American Handbook of Psychiatry

Planning the Delivery of Mental Health Services to Seriously Disadvantaged Populations

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PLANNING THE DELIVERY OF MENTAL HEALTH SERVICES TO SERIOUSLY DISADVANTAGED POPULATIONS

Twelve years ago America's health planners took the momentous step of designing the first comprehensive healthcare system for the nation. The Community Mental Health Centers Act of 1963 proposed the greatest innovation in health services in our history. Its more ambitious aspect was the proposal for the delivery of comprehensive mental-health services to seriously disadvantaged populations.

For the first time in American medicine, comprehensive health planning defined the future dimensions of a field of medicine, and for the first time public-health concepts played a major part in planning the practice of a clinical specialty. For, eschewing the traditional approaches to individuals, this act took as the target of medical concern "catchment areas" of 75,000 to 200,000 persons. It assigned responsibility for the mental health of the persons within these areas to community mental-health centers geographically located within them and proposed a goal of 2000 such centers by 1980, to provide comprehensive mental-health care to the entire nation.

This act had significant impact upon the development of American psychiatry. It provided strong impetus for a movement away from its traditional concern with individuals and toward a public-health model of care for populations. And it brought psychiatry face to face with the massive

problems of poverty, which it had known until then only indirectly and derivatively. For the highest priority in the funding of community mental-health centers has been given to those in poverty areas.

A decade of effort in the delivery of mental-health services to seriously disadvantaged areas has produced bitter disappointment and some limited progress. It has, however, helped to define some of the issues and problems and indicated some methods of analyzing them. In this chapter we will deal with four of these issues: the culture of poverty, the ethos of American psychiatry, the financial underwriting of mental-health services, and some characteristics of these services, especially in poverty areas.

The Culture of Poverty

Let us begin by considering some characteristics of the members of seriously disadvantaged populations. First, what do we mean by "disadvantaged"? In general, disadvantaged persons are those who do not have the economic necessities for reasonable human living. They live precariously in every sense—environmentally, biologically, socially, educationally, and economically. They do not have a reasonable degree of autonomy and control over their destiny as individuals and as populations. They do not have access to the essential channels for their economic, social, educational, health, and cultural needs. They do not have access to those

individuals who could improve their status. Disadvantaged is not defined by class or ethnic or minority group membership. However, the risk of being a member of the so-called disadvantaged community is greatly increased if one is also a member of a minority group. In short, people who are disadvantaged are those who are described by Harrington as "poor because they are poor and stay poor because they are poor."

Throughout the remainder of this chapter we shall simply refer to the "poor" without further elaborations. This is a generalization not without its dangers, but we anticipate that the reader will accommodate himself to this convention.

The poor share many characteristics in common and a cultural anthropology literature of the poor has developed. It has become fashionable in some quarters to confuse a "culture" of poverty with a black culture. An understanding of the historical roots, life style, and values of the black person is not the same as understanding the life style and values of the poor. We are, in this chapter, concerned with the poor and this cuts across issues of race and ethnic origin, even while race and ethnicity modify some of the features of the poverty culture.

Mental-health planners and shapers tend to overlook the fact that the most serious poverty is rural and white. Instead, they talk in terms related to

cities and usually to city blacks. There are, of course, good reasons for this. Population density is greatest in our cities and so the density of poverty is likewise to be found in our cities. From a public-health perspective, it is reasonable to be concerned with geographically accessible high-risk groups. Hence, the urban poor, compressed as they are into discrete, high-density areas, become “attractive” for study and for service plans. The rural poor and particularly the Southern rural poor have no ready advocates because of their geographic remoteness, and so there is little “public concern” or indignation. Add to this the natural tendency of service professionals to live and work in urban areas and we have the makings of a self-reinforcing pattern of service shortage for the rural poor.

What can we say about the culture of poverty that has relevance to our concern, namely, the development and maintenance of mental-health delivery systems?

Bernstein and others have pointed out that the verbal abilities of the poor are significantly less then among the middle and upper classes. Speech tends to be impersonal, concrete, and reflective of social identity rather than personal identity. And so, to the extent that these characteristics are at the core in most psychiatric-care strategies, the verbal gap between the poor consumer and the middle-class health purveyor, hits at this most basic precondition for psychotherapeutic care.

An inability or unwillingness to defer gratification has been cited as another characteristic of the poor.' Such a pattern seems adaptive for persons who have known deprivation as a way of life and who, therefore, take their gratifications as quickly as possible before returning to the familiar state of deprivation. Nevertheless, this emphasis on the here and now conflicts with the requirement of many forms of psychiatric treatment for a long-range orientation, and for an ability and a willingness on the part of the patient to plan for the future.

Although the prevalence of depression in the poor cannot be noted in sound epidemiologic fashion, descriptions of apathy and hopelessness characterize much of the descriptive literature. This apathy and hopelessness are not parts of a circumscribed psychopathologic state as much as they are characterologic and inbred habits, coming from years of deprivation and disadvantage. As such they are difficult to “treat” clinically, and they compromise motivation for pursuing help for other psychosocial problems.

With the increased awareness of poverty as a serious problem in the last decade, there has been a corresponding increase in attention paid to the issue of poverty by all of our communications media. Poverty has become a fashionable topic at cocktail parties and on radio or television talk shows. The attention at the public level has promoted, as one consequence, an increase in the bargaining power of poverty persons. But that bargaining power has been

largely illusory when social changes on their behalf have threatened the status quo of those classes higher on the socioeconomic ladder. Such highly charged issues as busing, suburban low-cost housing, hiring quotas of minority members, welfare reform, and healthcare insurance are testimony to the conflictual nature of anything that threatens the social-class status quo. This reality of conflict between classes brings an element of hostility to many other interclass relationships. This potential hostility is no less the case in psychotherapeutic relationships that bring middle-class "therapists" into charged settings with poor patients.

The poor have also been described as having an uncanny ability to sense the expectations for them by the more affluent, and so to "perform" in a fashion that will yield the greatest gain in their interpersonal relations with the "richer outer world." The subservient role may be the caricature, but this role is often used to manipulate the immediate interpersonal situation. This ability to say what is necessary rather than what may be true is antithetical to the implicit value of speaking and "feeling" the truth, which the psychiatrist requires of his patient.

The relationship of poverty and educational attainment is of fundamental significance, and the full implications go far beyond the focus of this chapter. The inability to comprehend the complicated bureaucratic organization of urban America has forced many to retreat into unproductive

but safely simple and more primitive life styles. The development of the ghetto is often the net result of not only the rejection by an alien majority, but also the pursuit of a simple, less complicated life style. The plight of the unsophisticated Southern black or white who migrates to the big Northern city is particularly relevant to this point. This, in a real sense, is an example of culture shock. But it is also reflective of the deficient opportunity "to learn" about "how to make it" in the middle-class ethos that directs the organization and values of American society. This deficiency is as much a problem in Northern urban education as it is in the South. In many ways, the health bureaucracy resembles the complexity of many other social institutions, and a person's ability to extract maximum benefit depends upon his ability to understand the complexity. He must compensate for the fragmentation and pursue his needs despite a lack of clarity within the health institution. This calls for rather sophisticated initiative on the part of the would-be health consumer. When we focus upon the poor, we see just the opposite. Their lack of sophisticated understanding of the health (including psychiatry) bureaucracy puts them at a further disadvantage.

It should not be surprising that all of these foregoing factors contribute to the unhealthy relationship of the poor to the health-delivery system in this country. The patterns of health care, with the implicit requirements placed upon a potential health-care consumer, work uniformly against the likelihood of the poor receiving adequate quantitative and qualitative service. It is to

psychiatry's tentative credit that, despite health-care failures in delivery to the poor, it has taken a leadership role in struggling with the problem through its community mental-health movement.

The Ethos of American Psychiatry

How has American psychiatry coped with the special problems posed by the culture of poverty? And what strengths and weaknesses does the specialty bring to the development of more effective mental-health services for the poor?

To answer these pressing questions, it may be in order to take a brief look at the history of American psychiatry. Its development can be separated into three phases, each of which contributed important elements to the field as we know it today and each of which occurred as a result of a fortuitous combination of circumstances. There was, in each instance, a favorable social climate into which a new scientific theory or technology was introduced. The interaction of social climate and scientific base defined psychiatry's new tasks and suggested new ways of carrying them out.

This kind of interaction between social climate and technology appears to have had a profound influence on the establishment, nearly 200 years ago, of modern psychiatry. The social climate was that of the French Revolution and of Quaker hospital reform. The scientific innovation was the classification

introduced by Linnaeus and applied with consummate skill by Philippe Pinel at the Bicètre and the Salpêtrière. Pinel selected, from among the large numbers and variety of the socially disabled, a group of individuals with discrete behavioral disorders, many of whom had good prospects for recovery. By demonstrating the effectiveness of a uniquely humane mode of care for these persons—the so-called "moral treatment of the insane"—Pinel and his contemporaries defined the traditional tasks of psychiatry, the diagnosis of mental illness and its treatment in hospitals specially designed for this purpose.

Initially, the care rendered in these hospitals, which catered to the more affluent members of society, was humane and surprisingly effective. But in time the quality of hospital treatment of the mentally ill declined to the low level we have come to associate with the old, isolated state mental hospitals. This deterioration appears to have begun in the years following the Civil War. During this period, large numbers of poor people, many of them immigrants, overwhelmed the facilities of the small, treatment-oriented hospitals. As larger and larger public mental hospitals were built, the earlier therapeutic functions were replaced by custodial ones and therapeutic optimism gave way to pessimism and to self-fulfilling prophecies about the incurability of mental illness.

It is this aspect of psychiatry—the large, isolated, human warehouses—

that the poor have traditionally known, feared, and avoided, and it is in such unpromising settings that psychiatrists have traditionally made the acquaintance of the poor. Here the dehumanizing effects of the environment accentuated what psychiatrists already perceived as the alien character of the immigrant and the perplexing qualities of the poor.

The second major development, in American psychiatry at least, was heralded by a profound social event of our recent past— World War II. In those days, a heightened concern with political freedom and personal liberty was coupled with shock over the high rates of psychiatric disability being disclosed at induction centers and on the battlefields. At this critical time, psychoanalysis was introduced into American psychiatry. For the first time, a systematic theory of neurosis and a therapy that claimed not only to cure neurosis but to change human nature itself became available.

It would be hard to overestimate the impact of this interaction of social need and psychoanalytic theory. The long-standing pessimism born of years of heartbreak in the treatment of the mentally ill was shattered and all of American psychiatry was suffused with enthusiasm and élan. As it turned out, many of the hopes raised by psychoanalysis were never realized, but it remains an important factor in the background of most psychiatrists. Its emphasis upon neurosis, verbal interchange, and insight continues to exert a powerful influence.

The social climate that fostered the third development in American psychiatry was epitomized by the Kennedy-Johnson social legislation of the 1960s and that decade's generous institutional support for psychiatry. In this climate, a variety of scientific and technologic advances were made. Some have come out of clinical practice: short-term psychotherapies derived from psychoanalysis, group therapy, family therapy, milieu therapy. Others are applications of basic science. A vast and rapidly growing selection of psychopharmacologic agents has made it possible to treat a broad range of disorders, in an expanding number of patients ever more precisely.

The field of behavioral therapy, based upon principles of learning once considered useful only in mild neurotic fears, then applied successfully to more severe phobias and inhibitions, is now used in the entire gamut of mental and emotional disorders. Finally, extensive epidemiologic studies have demonstrated that close correlations exist between many aspects of the culture of poverty and psychiatric disability.

The background of today's psychiatrists includes all three historic elements: the mental hospital, the private-office practice of psychotherapy, and the newer, more eclectic orientations. The degree to which an individual psychiatrist is interested in the development of mental-health services in poverty areas, and his ability to contribute to such development, reflect his predominant professional orientation.

Psychiatrists working in mental hospitals still provide most of the psychiatric care the poor receive. Most of the patients in our state hospitals are from the lower social classes; much of their treatment still takes place within the walls of the hospital. But many state hospitals have shown admirable initiative in developing close ties to the communities from which their patients come, and to treatment programs within these communities. Unfortunately, the chronic underfunding and neglect of so many of these hospitals, and the resulting inadequacies of staff and facilities, have limited their efforts to develop better mental-health services.

Private mental hospitals have developed a surprising number of treatment programs in the communities outside their walls. But these hospitals are seldom located in poverty areas.

The continuing high prestige of psychoanalysis has meant that office practice of psychotherapy remains the most popular field within psychiatry. Many psychotherapists spend a great deal of time and effort on public service and some have worked long and hard to develop mental-health services for the poor. But psychoanalytically oriented psychotherapy requires introspection on the patient's part and a willingness to defer gratification, plus a high regard for insight and considerable verbal skill. These traits are far more common among middle- and upper-than among lower-class persons. Since, not unreasonably, psychotherapists prefer to treat those who stand the

best chance of responding to treatment, there is a tendency to restrict psychotherapeutic practices to the middle and upper classes, even when subsidies remove the financial barrier that usually excludes the poor. Psychotherapy for lower class patients requires experience, a particular aptitude, and extensive modification of technique. As a result, the traditionally trained psychotherapist is unlikely to make important contributions to the development of mental-health services for the poor.

The recent graduates of psychiatric residency-training programs constitute a promising new source of psychiatric manpower. Many of these young psychiatrists have mastered a wide variety of treatment techniques and have had at least some experience in applying these techniques to the poor. Their training, and their strong commitment to social values, make these newcomers far more capable of developing new services for the poor than their older colleagues with their traditional values and limited treatment repertoires. Furthermore, the training the younger psychiatrists receive in psychopharmacology and in the behavioral therapies encourages them to scrutinize more critically the results of treatment. Recent psychiatric graduates are far more inclined to demand a reasonable cost-benefit accounting of the investment of their own efforts and of those of their peers.

On the debit side, an excess of youthful zeal may limit the effectiveness of their efforts. They do not always extend the admirable powers of criticism

they apply to traditional psychiatric methods to their own activities. Enthusiasm for social action untempered by good judgment can be quixotic. But on balance, recent graduates of residency-training programs have far more to contribute to mental-health services for the poor than their elders. These young doctors must provide the leadership in this endeavor. Their point of view and the greatly improved training they have received give grounds for some optimism as they approach their pioneering task.

Financial Underwriting

The major current effort to deliver mental-health services to the poor is centered around the Community Mental Health Centers Act of 1963, which involves a combination of funding patterns. The act was passed during the period before the full impact of the Medicare legislation had become clear. We still believed that our health-care delivery system was excellent, and that all we needed was to put money in the hands of low-income groups to permit them access to the system. It was expected that health insurance would eventually permit all Americans to seek health services, including mental-health services, on a fee-for-service basis, with reimbursement by third-party sources. The planners recognized, however, that mental-health services available a decade ago were inadequate to meet the needs of vast numbers of our citizens, even when they were able to pay for psychiatric care. Therefore, funds were made available from the federal government, with matching

support from local sources to initiate community mental-health programs. This funding was viewed as a temporary expedient, designed to reorganize the pattern of delivery of mental-health services in a more effective and equitable manner. Once this reorganization had taken place, it was expected that the increased purchasing power conferred by third-party payments would permit all Americans access to the restructured mental-health services, and support of these services would revert to a fee-for-service pattern. Accordingly, federal support for community mental-health centers was distributed on a declining basis, with support for new programs totally phased out over a period of from five to eight years. The centers were thus initiated on a prepayment-group-practice model with the expectation that they would revert to a fee-for-service model over a period of years.

Budgetary restrictions have slowed the initial plans and no more than 480 of the projected 2000 community mental-health centers have been constructed. But considerable experience with this dual system of funding has been gained. In general, federal support has worked well in assisting the initiative of local planners in establishing community mental-health centers. The expected shift of support to a fee-for-service basis funded by third-party payments, however, has occurred very slowly and still provides only a fraction of the support of most community mental-health centers.

The poor have always been provided services, health and otherwise,

with the requirement that they get it where they are told. The inability to choose from among competing services is one of the most critical differences that sets off the usual service for the poor from the free-market system used for middle- and upper-class health consumers. Competing purveyors must maintain quality standards to survive. No such requirement is made of the usual health purveyor for the entrapped poverty-health consumer—beyond governmental standards that are often difficult to police.

And so, as we turn our attention to the fiscal system underlying a mental-health-service plan for the poor we must take into account the above traditional handicaps to the development of quality-service systems. But this fiscal issue leads to an associated question. Who wants to plan, develop, and maintain delivery systems for the poor? It would be foolhardy to suggest that compassion, benevolence, and altruism are in sufficient supply to generate manpower interests (at all levels) in this health-delivery problem. It is perhaps unfortunate that there have, in fact, been such idealistic and hard-working individuals involved in health delivery to the poor since they have never been able to adequately meet the enormous needs and have rather dulled the edge of urgent demand from the poor that might have generated a more comprehensive and efficient system.

Prepayment Plan

A physician working in a prepayment health-delivery system can expect his income to be directly related to the efficiency of the medical organization, the control of cost (including level of amenities) and the ability to anticipate costly illnesses in subscribers, providing prevention-directed care so as to avoid such costly illnesses wherever possible. The consumer is free from unexpected financial liability—since he pays only a fixed amount regardless of his medical risk. This seems an attractive arrangement since it protects the consumer while assuring him of medical care and gives physicians financial incentive to provide preventive medicine. It also stabilizes the workload of physicians and stimulates organizational efficiency.

The prepay group plan presents a difficult problem when related to mental-health services. In most of medicine there exists a clarity at the level of illness categorization and at the level of indicated treatment. The criteria for diagnosis are reasonably well worked out and the standards of care (as well as choice of appropriate treatment) are also spelled out. The monitoring of a health-delivery system requires this dual-level clarity (illness criteria and treatment criteria). Without this dual clarity it would be very difficult to determine when a consumer is entitled to care and very difficult to determine when a consumer is receiving the most appropriate kind of care. In mental-health services the development of clear illness criteria and related treatment criteria is rather primitive. Consumers, in a prepay plan would probably be unsure as to what qualifies as a “bona-fide” mental disorder. The listing of

such bona-fide disorders would be equally difficult for the professional because, although a standard nomenclature exists (DSM-II) its diagnostic criteria are not tight, resulting in great variation in diagnostic convention. Difficulties would also result from the great variation in treatment strategies that compete through rather zealous psychiatric practitioners. The cost-benefit implications of such ambiguity is quite alien to the prepay group plan, which depends on careful cost-accounting principles.

When considering the poor, such a system is even more confusing. As practitioners in urban community mental-health centers have discovered, mental-health problems of the poor are difficult to separate from their social and economic problems. The apparent interlocking of problems has led many to a radical brand of treatment requiring a good deal of social intervention. The borders of such strategies are enormously ambiguous and so we have further difficulty in meeting the dual-level clarity requirements of a sound prepay group plan.

Quality of care maintenance has always been a problem in poverty-oriented health systems. This might be partially solved through a prepay plan, since the consumer (or his employer in cases where the employer pays for the plan) could withdraw their support if the health purveyor could not meet quality standards. But, as noted earlier, in mental-health services there is poor standardization of quality standards.

Fee-for-Service Plan

The second major approach is based on a fee-for-service plan. There are many variations on this theme, whether the fee is paid directly by the consumer or by partial or total subsidy through an insurance scheme. Whereas in prepay plans there is a probable tendency for patients to over-utilize medical care, in fee-for-service plans there is a probable tendency to underutilize medical care, particularly where out-of-pocket costs threaten to embarrass already limited family budgets. It can be argued that, where health care is concerned, it is better to err in commission rather than in omission. This suggests that the prepay plans are best, but let us continue our consideration of the fee-for-service plan before making such a conclusion.

One of the claims made by fee-for-service proponents is that this system allows for the greatest freedom for both the consumer and the purveyor. The consumer can choose his purveyor from among many and can base his choice on his own idiosyncratic set of criteria. It is common knowledge that this choice is often based on criteria that would probably never enter a formal quality control system; such criteria as a physician's personality, location of his office, amenities he can provide, his religion or nationality, his color, his social status, the type of hospital to which he admits his patients, and so on. This range of preference for the consumer certainly would not apply with most prepay type schemes. Whether such freedom of choice is a valid point

upon which to build a case for fee-for-service plans is subject to much debate. Certainly these are not the primary considerations in the development of a high quality and equitably distributed health-care system. Whereas this seems reasonably clear in a consideration of health care in general, it is much less clear in specifically considering mental-health care.

A conclusion is warranted at this point. Because of poor standardization of treatment (and all that entails) on the one hand, and poor standardization of patient problems (and all that entails) on the other, no broad fiscal plan is clearly preferable over another when viewed as part of a mental-health delivery system. Psychiatric treatment is too unsystematic to easily fit into the systematic requirements of a fiscal-health plan. But what are the ramifications of this pessimistic conclusion when viewed in the light of our discussion of mental-health delivery systems for the poor?

Everything seems to get worse when we add the dimension of poverty. And so, too, when considering a fiscal-health plan to underwrite a mental-health delivery system for the poor. Should buying power be given directly to the prospective mental-health consumer (fee for service, insurance, etc.) or should money be given directly to purveyors in advance of any service rendered (prepay, health maintenance organizations, etc.) or should there be some variable mix of these alternatives?

With a public-health perspective we must begin by stating that our goal is to develop a system that is *most likely* to provide the *highest quality service possible* in the most *equitably distributed* way *possible.* This leaves us with the question: which is more important, quality or equitable distribution? And more specifically, which is more important in mental-health services for the poor? When we look at the current scene in mental-health delivery to poor people, is the larger problem the inequitable distribution or is it the poor quality of care? It is likely that different answers could be given, with strong arguments for each. Certainly, both quality and distribution have been deficient and the question of which has been worse may be a futile exercise in semantics.

If we were to choose quality or equity as a greater priority, is there a prospect of improving the other through a non-fiscal strategy? If we decided that quality care was most important and opted for a fee-for-service approach, how could we correct for the probable maldistribution problem? And if we decided that equitable distribution was most important and therefore opted for some kind of pre-payed plan, how could we correct for the probable quality of care problems?

Fee for service would be an option for the poor if they were included in a universal insurance scheme that provided for reimbursement to the purveyor of choice. If the insurance were in fact universal (i.e., available for

everyone) then, potentially, our distribution of buying power would be accomplished. But it is not likely that the already short manpower supply in psychiatry would be able to absorb the demand, nor is the available manpower adequately prepared for the service needs of the poor, nor is it likely that the geographic distribution of this manpower would shift. And so we would continue to face distribution problems (manpower type and supply and geographic concentration) despite our provision of more equitable buying power to the mental-health consumer.

Prepay group plans offer the advantage of setting conditions on the health purveyor. One of those conditions could be in determining where he could work. Payment to the group purveyors could be contingent upon their willingness to establish their work in areas of greater need. This arrangement frees the consumer from financial liability (a necessity when talking about the poor) and insures a greater control in developing geographic distribution. The question of manpower remains unsolved in either approach and will be discussed separately. And we are still left with the problem of quality.

Quality of care, as developed within a pre-payed psychiatric service plan, will be most possible in those areas of service which are most explicit and measurable, and least possible (to regulate or monitor) in those areas of service which are vague, overly general (or philosophic) and hard to measure. Much of American psychiatry fits into the latter rather than the former, and so

the suggestion that a fiscal change from the current fee-for-service system to the pre-payed system is necessary (for reasons of distribution) brings with it the corollary that psychiatric practice will be forced to change from the largely intuitive and interpersonal practice of today to a more specific, measurable practice (for reasons of quality control).

This type of radical shift is unlikely to occur very rapidly since the bulk of our current manpower is committed to a poorly standardized brand of practice. It probably would not, nor could it shift in rapid fashion. And so, the tentative conclusion is that, as far as well-distributed, quality mental-health service for the poor is concerned, we can make rapid strides to resolve distribution problems through a change in the underwriting fiscal system, but the development of quality services will be only as good as we can make explicit standards, on the one hand, and develop new manpower (with new orientation) on the other.

The fiscal system used to underwrite medical developments in American medicine, and psychiatric practice in particular, will have an effect on the distribution and quality of services far beyond our ability to anticipate such change. It is naive to think that the problems of distributing and upgrading the quality of psychiatric services to the poor can be resolved by simply redistributing money.

Mental-health Delivery System for the Poor

Mental health is a connotative concept in that it suggests a variety of meanings. There is some consensus about the concept when it is thought of as "the absence of" mental illness. This negative definition leads some advocates of mental health to promote plans that are designed to prevent, treat, or rehabilitate specific mental illnesses.

On the other hand, there are those who think of mental health as "the presence of" a variety of personal psychologic characteristics considered "healthy."' This positive definition leads these advocates of mental health to promote plans that are designed to develop these healthy personal characteristics. For the sake of clarity, we might categorize the former group as *clinical* and the latter group as *developmental.*

The connotations of mental health lead us to other considerations as well. Some consider mental health (whether of the *clinical* or *developmental* types) to be the property of individuals, as is the usual traditional view of psychiatry. Others extend it to social groups that may include family, social network, community, nation, and even world. Again for the sake of clarity, we can categorize the former as *individual* and the latter as *social.* So, then, we can speak of the clinical mental health of individuals or of families and we can also speak of the developmental mental health of individuals or of families or more extended social groupings.

Our differentiation then allows for two adjectival concepts (*clinical* and *developmental*) and two nominative concepts (*individual* and *social group*). The failure to make these critical distinctions in the discussion of mental-health services has caused immeasurable confusion in the past, and this confusion is considerably increased in discussions about mental-health services for the poor, for reasons that shall become apparent.

Attempts to deliver mental-health services to the poor have been characterized by a variety of understandings of the concept of mental health. Some programs are clinical and individually oriented. Other programs place their emphasis on clinical problems of families and "the community." Still other programs have emphasized the promotion of inherent strengths among poor people (developmental). And, lastly, some have emphasized the development of community strength, which may include politicalization and ideological community organization, f If all of these can be connotatively linked to mental health, then, we have a task of differentially choosing between these alternatives as we move closer to the planning of specific programs for mental-health delivery to the poor. The basis of our choice should follow an analysis of the *validity* of the alternatives, the priority of the valid alternatives, and the *feasibility* of each.

The Concept of Delivery System

If mental health is the product we wish to deliver, and if mental health is the ubiquitous concept tentatively analyzed in the preceding section, then the delivery system can vary considerably. However, before becoming specific about any one delivery system, it should be possible to develop those general features of a mental-health delivery system which should apply in all instances.

There are undoubtedly many ways to approach this issue, but we shall focus on certain system characteristics that are particularly relevant in mental-health delivery systems. A primary requirement for a system is that it be *explicit.* This suggests that the goals of the system be as definite as possible. In something as ambiguous as the mental-health field this becomes all the more essential. The requirement for explicitness applies to more than the stated goals. We must also define the various strategies within the system that shall characterize its activities in pursuit of those goals. Explicitness makes the likelihood of all members of the system pulling in the same direction more likely. It also provides the necessary clarity that will be needed to assess effectiveness. Explicitness must be applied to attempts to make the system comprehensive as well as continuous. How far out will the system operate? Will it be population focused (as in the catchment-area concept of community mental health) or will it be limited by its internal capacity?

A second requirement for a system is that it be *manageable.* Are its explicit goals within the limitations imposed by the system's resources? Are the resources prepared for their explicit tasks, and are they aware of the requirement that they be responsive to supervening management? What is the likelihood of the durability of the resources? Management is not possible if explicitness has not characterized the system first.

A third requirement for a system is that it be *effective.* Are the goals stated so that they are measurable in some way? Can the system recognize the difference between success and failure in the pursuit of its goals? Does management recognize its role in responding to the data of testing of effectiveness and can it redirect or maintain the system in accordance with effectiveness data?

These three requirements of systems, *explicit, manageable,* and *effective* can be of help in determining the feasibility of any mental-health delivery system for the poor.

Program Goals

Now our task is to spell out goals that could direct our delivery-system design and then to develop programmatic strategies that offer means to these goals. Both the development of goals and of strategies must take into account, as best they can, all of the foregoing problem areas.

We have already differentiated four variations within the concept of mental health. Presumably, then, we have four alternate or complementary general goals we can pursue. We can focus on individual types of psychopathology (clinical individual) and develop treatment programs (or preventive, if feasible) to deal with various types of such psychopathology. This is the most traditional approach and most of clinical psychiatry is directed in this fashion.

If we focus on what we have termed a *developmental-individual* concept of mental health, our programs would take on a different design. In this instance we would place far greater emphasis on the *promotion* of certain *personal characteristics* that we could identify as being necessary and/or helpful to the individual in his task of lifelong adaptation. This suggests the development of impact in educational institutions, both school and family.

If we focus on a *clinical-social* model, then our tasks will be even more unlike the traditional clinical-individual orientation. This approach would require us to develop programs aimed at designated problems of either social process or social structure. As stated earlier, we will then be committed to social action and social renovation. And if our focus be *developmental social* then our programs must be politicized.

We need not debate the nobility of one over another as we consider

these variations in the concept of mental health. Only cursory familiarity with the problems of individuals and society will allow us to make the general statement that there is great need in all of these directions. And this is certainly most graphically true when considering the plight of the poor.

But when this question is examined from the particular framework of psychiatry and against the criteria of *validity, priority,* and *feasibility,* we can reduce our alternatives. The concepts of mental health, when viewed in their social perspective (either *clinical* or *developmental)* are subject to much ambiguity. We can argue the validity of one social structure as against another, or of one social process as against another, but, ultimately, we are anchored by the values of one social philosophy or another. It is quite possible that mental health, in a social sense, would demand a higher *priority* than individual mental health, particularly when confronted with the social structures and processes that beget and perpetuate poverty. There are few mental-health professionals who have not experienced frustration and a sense of powerlessness after experience in dealing with clinical problems among the poor. There is a feeling of engulfment as one recognizes that one problem is related to another and yet another. The so-called multiproblem family is everywhere in the poverty population. It is almost invariable that the mental-health professional in such a setting develops a resentment toward the ubiquitous "social system" that seems to strangle his patient. The natural tendency is to want to "get at" the social system. This is an ideal place from

which to gain a perspective about the individual casualties that can be created by social structures. Unfortunately, it does not follow that this is an ideal place from which to bring significant influence to bear on those same social structures. Our analysis leaves us with tenuous *validity,* on the one hand, and strong *priority* on the other, particularly in reference to mental-health goals for the poor.

The watershed comes from an understanding of the *feasibility* of efforts directed at the social definition of mental health. It must be kept in mind that this entire chapter is intended to be relevant to the study and work of psychiatrists, not political scientists, sociologists, lawyers, legislators, or lay activists. If reconsidered from other perspectives, the question of feasibility might be answered in an entirely different way. But when viewed in relationship to psychiatry, feasibility analysis dictates that programs for mental health, directed at the social connotations of that concept, are unlikely to be productive. The identity of psychiatry, as amorphous as that has been in operational terms, has nonetheless been firmly fixed to maladaptation of individuals, with some expansion to small groups (family, etc.). The resources of psychiatry, whether its information store, its financial underwriting, its technology, or its historical legacy, are all heavily committed to problems of the individual and his immediate context. The constraints, were psychiatry to launch into an operational focus on social structure and function, would be enormous. Hence, the feasibility of such a-goal is seriously compromised. We

can leave to history the determination of whether a new discipline, dedicated to intervention (in the service of "social-mental health") in social structures and functions, will emerge from that wing of psychiatry which has become intrigued with this problem.

We are left with rather mundane and traditional goals: the development of psychiatric service systems focused upon the individual (whether clinical or developmental) with "individual" being expanded to include contextual group and family. With this start we can next consider the implications of the system requirements noted earlier: *explicit; manageable; effective.*

We can approach the requirement for explicitness both from the perspective of the individual patient and of the therapy. This is to say that *systematic* service delivery should be characterized by problem standardization, on the one hand, and therapy standardization on the other. Which therapies are indicated for which problems? As complicated as this is for psychiatric delivery in general, it is considerably more complicated for psychiatric delivery to poor populations.

True standardization of those kinds of behavior included in the DSM-II has yet to be successfully accomplished, although there is considerable effort in that direction.' The confounding problem of viewing maladaptive behavior in a socially disordered setting, as is the case so often among the poor, is to

add anguish to pain.

The only safe statement that can emerge from this consideration is that we will have increasing difficulty in the delivery of psychiatric services to poor populations, in direct proportion to the degree to which we fail (or are unable) to make the target problems explicit. And so the general goal of "mental-health service for individuals" is far too vague. Mental-health services for alcoholism, for drug abuse and addiction, for problems of the aged, for schizophrenia or like psychoses, for mental retardation—these are in the order of explicitness that allows for more systematic treatment.

Emergency and Diagnostic Centers

We are arguing for a categorical approach to service delivery and for some greater degree of standardization of therapeutic interventions. When translated into the operational terms of service structures and functions, we may begin by opting for centralized diagnostic services. Such services should be in a readily accessible location, with good public transportation. A study of psychiatric, utilization rates in an urban ghetto revealed highest rates occurring in those areas which had good public transportation linkage with the mental-health facility. It is more feasible to centralize such services because of the high level of sophistication (and hence shortage) of diagnostic personnel. To deploy staff into so-called satellite locations for diagnostic

functions is not generally economically feasible, although a tendency in this direction is nonetheless developing. The principle of reaching out has gained increasing currency and seems valid in the face of data that suggests that patients (particularly from poverty areas) do not readily initiate contact with the health network themselves until their condition deteriorates. But we have been more impressed by limiting the outpost or satellite (or other outreach equivalent) to an initial contact and triage function, rather than careful diagnostic and planning function.

We can respond to another characteristic of the poor if we expand the idea of a centralized diagnostic process to include emergency service. As has been noted, the poor tend to seek help only when the situation has reached crisis proportions. They are most likely to initiate contact themselves during crisis and more likely to maintain contact and involvement only as long as the crisis continues.'' It behooves the planner of psychiatric services then to capitalize on this characteristic by emphasizing the emergency-diagnostic function of his delivery system. This means a far greater investment of space and manpower in "emergency" units than has been the case to date. An entire sub-discipline is emerging in medicine in general, and this includes psychiatry. The day of the on-call resident who reluctantly "comes down," after being cajoled by the medical resident, to evaluate and "quickly" refer a patient in the emergency room, although currently the "tradition" in the majority of instances, is certainly passe. It will hopefully give way to

arrangements of specialized, staff-level teams, able to absorb large numbers of complicated cases, giving intense treatment and providing sophisticated diagnostic work at the entry to the medical- and/or psychiatric-service system. This is a requirement of rather urgent proportions in programs focused on poor populations. This "emergency" of emergency services has certainly generated renewed interest in the emergency department and in the theory of crisis, but the translation of this interest into tangible structures is just beginning. One of the inhibiting factors is cost, since intensive care or sophisticated diagnostic process is expensive. We see no way around this issue until we are better able to frame cost-benefit studies. There is good reason to anticipate that, once such studies are feasible and under way, we shall discover that benefits at the acute end of the treatment continuum will indicate a dollar bargain in comparison to cost benefits at later stages of therapeutic contact.

The community mental-health movement has given the most concrete impetus to the development of emergency services through its mandated requirement for emergency service in every community mental-health center. But the experience to date suggests that most centers have approached this task most conservatively and so, overwhelmed, understaffed, under-sophisticated, and tenuously financed operations are more the rule than the exception.

Such emergency and diagnostic centers should follow the lead already provided by various innovative emergency programs. Practices such as the provision of emergency-unit holding beds, emergency home visits (especially for diagnostic purposes), walk-in clinics, group screening, team treatment, telephone-supportive services or telephone triage, police assistance, police and clergy training, detoxification units (for drugs and alcohol) and other variations on these themes are all of variable utility in the emergency-diagnostic center. Some of this technology overlaps, but most adds to the total resources in a way that suggests that the more of them you can incorporate into the service design the better the total treatment impact.

But lest we overemphasize the emergency aspect to the detriment of the diagnostic, let us say a few more words about this part of the emergency-diagnostic-center idea. Current practice often suggests that we can use (and some feel it preferable to use) less sophisticated personnel in diagnostic work with poor patients. The opposite is true. The problems of the poor, particularly when mixed with psychological issues, are difficult to organize, categorize, and diagnose—and even more difficult to conceptualize for treatment strategy. Well-trained and experienced personnel are a requirement at this earliest level of diagnostic and therapeutic contact. If our service plans are to proceed along categorical lines, as discussed previously, it is critical that diagnostic evaluations be done well, particularly with explicit guidelines as to interventional strategies that are considered most useful. It is

likely that less-trained and less-experienced staff will comprise much of the ongoing treatment, and this makes it particularly necessary to start off well.

Categorical Perspective

Beyond the diagnostic-emergency functions, the variations of further treatment are many. Certainly one must keep in mind the idiosyncrasies that may obtain in one area as against another. Unfortunately, the epidemiologic help of incidence and prevalence studies is quite limited. Such studies, when focused on poor populations, tend to give a picture of gross psychopathology without differentiation into categories that can serve as treatment objectives. And there is no assurance that the findings of one study, focused on a discrete geographic population, are applicable to another discrete population, even if the two populations share common demographic characteristics. What we do know with reasonable certainty, however, is that the problems of alcoholism, drug abuse, geriatrics,! psychosis,| and mental retardation are significant in their prevalence and disruptive to individual, family, and community. It is an unfortunate distortion in priorities when mental-health programs can be developed in areas of poverty without special attention being paid to these high visibility conditions.

Of perhaps equal morbid impact are the difficulties that beset the children and youth in poverty areas. With disrupted family structures,

maturation and identity formation often tend to take on dyssocial characteristics. Whether this problem can be effectively resolved without massive social restructuring (family, school, and community) is unlikely. Certainly we have learned that it is futile to approach the problems of children and youth from the traditional child-guidance perspective. In-office, intra-psychically oriented psychotherapy is gradually giving way to family-oriented interventions with greater emphasis on problem solving, communication, and cognitive skills, and collateral network support.

In general terms then, we are faced with several problem areas sufficiently prevalent and morbid to warrant our concern. From a psychiatric perspective, as focused on the problems of poverty, these above-noted categories should receive the highest priorities for our treatment plans. If we approach our service plan in the general and open-ended way that is implicit in an emergency-diagnostic center beginning, then it remains for such a center to develop a way of coping with those problems which may come into the center, but for which no ongoing treatment program has been developed. The requirement for efficient coordination with the community's network of social, health, and educational agencies is critical for the survival of an open-ended emergency-diagnostic center.

It is not the intent of this chapter to develop specific treatment-team strategies for each category of disorder. The technology within each category

will vary from place to place and likewise will vary between categories. There is certainly no unequivocal body of data or treatment approach able to supersede the variety of points of view and variety of treatment strategies that now obtain. The plea is not that all treatment programs mirror one another—or that they all use this "correct" approach or that one—but rather that each treatment program organize itself so as to be quite explicit as to what disorders it plans to treat and what it plans not to treat. And once having been committed to specific treatment objectives, a program must *explicitly* set out each phase of the treatment strategy for each category, from initial contact through termination.

Manpower

We can make three statements about mental-health manpower that are germane to our present concerns: (1) there is a shortage of manpower in absolute terms; (2) psychiatrists are unevenly distributed geographically; (3) they spend the bulk of their time treating the least sick and/or most affluent with essentially unproven techniques. The recognition of these problems has led to a variety of suggestions and activities designed to "improve" the situation, referred to by Pasamanick as "health care anarchy and social irresponsibility."

To reduce the manpower deficit some would have us simply increase

the number of psychiatrists trained annually. This would mean increased governmental subsidies to psychiatric-training programs, an unlikely event when the opposite has, in fact, become a strong possibility. There are already more psychiatric training positions than there are resident applicants. And even if the absolute number were increased, it would not be of the order or magnitude required to bridge the gap significantly.

Some would have us change the educational content or emphasis in psychiatric training, so as to discourage the intensive treatment of the least sick as *the* status activity. A tendency in this direction is perceptible in many training programs that have incorporated the ethos and practices of the community mental-health movement. However, significant exposure of trainees to the severely ill and chronically ill has yet to occur.

The development of team approaches to treatment has been another response to the manpower problem. The use of psychiatrists, psychologists, social workers, and nurses (especially public-health or visiting nurses) has been a long-standing arrangement in mental-health-service organizations. Now, however, this team has been supplemented by new mental-health careerists. A specificity of role for the new careerist has not yet developed and, instead, there are multiple variations in the use of this new manpower resource. They have been called mental-health counselors, mental-health workers, mental-health assistants, paraprofessionals, expeditors, linkage

workers, mental-health advocates, and a variety of other connotative terms. There is an abiding consensus, by those who have had experience in the use of manpower from this new career movement, that there is a valid and useful role for such personnel. It is still too soon to know precisely in what direction the developing role identity will go. It is likely that several differentiated roles and functions will emerge eventually. It is our contention that this movement, if not aborted by political or economic backlash, shows great promise for the future and is likely to radically change the eventual role identity of the psychiatrist as well as the clinical psychologist.

Such a manpower development could serve to respond to a number of problems both from the "culture" of poverty and from the ethos of American psychiatry sides of our dilemma. As new personnel would be developed from class origins closer to our target lower classes, we could expect less difficulty in communication between consumer and treater.

It is possible to think of this new manpower in two ways. On the one hand, it is quite plausible that it could emerge with responsibilities for direct care. Whether it engages in supportive roles, directive roles or educational roles remains as an unresolved issue. On the other hand, it is also possible that the new manpower can be used in roles that relate to delivery management and not to the direct care itself. When health systems are thought of in coordinated and comprehensive terms, it follows that they

become quite complicated. Complicated systems cannot be manageable or effective if consumers are left to this complexity without help. We are already aware of the problems in continuity that occur when consumers are faced with the health bureaucracy. Specialization has resulted in a hodgepodge of mutually exclusive services without any corresponding specialization (excellence or efficiency) in the process of referral, transfer, or consultation. The movement to improve these management components of new health-delivery systems might readily use new career personnel. The need for systematic delivery and the need for comprehensive and coordinated services for the poor makes this development doubly necessary and attractive.

New careerists then can fulfill many of our needs. They can fill in manpower shortages at the level of direct care and they can provide manpower at the level of delivery management. They can also bridge some of the "culture gap" between consumer and therapist. They can help in the task of sensitizing the health-delivery organization to the needs of its consumers in poverty areas.

Evaluation

We would like to close this section with an urgent plea for what we view as the most pressing need in the delivery of health services in poor areas. It is for evaluation. Nor is this need confined to mental-health services in poor

areas; evaluation is the crying need in all aspects of the community mental-health movement. For the construction of community mental-health centers got under way before any pilot project had tested the feasibility of this approach, and its feasibility still has not been evaluated. Seven years and over 400 community mental-health centers later, we still lack any assessment of the effects of these centers upon the mental health of the populations they serve.

This failing is the more poignant in that evaluation was accorded a very high priority by the sponsors of the Community Mental Health Centers Act in the congress. In a largely unprecedented move, these sponsors wrote into the legislation establishing the community mental-health centers the requirement that 1 percent of all operating funds be assigned to evaluation. These funds have been spent, and some evaluation has been carried out. But this evaluation has been carried largely to assessing the relationships between various of the care-taking groups within the centers—so-called input measures. To this day we lack any careful output measures—evaluation of the impact of a community mental-health center on its community. We do not know if they have any impact at all.

Cost-accounting procedures have made inroads in various mental-health centers, however the need is for an even more sophisticated approach. Cost-accounting is limited to giving primarily administrative information

regarding manpower and operational cost. Cost-effectiveness (cost-benefit) carries with it the further information regarding the cost for explicit clinical or social benefits. It is this sort of information that must be acquired to justify (or not) the continued financial support of these mental-health delivery systems.

This kind of output evaluation is very difficult to carry out. And it may be beyond the capacity of any agency to carry out an evaluation that could reflect unfavorably upon its highest priorities. Yet, a beginning must be made; we must obtain some measure of the effects of the centers in decreasing rates of mental illness or increasing indicators of mental health. For we are living in a time when the limits of our national budget have never been more clearly defined nor the need to choose between competing priorities more urgent. Humanitarian motives are no longer sufficient rationale for programs that now cost well in excess of 100 million dollars a year. Determining the cost-effectiveness of community mental-health centers has become a precondition for continuing to support them.

Concluding Remarks

When all is said and done, there remains and will probably always remain a gap between the "best-laid plans" and reality. The poor embody that part of the human condition that every man seeks to escape. The poor

embody failure and deprivation. Poverty is the "pathologic" class that collects the rejects of the middle working classes and the upper "arrived" classes. It is the "pathologic" class that spawns frustration and new members in the poverty cycle. As Harrington effectively reminded us, poverty is something "we do not see" nor is it something we really wish to see. We shall seize every opportunity to deny its existence or its severity.

There are very few persons who can maintain their commitments to working with or for the poor very long. Enthusiasm burns out in the face of seemingly insurmountable obstacles. The psychiatrist who turns his attention toward the problems of the poor does so with few allies among his colleagues. He cannot do it alone and so his commitment is tied irrevocably to the fickle enthusiasms of government. To even begin to accomplish the task described in this chapter many hands are needed. It is a task that relies on the initiative of the mental-health professionals, their nonprofessional colleagues, the entrapped poverty-ridden consumers, government and university—and the will of the public that something more be done.

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