Current knowledge and thinking about State agency planning for community mental health services are examined.

State Agency Program Planning for Community Mental Health

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IN SPITE of the rapid advance of community mental health services, the dominant theme at national and regional meetings of State mental health personnel is still largely mental hospitals and mental patients. Yet severe mental illness is such a small part of the total picture that it seems important to look at the whole range of mental health needs and services.

The latest available estimates indicate that about 10 percent of the population of the United States have significant mental health problems, but only 0.6 percent are ill enough to require care in a psychiatric hospital (*1*, *2*). The other 90 percent, the so-called normal group, need mental health education and counseling services to help prevent the development of disabling mental illness. In planning programs for community mental health services we have to look at the entire spectrum and visualize all potential needs.

About 10 years ago, in the early stages of community mental health planning, it all seemed pretty simple to us in State mental health agencies. First, we were supposed to develop further the existing mental health clinics and to start new clinics as rapidly as possible. There was little question as to what kind of clinics they should be. Second, we were supposed to set up an educational program, consisting of talks, workshops, films, and pamphlets, aimed at whatever groups seemed to be interested.

Now we are not quite so glib in discussing or plunging into these activities. We do more systematic and down-to-earth planning, and we use criteria for program selection. But we need to reexamine these criteria frequently and look at the assumptions and principles that underlie them.

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Current Assumptions

These are the current assumptions that influence our planning:

★ Two attitudes seem to predominate among those persons who are concerned in some way with community mental health programs. One is the extreme optimism reflected in the idea that "mental health is all," a sort of cultist mental health movement. The other is a pessimistic attitude that "this preventive stuff" is all a nice frill, but "you can't prove that it prevents anything and it is not a real program like some others, and not nearly as important as taking care of the acutely mentally ill."

Somehow we have to find a middle ground and recognize the climate of public opinion in which we have to operate.

★ Community mental health programs in most States are going to be small for a long time, because no large appropriations will be made until we have specific preventive methods that are more definitely proved. Moreover, there are not likely to be pressure groups available, such as the councils for the mentally retarded, to get funds for our programs. We don't have an organization of relatives of the neurotic who are going to work with State legislatures to get funds.

★ The number of professional mental health personnel will not greatly increase in the next 5 to 10 years.

★ No one type of program will do the job, nor is it possible to carry out all of the potentially productive community mental health activities.

★ Mental health associations and other lay groups are already carrying on educational programs, some of them in community mental health. Such programs are likely to increase further in both number and scope in the future.

★ Many nonmental health professional persons and agencies already perform various community mental health functions. They have varying degrees of awareness of their actual and potential roles. These people and agencies can be aided through consultation and organizational measures to do a much more effective and comprehensive job. Some already are seeking such help.

★ Existing mental health clinics are not being fully utilized. For example, the recent study of the Los Angeles Child Guidance Clinic showed that nearly 80 percent of the cases seen in 1 year could have been treated just as well or better by other local agencies or by private practitioners (*3*). In addition, it seems obvious that clinics can do much more consultative and educational work with other agencies and practitioners and can relate their traditional services more directly and meaningfully to those of other agencies.

★ Psychiatric services in general hospitals are growing rapidly in number, size, and function. It is an open question how well such services are currently integrated into local and State patterns of community mental health services.

★ Local policymaking and control are essential for long-range, permanent growth of community mental health services, if the services are to endure. State control and operation tend to inhibit local growth and participation. Of course, this assumption is affected by State and local traditions and the geography and economy of a particular State.

★ State agency planning for local mental health services must take into account local experience and the attitudes and methods traditionally used in other civic projects. Hunter has highlighted the importance of local power structures in this connection (*4*, *5*).

★ The nature of the State program for community mental health will be markedly affected by its parent agency and the value systems of the particular professional disciplines on the staffs of the State program and the parent agency.

Principles and Basic Questions

The State agency obviously must accept the dual responsibility of developing further existing patterns of service and of initiating projects which test different combinations of approaches to preventive services in mental health while evaluating the effectiveness of both the old and the new.

Selecting preventive program areas is difficult. We need activities which are tangible, dramatic, convincing, and based directly on need. We cannot continue indefinitely on faith or on the basis of testimonial evidence that we are doing something that justifies our use of the taxpayer's dollar.

Also we are recognizing more clearly that clinics are expensive and that they alone cannot meet all the mental health needs of the community. Clinics provide an essential service, but perhaps should be thought of as a springboard for other activities.

It seems helpful to categorize the kinds of possible activities according to four levels of prevention so that we get some idea of the scatter of our various activities among these levels.

Level 1 prevention consists of building and

maintaining mental health through programs that teach the best current knowledge and the best methods of fostering healthy parent-child relationships and human relationships generally.

Level 2 includes all the activities carried out by the nonmental health professional people in private practice or as staff of health, welfare, and education agencies. The physician, nurse, teacher, social worker, clergyman—all those in a "caretaking" capacity in the community—can do early casefinding and provide counseling and guidance to individuals, particularly children, showing symptoms of emotional disturbance.

In this level, we are inclined to overlook the significance of the clergy. A public opinion study done in Louisville, Ky., a few years ago showed that people turn most frequently to their clergyman when they have problems.

Level 3 prevention consists of services provided in clinics, primarily diagnosis and treatment of moderate emotional disturbances.

Level 4 consists of services in general hospitals for the acutely ill psychiatric patient, as well as rehabilitation of mental hospital patients who have returned to the community.

Probably the major dilemma in program planning is where to begin in the whole spectrum of possible services. Should we try to improve the mental health of the entire population, or concentrate on the 6 percent of the families who have a high incidence of social and emotional disorders?

A promising approach is to focus on populations at risk. Schwartz lists nine groups worthy of concentrated efforts in community mental health (*6*):

1. Juvenile delinquents. For his purpose Schwartz limits this category to delinquents whose parents have been in trouble with the law.
2. Persons who have attempted suicide.
3. Those in urban areas where the rate of incidence for mental illness is high.
4. Expectant mothers who need help in preventing organic damage to the unborn child and in emotional problems.
5. Children under 3 years of age who are physically and emotionally deprived of mothering (*7*).
6. Families on relief.
7. Bereaved persons who need help in handling their "grief work," as described by Lindemann (*8*).
8. The acutely psychiatrically ill. Psychiatrists and other mental health staff can provide emergency services at home to prevent hospitalization. Successful programs of this kind have been carried out in Amsterdam in the Netherlands and in Philadelphia, Pa.
9. Persons who are slated for promotion to positions at a higher level. This group has a high incidence of problems.

Another approach, advocated by Caplan of the Harvard School of Public Health, is to center efforts on the crisis periods in people's lives when they are most amenable to changes in basic attitudes (*9*).

Certainly we must compromise in considering the direction and the distribution of mental health activities. For example, if we can conduct only two special demonstration projects during a given period, probably it would be a good idea to work with one group in which the risk is not commonly recognized, such as gifted children. The other might focus on a group, such as aged persons in nursing homes, whose actual or potential mental health problems are apparent to most people.

Should we try to provide services to all geographic areas of the State? We might provide educational materials to the entire State; then, in a few areas, set up projects as demonstrations and encourage other communities to emulate those which appeal to them.

Another question is whether to move into communities that do not request services. When there are epidemics or excessive mortality or morbidity rates, public health teams traditionally have moved in without waiting for an invitation. Yet most of us question whether permanent gains in community health are made without local initiative and local assumption of responsibility and leadership. How long do we wait before we approach a community which requests no services but has obvious and critical needs?

Developing Existing Services

In considering existing patterns of services, probably nobody claims that the mental health clinics at present are working at their maximum

potential in community mental health. Perhaps the most important task of the State agencies is to convey a spirit of experimentation and evaluation of diagnostic and treatment functions to the clinics and the psychiatric services of the general hospital.

Perhaps we can, to some extent, motivate clinic directors, boards, and staffs to reexamine traditional procedures, such as the handling of waiting lists, diagnostic procedures, treatment methods, preventing dropouts of patients, followthrough of treated patients with referrals to other agencies, and followup studies of patients already seen.

Another goal might be to encourage existing clinics to devote more staff time to consultation, education, and community organization functions. Perhaps we should insist that new clinics devote a certain portion of staff time to these functions in addition to diagnostic and treatment services.

Clinicians in general are increasingly aware of their potential contribution to and of the value of such activities, but to what extent are they able to perform consultation and education functions? Should we encourage the clinics to serve as a hub for all community mental health activities? Can we expect them to do this without special training for their staffs? And should the State agency provide scholarships for advanced training to help clinic staffs carry out new methods of service to the community? Where can one get such training? Perhaps the State agency should attempt to provide it.

Another question concerns existing services. What are the disadvantages and advantages of written agreements if financial aid is provided to the clinics? Is it sound to use such agreements as a basis for periodic discussions of the clinic's program and function? Few persons would argue that the State agency should not set some standards, particularly for personnel. It is surely appropriate to encourage the clinic to use State agency staff in a consultative capacity, both in basic administration and in various specialized clinic functions.

In a number of States, statewide workshops on a variety of topics or inservice training programs for staffs have been undertaken with considerable success.

The recently developed statistical reporting system for psychiatric outpatient clinics provides an opportunity for an overview of clinic services. In Texas we found that having our annual workshop of psychiatric clinic staffs immediately following the publication of the annual statistical report seemed to stimulate clinic staff thinking and resulted in productive discussion.

Developing New Services

New services can be divided into those which are initiated by the State mental health agency, those initiated by another State agency, and those initiated locally. This is an arbitrary grouping, and any of the following kinds of services could be initiated by any one of the three sources, but in our experience this grouping seems reasonable.

At the present time we are convinced that four professional groups, physicians, nurses, teachers, and clergy, are in a strategic position to foster the mental health of the people they serve. What is the State mental health agency's responsibility to them? Should we at least be aware of the extent to which the schools of medicine and nursing, the teachers colleges, and theological seminaries include in their regular curriculums indoctrination and training in concepts and methods in community mental health? The National Institute of Mental Health, Public Health Service, is providing grants to schools of nursing, among others, for this purpose. But it is our experience that the professional schools want to know how to integrate community mental health into their curriculums and how to relate this to professional practices in the State as a whole.

Another kind of new project, mentioned previously, might consist of detecting early cases of emotional or personality disturbance in gifted children and providing prompt treatment for them and their families. The State agency might initiate this service in one or more school systems and test it for several years. Such a program should be set up to encourage continuation by the schools following completion of the pilot project.

Many States have services for expectant

mothers through maternity clinics and for mothers and children in well-child clinics. Frequently such services have been initiated locally or through the maternal and child health programs. But what is the responsibility of the State mental health agency for seeing that the potentials of these services are utilized throughout the State?

More adequate interagency services to disorganized families are seldom initiated locally or by another State agency. The studies of Community Research Associates in St. Paul, Minn., (*10*) and elsewhere indicate that a small proportion of families produce a great proportion of the behavior and personality disorders as well as other problems in a given community. Few would question the assertion that community health, welfare, and education agencies are not collaborating extensively in making comprehensive family diagnoses, for example, or in providing long-term, integrated services to such families. Should the State mental health agency initiate and help plan such collaboration? Perhaps the State agency should at least initiate local conferences or studies on the maximum use of mental health clinics by local agencies.

The State agency might also initiate an epidemiological study of the incidence of various kinds of mental illnesses. A very modest study (*11*) we did recently revealed that of first admissions to mental hospitals, almost half of the patients and their families had been known to one or more local agencies within a 3-year period immediately prior to hospitalization. Such a study can generate local projects in level 4 prevention which involve systematic interagency collaboration and stimulate the setting up of a system of psychiatric consultation and other supplementary services to the agencies serving these families. Such services would help the agencies to stabilize the family, prevent illness which would require hospital care, and perhaps result in long-time rehabilitation of some families.

A project we co-sponsored in a Dallas, Tex., general hospital assumed that if a family member has a psychiatric illness so acute as to require hospital care, his family also may be sufficiently disorganized to require considerable long-range health and welfare services. A deliberate effort was made to marshal the various community health and welfare services for the families of the patients who are admitted for psychiatric treatment. We hope to learn if the assumption is accurate and whether the marshaling of the services results in some demonstrable long-term rehabilitation or maintains the health of these families, or both.

We need to remind ourselves frequently that community mental health is not the exclusive property of our agency. And since many other State agencies and organizations are vitally interested in, and frequently initiate, mental health services, it seems important for us to develop and maintain good communication with them. Some of these are the crippled children's services; programs dealing with tuberculosis, chronic disease, alcoholism, venereal disease, and occupational health; State departments of education; State universities, especially extension divisions; medical and nursing schools; housing agencies; divisions of child welfare; vocational rehabilitation agencies; institutional services for the mentally ill and mentally retarded children; and mental health associations.

A State agency for community mental health might well collaborate with one or more other State agencies to strengthen services for children deprived of maternal care. State child welfare agencies usually have the responsibility for licensing children's institutions. Children in such institutions are definitely a population at risk for whom few State mental health programs are doing anything.

Another program might be to provide psychiatric consultation in crippled children's clinics. Public schools have a variety of mental health services, many of them initiated by State departments of education or by local school systems.

We have hardly scratched the surface in developing industrial mental health programs, yet there is currently a great deal of interest in mental health among occupational health people. Projects to prevent delinquency are started almost daily, and the State mental health agency should at least be informed about them. Other currently popular projects are community rehabilitation of the mentally ill, mental health services to the chronically ill, and counseling services for the aged. Activities

often initiated by other agencies are teaching child development, parent-child relationships, and other topics through study groups such as those sponsored by local mental health associations. Another such program carried out by many universities is mental health inservice education, consultation, and similar services to agency staffs such as public health nurses, teachers, and other professional persons.

A broad new area that seems to be commanding a lot of attention is accident prevention, as exemplified by the special psychiatric project in Detroit, where persons who have second accidents involving drinking are required to have a psychiatric evaluation (*12*). In this way an effort is made to find the accident-prone or the severely disturbed persons, and a frightening number of people have been discovered who have really severe personality disorders.

We need to encourage the various agencies to take more and more responsibility for continuing all these projects. We are kidding ourselves if we think we can do the whole job. We can only serve as stimulators, collaborators, and helpers.

Any of the activities previously listed could also be initiated by a local agency or planning group. We have to consider the particular situation in any given State to determine whether such locally initiated services should be organized on a local, regional, or statewide basis. But wherever a project is set up and whoever initiates it, it does seem appropriate for the State agency to provide consultation in helping to define and clarify the problem which prompted the request for service. The extent to which we continue to help define the problem or engage actively in planning, organizing, and operating a project depends on the whole constellation of services that we are trying to carry out and the role we have assumed as a State agency.

Since we cannot cover the whole State with intensive services, we need to consider how best to undertake at least one or two demonstration projects in local areas. Before initiating such demonstrations, there must be a readiness in the community for the project and involvement of citizen leaders, and the project must have the potential for a long-term contribution to the broad objectives of the State program, as well as to the immediate local situation. Such new projects may demonstrate a new kind of service, a new pattern of services, or a different application of existing services.

We think in the Texas program that probably the most important component of such a project is a built-in system of data recording for evaluation at the end of the project. Projects seem to require at least a full year of advance planning and, based on our experience during the last 4 years, at least 5 years of operation to accomplish lasting and convincing results.

In planning for a local project, staff must be adequate to meet the local demands for service, to handle community organization and interpretation activities, and to do the research work, including the project report. Such projects, we find, quickly generate more demands for service than the staff can handle, and it is extremely important to have sufficient staff, particularly persons assigned primarily to the research phases. The project might be aided either by a financial grant from the State agency or by lending a State agency staff member.

Policymaking, however, should be a function of a local representative group. We have used a written agreement in such projects, and have found it is valuable as a means of clearly defining the responsibilities of the two parties involved. If a community council exists, the new project should be developed by working in cooperation with and sometimes through it.

A staff development and training component is needed to develop the type of State community mental health program I have described. For many years most States have provided scholarships for the various mental health disciplines and have found this practice an effective method of recruitment. But as community mental health services move into untested kinds of program activities, the existing staff and the staff that is added as programs grow will need advanced training.

We think it is very important to work cooperatively with existing clinics and other psychiatric services and with universities and training centers to develop more training facilities within the State. If this is not feasible, regional agreements, similar to those developed by the Southern Regional Education Board,

can be worked out. Whether the staff development program is on a State or regional basis, we must inaugurate it early or we shall find ourselves with insufficient staff or a staff that is not able to move forward into new program areas.

Yet even the best staff is on shaky ground in attempting its program planning alone. Some mechanism is essential to obtain the counsel and advice of both professional and citizen leaders in shaping broad program outlines. The staff will be kept closer to reality if there is a general advisory committee or a general committee and a technical committee.

Program Criteria

The following tentative criteria for a comprehensive, effective, and reasonable State program for community mental health are based on the foregoing assumptions, principles, and questions. As we become more experienced, the list should be critically reviewed and revised at regular intervals.

1. Are all four levels of prevention covered by some agency in the State if not by the State mental health agency?
2. Are existing services being developed with an attitude of experimentation, testing, and retesting?
3. Are there areas of activity with both well-known and less well-recognized risk groups?
4. Is there a built-in evaluation component for all program activities?
5. Are program areas being planned and carried out in cooperation with other agencies to stimulate them to expand their own preventive activities in mental health?
6. Are at least some program areas of the State agency tangible, dramatic, and convincing?
7. Does the program encourage citizen as well as professional participation in policy-making, at both the State and local levels?
8. Is the program's content timed both for current public concern and long-range needs of the State?

REFERENCES

(1) Hollister, W. G.: An overview: Providing better mental health for our people. Atlanta, Cullom & Ghertner, 1956, pp. 2–3.

(2) Pasamanick, B., Roberts, D. W., Lemkau, P. V., and Krueger, D. E.: Mental disease prevalence in an urban population. Pub. Health Rep. 72: 574–576, July 1957.

(3) Anderson, F. N., and Dean, H. C.: Some aspects of child guidance clinic intake policy and practices. PHS Pub. No. 485 (Public Health Monogr. No. 42). Washington, D.C., U.S. Government Printing Office, 1956.

(4) Hunter, F.: Community power structure. Chapel Hill, University of North Carolina Press, 1953.

(5) Hunter, F., Schaffer, R. C., and Sheps, C. G.: Community organization: Action and inaction. Chapel Hill, University of North Carolina Press, 1956.

(6) Schwartz, A. D.: Some population at risk. California's Health 15: 33–36, Sept. 1, 1957.

(7) Bowlby, J.: Maternal care and mental health. World Health Organization Monogr. Series, No. 2. Geneva, 1951.

(8) Lindemann, E.: Symptomatology management of acute grief. Am. J. Psychiat. 101: 141–148, September 1944.

(9) Caplan, G.: Mental health aspects of social work in public health. Berkeley, University of California, 1955.

(10) Buell, B.: Community planning for human services. New York, Columbia University Press, 1952.

(11) Mandell, W., and Cromack, I.: Prehospitalization contacts by community health and welfare agencies with individuals having major mental illnesses. Ment. Hyg. 32: 511–520, October 1958.

(12) Schulzinger, M. S.: The accident syndrome. Springfield, Ill., Charles C. Thomas, 1956.

New Water Pollution Control Division

A new Division of Water Pollution Control has been established in the Bureau of State Services, Public Health Service. Gordon E. McCallum, former chief of the Water Supply and Water Pollution Branch, Division of Sanitary Engineering Services, will head the new division.