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U.S. Governmental Organization for Human Services

Implications for Mental Health Planning

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Historical Perspective

The American people have never suffered government gladly. From colonial times to the present, suspicion of government has always existed, among the governors as well as among the governed. Even the authors of the U.S. Constitution, while creating the federal system, agreed with Thomas Paine's comment that "government, even in its best state, is but a necessary evil; in its worst state, an intolerable one."

The concept of comprehensive social planning as a responsibility of government simply did not exist in the America of farms and frontiers. The scope of federal intervention in the social field grew sporadically, in response to the pressures of industrialization and the growth of cities, until the great economic depression of the 1930s, when individuals and states were willing to accept a series of federal governmental programs designed to bring the nation out of its economic stagnation.

The New Deal, in responding to the demands for help, created new mechanisms to regulate the economy and supervise some of the operating practices of corporate enterprises, which had developed during the

nineteenth century. In establishing governmental controls, the New Deal departed from the philosophical bases of laissez-faire, propounded by Adam Smith and the classical British economists as the foundation for industrial growth. Even more significantly, in terms of the delivery of human services, the New Deal attempted to promote the general welfare with a variety of programs to assist individuals suffering the consequences of the depression. These programs included such social innovations as the Work Progress Administration, the Civilian Conservation Corps, and the National Youth Administration. These experiments in governmental planning of social benefits for its citizens were dropped when the economic ills of the depression dissipated in the frenetic preparations for war.

Urban unemployment rapidly disappeared. The factories producing war material became strong magnets, stimulating some of the greatest internal migrations in American history—from dust bowl farms to big cities, from South to North, and from the interior to the Pacific and Gulf coasts. So great was the demand for workers that for the first time women were drawn into the labor force in significant numbers.

Thus, World War II was a strong catalytic agent, forcing movements and social changes throughout the population; these served to create new problems and highlight others that had been largely ignored. Poverty, unequal participation of minority groups in any facet of society,

transportation, and housing needs of a growing population began to be considered as national problems as technology developed, industry advanced, and the increasing population became more mobile.

By the end of World War II, an increasing number of American people came to the conclusion that national problems required national solutions. This change in public attitude resulted in the increased development of many of the domestic programs that had been initiated during the New Deal or earlier periods. These programs included development of national parks and recreational areas, national forests, water resources, soil conservation, and interstate highways, all related to the general physical environment to be shared by the total population. Other governmental controls proliferated among regulatory agencies, created under statutes designed to protect the public's rights to services by public utilities, railroads, airlines, communications, and other facilities that were being required to operate in the public interest.

Simultaneously, government began to assume in peacetime a greater responsibility to assist in helping individuals to share in the wealth, resources, and services of this country. As a result, the greatest growth in domestic programs of the federal government during the past twenty-five years has occurred in support of the delivery of human services designed to improve the quality of life in the American society.

The Employment Act of 1946 committed the government, as a matter of public policy, to maintain full employment throughout the nation and to pursue economic policies and develop programs to achieve that goal.

Federal housing legislation changed the living patterns of millions of Americans who were able, for the first time, to become homeowners rather than tenants, as the government underwrote support of low-cost housing.

Adoption of the Social Security Act provided for a measure of old age security for the majority of the people, and succeeding amendments to that statute continue to add to these benefits. Second only to the original statute has been the effect of Medicare and Medicaid. Still controversial, this system of federal support for the delivery of health care to the aged and the medically indigent continues to change. The basic provisions, however, have become a part of the public's expectations of governmental responsibility and the statutory patterns developed in this area have been adapted in other fields.

The Higher Education Act and the Elementary and Secondary Education Act were adopted in the belief that, though the federal government should not assume responsibility for curricula, it should provide assistance through federal grants to colleges, universities, and schools to finance the improvement of educational facilities.

Legislation and judicial discussions have brought the federal

government more forcefully into the quest for civil rights and equal opportunity for persons of all races and creeds.

Through federal legislation, assistance to law enforcement agencies in the states is now available through grants designed to improve the system of criminal justice and to explore means to rehabilitate juvenile offenders.

The scope of the federal government's involvement in human services has broadened considerably since World War II. So, too, has its investment, with federal expenditures for social welfare programs—including health, education, income maintenance, housing, and veterans' benefits—growing from less than $5 billion in 1945 to more than $90 billion in 1971.

Seldom during this period of growth has the federal government set out to provide services directly. Federal support of human services comes from grants in aid and other funding help, technical assistance, and staff leadership; all these are made available to the states, regions, and municipalities and the private sector, which actually organize and operate those services made possible through federal support. (Exceptions to this basic pattern are, of course, to be found: health care and treatment facilities operated by the armed services, the Veterans' Administration, and the Public Health Service are limited to specific segments of the population and do not serve the general public.)

Current Considerations

Throughout all these developments, however, the federal government has only recently begun to tackle the problem of distributing human services on the basis of comprehensive planning. Based on the pragmatism of the legislative process in the United States, most of the federal government's support of health, education, and welfare programs has been supplied on a categorical basis, with grants in aid earmarked for specific utilization within fairly limited program categories.

In order to make sure that federal money is disbursed and spent in accordance with the mandates of the Congress and that quality control is maintained, the federal agencies responsible for administration of support have set standards of performance and formulated regulations binding on applicants for federal funds.

Development of this process has resulted in the creation, within the federal government, of a huge, centralized control mechanism. At the same time, even though the federal control mechanism is centralized, federal agencies have proliferated to such an extent that support of human services programs has been fragmented, and, from the point of view of applicants for federal support, what is known as "grantsmanship" has become complicated, unwieldy, often competitive, and frustrating.

This latter circumstance is probably the single most compelling factor underlying current clamor for change in the system. However, there are other prevalent attitudes that will give direction to impending changes in governmental organization for delivery of human services in the immediate future. There is, for example, a very real belief that too many federally supported programs are designed to perpetuate the power of the administering agency or institution, rather than to provide real services for the individual. From the people to the Congress, there is an increasing demand for cohesive administration, planned in such a way that support mechanisms are integrated to achieve maximum results at the level of the persons or communities in need of help.

The demands for equity in federally supported programs—a share of the action—have clearly put an end to paternalism in government or the Lady Bountiful syndrome in the private sector. Minority groups are actively protesting programs designed to improve their lot, unless individuals within the minorities have a major role in planning, administering, and operating them. This attitude is shared and expressed by all disadvantaged groups. If the age of docility has ended and the age of dissent is to have constructive results, future planning for the delivery of human services must be achieved by the clients of those service programs as equal partners within the power structure.

In actuality, the demands for equity and for participation cannot and should not be separated in program planning; but it is helpful to recognize that these demands come from several quarters and are based on disparate points of view. Therefore, although a wide consensus on these attitudes is apparent, there is an equally wide divergence as to the means by which federal support will be made effective.

To analyze these differences is to realize that they will not be easily resolved and furthermore, that the resolution will respond to the traditions of the swinging pendulum or to the cyclical changes that have often characterized public attitudes toward governmental participation in the daily lives of the people.

For example, decisions on the content of human services programs, and the administration and the delivery of those services, have been made, since World War II, to a great extent by professional experts. Probably at no time in the history of this nation has the cult of the professional expert and the specialist been so much in the ascendancy as in the formulation and administration of governmental policies since the 1940s. But today, dissent against the status quo of the establishment has brought with it a general questioning of the professionals' right to an exclusive expertise in designing and delivering human services. And the professionals themselves are questioning their respective and combined roles in terms of the

comprehensive planning of the programs within their areas of responsibility. It is, therefore, almost certain that governance by professional experts will continue to yield to citizen pressures in the next few years.

This, however, is only a part of the change in patterns of administration. Another of the major developments is the current effort to readjust the assignments of responsibility and control within the various levels of government itself.[1]

Almost everyone concerned will give at least lip service to the statement that the authority of the federal government and the control mechanisms centralized in Washington must be reapportioned. Concerning the manner of reapportionment, however, there is no general agreement.

State and municipal governments are reasserting their demands for control of federal support mechanisms, in making funds available for local and regional programs. The debate on differing means of funding, for instance, encompasses methods of revenue sharing, distribution of block grants as opposed to categorical grants, health insurance, educational vouchers, and family assistance programs, to name a few components of the methodology debate.

From all this has come a trend toward decentralization of the distribution of federal funds and the administration of federal support.

Operational authority for many grant programs administered by the U.S. Department of Health, Education and Welfare, for example, has now been assigned to the ten regional offices of the department. It is too early to begin to evaluate the effects of this change; but it is not too early to point out that decentralization will be effective in direct ratio to its ability to be responsive to the people who need service.

Advocates of central control have produced a great amount of rhetoric about quality control of programs, but often there is little concrete evidence that quality control, per se, results from centralized administration. In terms of the cost of central control, it can be demonstrated that it is wasteful of time (in producing results following appropriation of funds) and that the overhead of administering programs centrally is expensive.

It would appear that there will continue to be a need for the centralization of decisions on means and on certain standards. Within overall guidelines for federal programs, authority to decide how the pieces of human services systems receiving federal support are to be organized and how the pieces are to aggregate in terms of their relevance to the local population will have to be made to an increasing extent by states and localities.

Much has been said about the uneven quality and quantity of resources among the several states. Certainly, the quality of the product, in any locale,

will be circumscribed in relation to difference in values, variations in the quality of governmental and professional expertise, and financial capabilities.

However, these problems are not new, and at least some of them have been successfully attacked by the mental health community in the United States. Therefore, it is imperative that those who are charged with the responsibility for mental health planning in the 1970s realize that the recent past developments in mental health are, and must be, considered as prologue and that recent experience within the national mental health program can serve as a nucleus for expansion into a national human services program.

Mental Health and Human Services

From the standpoint of treatment modalities, psychiatric practice in the United States has developed from a public system of custodial care of mental patients, through a period of intense professional concern with psychoanalytic treatment, into various short-term intensive therapies designed to alleviate symptoms of pathology and maintain the patient at his most productive level. These modalities coexist today, but by far the greatest emphasis will continue to focus on the development of community based preventive and treatment measures.

The initial application of the concepts of community psychiatry began from the pressure of necessity. The literature is rich in its accounts of the

chronological progression of the treatment of the mentally ill, from the points of view of psychiatry, muckrakers, do-gooders, concerned individuals, and citizens' voluntary groups. Suffice it to say that mounting pressures over the past century resulted in governmental organization for mental health services.

Querido put it this way,

> Since psychiatry is being realized as a special field of human behavior and since the behavioral sciences are coming of age, psychiatric problems have become centered in society instead of remaining isolated in the ivory tower of clinical procedure. And, to become a patient is no longer to acquire a condition, but the expression of a social role.
>
> In this way, the psychiatrist and the facilities in which he plays a leading or an advisory role become elements in a homeostatic system which creates the conditions for the equilibrium we call mental health.

The creation of such a balance between the behavior and the environments of people is the ultimate objective of the current effort to establish a national program of human services in the United States. This is what the development of comprehensive, integrated community human services programs means. The challenge, in terms of mental health planning, is to develop the ability of all the relevant professions to augment crisis intervention with crisis prevention. Since, in large part, the directions of future mental health planning will be closely related to the nature and size of governmental support of research, training, and services, a brief review of the

government's role in the past illustrates the significant change from a concern with mental illness to a concern for the development of mental health in the entire population.

From the mid-nineteenth century until 1940, the role of the federal government in support of mental health services was of no effective consequence. A few psychiatrists attempted to establish a federal posture in the area, following their experiences in treating the psychiatric casualties of World War I; but attitudes toward federal involvement had not developed sufficiently to cause an acceptance of responsibility within either the Congress or the executive branch. State governments had assumed the responsibility to provide for custody of the mentally ill and for whatever treatment could be financed. Public mental hospital systems were supported by state funds; psychiatrists and other physicians practiced within the system, separate and apart from the rest of the medical profession. Officials became protective of their prerogatives under the system, and professionals became defensive about the quality of care provided within these overcrowded and underfinanced institutions.

In retrospect, it becomes obvious that one federal statute brought about both public and professional rejection of institutional incarceration as the national treatment of choice to which mental patients were committed by the courts. Under provisions of the Selective Service Act of 1940, men eligible for

the draft received psychiatric screening as part of their medical examination. The high proportion of men diagnosed as emotionally or psychiatrically unfit for service in the armed forces drew national attention. During World War II, psychiatrists developed and utilized a variety of short-term therapies for psychiatric patients. The need for federal support of these developments was first recognized by the Congress with the adoption of the Mental Health Act in 1946. Adoption of this statute made possible the initial organization of the National Institute of Mental Health, to develop mental health research, manpower, and state programs through incentive grants designed to increase state expenditures for treatment programs.

Improved treatment and the demonstrated effectiveness of psychoactive drugs brought about the next congressional response to public demand in 1955. The Health Amendments Act (Title V of the Public Health Services Act) was adopted to provide federal funds to states to support demonstration projects in mental health services. To a limited extent, Title V programs contributed to the development of community based mental health services; but the federal intent was to provide short-term aid to states rather than to establish a permanent supportive partnership.

More important in 1955 was the congressional resolution establishing the Joint Commission on Mental Illness and Health to undertake the first nationwide survey and analysis of mental illness in the United States. The

commission report, *Action for Mental Health,* was published in 1961. It took just two years for the commission's findings to cause the Congress to adopt the Comprehensive Community Mental Centers Act of 1963. The intent of this act permitted a wide interpretation within which the federal government, the states, local governments, and private resources within communities could evolve coordinated patterns in providing mental health services.

The development of support mechanisms under the Centers Act and its succeeding amendments is a matter of legislative history; but even today, mental health professionals do not always appear to realize the role they have developed in terms of their responsibilities and opportunities for leadership in the projected expansion of mental health services into a comprehensive program of human services.

Under provisions of the Centers Act, provision of preventive services became mandatory in a publicly supported mental health program.

In order to establish state eligibility for federal funds under the statute, literally thousands of citizens voluntarily surveyed and catalogued the mental health resources of their states and prepared comprehensive state plans for the development of mental health services.

The regulations under which the Centers Act is administered have, in only five years, established the bona fides of outpatient, emergency, and

partial hospitalization services as valid substitutes for twenty-four-hour-a-day inpatient services in the great majority of cases.

In practicing experience, mental health personnel have learned to identify a wide spectrum of social as well as pathological causes for the psychological and psychiatric troubles of the population. Such conditions as poverty, racism, narcotic and drug abuse, bad housing, and inadequate public transportation have become identified by mental health workers as symptoms of a malaise that cannot be treated solely within a medical modality.

Mental health community-based service needs have brought about the initial development of expanded insurance benefits under third-party payment programs.

Community mental health centers have planned their programs to serve people rather than to serve institutional systems. The concept of continuity of care, in which treatment is provided and adapted to the patient's needs, has been accepted as an operational verity. And, the meaning of the word "comprehensive" has been expanded to include the recognition of many social conditions as root causes of psychological disruptions, dissents, and violence.

Governments at all levels now accept responsibility (albeit of varying degrees) for support of the provision of services to enable the citizenry to live

productive lives in the midst of an increasingly complex society.

There are opportunities for many comprehensive health and human services delivery programs to be built in the next few years on the foundations established by the mental health community. In a national sense, a mental health services program exists. In developing a broader human services delivery system, the mental health experience can serve as a pattern.

Implications for Mental Health Planning

The development of a national, community-based program of mental health services is unique within the health industry of the United States, but its patterns for the delivery of services are still exploratory. Therefore, at a time when the public and governments are seeking to achieve better integration of all human services, mental health planners have opportunities to lead from their strength of experience.

The potential for political and leadership roles of mental health professionals is still to be fully realized, but the opportunity for development of that potential is at hand. Of primary importance will be the ability of professionals to change some of their traditional attitudes of separatism. In many instances, mental health professionals may have to forego the tradition of command in favor of leadership and working together with professionals from other disciplines as well as nonprofessionals and citizens in the pursuit

of human service goals. If such leadership is successful, it can result in a cooperative advocacy for the delivery of human services and initiate planning procedures in which educators, the judiciary, ecologists, economists, physical and behavioral scientists, new careerists, and others must and can share. Initial efforts of this sort of collaborative mode of procedure are already evident. The immediate task is to expand and refine the process.

Based on their experience to date, mental health planners can suggest as fundamental to the delivery of services the following characteristic requirements.

1. Service programs must be based in local communities and made easily accessible to all residents of a given community.

2. Staffs of service programs must include men and women trained in a variety of disciplines, who will work together as teams to ensure coordination and continuity of services, in the same way that community mental health staffs are organized to provide continuity of care for their patients and clients.

3. Human services programs must be responsive to consumer needs, and the programs must be organized to include consumer participation in their development and operation.

Just as the mental health community has recognized the need for preventive intervention prior to crisis, the entire medical profession is now wrestling with the demand for service programs to prevent, as well as to treat

illness. The public demand, consciously or not, goes further, in a growing recognition that health means more than the negation of illness, in physical as well as in psychiatric terms. This point of view is already bringing about new service delivery patterns. Medical group practice is increasing, and governmental support will be forthcoming in the establishment of health maintenance organizations. Health maintenance organization planning is based on the notion that interdisciplinary health teams can maintain the health of population segments to a greater extent than have the traditional treatment facilities.

Financing of services from the standpoint of federal support will undoubtedly continue to move toward some forms of revenue sharing, block grants, and increased efforts to involve the private sector of the financial community. And, basic to financing patterns will be the tremendous expansion of health insurance, based on indirect or third-party payment.

The widespread, although diverse, pressures for establishment of a national health insurance program of an as yet undetermined type will have a tremendous effect on the kinds of services to be delivered and the means for delivery.

These decisions are as yet unresolved, but mental health planners already have enough experience to predict to their colleagues what some of

the results of such financing will be. Mental health services have generally been excluded in one way or another, and for various reasons, in health insurance programs. However, current data and experience establish that it is economically feasible and programmatically sound to provide mental health benefits on an equitable basis with benefits for general health care. Even as mental health services receive greater coverage in insurance programs, the planners must recognize that only when the benefit is comprehensive, with adequate, appropriate, and equitable benefits for inpatient and ambulatory care, will the maximum role of the entire care system be realized.

Conclusion

Governmental bodies at all levels in our U.S. system are moving toward greater integration of human service programs. Concurrently, the federal government, whose involvement in the human services arena has grown so considerably during the past twenty-five years, is moving increasingly toward noncategorical and indirect methods of financial support for human services. These two phenomena will pose difficulties for mental health planners, since traditionally mental health services have been organized in relative independence and have been financed, in the main, through direct public appropriations.

The challenge for mental health leaders and planners will be to see

whether they can achieve their goals through aggressive and cooperative action in the new mode. As we have indicated in this brief chapter, the experience of the mental health professionals is rich, and they have much to contribute not only in the further development of mental health services but also in the coming evolution of better integrated, more responsive total human service delivery systems.

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Notes

1 President Nixon has proposed a comprehensive reorganization of the executive branch of the U.S. government and set forth far-reaching plans for decentralization of governmental decision-making as part of the "New American revolution."3 The plan would consolidate the present subject-oriented federal departments into four purpose-oriented departments: community development, human resources, natural resources, economic affairs. The Departments of State, Treasury, Defense, and Justice would remain as they are. Ink and Dean2 wrote a widely disseminated article outlining the purposes of the decentralization plan.