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PRINCIPLES OF COMMUNITY MENTAL HEALTH PRACTICE

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Despite widely different opinions with respect to the nature of community mental health practice, there is a growing consensus among the more experienced practitioners that an arrangement of concepts and principles may be attempted as a step to encourage others to make their own synthesis out of their own experiences. There remain so many unknowns and questions to be investigated that it would be premature to present in a dogmatic way the principles of community mental health practice that are just beginning to emerge. However, more knowledge may already exist than some practitioners now care to apply in the face of economic considerations, manpower shortages, or professional pressures. Therefore, even provisional or incomplete principles may offer better guides than personal opinions, outmoded notions, the preferences of vested interests, or arguments based on expediency.

Experiences in community mental health practice that have been described in a rapidly growing literature exhibit considerable diversity. This may be due less to basically different viewpoints than to the necessity of accommodating administrative guidelines dictated by major sources of funds or to the obvious shortage of trained manpower available to community-based programs. A related, widespread phenomenon is the resistance of

communities and consumers of mental health services to being stereotyped. On the other hand, there are reports of programs that replicate those essential elements without which an endeavor may not be said to exemplify community mental health practice. Such practice may be broadly defined, then, as an organized effort for the dual purpose of meeting a particular community's mental health needs while attempting to reduce mental breakdown in that community to a minimum. In other words, community mental health practice is oriented to mental health and not solely to mental illness; the approach to mental disorders is a preventive one based on a public health rather than on a medical model; each community's concerns and sanctions, along with the community's ability to organize its resources, shape the characteristics of practice in each example.

While comprehensive community psychiatry plays a major role in community mental health practice, it is not the whole of it. For example, the indirect services provided by community psychiatry are so called because they are extended beyond direct, clinical contacts with patients to a sector of the population likely to break down, that is, to people in trouble, who seek help from those who may become the consultees of the mental health consultants. It is those consultees, working in nonpsychiatric, care-giving agencies, professions, and organizations, who represent the community's most significant resources for the maintenance of mental health at the level of primary prevention.

The purposes that give direction to community mental health practice provide both long-range and short-term objectives that distinguish community mental health practice from more conventional approaches. Some of the latter may focus, for example, on the elimination of individual psychopathology, that is, on the visible, mentally disordered members of the population who seek diagnostic evaluation and treatment. Other approaches, emphasizing the link between noxious, societal factors and dangerous or deviant behavior that is equated with mental illness, may emphasize social and political action for either of two reasons: to protect society from the "insane" or to change the societal conditions held responsible for "the myth of mental illness." Whatever the merits may be of such partial or partisan approaches, the position, which amounts to a given in community mental health practice, relies on a sound body of scientific evidence for the multifactorial nature of mental disorders, a theory that is as basic to preventive psychiatry as to clinical psychiatry.

Traditionally, psychiatry has provided all kinds of services for identified, psychiatric patients, from special housing in hospitals, nursing, or foster homes to medical, surgical, dental, educational, and social services in intramural or extramural settings. By contrast, in community mental health practice, psychiatric patients are not segregated unnecessarily from the rest of the population; their eligibility for the basic community services available to other citizens is promoted in every possible way. An institutional approach

to the mentally disordered and retarded is replaced in community psychiatry by a conviction that most psychiatric patients are best treated as close to home as possible, with a minimum of interference with their coping and working capacities and a maximum of protection against interventions likely to increase psychopathology and dependence.

"Mental health" is a term that, like "public health," cannot be abstractly defined; in practice, it refers to the application of public health approaches to the reduction of mental disability within the population identified with a geographically or functionally defined community. Community mental health practice may thus be further described within the conceptual framework of preventive psychiatry as a community's system for the delivery of services. At all three levels of prevention (primary, secondary, and tertiary) such a delivery system involves both the nonpsychiatric and the psychiatric resources of the community, that is, a complex network of care-giving agencies and professions; of both incorporated and publicly elected governing bodies; of both public and voluntary tax-supported services; of social institutions and human resources, both professional and nonprofessional. Most of the organizations and individuals participating in such a network do not have community mental health as their primary responsibility or basic reason for existence. For example, the detection, apprehension, prosecution, and defense of criminals are primary functions of police, courts, and correctional facilities. The professionals engaged in such

public programs, as well as lawyers in private practice, have for ages been formally involved with forensic psychiatrists once known as alienists, but they are scarcely aware of their own mental health functions. Yet, community mental health practice relies on the acquired recognition and acceptance of their special mental health functions not only by nonpsychiatric professionals but also by the community's policy-makers, public officials, directors, and staffs of agencies affording services not generally identified with public mental health.

Within the network comprising a community mental health system, the component subsystems have varying degrees of responsibility for, and make different kinds of contributions to, all three levels of prevention of mental disability. In the process of identifying the mental health function that is specific to, or uniquely provided by, a particular profession or resource involved in community mental health practice, it is essential to preserve the integrity and independence of the individual or agency whose basic purposes are obviously more related to the general health and welfare of the community than to mental health in particular. Working relationships are coordinate, as between mental health professionals and agencies, whose primary responsibility is community mental health, on the one hand, and those other individuals or organizations secondarily contributing to the mental health delivery system, on the other hand; the former do not supersede or attempt to transform the latter into their own image and

likeness. On the contrary, the optimal utilization of community resources in meeting the mental health needs of a community is achieved to the extent that differences of degree and kind with respect to mental health functions are preserved and clarified, rather than blurred or nullified. The coordinating principle that guides relationships between coequals is circumvented when coordination is attempted by merely placing previously independent entities under a single authority. This maneuver will not of itself produce coordination; at best, it may mandate a process of developing and maintaining the working relationship between equal but different contributors to the mental health system.

The Community

The elements of community mental health practice are often described in stereotyped terms and classified like the bits and pieces of a mosaic. Here they are presented not so much as structural elements but as a community's ranked order of purposes, each of which is achieved through certain processes, methods, and components of practice. The functional elements of practice aimed at the achievement of each major purpose are thus seen as occurring in clusters, and each cluster demonstrates a principle that maximizes the chances of successful outcomes while minimizing the restrictions of more rigidly structured, goal-limited, and predetermined forms of practice.

Mental health practice is here viewed as more than a blueprint for the application of preventive psychiatry to any or all communities. However useful a conceptual framework and its related guidelines may be, principles derived from the adaptation of mental health practice to a community are precisely those that make it possible for potentialities to be realized within a given community matrix, that is, the parenchyma of mental health work. The community setting in and for which the work is done provides the driving force that vitalizes and shapes the organization of practice. Any organization needs some structure, but the point to be made is that the functional elements of a community mental health program take precedence over its structure. In other words, the structural elements are too frequently dictated by power struggles, professional boundaries and resistances, or institutional investments with resultant limitation or loss of important functions.

In the absence of indications by a community of its concern about mental health matters, the resultant practice may represent a conglomeration of the different schools of thought favored by individual practitioners or by consumers of mental health services. Unless a community's purposes are known, the direction taken by mental health practice may be haphazard and suffer from lack of planning for stated objectives, either short term or long range. Without a community's identification of its own priorities, it is difficult to initiate, let alone to evaluate, any element of community mental health practice. Each community varies in awareness of its mental health needs,

degree of concern, and ability to take the initiative. Leadership and timing are essential to genuine, active community involvement in mental health.

In the systematic application to community mental health practice of a public health approach at three levels of prevention (primary, secondary, and tertiary), the population at risk refers to the whole, as well as to special sectors, of the populace inhabiting a particular community. Just as an individual in relationship to his environment is the focal point of clinical interventions, the population at risk in relationship to its community is the center of attention in the practice of preventive interventions, including those that are remedial and rehabilitative in nature. The ecological, socioeconomic, sociocultural, and political features that identify a community's profile constitute the environment that is as significant for community mental health practice as the familial and psychosocial milieu of an individual patient in clinical practice.

In epidemiological studies of a specific mental disorder, the community may be conceptualized as a population in which there are carriers of the host factors responsible for mental breakdown. At the same time, a community may be identified as the source of pathogenic, environmental factors (physical, psychosocial or interpersonal, socioeconomic, and sociocultural), which, in varying degrees, contribute to a particular form of organic, psychosomatic, or psychogenic mental disorder. The host factors of general

significance for mental health are an individual's potentialities for adaptation, both inborn and epigenetic. Of paramount and comparable importance is the community's capacity to respond through its resources by forestalling or relieving individual likelihood of mental breakdown due to environmental deficits and hazards in conjunction with individual vulnerabilities. In short, community mental health practice need not be limited to belated, clinical, psychiatric interventions on the grounds of epidemiological ignorance about the cause of every mental disease. There are known, general, epidemiological factors contributing to the most commonly encountered forms of mental breakdown which provide the guidelines for preventive measures.

It is not useful to define too narrowly the community in community mental health practice. In specific aspects of program development the community means different things, such as a geographically or jurisdictionally defined area (for example, a neighborhood, city, county, state, region, nation); a population of a limited size in relationship to location ("catchment area"); or a community of interest making common cause in behalf of mental health, that is, a social system. Each of these definitions is useful for particular elements of practice. A generally useful and functional definition is one that conceives of a community as a system of systems. Here, intergovernmental, interagency, interprofessional, interpersonal, and administrator-consumer relationships, among others, are viewed as essential to the initiation, development, and effective utilization of all available

resources for both remedial and rehabilitative measures as well as for interventions and provisions that safeguard mental health.

Every example of community mental health practice can be identified by its community setting and the nature of the population it serves. However hidden the community's involvement in the undertaking, or however indifferent a community may appear to be, the community is nevertheless a dynamic element of practice. The more openly the community mental health system is linked with other community systems, the more it can avoid fragmentation and dissolution. Community mental health practice should reflect the processes that can be, but are not always, generated and shaped by the community in which it is based, whether the endeavor be broad or narrow in actual scope, ambitious or modest in its objectives. These processes reflect more or less persistent efforts to keep open two-way channels of communication between systems, to replace a community's fear or complacency with constructive concern, to promote public airing of differing viewpoints, and to mobilize leadership. For a community to determine what actions for mental health will best meet its needs, a process of community organization is required, following the principles of appropriateness and community determination of policy.

The drawing of a community's boundaries through clarification of its component subsystems in terms of their potential, if not actual, mental health

functions serves the purpose of identifying both the environment and the population to which community mental health practice must be related. The process involved is the systematic adaptation of a public health model to community needs. One of the methods employed is the uncovering of the latent interdependencies of health, education, and welfare subsystems, social and governmental institutions, the various professions, and labor-management organizations, to name the more obvious examples. Other methods involve applications of the principles of human ecology and demography to the population at risk of mental breakdown. The more stable and cohesive the community turns out to be, the more its population can be fitted into the concept of the catchment area designated in the guidelines of the National Mental Health Act of 1963. The more mobile, displaced, and dense the population at risk, the more it needs to be related to a system of systems (that is, a community) that has the capability of serving much larger and more heterogeneous populations that can be fitted into the federal guidelines. Whereas community mental health practice should be suitable and adapted to a community's mental health needs, it is equally true that the needs of certain kinds of populations can be met only by broadening the boundaries of the community.

Community Organization for Mental Health

The ways in which a community becomes purposefully and willingly, as

opposed to accidentally or coercively, involved in mental health practice are manifold. Persistent demands from minorities, who must be heeded, may or may not be representative of objectively evaluated, community needs; yet the most deafening clamor may express both a genuine concern and a valid need couched in terms that do not have to be taken so literally that they can be conveniently ignored. Demands from professionals also have to be evaluated and interpreted since they, too, may suffer from lack of objectivity with respect to the community's priorities and mental health needs.

The most frequently effective, initial spokesmen for mental health are neither consumers nor providers of services but rather veterans of organizations with a history of volunteered, successful leadership in other fields related to the welfare of the community. Such leaders are apt to qualify as experienced listeners, respondents, and catalysts who have earned a necessary degree of trust and who are, consequently, in the best position to form the nucleus of a group more broadly representative of the community's opponents, as well as proponents, of mental health. Every such nuclear group needs a base of operation. If there exists in the community some form of health and welfare planning council, it could be the most suitable vehicle for constituting a mental health committee. The alternatives for a voluntary group of citizens are numerous, since even the smallest communities are surprisingly rich in organizations, to which the potential mental health spokesmen already belong and within which an initial mental health effort

can be mounted, leading perhaps to the eventual formation of a citizens' mental health association. In any case, those who undertake to advocate mental health in their community should be volunteers, although they may soon need to acquire the professional consultants and staffing assistance needed by any voluntary group with demanding work to do.

Community organization for mental health goes beyond the formulation of public policy in terms of goals to be implemented or actions to be taken in rapid response to expressions of needs that have not been examined or validated. The implementation and development of community mental health resources is the last, rather than the first, step in the process of community organization. The advocates for mental health enter into the community organization process (1) by investigating as objectively as possible the ways in which the community customarily behaves in responding to its mental health needs; (2) by surveying the professional or agency providers of clinical services to the mentally ill or retarded, as well as nonclinical services contributing to the maintenance of mental health; (3) by studying the utilization actually made of the resources in relationship to the utilization-patterns of the people who need such resources the most (that is, realities as opposed to unfulfilled potentialities); and (4) by identifying the major problems and gaps in the existing delivery of services. In short, the first step in the community organization process is fact-finding, from which a valid estimate of the community's unmet mental health needs begins to emerge

while continuing to provoke questions that demand still further investigation. The data gathering could become an end in itself unless this process is accompanied by review and interpretation of the data from all sources for consistency and meaning. This aspect of the investigative process can be accomplished, as a rule, only through interviewing the providers of the data, instead of relying solely on written questionnaires.

Once the meanings of the assembled facts have become clear, recommendations for action begin to take shape. As they accumulate and are reviewed, some may be eliminated as duplications, while others may be combined. The next step in the community organization process is, therefore, a classification of groups of related recommendations under major headings, which in turn leads to giving a different kind of order to the recommendations, namely, the assignment of priorities. The whole question of which community mental health needs take precedence over which others is undoubtedly the most difficult part of the planning process, whose rationale depends, however on the setting of priorities. The community's broad policy on mental health is molded when a report of the survey is made public and the priorities are questioned, clarified, or debated in an open forum.

The eventual and never-ending phase of the community organization process, after all the planning, is the implementation of the priorities that

have won community acceptance. The whole process of community organization represents the best possible method of public education in mental health. The reason is that, when education leads to action, as well as to increased information and knowledge, a learning process associated with active participation and personal commitments has been set in motion, continues, and finds expression in the smaller or larger preliminaries to, and engagements in, implementation of the priorities over however long a span of time is appropriate.

The initiators of the community organization process and all who participated in it acquire some new functions as mobilizers of implementation through the recommendations they have formulated. They also may continue to function indefinitely, on a voluntary basis, as investigators, interpreters, or evaluators of changing community mental health needs. That is to say, their advisory capability in relationship to the community mental health system, whatever form it takes, should not be lost to those who are given the authority and responsibility for implementing and developing a community mental health system.

A voluntary organization that has engaged in the surveying and interpretation of the data, as well as in the formulation of recommendations and priorities, has a choice between incorporating itself as an administrative board or commission or of looking beyond itself to the community's

governing body or to an already incorporated, nonprofit, private agency to implement the planning group's recommendations. In such states as California, where enabling legislation provides state funds to reimburse 90 percent of city or county net costs for mental health services, the choice is likely to favor the local governing body as the most desirable locus of authority and responsibility. In other places, for example, in the State of New York, enabling legislation specifies a particular kind of administrative board for city or county programs supported by the state. Under the federal legislation for community mental health centers, the board may be constituted either as a public agency or as a privately incorporated board of directors such as a general hospital's board of trustees. But the possibility remains that the volunteers who engaged in the community organization process may find none of the above alternatives available or suitable to their purposes, and, consequently, they may incorporate themselves for the purposes of implementing and organizing the kind of community mental health system they recommend.

Implementation and Organization of a Community Mental Health System

It cannot be assumed that actual implementation and organization of community mental health practice will follow, even though a mental health survey of any community is bound to uncover some existing mental health resources as well as recommending new ones. Existing resources may range

from isolated, individual, or agency efforts to meet the mental health needs of selected members or sections of the community all the way to well-endorsed and established programs of clinical, social, or community psychiatry. Whether to create *de novo* a community mental health system or to enable an existing program to better adapt to the ever-changing circumstances and priorities of the whole community, organization or reorganization is necessary to provide for the unmet or new community needs identified by means of the community organization process. Whereas some organizational structure is essential, the functional aspects of organization can scarcely be overemphasized. The structural elements should be strong enough to provide some stability and continuity without sacrificing the flexibility essential for coordinating the multiple functions subsumed under the heading of community mental health practice.

There needs to be a governing board, either privately incorporated or publicly elected, that accepts both the authority and responsibility for carrying out the general purposes developed through the community organization process. In order to do its job with respect to the given purposes, the board needs staffing and funding, along with continuing support and guidance from the community's advocates for a mental health program meeting community needs. For example, the financing of an organized program requires consideration of the various sources of funds, both public and private, and assessment of the alternatives or possible combinations of

funds to be used. Whether the governing board be publicly elected or privately incorporated, public taxes are apt to be one source of financing, if not the major one; an informed electorate supporting the use of public funds for mental health services in private or public agencies needs to be heard from by any governing body before it makes decisions.

The options of a governing board with respect to funding go hand in hand with its options in regard to the locus of authority and responsibility for professionally directed mental health services. Before exercising either type of option, the board needs advice from the community, that is, a mental health advisory committee with three kinds of membership: as many community advocates as necessary to constitute a majority, one or more mental health professionals, and one or more representatives of the existing resources for mental health. Because of the possibility of conflicts of interests, the advisory committee, whose main function is to keep the community's mental health needs before the governing body, should not be dominated by either professional or competing, vested interests. When advice on professional matters or questions about augmenting or coordinating resources are sought by the governing body, ad hoc subcommittees, chaired by an appropriate member of the advisory committee, can be added at any time to fulfill such special advisory functions. Another example of the usefulness of ad hoc subcommittees would be a selection committee for the guidance of the board in appointing (or replacing, as the case might be) a director of community

mental health services; the selection committee would spell out the qualifications to be included in the description of the position in terms of functions, authority, and responsibilities delegated by the governing board. To the extent that the director's responsibilities include most of the administrative decision making within the broad policies laid down by the board or embodied in enabling legislation, the mental health advisory committee may eventually serve the program director as well as the board; however, care should be taken lest the advisory committee lose sight of its primary responsibility to the governing board, become subservient to the program director, and permit the director to speak for the advisory committee to the governing body designated as the community's mental health authority for the organization of the community mental health system.

The role of the community mental health director is, organizationally speaking, a dual one. There is direct, line responsibility only for the mental health services under his or her direction. But there is another, quite different kind of responsibility for the development of coordinate relationships with the directors of nonpsychiatric public or private agencies, with professional and nonprofessional organizations, and with psychiatric agencies and professions, all of which may be engaged in some aspect of mental health practice of their own. An example would be the working relationship between the community's health officer and the mental health director. The latter's dual role exists no matter how comprehensive the program of community

psychiatry may be for which a director has direct responsibility.

However, amongst the ingredients of comprehensive community psychiatry there are included the provision of the so-called indirect, consultative services and direct collaborative (sometimes called “liaison”) services to joint cases, which afford coordinate working relationships at both directors’ levels and below.

The responsibility for community mental health practice at the level of primary prevention is rarely authorized as such. It is, however, sanctioned, with or without informed consent or intent, as a secondary function or effect of such basic services as education, health, welfare, rehabilitation, social planning, and various types of counseling. The better such services are in accomplishing their primary purposes, the stronger their effect in supplying basic human needs and in reducing the deficits that increase the risk of mental breakdown by adding to individual vulnerability. Primary prevention is also furthered by immediate and supportive response to individuals experiencing a life crisis of either a predictable, developmental type or an accidental, traumatic, and unpredictable character. People in such trouble, to which no one is immune, have as greatly enhanced risk of mental breakdown as the deprived and underprivileged sector of a population. The latter are, however, in double jeopardy, and they require the utmost collaboration between the caregivers in community mental health practice. The first

priority in the organization of community mental health practice by a mental health professional may well be to provide mental health education and consultation to nonpsychiatric agencies and professionals in order to enhance their potentials for primary prevention of mental breakdown. But, since authority for the latter is rarely made explicit within the only agencies and professions in a position to practice mental health at the level of primary prevention, the negotiation of working agreements is a responsibility of the mental health director. He is authorized to undertake such engagements as a major step in organization that cannot be neglected, although it may have to be preceded by a great deal of mental health education, that is, program-centered administrative consultation by the mental health director in behalf of the administrator of a health, welfare, or educational system.

There are a number of alternative patterns of organization from which to select the most suitable to the mental health needs of a particular community. Three of the most important are (1) a program representing comprehensive community psychiatry with inherent (potential if not actual) capability and responsibility to coordinate community mental health practice, (2) a program that is less than comprehensive while filling one or more important gaps in existing resources and assuming partial responsibility, at best, for coordination, and (3) a consortium (incorporated) of cooperating but independent mental health agencies, each of which gives up some of its autonomy by submitting to the consortium's board of directors for purposes

of cooperation, coordination, and planning. Each pattern has its own advantages and disadvantages.

In favor of comprehensive community psychiatry is its potentiality for responsible planning with the community, program and staff development, plus program review and evaluation. The kind of manpower required for this organizational model is, however, exceedingly rare. Not only are clinicians with special kinds of expertise in clinical evaluation, consultation, and collaboration demanded, but also mental health consultants and administrators who (1) are capable of coordinating their mental health functions, both within and outside their own program, (2) are capable of functioning as change agents, (3) are competent to recruit, deploy, supervise, and develop the staff, (4) are sophisticated in community organization, program planning, and evaluation, and (5) above all, possess convictions about accountability and responsibility to the community.[1]

A somewhat less than comprehensive program is much easier and may represent a step toward an eventually comprehensive program. It readily provides for demonstrably needed but hitherto missing services of particular and often familiar kinds, in which the mental health professionals feel most comfortable and competent and which demand less planning either within the program or in relationship to other agencies in the community. Such a program may be greatly needed and occupy a comfortable niche. But its role

in the total community mental health system is precarious to the extent that it very easily may remain isolated from the community's other mental health resources with equal claims to mutual support.

The disadvantages mentioned above are considerably alleviated by a consortium, which provides a vehicle for separate mental health agencies to get together, a structural basis at least for cooperation without undue duplication of services. There are hazards, however, in a consortium of member organizations inevitably possessing unequal powers in their own right and optimistically assuming that coordination is guaranteed by the consortium structure alone. Unless the board of directors of the consortium is truly independent and stronger than that of its strongest member, it cannot provide to the member organizations equal opportunity for either growth or coordinate relationships. By and large, the consortium structure tends to invite struggles for power, competitiveness, and substitution of the easy appearance of cooperation for the far more demanding involvement in continuous processes of coordination and collaboration.

The kinds of services constituting the content of a community mental health system are determined by the priorities issuing from the planning process. In general, they fall into three categories of preventive services when a system is fundamentally focused on the mental health of the population: primary, secondary, and tertiary prevention. The amount of any service that

is provided depends on a given service's position in the priority listing, as well as on the kind of manpower and total funds available to the community from all sources, that is, fees for clinical services, third-party payments, special and time-limited grants, voluntary contributions, and money from federal, state, and local taxes. All but the first listed source of funds impose some restrictions or requirements on their uses, but a community mental health system cannot depend solely on fees for clinical services without making most of the population ineligible. Furthermore, clinical services are the most expensive unless they are limited to diagnostic evaluations and brief preventive-therapeutic interventions. On the other hand, the most economical use of mental health funds is made by the indirect services provided to the population at risk via the nonpsychiatric agencies and professions already reaching most of the population one way or another. Indeed, mental health consultation and education (if they are provided by sufficiently experienced and competent mental health consultants from any of the major psychiatric professions), when coupled with clinical, psychiatric consultation, and collaboration in the treatment of joint cases, may provide with the greatest economy of money and manpower most of the essentials of primary, secondary, and tertiary prevention. The economies thus effected with respect to the psychiatric elements in the community mental health system are beneficial not only to the population at risk but also to the nonpsychiatric collaborators who are able to be more effective with many of

their clients or patients, when they are backed up by mental health professionals. The reason is that a variety of impending or actual mental health problems harass the providers as well as the recipients of health, education, and welfare services. The providers most frequently suffer either from insufficient knowledge and awareness of their mental health service potentials at any level of prevention or from the hampering theme interferences that represent agency or professional stereotypes with respect to mental illness or mental retardation.

Collaboration and consultative services, together with conjoint planning for the development of the community mental health system, constitute the essential, functional elements of practice to which psychiatric and nonpsychiatric personnel from every level within their respective organizations may contribute. The corresponding structural elements go by various names in community psychiatry, such as screening, emergency, detention, liaison, pre-care, after care, mental health consultation and education, public information and education, to name the common labels. The important administrative functions of community organization, planning, staff development, program development, and program evaluation are usually dismissed as administrative overhead, which is figured as a percentage of the total budget or inadequately itemized as training and research.

The clinical, psychiatric services mentioned above may be provided on either an inpatient or outpatient basis. Extended twenty-four-hour or partial hospitalization, as well as all-purpose or specialized outpatient clinics and residential treatment facilities represent desirable, but expensive, options, which must enjoy a very high priority rating in order to be justifiably included in a community mental health system. In any case, such inroads on the community's total budget for mental health services should not be used as an excuse for their displacing the more essential, psychiatric components of a community mental health system.

Conclusion

Community mental health practice is too often characterized by good intentions and beliefs in the power of community or social psychiatry to provide solutions to major social problems with overriding, political, economic, or cultural complications. It is all too easy to ascribe a mental health component to group-determined, social behavior of the human species, and to be diverted from the demanding tasks of a public mental health program befitting the needs of a community where every member of the population is a potential consumer of mental health services. The popular techniques of group intake, group evaluation, and group treatment are justified by specious arguments implying a belief that social stereotyping is preferable to psychiatric labeling. Neither, of course, is desirable, and

fortunately there are other alternatives. A belief in the personal value and uniqueness of the individual is a basic tenet of community mental health practice, and it applies to both the providers and consumers of services in a given community. The evaluation of an individual's mental health problems or needs has its counterpart in the evaluation of the mental health responsibilities of professional or paraprofessional providers of services, whose mental health functions become effective to the extent that the administrative interferences and professional inadequacies they experience in coping with their work are correctly diagnosed and removed. Furthermore, the life crises that affect the population at risk also affect the providers and administrators in a community mental health system, where both professional and administrative crises and deficits are not at all uncommon. A purely structural organization of community mental health practice is too easily fractured by the developmental and accidental crises that beset it. Organization along functional lines with reliance on processes, methods, and principles related to purposes is more adaptable to the vicissitudes of community mental health practice.

Bibliography

Bellak, L., ed. *Handbook of Community Psychiatry and Community Mental Health*. New York: Grune & Stratton, 1964.

Bindman, A. J., and Spiegel, A. D., eds. *Perspectives in Community Mental Health.* Chicago: Aldine, 1969.

Brickman, H. R. “Community Mental Health: Means or End?” *Psychiatry Digest*, 28 (1967), 43-50.

Caplan, G. *An Approach to Community Mental Health*. New York: Grune & Stratton, 1961.

----. *Principles of Preventive Psychiatry*. New York: Basic Books, 1964.

----. *The Theory and Practice of Mental Health Consultation*. New York: Basic Books, 1968.

Carstairs, G. M., et al. *The Burden on the Community: The Epidemiology of Mental Illness, A Symposium*. London: Oxford University Press, 1962.

Freeman, H., and Farndale, J., eds. *New Aspects of the Mental Health Services*. Oxford: Pergamon Press, 1967.

Gruenbehg, E. M., and Huxley, J. “Mental Health Services Can Be Organized To Prevent Chronic Disability.” *Community Mental Health Journal*, 6 (1970), 431-436.

----, Snow, H. B., and Bennett, C. L. “Preventing the Social Breakdown Syndrome.” *Social Psychiatry*, 47 (1969), 179-195.

Grunebaum, H., ed. *The Practice of Community Mental Health*. Boston: Little, Brown, 1970.

Hallock, A. C. K., and Vaughan, W. T., Jr. “Community Organization: A Dynamic Component of Community Mental Health Practice.” *American Journal of Orthopsychiatry*, 26 (1956), 691-706.

Hume, P. B. “Community Psychiatry, Social Psychiatry and Community Mental Health Work: Some Interprofessional Relationships in Psychiatry and Social Work.” *American Journal of Psychiatry*, 121 (1964) 340-343.

----[2] . “General Principles of Community Psychiatry.” In S. Arieti, ed., *American Handbook of Psychiatry*. Vol. 3. New York: Basic Books, 1966. pp. 515-541.

Joint Commission on Mental Health of Children. *Crisis in Child Mental Health: Challenge for the 1970’s*. New York: Harper & Row, 1970.

Lamb, H. R., Heath, D., and Downing, J. J., eds. *Handbook of Community Mental Health Practice.* San Francisco: Jossey-Bass, 1969.

Levinson, H., Price, C. R., Munden, K. J., Mandl, H. J., and Solley, C. M. *Men, Management, and Mental Health*. Cambridge, Mass.: Harvard University Press, 1966.

Parker, B. *Mental Health In-Service Training: Some Practical Guidelines for the Psychiatric Consultant*. New York: International Universities Press, 1968.

Reid, K. E. "Community Mental Health on the College Campus." *Hospital and Community Psychiatry*, 21 (1970), 387-389.

Ryan, W., ed. *Distress in the City: Essays on the Design and Administration of Urban Mental Health Services*. Cleveland: Case Western Reserve University Press, 1969.

Sells, S. B., ed. *The Definition and Measurement of Mental Health*. Washington, D.C.: U.S. Government Printing Office, 1968.

Shore, M. F., and Mannino, F. V., eds. *Mental Health and the Community: Problems, Programs, and Strategies*. New York: Behavioral Publications, 1969.

Zubin, J., and Frehan, F. A., eds. *Social Psychiatry*. New York: Grune & Stratton, 1968.

Notes

1 For a listing of the ingredients of a program representative of comprehensive community psychiatry, see my "General Principles of Community Psychiatry."

2Contains a bibliography of 250 references on the subject of community psychiatry.