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SOCIAL WORK

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Table of Contents

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It will be the purpose of this chapter[1] to reflect four main themes: an overview of the emergence of social work and its relation to psychiatry and mental health over the last century; a review and analysis of significant events influencing social work in the past decade; a discussion of social work as a professional resource in mental health; and an assessment of the main issues in social work practice as it relates to mental health.

When stripped to the barest essentials, the goals of the professions of social work and psychiatry can be said to be derived from a mutual concern for the continued well-being of the individual and for the preservation and enhancement of the health-generating capabilities of the family, community, and society in general. The antecedents of the two callings have deep roots in antiquity, in the Middle Ages, and in the colonial period of American history. The Biblical injunction to tithe for the welfare of the widow, the orphan, the stranger implies a concern for the economically deprived that translates in modern times to the guaranteed annual income, still distant in any terms satisfactory to social workers. It was the fate of the mentally ill or disordered to be regarded either as holy or demon-possessed, with only painfully slow emergence of more humanitarian efforts at care and treatment as the science of medicine emerged from the Dark Ages and men like Benjamin Rush in

America, Philippe Pinel in France, and William Tuke in England introduced immense changes in the care and treatment of the mentally ill.[28] In colonial times the almshouse was the traditional community resource for the indigent and disabled citizen, if he was not auctioned to the lowest bidder who offered to provide care at the least cost. Almshouses were administered by overseers of the poor under pauper laws derived from the Elizabethan Poor Law of 1601. The need for more specialized care was recognized with the founding of the first state mental hospital at Williamsburg, Virginia, in 1773, but these early hospitals were frequently nothing more than almshouses under another name.

A number of authors have described the growth and development of institutions for the provision of care for the mentally ill during the nineteenth century.[20,26,70,75] Perhaps one of the most significant contributions to improvement of care for the mentally ill was made by Dorothea Lynde Dix, a pioneer in reform who was active in mid-century. Albert Deutsch[28] describes at some length her vast contributions to the cause of the mentally ill. She was responsible for changes in the programs for the care of mental patients in 20 states and in foreign countries as well. She was directly responsible for the founding or enlarging of 32 mental hospitals in the United States and overseas, including the Government Hospital for the Insane in Washington, D.C. (now known as St. Elizabeth's Hospital). It is worth noting that Miss Dix was successful in securing passage through the Congress in 1854 of a bill that

would have allocated federal land to the support of "the indigent insane." This bill was vetoed by President Franklin Pierce in a message that contained a flat denial of federal responsibility for provision of resources for the care of the mentally ill.[70] It took almost a full century to bring about a complete reversal in the philosophy of government, which culminated in President Harry S Truman's signing of the National Mental Health Act in 1946.

Social workers of the nineteenth century were concerned with problems of poverty and social pathology. They took the lead in moving states toward taking responsibility for the more orderly structure of social services in the nineteenth century. This tended to be in the form of institutions derived from the almshouse of the colonial period. The range of public and other eleemosynary institutions included not only hospitals for the insane but also institutions for orphans, the mentally retarded, and aged persons.[75] These organizations for congregate care were built with the best of intentions to provide a place where food, clothing, and housing, the essentials of life, could be provided in a central location and at the lowest cost to the community. Frequently these institutions were built out in the country adjacent to farm property so that the residents, or "inmates," could be employed.

American social work in the nineteenth century was concerned with the organization of charity and the extension of welfare benefits to the poor and

disabled members of the population. The early charity organization societies were intended to bring together the various existing charitable institutions so that they could provide service in a more systematic manner. Borrowing on a model already established in England, the first Charity Organization Society was established in Buffalo, New York, in 1877. The problems of poverty in the big cities were addressed mainly by the social settlements established along the model of Hull House in Chicago. Here Jane Addams established a service unit in an old home in the midst of the immigrant area. The concept of service established by Jane Addams at the turn of the century was one of forthright advocacy for the dependent and immigrant populations. Hers was one of the early social service centers that offered multiple services to the community. These services included educational activities for adults and children, counseling resources for people with problems, and promotional activities to correct injustices in the community. Jane Addams was an early supporter of the labor movement in this country, aggressive efforts toward achieving women's rights, correction of child labor abuses, and improvement of the human lot through social legislation.

The end of the century saw the beginning of professional social work education in the establishment of the New York School of Social Work in 1898.[22] Social services of the pattern offered by the typical charity organization society were the model for voluntary effort in behalf of the urban poor.[110] The first decade of the twentieth century saw the

establishment of medical social work in Boston and psychiatric social work in New York City.[58-65] In 1906 the addition of a trained worker, Miss E. H. Horton, to Manhattan State Hospital under the auspices of the State Charities Aid Association marked the first effort to employ a trained person in social services related to the mentally ill.[28] The development of social work as a profession brought early recognition of the remedial nature of this occupational group. The emergence of social case work was noted with the publication in 1917 of *Social Diagnosis* by the Russell Sage Foundation. Miss Mary Richmond, an early pioneer in social case work, very soon emphasized the need to consider the broad social planning aspects as well as the individual treatment issues involved in dealing with human problems.[71]

The period of World War I gave birth to a school for social work devoted entirely to the training of psychiatric social workers (Smith College). It also gave impetus to the development of the mental health movement, a field in which social workers became much interested ever since Clifford Beers wrote his stirring account of his experiences as a patient in *A Mind That Found Itself.* An additional impetus came from the establishment of the first child guidance clinic in Chicago, involving collaborative work between social workers, psychologists, and psychiatrists. The need to provide servicc for mentally ill soldiers and later for veterans provided an incentive for social work to move substantially into the area of social services for the mentally ill. The first social services for veterans were established under the auspices of the U.S.

Public Health Service and then transferred to the Veterans' Administration. This was the period that saw the emergence of the American Association of Schools of Social Work in 1919 and the American Association of Social Workers in 1921. The former was concerned with standards for education of members of the profession. In 1926 the American Association of Psychiatric Social Workers (AAPSW) began with a requirement for rigid training patterns that would assure that the graduate social worker would have an adequate orientation in mental health and psychiatric content. This type of instruction was introduced in a number of schools in the 1920's. Following World War I psychoanalysis came into vogue and was introduced in schools of social work. This event preoccupied the field for 20 years. Some have felt that the dominant role of psychoanalytic theory retarded the emergence of advocacy as a role for social work.[17]

During this period the Commonwealth Fund financed a series of child guidance clinic demonstrations in several American cities. Social workers participated in the team activities in these demonstration clinics, many of which still exist today. Another important innovation developed by the Commonwealth Fund was that of school social work. Psychiatric social workers found themselves very much involved in social work in the schools because of the possibility for preventive work with children at an early stage in their lives. The Commonwealth Fund fostered the development of psychiatric social work not only in the United States but also in England.[85] A

number of English social workers came to the United States for training and returned home to establish training for psychiatric social work, first at the London School of Economics and Political Science in the late 1920's and then later in other universities throughout the United Kingdom.

Of all the vulnerable population groups requiring social services, the mentally ill seem foremost in this respect. The nature of mental disorder is such that it causes serious problems not only for the individual but also for the family. The unpredictable nature of schizophrenia and the devastating effect it can and does have on the immediate family is cause for social concern. The same is true of mental retardation or childhood mental disorders, which are so frequently beyond the scope of parents' ability to deal with without expert help. Psychiatric social workers moved very quickly to develop working relationships with psychoanalysts and psychiatrists in the provision of individual and group services for the mentally ill.[5] Social workers also pioneered in the development of foster care as a means of treatment for the mentally ill. Borrowing on ideas for home care developed in Belgium and elsewhere, New York State and later Maryland pioneered at an early stage in the movement of patients into foster homes in the community as the alternative to hospital care.[20] These foster homes were the predecessors to the halfway houses of today, which provide for group care for patients on an extramural basis.

A study by Lois M. French[35] published in 1940 surveyed the field of psychiatric social work and recorded the distribution of social workers in mental hospitals and child guidance clinics. It also revealed the numbers in training at the time and reviewed the educational programs available to them. This was a period of organization for psychiatric social workers, and they developed a powerful professional organization that played a most useful role in the ultimate development of community mental health services and of wartime social services for mentally ill soldiers. An ample literature describes both of these developments.[13,58]

Major changes occurred in the 1930s and 1940s when the major national and international events of the Great Depression and World War II visibly affected the field of social work.[20,22] The Great Depression of 1931-1939 saw a large number of social workers drawn into public assistance and public child welfare. The public social services became a major arena for the practice of social work. Similarly the impact of World War II provided new challenges to the field.[22] Both on the home front and in the military services social workers were called upon to do more to become involved with problems of individual and social pathology. Social workers in the American Red Cross carried on the work of their predecessors who were field agents for the U.S. Sanitary Commission during the American Civil War. The social workers were very closely related to problems of military families left behind and to crisis situations. In the military services case work and group work

were the typical methods used in direct services for military personnel. A most significant development took place through the encouragement and reinforcement of psychiatrists outside and in the service.[54] The result of the introduction of social services into the military establishment was a creation of a group of social work officers, with career lines for enlisted men as well in the role of social work technician. The most far-reaching development took place in the U.S. Army, beginning with psychiatric social work at first, but extending to include medical social work and eventually developing as a program of community services. A somewhat similar development has taken place in the U.S. Air Force. The Navy never developed a uniformed military social service program, and as a result it is without the benefit of an infrastructure of social services for its personnel.

The pattern of development of social services for veterans provided for both institutional and community services during the postwar period. The Veterans' Administration has responsibility for care, treatment, and rehabilitation of over 100,000 hospital patients (more than one-half of these are mental patients). There is an acute need for personal and community social services for veterans and their families.[7] The VA now employs over 2,000 qualified social workers as part of the manpower devoted to the provision of services to veterans.

Some of the research conducted by the Veterans' Administration has

had significant import for the practice of social work and psychiatry. For example, an outplacement study, which provided for a large-scale evaluation of all patients from 16 VA hospitals, found that 16 per cent of the medical, surgical, and neurological patients and 50 per cent of the psychiatric patients could have been cared for in a nonhospital setting if "appropriate services and/or living care situations were or could be made available."[61] It is quite possible that similar studies in other mental and general medical and surgical hospitals would reveal somewhat similar findings. This places the important responsibility on the professional staff to insure that patients are properly evaluated and are not retained in institutional situations longer than is necessary. In the mental health field the development of halfway houses and intermediate institutions has done much to curtail the lengthened hospitalization of patients beyond the period actually needed.

The period following World War II brought about profound change in the direction of social work and the mental health field. During the war the ferment began that led by 1955 to the amalgamation of five separate social work organizations into a single united national organization called the National Association of Social Workers (NASW). The immediate effect of the experience gained from the problems of mental illness among soldiers, coupled with the unrest emerging from the dismal record of the mental hospital system as a means of providing care, led to the passage on July 3, 1946 of the National Mental Health Act (Public Law 79-487). The National

Mental Health Act made matching funds available for the expansion of state mental health services, with particular emphasis on outpatient care[32] Funds were made available on a much expanded basis for support of mental health research and training. The availability of teaching grants and stipends for students permitted the training of greatly increased numbers of psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses for work in mental health. A number of related projects advanced work on educational standards in the core professions.

At Dartmouth College in 1949 a group of practitioners, educators, and psychiatric social workers on the faculties of schools of social work met to review the status of training for psychiatric social work. A system of communication was established among these educators that led to the introduction of more modern teaching methods and to the adaptation of content from psychiatry and the social sciences into the social work curriculum.[6]

The publication in 1952 of the AAPSW Study, *Social Work in Psychiatric Hospitals and Clinics*,[11] permitted an overview of where social workers were to be found and what they were doing in the mental health field. During this period the state mental health authorities were established in all 53 states and territories, with state-level planning and administrative staff dedicated to the improvement and expansion of services throughout the state. There was a

period of reassessment of mental hospital care and its relation to community mental health. It was during the 1950's that the existence of case work as a dominant social work method was emphatically challenged. A significant growth took place among practitioners and educators who were prepared to offer the group method or community organization method in social work practice.

It was also a period in which the field of social work education moved toward assessment and evaluation. The publication of the Hollis- Taylor report led to the establishment of the Council on Social Work Education, which became the standard-setting body governing preparation for the field of social work and social welfare.[44] The curriculum policy activity of this organization led eventually to the declaration of the end of specialization in social work training at the master's level. By 1959 it was agreed that all specialization training would end, and that the master's degree would be regarded as a generic concentration, which would only provide for a specialization by method rather than field of practice.

The Council on Social Work Education in the late 1950s undertook a massive national curriculum study. The result was publication of 13 volumes dealing with several areas of the social work curriculum and with general issues affecting social work education. The study gave a strong impetus to the development of undergraduate social work education. One of the major

recommendations was that there be exploration of the continuum from undergraduate to graduate education in social work.[15]

During the same period a National Joint Commission on Mental Illness and Mental Health was established by the Mental Health Study Act of 1955. After five years of survey and research the final report of the Joint Commission was published as a volume entitled *Action for Mental Health*. This report was released in the early years of the Kennedy administration, and by 1963 new legislation was passed that established the community mental health center as the focal point for the delivery of community mental health services. It should be noted that during the 1950's the advent of drug therapy and its widespread use led to a significant decline in hospital populations. The number of people in hospitals began to decline at the rate of 5 to 7 per cent a year. The result was an increasing demand for community care facilities. The Mental Health Centers Act provided for a planning period with the allocation of funds for this purpose to each of the states and territories. The states' plans permitted a restructuring of resources to include a complex of hospital and community treatment and rehabilitation facilities as a single network. Many states moved quickly to pass their own community services acts as a means of providing a legislative framework for the restructuring of the delivery of mental health services.[5]" As the new community mental health centers came into being through the availability of construction funds and staffing grants, new modes of practice began to develop. A considerable literature now exists

on the early stages of the operation of community mental health centers.^14,21,82 jhp ro]e 0f social work in these centers is significant. Social workers participate not only in the treatment services, which in many cases still operate along traditional lines, but also in the outreach and community organization functions of the community mental health center. An early study of professional staff functions in mental health centers indicated that over half of staff time was directly related to patient care.[36] Outreach functions were in their early stages.

Significant Developments in the 1960s

During the 1960's a number of highly significant events took place in social work education. The development of a new curriculum policy statement in 1962 provided a reorientation of master's level education in social work. Increased prominence was given to development of the social work methods of group work and community organization. The curriculum policy moved toward a much more integrated curriculum involving human growth and behavior and content on the social environment. Expanded content in social welfare policy and services was added. The guidelines provided for flexibility of curriculum organization and structure. A number of schools of social work conducted curriculum studies that led to the reorganization of program content in social work education.

Under the aegis of the Council on Social Work Education, a five-year period of consultation service intended to foster the development of new schools of social work in unserved areas resulted in the addition of a number of graduate schools of social work in states that had hitherto been without social work education. These were mainly Southern states such as South Carolina, Arkansas, and Alabama. In addition, unserved regions in other states such as western Michigan, central Kentucky, and northeastern Pennsylvania also developed educational resources.

Perhaps the most significant shift in social work education came from the rising recognition of the place in the curriculum of community organization and social policy. Several influences arising from social and economic developments in the 1960's contributed to this situation. One was the rise of the movement toward comprehensive health and mental health services and the introduction of national legislation calling for regional planning and for the development of community health planning as a collaborative effort to organize health services for more effective and efficient delivery at the local level. A second major influence was the introduction of the poverty program in 1964. This massive "war on poverty" resulted in a host of federally funded endeavors aimed at creating "equal opportunity" for the poor and underprivileged in American society. Community action programs were introduced in most major urban areas and in many rural areas that had never before had a consciously directed effort to look at the

causes of poverty and to take some action about them.[72] As inadequate education was seen as a major deterrent to upward mobility, the Head Start program was introduced as a means of upgrading the educational prospects for children in families where deprivation was the characteristic mode of life. Lastly a new modality of service for local delivery was developed in the neighborhood service center. These centers were established to serve as a basis for community action programs and other types of social services in the community. An outstanding example of such a center was the Mobilization for Youth program in New York City, which served as a model for a research training and service agency based in a poverty area and making use of new careers and paraprofessional personnel drawn from the indigenous population in the community.[10]

By the end of the 1960's a new network of services was spread through the community, calling for entirely new modes of professional behavior. Social work and social workers were profoundly influenced by these developments. This was particularly true in the mental health field.[33 93]

During this period case work as a method for delivery of service came under fire as being too narrowly related to the individual and his personal problems and not sufficiently related to problems of society and the welfare of the community as a whole.[49] Social case work has been described as a "problem-solving process"[64] and as "psychosocial therapy"[45] by leading

theorists in the field. The activist atmosphere of the 1960's led to greater concern for factors influencing the entire social system.[29,82] Students and minority groups pressed for changes. Consequently much more of the curriculum was devoted to studying the social forces influencing society and the means of changing social policy. There was considerable increase in the proportion of students enrolled for field instruction in community organization and in group work.[24] In addition, there were increasing numbers enrolled in social work educational programs that provided for training in integrated methods, bringing together case work, group work, and community organization as a single integrated social work practice method.[1'] The pioneering efforts in this regard began on the West Coast and have influenced social work education throughout the country.

Schools of social work have responded to this challenge by developing learning and teaching centers built principally around a single field instruction agency, or a cluster of agencies, where a variety of experiences can be made available to the student in individual treatment, group work or group therapy activities, and community organization.[56]

The development of Medicare and Medicaid as an extension of the poverty program was intended to aid the aged and those who are in economic need for any reason to receive the full range of medical care. The application of Medicare and Medicaid to problems of mental health and mental illness has

not been easy. One problem is the lack of adequate facilities throughout the country to provide the required care; the second is the problem of articulation of these programs with the existing health and welfare establishments in order to provide a good coordinated effort.[88]

A particularly important influence on the field of social work in the past decade has been the advent of the community mental health centers program. By 1970 there were 425 such centers throughout the country, serving catchment areas of from 75,000 to 150,000 population. As Bertram S. Brown[19] has pointed out, these facilities will need to plan for interaction with the proposed health maintenance organizations. Social workers have taken the initiative in helping develop new roles for consultation and education,[67] for emergency services,[59] and for community planning.[48] Social workers have also taken the initiative in the introduction of group work and group therapy into mental health settings.[60] [76] One of the early studies of social work practice in hospitals and communities demonstrated that about 12 percent of social workers were conducting some form of group activity in their hospitals and clinics.[11] The role of social work in community mental health in stimulating citizen participation is increasing, and much work has been done to help organize consumers. More social workers are found in institutions involved in delivery of mental health services.[58] It has been found that aggressive work in the community can frequently avoid hospitalization of mental patients.[83] This takes careful work with the patient, with his family,

and with the community resources that provide the support system.[30]

In summary, it could be said that the decade of the 1960s was a period of development and consolidation of the practice of psychiatric social work beyond the clinical concept of personal treatment on an individual or group basis. The role of social work as the communication link between the patient or client and the community continued to be regarded as essential to total service for patients. Many social workers took an important part in the revolution in mental health, which found some mental hospitals serving more frequently as diagnostic and short-term treatment facilities as an adjunct to their former status as longterm care institutions. Unfortunately there remains a hard core of mental patients who have become so adapted to the culture of the institution that it is difficult to interrupt what has become a satisfying social situation. In addition, for many of these patients their families have disappeared over the years, and there would be no way to arrange for community care except through foster care or similar arrangements. The use of more home care facilities and extended community care has permitted the prevention of hospitalization or the reduction of its length and the provision of services closer to the client's home or in his own home. The development of the community mental health center had by the end of the 1960's pointed a new way to service provision at the local level.[62]

Social Work as a Professional Resource in Mental Health

French's[35] 1940 study outlined the characteristics and deployment of psychiatric social workers at that time. Social workers were found in mental hospitals, in mental health clinics, in child guidance clinics, in school social work programs, and in a wide variety of services where their training and background permitted the application of knowledge about human growth and development to psychosocial problems of individuals and families. Psychiatric social workers were envisioned as team members making a specific contribution to the diagnosis, treatment, and rehabilitation of mental illness. These support and treatment dimensions have continued to the present.[58] Social workers are found in a wide variety of mental health resources, including the new community mental health centers.

The psychiatric social worker provides service throughout the cycle of illness and recovery by being available from the point of intake into the clinic or hospital through ultimate recovery. An important initial screening function takes place at intake. Situations involving serious interpersonal conflict or parent-child dysfunction in social relationships require prompt action in terms of interpretation to the sick person or to the concerned relative. In emergency services the social worker frequently initiates a plan for the temporary care of children or for counseling and advice to a spouse who is left without his or her mate. When mental breakdown requiring hospitalization occurs, these pressures are met through the development of alternate care within the childrens' own home with the assistance of relatives

or homemakers or through alternate means of care that can be provided through child welfare facilities in the community. The advent of drug therapy has frequently meant that it is possible for the affected parent to be returned home fairly soon. This is another point at which the psychosocial evaluation is materially aided through the participation of the psychiatric social worker. During the early stages of assessment and evaluation of psychiatric illness, the social data are compiled and made part of the total assessment of the factors that lead to treatment plans and to continuing evaluation of the patient's progress and his capability for being returned to his home environment. The better equipped communities now have a number of alternatives available that materially affect the possibilities for convalescence and complete recovery. These are favorably influenced by the availability of well-staffed day-care centers, halfway houses, and opportunities for partial hospitalization, which make it possible for the patient to resume employment using the hospital or intermediate care facility as a base. The social worker participates in planning for the continuum of care so that, as the patient moves toward control of himself and appropriate use of his capabilities, he is able to establish a stable relationship with his home and community. The social worker frequently is used as a resource for information regarding the service system of any given community.

In the child guidance clinic the psychiatric social worker, in addition to performing in the intake and evaluation function, carries main responsibility

for intensive treatment of parents and children in a collaborative team relationship with other members of the mental health service constellation. In addition to individual case work treatment, the social worker frequently provides group therapy, a modality that is now found in nearly every psychiatric resource. The responsibility for group therapy may be carried by an individual staff member or by a team working toward specific objectives with a selected group of patients or relatives. Group therapy may be conducted in the community with relatives of mental patients as a means of providing support and interpretation and as a means of assisting in the resumption of normal living when the patient returns home.

The provision of direct treatment by psychiatric social workers is a responsibility undertaken in the light of the long-standing tradition that social workers are equipped to undertake intensive treatment. Case illustrations describing the interaction of social worker and client in social and mental health resources are found in the case work literature. The Grayson Case in Perlman,[64] for example, describes work with a male veteran receiving service in a privately supported psychiatric clinic (pp. 207-222).

Case work involves direct application of knowledge about psychological and social behavior in the interaction with individuals and families with problems of adaptation to life stress and interpersonal conflict. The case work method is one of the primary tools available to the psychiatric social worker

in the practice of direct work with clients and patients. It is the most typical of the methods used by social workers providing direct services.[17] In addition to the application of case work and group work methods in mental health, many social workers are now being recruited because of their community organization skills. The community organization social worker is involved in developing citizen participation through advisory committees and similar structures. He also carries on linkage and liaison relationships with relevant social and health agencies. His function on the mental health team is critical to the development of community relationships so importantly linked to the education and consultation functions of community mental health.

The psychiatrist, psychologist, nurse, and social worker are seen as co-workers in service delivery administration and educational activities in the care, treatment, and rehabilitation of the mentally ill. Characteristically they are engaged in collaborative work on preventive activities as well. Parent education on child development is one frequent area for collaborative work. Another involves cooperative activities in the public school system with teachers and guidance personnel. Social workers initiate outreach activities that bring services directly to the community. A program of this type is described by Briar and Miller[17] (pp. 237-238). In this ease social workers work from a specially equipped van that is operated directly on the streets of an urban poverty area. There is growing interest in such experimentation with extended social services.

Trends and Implications for Future Practice of Social Work

There has been a considerable evolution in the role and function of social work in mental health. This change has reflected newer attitudes and applications of knowledge and skill throughout the structure of human services in the United States. In addition to manning the established agencies, social workers have moved into community mental health services from the very beginning. With the exception of psychiatric nurses they tend to rank highest in terms of numbers employed in mental health centers.[30] There are emerging a number of descriptive patterns of the work conducted by community mental health centers. The variety of programs offered can be seen from a report on the provision of mental health training for public welfare personnel.[67] The NIMH has periodically reported on the status of work in community mental health centers, including reference to community involvement and the use of paraprofessional personnel.[62] One of the more unique aspects of mental health center operations is that involving the emergency services. These are intended to prevent entrance of patients into the typical mental hospital system.[34] Active use is made of home care, foster care, and day care as means of providing alternatives to hospitalization.[4] here is also an extension of social service and mental health consultation in connection with outreach services.[21] These have been found particularly helpful in consulting around problems of illegitimacy in the community.[79] Some of the newer trends have involved the use of behavior modification as

part of the treatment armamentarium available to social workers.[84]

During recent years social work has penetrated deeply into such insitutions as the public schools,[47] the military services,[27] and the Veterans' Administration, where they have staffed community as well as mental health treatment services. Veterans' Administration social workers have experimented with outreach programs dealing with the physically as well as the mentally disabled.[7] Social workers with mental health preparation have been particularly useful in suicide prevention centers,[31] in alcoholism service centers,[51 74] and in narcotic treatment programs. Some have conducted long-range research in drug addiction dealing with the social factors involved in narcotics addiction.[18] Other social workers have developed programs in the fields of geriatrics[42] and of mental retardation.[68] In a number of institutions a wide range oPgroup work and group therapy services have developed.[60] The participation by social workers in such programs has increased considerably during the last decade.

It could be said that a wide range of skills is brought to community mental health- services by social workers prepared at the master's and doctoral levels. It is possible that the numbers of baccalaureate level workers will increase considerably as more use is made of manpower with less than full training. The number of community mental health workers trained at the associate of arts level will also be increasing as means are found for deploying

personnel with a wide range of skills and capabilities. Several studies have been conducted and a number of reports exist on work being done by paarprofessionals in the mental health field.[41 80] It is beginning to be seen that this group of mental health workers is essential to the offering of a complete mental health service in any community and in any institution. A number of special training programs have developed to help prepare paraprofessional workers in the mental health field.[80]

It can be anticipated that the number of patients in the older type mental hospitals will be changing in keeping with the trend away from custodial care toward treatment in the community.[40] Social work will be playing an increasingly important role in the development of extension and outreach services. Indeed, there will be a considerable development of social work in connection with prevention as well.[63 69 93] The capabilities of social work are particularly related to outreach and community organization aspects of mental health. If it is true that mental illness can affect no single individual without some lateral impact on his family, then it is true that attention needs to be given to the social factors in mental illness.[43] A continuum of care is needed from the time of onset to recovery and afterward. As is now well known, the prospects for success and treatment are much enhanced if the patient and his family already have some general conception of what mental illness is about and of what resources are available to provide for care, treatment, and rehabilitation of an individual who may

become mentally ill. Not only is it necessary for citizens of all economic levels to know about mental illness and mental health resources, but also it is important for individuals employed in the human services to have this knowledge and background. Public education has been undertaken nationally and locally by the National Association for Mental Health, the present-day national organization deriving from the old National Committee for Mental Hygiene founded by Clifford Beers. Education of the health services and human services professions tends to be undertaken by members of the mental health establishment of all disciplines. Social workers are found in medical schools and in service establishments. Eleanor Ireland has indicated[40] the range and nature of social work participation in the training of child psychiatrists.[48] From another aspect Imena A. Handy[42] has demonstrated the effect of social work in the care of mentally ill geriatric patients.

Social workers have undertaken a number of educational efforts directed to the several professions, while also they are concerned with the deepening of mental health content in sensitive areas of human existence. There has been increasing interest, for example, in the area of human sexuality in relation to social living. Harvey L. Gochros and his associates[38] have undertaken to develop content on human sexuality in social work education and also to communicate more knowledge in this area to the mental health and social service professions and to the general public.

Additional experimentation has attempted to relate existentialism to human treatment.[80] This implies the adaptation of philosophic reasoning to psychosocial therapy.

One of the problems in expanding resources for the care of the mentally ill is the massive ignorance about the nature of mental illness and its response to treatment. As a result there have been painfully slow developments in the coverage of mental illness by health insurance. A British visitor in the mid-ig6o·s, Bichard M. Titmuss,[80] reviewed the relationship of social policy to economic progress in 1966. His main theme was that the allocation of world resources has yet to be devoted to the fullest extent possible to the interests of the disadvantaged.[80] A breakthrough of major consequence occurred when mental health care was brought under Medicare and Medicaid.[88] The limitations of both of these programs still leave much to be desired in terms of universal coverage for the economically deprived and for older people who need mental health services. One of the secondary gains from the introduction of Medicare payments has been the highlighting of staffing shortages both in hospitals and in extended care facilities. The shortage extends not only to social work personnel but also to other trained personnel.

These shortages have been periodically highlighted in terms of care of the mentally ill. It is obvious that the physically ill and disabled need psychosocial services just as much as those who are mentally ill. A number of

authors have highlighted the shortages of personnel at several levels.[2 3 8] Melvin A. Glasser has touched on the major issues involved in the funding of mental health services through national health insurance. He proposes offering "health security" that resembles what is now available under law in terms of Social Security, with adequate funding; he calls for a national drive toward improvement of the standards of health care and the distribution of health care and services more generally throughout the population.[37]

There is a move within the field of social work to strengthen and further develop the clinical practice area of the field. One symptom of this development is the growth during the past decade of the number of practitioners who have entered the field of private practice, full- or part-time. These social workers may be employed in group practice, they may work eollaboratively with a number of other disciplines, or they may operate as independent private practitioners on a fee-for-service basis. Social workers have, therefore, promoted a system of registration or licensing throughout the country, seeking legislation that will establish a legal basis for professional standards for the practice of social work. It can be expected that, just as psychology has obtained recognition as a treatment profession in several states, social work will in time receive similar status in the community. Margaret A. Golton,[39] in her review of private practice in social work, indicates the first licensing of social workers began in 1952. There are four states that now require registration certification or licensing, and in a

number of other states chapters of the National Association of Social Workers are pressing for the legal recognition of social work private practice. As Wilbert E. Moore[57] points out, the move toward autonomous practice is one symbol of the achievement of full professional status. He indicates, moreover, that this is frequently a cause for role strain among the various professions.

Social work has its own critics who periodically call for re-examination of the objectives and purposes of the profession. John B. Turner[87] has pointed to the need to "avoid professional obsolescence" and proposes that the profession shift its manpower from preoccupation with traditional welfare institutions to increasing utilization in other institutions having an impact on the social structure. He sees the need to base planning on consumer-identified needs and to look at basic causes of social and psychological problem behavior. Social work, along with the other health professions, needs to look at its basic educational doctrines, the array of services, and the means by which these can be extended to the total population.

In the early 1970's the nation is in an inexorable crush from the pressures deriving from rapid industrialization, automation, and economic disequilibrium. At a peak of scientific development the fact remains that important segments of the American community are threatened with economic insecurity and insufficient provision of adequate means for maintaining life and health. There is poverty in the inner city and in the rural

areas of the country. There are vastly insufficient manpower resources to provide the health and mental health services needed to improve the mental health of individuals, families, and communities.[94] The complexities of the mental health manpower picture have been fully described.[12 25] The physical problem involved in the shift of personnel from mental hospitals to community centers is tremendously complex and defeating. The problem is how to assure adequate provision of social and mental health services for patients remaining in the hospital and for those being moved to, or being supported in, the community during the transitional period. It is apparent from the report submitted by Rehin and Martin[55] that even the British face perplexing decisions. In considering the shift to community mental health services, Pascal Scoles[77] has described some of the interesting problems that arise in the provision of care for the chronic mental patient in an urban community. He refers to a return to the "older ways in social work," a phrase that alludes to the return to concern for the patient through home visits and through direct activities referring to employment, job satisfaction, improved use of social and health resources, and other means for providing concrete services that tend to be overlooked very frequently in the intensive psychotherapy phase of rehabilitation. The application of common sense to the organization and delivery of mental health services frequently does require direct service provision that cannot occur without some flexibility in outlook on the part of the provider of services, and without an orientation to

the operation of the network of community systems, which function imperfectly with reference to individual needs.[91] Rockmore and Conklin[73] have demonstrated what can be done at the state level to provide for use of a state office as a referral agency. This is seen as a somewhat different interpretation of the role of an administrator in a psychiatric social service.[73]

As one projects ahead, the gradually increasing U.S. population (now well over 200 million) and the lack of significant change in the incidence of mental illness and disorder as a result of preventive or treatment measures lead one to speculate that the problems of providing adequate services will remain a pressing issue in the political, economic, and social environment for many years to come. In fact, it is quite likely that the dominating issue for the remainder of the twentieth century will be how to assure that threats to human existence can be resolved. Whether these exist in the form of war, poverty, hunger, ecological danger, or social deprivation, the aims of social work and social or community psychiatry are parallel. They are dedicated not only to the remedial efforts involved in social and psychiatric treatment but also to the elimination of causes for social and mental breakdown. It is the ultimate objective of social work and social psychiatry to project a social and economic system that will make appropriate services available throughout the life cycle of the individual. In addition, social work has as a primary objective the ultimate abolition of poverty and the reduction of social pathology to its absolute minimum. This can only be done by restructuring

community resources so that they provide basic services in the immediate environment of the individual.[92] Curriculum development in social work education needs to take social changes into account to remain relevant.[011] There is a great deal currently known about prevention and early intervention that suggests that health resources ought to be available in every community regardless of economic level.[09] There is also the notion of early intervention that can occur around crisis situations. These arise in entrance into the school system. They arise in day-care facilities and in nursery schools. They arise in industrial and commercial establishments that provide for the daily livelihood of people. It could be projected that counseling services, if available in sufficient quality and quantity, could do much to alleviate problems of drug addiction, alcoholism, and family breakdown. The need for better interpersonal understanding is cardinal and lies behind most parental conflict and marital disequilibrium.

The resources of the nation need to be mustered to provide the types of health and social services that will assure that every child born in the country can expect to receive adequate food, clothing, and housing,[23] and should be able, in moving into maturity, to obtain first-rate educational and health services as well.[86] The vast need for such assistance in the black community has been underscored by Whitney M. Young, Jr.,[95] but his admonition on needs for the country could be extended to every category of ethnic group and to the general population as well. Social work is an inherent part of the

mental health movement and is closely related to the service development in the American community. The pattern of participation in delivery of mental health services has reflected vast changes over the past decades. More social workers have moved to administrative, teaching, consultative, and research positions.[78] Social workers also have moved into social policy positions in governmental and voluntary structures. A strong continuity of interest in direct treatment services has manifested itself throughout the century. Social work clinicians hold firmly to the responsibility for direct involvement in behavior change so vital to social and emotional competence. One-fifth of the members of the National Association of Social Workers in 1969 were employed in or expressed an interest in psychiatric and mental health services.[81] The place of social work in mental health is one of essential involvement in the several levels of service, training, and research directed toward the well-being of people.

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Notes

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