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The Community Mental Health System: A Navigational Guide for Providers

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CHAPTER 1: An Overview of the Community Mental Health System



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CHAPTER

1

An Overview of the Community Mental Health System

OBJECTIVES

This chapter is designed to enable the reader to:

- Describe the community mental health systems approach.
- Describe the components of the community mental health system.
- Understand the difference between the community mental health systems approach and more traditional behaviorist or psychoanalytical approaches.
- Distinguish between prevention and treatment.
- Understand the importance of community mental health research in restructuring the system to improve its effectiveness.
- Understand the importance and impact of cultural diversity on mental health programs.
- Discuss the historical roots of the community mental health system.
- Discuss how social, economic, and political factors affect both the stigma and the treatment of mental illness.
- Recognize and discuss the challenges facing the implementation of the ideal community mental health service.
- Describe the community psychological/social work contribution to community mental health, and the Dohrenwend model.
- Discuss employment options in the community mental health system.

“We must learn to reawaken and keep ourselves awake, not by mechanical aids, but by an infinite expectation of the dawn, which does not forsake us in our soundest sleep. I know of no more encouraging fact than the unquestionable ability of man to elevate his life by a conscious endeavor. It is something to be able to paint a particular picture, or to carve a statue, and so to make a few objects beautiful; but it is far more glorious to carve and paint the very atmosphere and medium through which we look, which morally we can do. To affect the quality of the day, that is the highest of arts.”

Henry David Thoreau

The mental health professional of the twenty-first century requires a new set of paradigms, principles, and intervention strategies to be able to meaningfully address the problems presented in contemporary society. A systems approach to community mental health, developed by community psychologists and social workers in the last part of the twentieth century, is such a strategy. By focusing on both the needs expressed by individuals and the context in which they live and work, community mental health practitioners can effectively enhance the psychological well-being of people in the community. This is a new approach that transcends the traditional views of focusing solely on individuals or environments. As will be seen, the community mental health systems approach is a more accurate model of human behavior, since it is based both on common sense and on empirical research. The interventions generated are also more effective and more efficient than the traditional perspectives they replace.

Traditional psychotherapy that was provided in an institutional setting cannot adequately address the problems encountered by persons in need in today's society. The difficulties encountered in our cities, towns, villages, and rural areas are too great, and they overwhelm the resources of individual therapists. Albee (1998, 2000) observed that the acceptance of the medical-organic explanation of mental disorder and the reliance on individual psychotherapy has created a mental health service delivery system incapable of providing for all those who need assistance. Former United States Surgeon General David Satcher (2000) reviewed over 3,000 research studies and found that in any given year, although one in five Americans experience a serious diagnosable mental disorder, only half of this number receive treatment. Satcher further reported that mental illness is the second leading cause of disability and premature mortality in the nation. Only cardiovascular conditions produce greater loss of productivity and well-being.

This inability to meet mental health needs has affected the nation's quality of life. Miringoff (1995) investigated the changes in 17 indicators of psychological and social health. In 12 of these areas, conditions worsened over the course of the previous 25 years. The costs of providing such care using individual psychological counseling are prohibitive, and American society is unwilling to provide the necessary financial resources to do so. In 1996, the direct treatment of mental disorders and substance abuse cost the nation nearly \$100 billion, and indirect costs exceeded \$80 billion (Satcher, 2000). For most people, the fees and premiums required to pay for individual treatment are staggering, and traditional insurance, managed care, and health maintenance organizations recognize the need to cap the cost associated with providing these mental health services. When one considers the number of sessions individual therapists need to treat each instance of illness and the relatively high cost per session, it becomes clear that improved and more efficient methods of service delivery are greatly needed. Employers who are eager to preserve their investment in "human capital," one of their most valuable resources, also demand cost-effective programs designed to reduce staff down-time due to illness.

Not only is the traditional model of individual therapeutic service delivery inadequate to meet the needs of persons in difficulty, but also its effectiveness is limited (Lewis, Lewis, Daniels, & D'Andrea, 1998), particularly if the treatment method does not match the client's need. Many traditional therapists still adhere to a psychodynamic or insight-oriented model of care. Such an approach, which relies on uncov-

ering the inner workings of the psyche, might help healthy individuals achieve new understanding of their lives and might release a greater proportion of their creative potential and energies, but this approach is not able to help those with severe disorders in living. Mental health providers who use a behavioral approach with individual clients find that they can rarely alter the macrolevel societal factors that prevent these clients from achieving significant changes in their behavior. That is, such therapists can develop token economies, but they cannot enhance a community's sense of empowerment using behavior modification. Although there will always be a need for individual-oriented therapists, it is not conceivable that society can depend on this model to meet the mental health needs of all of its population. Thus, a new approach is needed, and one that will effectively meet the great and expanding needs in this area.

Even if traditional forms of therapy were successful, they would still emphasize treatment rather than prevention (Albee, 1990). Once individuals have succumbed to mental illness, their lives are already disrupted. The victim's job or family stability may be harmed by the episode. In addition, for each person who becomes mentally ill, the 2.6 others who live with the ailing individual experience stress as a result and may also need services. If the disorder in living is prevented, none of the related problems occur, and all the individuals involved can continue to lead productive lives. This is not to suggest that all mental illness, especially disorders with a biological component, can be easily prevented, but rather that there are many problems in living that can be ameliorated or minimized through prevention.

For example, there is a growing body of evidence (Hankin, 2002; May & Gosage, 2001; Ornoy, 2002) to support the idea that fetal alcohol syndrome can cause mental retardation. If even a short segment of an alcohol awareness lesson conducted in high school were devoted to the discussion of potential harm to the fetus by a pregnant woman drinking even a small amount of alcohol, it is possible that fewer individuals might be born with a developmental disability. Consider not only the financial savings but also more significantly the personal, familial and societal benefits that would be achieved by such a preventive program. Obviously, a new approach supplementing individual treatment and including a preventive component is surely needed.

In this chapter, the community mental health system is discussed. The components of the system are presented first, and then the historical trends that led to the development of the system are described. The challenges that inhibited the system from meeting its expected outcomes are also discussed. Finally, a solution to these challenges is defined and discussed: the paradigm of community psychology. This is an important approach that can be utilized by professionals in diverse disciplines within the community mental health system.

Components of the Community Mental Health System

When one is viewing the mental health system in the community, there are two main ways of describing its component parts. The first describes the types of agencies that comprise the system, and the second discusses the nature of the services provided. Former

U.S. Surgeon General David Satcher (2000), in the first ever Surgeon General Report that focused exclusively on the mental health system, noted that the system is “multi-faceted and complex, comprising the public and private sectors, general health and specialty mental health providers, and social services, housing, criminal justice, and education agencies” (p. 11). Satcher expressed concern that the components do not always interact in a cooperative manner and that providing a better coordinated service delivery system is a serious challenge to the nation.

In addition to the types of agencies cited by the Surgeon General, a comprehensive system serving the mental health needs of those in the community should include local transportation, as well as recreational and community gathering services. Also to be considered are the groups that fund the various services, such as governmental agencies at the federal, state, and local level; companies offering managed care and health insurance; and charitable sources such as private foundations, civic and faith-based groups, and individuals.

The second way of analyzing the system into its parts is to describe the types of unique programs or services that are provided under the umbrella of community mental health. The services should, of course, include the treatment and maintenance in the community of those who have already experienced episodes of mental illness and other disorders in living. The available services should enable these individuals to live productive and satisfying lives in the least restrictive setting. As a result of deinstitutionalization, many individuals who were previously “warehoused” in large mental hospitals or psychiatric centers have been discharged into the community, and their psychological and other human needs must be addressed by the community mental health system. In addition, the system should also provide “inoculation programs” (Seidman & French, 1998) that build and strengthen the skills of groups of healthy individuals to protect them from and prepare them for future difficulties. Promoting well-being is a form of prevention that will ultimately reduce the incidence of mental disorders in the community and consequently decrease the need for treatment.

The Need for Research

The mental health system should base the type of services offered on research. Prevention and health promotion services should be developed on the basis of empirically demonstrated research dealing with risk and protective factors. Large-scale epidemiological studies have shown correlations linking the prevalence of mental illness and various predictor variables, which either increase the likelihood of mental illness (risk factors) or reduce it (protective factors). Mental health interventions can target some of these factors through education and community change. The determination of the volume of mental health services offered in a community should be based on epidemiological surveillance (Satcher, 2000). This involves monitoring various population characteristics and social indicators to calculate the number of individuals who might need mental health services. Such monitoring should also study the level of access to services for those in need. Finally, research is needed to evaluate the effectiveness of

specific individual and group prevention and treatment strategies in promoting health and reducing illness. Providers are currently experiencing increased pressure from public and private funding sources to demonstrate that their strategies are effective, the basis on empirical evidence.

Restructuring the System

Seidman and French (1998) list a final activity the new community mental health paradigm can provide—that of restructuring the system. Restructuring involves altering the standing rules of a setting to devise new procedures for offering mental health services.

Such restructuring may involve providing cultural amplifiers. These amplifiers encourage individuals from diverse cultures in the community to utilize the available mental health activities. Cultural amplifiers could include incorporating the traditions, customs, language, and activities of the neighborhood in mental health programs. For example, the absence of a Spanish-speaking counselor in a particular agency may discourage members of the Hispanic community from utilizing the services of that agency. The need for such cultural amplifiers in the United States is increasing. Using the trends supplied by the U.S. Census Bureau, the nation is becoming more of a global society in which half of all Americans will be from four ethnic groups: Asian American, African American, Hispanic American, and Native American. Agencies that do not embrace a multicultural perspective will be able neither to relate to individuals from these groups nor to benefit the community.

Restructuring can also include the review of funding criteria to determine whether any requirements are counterproductive to enhancing mental health. In the past, Medicaid assisted only those clients who lived in institutions. An individual living at home could receive Medicaid-funded psychological assistance only by being placed in an institution. Instead of providing the counseling needed to enable the person to continue to live independently, this federally sponsored program encouraged a more expensive living arrangement that very likely reduced the quality of life. Similarly, as many community mental health centers and service-oriented agencies make treatment decisions based on reimbursement criteria rather than on client needs (Heller, Jenkins, Steffen, and Swindle, 2000), restructuring can include advocacy to ensure that the needs of clients are met.

Restructuring may also modify the way an individual accesses the various services. Often the process of receiving services can be time-consuming because of the number of bureaucratic forms to be completed, the time needed to wait to be helped by a provider, and the lack of coordination among components of the system. Developing more efficient procedures will enhance the effectiveness of the community mental health system.

As can be seen from the preceding discussion, the community mental health system is indeed multifaceted and complex. Understanding and navigating the system requires consideration of this complexity. Each of the aspects that comprise the system is discussed in greater depth later in this book.

Restructuring the community mental health system is one application of the cognitive reframing approach used in business organizations. Although there are many types of reframing, the model developed by Bolman and Deal (2003) is very popular. In their view, any organization can be viewed from four frames or lenses. Problems occur when managers or change agents focus on only one of the frames or even only one viewpoint within a frame. This practice leads to misinterpreting critical situations and failing to comprehend the total “picture.” The four frames include viewing the organization from each of the following perspectives, or frames:

- a. Structural frame, which involves studying the goals, policies, and organizational charts;
- b. Human resource frame, which focuses on viewing the staff and clients as an extended family, with each individual having specific needs, skills, and prejudices;
- c. Political frame, which emphasizes an awareness of the conflicts, the competition for power, and the scarce resources within the company; and
- d. Symbolic frame, which delves into the effect of metaphor on inspiring the staff to believe in the mission of the organization and to develop corporate loyalty.

Perceiving community mental health from a systems approach enables the practitioner to see all the frames. Through this perspective, one can generate creative and effective solutions to the challenges encountered in delivering mental health services.

These restructuring activities, such as the use of cultural amplifiers, advocacy, and reframing organizations, are themes that are described frequently in succeeding chapters of this book.

Historical Trends Leading to Community Mental Health

Deinstitutionalization

The deinstitutionalization process was a major contributor to the development of the community mental health system. The need for a community-based mental health system, in fact, was largely initiated by the preparation of many thousands of patients for discharge into the community. A number of historical trends led to this significant social change, including socio-political-cultural events that occurred during the 1960s in the United States. Although the deinstitutionalization movement was hailed as a humane reform, some individuals were released from the hospitals without adequate preparation, and this treatment led to new challenges for the nascent community mental health system. The deinstitutionalization process is covered in depth in Chapter 2.

Equal Educational Opportunity and the Civil Rights Movement

Social scientists in the middle of the twentieth century held to the belief that reducing inequity and psychological disorder could be accomplished to a great extent by altering the social environment. The roots of this belief can be traced back to the founding of the nation. Riegal (1972) and Gergin (1973) observed that social scientific theories emerge from the cultural beliefs of a society, and that these beliefs can be found in the documents held in high esteem by the citizens of that nation. In the United States, the Declaration of Independence is a seminal, almost a sacred, political statement of how Americans view the world as well as themselves. In 1776, Thomas Jefferson began this radical declaration by stating, “We hold these truths to be self-evident: that all men are created equal . . .” (Peterson, 1984). This statement implies that if we note there are substantial differences among individuals in that some are successful, healthy, intelligent, and contributors to society, whereas others are not, we can assume these differences could not be due to innate factors but must result from environmental causes. The founding fathers believed that oppressive political policies prevented citizens from achieving their full economic and social potentials. Perhaps we can observe how this environmental thrust implied in the Declaration of Independence has permeated American psychology by reflecting on the following statement of the behaviorist John Watson:

Give me a dozen healthy infants, well formed, and my own specified world to bring them up in and I'll guarantee to take any one at random and train him to become any type of specialist I might suggest—doctor, lawyer, artist, merchant—chief and, yes, beggar-man and thief, regardless of his talents, penchants, tendencies, abilities, vocations and race of his ancestors. (Watson, 1924, p. 82)

The educational system was targeted as critical to restoring equality among racial, ethnic, and social classes. Equal educational opportunity became a national goal, and the sociologist James Coleman and his colleagues were charged by Congress with the task of investigating whether the funds and human resources provided to schools were being fairly allocated. Congress also wanted Coleman to study whether reallocating these resources had an impact on raising the academic achievement of poor and minority children (Coleman et al., 1966). Many educators and social scientists concluded that students from disadvantaged and minority cultures did not have the same access to educational resources as those from more affluent mainstream backgrounds. On the basis of the cultural belief that successful performance depends on the opportunities present in the social setting, the lack of access to resources was viewed as a significant reason for racial and ethnic differences in achievement.

The civil rights movement also focused on providing a level playing field so that all people would have equal access to resources. Mental health and human service advocates conducted research that found those most in need of services—the poor, the

young, the elderly, minorities, and those who experienced mental and physical disabilities—received the least resources (Seidman & French, 1998). This finding led to many state and federal laws that prevented various forms of job discrimination. Legislation was also passed to promote residential integration, and public funds were channeled into reversing the long history of inequality that plagued the nation since the time of slavery.

Again, the national goal of the 1960s was to intervene in the social and political environment, usually by pouring funds into impoverished areas. Although the intention was noble, many believe the results were ineffective, as the programs were not fully thought out and lacked meaningful outcome evaluation measures (Levine & Perkins, 1987). Few politicians at that time would publicly state that the reason for poverty or low achievement involved any internal or individual factor. It was far more acceptable (politically correct) to emphasize the sociological causes of inequity. Currently, proponents of both models continue to debate this issue, as can be witnessed in the controversy regarding the accuracy of *The Bell Curve*, by Herrnstein and Murray (1994). This book was a major yet possibly biased review of literature concerning the basis of racial differences in intelligence. Psychologists realize the importance of limited access to resources and lack of political power as factors affecting behavior.

Crisis Intervention

Also during the middle of the twentieth century, views of the nature of mental illness and its treatment began to take an environmental emphasis. During World War II, many soldiers experienced symptoms of mental illness following involvement in a battle. Initially these soldiers were diagnosed as mentally ill and were confined to long-term treatment facilities. Appel (1999), a psychiatrist in the military at the time, was assigned to study the extent of the problem and “to prevent the seven million men in the Army from having nervous breakdowns” (p. 26). Appel noted that the number of days a regiment experienced combat was directly related to the percentage of men unable to fight because of mental trauma and other causes. Regiments that had been in combat for 120 days lost half of their members; and after 200 days, 90% of the regiment was unfit for battle. Appel further noted that all citizens were screened for mental disorders upon entering military service and that 12% of the men were rejected as a result. Thus, those who succumbed to “battle fatigue” had been judged to be mentally healthy at induction.

Some psychologists and psychiatrists began to provide these individuals with short-term, crisis-oriented counseling, and found that the soldiers could return to battle after a relatively brief time in treatment. Also, when they were discharged from the Army, they led normal and productive lives in the community. The diagnosis began to change from a mental illness with implications of genetic predisposition or character flaw to normal distress due to an unusual situation (Appel, 1999; Levine & Perkins 1987). As the rationale for these behaviors shifted, prognosis and intervention strategy changed dramatically. The “shell shock” or “battle fatigue” was understood to be caused by an abnormally stressful situation (combat), and once the individual was

placed in a more normalizing setting, he could live a productive life in the community. This more optimistic prognosis was predicated on the soldier's receiving short-term treatment as soon after the traumatic experience as possible. Similarly, Lindemann (1944) found that swift crisis intervention reduced the grief of relatives of disaster victims. This research is described more fully in Chapter 5. Both these studies led to the view that many dysfunctional behaviors are situationally caused and can be reduced through brief counseling.

Medication Breakthroughs

The effectiveness of crisis intervention and other short-term therapeutic approaches increased the hope that long-term hospitalization could be avoided. At the same time, the discovery of many psychoactive medications such as the phenothiazines, which tended to reduce the intensity of psychotic symptoms and the frequency of deviant behavior, raised the possibility that mental patients could be discharged and return to the community (Seidman & French, 1998). The impact of these new medications is discussed in more detail in Chapter 2.

The Politics of Mental Illness

Various researchers began to link mental illness and social class. In a landmark study, Hollingshead and Redlich (1958) found that the label of schizophrenia was more likely to be given to lower social class individuals, whereas middle-class clients received a less severe diagnosis. Since the study was correlational, it must be noted that there are many plausible interpretations for explaining this relationship. The study, however, did initiate an important line of research that investigated social determinants of mental illness. With this study, the belief that mental illness resulted solely from individual pathology was challenged.

Others, such as Thomas Szasz (1970), postulated that labeling behaviors as being indicative of mental illness was a political decision rather than a scientific determination, and that treating an individual through institutionalization and medication was a method of deviance control. In time periods when conformity was encouraged, minor deviations from the norm were punished through the application of labels such as "mental illness." During more liberal times, a greater range of behaviors was seen as normal and acceptable.

Currently, the power to declare a behavior indicative of mental illness is held by the members of the American Psychiatric Association, who vote on what syndromes are to be included in the Diagnostic and Statistical Manual (American Psychiatric Association, 2000). Psychiatrists in the 1970s voted, for example, to no longer consider homosexuality a psychological disorder (Rappaport, 1977). These decisions typically are based not on research but on the mental health professionals' perceptions of cultural norms and tolerance for behavioral diversity.

Such decisions, regarding what constitutes deviant behavior, are embedded in the societal context. In the former Soviet Union, dissidents who opposed the communist

principle that individual liberty should be subservient to the will of the community were diagnosed as having undifferentiated schizophrenia and were institutionalized. Whereas the rest of the world viewed this process as oppressive incarceration of political opponents, the Soviets interpreted this process as a scientifically based psychiatric intervention (Reich, 1983). This situation is by no means limited to totalitarian states. Meyer (personal communication, 1980), a practicing psychologist who worked in a state psychiatric center, noted that in the 1950s, an age of conformity, individuals were given psychiatric labels and institutionalized merely because of idiosyncratic personal preferences. In one instance, Meyer reported that a man who had no presenting symptoms except that he appeared disheveled and grew his hair long at a time when most other males had short hair cuts was labeled mentally ill and continuously institutionalized for over 20 years. Ruggiero (personal communication, 1980), a psychologist at a state developmental center, recalled a story told about an elderly woman. Apparently this woman, as a youth, was living at home and leading a reasonably productive life. Because she dated a man who was not liked by her family, her parents, to prevent the daughter's marriage, managed to have her placed in a "state school" for the mentally retarded. She remained institutionalized for many years, until the movement to return such individuals to the community occurred in the 1970s.

Applying a diagnostic label to a client demonstrates advantages and disadvantages. By diagnosing a client and attaching a psychiatric label, a therapist is better able to choose an appropriate treatment plan and assess therapeutic progress. In addition, applying a label enables the client to be eligible for relevant services. For example, once a student is assessed and found to have special needs, the school will provide beneficial programming not available to students not labeled. However, the client's individuality is lost, and the therapist tends to understand the person's behavior as being symptomatic of the developmental disability or mental disorder. The client becomes a "schizophrenic," and not a person who suffers from this disorder. Rosenhan (1973) studied the effect that applying psychiatric labels has on patients. This researcher recruited volunteers to serve as "pseudopatients." The volunteers were told to present themselves to the admissions unit of various mental hospitals and to tell the staff that they "heard voices." Each volunteer was admitted to the psychiatric center, usually with the label "schizophrenic." Rosenhan instructed the volunteers not to exhibit any further symptoms or unusual behavior once admitted. The staff, being aware only of the psychiatric label, interpreted any behavior as due to the mental disorder. One volunteer, a psychology student, thought it would be useful to keep a diary of experiences while on the ward. A staff member observed this practice and wrote on the patient's chart "compulsive note taker." Regardless of the fact that none of the pseudopatients had any episodes of hearing voices or any other symptoms of mental illness after being admitted, the average length of stay in the facility for these volunteers was over 70 days. The fixation on the labels prevented the staff from realizing that these individuals were normal. Thus, attaching the label of mental illness to individuals can have aversive effects on their freedom and can provide a rationale for others to exert control over their lives.

Observe how easy it is for staff trained in dysfunctional behavior to fall into the same problem pattern described in the Rosenhan study. Dr. Mayer Shevin described this concern well in this figure.

Language of Us/Them

We like things.	<i>They fixate on objects.</i>
We try to make friends.	<i>They display attention-seeking behaviors.</i>
We take a break.	<i>They display off-task behaviors.</i>
We stand up for ourselves.	<i>They are non-compliant.</i>
We have hobbies.	<i>They self-stimulate.</i>
We choose our friends wisely.	<i>They display poor peer socialization.</i>
We persevere.	<i>They perseverate.</i>
We love people.	<i>They have dependencies on people.</i>
We go for walks.	<i>They run away.</i>
We insist.	<i>They tantrum.</i>
We change our minds.	<i>They are disoriented and have short attention spans.</i>
We are talented.	<i>They have splinter skills.</i>
We are human.	<i>They are ...?</i>

Mayer Shevin

(Shevin, 1987, *used with permission of the author*).

Legislative Initiatives and the Mass Media

Regardless of the impact of new treatments, the most significant reasons for the great increase in deinstitutionalization during the 1960s and 1970s were not scientific breakthroughs or miracle cures. Legislative action at the federal level, judicial decisions, typically at the state level, and investigative reporting in the mass media served as the impetus to discharge mental patients into the community and create the community mental health system. Two significant trends dramatically altered the manner in which persons with either mental illness or developmental disabilities were viewed and treated.

The first trend was inspired by the federal government. President John F. Kennedy supported deinstitutionalization, partially on the recommendation of the Joint Commission on Mental Illness and Health (1961), and partially because of his concern for the treatment provided to his institutionalized sister (Rappaport, 1977). The recommendations of this Commission, which was established by Congress during the final year of the Dwight D. Eisenhower administration, were as follows:

- Provide improved care in small psychiatric hospitals for the chronically mentally ill.
- Provide improved aftercare services through partial hospitalization and rehabilitation.
- Provide intensive care for patients experiencing acute psychotic episodes.
- Offer increased public education regarding psychological disorders to reduce the stigma of mental illness.

President Kennedy's endorsement of these recommendations led to the passing of the Community Mental Health Centers Act of 1963, which encouraged mental health professionals to reintegrate the mentally ill into the community. Kennedy's political support for deinstitutionalization and community-based treatment, although controversial at the time, began a process that continues to the present. This legislation is detailed in Chapter 2.

Perhaps equally significant was the role of the mass media in affecting judicial decisions regarding the treatment of the mentally ill. In 1970, the network television reporter Geraldo Rivera conducted an exposé on the manner in which developmentally disabled adult residents of the Willowbrook State School in New York City were abused. He dramatically aired the dismal conditions, neglect, and mistreatment that were occurring. The public realized that disabled individuals were wasting away in this facility. The administration and staff were so unconcerned about the abuse of the clients that they did not object to the media coverage of the poor custodial care provided under their supervision. A group of parents brought suit against the state of New York (*A. R. C. v. Rockefeller*), and the presiding judge ruled that forced institutionalization without treatment was a type of illegal incarceration. The facility was ordered to provide treatment so that the clients could be prepared to return to the community as soon as possible. In order to speed up the treatment process, the "Willowbrook Consent Decree" required this state school to be dissolved and the 5,000 residents to be returned to the community within 5 years (Willer & Intagliata, 1984). This mandate, in modified form, was soon extended to all state schools (renamed developmental centers) and state hospitals (renamed psychiatric centers). This process significantly altered the manner in which those suffering from mental illness or developmental disabilities were treated. Similar judicial actions were taking place throughout the United States. At the federal level, a judge ruled in a 1972 landmark case, *Wyatt v. Stickney*, that institutionalized persons had a constitutional right to receive appropriate habilitation services. Normalization became the rationale for deinstitutionalization. It was felt that individuals with developmental disabilities and psychiatric conditions had the right to live in community settings free from unnecessary restraints (Willer and Intagliata, 1984). Over the years, through both judicial decisions and state and federal legislation, the nation began to realize that these individuals had civil rights, and hence statutes changed. These persons, originally called patients or residents, are now considered clients, consumers, program participants, and citizens. This significant change in thinking was evidenced more recently by the Americans with Disabilities Act, passed in 1990, which prohibited many forms of discrimination in the workplace. Also, in many states, mental health lawyers now advocate for the rights of those with developmental and psychological disabilities.

How the Willowbrook Decree Came About

This is a summary of an interview with lawyer Mickey A. Steiman, J.D.

No history of the community mental health movement would be complete without noting the tremendous influence of legislative actions and judicial rulings affecting the treatment given to consumers in the care of institutions and agencies. Among these landmark rulings is the Willowbrook Decree. In 1970, the Willowbrook State School in Staten Island, New York, housed nearly 5,000 adults and children who were diagnosed as having a developmental disability. In nearly all the cases, the residents were involuntarily admitted to this and to similar institutions. When individuals' liberty is restricted by the state through this admissions process, the state is expected to provide meaningful treatment. Otherwise, the forced incarceration reflects "cruel and unreasonable punishment," a violation of the Fourth Amendment to the U.S. Constitution. Treatment was nearly nonexistent at Willowbrook, as the residents were warehoused in an inhumane manner. Conditions did not change at Willowbrook because mental health professionals devised new counseling techniques. Rather, the situation improved because parents of the residents joined together with lawyers to sue the state, forcing it to provide better treatment. The following interview summary conducted in June 2004 is the story of one of the lawyers involved in litigating the case *NYS ARC & Parisi v. Rockefeller et al.* It is presented here so that psychologists and social workers can become more aware of the importance of the political process and the need to become involved in advocacy activities to assist their clients. In the process of reforming state institutions for both the mentally ill and the developmentally disabled, the role that the mass media played also unfolds. Mental health professionals can significantly improve the quality of life of the consumers by collaborating with print and electronic media journalists. From a systems perspective, intervening at the higher level of

the mental health system—reforming the minimum allowable standards of treatment—affects the clients' lives more completely than do many hours of individual one-to-one counseling.

In 1972, Mickey A. Steiman, a young lawyer recently out of the Syracuse University School of Law, landed a job with the Department of Justice's Office of Special Litigation in Washington, D.C. The Office of Special Litigation, with a staff of seven attorneys, was to protect the interests of the federal government wherever its interests were threatened. His supervisor, Michael Laughlin, had been involved in civil rights activities and learned about the plight of residents at the Willowbrook State School. In 1966, Burton Blatt wrote a book, *Christmas in Purgatory*, in which the conditions at this institution were described. The book included many photographs documenting the neglect and abuse of the patients and the extremely unsanitary facilities in which they lived. Geraldo Rivera, the television journalist, read the book and took a film crew to Willowbrook. His exposé of this state school on a national network brought great attention to this inhumane situation.

At about the same time, the parents of one of the residents, aware of the poor treatment at Willowbrook, contacted the New York Chapter of the American Civil Liberties Union (ACLU) and began litigation against the New York State Office of Mental Health and Developmental Disabilities. The suit was moved to a federal court and revolved around the issue of whether one of the original civil rights statutes passed in the aftermath of the Civil War had been violated. This law stated that no one shall be deprived of any privilege guaranteed by the U.S. Constitution by order of a state law. In this case, the New York state agency, acting in accordance with New York state law, restricted individuals' freedoms through involuntary admission to Willowbrook without providing meaningful treatment. The ACLU lawyer Bruce Ennis argued that

(continued)

How the Willowbrook Decree Came About (Continued)

this action violated the civil rights of the Willowbrook resident, a right guaranteed by the preceding federal statute. A parents' group, the Association for Retarded Children (ARC), had been recently formed, and this group joined the lawsuit with the Parisi family. The lawsuit became a class action suit, and all individuals admitted to Willowbrook between certain specified years, whether still residing at Willowbrook or elsewhere, were included in the class of plaintiffs. The federal judge assigned randomly to the case, Orren Judd, a civil rights advocate, concurred with this change. This modification was crucial in that any judgment resolving the suit would be applied to thousands of consumers rather than to just one individual. This created a systems level change.

As the suit dragged on, the plaintiffs, largely the parents of residents, were running low on funding. The lawyers for the New York state agency were willing to have the case drag on, as this outcome would eventually bankrupt the plaintiffs. Defense adopted this strategy, as the state realized that an unfavorable decision, such as being forced to provide meaningful and humane treatment, would be extremely costly. The defense discounted all the witnesses' stories of neglect and abuse as isolated incidents. At that point, Mr. Laughlin's Office of Special Litigation decided to become involved. The first obstacle to overcome was that to become involved, the Office needed to show the state violated a federal statute or a congressional mandate and that no law was directly relevant. Just prior to this lawsuit, however, the Office had become a party to another landmark case, *Wyatt v. Stickney* in Alabama that stopped the forced sterilization of mental patients. The Office argued that in an 1899 case, *In Re Debs*, the federal government was judged to have the right to halt a railroad strike led by Eugene V. Debs's labor union because the interest of the federal government was threatened by the loss of rail service even though no federal statute protecting rail service existed. (It is ironic that a ruling restricting the rights of union members would

be used seventy years later to uphold the rights of institutionalized citizens.) The Office of Special Litigation argued in the *ARC & Parisi v. Rockefeller et al.* that federal Medicare and Medicaid funds were used at Willowbrook and thus the federal government had a legitimate interest in the case. Justice Judd accepted the argument and made the Department of Justice a litigating amicus curiae, a "friend of the court." This ruling allowed the vast resources of the U.S. Department of Justice to be used to support the plaintiffs, and thus the case was revitalized.

In developing its legal strategy, the Office of Special Litigation reasoned that proving inadequate treatment was a subjective judgment that could be challenged, delaying any eventual settlement, but that describing nonfunctioning physical facilities was far more obvious and objective. Ten FBI agents were sent into Willowbrook to document that toilets and showers were not working for months at a time, and logs were kept. The agents photographed staff members wheeling groups of typically naked residents on a "cripple cart." Because the residents were unable to use the broken plumbing facilities, they were forced to urinate and defecate on the floor as they were wheeled around. Later in the day, the floor—and often the residents—were hosed down. The Office of Special Litigation hired experts who described how good institutions could be run, and how the conditions at Willowbrook were deplorable and unnecessarily inadequate. Parents documented substandard medical treatments. One resident broke his leg in a fall and died because of infection caused by woefully incompetent follow-up. Others documented that residents were used in Hepatitis B experiments and that some contracted the disease and died as a result.

Justice Judd, after hearing the testimony, strongly recommended that New York state settle the case. Over a weekend, after two years of litigation, the Willowbrook Decree was hammered out. The state was required to reduce the census of patients at Willowbrook to prevent

(continued)

How the Willowbrook Decree Came About (Continued)

overcrowding and also to increase the number of staff treating the residents there. So as not to enable the state to farm out residents to other facilities, thereby creating the same overcrowded and inadequate conditions elsewhere, the decree required that certain minimum staff-to-patient ratios be maintained in any facility in which a Willowbrook class client resided. Ultimately, this decree meant that every facility in the state had to provide a minimum level of physical, occupational, and speech therapy, and psychological service. All residents were assessed regularly and treatment plans were developed and revised as clients' level of functioning improved. A Willowbrook Review Panel was established to oversee the state's compliance with the Decree, and this panel continued to operate until Willowbrook was finally closed. Mr. Steiman, after leaving his position with the Department of Justice, was hired as the counsel for the panel, and he reviewed the monthly reports prepared by the state. At one point, the state failed to meet its requirement to fund the mandated services, and the panel filed suit to hold the state in contempt—with the intended remedy being that the then Governor, Hugh Carey, would be forced to live at Willowbrook for a month. The state swiftly provided the funding, and the lawsuit was withdrawn. Finally, the parallel agencies of other states observed

what happened in New York, and many decided to upgrade their services in anticipation of similar suits and decrees. The Willowbrook decision had far-reaching effects on the system, extending throughout the entire nation.

One may wonder what would have happened if the Office of Special Investigation had not become involved in the case. Perhaps the original plaintiffs would have limped on; but without adequate funding, their arguments, lacking expert witnesses and extensive objective documentation, would not have been as compelling. It is likely that the resulting decree would not have as significant an effect on the treatment of institutionalized residents.

One also might wonder how this Office of Special Investigations would have functioned had the Nixon Administration been more aware of its activities and the implications for enhanced services. During the time of this litigation, the administration was preoccupied with winning the 1972 presidential election, and then with managing the resulting Watergate scandal. Five successive attorneys general were in office throughout the case, since many of them were forced to resign in the aftermath of this scandal. Few in the Department of Justice cared what the nearly invisible office of seven lawyers were doing, yet they changed the community mental health system, perhaps forever.

Mental health professionals typically were reluctant participants in these dramatic “sea changes.” Psychologists and psychiatrists had no training in deinstitutionalization, and they were content to provide custodial service in the large state facilities. Szasz (1970) and Breggin (1991) noted that psychiatric drug administration to patients seemed to be primarily directed toward helping the staff manage disruptive patients, rather than to enhance the clients' ability to lead a productive life. Many, such as Yoosuf Haveliwala, former director of the (now closed) Harlem Valley Psychiatric Center in Dutchess County, New York, realized that the professional staff themselves had become institutionalized and that they required additional training to learn how to facilitate the clients' movement into the community (Levine & Perkins, 1987).

Later Developments in Community Mental Health

Unfortunately, the hoped-for changes to the delivery of mental health services in the community have not been fully realized. During the more than four decades since the passage of the Community Mental Health Act of 1963, a series of factors occurred that prevented the aims of the system from being fulfilled completely. Heller et al. (2000) identified these difficulties as follows:

- Beginning in the 1980s, during the time when the public seemed to be intent on reducing the size of the national debt, federal funding for mental health and human services was reduced dramatically. The financially well-off clients were able to receive private psychotherapy, whereas the poor and chronically mentally ill had access only to barely adequate basic supportive care.
- Since most mental health professionals were trained only in clinical psychotherapy, they felt uncomfortable providing preventive interventions and performing consultative and public educational activities that lay outside their area of expertise. Funding for such retraining was meager at best, and few universities developed programs for the next generation of professionals to be prepared for these nonclinical activities.
- Ambiguity existed regarding who was responsible for providing community mental health services. Prior to 1960, the states assumed the major part of the burden of providing mental health services, and the state mental hospital was the main location in which these services were dispensed. As described in Chapter 2, the Community Mental Health Act of 1963 initiated a new service delivery system, and the federal government provided much of the funding for its implementation. When federal funding sources dried up during the Reagan era, the states were reluctant to increase their share of the financial burden. The states did not accept ownership of the community-based programs, since the system had originally resulted from federal legislation.
- Advocates of the community mental health system assumed that the local communities would mobilize to protect the programs and would fight to reinstate the higher funding levels. Instead, community residents were more concerned that group homes and other programs and facilities for individuals suffering from mental illness would be placed in their neighborhoods. These citizens were relieved to learn that lower funding levels might mean that fewer community-based facilities would be opened. This pattern of community residents' being concerned that their quality of life and property values might decline if community mental health programs were established in their neighborhoods has been called the NIMBY ("not in my back yard") syndrome.
- When the boundaries of the 1,500 catchment areas were drawn, natural communities were not considered. As a result, some communities were split between two service areas, and in other cases neighborhoods that differed ethnically and socioeconomically were combined into the same area. This result caused great diversity within a community mental health center's service area, and no one community group could speak for the needs of the 75,000 to 200,000 people in a

particular catchment area. This outcome reduced citizen involvement and lack of local ownership for the programs offered. Professional mental health center staff were left to decide what services were to be provided. The professionals had not been taught how to collaborate with community residents in problem-solving activities, nor how to incorporate a concern for community traditions and needs in the services provided, and many of these professionals felt relieved when community input was not expressed.

Not all the problems facing the community mental health system were due to technical and funding issues. Heller et al. (2000) noted that the system failed to meet its expectations because of unexamined societal assumptions regarding mental health services. In other words, the public and their elected representatives as well as many mental health professionals held to an ideology more consistent with the pre-1960 mental health system. Some of the problematic assumptions are as follows:

- All individuals should be evaluated according to one standard. That is, there exists one acceptable normal behavior pattern, and all others are indicative of mental disorders. This belief leads to great conformity, and individual differences in behavior and preferences for diverse lifestyles are viewed as symptoms of disorder. The public frowned on diversity. Meanwhile, clinicians, who were trained to detect illness, tended to over-diagnose psychopathology.
- Similarly, community residents overgeneralized from extreme examples. Of course, it is true that *some* former mental patients behave impulsively and even in a violent manner. The overgeneralization—that all discharged individuals could be dangerous—was frequently used as a reason not to allow group homes to be placed in the community. Given proper predischarge skill preparation and adequate supervision in the community facility, such behaviors are much less likely to occur. Professionals concerned about liability were also reluctant to discharge individuals into the community. Energy should have been directed toward dedicating greater resources to ensure drug compliance and toward providing activities for daily living (ADL) training for the former patients, and to offer public education for the community rather than to discourage or prevent deinstitutionalization.
- Although research has pointed to multiple causes of mental disorders, many professionals adhere to a favorite therapeutic approach that emphasizes only one particular cause of psychopathology. Although psychological paradigms can enable practitioners to understand a problem deeply from one perspective, these paradigms also act as a type of blinder and thus can cause individuals to be unable to see the same problem from other viewpoints. Accepting a multiple causation approach to disorders in living leads to the development of multiple prevention and treatment options. Such flexibility in intervention alternatives increases the likelihood that the unique needs of those requiring assistance in the community can be met.
- Similarly, federal legislation tends to mandate and fund uniform solutions to mental health problems. Local communities that want access to these federal

dollars find they are not allowed to modify the funded programs to account for cultural differences or even geographical differences. A program designed with an inner city urban population in mind might not be appropriate for use on a rural Native American reservation.

- Frequently, funding priorities and the training most mental health professionals have received tend to produce a nearly exclusive focus on treatment and rehabilitation. Swift (1987) found that only 2.5% of all the hours worked by staff in community mental health centers are dedicated to prevention. Until more graduate programs offer instruction on developing, implementing, and evaluating preventive interventions, the near absence of prevention programs offered through community mental health centers is unlikely to change.

The Community Psychological Approach to Community Mental Health

The preceding assumptions had to be challenged. A new paradigm was needed to provide a better theoretical basis upon which to build innovative services for the community mental health system. Community psychology is an approach that provides this alternative strategy. All professionals working in the community mental health system—whether they be social workers, psychologists, mental health or school counselors—can utilize components of this paradigm.

Community psychology views mental health problems or disorders in living as being caused by a poor person-environment fit (Levine and Perkins, 1987). This model considers that focusing only on persons psychodynamically or only on settings behavioristically leads to ineffective treatment and solutions that can cause worse problems later on. The community psychological approach instead looks at the relationship between persons and their social settings. It accepts that there are individual differences among people and that each setting has its own strengths and weaknesses. No one setting is conducive to the happiness and productivity of every person, and no one person can exist or develop well in every setting.

Using an example from education, a highly conforming child would do well in a structured school but would do poorly in an educational setting that called for a great deal of individual initiative and creativity. Similarly, a curious, active child interested in exploring his/her own world would be frustrated and nonproductive in the traditional school but would be a leader in the more freestyle program. It is possible to label either child, who simply attended the wrong type of school, as a poor learner or an under-achiever, or even in the case of the active child, a behavior problem. Such labels are stigmatizing and self-fulfilling. By focusing on the child's inappropriate behavior alone, a proponent of the traditional paradigm would create a worse problem. Individual counseling for the child could imply that the child is at fault and has an intrinsic character flaw or psychological disorder. The same is true if we label either of the preceding schools as being bad. If all schools were judged according to how well they met the traditional standard of structure, they would become uniformly structured and unable to meet the needs of active, nonconforming children.

Continuing with the preceding example, a mental health professional utilizing the community psychology model would attempt to investigate the fit between the needs of the child and the resources and opportunities presented by the available schools. If no reasonably good fit were available, the provider would have many strategies for developing a better fit. One might use social or coping-skill training to increase the range of settings in which the child can function, or one might alter the school by providing diverse kinds of learning activities to increase the range of children with which the school system can help. In this way, the social worker, counselor, or community psychologist need not label either the child or the school as being problematic, but rather could place emphasis on forging a comfortable match between the two. In this example, an ecological approach is utilized, in which both the needs of the individual and the resources available to the person are considered together. The focus is on this person-setting unit, and not on just the person or just the environment. More specific examples of this ecological perspective are presented in Chapter 3.

Community Psychology's Central Thesis: The Dohrenwend Model

Perhaps the most significant statement of the orientation of community psychology was presented by Barbara Dohrenwend (1978). This internationally recognized scholar and then president of the American Psychological Association's Division for Community Psychology provided a blueprint for understanding problems in living and for developing intervention strategies to promote mental health. In doing so, she opposed the medical model. Dohrenwend noted that traditional medical models of mental illness view psychopathology as inherent within some individuals and as being due to early childhood experiences. This view is far too limiting in developing the types of treatment that can be utilized to reduce illness. The medical model sees symptoms as the effects of illness, and it stipulates that the root causes must be identified and treated in order for the individual to be healed. This view forces the helper to utilize only psychodynamic therapy or medication as treatment methods. The Dohrenwend model differentiates psychosocial stress from psychopathology. Psychosocial stress is the normal emotional reaction to a traumatic life event and does not imply that an individual is mentally ill. Rather than viewing the stress as a symptom of illness, it can be viewed as a self-contained process. Dohrenwend noted that if the stress is treated as soon as possible, the emotional reaction does not typically degenerate into psychopathology (Dohrenwend, 1978).

When an individual experiences psychosocial stress in response to a crisis, three outcomes are possible. First, the person might grow as a result of having mastered the crisis. In this case, the "survivor" learns that the coping skills utilized were successful and thus can feel a greater self-confidence when encountering similar stressful situations in the future. Second, other individuals could return to their precrisis state and consider the crisis as passed, and could feel that they can resume their normal routine. The third possible outcome is that the person could succumb to the stress and develop

psychopathology. This outcome usually occurs because the individual's coping strategies, social supports, and other resources are either insufficient or nonexistent, and the stress reaction changes from acute to chronic as a result. This third outcome is similar to Selye's (1956) more biologically based general adaptation syndrome. Stress-inducing agents cause an alarm reaction in the victim, and physiological changes occur in the body to mobilize its resources to deal with the stressor. After a relatively brief time, the body enters a resistance stage. During this stage, an attempt is made to return to a normal precrisis physiological state. If the stressor has not been eliminated or successfully confronted, a state of exhaustion results, and an abnormal pathological physiological state can occur. At this point, removing the stressor does not reverse the process, but rather, the abnormal psychological state or mental illness itself needs to be addressed.

In the Dohrenwend model, the timing of the intervention is critical if the third outcome, psychopathology, is to be avoided. Generally, the more swiftly the intervention is applied following the onset of the crisis, the more likely it will be successful in providing effective help. Psychopathology will be avoided, and the individual can lead a normal, productive life.

According to this model, there is no need to wait for a crisis to occur before intervening. Many developmental or life stage crises can be anticipated, and a community mental health practitioner can plan the type of resources and programs in a community to meet the likely needs of persons about to enter these developmental crises. The entire system of the delivery of mental health services can be analyzed to determine whether gaps exist in meeting these likely needs. For example, Scileppi (1976) used Erikson's (1950) stage theory of development to anticipate psychological crises and to ensure that agency services were available to meet the needs of individuals before and during these life-cycle milestones. This particular position paper focused on the Native American Reservation in Pine Ridge, South Dakota, and involved programs designed to meet developmental needs of individuals who were going through transitions, as well as the needs of their families. The services were designed to prevent healthy individuals from succumbing to stress as well as to treat those who had already been adversely affected by the crisis.

Additionally, by using the Dohrenwend model, the likely cyclical crises individuals encounter in institutions like schools, colleges, and hospitals can be considered. Gibbs, Lachenmeyer, and Sigal (1992) discussed how programs could be established in residential colleges to deal with expected needs of students at different times during the academic year. During the first weeks of school, students, particularly those in their first year at college, need to make friends and to experience a sense of belonging. Programs designed to teach social and interpersonal skills and various group activities can be provided. Enhancing listening and self-expressive techniques may reduce the fear of initiating a friendship and may increase the likelihood that such a relationship might develop. Later on, students might feel imposed upon by peers, and possibly exploited or abused, and the staff might provide assertiveness training workshops or date rape awareness programs. Stress management and time management workshops can help students during examination periods, and programs designed to prevent loneliness and separation fears are particularly useful for graduating students at the conclusion of the academic year.

The Dohrenwend model encourages the providing of services in the community that are proactive rather than reactive. Proactive services are available prior to the onset of the crisis, with individuals having access to these programs as soon as (or even before) stress is encountered. Examples of such proactive programs and their outcomes are presented in Chapter 4 on prevention. Preparing patients for surgical procedures, primary school students for middle school, employees for retirement, and couples for marriage are a few proactive-type programs. Such prevention-oriented programs require that the individual has at least a minimum level of motivation to participate, or else the effectiveness of the service will be limited.

Similarly, the model favors a seeking rather than waiting mode of service delivery (Rappaport, 1977). The traditional clinician sits in an office “waiting” for clients who have already succumbed to stress and are experiencing chronic disorders in living to present themselves. This method of service delivery is less effective, as typically the clients’ symptoms are in an advanced stage, and these symptoms have already disrupted the social and occupational aspects of their lives. The range of services provided in this waiting mode is also frequently restricted to individual psychotherapy and medication. Instead, community mental health providers utilize a seeking mode. Service providers anticipate crises and subsequently develop targeted programs in the community. They conduct needs assessments and analyze the programs offered in the community to determine what unmet needs or gaps in services exist. The community mental health professional then consults with agencies, schools, businesses, and neighborhood groups to provide enhanced services and to ensure that the persons needing these services have access to them. The mental health professional travels to the school, workplace, group home, and neighborhood organization. In a sense, the community practitioner’s office *is* the community.

In the seeking mode, some interventions might be focused on individuals. Conducting psychotherapy and developing individual behavior plans to enable an emotionally disturbed child to interact appropriately in school would be examples of person-oriented treatment, particularly if these services were provided in the child’s school setting. Other interventions could be offered to groups, such as to employees in their work setting. Scileppi and Montalto (1986) discussed the value of offering workshops on topics such as interpersonal communication and problem solving to workers in large corporations. The trainees learn skills that can be useful in their lives, both at work and at home. As will be seen later on in Chapter 6, having good interpersonal skills improves one’s social support network, and a worker who later experiences a crisis is more likely to have friends to assist in managing the crisis. Companies generally support such workshops, since they enhance the productivity of their employees.

Interventions could also be geared to changing social systems. Allen, Chinsky, Larcen, Lockman, and Selinger (1976) described a program in which community psychologists consulted to school administrators and collaboratively developed a multi-level intervention to promote students’ social problem solving, enhance their social skills, and reduce behavioral problems. Others have sought out persons occupying key roles in the community and have designed training programs that enable these citizens to become nonprofessional mental health providers. When encountering a crisis, it is highly likely that individuals will (either voluntarily or not) discuss their situation with a police officer, a clergy member, a teacher, or others. The result of this interaction

could be pivotal in determining whether individuals will grow from or succumb to the crisis. Offering training in crisis intervention, stress management and similar skills to these key community leaders could help the individuals in need to resolve the crisis in a positive manner. In addition, it could enhance the productivity of the helper. Police officers may have fewer repeat calls, and clergy members may become better pastors as a result of this training.

Such social system level intervention that utilizes the seeking mode is very cost-effective. A two-day interpersonal communication workshop training 20 clergy whose congregations each average 100 families will provide service for about 5,000 individuals, at a minute fraction of what individual psychotherapy would cost. Of course, as with any other workshop, the trainers must be sensitive to the cultural background and individual preferences of the trainees, and must encourage the trainees to do likewise with those they serve.

In studying the implications of the Dohrenwend model, the need for social workers, counselors, and psychologists to become involved in politics or the mass media becomes evident. The mental health professional must ensure that services are available in the community and that those persons in need have access to them. Communities, states, and nations must be made aware of the needs and the benefits of providing services to prevent mental illness and enhance the quality of life in society. Either through public funds, private foundations, insurance companies, or some combination thereof, financial resources must be provided. During a time when politicians get votes by striving to reduce expenditures, mental health professionals need to advocate the provision of more services that are cost-effective. This effort requires influencing voters by using the mass media and consulting with legislators regarding the sponsorship and passage of strong laws enhancing mental health services. There are many hidden (and overt) costs associated with not preventing substance abuse, domestic violence, school dropouts, and related social concerns, and the benefits of prevention programs must become more visible to attract funds and public support (Perla, 1997). Psychologists, counselors, and social workers need to make citizens more aware that cutting back services has detrimental long-term financial and social effects.

Finally, the Dohrenwend model does not lose sight of the individual in this person-environment fit paradigm. Each of the interventions mentioned earlier should be tailor-made to fit the needs of individuals. In many cases, the personality style of potential clients may clash with programs. Introverts, for example, may not seek out social skills training workshops. Some groups of suicide-prone individuals might not be inclined to call a telephone "hotline" service. Bereaved senior citizens who encounter the loss of their peers and the resulting shrinking social support network might not believe that joining a new social group is appropriate for them. Practitioners must develop creative programs for each of these groups. Some successful programs might involve multifaceted interventions. Encouraging older Americans to join volunteer groups, for example, might provide new opportunities for socializing that could be appealing to those who would not think of joining a group just to relieve their own loneliness. Research is needed to study utilization patterns of existing programs and to ensure that barriers to participation are removed for those in need of the service.

Frequently the barriers to participating in programs result from cultural differences. Programs established for rural teens may not be appropriate for inner-city

youth. The values of Hispanic families differ from those of African American families. Social networks of blue-collar workers are structured very differently from those of more affluent individuals. The community provider cannot generalize from the success of a program involving one population to a different group without modifying the program to make it amenable to the norms, values, perceptions, and traditions of the newly targeted culture. Rather than imposing one culture onto another, one needs to be sensitive to these differences and adopt the value of cultural relativity. To enhance this aspect of person-environment fit, it is useful to collaborate with leaders in the targeted community when planning interventions.

When utilizing the Dohrenwend model, ethical questions need to be raised. The seeking mode of service delivery should be balanced by a respect for the freedom of individuals to choose not to participate in a program. Although it is certainly appropriate to provide access to a program and to develop strategies to ensure that all those in need are aware of the program and its benefits, it is usually not appropriate to force individuals living in the community to participate. In addition, it is necessary to inform program participants of possible aversive effects. Providing assertiveness training for women is usually beneficial. However, a compliant woman who learns how to be assertive may find that a relationship with an exploiting boyfriend or husband may suffer (Foa & Emmelkamp, 1983). Another ethical question concerns whether the goal of an intervention is a desirable one. Beliefs regarding the proper styles of parenting vary from culture to culture and from time to time. What was once thought of as discipline is now considered child abuse. As previously suggested, community mental health experts should consult with local community leaders to ensure the intervention is not an imposition on the culture.

Social Work, Community Psychology, and Mental Health Counseling

Social work and community psychology share a common ecological framework, and practitioners in the field, regardless of title, are truly “kindred spirits” (personal communication, Murray Levine, 1990), who are united in attempting to enhance the quality of mental health in the community. Mental health counselors—whether they are school, community, or pastoral—draw freely from both social work and psychology.

Perhaps the major difference between social work and community psychology is that the latter is an approach within psychology. It is affiliated with psychology, as it supports this field’s emphasis on enhancing the mental health of individuals. Social work emphasizes a sociological approach, noting how structural role characteristics of organizations, systems, and communities affect the mental health of groups. Although community psychology focuses more on individuals, it draws on other disciplines such as sociology, anthropology, and political science. Both disciplines acknowledge that behavior occurs only in a context. All behaviors, both healthy and symptomatic of disorder, are influenced by the quality of the match between a person’s needs and abilities *and* the setting’s resources and opportunities. Both social workers and community psychologists view the person-environment fit as the appropriate unit of study, and each discipline contributes its distinctive orientation to this understanding.

In either discipline, behavior is seen from a system's perspective that allows for interventions to be generated at many levels: individual, family, groups, institution, and community. This approach enables practitioners to predict likely problematic transitional periods, allowing them to plan programs that not only treat but also prevent difficulties in living.

Both social work and community psychology focus on the community. Interventionists are sensitive to the local cultural norms and traditions, and they develop programs in cooperation with community residents and organizations.

Finally, proponents of this joint perspective note that many difficulties in living are intensified by lack of access to resources and political inequity. Programs that empower communities to remedy these problems are encouraged. As can be seen, many of the defining qualities of community psychology and social work have the Dohrenwend model as their basis.

Work Settings in the Community Mental Health System

The Dohrenwend model provides the blueprint for developing many useful interventions to promote mental health in the community. A question might be raised regarding where community practitioners are employed to implement these ideas. Although this question is discussed in many of the succeeding chapters, it is beneficial to introduce the issue briefly here.

Professionals can be employed in community mental health centers. Ruth Schelkun (2000) recently described activities such as consultation, education, and prevention that she performed while being employed in a community mental health center in Ann Arbor, Michigan. For example, she collaborated with a local neighborhood group to design enhanced community resources to meet the needs created by a sudden influx of people when a 2,000-unit, low-income project was opened. In another activity, Dr. Schelkun designed a program to teach school staff and administrators how to collaborate with members of students' families to create school-level change. In addition, she also worked with the staff of agencies that served homeless populations, and she developed video and live in-service programs to teach such community competency skills as how to manage difficult situations. Finally, Dr. Schelkun offered programs to train the staff of volunteer organizations and social service agencies in organizational development skills. In these activities, she worked with teachers, school administrators, outreach workers, agency staff, and local residents to promote the well-being of those who live in the community. Although Dr. Schelkun was a psychologist, knowing the professional's title or discipline does not always identify the type of work activities performed. In different centers, the same activities described before—and many more—could have been done by social workers or counselors as well as psychologists.

Social workers, counselors, and psychologists can be employed in a variety of other settings; some are university- and school-based, others are agency, government, or corporation affiliated, and the remainder are self-employed as private consultants and practitioners. In these settings, most are employed primarily in other roles such as

educator, administrator, program evaluator, researcher, or therapist. In each role, practitioners who are knowledgeable about the community psychological perspective and strategies creatively search for opportunities to utilize this approach.

Teachers at any level, for example, could incorporate topics related to mental health enhancement in the educational curriculum. Teaching interpersonal communication and problem-solving strategies not only helps students to become better learners but also enables them to deal more effectively with the common stressors in life. Administrators and program evaluators, in pursuing their usual duties, might develop new programs that provide easier access to needed resources in the community. These new programs might be designed either to keep healthy citizens well or to enable those already affected by mental illness to lead more productive lives. Staff at various levels of government might facilitate the enacting of legislation, the setting of public policy, and the funding of proposals to implement productive community psychological principles more fully. Finally, private consultants and practitioners might work with grassroots groups, support groups, and any of the preceding staff to offer workshops and to design and implement programs to enhance the quality of mental health. For example, a consultant might offer stress management programs to managers and employees of corporations. Therapists could consult to area clergy to develop empathy skills for use with members of their congregation. Still others might use mass media to disseminate practical mental-health-enhancing techniques to area residents. The list of employment opportunities is dependent largely on the level of creativity of the community provider. As more mental health professionals learn about this approach, it is expected that the list of possible applications will grow larger.

The Organization of This Book

The remainder of this book elaborates on many of the issues discussed earlier. Since deinstitutionalization is so central to the community mental health system, the following chapter is focused on this process. After the deinstitutionalization chapter, the book is divided into sections that deal with theoretical perspectives, the values of practitioners in the field, methods and techniques used in community mental health, and projections regarding the future of this service delivery system.

The major theoretical perspective in community mental health is the ecological approach. Recognizing that the quality of the person–environment fit is the appropriate unit of study, preventive interventions can be devised to enhance this fit. Each aspect of the fit can be studied. The process describing how individuals encounter crises and the types of coping skills they can be taught emphasize the person component. Community mental health counselors also conduct forms of brief psychotherapy to assist those in crisis. The role that the social support network plays in making the setting more conducive to mental health targets the environment side of the fit. The therapeutic and social system interventions are aimed at enhancing an individual's ability to remain in the community. Thus, the chapters on ecology, prevention, crisis and coping, and social support and systems level interventions form a unified approach to the field.

Community mental health practitioners are not value-neutral. Interventions that increase sensitivity to diversity, empowerment, and ready access to needed resources are viewed as desirable, and their opposites are discouraged. The ethical principles involved in creating and implementing interventions at all levels are discussed, along with the ethical implications of nonintervention.

The methods and techniques utilized by practitioners to concretize the theory base follow. Community mental health professionals consult with staff of other agencies, organizations, and institutions in the community, and this consultation allows for both individual- and systems-oriented interventions. Following the chapter on consultation, the next technique discussed is research. This is consistent with U.S. Surgeon General Satcher's encouragement that all interventions in the mental health system be based on empirical studies. Thus, program evaluation and outcomes assessment techniques are described. The final method concerns how to reform the system and to develop new programs. Frequently, service components need restructuring, and community mental health practitioners need to be aware of the many strategies to create change. The ability to secure funding through grant-writing is also covered.

The final section projects into the future. The elderly population is the fastest-growing segment in the United States and elsewhere. The needs of this group and the types of new services to meet their emerging needs are explored in a chapter on gerontology. The costs of behavioral care are rising swiftly, and it is likely that managed care and health insurance companies policies will dramatically change during the next ten years to find and fund cost-effective methods of enhancing the quality of mental health in the community. The strategies likely to be adopted are discussed, and the implications for how this outcome will affect the delivery of mental health services are considered. In its entirety, this text is intended to provide a more complete awareness of the community mental health system and will enable practitioners to navigate the system more effectively.

DISCUSSION QUESTIONS

1. What is the community mental health approach? Is it likely that this approach will be effective in producing positive change in the mental health field? If not, what are the impediments? Why did the traditional model of psychotherapy need to be replaced?
2. How would a community mental health interventionist use the Dohrenwend model to design and implement a needed program? How might the cultural diversity in the locality affect the way the program is designed and put into practice?
3. What benefits can community mental health impart to the mentally ill? What are some benefits and detriments of applying labels? Are they necessary? Are they helpful?
4. What is the purpose of epidemiological surveillance? Why is it important to monitor population characteristics?
5. How did the deinstitutionalization process spur the movement toward reforming the mental health industry? What events contributed to the shift? How did the state of behavioral health care in the past differ from the methods that are commonly used today? How might these methods change if the community psychological approach becomes implemented more fully in the future?