federal involvement and support for new programs that would reach vastly increased population groups in need of care; funds became available for construction of facilities that would provide new and improved patterns of care; research and training programs grew in scope and size; attitudes about mental illness were to be changed; the community would receive attention in terms of involvement and participation

in programs for recognition and care of mental disorders; education of the public would help prepare communities to receive former patients so that they could reenter the community as useful and participating members. In short, the picture drawn by the Joint Commission of conditions as they had existed was to be drastically altered.

Now, ten years later, as we look back over the achievements we must recognize that although strides have been made, and some of them very significant, many of the changes we had hoped to effect have not taken place. Many of the challenges remain and we face new ones. We must ask ourselves today where we have failed, why, and how.

It might be said that our profession's attempts to find new and more effective ways of treatment have mirrored a pattern of how as a nation we tend to deal with problems. Each new discovery is hailed as the definitive answer, the ultimate panacea. We throw all of our energies into the new discovery and we are impatient for quick, palpable results. Without pausing to evaluate the new idea, because we believe in it so strongly, we overload the new idea, we oversell ourselves on it, so to speak, and set our expectations too high. Armed with the new idea we energetically go about correcting previous wrongs, not always wisely, and in so doing we tend, as Bernard has written, ". . . in correcting some abuses [to] unwittingly perpetrate others. (The freshly perceived concept of today is all too likely to be corrupted into

the cliché of tomorrow.)" [p. 256) Our enthusiasm for the idea is so great that we tend to ascribe to the idea itself the power of becoming the change agent and often overlook the fact that the idea must be backed up with mechanisms adapted to the new idea, sufficient resources, and, at times, new mechanisms so that it can be implemented. By being so sold on the idea ourselves we tend to ignore that others are not and need to be convinced and invited to share our enthusiasm. If we let ourselves get carried away, we can be seriously instrumental in defeating the idea. We need only remind ourselves that while construction of the state hospital system was the bright new idea of its day, we did manage to take mental patients out of deplorable conditions. But not only did we overload these facilities, we failed to make proper use of them and soon we found that we had exchanged one abuse for another. As William Alanson White, observed about his experience as a young assistant physician in a state hospital: "About the only virtue I was able to discover in the state hospital as an agency for the application of therapeutics to the mentally ill was that the patient who came there had been removed from the conditions under which his psychosis developed." [p. 20] Similarly, there exists today the danger that the idea of community mental health will be considered the ultimate panacea, will be overloaded, will be inadequately supported, and thus will falter because we have failed to implement it properly. Some of these signs have already appeared. It is essential that we carefully scrutinize these signs, recognize our mistakes, correct them, consolidate our gains and

not only salvage the idea but meet present challenges to it, and truly make it work.

In 1972, Barten and Beliak wrote, "ideas and movements go through fairly definite stages of development . . . when ideas make a major breakthrough, they are in a heroic phase of heady spirit. In the second phase, there is bound to be some letdown when limitations and obstacles become apparent and the one visionary idea turns out to be no panacea. Typically, misconceptions in the original proposition are discovered and some feelings of disappointment follow. Community mental health is now in this skeptical second phase." [p. xi] This formulation can serve as a useful yardstick for scrutiny and assessment. If we apply a constructive skepticism, we can discern some misconceptions in the original proposition, some limitations and obstacles, all contributing to the much less than full realization of our expectations at the outset. Candor demands, however, that we recognize that we who were given the opportunity to implement the "bold new approach" have fallen considerably short in our implementation and that many factors have contributed to our failure.

The very legislation that appeared such a boon at the outset had built into it several misconceptions that in the course of experience have proven to be true obstacles. The underlying belief that the community-mental-health center would be the total panacea— derived from the assumption that the

center would and could completely replace the state hospital—appears to have been an error. Rather, each has a role to play in a spectrum of provision of comprehensive services that, after all, was the basic goal of the initial idea. Countries such as Holland, England, and the USSR have had experience in operating successful community-based programs, yet the need for hospitals has not been eliminated, [pp. 11-13] The overlapping timetables inherent in the federal funding structure created other obstacles. The stress was on construction while the money was available. Thus in many instances there was poor and inadequate planning and a lack of ongoing evaluation. The community to be served in some cases was incorrectly defined and its needs inadequately recognized. In other cases where there had been some groundwork done, the recognized needs and size of the community did not fit the federally mandated requirements. Consequently, in order to be eligible for funding, the findings were modified to suit the guidelines, often to the detriment of the success of the program. Since the funding structure was based on a matching pattern of federal funds with state and local funds, additional obstacles were created. As observed by Connery et al., "existing governmental units prefer to handle new functions in the same way as they treat present services. . . . Public officials prefer to budget for the new service within existing program structure. . . ." Thus, the emphasis on catchment area as implied in the federal legislation, coupled with the necessity to channel implementation through existing structures not adapted to the needs of the

mandate, can result in the type of experience reported by Kaplan with the Lincoln Hospital Community Mental Health Center: ". . . the size and population in ghetto areas best served by a neighborhood mental health unit was 25,ooo." This was based on experience gained in operating a Neighborhood Service Center with Office of Equal Opportunity (OEO) funds. He goes on to say that "despite our experience and detailed exposition to program concepts, our original staffing plan had to be modified [to meet] the federal standards. One third of the number of staff we had suggested for 25,000 were assigned to service 50,000. Thus, the contractual negotiations for federal staffing followed a familiar bureaucratic pattern through municipal, state and federal agencies without regard to our prior experiences. This occurred despite the fact that the evaluation research upon which our grant request was based has been supported by funds from NIMH and highly regarded by the branch. . . . The Community Mental Health Centers Act represents a sophisticated advance in the framing of a public health law, the implementation of the regulations have been and are carried out through outmoded models of interagency structures." [p. 30] In discussing some of the theoretical considerations for development of the community mental health centers Sanders and I pointed out that "the emphasis must be on *program not center,"* that "the center must have a relatedness to the community which it serves; a relatedness which can be developed by an awareness and understanding of the expectations each has of the other . . that there is a

necessity for "interaction of the staff of the center with the community and its agencies and facilities in consultative, collaborative and educational roles," that the "primary function of the community mental health center is that it serves as a *coordinating mechanism* for all of the existing community facilities" and that "the 'consumer' of this network of coordinated and differentiated services must also be kept in mind. Mental health professionals might develop a wide range of services which are considered adequate and reasonable, but the individual member of the community may not perceive them as such." Unfortunately, so far, we have not succeeded in fulfilling most of these goals. We have until now insufficiently developed and used community resources and although we have stressed a return to the community, we have tended to defeat this goal by paying insufficient attention to ways and means of integrating the patient for useful function and maintenance of mental health. This has been a failure due in part to inadequate stress on the education of members of the community and in not truly implementing the initial goal of a pluralistic approach and combined treatment idea that underlie the very philosophy of community mental health concepts. Although we have achieved a considerable increase in available manpower—and in the process have trained a variety of different types of personnel—we have failed to some extent with regard to proper role definitions and liaison at all levels. As a result, new problems have been engendered that tend to interfere with efficiency of functioning, and thus we

have under-delivered both in quantity and quality of care. A further hampering factor has been a lack of flexibility in suiting treatment modalities to specific needs and situations, in part exemplified by the adherence of practitioners, both traditionally trained and new types, to the medical model.

In appraising efforts at implementation of the community mental health center movement so far and in trying to pinpoint the shortcoming of such efforts, certain trends are appearing that suggest we may be repeating some of the mistakes of an earlier, similar movement—the neighborhood health center movement of the first decades of this century—mistakes that in large measure contributed to its demise. However, the community mental health center movement need not follow a similar inexorable course to decline and demise. There is still time to examine mistakes being made, to identify some parallels in the earlier movement, and thus to deflect our course toward success.

The health center movement had its roots in the recognition during the latter part of the nineteenth century and the early years of the twentieth that the growing cities in this country were increasingly faced with problems of poverty, crime, disease, and other slum conditions most frequently associated with immigration. At that time settlement houses, milk depots, and charitable relief organizations located in immigrant and slum neighborhoods attempted to deal with these problems. The early health centers, financed by local taxes

or philanthropy, or both, organized by voluntary agencies or municipal health departments, were located within city neighborhoods or districts. These early centers were intended to solve special out-of-hospital health problems of the poor, primarily with regard to infectious diseases and infant malnutrition. The emphasis was on prevention and on education. As Stoekle and Candib point out, "most health center enthusiasts viewed the programs of centers as preventive and educational, complementing the creative work of private practice and carefully avoiding competition with it: 'no prescription given; no sickness treated.' "

Four ideas of organization and program dominated the health-center movement: district location, community participation, preventive care, and bureaucratic organization. Health services were to be within easy reach and thus would have greater use, and the very location would bring about influence from local residents in pointing out needs. Initially, the health center was viewed as a decentralization designed to make care more accessible and available. However, simultaneously, there existed a quite different view, namely that it represented a centralization of clinics and welfare agencies. Since these were scattered in various locations in the community and managed by diverse voluntary efforts, frequently overlapping and duplicating services, it was argued that they must be brought together under one organization for efficiency and coordination.

The health center movement was also a manifestation of the progressivism of that period, which placed a high value on social reform. In the progressive era, the roots of poverty and illness were seen as environmental and, thus, social work and public health allied themselves with reform movements seeking to improve the environment. At the same time, however, there were two developments in social and political thought of the period: scientific management with its stress on efficiency, and the rise of professionalism. Efficiency at first had as its goal cooperation and coordination, use of nonprofessional aids and ancillary personnel with the aim of 100 percent participation and availability of services, cost reduction through shared facilities, and elimination of overlapping services. Soon, however, efficiency became so powerful a concept in industrial work and seemed so impressive a solution that it also became "almost a central value of the health center movement." As a result there was extreme coordination of organization but not of care. To cite an example: "the demand for bureaucratic efficiency was so persistent that nurses had to prepare a detailed write-up of how much time they spent on each 'unit of work.' When the accounting became as important as the 'unit of work' then the trade-off between efficiency and effectiveness ceased to be manageable." [p. 2,3]

The rise of professionalism manifested itself in several ways. Public health work and social work had until this time been largely an outreach function, motivated by concern for improving social and health conditions.

Under the influence of the new trend toward efficiency and management there grew the belief in specialization and the need for experts. This gave rise to a consciousness of professionalism, and as preoccupation with professional codes and standards grew there was a shift in the concern from community work to internal hierarchy and organization with a consequent withdrawal of community involvement. Social workers shifted emphasis from work in the community and social reform to casework and emulation of the medical model of treatment; public health awarded its first professional degree in 1910 and began to stress public health administration. In the years immediately following World War I interest in volunteer work declined, and with the growth of professionalism and stress on bureaucratic structure the health center as a small local undertaking gave way to large-scale efforts in health and welfare. The basic neighborhood orientation yielded to the new ideas of scientific management and the fundamental idea of the center was altered to a considerable extent.

Health departments began to see the value of the districting idea—a cornerstone of the early health centers—and the value of coordination of diverse services. The First World War had brought about governmental concern with public-health issues and Progressives welcomed such participation as a promise of sweeping gains. However, there was in the 1920s a widespread fear of government control implying socialism and even communism.

As Candib writes: ". . .doctors felt that the expansion of the state into the realm of preventive medicine was sure to be followed by forays into therapeutic medicine as well. Consequently, they approved of health centers only when their program involved no therapeutic medicine." [pp. 50-51]

A major innovation of the 1920s was the "health demonstration," a "comprehensive, well-publicized project to improve the health in a given area through extensive health campaigns for inoculation, screening, diagnosis, and health education." Demonstrations were funded by the private sector with the specific understanding that municipal governments would assume funding once a demonstration had proven successful. "Health departments could not respond until the value of a given demonstration had been proved. . . . During this period, innovative projects were considered 'peculiarly the province of private enterprise." [pp. 41-42] For purposes of these health demonstrations the district size was expanded in the interest of efficiency and bureaucratic administration, thereby distorting and subverting the original districting idea. In the opinion of Candib, they "adopted a district plan more to benefit from a discrete scientific control with other neighborhoods than to develop local roots in the neighborhood. Furthermore, with a larger district, the success criterion of reaching 100% of the population was sacrificed to the more measurable scientific goal of reducing the 'extent of sickness' and the mortality rates." [p. 43] Thus, the health demonstrations and their successors were not health centers as originally envisioned and operated. The

demonstration came to be “regarded as the focal point of modern district health administration—a model for decentralizing the phlegmatic municipal bureaucracy totally inadequate to meet the health needs of a large urban population.” [p. 43] The district had become an administrative technique rather than a nucleus for care giving.

The health center concept was further diluted by another aspect of the stress on professionalism. Rosen points out that “as is not infrequently the case when a professional development or trend is in ‘fashion,’ the name by which it is designated acquires an aura of approval, and is used to describe activities and enterprises that differ widely, so that they may share some of the aura. This was also the fate of the health center concept, and is in part responsible for its decline.” [p. 1630] He goes on to enumerate the different types of facilities that went under the name of health center. These included child welfare stations, tuberculosis dispensaries, outpatient departments of hospitals, settlement houses, and venereal disease clinics.

The demise of the health center movement can be ascribed to several factors, some of which can be discerned in developing trends in the community mental health center movement and from all of which valuable lessons can be drawn. The community mental health center is seen now not only as a means of bringing services to the poor, but as an important modality of care and delivery of mental health services to the entire community that

links treatment and prevention with an application of community psychiatry knowledge and techniques in the promotion of mental health. One of the failures of the health center movement is ascribed to the "rigid confinement to a program of preventive medicine" that "served to perpetuate the artificial distinction between the preventive and therapeutic functions in medicine, and Stoekle, quoted by Candib, considers "this restricted program of health centers as a fundamental barrier to their success." The community mental health center offers a unique opportunity to fuse our response to immediate needs through therapeutic intervention and to put into practice true primary prevention that addresses itself to anticipated societal difficulties that we now know are causative factors in mental illness. As stated earlier, the progressive era saw the environment as the root cause of poverty and illness. Gradually there was a movement away from this and the focus in social work and welfare shifted to the individual. This shift is ascribed to the impact of Freudian ideas. "The social worker minimized environmental factors in causation and treatment and elevated the study of the personality into the all-powerful explanatory tool. . . . Social work . . . came to emphasize the adjustment of the individual to social stress . . . and to society as it was. This view stands in sharp contrast to the earlier progressive belief that the society needed to change before poverty and illness could be eliminated." In the years since then we have come back again, or perhaps learned anew, that environmental and social factors must be included in the spectrum of

causative factors. Freud taught us to consider the individual and the importance of the study of personality, but he also "expressed the opinion that the best access to the psychology of the ego might be through investigating the disorders of society." [p. 337]

The development of the community mental health center movement can certainly be seen as an important expression of our renewed awareness. It is essential, however, that in our search for maximum effectiveness we do not lose sight of it as a care-giving tool and do not become excessively preoccupied with technical concerns. It is well to remember that students of the health center movement found that "the movement wholeheartedly adopted the bureaucratic ideal of efficiency and professionalism. These values ultimately served to undercut the theoretical principles of the health center movement . . . the district idea and the coordination idea were not invalidated but rather discarded and altered for the benefit of bureaucratic and administrative goals. Community based facilities were not unworkable, but could not succeed when efficiency and professionalism had become dominant values." [p. 53]

The call to efficiency is heard again, as is the stress, or rather, overstress on professionalism. These are new challenges we must meet along with our increased efforts to preserve and implement the basic goals of the community mental health movement. One of the guises in which efficiency is appearing is

cost accountancy. But in our concern for rising costs we must guard against the ascendancy of cost accountancy over commitments to quality service and care giving. There is still the persistent belief that efficiency as applied to industry can be transplanted to the delivery of human services. Although much can be learned from administrative techniques developed in industry, it would be a mistake to assume that these techniques in toto can be transplanted to management of human service delivery. We are seeing today proof that efficiency as a goal in itself can fall victim to the law of diminishing returns. Reports from a variety of industries, from automobile to dog food manufacture, underline this and point to an interesting paradox. Industry has learned from the behavioral sciences and is beginning to apply their concepts to management practices while we are still calling, in many ways, for application of techniques that industry is beginning to discard. Just as we have been able to evolve the innovative notion of the community mental health center so we must, by applying our own expertise, evolve innovative techniques for the management of human service delivery.

Industry is learning that workers can master a variety of tasks and, by becoming involved in these, perform well in all of them. We, however, tend still to stress specific and individual tasks. True efficiency and constructive cost accounting can be accomplished if we become committed to constructive change, comprehensive planning, and flexible organization. This will require involvement of mental health professionals in a diversity of tasks and in areas

of activity outside the consulting room.

To quote Candib once more, “internal organizing ideas in public health may depend more for their success on the values common to the society in which they occur than on the inherent validity of the ideas themselves. Although the health center idea was not without internal difficulties . . . these drawbacks could have been overcome in a society more open to ideas of popular participation and universal access to health and welfare services.” [p. 53]

Though addressing itself to public health, this statement can as easily be applied to mental health as we look to the tasks ahead. What are the common values of the society in which we are attempting to implement community mental health? It can be agreed that side by side today is the demand for more and better care with a concern for rising costs, and decreased availability of public funds. As mental-health professionals we have the multiple task of proving to the public and to legislators that the challenge of mental illness is there to be met and must be met and that with their help we can meet it. We must be able to show that funds are not wasted but are used effectively and beneficially. To do so we must redirect our philosophy of care. We must aim at true implementation of a pluralistic approach to care and, in the process, we must recognize the limitations of the various modalities of treatment and assign each to the appropriate facility in the total spectrum of

care giving. We must also be willing to find ways so that federal, state, and local sources can share the responsibilities for care and funding to avoid overloading any one of them and, in the process, render them ineffectual. As Schwartz wrote recently, "although mild overloading may stimulate creative discoveries of ways to do the job more effectively, extreme overloading causes demoralization, apathy, and decreased effectiveness. . . . The failure of the state hospital system to solve mental health problems for most of the community is one illustration of severe overloading leading to demoralization and decreased effectiveness. A similar kind of overloading of community facilities can have the same result." [p. 11] Mental health professionals must be prepared to include in their dealing with mental health problems a willingness to step out of their purely therapeutic roles and aim for greater involvement in the political and social process as it affects mental health planning and programming. As Bernard has said, practioners must aim to have "a voice in the councils that make social policy." She reminds us of "the interdependence of psychiatric, social, health, educational and other specialized constituents of 'combined treatment,' " and goes on to say that "such indirect application of clinical and administrative knowledge is not a departure from but an extension of our central professional concern with mental disorders." [p. 265] Today, as we face a federal fiscal retrenchment and a discernible shift in social philosophy away from federal involvement in social programs with increased responsibility shifted to state and municipal

governments, we face the challenge of seeing to it that funds allocated for these programs are indeed so expended, for ". . . being financially able is not the same thing as being politically willing." [p. 504] From a field study on organizing community mental health, Connery et al. report that "legislatures have been willing to take favorable action whenever sufficient leadership was available to give saliency to the issues. . . . There is reason to believe that the basic difficulty is not so much hostility as indifference and ignorance. It is less a problem of changing legislative opinion than a matter of getting opinions formed at all. The function of educating . . . legislators on the needs and problems of mental health has not always been properly performed." [p. 542] It *is* our task in the immediate future to perform the function properly and to provide leadership to give saliency to the issues, whether it be on the state and local level with regard to proper expenditure of funds, or on the federal level to exert influence in planning for new health insurance measures, formation of review mechanisms, or administrative techniques and approaches for comprehensive service delivery.

Legislative, Social, and Organizational Trends

Based on the philosophy that health care in America is a right and not a privilege, there has been, in the last fifteen years, a flurry of legislative activity at all levels of government as well as organizational changes on state and local levels designed to provide comprehensiveness of care of high quality

and accessibility for those in need. Despite this activity, which will be described briefly in the following paragraphs, there is little evidence that any dramatic breakthroughs have occurred. The community mental health center movement brought into sharp focus the need for careful program planning and design, consumer participation, new methods of delivery, and public accountability. Thus, some of the more recent legislation has incorporated these various elements to ensure that the American public plays an active participant role in the type of health and mental health care it receives. Many plans have been put forward by different organizations outlining various approaches to a national health insurance plan. Other forms of legislation have defined new types of organizations, such as Health Maintenance Organizations (HMOs) and more recently PSROs. Yet we are still no closer than we were to a well-formulated, feasible, comprehensive health care system for this country. There has been no coordinated effort among the various federal, state, and local levels of government to ensure the implementation of new programs, particularly with regard to HMO's. Finn guidelines were never established under which such organizations might become operational. The Administration's position was that the various groups should design their own plans, within certain broad limits, to avoid proliferation of organizations that might soon become outmoded and obsolete.

In 1972, in a message to Congress, President Nixon outlined the

components of the Allied Services Act, designed to plan for and provide comprehensive care through programming at the state and local levels—a proposal that was closely tied to the concept of revenue sharing. This concept held great promise as a substitute way of maintaining programs that had been operated under other types of federal funds, but so far it has not lived up to initial expectations. The likelihood of health and mental health programs receiving substantial assistance through the instrumentality of revenue sharing is indeed meager.[1] The act did not receive Congressional approval. It was reintroduced in the Ninety-third Congress.

Also in 1972, the Health Maintenance Organization and Resources Development Act was introduced in Congress and passed by the Senate, but it did not become law.[2] It was proposed on the basis of findings that indicated a shortage and maldistribution of quality health resources in the United States; that the present health care system is not efficient nor economical and is based primarily on the treatment of disease, rather than the maintenance of health; that technical assistance, new types of educational facilities, and extreme variations in the quality of care in different parts of the country necessitated the development of a new type of organization that would come to be known as the Health Maintenance Organization, or HMO. This legislation provided for coverage of comprehensive care on the basis of a prepaid plan. Subscribers to such a plan would receive health care through contractual agreement with a health maintenance organization, or a health service

organization that would assume responsibility for the provision of health services to groups of subscribers. The legislation stipulated that mental health services, including those for drug abuse and alcoholism, would be covered, and that existing community mental health centers should be utilized on a priority basis to provide the mental health component of comprehensive health care. In view of the previous experience of the community mental health centers, it was thought that such centers could be the focal point for the development of the comprehensive health care model. Except in a few instances this has not happened. There has been since then a rapid formation of numerous HMO's throughout the country, each with its own organizational and service patterns and each with its own set of problems. Present judgment would have to be that HMO's are not the answer to the provision of comprehensive health and mental health care for the citizens of this country.

Because of the astronomical costs of health care in this country, it has been believed for some time that we will eventually move toward a national health insurance plan. Blatant partisan political considerations, as well as the vested interests of many groups that include legislators, third-party payers, consumers, and professionals have prevented the legislative enactment of such a national-insurance plan. The details of the various plans have been described elsewhere and will only be mentioned here to illustrate the plethora of approaches, ranging from National Health Insurance Partnership

Act of 1971 (the Nixon Plan), involving a significant role for private carriers, to the Committee of 100 for National Health Insurance (the Health Security Act of 1971—Kennedy Plan) which proposes compulsory national-health insurance for all Americans, financed by a formula based on a tax on employers' payrolls, a tax on salaried, self-employment, and unearned incomes, and federal general tax revenues. Under this plan there would be no charge to anyone for covered services. Providers of health care would be paid directly by the program. Other plans include the American Medical Association's plan (Medicredit); the Javits plan, (National Health Insurance and Health Services Improvement Act of 1971); the National Catastrophic Illness Protection Act (Boggs); the American Hospital Association Plan (Ameriplan); the Health Insurance Association of America Plan (The National Health Care Act of 1971); Catastrophic Health Insurance Plan (Long). Other plans, less comprehensive in scope, have been introduced but are not listed here. The point to be emphasized is that psychiatric care is excluded from most of these plans, and where included it is not adequately covered. At the start of the Ninety-third Congress the Health Security Act (Kennedy Plan), the Nixon Plan, and the Health Care Insurance Act (Medicredit), as well as some of the other plans were reintroduced in both Houses with no appreciable change in the provision for psychiatric care. Still another bill known as the National Health Care Services Reorganization and Financing Act was introduced as the first bill of the Ninety-third Congress. It calls for health

insurance coverage with 75 percent provided by employers and 25 percent contributed by employees, with the federal government paying for the cost of health care for the poor and the elderly and for some of the costs for everyone else. The bill is based on the administrative concept of a health care corporation, a community-based operation providing comprehensive health care at the local level. The corporations would be built upon existing delivery systems but reoriented and reorganized to meet local needs overseen by newly formed state health commissions. This bill, too, contains provisions for treatment of mental illness that must be considered inadequate. Inpatient hospital care for mental illness, alcoholism, drug abuse, and drug dependence is limited to ninety days per benefit period for registrants of local health care corporations and to forty-five days for other persons. In addition, a $5-per-day copayment by the patient is required. The outpatient care program for these disorders calls for a $2-copayment per day, but such care would be limited to three visits or treatment sessions for each day of inpatient care allowable during the benefit period. That is, registrants in corporations would be allowed 270 treatment sessions and non-registrants 135 treatment sessions per benefit period. The financing formula is one of multiple sources including general federal revenues, direct contributions from individuals depending upon income level and family size, and Social Security taxes. Medicare and Medicaid would be consolidated into this proposed program of national health insurance.

Despite the considerable preoccupation with the development of a comprehensive, feasible health care plan, insufficient attention has been paid to an accurate estimate of the cost and how it will be paid. The Rand Corporation has recently done a series of retrospective studies, based on the demand system, in which the impact of copayment on the quality of medical care was brought into question. A comparison was made of coinsurance rates under the current health system, the Nixon plan, and the Kennedy plan. The classes of services covered were broken down into three categories: hospital costs, physician costs, and "other." ("Other" includes some dental services, nursing homes, some prescription drugs, eyeglasses, prosthetics and outpatient mental health care.) The coinsurance rate is the amount, in percentage, that the patient pays. Under the current system, the coinsurance rate allocates 13 percent to hospital costs, 40 percent to doctor's costs, 90 percent to "other." Under the Nixon plan, hospital and doctor costs would have a floor of 25 percent, that is, nobody would have a coinsurance rate higher than 25 percent. Under the Kennedy plan the same two categories would have a coinsurance rate of o percent. It is important to note that in both the Nixon and Kennedy plans, the latter being considered the most comprehensive, the category of "other" is not covered and this category has the greatest price responsiveness. It has been estimated, using fiscal year 1975 as a baseline, that under the current health system, the aggregate health care bill for the country will be $100 billion of which two-thirds are paid by a

third-party payer and one-third by private payment. Under the Nixon plan, the total will be $105 billion with $71 billion covered by third party (government). Under the Kennedy plan, the cost will be $130 billion totally covered by government health insurance financed as described. This $130 billion is an estimate made by the Rand Corporation. Other estimates of this plan range between $110 billion, made by the Social Security Administration, and $185 billion made by Rosette at Rochester. Clearly, this implies a major government expenditure and raises serious questions as to whether this type of comprehensive national health insurance plan can be afforded. The Rand Corporation concluded that the information necessary to plan effectively for national health insurance could not be obtained through retrospective studies. Thus, another study is expected to be undertaken by the Rand Corporation with the following objectives: to understand the impact of coinsurance and deductibles on the demand for care; to understand the administrative feasibility of plans in general and, in particular, increases related to coinsurance and deductible rates; to understand the impact of utilization on health status and the impact of insurance mechanisms on the quality of care. The methodology involves the choice of five to nine geographic sites in this country in which different designs of health-insurance plans will be tested. There are approximately sixteen different designs that will consist of various combinations of plans for coinsurance deductible, prepaid insurance, and coinsurance with high inpatient and low outpatient

rates. It is planned that each site will enroll about 400 families with incomes under $12,000. People will be drawn at random, signed up, and randomly assigned to one of the sixteen plans. Dayton, Ohio, is planned as the first site. For design reasons the experiment will be conducted on some families for three years and others for five years. It is important to note that in all of the plans in the experiment almost all categories listed above in "other" are covered. Provisions for mental health care consist of complete coverage of all inpatient costs, fifty visits to a psychiatrist during each benefit year or to other nonpsychiatric mental health care providers. Fees for nonpsychiatric mental health care providers will be based on a profile of prevailing area fees for group therapy.[3] One of the interesting aspects of this experiment is the intent to incorporate into the insurance plans a maximum-limit health insurance to be related to family income. In effect this means that all costs beyond a certain percentage of family income would be paid and thus catastrophic health insurance would be provided for everyone. This concept is included in all plans of the experiment except for the mental illness coverage. It is hoped that at the end of the experiment the Rand Corporation will be able to answer some of the questions in the objectives. The fact that the foregoing discussion has addressed itself primarily to health care delivery systems underscores that mental health care is not included in any appreciable way.

The most recent major health legislation enacted has been contained in an amendment to the Social Security Act, known as the Bennett Amendment.

It deals with the establishment of Professional Standards Review Organizations and was passed by the House and Senate in October 1972. The Bennett Amendment is based on the assumption that there is

no better alternative than the use of the practicing physician in the delivery and supervision of medical care. PSRO is structured to provide practicing physicians with an opportunity to assume responsibility, in publicly accountable fashion, for assuring that Medicare and Medicaid benefits are provided only when medically necessary and in accordance with professional standards, in keeping with accepted norms in a given area. It also stipulates that the federal government has the general obligation to oversee overall PSRO operations and that it does not intend to abdicate its ultimate responsibility in this sphere. At present, PSRO will deal mainly with review of services under Medicare and Medicaid. It is envisioned that ultimately this type of organization will be the review mechanism for any national health insurance program.

In this connection it should be noted that both the Nixon and Kennedy Plans call for standards review and control. The Nixon Plan, sponsored by Senator Bennett, includes the establishment of PSRO to review health insurance and HMO contracts, and quality standards. The Kennedy Plan calls for establishment of a quality-control commission, and national standards for participating professional and institutional providers with regulation of

major surgery and certain other specialist services, national licensure standards and requirements for continuing education. The newly introduced Health Care Services Act calls for establishment of a federal, cabinet-level Department of Health that would set basic standards for care, establish the scope of health insurance benefits, and would have final authority over program activities at the state level.

As stated in the Bennett Amendment, "The Professional Standards Review Organization is designed to promote the effective, efficient and economical delivery of health care services of proper quality for which payment can be made in whole or part under the Social Security Act and in recognition of the interests of patients, the public, practitioners and providers in improved health care services. The purpose of this program is to assure, through the application of suitable procedures of professional standards review, that the services for which payment will be made conform to appropriate professional standards for the provision of health care and that payment for these services will be made only when (1), and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; (2) and in the case of services provided by hospital or other health care facility on an in-patient basis, only when and for the period those services cannot, consistent with professionally recognized health care standards, effectively be provided on an out-patient basis or more economically an inpatient health care facility of a different type, as

determined in the exercise of reasonable limits of professional discretion."

The bill authorizes the Secretary of Health, Education and Welfare to designate specific areas of the country by January 1974, and to enter into conditional contracts for a PSRO in each area as soon as possible. Until January 1, 1976 the Secretary may only contract with qualified organizations that represent a majority of the physicians in each area. A qualified organization is a voluntary professional organization, for example, a County Medical Society, or one without requirement of dues and represents three hundred or more physicians. In general, it is anticipated that the County Medical Societies will be the instrumentality for the establishment of functioning PSRO's, thus ensuring the active participation of physicians in this program. While PSRO's are becoming operational, ongoing review will be carried out side-by-side with PSRO review until the Secretary of Health, Education and Welfare is satisfied that a given PSRO has demonstrated the ability to do the job. In keeping with this provision of the law, state councils will be established in states where three or more PSRO's are operational. Such a statewide program review team will include representation from each PSRO in the state, other physicians, and the public. In addition, on the national level, a council has been appointed by the Secretary of Health, Education and Welfare that includes eleven physicians of national stature, a majority of whom have been nominated for membership on the council through their professional organizations. To implement this review mechanism, it is

anticipated that each county medical society will ask the various subspecialties to establish committees to review the various models of treatment and care within their respective specialties and to serve as a source of feedback to the county medical society PSRO. In New York City, for example, the New York County Medical Society has established a PSRO. The New York District Branch of the American Psychiatric Association has appointed a committee of its members to review psychiatric patterns of care and to evolve ways in which peer review can be effectively implemented for psychiatry. A member of this committee of the District Branch of the APA is also a member of the medical society PSRO making possible ongoing and meaningful psychiatric input into that body. On the New York State level, a mechanism has been established, through the formation of a state committee, to share the information on PSRO activity of the various district branches of the APA.

PSRO's will evaluate the utilization and quality of institutional services. They will utilize norms of care based on typical patterns of practice in the region for this purpose. And they are encouraged to involve practicing physicians to conduct ongoing review through existing hospital utilization review committees and, where necessary, to upgrade this activity. For psychiatry, the goal is to establish "norms of care" for psychiatric services in hospitals and, ultimately, for outpatient treatment; to evolve "relative value scales" as a mechanism for deciding which procedures and modalities of

treatment are most effective in determining quality of care at the most reasonable cost; and, in addition, to make decisions regarding variations in patterns of care to include legitimate philosophical differences in treatment approaches.

In evaluating and determining whether existing in-house review procedures are at levels of performance acceptable to the PSRO, PSRO's must make certain that there is broad and rotating physician participation in the review process on a continuing basis. PSRO's must be organized on a local basis, of the stipulated minimum of 300 physicians, with the expectation that the average PSRO will be drawn from 1000 or more in the area. PSRO and its review organization must employ acceptable parameters of care and norms for the region. Data must be maintained in an orderly and adequate fashion to facilitate evaluation and comparison of PSRO performance. The PSRO legislation is designed to utilize professional expertise, through peer review, subject to public accountability, to assure the appropriateness and quality of services purchased under the provisions of the Social Security Act. The amendment explicitly states that the following should be included in the review: determination of the necessity for institutional admission, the duration of institutional service, the appropriateness of the level of institutional care, the adequacy and relevance of the institutional and ambulatory services provided. Implied in the objectives of the amendment is the attempt to restrict the utilization, and, thereby, the cost of federal health services to a

minimum.

Initially, one of the major functions of the PSRO is education of the medical profession regarding the meaning of PSRO legislation in order to obviate difficulties later. There is considerable unfamiliarity with and, in some cases, outright denial of the legislation. Yet, sooner or later it will affect every practicing physician in the United States. It would be most helpful if this peer review could be seen as a form of consultation and continuing education rather than as a system of monitoring physicians' activities, determining penalties for violations, etc. It is important, therefore, in establishing PSRO committees that the best skills of the various specialists be represented, and in the case of the specialty of psychiatry to include those who will not consistently advocate one particular modality of treatment and who will not reflect the philosophy and patterns of only one particular segment of the psychiatric profession. Newman, et al. have recently reported on their experiences with a peer review program in California, where the emphasis was a consultative and educational one. Their experiences confirm that not only can peer review work, but it can be sought after and be considered helpful by participating therapists.

Many questions will arise for our profession as this legislation is put into effect: will the confidentiality of the patient-doctor relationship be maintained? This is an issue of justifiable concern to all psychiatrists. Will

various institutions, such as teaching centers or community general hospitals, be equally represented on such committees? Should doctors review doctors? Or should there be some input from consumer groups in keeping with current trends of greater emphasis on consumer and community participation? Is the law requiring such review constitutional? This question has already been raised. If PSRO is a function of the county medical society, will the specialty of psychiatry be given appropriate representation? This is an important task for the psychiatric profession. What are norms of psychiatric care? Since it is generally agreed that diagnoses and modalities of treatment vary from one region of the country to another and, indeed, from one area of a city to another, who is to decide which treatment modality is most appropriate? How will peer review, currently limited to Medicare and Medicaid services, operate when applied to the private practice of psychiatry? Not directly related to PSRO but implicit in any national health insurance plan proposed so far is the existence of coinsurance rates—the portion of the service for which the patient must pay. In the specialty of psychiatry will this factor tend to encourage patients to seek less expensive care from other mental health practitioners? Myriad potential problems are contained in this legislation, but PSRO is now part of the law. As such it must be recognized as a fact of life that the medical profession can no longer ignore. Yet, associated with this major legislative enactment is a real opportunity for change and progress. If we involve ourselves meaningfully, peer review can be developed to engage the

best skills of the profession for upgrading the quality of care. If we don't, we will forfeit our participation in any way since the legislation states that if a PSRO is not functional within a certain period of time, or if the Secretary of HEW decides that an existing PSRO is not functioning adequately, other organizations can be duly constituted as the PSRO instrument. Such organizations must demonstrate professional medical competence to function as a PSRO, and might include state or local health departments, an aggregation of hospitals or similar governmental or nonprofit organizational structure with professional competence.

Organizational changes are taking place at various levels of programming throughout the country, specifically related to the provision of comprehensive mental health care. It is my opinion that whatever changes may be made in the delivery of mental health care, concerted efforts must be made on the part of all to ensure dovetailing of such plans into a total comprehensive health care delivery system. In New York State, for example, a Unified Services approach is proposed in which the state mental hospital system would assume overall responsibility for total mental health care through subcontracts and other types of collaborative and fiscal arrangements with local agencies and programs to achieve comprehensiveness.

As part of such a Unified Services approach, a reporting system will be

developed. The New York State Department of Mental Hygiene has committed itself to establishment of a Unified Services Information System. Toward that end a Unified Services Information Executive Committee has been appointed and commissioned to oversee the development of the system and a full-time task force has been assigned to conduct the information study under this committee's direction and supervision. Among the charges to this task force are the responsibility for keeping itself aware of developing systems within the department and for seeking compatibility with related systems at the federal, state, and local levels. In designing the Information System, the task force will aim at relevance, usability, timeliness, and economy. The task force will also have a Unified Services Information Advisory Committee with members appointed by the Commissioner. The membership of this advisory body will be representative of voluntary agencies, units of local government, and programs of the New York State Department of Mental Hygiene responsible for the provision of mental health, mental retardation, and alcoholism services. The purpose of the committee is to review task force recommendations for the Information System to enable the organizations represented on the committee to jointly plan, deliver, and evaluate services for the mentally disabled. While a unified system of care is a sound and potentially viable concept, formidable difficulties are anticipated in its implementation.

In several states there is a move toward the development of

Departments of Human Services within state governments. Such departments would encompass health, welfare, educational, and correctional services under the direction of a Secretary. In over a dozen states such reorganization is taking place; some Departments of Human Services are already in operation, as in Massachusetts, for example. Connecticut has recently established a Commission on Human Services. The purpose of such an organizational shift is to coordinate services and to minimize the fragmentation and discontinuity that exist within the various departments concerned with the provision of human services. Once again, conceptually such an approach has considerable merit; operationally it is fraught with risks. For example, Departments of Mental Hygiene have for many years maintained a degree of autonomy that they have come to cherish. Under this new concept such departments would become integral parts of superagencies. This could give rise to myriad problems at different levels, and might make implementation difficult. The same might apply to other departments. What is really needed, as Litwak and Meyer have proposed, are coordinating mechanisms that will provide linkages and balance between existing bureaucratic and other organizations, and thus permit more efficient functioning and yet maintenance of individual frames of reference.

Another approach to comprehensive mental health care delivery is that of regional planning on the local level to parallel the development of statewide human services departments. It is proposed that a network of

human services be developed, bounded by manageable geographic limits, including a number of service components equal to the identified problems at hand.[4] Personal service would, of course, be an intricate component of this network—for reasons both human and political. But of strong weight also should be a research-planning-and-evaluation component that would assume primary responsibility for the essential tasks of social problem prevention.

The organization of such a service network depends on the operational environment, but basic features should include:

1. all existing service agencies—both voluntary and public—in order to prevent duplication,

2. community groups in order to ascertain existing and potential problems,

3. representatives of the mass communications industries, and

4. a coordinating and planning apparatus to establish short- and long-range policy.

If such comprehensive area-wide planning is to prove effective, it is mandatory that legislative bodies "will" such efforts to succeed. And by this I mean that local, state, and federal programs should be subsumed under the aegis of the local coordinating mechanism. If this does not occur, then duplication of service and competition among agencies will inevitably occur.

Again the appropriate governmental bodies should guarantee the financial base of this coordinating mechanism—not on a year-by-year crisis intervention basis, but on a five-, ten- or even twenty-year basis.

Should this network planning effectively take place, I am convinced that we will not only experience perhaps our first national attempt at multiproblem prevention—and I firmly believe that social problems are inter-dependently interrelated—but we will also move toward elimination of service failure by introducing almost universal accessibility.

Moreover, as the various social classes become exposed to a variety of human services and their close interrelation, we can expect that at least some services will lose the stigma that has traditionally been attached to their service delivery.

The network planning of which I speak represents the developmental approach to social welfare as a front-line function of modern industrial society in a positive collaborative way with other major social institutions working toward a better society. Needless to say, some public resistance and coordinating failures will appear quite early. But the alternative at this point in time is a continuation of the fragmented residual approach of intervention on a crisis basis when the normal structures of society break down, which has the connotation of a dole or gift. This approach has failed significantly in the

past, and will fail even more grossly in the future as our complex society continues to develop.

Looking Toward the Future

Based on the assumption that in the foreseeable future mental health care delivery will become more integral to comprehensive health care within the same overall organizational framework with similar standards, setting procedures and mechanisms for determining quality care and funding arrangements, the delivery of mental health services will expand the organizational base through a more critical linkage with other social, educational, and health services. This linkage will prove to be much more than a shadow of past practices by mental health professionals—practices where haphazard referrals were made to unfamiliar agencies for supportive services in treatment situations. Such linkage will aim at more than service collaboration between independent programs that establish contractual agreements for meeting jointly clusters of problems reflective of purposes of the individual programs involved. At a rapid pace there is now developing in our nation a new philosophy of care, a conceptual process that chooses health over sickness and in this divorces itself from the past. This assertion is not merely idle rhetoric or academic semantics, for it entails a view of the human situation that has as its goal the development of an optimal social existence for all who seek help for specific problems in the areas of human service

(health, education, and welfare). It seeks to generate the response of professionals in a *comprehensive* manner that realizes the extensiveness of interrelated problems in our nation's fabric. The precipitating factors of mental illness are often found in the problems of family life, poverty, and poor health, and the only solution available is to address these concomitant problems, simultaneously, to whatever clinical treatment is prescribed. This is not to say that psychiatrists must consider themselves experts in the field of education, or that welfare workers must assume primary responsibilities in the treatment of alcohol or drug addiction. Rather, it is to say that all professionals should think in terms of a comprehensive human service response to the problems of a citizen seeking help. As an ideal, the concept of comprehensiveness may never fully be achieved, yet the current movement in this direction outlines a pattern of care that has already rejected, in practice, the fragmentary character of the past.

The Political Setting of Comprehensiveness

For the past decade, the federal government has addressed its time, staff, and money toward the unification of human services in the nation. Because of the many complex administrative mechanisms that form the substance of our federal system of politics, this movement cannot yet be considered especially efficient in its undertaking. The many attempts aimed at eliminating fragmentation in human service delivery have resulted in a fed-

eral design, radical in nature, that calls for "de-bureaucratization" at the federal level. Eisenstadt has referred to this process as

> . . . the subversion of the goals and activities of the bureaucracy in the interests of different groups with which it is in close interaction, [p. 259]

Combined with managerial techniques such as Program-Planning-Budget Systems (PPBS) and political considerations such as the political pressure for decentralization of decision-making, the federal government is engaged in an effort that seeks to (1) localize the planning and delivery of services for greater response to community needs; (2) coordinate the multiplicity of public and voluntary efforts to avoid overlap and duplication; and (3) place the responsibility for fiscal decision-making for funding of local programs in the political setting that is most immediate: state and local government. An illustration can be seen in the proposed Allied Services Act. The stated goals of this act include the coordination of complementary but separate services at state and local levels, and provision of "the necessary tools" to allow such governmental units to eliminate bureaucratic obstacles in service delivery. The clearest testimony of the federal movement toward comprehensive service delivery is contained in the following language of the act declaring an intent to:

> . . . give state and local officials authority to consolidate the planning and implementation of the many separate social service programs into streamlined, comprehensive plans—each custom-designed for a particular area.

> Such plans could eventually make it possible to assess the total human service needs of an entire family at a single location with a single application. Most applicants need more than one service, and now must trudge to office after office applying for assistance from one program at a time—with the result that they may not obtain all the services they need, or may be discouraged altogether from seeking help. [p. 259]

Under the act, the federal government proposed to make up to twenty million dollars available in the first full year for the costs of developing such comprehensive plans, and was prepared to underwrite administrative start-up costs necessary for comprehensive service program implementation. In effect, the act was designed to have major impact on over two hundred categorical health, educational, and social services programs now emanating out of Washington.

To date, the act has not received congressional support for a variety of reasons. Technical issues such as (1) adequacy of initial funding; (2) local planning mechanisms for problem identification and resolution; and (3) availability of future operational resources from the federal level vis-a-vis state and local contributions are critical areas of concern. There are also a multitude of clearly partisan political issues that have prevented passage of the act. But closely related to the movement toward localized comprehensive service has been the enactment of legislation for federal revenue-sharing to state and local governments, as well as the reorganization and consolidation of the executive branch of government following the presidential election of

1972. Together with the direction for service delivery set in the proposed Allied Services Act of 1972, these actions if sustained by Congress forecast significant movement toward the concept of comprehensiveness in care for the immediate future.

The Conceptual Base for Comprehensiveness

Sayles and Chandler have noted that:

> . . . an obvious characteristic of modem society is ever increasing interdependency; little can be changed without affecting a wide array of institutions, and many new developments depend upon close, collaborative, and integrated activities that crisscross organizational boundaries and the dividing line, between the public and private sectors, [p. 2]

To understand the nature and consequences of this interdependence in a service delivery or organizational setting requires a new approach in the conceptualization of individual and group action, as well as of its management. Instead of limiting perceptions to the plane of individual action or small group cohesiveness (formal or informal), it is necessary today to conceptualize actions in terms of the totality of the situation, in other words, to do "systems thinking" or to view it in "the systems approach." Such a view, usually incorporating the situational processes of input-conversion-output, recognizes the critical impact of the surrounding environment on any particular system (biological, social, economic, political, management, etc.).

By focusing on the system, there develops a concern for the comprehensiveness of the situation and the various elements that affect the decision or action involved. In reality, the systems approach is a philosophy of action based on the belief that enough of the complexity of existence can be analyzed and interrelated to describe reasonable human goals as well as the means for their achievement.

On a philosophical level, it has been noted that there are two basic viewpoints on social systems, monism and pluralism:

> . . . the pluralist does not believe that organizations have values, only individuals do. He believes in a balance of forces and that the decision-making process of society ought to be the result of that balance—the legislators, the planners, the mental health officials and others—converging together, but with no overall conceptualization of where they are going. Monism, on the other hand, is a philosophy that says, in principle at least, that all of the pieces can be put together into a whole picture. The monist believes it is possible to identify the objectives of the system, and to think through the alternatives that lead most successfully to the desired goals, [p. 360]

On a practical level, it must be stated that reality is never such an either/or proposition. Rather, society finds itself in an ever-fluctuating position between these polar views, striving to introduce order where elements of chaos exist while seeking to develop decision-making mechanisms that join the process of rational planning with the unclear and uncertain demands of practical politics. Systematic planning based on the

rationalism that the monistic view entails can never fully be achieved. Questions regarding the intent, the scope, the personnel, and the organizational position of the planning process in any particular service delivery model bring a variety of conflicting opinions from recognized management experts. Yet the analytic base of systems analysis, along with modern computer technology for the collection and dissemination of relevant information, does provide a meaningful advance in the planning and delivery of human services. As C. West Churchman has noted:

1. The systems approach begins when first you see the world through the eyes of another.

2. The systems approach goes on to discovering that every world view is terribly restricted.

3. There are no experts in the systems approach.

4. The systems approach is not a bad idea, [pp. 231-232]

Systems Analysis and Planning for Service Delivery

Planning has become a condition of modern existence. As David Ewing has observed:

> The big question in planning becomes not whether it is justified but to what extent and in what manner it shall be practiced, [p. 4]

In essence, planning is a rational tool for the production of recognized and desired changes in an organization's structure or manner of operation. It is a process that enables an organization to respond to the actions and pressures of the surrounding environment as well as internal organizational requirements. In modern management theory, the planning, budgetary, and operational actions of an organization are usually joined in a conscious systematic manner, such as the use of Planning-Program-Budget Systems (PPBS) and the techniques of Project Management, Planned Evaluation and Review Techniques (PERT), Line of Balance (LOB), Critical Path Method (CPM), etc. For human service delivery, this approach allows for an effective mixture of administrative and programmatic elements in response to identified social problems. The systems approach seeks to minimize the negative impact of excessive bureaucratization through a flexible realignment of decision-making and control mechanisms.

PPBS is essentially an information process around the "cost and benefits" of alternate courses of organizational action. Its aim is to help management arrive at "better" decisions on the allocation of resources toward attainment of organizational objectives. It entails the development of cost-accounting and performance-reporting mechanisms for the collection of information. It does not relate in purpose to budget implementation, productivity, or cost control.

In its use at all levels of government, several variations of the PPBS model can be identified. Governmental units have introduced modifications according to need. However, there are several major components of PPBS that remain constant:

1. An "across-the-board" governmental program structure aimed at the identification of fundamental objectives, and subsequent grouping of governmental activities relative to objectives, regardless of organizational placement.

2. Development of a multiyear program and financial plan.

3. Program analysis that considers objectives, alternatives, costs, benefits, assumptions, and impact on other programs.

It has been shown that a significant investment in time and money is required by a governmental unit to implement PPBS successfully. The "start-up" time has taken several years in many instances, and the mandatory use of computer technology as well as the increase in systems-related staff can prove costly, [p. 241] Beyond these considerations there exists an often present political opposition that must be overcome. As PPBS is representative of the "monist" approach to social systems, the political process can often be considered in pluralist terms. Politicians who may favor the development of PPBS must also consider the impact of such a planning process on pork-barrel legislation and logrolling transactions. As a result, there is an inherent tension

between rational planning techniques, that are epitomized perhaps by PPBS, and the multifaceted and often self-contradictory political structures that are expected to make use of planning techniques.

Project Management is a management approach that was developed in the military/industrial complex as a means of satisfying the requirement for management of defense resources from inception to operational employment. It entails the blending of the technical know-how of many functionally oriented organizations under one centralized coordinating and managing mechanism whose prime role is to synchronize and integrate an aggregation of resources. Project Management is based on the systems approach to action. It has proven to be particularly successful when applied to a one-time undertaking that is definable in terms of a specific end result and bigger than the organization has previously undertaken successfully, [p. 2g3] By definition, a project has an objective end point in time. The project management approach entails the appointment of one man who has the responsibility for the detailed planning, coordination, and ultimate outcome of the project. The essence of Project Management is that it cuts across, and, in a sense, conflicts with, the normal organizational structure. Throughout the project, personnel at various levels in many functions of the organization contribute and are recognized as the "team." With sanction from the top, the team members concentrate on their target under the direction of the, project manager, any relationships to their functional departments during the project period being

of a qualitative nature only. Project Management is “adhocracy.” [p. 125]

In the future, the movement toward comprehensive human service delivery programs will rely heavily on both PPBS and Project Management. As governmental limits develop program goals that require interorganizational collaboration for their attainment, action will be framed into temporary settings, where the meaning of “management” will have fuller significance (“How can we *manage* this problem?”), and the negative aspects of bureaucracy will subside due to team involvement in decision-making and environmental input from the community. Such a comprehensive approach will rely on staff development and in-service training programs to provide team members with the tools for effective collaboration. It will also require a pertinent program evaluation and review component to analyze the progress of interdisciplinary team collaboration in goal attainment as well as obstacles to attainment that are related to the functional units from which team members are' drawn. Much thought must still be given to the relevance of the professional education models upon which the various human services are founded, and what reforms might be conducive to comprehensive team functioning. Finally, the limits of team functioning must also be considered, so that one form of bureaucracy is not simply replaced by another irrelevant style of service delivery. The process of planning is never automatically correct and never free from the intrusion of human values. However, the only alternative is haphazard ignorance.

Service Delivery in a Systems Setting

How human service will be provided in the future is closely related to the above propositions. If the governmental response to societal problems is to advocate the concentration of public resources in priority fashion with limited emphasis on organizational jurisdictions, then both governmental units and large organizations will be involved in the development of smaller, more time-limited service units that will function as microsystems in their service delivery patterns. These units, whether created through interagency collaboration or through intra-agency mandate, will be functioning in an atmosphere of management-by-objectives where the individual's preference for how his job can best be done is considered a primary factor in planning goal attainment. These units, or teams, will not be found by the limitations of traditional authority and control; rather, they will be working in an environment beyond the current understanding of bureaucracy.

For the most part, today, professionals in the field of human service adhere to the concept that the individual worker is the prime conveyor of service delivery—a concept with roots in various schools of professional training. The organization is seen as a means by which professionals can utilize their skills. In such settings caseloads, colleagueship, and compensation, within rather rigidly defined patterns, are provided. The organizational requirements are tolerable; the interpersonal relationship

between professional and client, however, is primary.

As a result of this situation, professional agencies today abound in conflict. With external pressure from both governmental and community groups for effective resolution of social problems, the primacy of the one-to-one mode of service delivery is being questioned by agency executives on two counts: the impact of profession-specific intervention in increasingly multiproblem situations, and the fiscal and social costs of specialized service delivery, vis-a-vis fragmentation, duplication, and inappropriate response. Internally, the problems inherent in organizational change that relate to roles, status, informal groups, professional values, etc., have created near or at times open confrontation within many agencies. Consequently, in the past decade human service organizations have attempted to go beyond their specialized boundaries in a variety of ways, most of which have not achieved their limited goals due to lack of impact on the organizational structure. Some agencies have attempted to collaborate by placing their staffs in close geographic proximity (i.e., the same building) with reliance on daily contact. Others have functioned through the use of interagency conferences, meeting locally as needed to discuss problems of coordination, [p. 37] Still others have introduced project management, wherein agencies surrender part of their jurisdiction over staff chosen to form an interagency-comprehensive service delivery model. This approach is perhaps the optimal form of interagency service collaboration that can be achieved as long as bureaucracies continue

to exist.

However, an alternative to the approach of interagency coordination is a real possibility, especially in the public sector. Large organizations will emerge, characterized by such features as diversity of interest, complexity of relationships, unity of control, and decentralization of service delivery that is comprehensive in nature. Such agencies will employ the techniques of PPBS, Project Management, Organizational Development, etc. in the achievement of their quest for responsive service delivery. Staff patterns will increasingly reflect multidisciplinary training, for such organizations will attempt to avoid the extrusion of people needing help by broadening the service delivery base. Knowledge of mental health, child care, education, etc., will readily be available for input into case situations, and the means for such availability is seen in the unit or team structure.

In this setting, the role of the project or team manager is of primary importance, for it is he who meets the *team* response to the patient need. Coordination is the essence of this decision-making role, for the manager must match the skills of his personnel with the multiproblem situation under consideration. This role should not conflict with the content of professional involvement; rather, it sets the boundaries of the unit's (and ultimately the agency's) systematic intervention into the case, based on the recommendations of the multidisciplinary team. To achieve efficiency of team

functioning, a process of organizational development is essential so that the limitations or confines of prior professional training do not retard the achievement of comprehensiveness in service delivery. Ultimately, it should involve considerable "self-analysis" on the part of each professional to determine if his personal goals are congruent with those of the organization.

If the preceding comments seem unrelated to what the field of psychiatry is engaged in today, it may be more a conflict in values than one of fact. What this exposition has intended to accomplish is to state a personal viewpoint of an emerging reality. As Machiavelli has cautioned: "There is nothing more difficult to take in hand, or more uncertain in its success, than to introduce a new order of things." Let judgment occur in this light.

Such judgment will be affected by the fact that in the next few years major changes will be effected in the health-care delivery systems in this country. It is difficult to predict the nature and extent of such changes except to speculate that they will be of major dimensions because of increasing technology, cost factors, consumer expectations, and many other considerations.

At a time when we face the possible loss of a generation of caregivers as a result of phasing out of federal support for training programs in the mental health professions, there will have to be a redirection in our training

emphasis. Continuing education programs for all mental health professionals, of relatively short-time duration, and thus less costly, might be one answer. Such programs can be evolved with state and local support, perhaps even some federal support, to keep our manpower pool abreast of such factors as social causation, consumer needs, and needs in treatment methods as well as the best administrative and management techniques applicable to make available quantity and quality of care in a continuum of human service delivery. Therefore, it is incumbent upon every practicing physician and psychiatrist to keep himself abreast of changes that are taking place; each in his own way to involve himself meaningfully, thus ensuring the development of safeguards, in whatever system of care is adopted, for the protection of the patient, the public, and the profession.

Bibliography

Alexander, J. B. and J. L. Messal. "The Planning-Programming-Budgeting System in the Mental Health Field," *Hosp. Community Psychiatry,* 23 (1972), 357-361.

Barten, H. H. and L. Bellak, eds. *Progress in Community Mental Health,* Vol. 2. New York: Grune & Stratton, 1972.

Bennett, W. F. Statement at National Conference on Professional Standards Review Organization, Albuquerque, N.M., Feb. 1973.

Bernard, V. W. "Some Principles of Dynamic Psychiatry in Relation to Poverty," *Am. J. Psychiatry,* 122 (1965), 254-267.

Candib, L. M. "A Social Study of the Health Center Movement: A New Approach to Public Health

History." B. A. thesis, Harvard University, 1968.

Churchman, C. W. *The Systems Approach.* New York: Dell Publ., 1968.

Congressional Record. "Allied Services Act of 1972," May 18 (1972), S8124.

Connery, R. H. et al. *The Politics of Mental Health.* New York: Columbia University Press, 1968.

Eisenstadt, S. N. "Bureaucracy, Bureaucratization, and De-bureaucratization," in J. A. Litterer, ed., *Organizations,* Vol. 2, pp. 255-263. New York: Wiley, 1969.

Emery, F. E., ed. *Systems Thinking.* Baltimore: Penguin, 1969.

Ewing, D. W. *The Human Side of Planning.* London: Macmillan, 1969.

Foley, A. R. and P. Gorham. "Toward a New Philosophy of Care: Perspectives on Prevention," *Community Ment. Health J.,* 9 (1973), 997.

Foley, A. R. and D. S. Sanders. "Theoretical Considerations for the Development of the Community Mental Health Center Concepts," *Am. J. Psychiatry,* 122 (1966), 985-990.

Glasscote, R., D. S. Sanders, H. M. Forstenzer et al. *The Community Mental Health Center: An Analysis of Existing Models.* Washington: Joint Information Service Am. Psychiatr. Assoc, and Natl. Assoc. Ment. Health, 1964.

Glasscote, R., J. N. Sussex, E. Cumming et al. *The Community Mental Center: An Interim Appraisal.* Washington: Joint. Information Service Am. Psychiatr. Assoc, and Natl. Assoc. Ment. Health, 1969.

Gulick, L. and L. Urwick. *Papers on the Science of Administration.* New York: Inst. Pub. Admin., 1937.

Hatry, H. P. and J. F. Cotton. "What Is a PPBS System?" in R. T. Golembiewski, F. Gibson, and G. Y. Cornog, eds., *Public Administration,* 2nd ed., pp. 230-247. Chicago: Rand McNally, 1973.

Jones, E. *The Life and Work of Sigmund Freud,* Vol. 3. New York: Basic Books, 1957.

Kaplan, S. R. "The Use and Abuse of Federal Derived Health Delivery Funds as Instruments of Political Action: The Lincoln Hospital Community Mental Health Center." Presented Annu. Meet. Professors West of the Mississippi, La Jolla, Calif., Sept. 1972.

Litwak, E. and H. J. Meyer. "A Balance Theory of Coordination between Bureaucratic Organizations and Community Primary Groups," *Admin. Sci.* (J., 2 (1966), 31-58.

Meyer, A. Address presented to the International Congress of Medicine, Vienna, 1913.

Newhouse, J. P. "A Design for a Health Insurance Experiment," Rand Corporation Study-965-OEO (1972).

Newman, D. E., H. S. Goldstein, and V. Kazanjian. "A One-and-a-Half Year Experience with Peer Utilization Review." Presented 126th Annu. Meet. Am. Psychiatr. Assoc., Honolulu, May 1973.

Nixon, R. M. "Veto Message of Labor-HEW Appropriation Bill," *Congress. Q. Almanac,* 26 (1970), 19A-21A.

Peabody, F. Quoted in *Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health.* New York: Basic Books, 1961.

Rockwell, M. A. Seminar presentation, Columbia University, Feb. 1973.

Rosen, G. "Public Health: Then and Now. The First Neighborhood Health Center Movement—Its Rise and Fall," *Am. J. Public Health, 61* (1971), 1620-1637.

Sayles, L. R. and M. K. Chandler. *Managing Large Systems: Organizations for the Future.* New York: Harper & Row, 1971.

Schwartz, D. A. "Community Mental Health in 1972: An Assessment," in H. H. Barten and L. Beliak, eds., *Progress in Community Mental Health,* Vol. 2, pp. 3-34. New York: Grune & Stratton, 1972.

Stewart, J. M. "Making Project Management Work," in D. I. Cleland and W. R. King, eds., *Systems, Organizations, Analysis, Management: A Book of Readings,* pp. 291-302. New York: McGraw-Hill, 1969.

Stoekle, J. D. and L. M. Candib. "The Neighborhood Health Center—Reform Ideas of Yesterday and Today," *N. Engl. J. Med.,* 280 (1969), 1385-1391.

Toffler, A. *Future Shock.* New York: Random House, 1971.

United States Congress. *Mental Health Study Act of* 1955. *Public Law,* 84-182.

----. *Declaration of Purpose: Professional Standards Review Organization.* Sect. 249F of HR 1, g2nd Congress. Public Law, 92-603.

----. *Health Maintenance Organization and Resources Development Act of 1972.* S327 of 92nd Congress; reintroduced as S14 in 93rd Congress.

White, W. A. Quoted in R. H. Williams and L. C. Ozarin, eds., *Community Mental Health: An International Perspective.* San Francisco: Jossey-Bass, 1968.

Wilensky, H. L. and C. N. Lebeaux. *Industrial Society and Social Welfare.* New York: Russell Sage Foundation, 1958.

Notes

1 This pessimistic view appears to be confirmed by a survey released by the Office of Revenue Sharing at the United Conference of Mayors in San Francisco on June 19, 1973. According to the survey, which covered the reported use of $5.1 billion of general-revenue-sharing funds by 574 units of state and local governments, during the first year's activities under a new revenue sharing program, only 8 percent of the total was invested or planned for use in social-service areas. (*New York Times*, June 20, 1973.)

2 The act was reintroduced unchanged at the start of the Ninety-third Congress.

3 The description of the coverage for mental health care was provided by M. A. Rockwell of the Rand Corporation both during his seminar presentation25 and during a subsequent personal

communication. It expands on information contained in reference 21.

4 I first suggested this approach in a paper presented at the Twenty-third Institute on Hospital and Community Psychiatry, Seattle, Washington, September 1971. It is contained in a somewhat different form in reference 11.