The opportunity to observe every environmental aspect of a patient's life is afforded the staff of a mental health clinic located within a settlement house serving a large community in New York City.

A Settlement House Approach to Community Mental Health

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A PSYCHIATRIC clinic, known as the Hudson Guild Counseling Service, offering diagnostic and treatment service to children, adolescents, and their parents, individually and in groups, is operated by the Hudson Guild, a settlement house in New York City. This psychiatric clinic is not part of a hospital. It is a special division of the Hudson Guild's community service, which carries also a day-care and nursery program (ages 3 to 6), and a group work program for school-age children (both preteens and teenagers) and adults. It is a community service established with the objective of meeting the mental health needs of a neighborhood composed primarily of residents of a low-income housing project. Sixty-six percent of the tenants are Negroes or Puerto Ricans.

The following factors led to the establishment of the Hudson Guild Counseling Service:

1. The growing complexity of mental health needs in a rapidly changing, multiracial neighborhood and the resulting increases in demands on the settlement house staff.

2. The special demands for help with mental health problems of children, stressed by the 608 families of young veterans who moved into the newly opened John Elliott Housing Project in 1947.

3. The strategic position of the settlement house, making the service readily accessible and usable by the community.

Ordinarily psychoanalysis and psychotherapy are accessible mainly to middle-class or high-income families. In facing the need of members of our families for psychotherapy, we were also faced with the need for seeking new ways and means of providing it. A concerted effort of various agencies in and around the settlement under the guidance of the counseling service seemed to be the logical approach.

Sponsorship and Staffing

The initial project, licensed by the State as a psychiatric clinic in 1951, was sponsored in its beginning year by the Hudson Guild alone. In the following years until 1955, the counseling service was sponsored jointly by the settlement house and the New York State Committee for Mental Health. Since 1955, the New York City Mental Health Board has become the secondary sponsor.

When the counseling service opened in October 1948, funds available were sufficient to

Miss Lambert, before her death in August 1958, was a psychiatric caseworker and director of the Hudson Guild mental health clinic. Dr. Mahler and Dr. Moore are psychiatrists on the clinic staff.

hire one full-time caseworker, one part-time psychiatrist and one part-time secretary. At present, it has a staff of three part-time psychiatrists, two part-time psychologists, two full-time and four part-time caseworkers, one group therapist, one group therapy consultant, and five psychiatric casework students.

The medical director of the counseling service is one of the psychiatrists. He is also supervising psychiatrist and the diagnostician for adolescents and adults. The second psychiatrist is the clinic's chief consultant for the preschool child. The third psychiatrist diagnoses school-age children, leads initial team conferences, and treats some children.

The counseling service director and case supervisor is a psychiatric caseworker. She is also in charge of the training program for psychiatric social workers as well as the coordinator of the special projects sponsored by the service.

In developing the staffing pattern, we considered it essential to have psychiatric caseworkers professionally well qualified, capable of using supervision constructively, and interested in working in the community. It was found most economical (and not only in the budgetary sense) to use competent psychiatrists according to their area of specialization. In selecting psychologists, we looked for ability in testing and additional training in therapy. These staff qualifications permit us to use representatives of all three professions in treatment, the psychologists and caseworkers working under a psychiatrist's supervision.

The supervising psychiatrist (medical director) maintains a constant inservice training program for the staff. Actually, the psychiatrist supervises the treatment in individual conference with the caseworker. At intervals, case review conferences are held at which the case supervisor is present as well as all workers active with the family. It is at these conferences that the community aspects as well as the general treatment policies of the clinic are considered.

Difficulties with the untrained workers who comprised the staff of the group work department—the social service area related to group activities of school-age children and adults—arose at the inception of the counseling service. These difficulties were related to the staff's unwarranted apprehension that the ability of a counseling service worker to help a child who displays behavioral deviations within the group would, by implication, undermine the professional status of the group worker. There were other thoughts and apprehensions as well.

These difficulties resulted in a turnover in this department's staff, replacing untrained workers with trained.

It was a much slower process, however, to develop understanding of the counseling service, even with a trained staff. In view of these complexities, special emphasis was placed on clarification of the role of the counseling service within the setting of the settlement house.

Stimulation of understanding within the group work department was aided through placement of students from the New York School of Social Work, bearers of the professional approach, within the framework of the department as professional working observers. The trained workers on the staff of the group work department are fully occupied with their administrative functions. The actual work with the groups is carried on by volunteers and part-time workers giving limited time. Thus the students are the only workers with the time and interest to concentrate on their groups, eager as they are to intensify their training through a liaison contact with the counseling service.

In the last 2 years, the counseling service has supervised group work students on special assignment, with emphasis on psychiatric orientation.

Since 1955, the State Committee for Mental Health has been sponsoring an enlarged training program for psychiatric social workers. A small number of these in-training workers have been placed with the counseling service since January 1949.

In addition to training programs for the counseling service staff itself, seminars with staff workers from the other departments of the Hudson Guild are held frequently. At these seminars, the work of the counseling service is explained and factual knowledge conveyed about children in different ages and stages of development (biological, social, emotional, structural, and behavioral differences).

The teaching is also aimed at developing more understanding of deviational behavior and its causes.

These seminars are conducted with the active participation of all members. Reports are given on individual cases or group activities, assignments of appropriate reading material are discussed, and the like, but the seminars are aimed at synthesization of general knowledge with the facts given on individuals and groups.

We believe that the following professional groups could benefit from training placement in such a service: psychiatric caseworkers interested in work with children and parent-child relationships; students of social organization seeking to obtain an understanding of interaction between personality factors and social conditions; group work students, who may become sensitized to the personality structure of the individual and so acquire a special skill in doing group work in a psychiatric setting; and psychiatrists who seek training in the community aspects of mental health.

The Caseload

The primary objective of the counseling service has been to meet the mental health needs of children and adolescents. This objective was the determining factor in evaluating the caseload of the clinic. We established the following policy.

All requests or self-referrals for mental health services are given attention to the extent that the problem at referral is diagnostically understood. If the problem falls beyond the scope of the clinic, a referral to an appropriate resource in the community is made. In making such a referral, care is taken to prepare the person and the agency for the contact.

Collaboration between the counseling service and agencies referring cases, especially the children's center and the group work department of the Hudson Guild, starts at the point of referral and continues through diagnostic study and treatment. The collaboration takes the form of interdepartmental conferences. At the initial conference, the basis for the referral is discussed; reports are obtained from the nursery and public school teachers, and from group workers; observational and informational material on the family acquired from participation in the settlement house program is developed and is extremely valuable in reaching a decision on acceptance and further disposition of the case.

Several questions arise. How much can really be done in cases of severe disturbances? Is the effort to help commensurate with the results? Is a mental health service needed for lesser problems? Our experience has shown that no matter how much or how little is done, it should be done with awareness of what is being done and what is left undone. To get this clear awareness, a solid diagnostic study is very much indicated—not for the purpose of labeling but for the purpose of understanding the degree of pathology, the presence of positive strengths, and the interrelation of those strengths within the individual and the family. It is for this reason that we consider one of the functions of a community mental health service in a setting such as ours is to arrive at a diagnostic understanding of the problem referred in the intake study, even in cases which are then referred to other resources, possibly in another community.

Our intake policy has been to carry out the diagnostic study as soon as possible, establishing priority for acceptance on the basis of the results. The wealth of authentic, factual information available to us through the physical location of the clinic within the settlement house, with its close-knit ties to community life, plus the extensive diagnostic study, permits us to differentiate the further disposition of the case as follows:

1. In cases where children can be helped while remaining in their groups, guidance of the nursery teachers or group workers and treatment of the parents is given by the clinic.
2. Adolescents, in need of treatment but not ready for it, are worked with by our group leaders under the guidance of the counseling service, in preparation for a contact with the clinic.
3. Children in need of individual treatment and parents in need of a treatment contact in relation to their children's problems comprise the bulk of the clinic's caseload. It is for these children that frequently a multifaceted treatment is set up.

Our work with parents in groups started almost with the opening of the service. At first, the group work was educational. It gradually changed into "emotional reeducation."

At present the caseload amounts to 125 cases each month. Primarily, children accepted for treatment have behavioral and personality development problems and impulsive and compulsive neurotic character disorders. There are some borderline cases and problems of parent-child relationship. This means intake and diagnostic studies, individual treatment, and group therapy.

A series of "hardcore" families were referred to our service by the housing authority in December 1956. We started our work with these families with a psychiatric evaluation of the pathology and of the healthy potential of the family unit. We believed this would help us avoid hit-or-miss attempts to clarify what could be done and to concentrate our efforts within the realm of possible achievement. Our main goal was to give appropriate support to these deprived, damaged, and disturbed parents to an extent that would permit us to help the children. Although a grant for this project (which we planned to carry out as a research-in-action project) was not available to support our work with these families, there have been some positive results.

In addition, the clinic has a discussion group for mothers of children 3 to 5 and a therapeutic nursery group for children 4 to 5 years of age. The therapeutic nursery group is a pilot demonstration project under the sponsorship of the New York State Commission on Mental Health.

The caseload consists of 70 percent children and adolescents and 30 percent parents in treatment, and counted as separate cases. In a sizable number of families, more than two members are under treatment.

A constant factor is the waiting list and the large number of cases studied, accepted, but not yet assigned.

Group Work

The group work department of the settlement house conducts the social, educational, and recreational group activities for adults and children. There is no mental health emphasis as such, but the activities are designed to contribute to the community's mental and social health.

The staff is composed of a graduate social worker, who acts as department supervisor, and five full-time associates, some with degrees in the social sciences and others with advanced training. In any one year, approximately 30 other individuals lead group activities for the Hudson Guild as volunteers or part-time paid workers. In addition, from one to five graduate students from schools of social work in New York City are assigned to the staff as field work placements. All volunteers and part-time workers are skilled in an activity such as handicrafts, dramatics, or dancing.

Group workers are encouraged to request consultation with the counseling service staff whenever they feel they need help in understanding the behavior pattern of a member of their group. When such a request is received, the group worker and a counseling service worker discuss the person and decide whether a formal referral to the clinic is indicated. If it is decided that such a referral is required, the group worker prepares a written report describing the person, his problem, family situation, and his potential acceptance of counseling.

The clinic established this procedure to encourage the group workers to "think through" the help the person needs and is ready to accept. An attempt has been made to avoid either impulsive or inordinately delayed referrals or building barriers to referrals.

From the beginning of the counseling service, the children's center has been the main source of referrals. During the past year, however, there were a large number of teenage referrals from the group work department, and the number of referrals from other Hudson Guild departments has steadily increased.

The Preschool Child

We feel that the specific value of our work with the nursery child lies in:

1. The early detection of deviational behavior (gauged, as it were, by comparison with the normal range of behavior of the identical age group in question).

2. The evaluation of the child's problem in the intrafamilial psychopathology, and of the role of the deviant child in cementing the intrafamilial pathological emotional balance.

3. The combining of a nursery of good educational standing with a good clinic staff.

At the opening of the counseling service in 1948, there had been a teaching and working contact of 3 years' duration between the day nursery, called the children's center, and the psychiatric caseworker who became director of the service. Thus the establishment of the counseling service presented an opportunity to expand and deepen the contact. From the very beginning, the collaboration was focused on improving the diagnostic methods, intensification of efforts to improve timing of referrals, and closer and more intensive work with the children referred.

Other factors contributed toward the productivity of this collaboration. The children's center was adequately staffed quantitatively and qualitatively. The general educational level of the nursery program was high. The nursery teachers and parents of the younger children were willing to work toward better understanding and handling of the children.

In view of these contributing factors, the counseling service has been able to carry the basic program with the children's center and also to launch small study projects. A study of 6-year-olds and a study of early "runners-away" are examples. These projects have culminated in the demonstration project, the therapeutic nursery group for 4- to 5-year-olds.

The idea of the pilot project arose when we realized that the most intensive and extensive outbreak of difficulties occurred in the whole group aged 4 years. The nursery staff at times felt that the whole group should be referred to the counseling service. This particular phenomenon, understandable in the given developmental stage, led to the idea of trying out the medium of group therapy for those children referred to the service. This project is in its second year. A third year will be necessary in order to arrive at more definite conclusions.

So far, the experience of the first year has shown that children of this age do respond to modified activity group therapy. All children in this therapeutic group have shown progress and improvement in varying degrees, corresponding to the severity of their difficulties. The children whose deviations were reactions to family attitudes and environmental conditions, have "blossomed" in response to their therapist's handling and to a better understanding by their parents. These children also have been able to function differently in the large nursery group from which they were originally taken to the therapy group. Children with more severe disturbances have shown improvement in their adjustment and relationships to age-mates although their basic disturbances remain.

Under the guidance of our psychiatrist for this age group, we have been able to achieve positive results in the majority of cases in correction of deviational behavior and of developmental growth problems and in strengthening emotional stability.

Positive results have been achieved with parents of younger children in the integration of changed attitudes. Individual contact with the parents has been a part of our study and treatment plan for the child. With most of the preschool children, the contact with the parent (usually the mother) developed into a treatment contact aimed at assimilation of new attitudes toward the child, in accordance with the child's needs and with the parent's capacity to meet them.

Frequently the treatment was focused on the parent's own problems which had led to the difficulty between the parent and child. Where the parent showed a certain degree of self-awareness and insight into the child's difficulty, the contact amounted to counseling. In cases of very disturbed parents, a supportive contact with the parent aimed at forestalling further damage was maintained.

Close collaboration between the counseling service and the children's center has proved invaluable in many ways, particularly in early detection of children's difficulties. Where the deviation was not severe but presented rather a developmental difficulty typical for the given age, it could be helped and would result in a developmental "spurt" of the child. When the difficulty was severe, a thorough diagnostic study enabled us to do "right" from the very beginning. This made it possible to lessen the

disturbance or arrest it. Such a lessening of the disturbance would improve the adjustment and functioning of the child at a given period, which had a therapeutic value as well. These children frequently still need therapy at a later point, but they enter therapy with a better prognosis. In a few cases our first contact with a severely disturbed child was at nursery age, and such a child, returning to our clinic in the early teens, benefited from the treatment contact.

The School-Age Child

In the school-age group of children referred to the counseling service, not a few have suffered severe traumata in infancy and early childhood, reflected in ego weakness expressed symptomatically in their behavior and functioning. These children will not respond to relatively short-term treatment. Less damaged and less vulnerable children, when assisted in reducing an immediate phasic anxiety, frequently respond with a developmental spurt which consolidates treatment gains sufficiently for them to make satisfactory adjustment without further clinic help. The severely traumatized school-age child does not possess as much basic ego strength to build upon. Therefore, a proper treatment plan for such a child must anticipate long-term contact which will continue to provide constructive, anxiety-diminishing types of help over a period of years.

Psychiatric treatment is of enormous value and definitely indicated. An adequate treatment plan for these particularly vulnerable children must include, however, more than direct psychotherapy, as the therapist possesses no magic which can provide other kinds of therapeutic experience equally important to such children. A severely damaged child may make increasingly secure contact with his therapist, but the gulf between this contact and the therapeutic vacuum to which he returns outside the clinic can be a gulf too wide for psychotherapy alone to bridge. Mobilization of therapeutic potential requires extension of treatment planning to include usual aspects of the severely damaged child's life, not only inside but outside his home.

In this regard, the very position of a psychiatric clinic in a neighborhood settlement house makes a multifaceted treatment plan, extending constructively into various channels of the child's usual life, easier to achieve in a well-integrated, closely knit fashion.

Since the number of such children is large and the need great, it is highly pertinent to consider what community treatment resources can be developed for them. In this regard, a clinic in a neighborhood settlement house lends itself to becoming such a community treatment resource.

The clinic, through its position, is readily entwined with other strands of the school-age child's specific neighborhood life. Obviously, the more such entwining occurs, the stronger the clinic can make its net of supportive therapeutic assistance. In this respect, it is a very real asset to have the clinic sharing the same neighborhood with the child's home and the school he attends.

As a result, the clinic's clear understanding of the child's personality organization and special needs can be shared with the school, sometimes at the point the child enters the elementary grades. The clinic can continue contact as these nursery children enter the pre-adolescent period between 6 and 12.

The severely damaged child, with low self-regard and insufficient sense of being able to hold his own adequately with peers, can profit by a special facility set up purposively to help him find group contact as therapeutic for him as it can become. This need is supplied as part of a total treatment plan when such a child, with weak ego and low self-confidence, is placed by the settlement house clinic in a special small group (therapy or transitional) which has an adult leader from the clinic staff and group members who are familiar neighborhood peers.

It is significant that when a multifaceted treatment plan for the severely damaged school-age child occurs in a settlement house setting, the child's relationship with the clinic assumes a particular social meaning. The settlement house, as a structuralized social unit, becomes increasingly a part of the child's and the family's neighborhood life. The clinic therefore becomes to the child not only specific contacts at regular intervals with a therapist but also "the Hudson Guild" to which he feels that he

belongs and that it belongs to him. In other words, he feels that he has a real and personal place in this neighborhood social unit with which he soon becomes highly identified. Therefore, whatever the clinic sets up for him in situ psychotherapy, special group experiences, and treatment contacts with his parents become joined for the child as concrete evidence of his personal importance and place in a specific structuralized social unit—the settlement house.

Everyone needs a sense of possessing positive social significance, but no one needs this more than the severely damaged child whose self-identity requires strengthening. The increasing development of positive object relationships, with their concomitant stimulation of ego development, requires satisfying experiences. When the school-age child achieves gratifying relationships with the individual staff members of the counseling service, to whom he is in reality important as a warmly valued human being, he is concomitantly feeling that he has positive meaning in the wider social context of the community center itself. This serves to reinforce the constructive aspects of his total experience in relation to the Hudson Guild.

It is interesting and significant to see the functioning of these severely damaged children change in response to such a multifaceted treatment plan. Typical of such children is Billy.

At the age of 4 years Billy was placed in the nursery by his mother. His nursery teacher described him as follows: "Billy has a downcast, sad expression on his face, but laughs a gurgling, baby laugh when played with individually. His relation to adults is complicated. He is quite dependent and wants a lot of exclusive attention. He accepts affection hungrily but does not ask for it. When picked up, he just seems to melt into one's shoulders. He is responsive to firmness but bewildered by choices. He is not ready for group activities but resents being left out. When the group is together, he throws himself on the floor with his eyes closed." His relation to other children was further described by his teacher as extremely hostile. "He hits, pushes, pounces on children, pulls their hair or pretty nearly chokes them without apparent reason. He often brushes his hand in front of his face as though to dispel unpleasantness and trouble."

Billy's disturbed behavior at the age of 4 was rooted in developmental traumata which left him with a great deal of anxiety. Billy is now 9. From the age of 4 until the present, the clinic has been in contact with Billy and his mother. Billy has been given the multifaceted treatment plan in situ, which has included psychotherapy and also therapeutic types of group experiences. He is now in the fourth grade of school. He has done good school work since the first grade and was described by his last teacher as concentrating well upon school work and progressing in each subject. He "participates in classroom discussion, does beautiful art and clay work. He continues to make friends and is popular."

In the last 2 years, Billy has, without regression, met the birth of a third sibling and situational stress at home set up by acute marital discord and increase in his father's alcoholism. He has maintained an obsessive-compulsive line of defense against regression. He feels that he has both peer age and adult friends. He can increasingly express his conflicts and feelings in psychotherapy, and he has developed a far more secure relationship to his mother, who has also been in treatment contact with the clinic. He is still a particularly vulnerable child with ego weaknesses disclosed clearly in his Rorschach, but his functioning has improved tremendously. He can now enjoy social contacts, visualizes himself as having a future, and has achieved modes of mastery and sublimation which are social modes.

It is reasonable to assume that without the early establishment of a treatment plan which anticipated continuing, long-term contact, this severely damaged child would not have ceased to be such a behavior problem in groups where he had become a menace to other children. Neither would he have developed as well his capacity for academic achievement and for finding gratifying and socially acceptable outlets for his fantasy life.

Billy is only one of many children who have been highly deprived in this oral period and whose maturation continues to be uneven because of continued traumatic experience before the age of 4. Children of this type need com-

munity provision of a specific treatment resource which will focus upon their special long-term treatment needs.

The school-age child has been treated individually and in therapeutic groups (adjustment, transitional, and activity). For the severely disturbed children, we have set up the multifaceted treatment plan as described. The public school plays an important role in the functioning of this multifaceted treatment plan. At present, a number of these severely disturbed children still on our caseload have been suspended from school. They are not delinquent and are of prepuberty age. A special effort is very much needed to provide the necessary help for these children.

exhibit

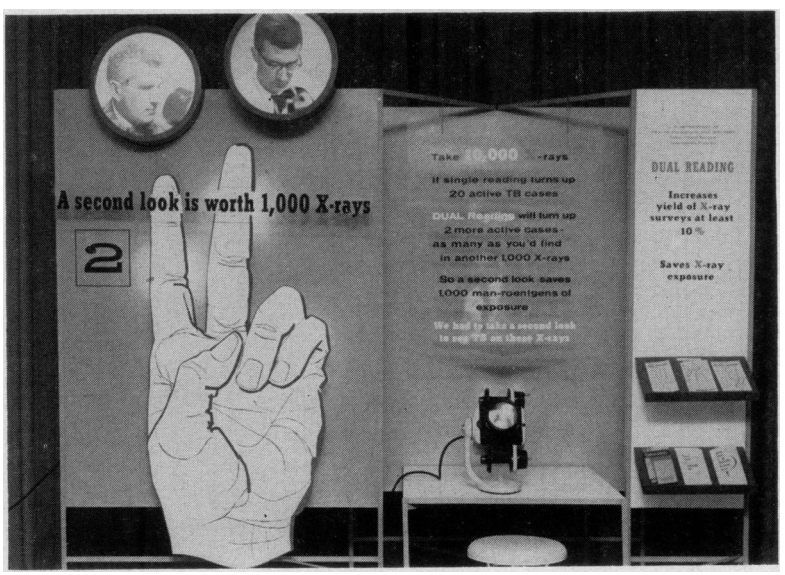
A Second Look is Worth 1,000 X-rays

Dual reading of chest X-rays taken in tuberculosis casefinding programs is generally recognized as being productive but as yet has not been employed extensively in the United States. The Tuberculosis Branch of the Public Health Service is promoting the use of this technique in tuberculosis control by various means, including the exhibit shown here.

The exhibit points out the two main benefits of dual reading: increased yield of new cases from the same number of films and reduced radiation exposure. A roll of films with examples of suspected abnormalities missed on a single reading is shown in a viewer to allow physicians to check their own interpretations. Reports which indicate that dual reading increases the yield of new cases by at least 10 percent are summarized in an accompanying leaflet, which can be used for future reference.

Designed for use at national, regional, and other meetings and conferences of people concerned with tuberculosis control and exposure to radiation, the exhibit is available free upon request. However, it must be manned by a Tuberculosis Branch staff member, and its availability will depend on whether a member can be assigned. Shipping costs are paid by the borrower, but leaflets are provided for free distribution.

For further information write the Tuberculosis Branch, Division of Special Health Services, Public Health Service, U.S. Department of Health, Education, and Welfare, Washington 25, D.C.



Specifications: A 3-panel exhibit on legs, fabricated of lacquered plywood and steel framing, 9 feet long, total weight 580 lbs., including 2 packing crates. Only one electrical outlet, 110 a.c., 500 watts, is needed for illumination. The film viewer, containing X-rays, is an integral part of the exhibit.