THE DETERMINANTS OF COMMUNITY MENTAL HEALTH CENTER PROGRAMS:
REGULATIONS, NEEDS, PLANNING, STRUCTURE, AND IDEOLOGY

by

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Determinants of Community Mental Health Center Programs:
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ABSTRACT

Community mental health centers have become an important force in many communities since the 1960's. A considerable body of literature preceded the legislation, suggesting that numerous types of activities could fall within the domain of mental health services. The federal and state legislation and guidelines, however, considerably narrowed the scope assumed by centers, with emphasis given to treatment rather than to prevention. Two centers, one in Somerville-Cambridge and the other in Lowell, were examined to compare their programs. While differences in needs and characteristics of the areas served by the centers might also influence the types of services provided, we find that characteristics of the areas are often difficult to translate into programmatic terms. In addition, the two areas studied are very similar in their socio-economic characteristics.

Additional influences on the mental health center programs are the planning processes, organizational structure, and ideology. Although the centers are mandated to do comprehensive planning, they tend to engage in disjointed incrementalist planning, which results in more traditional programs. The structures of the two centers studied differ in that one is primarily a centralized facility and the other a decentralized service delivery system. The differences in ideology, largely the philosophies of the directors and key leaders at each center, are based on differing views of the types of programs that should be included in a mental health center and differing priorities among the services.

The two centers are compared in terms of their service mix, staffing patterns, coordination and continuity of care, and innovation. The regulations, similarities in the areas served, and the fragmented planning all tend to render the centers similar. Within the limitations imposed by these
factors, however, there are differences attributable to the differing structures and ideologies. For example, it is noted that the centralized center insures better coordination and continuity of care, while the decentralized program allows for more innovation. The service and staffing mix, on the other hand, are more a result of the differing ideologies of the key administrators.

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Chapter 1
INTRODUCTION

The community mental health center has been established as a major source of comprehensive mental health services in the last five years. Since 1965 the federal government has been involved in the effort to develop local mental health centers, where people can get comprehensive and continuing treatment in their own communities. By January 1, 1970, the federal government had provided grants (with matching state support) to 383 centers across the country for construction and/or staffing for services. When fully operational, these 383 centers will serve about 53 million people, or 26% of the nation's population. In fact, when the original legislation was up for consideration by Congress in 1963, President Kennedy proclaimed the goal of 2,000 community mental health centers by 1980. Clearly, therefore, the community mental health movement has become an important element in many communities throughout the country.

Because the community mental health center was a new concept, open to numerous definitions and interpretations, the literature stressed that many of the decisions regarding the approach and mix of services would be left to local discretion. It was assumed that each community mental health center could have its own characteristics, reflecting the community's special needs and resources. Likewise, a center could assure any number of organizational and administrative structures.
The essential service elements could be housed under a single roof, could be adjacent to each other, or could be in units located throughout the community. Some could be comprehensive free-standing centers and other could be small units added to bridge gaps in existing services and facilities.

This study was undertaken to describe the services provided by two such centers and to account for the similarities and differences in their services. Two centers, with differing organizational structures, serving comparable populations, were selected for the case studies: the Harry C. Solomon Center in Lowell has a large facility housing the program, while the Somerville-Cambridge (S-C) program is a decentralized service delivery system dispersed throughout the two communities. In order to analyze the impact of centralization and decentralization on the services provided by the two centers, I interviewed twelve to fifteen staff members in each center, as well as the area directors and area board presidents.

In the course of my analysis, however, I came to two central conclusions. First, the organizational structures of the centers alone do not account for all of their differences in (1) service mix; (2) staffing patterns; (3) coordination and continuity of care, and (4) innovation. Another factor, the values and ideologies of key people in each center, was added to the study, therefore, to help account for some of the unexplained differences. Second, and of greater importance, the differences between the two centers were not as great as I had initially anticipated. While there are some differences,
principally in terms of program and personnel mix, they reflect differences in emphasis more than radical differences in types of services being offered. The overall similarity of the two programs, despite differing organizational structures, is largely explained by the federal legislation and administrative guidelines, state legislation, similar characteristics of the two areas involved, and the type of planning process employed by the centers. Within the constraints of the above layers of guidelines, needs, and methods of planning, it is not surprising that the centers are so similar.

The early part of the paper will deal with the macro-level considerations filtering down to the centers from the federal and state levels. The conclusions concerning the impact of the federal and state actions will be followed by the roles of the characteristics of the two areas and planning processes utilized in the determination of what the two centers do. While these considerations all tend to homogenize the various centers, there are still some discernable differences. These differences between the two centers will be examined in terms of the centers' organizational structures and ideologies. Finally, we shall see that while differing structures and ideologies do lead to some differences in priorities between the two centers, the constraints of the macro-level considerations take precedence and tend to minimize the differences between them. We shall see too that as the two centers develop they are currently becoming more alike; with each realizing the problems inherent in its structure, the centralized center
is working towards a decentralization, and the more decentralized center is striving for more centralization in some areas.

Before turning to the chapters on the roles of the five explanatory variables -- regulations, needs of the areas, planning processes, organizational structures, and ideologies in the centers -- we shall describe the structures of the centers and summarize their services.

**Structures of the Centers**

The Solomon Center is housed in a large building, built expressly for the center, in an outlying area of the city of Lowell. Apart from a handful of staff members who work in the community as consultants to hospitals, nursing homes, or part-time in a housing project, the bulk of the center's work is accomplished within the center itself. On the other hand, without a central building of any sort, it is perhaps a misnomer to call the Somerville-Cambridge program a mental health "center". In order to contrast the two, it is important to understand how the various components of the S-C program are organized.

The S-C mental health program is a decentralized one, but the decentralization is not on the basis of simply one of the four principles suggested by Etzioni. In fact, the dispersion is a combination of decentralization by geographic

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areas, by clientele, and by tasks, as a summary of the various units will indicate. Services for children in Cambridge are provided at the Cambridge Guidance Center (CGC), and children in Somerville are treated at the Somerville Guidance Center (SGC). Adults in Somerville seeking outpatient care or day care are also treated at SGC. For Cambridge adults all services are offered at the Cambridge Hospital. Inpatient services, as well as the alcoholism and drug addiction programs, for the entire catchment area are provided at Cambridge Hospital. The Cambridge Court Clinic does not serve Somerville but a similar court program is now in its early stages in Somerville. Finally, the preschool nursery classes and retardation programs, which serve residents of both Cambridge and Somerville, are scattered in various locations (primarily churches and public buildings) throughout the two towns. Thus, the provision of children's services at both SGC and CGC (each of which in turn have additional outposts in their communities) is an example of decentralization by area. The pre-school nursery classes which meet at four locations in Somerville and Cambridge, however, are decentralized by clientele, since each class serves a different classification of retarded or disturbed children. Finally, the arrangement providing for Somerville adults to be treated at SGC on an outpatient basis, but at Cambridge Hospital for inpatient care is an example of decentralization by function.² Thus,

²It should be mentioned too that the S-C program is decentralized by default due to a lack of space in any one location,
while the Lowell and S-C centers are both clearly mixed systems, the Solomon Center is more centralized and the S-C program more decentralized; and we shall use them to represent such models throughout the rest of the paper. Aware of their differing structures, we shall now summarize the various types of services provided by the centers.

**Services Provided by the Two Centers**

A brief checklist of the services at the two centers is given in Table 1. Here we shall briefly describe each type of service.

1. **Inpatient Service**

   Inpatient services for the S-C area are provided at the Cambridge Hospital by the Psychiatry Department, which was established there in 1969. The psychiatric ward is a 20-bed unit used for evaluating and treating acutely disturbed individuals. Lowell has had an inpatient ward of 40 beds; however, due to a recent fire there are currently only about 18 inpatients, and when the ward reopens, there shall be 30 beds. Diagnoses range over the whole psychiatric spectrum, but the majority are psychotic and schizophrenic patients. In both centers there is an average stay of 26 days, although for

(2) rather than by choice. The program recently made application for a grant for studying possible construction. While the center would like to maintain a decentralized program, based on the belief that some services should be housed as close as possible to the area served, some central location is presently needed to provide some cohesiveness to the mental health program. Much of the rented space is currently overcrowded and some of it will probably not continue to be available. A new central building would serve administrative purposes and house programs which cannot be housed in Cam-
those who stay longer than a month, the average stay is on the order of two to three months.

The wards are seen by the staff as therapeutic environments, where daily contacts between staff and patients and among patients are important in recovery and rehabilitation. Each patient is a member of a therapy group, which meets daily in Lowell and twice weekly in S-C. In addition, a staff member is generally assigned to each patient upon admission for a one-to-one relationship. For depressed and psychotic patients, medication is often used, and there is limited use of electric convulsive therapy. After discharge from the ward, most patients are followed in therapy groups, in individual therapy or in a day care program.

2. Partial Hospitalization

In S-C partial hospitalization is available at Cambridge Hospital, with schedules varying according to individual need, and there is a day center program at SGC, which meets two afternoons each week. In Lowell there is a day care program meeting mornings and afternoons five days per week. As an emergency procedure after the recent fire in Lowell, a day hospital program was instituted, in addition to the day care program. The day hospital patients decide each day whether to stay overnight or go home. It is used more as an alternative to hospitalization, while the day care programs are primarily used for aftercare. An attempt is being made

(2) bridge or Somerville community facilities, or which may be displaced in the future by the squeeze for land and housing in the two communities---"A Proposal for Somerville-Cambridge Mental Health Center."
Table 1

PROVISION OF SERVICES BY THE MENTAL HEALTH CENTERS

<table>
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<tr>
<th>Center</th>
<th>Partial Hospitalization</th>
<th>Consultation &amp; Emergence Education</th>
<th>Drug Education Program</th>
<th>Alcohoholism Court Program</th>
<th>Retardation Program</th>
<th>Occupational Therapy</th>
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|                | Somerville             | Cambridge                        | Lowell                |                         |                      |                     |                        |          |          |
|                | Preschool              | School age                        | Adult                 |                         |                      |                     |                        |          |          |

|                | Psychiatry             | Psychology                        | Social Work           | Nursing                 | Volunteers           |                      |                        |          |          |
|                |                        |                                   |                      |                         |                      |                     |                        |          |          |
|                | Somerville             | Cambridge                        | Lowell                |                         |                      |                     |                        |          |          |
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to continue this program even after the ward reopens.

3. Outpatient Services

Outpatient care is the broadest category of service, since it includes the broadest range of age and diagnostic patterns. This section is addressed to the basic outpatient services for adults and children; services for special groups, such as alcoholics and addicts, will be considered later. Clients are referred for evaluation and treatment by a variety of sources: inpatient care, emergency services, family doctors, schools, and the whole range of welfare, community, and social service agencies. Many, however, hear about the centers through friends and relatives and are simply self-referred. Regardless of the referring source, the patient must generally contact the center himself, either with a phone call or a visit. The intake and evaluation process generally takes from one to three sessions with a social worker or psychologist, or occasionally with a psychiatrist, and may include diagnostic testing. Appropriate community or private referrals are made, as well as referrals for inpatient or day care consideration, or else treatment begins with the staff in the forms of individual, couple, group or family psychotherapy.

In both centers outpatients are served primarily in individual interviews, although some use is made of groups, particularly in Lowell. Groups range from activity groups for children, adolescent therapy groups, to groups for single mothers, parents of retarded children, aftercare patients,
couples therapy groups, men who have been married previously, and couples in which one or both spouses has had a period of psychotic breakdown. Most groups meet weekly, but some meet considerably less frequently. For example, in the Brief Contact Clinic in Lowell, about 80 women, mostly chronic after-care patients, are seen about once or twice a month for about fifteen minutes. The main purpose of this clinic is to check on these patients' medications and to maintain contact with them, since most of them will probably be back in inpatient or day care at some time.  

There is more variation in the patterns of service offered to children, depending primarily on how well the center is staffed for children's services. Again treatment modalities include individual psychotherapy and casework, family therapy, group psychotherapy and casework, family therapy, group psychotherapy for parents and children, and also nursery classes for emotionally disturbed pre-school children. In addition, particularly when staff resources are short, much use is made of volunteers in specialized tutoring, therapeutic boys' clubs, and supportive one-to-one relationships. In the Lowell center, which has fewer staff members in childrens' services than does S-C, as many as 75% of the children are handled by volunteers.  

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3 Interview with Jerome Klein, Chief of Psychology, Solomon Center, March 1, 1971.

4 Interview with Siglinda Ruehl, Head Psychiatric Social Worker Children's Unit, Solomon Center, March 1, 1971.
school and college students. The use of psychoactive medications is closely supervised, and when drug therapy is employed it is almost exclusively for hyperactive children.

4. Emergency Services

Both areas have around-the-clock emergency coverage. Staffing is provided by psychiatric residents and psychiatric nurses and aides at the inpatient facilities. Walk-in care is always available for Cambridge and Lowell residents but a 24-hour answering service is provided in Somerville with a staff member on call. This is not a hotline, however, and is basically a service for the ongoing clients of the center. Dispositions from the emergency services of all centers include referrals to inpatient treatment or day care, referrals to outside agencies or doctors, or most frequently arrangements are made for outpatient care.

5. Consultation and Education

This category probably includes the most diverse group of activities, since almost every professional group in the mental health centers is involved in some form of community service, consultation, or education. The Cambridge Hospital and Guidance Center have rather extensive consultation relationships, sometimes upward of 25 ongoing communications, ranging from meetings several times a week to monthly contacts, to consultation upon request. The community programs offer services to social service agencies, schools, day care centers, community planning agencies, and police forces. In some cases they work with a limited number of clients served by
the agency or assist in crisis situations. With welfare departments, for example, staff members consult on individual cases and also lead training sessions for welfare workers. Social service agencies typically included, in addition to welfare departments, are Family Services, Catholic Charitable Bureau, YWCA. The centers sometimes do psychiatric or psychological testing for such groups. In Lowell, the mental health center hosts a regular meeting of a case conference committee under United Community Services to deal with multi-problem families. This liaison group thereby tries to eliminate some of the duplication of efforts. Consultation is also provided to Headstart and Follow-through programs, as well as to a Community Development Section of the City Manager's office in Cambridge and the Director of the Lowell Housing Authority.

Educational meetings are organized, usually on request with groups such as PTA, clergymen's groups, women's groups, Rotary, and the like, who are interested in particular mental health problems. One social worker, for example, is participating regularly in a program at a community school in Cambridge in which topical films are shown to teenagers, followed by group discussion on such issues as race and drugs.

Other forms of consultation and education are provided to medical professionals in the areas at medical schools, the general hospitals, nursing homes, and a well-baby clinic. In the hospitals, (Cambridge Hospital and three general hospitals in the Lowell area) the psychiatric consultants function to
clarify the emotional problems of patients who are hospitalized for medical reasons, collaborate in the evaluation and care of psychosomatic illnesses, and educate the non-psychiatric physicians, nurses, and social service staffs on the emotional dimensions of being ill and on specific mental health issues. This last function is generally accomplished in lectures, seminars, and clinical case conferences for members of the hospital staffs. In addition, the members of the mental health center in this way educate hospital personnel about the services offered by the center and encourage appropriate referrals. Similarly, at the well-baby clinic in Lowell a nurse from the mental health center meets with other nurses and helps in referring mothers to the center or other appropriate agencies, such as family planning. Lowell also has a nurse who spends almost full time consulting to 13 nursing homes in the area. She is called particularly to help with assaultive or abusive patients. She does evaluations, continues to visit the patients, and often recommends medication. Some of the nursing home personnel are now requesting inservice training from the consulting psychiatric nurse.

6. Occupational Therapy

This service is more extensive in the Lowell center, where there are more hospitalized patients. It is an integral part of treatment for inpatients and day care patients, particularly those who are too debilitated to make use of the rehabilitative program. Social skills such as cooking, sewing,
product and clothes-buying are all taught within the Lowell occupational therapy program. In addition, the staff offers daily recreation programs in the center's gymnasium. Art workshops, crafts, and volunteers have also helped offer special skills to patient groups such as sculpture classes, typing classes, and a weekly homemaker's group.

7. Rehabilitation

As patients improve somewhat, the rehabilitation service takes over from occupational therapy in the Solomon Center. Patients often work several hours a day within the mental health center doing maintenance work or running the coffee shop. In addition, the rehabilitation staff makes arrangements for some patients to get additional training as hairdressers, printers, etc., and it has also become increasingly involved with community agencies and individual employers. A weekly meeting with Massachusetts Rehabilitation Commission, Community Teamwork in Lowell, Division of Employment Security, Lowell Association for Retarded Children (LARC), and the Welfare Department examines cases, and resources are examined and developed.

8. Court Programs

Court programs range from a single social worker from the center in Lowell acting as a liaison with the court to a full-fledged court clinic in Cambridge. The purpose of the liaison is to establish better communication and a better working relationship between the center and the district court and its representative -- the justices, the court psychiatrists, and
the probation officers. The social worker goes to the court weekly to join in discussion around specific cases or issues of a more general nature. The emphasis is on establishing an interdependence in meeting the needs of the people of the area, referring cases, and evaluating what type of treatment is best for an individual. As part of their conditions of probation, juveniles are often referred to the center for evaluation and treatment.

The court clinic approach has some similar aims, but its primary responsibility is to the court and provides basic evaluation and treatment resources within the context of the court clinic, rather than making referrals to the other mental health services. Its staff of psychiatrists, social workers, and psychologists provides longer term treatment for offenders. The court clinic also does some consultation, most of which is client-centered and provides educational information and makes recommendations to the probation officers, lawyers, and police.

9. Retardation Programs

Retardation services in both centers are primarily for children under age 7 (when children become eligible for special education classes), and for severely retarded children over 7 who do not attend school. Many of the children come to the center for diagnostic evaluations, often centered in a diagnostic nursery, and there is also active family work in most cases. Groups for mothers or parents of retarded children are standard. In addition to the usual half-day nursery
classes for preschool children, there are also small groups for extremely young retarded children. Special attention is generally given to those children who will be entering school the following year.

The programs for school age children, which are more extensive in S-C, serve two classes of retarded children. The first is for the most profoundly retarded children and aims at teaching them total self-care, using behavior modification techniques. The second group is for school age retarded children who are capable of learning. There are both trainable and educable children who were previously in public school but had been dropped because of their severe behavior problems. The centers also generally help the city recreation departments organize summer programs for retarded children.

In Somerville-Cambridge there are also programs for adult retardates. There is a day care program, also using behavior modification techniques, for trainables and several educables, and an evening social program for retarded young adults.

10. Alcoholism Programs

The centers' approach to alcoholism is a two-pronged approach of education, prevention and consultation on alcoholism, as well as direct service to alcoholics and their families. The social workers on the staff meet with representatives of groups and other resources, such as civic groups, Alcoholics Anonymous, courts, police, Model Cities, etc. Training for work with alcoholics is provided for social and health agency personnel, clergy, police and others through inservice programs
and special seminars and conferences. Training, educational materials, films and speakers are also available to community groups, teachers and staff of youth agencies relating to decision-making with regard to responsible drinking. The personnel often have ongoing relations with the courts, where they help screen, and make referrals for alcoholics.

Both centers have some beds available for detoxification of alcoholics, which generally takes five to ten days, and Cambridge Hospital is planning to open a separate unit for this purpose in July. Individual counseling and some group therapy is also available for alcoholics. In Cambridge, where the alcoholism program is more extensive than in Lowell, the alcoholism staff operates an emergency and walk-in service weekdays for patients and family members. Twice weekly there staff members lead open discussion groups, which are aimed at getting the people to join AA, rather than attempting real therapy. In this way, their staff view themselves as helping patients primarily in crisis situations and in making plans to seek long-term support, in such organizations as AA.

11. Drug Programs

Both centers have recently set up drug programs which are still in the developing stages. At Cambridge Hospital there is a heroin treatment program, involving methadone detoxification and maintenance, as well as group therapy, counselling, and work rehabilitation. The intake process consists of rap groups, which meet a couple of hours a day, five days a week. The emphasis of the group is on defining the individual's prob-
lems and on clarifying what treatment is available and what is expected of the participants. The staff do most of their evaluation work by observing the rap groups to determine who is ready for what types of treatment. Once an addict is on methadone, he is seen in individual therapy or participates in small group psychotherapy sessions three times a week.

In addition to similar methadone programs at the three general hospitals in Lowell, other types of addicts are handled and other types of programs are offered. Self-help aspects of the programs include a halfway house for 40 ex-addicts, a leased gas station which provides jobs, drop-in centers, and a free school, as well as a hotline. There are a number of therapy groups for addicts, meeting regularly at the halfway house, which include parents of outpatients as well. The drug programs also are involved in consultation and education programs with schools, social agencies, parents, probation officers, and police.

12. Research and Evaluation

Research done by the mental health programs relate to more effective service delivery, clinical types of problems arising out of an individual's work, and research in more general areas, such as learning potential of retarded children. Studies of the first type include research on the use of groups in the mental health center, various evaluations on how well the centers serve their communities, on patterns of referral, service utilization and disposition of patients, and on how staff
divide their time between rendering direct service, teaching, and other activities. Clinical types of research include evaluations of the heroin addiction treatment program and pharmacotherapy in the treatment of acute alcoholic withdrawal, behavior of group members, and work on various types of legal offenders, such as exhibitionists, juvenile users of alcohol and juveniles involved in auto thefts. Finally, broader scale research is undertaken, particularly by the Research Institute for Educational Problems, associated with the Cambridge Guidance Center. This unit is researching the learning potential of mentally retarded children and developing specialized educational procedures and materials for retarded children. The Institute is also working on a remedial learning center with individually designed educational programs for children who are failing academically.

13. Training

The mental health centers are training grounds for students in the major mental health disciplines. The training programs help serve additional numbers of patients, and also help indoctrinate potential mental health professionals, in the philosophy of community mental health practices. In Cambridge, psychiatric residents may spend three years in an approved program at Cambridge Hospital, and the Cambridge Guidance Center is an approved unit for training residents in child psychiatry. In addition, psychiatric residents may rotate for a six-month period through the Cambridge Court Clinic for education in the diagnosis and treatment of various types of offenders.
Students in fields covering the full range of clinical and counselling psychology, education and school psychology, human relations, community mental health, and community psychology also receive training in the Cambridge mental health center.

Both centers have training for social workers and nurses. Staff in the Department of Psychiatry at Cambridge Hospital are now developing seminars for non-professionals working in agencies in the community, and Lowell has also provided on-the-job training to trainees enrolled in the New Careers Program in Lowell. Such training generally includes discussion of community issues, interviewing skills, and fundamentals of psychopathology. Other types of education seminars and training on specific problems in the section on consultation and education.

Having this knowledge of the types of services which the centers offer, we can focus on the roles of the federal and state regulations, the characteristics of the two areas, the planning process employed, the organizational structures, and the ideologies of the two centers in the five succeeding chapters. We shall be concerned primarily in analyzing the similarities and differences in terms of service mix, personnel mix, coordination and continuity of care, and innovation, and this analysis shall be drawn together in the concluding chapter.

A word of explanation is called for in regard to the evidence presented in the ensuing chapters. Unfortunately, many of the desirable types of data (e.g. comparable budget statistics, breakdown of staff time by services, utilization
patterns, characteristics of the clients, etc.) were simply not available. Although one of the two centers often had some of this data, the other generally did not have commensurate data, rendering comparison impossible. The scope of this study was largely determined and narrowed by this lack of data, but nonetheless in some areas the evidence remains somewhat impressionistic. My impressions, however, are based on about a dozen visits and interviews at each center. Thus, while some of the information cannot be specifically documented from one source, it is based on field work done at the centers.
Definitions of mental health, community mental health, and the scope of activities to be encompassed in community mental health centers are generally vague and open-ended. Much of the theoretical literature describing community mental health is so broad as to suggest that the entire universe of human affairs should be the concern of mental health programs. As the first part of this chapter will suggest, one might surmise from this literature that various community mental health centers would undertake different functions and types of programs in response to their differing needs, resources, and views of the problem.

This anticipated variation between centers, however, tends to be diminished by the federal and state regulations pertaining to government-supported centers. We shall see that although the federal legislation is not at all explicit about the types of services to be offered, the administrative guidelines and the state legislation do inhibit the types of programs. By enumerating "essential" and "adequate" services, the regulations give definite priority to certain types of programs. Thus, while conceptually different, mental health centers may emphasize many differing types of services, in fact they tend to offer similar services, due to the influence of the federal and state regulations.
Theoretical Literature

Most definitions of mental health are based on the concept of a desirable state which exhibits an optimal equilibrium between internal mental comfort and the external world. While there is no operationally adequate description of what constitutes mental health, there are some predominant criteria in the literature.

1) attitude about the self -- described by such terms as self-acceptance, self-confidence, self-reliance, self-actualization;
2) adaptation and environmental mastery -- adequacy and capacity for adaptation in work, love, and play;
3) ability to respond to situations that bring the individual under emotional stress -- ego strength, and resilience of character.

While the definitions and criteria suggested for mental health remain vague and subjective, the issues become even more difficult to translate into programmatic terms when one focuses on the community mental health literature. The uncertainty of mental health professionals about their goals and about courses of action appropriate to their goals has certainly been compounded by the "community" aspects of mental health:

"Now I am a community psychiatrist and I function in an undefined role catering to undefined needs of an undefined clientele." In talking about improving the health, productivity and creativity of the people, such psychiatrists share the unanswered problems of all mental health professionals; but in addition their domain of concern extends beyond the individual.

According to Dumont, mental health may be viewed as freedom, or the widest conceivable range of choice in the face of internal and external constraints. Within this context, community mental health professionals recognize that changes in the environment also change the man; and the purposes of psychotherapy and societal change are both to increase the options of human behavior -- i.e., to enhance freedom. In this way, the community mental health literature begins to encompass ideas of societal change, as well as work with individuals.

Some argue that for many, only changes in the environment (both physical and social) can free the individual so that he can acquire the competence to move on and escape from powerlessness. With this line of reasoning, it becomes apparent that mental illness does not reside entirely within the individual. Thus, the high incidence of mental illness among the poor calls for not only therapy, but also the elimination

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2 Connery, p. 148.
4 Ibid., p. 50.
of poverty. Certainly such community problems as crime, delinquency, addiction, and alcoholism are now considered mental health problems.

Another community mental health theoretician, Gerald Caplan, has stressed that the community mental health movement is to be preventive in nature. Its purpose is to plan and carry out programs to "reduce the incidence of mental disorders (primary prevention), the duration of those disorders which do occur (secondary prevention), and the impairment which may result (tertiary prevention)." Primary prevention focuses on correcting harmful environmental forces which lead to the individual's resistance. Thus it recognizes that adaptation may at times be pathological and that acquiescence may not contribute to mental health. It is based on the idea that while mental disorders result from maladaptation, altering the balance of forces may make a healthy adjustment possible:

"Mental health is an issue with which every institution in our society is involved: the family, the school, the church, the employer, organized labor, the hospital, the settlement house, the police, the drug store, even the poolroom and the bar. Independent of its location and its sponsorship, the community mental health program must relate and direct its efforts towards other significant institutions."

Clearly, the concerns of mental health professionals have been widened considerably in such writings. Mental health workers are to deal with professional and non-professional

\[5\] Ibid., pp. 62-80.

\[6\] Caplan, Principles of Preventive Psychiatry, pp. 16-17.

\[7\] Massachusetts Mental Health Planning Project (MMHPP), "Mental Health for Massachusetts," p. 2.
workers in the health, educational, legal and social aspects of community planning. Caplan suggests that they also should visit such institutions as churches, factories, medical clinics, hospitals, schools, prisons, detention homes. In this way, the community mental health movement should reach patients who never sought (or could afford) treatment previously. The only legitimate limitation of the population focus is the boundary of the community which itself can not be defined. The community approach places particular emphasis on people who are significant influences on a number of people, by virtue of their role as caretaking agents of the community—family members, doctors, clergymen, teachers, policemen—and this forms the basis of many of the centers' consultation services. Thus the concept that the root of some mental health problems is in the community has been incorporated in the concept of primary prevention.

Particularly by adding the whole dimension of prevention, the concept of community mental health broadens a movement that was once considered the exclusive concern of the psychiatric professions to include issues that fall within the domains of psychology, sociology, anthropology, social work, urban planning, nursing, etc. In addition, it expands the movement, perhaps most significantly, to include matters "within the province of the political process itself." Given such broad theoretical foundations, a mental health center clearly

8 Caplan, Principles of Preventive Psychiatry, pp. 72-74.

can engage in many types of varied activities. To summarize the basic possibilities: "A community mental health center is a concept or program of action, not a single organization or facility. Its purpose is to coordinate efforts to improve the community in ways that will enhance mental well-being, decrease to bearable limits the occurrence of personal and social stress, relieve troubled persons, prevent mental illness when possible, and treat and rehabilitate those who become ill or disturbed."\(^{10}\)

Given the limited resources available to any particular center, it seems clear that a center could not accomplish all of the above functions, even if the technology for doing so were known. Thus, a center must make decisions and set priorities for its operations. One might expect the approach and mix of services that a given center provides to reflect the community's characteristics, special needs and resources. From the theoretical literature described one would certainly expect to find differences in the relative emphasis different centers place on prevention, and on the attention given to the social deviant and neurotic in the community, as compared to the traditional responsibility of psychiatry -- caring for the severely disturbed or psychotic. With this wide open field suggested by those who wrote about the theory of community mental health centers as a background, we turn next to a review of the federal and state regulations. Initially we

shall explore how the scope of mental health activity came
to be defined at the federal level. We shall see in that
history how the social science and community activist models
were replaced by a medical basis for community mental health
programs.

Federal Legislative History

The first national commitment in the area of mental
health came in 1946 with the passage of the National Mental
Health Act. This legislation established the National Instit-
ute of Mental Health (NIMH) and also authorized grants-in-aid
to states for community mental health programs. While this
act established the principle of state-federal partnership
in mental health, NIMH at that time defined the field of
mental health very narrowly. As a result of pressures created
by the new concerns of mental health professionals with other
social sciences and those created by the growth of lay inter-
est in mental health, however, the professional focus of NIMH
gradually expanded from the comparatively narrow study of
mental illness to the broader subject of mental health.11

In 1955 the Mental Health Study Act mandated the Joint
Commission on Mental Illness and Health to survey the resources
and make recommendations for combatting illness in the United
States. The activities of the Joint Commission were largely
responsible for exposing the differences of opinion as to what
the scope of psychiatric concern should be. Under the dir-

11Duhl and Leopold, pp. 8-9.
ection of Dr. Jack Ewalt, then Massachusetts Commissioner of Mental Health, the study was transmitted to Congress, the Surgeon General, and the state governors on December 31, 1960. The final document, entitled *Action for Mental Health*, "reflected its board's narrow construction of NIMH responsibilities. The report was hospital-oriented; it proposed to enlarge state mental health programs; and it implied that to plan for the prevention of mental illness was a useless exercise. It stimulated a heated response from community-oriented psychiatrists at NIMH and elsewhere."\(^\text{12}\)

The report, primarily concerned with the upgrading of the state hospital systems, thus took on a modest and narrow definition of the task in comparison with the literature previously discussed. It suggested that state hospitals be scaled down to not more than 1,000 patients each. In addition, however, the Joint Commission did recommend that they be supplemented by small outpatient clinics. The report stated:

"It is apparent that the modern concept of treatment and the modern reality of mounting costs of state hospital operations have combined to stimulate efforts to keep mental patients out of mental hospitals as long as possible and to discharge them as quickly as possible. In either the instance of early treatment on an outpatient basis, or that of after care of discharged patients, the mental health clinic occupies a pivotal position. It is also the fulcrum of efforts to remove the barriers isolating mental hospitals from the community."\(^\text{13}\)

Thus, while many felt that the report emphasized the problems

\(^{12}\)Ibid., p. 11.

of state mental hospitals to the exclusion of broader concerns, it also contained the seeds for the later germination of the concept of community mental health centers. The report evoked considerable response from all quarters and in January, 1961, the Surgeon General's Ad Hoc Committee on Planning Mental Health Facilities recommended that each state develop a plan for mental health facilities. President Kennedy also expressed a deep interest in the problem and appointed a Secretaries' Committee consisting of the Secretary of Health, Education and Welfare, the Secretary of Labor, and Administrator of Veterans' Affairs, and other representatives from the Bureau of the Budget and the Council of Economic Advisors. This group (notably non-medical and non-psychiatric) reviewed the Joint Commission's Report and emerged a year later advocating the development of community mental health centers. President Kennedy subscribed to this approach in his Message to Congress on February 5, 1963:

"I propose a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill...which (will) make it possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society. When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away."

In this way,
President Kennedy set the stage for a compromise between the hospital orientation of the Joint Commission and the comprehensive community program urged by the community-oriented members of the mental health world and between a conception of mental health which included mental retardation.

Thus, historically the concept of community mental health centers was propounded largely as an ameliorative measure for improving the state mental hospital systems. The Joint Commission had stressed provision of community services as a means of prevention and treatment to avoid long hospitalization with its debilitating effects. Such a background led to a particular orientation in the ensuing legislation and regulations, since the primary thrust of the movement was to relieve the state mental hospital situation. While the act reflected some expansion of mental health concerns, psychiatry continued to be the ruling discipline. We see, therefore, that while the theoretical literature contains conceptions of a mental health movement based on social science and community activist models, the political history of the community mental health legislation primarily advanced the movement within the construct of a medical model.

It should be pointed out that the availability of new drugs since the early 1950's has been of paramount value in the new treatments of certain types of mental disease and has contributed greatly to the possibilities for treatment within the community. Psychotropic medication to energize the depressed patient and tranquilize the agitated patient make it possible for patients to avoid the life-time of dreary custodial care. Without the introduction of this medication into treatment, it is doubtful that the community facilities would have even had the potential to remove many patients from the state hospitals.
Federal Legislation

On October 31, 1963, "The Community Mental Health centers Act" became law, (PL88 - 164), authorizing appropriations to assist the states in the construction of community mental health centers. This act and the ensuing legislation, however, are concerned primarily with the mechanics and procedures through which the states establish centers; the regulations concerning the provision of services by the centers was left to administrative guidelines issued by the Secretary of the Department of Health, Education and Welfare, after consultation with the Federal Hospital Council and the National Advisory Mental Health Council.

As defined in the legislation, "the term 'community mental health center' means a facility providing services for the prevention or diagnosis of mental illness, or care and treatment of mentally ill patients, or rehabilitation of such persons, which services are provided principally for persons residing in a particular community or communities in or near which the facility is situated." The legislation, however, does not define "community" or suggest what services constitute the types enumerated in the definition. It states only that the services to be provided by the center will be part of a program providing "at least those essential elements of comprehensive mental health services for mentally ill persons which are prescribed by the Secretary." Thus, while

15 U.S. Public Law 88-164, October 31, 1963, Title IV, Section 401(c), as amended.
16 Ibid., Section 205(a) (6) (D).
the legislation states that a mental health center may provide preventive, diagnostic, treatment, or rehabilitative services in its definition of such a facility, in another place the legislation states that each center must provide certain elements of "comprehensive services" (which is not defined) for the mentally ill. Clearly, therefore, although the legislation does not define the necessary services, it does give priority to work with the mentally ill over preventive work.

Since we shall later examine the role of the planning process, it is important to note the federal requirements in this area as well. Because the federal funds are to be turned over to the states for the purpose of building centers in the communities, the Act requires each state to draw up a State Plan, based on a statewide inventory of existing facilities and a survey of need. Again, more detailed specifications concerning how the statewide planning was to be carried out is contained in the administrative guidelines, rather than the legislation itself, although the latter does imply that comprehensive planning will be required.

The later pieces of legislation basically extend and expand the earlier laws. While the 1963 legislation only provided funding for the construction of centers, the 1965 legislation (P.L. 89-105) authorized federal assistance for the initial costs of professional and technical staff serving in the centers. Again the state mental health authorities were to work with the communities in developing plans. In addition
to extending the program of assistance, the amendments of 1968 (P.L. 90-574) and 1970 (P.L. 91-211) were concerned with special types of programs. P.L. 90-574 authorizes federal grants for construction and staffing of facilities specifically for narcotics addicts and alcoholics (and permits states to use a portion of their allotments for centers to help cover the cost of state planning). Similarly, the 1970 amendments establish a program of grants for children's services, including construction, staffing, training and evaluation.

It is interesting to note that while the earlier legislation did not enumerate special groups to be served other than the "mentally ill", the later amendments are concerned with alcoholics, narcotics addicts, and children. As was pointed out earlier, the history of the original legislation was grounded in concern for the state mental hospitals. Later, however, we see that the concern, as reflected in the legislation, was broadened to include community mental health problems that would not normally be included in the domain of state mental hospitals. In order to fully appreciate this change in approach, we must next examine the administrative guidelines, which explicate the original legislation. As we observed, the legislation in itself was not particularly restrictive.

Administrative Guidelines

We shall be concerned here with the regulations pertaining to the elements of service to be provided by the cen-
ters and to the instructions for formulating state plans, as well as the definitions provided in the guidelines. First of all, each center is to serve an area of 75,000 to 200,000 people, whose delineation is "based on such factors as population distribution, natural geographic boundaries, and transportation accessibility." 17

The section of the guidelines relating to adequate services clarifies "the essential elements of comprehensive mental health services" mentioned in the legislation. According to the regulations, the following elements of service, "which are necessary to provide adequate mental health services," constitute "the elements of comprehensive mental health services:"

1. Inpatient services;
2. Outpatient services;
3. Partial hospitalization services, such as day care, night care, week-end care;
4. Emergency services 24 hours per day must be available within at least one of the first three services listed above;
5. Consultation and education services available to community agencies and professional personnel;
6. Diagnostic services;
7. Rehabilitative services, including vocational and educational programs;

(8) Precare and after-care services in the community, including foster home placement, home visiting and half-way houses;

(9) Training;

(10) Research and evaluation.

Comprehensive mental health services therefore means a complete range of all the elements of service listed above "in sufficient quantity to meet the needs of persons residing in the community served by a community mental health facility, taking into consideration factors such as the age group served, diagnostic categories treated, and the (pre-existing) availability of short, medium and long term care." Thus, while ten types of specific services are now listed in the regulations, the guideline, "in sufficient quantity to meet the needs", remains subject to individual judgment.

While all ten types of services are needed to constitute a comprehensive program, the regulations state that only the first five services are the "essential elements of comprehensive services." Thus, before considering the additional types of service, a center is compelled to offer the basic five, in order to be eligible for government funding. It is interesting to note, therefore, that of the five, only one--consultation and education--is preventive in nature. In this way, we see that the open definition of community mental health centers provided in the legislation, has been narrowed

18 Ibid., Section 54.201 (g).
down considerably in programmatic terms through the guidelines, and the result is that centers are to be primarily concerned with the mentally ill. Thus, the guidelines reinforce the bias of the early legislative history, in being most concerned with patients who were traditionally institutionalized.

In addition to providing at least the essential elements of care, the guidelines state that programs must also "assure continuity of care for patients and assure that the relationship between the individual elements of the services meet the following criteria:

(1) (i) That any person eligible for treatment within any one element of service will also be eligible for treatment within any other element of service;

(ii) That any patient within any one element can and will be transferred without delay to any other element (provided that adequate space is available) whenever such a transfer is indicated by the patient's clinical needs;

(iii) The clinical information concerning a patient which was obtained within one element (will) be made available to those responsible for that patient's treatment within any other element;

(iv) That those responsible for a patient's care within one element can when practicable and when not clinically contra-indicated, continue to care for that patient within any of the other elements; ...
(2) That a qualified psychiatrist will be responsible for the clinical program. . ."\textsuperscript{19}

Thus, the regulations suggest four specific means of assuring continuity of care. The final clause above reinforces the narrower construction of the role of a mental health center, by invoking the medical model, with a psychiatrist as head. The section on continuity of care is the only attention given to program requirements, aside from the listing of elements of comprehensive services. Continuity of care shall be of particular interest to us later when comparing the impact of organizational structure on the delivery of services in the two centers studied.

Finally, we must consider the administrative guidelines pertaining to state plans. The regulations state: "Based on comprehensive mental health planning, the State plan shall provide for adequate community mental health facilities for the provision of programs of comprehensive mental health services to all persons residing in the State and for furnishing such services to persons unable to pay therefor. . . "\textsuperscript{20} Comprehensive mental health planning is defined as "the planning on a statewide basis for the provision of adequate mental health services, taking into consideration such factors as problems of availability of manpower and facilities, the role of mental hospitals, the development of new improved methods for the treatment or prevention of mental illness and laws

\textsuperscript{19}Ibid., Section 54.212 (c).

\textsuperscript{20}Ibid., Section 54.203 (b) (1).
applicable to the mentally ill." 21

. More specifically, the regulations require that the state plan delineate the geographic areas and then rank them according to their relative need for mental health services. The relative need of areas is to be determined by (1) the extent of mental illness and emotional disorder and (2) the present availability and accessibility of community mental health resources. In determining the extent of mental illness and emotional disorder, the regulations suggest taking into account such related indices as: (a) the existence of low per capita income, chronic unemployment, and substandard housing; (b) the extent of problems related to mental health, such as alcoholism, drug abuse, crime and delinquency; and (c) the special needs of certain groups within the area, especially the physically and mentally handicapped, the aged and children. 22 Finally the state agency is to determine the relative priority of projects on the basis of relative needs of the area, but giving special consideration to the extent to which the center will provide comprehensive services and will be associated with a general hospital. Thus, in addition to the emphasis previously mentioned on continuity of care, comprehensiveness and association with a hospital are also stressed. This instruction to the states, therefore, again reinforces the medical orientation.

21 Ibid., Section 54.201 (f).

22 Ibid., Section 54.204 (b).
To summarize the role of the administrative guidelines, we have seen that the regulations are very specific in enumerating the ten elements that comprise a comprehensive program. In addition, the enumeration of five essential services which are mandatory for funding definitely reduces the scope of problems that a center will initially address; and four of the five are types of treatment geared particularly at a transition from institutional care to community care. In addition to comprehensiveness of services and ties with a general hospital, continuity of care and comprehensive state planning are also emphasized in the guidelines. It is interesting to note that while no particular attention is devoted to services for alcoholics, drug addicts, criminals, delinquents, mentally handicapped in the early legislation, their needs are to be accounted for in the comprehensive planning. From this one can surmise that the intent was there to later enlarge the types of services to be offered in the centers.

Massachusetts Plan and Legislation

The Massachusetts State planning and legislation followed the prescripts of the federal legislation, involved a number of the same individuals, and therefore reinforced the federal regulations. In addition, the state set up local citizen boards to participate in the local planning. The comprehensive state planning was done by the Massachusetts Mental Health Planning Project, which submitted its report, Mental Health for Massachusetts, on June 30, 1965. The state was divided into 37 areas, and the Planning Project gathered
and analysed the data to allow for the selection of goals, priorities, allocation patterns and methods for achieving the selected aims, as suggested in the federal guidelines. (See Chapter 4) The study, however, left to local discretion the precise manner in which existing and planned resources within a given area coordinated their efforts to provide a comprehensive program.

Based largely on the recommendations of the Planning Project, "An Act Establishing A Comprehensive Program of Mental Health and Mental Retardation Services" (Chapter 735) was approved for the state on December 28, 1966. This legislation established the Massachusetts Department of Mental Health and provided the apparatus of dividing the state into 37 areas and six regions to help coordinate the activities of each area. It is noteworthy that at the state level a single program was established to handle both mental health and retardation services, while federally the two are handled separately.

Of particular interest is the legislation regarding the creation of community mental health and retardation area boards, since we shall later examine their roles in the planning process. In each of the state's 37 areas, the board is to consist of twenty-one members, who are selected by the State Commissioner, of Mental Health, after a process of community discussion. While two-thirds of the members must live within the area, the remaining members may either live or work within the area. Four members of the area board must be selected from the associations for mental health within the area, and
four members must be selected from the associations for the mentally retarded within the area. In fact, the 37 areas are based on the pre-existing areas served by Child Guidance Centers set up by local Mental Health Associations. The Commissioner is instructed to seek to provide proper geographical representation in the membership of each board. Vacancies at the expiration of staggered three-year terms of office are to be filled by the Commissioner from nominations provided by the Board.

The primary duties and powers of the area board which meet monthly, are as follows: to act as the representative of the citizens of the area; to advise regarding local needs and resources in the development of comprehensive mental health and retardation services; to review and approve the annual plan and to review and make recommendations concerning the annual budget; and to consult with the Commissioner in personnel recruitment and appointment policies, the establishment of program priorities for the area, admission policies for all facilities and services, and policies regarding relationships with other agencies and organizations. The area board is also mandated to appoint an advisory committee on mental retardation services and any other such advisory committees as it may deem necessary.

Finally, the state legislation states that in accordance with standards established by the Department, each area is to develop and maintain, subject to appropriations, comprehensive community mental health and retardation services including
specialized services for both children and adults. It enumerates the five essential services required by the federal government, and it states that where practicable mental health services should include the five other services that complete the comprehensive community mental health program. In mental retardation services, major consideration is to be given to (1) diagnostic, evaluation and re-evaluation services; (2) various treatment services; (3) various training programs; (4) preschool clinical services; (5) long and short-term day and night-care residential services for various purposes; and (6) mental health consultation and educational services to community agencies and professional personnel practicing in the area. Where practicable mental retardation services should also include: (7) research programs including evaluation of effectiveness of efficiency of the various programs in the area; and (8) preventive services. The act stipulates that programs and services may also be developed in cooperation with facilities or other resources.

As in the federal legislation, continuity of services, as well as comprehensiveness, is stressed; those eligible for participation in any one service must be eligible for and have access to other services made available by the area. Services must be offered without discrimination to all people in the area. Within these guidelines each area was left to develop its own particular program of services.

Summary

This chapter began with an exploration into some of the
literature on the community mental health movement. The theory of what constitutes mental health, and particularly community mental health is amorphous. The literature suggests many possibilities for the proper scope of a community mental health center. Much attention is given to action that would alter the conditions or environments in which people live, a role outside the traditional work of mental health professionals. Given such wide-open conceptions in the literature, the various mental health centers might be expected to assume very different patterns of services, according to the needs of their areas and the resources available -- both monetary and types of personnel. While the attention devoted to prevention is notable in the literature, the legislation moves in a different direction.

A survey of the government regulations revealed that the range of possibilities open to mental health centers is narrowed considerably by federal and state legislation and guidelines. The federal legislative history, while reflecting considerable ambivalence, finally emphasized a concern for the mentally ill previously placed in institutions. Indeed, in the federal regulations and state legislation, four of the five essential services are aimed at treating the mentally ill. Only the consultation and education service embodies much potential for doing preventive work in the communities. Later legislation drew increased attention to programs for alcoholics, drug addicts, and children, but these still could only be undertaken by the centers after they were already pro-
viding the five essential services.

In addition to emphasis on medical services (centers should be associated with general hospitals and headed by psychiatrists), the guidelines stressed comprehensiveness and continuity of care. The term "comprehensive" is used to refer to the availability of all mental health services, and the availability and accessibility of such services to all people in the center's area. The definition, however, that comprehensive services must be in sufficient quantities to meet the "needs" of persons in the area remains vague. Continuity of patient care between the various program elements is also emphasized in both the federal regulations and state legislation.

Planning for mental health services was also to be carried out in a comprehensive fashion, surveying needs and available resources in all areas. In fact, the needs of specific groups of potential clients were to be included, even though initially there were no provisions for the appropriate programs for them. In the state legislation, area boards were designated to participate in the planning and development of comprehensive mental health and retardation services. In Chapter 4 we shall be interested in analyzing how the planning process, in addition to the legislation and guidelines, helps narrow the range of activities undertaken by different centers. Before exploring the role of planning in the two case studies, however, we must describe the areas served by the two centers; therefore, Chapter 3 will examine the impact of each of the area's characteristics.
Chapter 3
EXPECTED IMPACT OF AREAS' CHARACTERISTICS
ON SERVICES

In the previous chapter we saw how the legislation and guidelines influence the functioning of mental health centers. There are additional factors, relating to the particular characteristics of each mental health area, that we would also expect to influence the centers. This chapter shall explore the expected ramifications of the characteristics of the two areas. These aspects shall be considered in three categories: (1) geography, (2) extent of mental health problems, and (3) social and demographic characteristics of the areas.

1. Geography

The total population of the area served by the Somerville Cambridge Mental Health Center is 185,989 people; and that served by the Harry C. Solomon Center in Lowell is 228,881 people.¹ The Somerville-Cambridge area, which is comprised of only those two towns, is extremely dense and therefore encompasses only 10 square miles. The Lowell area, on the other hand, includes eight towns in addition to Lowell, and covers 184 square miles. This difference in geographical size of the areas might lead one to expect the Lowell center to have to be more dispersed than the S-C center in order to be accessible to all the people of its area. Ironically, the

history and development of the two centers have resulted in the reverse.

2. **Extent of Mental Health Problems**

It is conceptually difficult to assess the extent of mental health problems. In the absence of a detailed diagnostic survey, utilization of services is one crude measure, even though such rates are affected by the availability of resources and local attitudes toward mental illness. In 1966 (prior to the creation of the mental health center), there were 475 new admissions to mental hospitals from the populations of Somerville and Cambridge, largely alcoholics and schizophrenics. This was at a time when there were no adult psychiatric services available, except for those people in Cambridge who could afford to pay $25 per hour or more for private treatment. From the Lowell area there were 224 admissions to Worcester State Hospital which serves that area, during fiscal year 1966. Since the Solomon Center Inpatient Service did not open until April 17, 1967, there were no adult psychiatric services available for most of fiscal year 1966 in the Lowell catchment area either, and at that time "the state hospital staff felt that the Area sent more than its share of difficult and/or chronically ill patients. They had observed that Area patients appeared at admission in 'sicker'

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condition than patients from other (more adjacent) areas that feed into the hospital. Caution must be used, however, in interpreting such comparisons. While the above numbers seem to indicate that the S-C area has a much higher rate of mental illness, it may merely reflect that more of the mentally ill from that area are treated, since among other possible reasons, the state hospital serving that area is closer. Using similar data for the period 1958-61, the Massachusetts Mental Health Planning Project, in its comprehensive study of comparative need ranked the S-C area fourth out of the state's 37 areas on its rate of first admissions to mental hospitals, while the Lowell area was ranked 34 on that item. (See table 2). Again from utilization rates alone, it is difficult to know which area has greater need, or would have to devote more attention to the mentally ill.

On the numbers of mentally retarded children per 100,000, the S-C area was ranked 23, and Lowell 18 out of the 37. Similarly for rates of physically handicapped children per 100,000, the Lowell area was ranked significantly higher than S-C. Thus, in terms of programs for children, particularly the retarded and handicapped, one might expect the Lowell program to devote relatively more attention than the S-C program.

Since mental health programs were being increasingly conceived of as efforts to reduce social pathology, as well as traditionally defined psychiatric illnesses, the Planning

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5 MMHPP, p. 18.
Table 2

INDICES OF RELATIVE NEED FOR MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>Indices</th>
<th>Wt. of group</th>
<th>Wt. within group</th>
<th>Rank within State*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cambridge</td>
<td>Lowell</td>
<td></td>
</tr>
<tr>
<td>Total Rank</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socioeconomic (1960)</td>
<td>3</td>
<td>8</td>
<td>23</td>
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<tr>
<td>Income levels</td>
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<td></td>
<td></td>
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<tr>
<td>median income</td>
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<tr>
<td>% less than $3,000</td>
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<td>unemploy/100,000</td>
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<tr>
<td>Housing</td>
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<tr>
<td>median value</td>
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<tr>
<td>% deteriorated &amp; dilapidated</td>
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<tr>
<td>Education</td>
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<tr>
<td>median yrs completed</td>
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<tr>
<td>less than 5 yrs per 100,000</td>
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<tr>
<td>of age</td>
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<tr>
<td>Illness</td>
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<td>9</td>
<td>33</td>
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<tr>
<td>First admission to Mental</td>
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<td></td>
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<tr>
<td>Hospitals per 100,000 (1958-61)</td>
<td>2</td>
<td>4</td>
<td>34</td>
</tr>
<tr>
<td>Mentally Retarded/100,000</td>
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<td></td>
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<td>Physically Handicapped per 100,000</td>
<td>1</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>Social Pathology</td>
<td>4</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>Total Arrests/100,000 1961</td>
<td>1</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Youth Services Board Committments/100,000 (1958-1963)</td>
<td>1</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td>Arrests for Drunkenness per 100,000 (1963)</td>
<td>1</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Arrests for Narcotics per 100,000 (1963)</td>
<td>1</td>
<td>9</td>
<td>29</td>
</tr>
<tr>
<td>Welfare</td>
<td>3</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Old Age Assistance/100,000</td>
<td>1</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Medical Aid to Aged/100,000</td>
<td>1</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td>Disability Assistance/100,000</td>
<td>1</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>ADC/100,000</td>
<td>1</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>General Relief/100,000</td>
<td>1</td>
<td>11</td>
<td>12</td>
</tr>
</tbody>
</table>

*The local area's rank on each measure ranges from 1 to 37, since the study was done for the 37 catchment areas in the state. A rank of 1 indicates the area of highest need, and 37 indicates the area of lowest need. Compiled from "Mental Health for Massachusetts," pp. 14-18, 101-104.
Project decided to consider the levels of social pathology in each catchment area. In this category four indices were used: 1) Rates of arrest by local and state police; 2) Rates of commitment to Youth Service Board facilities; 3) Rates of arrest for drunkenness; and 4) Rates of arrest for violation of narcotics laws. The Cambridge Area was ranked 2, 8, 6 and 9 for the four categories respectively, and resulted in an overall rank of 5 in social pathology, with each of the four indices being weighted equally. While Lowell demonstrated less need in this category with an overall ranking of 18, it did rank 11 on both total arrests and arrests for drunkenness. From these indicators, one would expect the mental health programs to extend their services into the courts, and particularly into more preventive types of programs for potential juvenile offenders. Based on the comparisons, we might expect the S-C program to give relatively more emphasis to such programs. Alcoholism is also a special problem in both areas that one would expect the mental health program to address. It is estimated, according to the Jellinek formula based on reported deaths from cirrhosis of the liver, that one out of eleven persons in Cambridge is an alcoholic, and one out of eight in Somerville. Although there are no current statistics available to document the extent of the problem, it is also believed that alcoholism is a major problem in the Low-


7 Interview with Betsy Leavitt, Social Worker, Alcoholism Program, Cambridge Hospital, January 13, 1971.
ell area, requiring special attention.

Drug abuse is also a special problem in both the areas, and the Planning Project statistics on arrests for narcotics are out of date and misleading. In Cambridge in the first nine months of 1970, there were 303 drug-related arrests, over 80% of which resulted in convictions. The police have seized 336 decks of heroin in approximately 150 separate raids, and a survey by Cambridge Community Services estimates that there are at least several hundred heroin users in Cambridge. Similarly, in the Lowell area drug abuse has been increasingly prevalent. From January to November 1970 there were over 255 drug arrests within the Lowell catchment area. In the Lowell District Court (Adult Division) there were 60 convictions for such offenses in January-November 1970. In fact, these statistics cannot be construed as totally indicative of the severity of drug problems since many users and addicts are never arrested, and secondly because others do appear before the court on charges not included in drug violation statistics, such as breaking and entering, larceny, and other drug-related crimes. From these reports, it is clear that drug abuse is a problem in both catchment areas, although slightly more

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8 City of Cambridge, Department of Health, Hospitals and Welfare, "Action Grant Application for Cambridge Drug Program."

9 Ibid.

10 "SHARE Proposal to Division of Drug Rehabilitation, Department of Mental Health" (December 7, 1970), p. 138.

11 Ibid., pp. 139-140.
severe in the S-C area, so that one might expect that center to be a little more active in such work.

3. Social and Demographic Characteristics of the Areas

In addition to the impact of the areas' geographical characteristics and the extent of mental health problems in the determination of the centers' programs, the social and demographic characteristics of the populations served should also have some influence. As an overview, it should be stated that both areas are predominantly deteriorating industrial areas, with very high unemployment rates, low incomes, low levels of education, and severe social problems. Table 3 presents comparative statistics, on such characteristics, based on the 1960 census for the two areas and the state as a whole. From the age distribution of the populations, one might expect the Lowell center to give relatively more attention to children's services, than the S-C center. Similarly, from the statistics on marriage and fertility, the Lowell center might be more concerned with offering services to families as units. Conversely, one might expect the S-C center to have programs for divorced and separated adults, as well as for the large number of single adults. On the other hand, as a preventive service, the S-C program might be more concerned with couple and family counseling, since marital instability is such a common condition. Another readily identifiable mental health target group is composed of the elderly. Since Cambridge has the largest proportion of elderly in any city in the state.
it is not surprising that its area has a larger percentage of elderly than Lowell. Since these people are more often poor, isolated, sick and have less access to social services and community resources than do younger, healthier people, one might expect both areas, and particularly the S-C center to offer special programs for the aged.

The social characteristics included in Tables 2 and 3, such as income levels, housing, education, welfare and unemployment are more difficult to translate into programmatic concerns for the mental health center. The Planning Project (see Table 2) included socioeconomic and welfare indices, although weighted less heavily than the illness and social pathology rates, in its evaluation of each area's comparative need for services. It is unclear, however, exactly how the Planning Project thought such characteristics should influence the scope of a program. One might imagine that both centers, and particularly the Lowell center (where the current unemployment rate of 9.3% is the highest in the state) would be involved in efforts to retrain people for new jobs and particularly for jobs in the mental health center. In Lowell too where the level of educational attainment is generally lower, the center might also be involved in encouraging more people to take courses to further their education. Speculating from the number of working mothers with children under six years of age, one might also expect the centers, and again partic-

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Table 3
SOCIAL AND DEMOGRAPHIC
CHARACTERISTICS OF THE TWO AREAS

<table>
<thead>
<tr>
<th>Age-% tot. pop.</th>
<th>Ethnicity-% tot. pop.</th>
<th>Marital Instability Ratio</th>
<th>Non-Residential Adults Stability</th>
<th>Foreign stock: foreign-born or foreign parentage. Marital instability: (# divorced or separated/# married &amp; living with spouse) x 100</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Foreign</td>
<td>Black Stock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mass.</td>
<td>18.3 53.0 11.1</td>
<td>2.1 40.1</td>
<td>5.2 545.4</td>
<td>19.1 57.1</td>
</tr>
<tr>
<td>Som-Camb.</td>
<td>14.8 56.2 11.6</td>
<td>2.8 47.4</td>
<td>7.1 470.6</td>
<td>29.2 54.1</td>
</tr>
<tr>
<td>Lowell</td>
<td>20.4 51.0 9.5</td>
<td>0.3 37.2</td>
<td>4.6 631.1</td>
<td>16.9 57.4</td>
</tr>
</tbody>
</table>

- **Fertility Ratio**: (# age 0-4/ # females 15-44) x 100.
- **Non-Family Adults**: (# primary individuals/# primary families) x 100.

- **Inter-County Migration**: % age 5+ in diff. city in 1955.
- **Room Crowding**: % with 1.01+ persons/room
- **Working Mothers**: % of married couples with child under 6 yrs with wife in labor force.

- **Income-% of families**

- **Education - % pop. age 25+**
  - less than 8 comp. grades
  - 1+ yrs college education
  - males unemp. prof.,mgr.
  - male blue collar
  - female in labor force
  - working Blue collar

<table>
<thead>
<tr>
<th></th>
<th>Males Unemp. Prof., Mgr.</th>
<th>Male Blue Collar</th>
<th>Female in Labor Force</th>
<th>Working Blue Collar</th>
<th>Female Less than $3,000</th>
<th>Female over $10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass.</td>
<td>4.3 24.3</td>
<td>50.4</td>
<td>38.4</td>
<td>17.3</td>
<td>26.5</td>
<td>12.4 17.0</td>
</tr>
<tr>
<td>Som-Camb.</td>
<td>4.3 22.2</td>
<td>50.5</td>
<td>43.4</td>
<td>16.5</td>
<td>22.1</td>
<td>13.4 15.1</td>
</tr>
<tr>
<td>Lowell</td>
<td>4.5 19.9</td>
<td>57.7</td>
<td>38.9</td>
<td>21.4</td>
<td>38.8</td>
<td>12.2 12.8</td>
</tr>
</tbody>
</table>

---

ularly Lowell, to be sponsoring some types of day care programs for children in the community. Housing conditions appear to be below par in both areas, and if the centers were to become involved, the solutions would have to be somewhat different since over 60% of the units are owner occupied in Lowell, while the figure is less than 30% for S-C. In Lowell the center might be involved in bringing home owners together to discuss how they could improve their physical surroundings and get assistance in home improvements. In S-C, on the other hand, the approach would have to be different since few families own their own homes.

Perhaps a more useful way to analyze the social and economic data is in terms of neighborhoods. The core area of the city of Lowell and East Cambridge both suffer significantly from urban blight and a full array of social problems. These target areas, which have been designated Model Cities and Urban Renewal areas are predominantly low income and include the vast majority of both cities' black and Spanish-speaking populations. These areas are characterized by very high density, older housing, exceedingly high unemployment rates, a higher degree of welfare dependency, and lower educational levels. That such areas exist -- with 44% of their resident families having incomes under $3,000, 14 32% of the families on some form of public assistance, 15 and unemploy-


15 Ibid, p. 17.
ment rates of 30-35%\textsuperscript{16} -- might indicate to the two centers that special programs should be undertaken in these geographic sections, perhaps aimed at employment possibilities, community organization, and programs for youth.

**Summary**

The characteristics of the two mental health areas outlined in this chapter suggest certain types of programs with which the centers might be concerned and certain forms that the centers might assume. The most basic difference between the two areas is that Lowell encompasses about eighteen times the geographical area of the S-C center; hence it should be more inclined to be dispersed throughout its area. The statistics on previous mental hospital admissions were difficult to project into program emphases since Lowell, which had far fewer admissions, was located at a great distance from its state hospital, and may therefore have been in greater need for inpatient services. On the basis of other statistics in their areas, one might expect the Lowell center to be more concerned with serving retarded children and other children in general, although the S-C area seems to have a greater problem with juvenile offenders and so might be working with them. Both areas clearly have severe problems of alcoholism and drug addiction, although the problems seem to be somewhat more prevalent in S-C, and therefore that center may be devoting more attention to them. As was discussed earlier, the social characteristics relating to employment, income levels, housing, etc., are more difficult to project into programmatic

\textsuperscript{16}Ibid., p. 16.
expectations. Some programs, however, were suggested. On the basis of the large number of working mothers with young children, particularly in Lowell one might expect some types of child care services sponsored through the mental health center. Finally, in the most blighted neighborhoods in both areas, the centers might be inclined to engage in social projects.

Having described the differences between the areas, it should now be pointed out that in overall characteristics, the two areas are generally similar. They share the problems of deteriorating industrial areas, suffering from high unemployment rates, low incomes, low levels of education, and severe social problems. Certainly, there are many other areas within the state that would have been markedly different from these. Thus, in the final analysis we should expect the programs of the two centers to be similar to the extent that they reflect the characteristics of the areas.
Chapter 4

PLANNING PROCESSES

The term planning is used to refer to a method devised for making or doing something or achieving an end. It is generally used to describe rationally calculated action to achieve certain goals or a means for facilitating decision-making to make it more realistic and rational. Thus, when we speak of planning in the mental health center, it refers to the processes by which decisions are made and policies formulated. Many strategies of planning have been advanced, and they often are differentiated according to the degree of forethought or rationality inherent in the processes.¹ For the purposes of analyzing the planning processes in the mental health centers, two planning models shall be discussed here: a comprehensive strategy stressing rational action, and a more fragmented approach known as "disjointed incrementalism".

As we shall explain in this chapter, the type of planning process employed by the centers has an impact on the types of programs they offer. Therefore, in addition to examining to what extent and why the centers carry out the two types of planning, this chapter shall be concerned with identifying some of the ramifications of the processes. We shall see that the planning process, as well as the regulations and characteristics of the areas, influences the programs offered by the centers.

¹For an idea of the range of planning models, see Alan A. Altshuler, The City Planning Process (Ithaca: Cornell University
Comprehensive Planning

As described in Chapter 2, the legislation, both federal and state, regarding the establishment of community mental health centers called for comprehensive planning. Therefore, we shall first explore a theoretical model of comprehensive planning. The rational action model (alternatively referred to as the synoptic model or comprehensive model) implies a consciousness of the decisions that are being made and the goals that are being served. The components of this type of decision process include values, clients, goals, standards, means, programs, action or effectuation, and feedback and evaluation. Since this discussion shall be applied to mental health planning, it may be instructive to look at the field of health planning:

"Comprehensive health planning entails: identification of current and emerging health needs; adoption of positions on issues of the public's health and their translation into specific goals; formulation of long-range plans providing general guidance for the development, coordination and administration of all programs focused on the health of the community, and continual evaluation of implementation.

In essence, therefore, comprehensive health planning must examine the health needs, goals, and resources

of the total community, then interrelate them for the overall health of the community. Implicit in this definition also are a) development of criteria for evaluating and correlating specific plans and programs and b) establishment of priorities, and phasing schedules. This process places comprehensive health planning in an arbiter role where it must reconcile the sometimes conflicting and competing claims for money, personnel and other resources of the various programs responsible for meeting only parts of the community's health needs.²

An outline of a comprehensive health planning process would include the following steps: general evaluation of community health and resources, goal formation, identification of applicable resources, consideration of alternative solutions, selection and development of a plan of action, implementation and evaluation. It should be pointed out, however, that it is actually an iterative process, rather than a one-time sequence. Thus, the measurement of progress in an action program is designed to determine the program's effectiveness or value (and also unexpected consequences) so that this information can be utilized in the next round of planning and implementation. In order to achieve better planning and improved implementation, "channels of communication need to be defined and kept open in both directions, up and down the line of command. Responsibilities must be clearly defined, and authority assigned."³

For an example of an attempt to carry out comprehensive

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mental health planning, we can examine the report, *Mental Health for Massachusetts*. We recall that the initial federal legislation required each state to draw up a comprehensive plan for centers, based on a statewide inventory of existing facilities and a survey of need. With a federal grant-in-aid financing their work, the Massachusetts Mental Health Planning Project was assembled. This group adopted a broad outlook in trying to define relative overall community need for mental health centers. Nineteen different indices were used, and they were weighted to determine the overall relative need of each of the state's 37 areas. (See Table 2).

After ascertaining the relative needs of each of the catchment areas, the Planning Project had to consider the extent of existing resources to cope with the needs of each area in order to determine the overall state priorities. One of four classifications was given to rate the availability of resources to an area for each essential element of service in a comprehensive program (See Table 4 for the specific ratings of the S-C and Lowell centers). Facilities to serve the mentally retarded were not considered in this analysis.

Finally, to lay out the area priorities in program development, the Planning Project constructed a 3 x 3 matrix, showing each center's overall need (low, medium or high) and its available resources (limited, average, or major). (The Cambridge area fell into the category of high overall need with major resources available; the Lowell area had medium overall need and limited resources available). In setting
### Table 4

**AVAILABILITY OF MENTAL HEALTH RESOURCES**

<table>
<thead>
<tr>
<th>Area</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Emergency</th>
<th>Partial Hospitalization</th>
<th>Consultation &amp; Education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children</td>
<td>Adults</td>
<td>Children</td>
<td>Adults</td>
<td>Children</td>
</tr>
<tr>
<td>Cambridge</td>
<td>0</td>
<td>1A, 1B</td>
<td>0</td>
<td>1A, 1B</td>
<td>0</td>
</tr>
<tr>
<td>Somerville</td>
<td>0</td>
<td>2, 2</td>
<td>0</td>
<td>1A, 1B</td>
<td>0</td>
</tr>
<tr>
<td>Lowell</td>
<td>0</td>
<td>0</td>
<td>1A, 1A,</td>
<td>1A, 1B</td>
<td>0</td>
</tr>
</tbody>
</table>

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0 - No resources available

1A - Limited resources available

1B - Resources provide service to restricted populations

2 - Major general resources available

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*MMHPP, pp. 22 and 26.*
out these overall priorities for the state, the Planning Project did, however, caution that there were other factors that were not given adequate consideration, "such as the urgent need for special services to specific groups like children, the readiness of communities to proceed, the availability of matching funds and the importance of giving special emphasis to teaching institutions in order to enlarge the manpower base."\(^5\)

In this way, the Planning Project carried out its mission in a somewhat comprehensive fashion, taking into account the needs and resources of each area in determining the state's plan of action. Although this document is probably the most comprehensive piece of mental health planning done in the state, it is not truly comprehensive, when compared with the procedures previously outlined. The formation of goals and consideration of alternative solutions do not receive much attention in the report. In addition, in examining the needs and resources, a number of factors had to be omitted, as suggested in the previous paragraph. Finally, because the planners in this case were not responsible for implementation and evaluation, there was no way to assure that there would be the proper feedback to continue a comprehensive planning process. Since the project intended to do a comprehensive state plan, it is important to investigate why their planning processes tended to deviate from the original model. After that, we

\(^5\)Ibid., p. 30.
shall examine an alternative planning model, known as "disjointed incrementalism", which is more akin to the types of planning the centers engage in, and finally we shall explore the ramifications of such processes.

Difficulties in Carrying Out Comprehensive Planning

A number of arguments have been put forth claiming that there are cognitive, organizational and political difficulties in carrying out a rational decision-making process. Except for neatly circumscribed problems, the comprehensive method remains an ideal, rather than an accomplishment. Perhaps the most basic problem is that a decision-maker cannot be rational without fully understanding the problem, and this requires comprehensiveness of information and analysis. In addition, he must be able to identify just what he wants and then determine alternative means of attaining these wants. Such difficulties lead Braybrooke and Lindblom to conclude that at its best, the synoptic method has conditions whose attainment would imply that a solution is at hand, but it gives no clue as to how people actually deal with problems. This would lead one to conclude that even when planners strive to use a synoptic approach they often in fact do not carry out a process of comprehensive planning. Such appears to be the result in the state plan, and it is important to enumerate some of the specific reasons for such a modification.

Some of the principal shortcomings of the synoptic

6 Braybrooke and Lindblom, p. 45.
ideal as set forth by Braybrooke and Lindblom do seem to apply to this situation. They are principally: man's limited problem-solving capabilities, inadequacy of information, and the costliness of analysis. These are realities which impinge against the synoptic ideal.

First of all, definitions of mental illness and mental health are so vague, and the steps to be taken for curing problems and promoting health are so uncertain that it is difficult to formulate specific goals and measures of performance.7 This renders it almost impossible for a planner to achieve the necessary comprehensiveness of information and analysis. This tremendous uncertainty about techniques in the mental health field from the start therefore leads the planner away from the comprehensive strategy. At the same time, the open universe of problems that can be defined as related to "mental health" would render the synoptic process far beyond the problem-solving capabilities of any group of individuals. In addition, the time and cost involved in such an attempt would be enormous.

Meyerson and Banfield in their study of policy formulation with respect to the location of public housing address the problem of time and costs involved in gathering information. They state that the Chicago Housing Authority could not be expected to have carried out the amount of research that would have been required to execute a thorough examina-

tion of the problem. Similarly, the Massachusetts Mental Health Planning Project could probably not have been expected to carry out a truly comprehensive research project.

Other barriers to doing comprehensive planning, which shall arise in our discussion again later, are (1) the failure to construct satisfactory evaluative methods when a number of individuals, with differing personal values are involved; and (2) the diverse forms in which policy problems actually arise. An example of the latter problem is the situation in which policy problems arise because a useful new means comes to hand for achieving a variety of ends, rather than the need for analysis being triggered simply by identification of an unachieved goal. Clearly, this was the case when the Planning Project undertook the study of mental health resources and need in the state: federal money had become available to establish community mental health centers, and the Planning Project, therefore, had no latitude to consider whether such centers were actually the most appropriate solutions to the problems at hand. Before going on to examine the planning utilized in the establishment and operations of the centers, we shall next consider another planning model, so that we can then examine their planning in that context.

Disjointed Incrementalism

Given their objections to the comprehensive planning

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9 Braybrooke and Lindblom, pp. 48-57.
model, Braybrooke and Lindblom lay out an alternative strategy, known as "disjointed incrementalism", which they claim many policy analysts do in fact use to adapt to the difficulties of evaluation and decision-making. In incrementalism only "policies whose consequences differ incrementally from the status quo (or from each other) are considered, and the examination of policies proceeds through comparative analysis of no more than the marginal or incremental differences in the consequent social states rather than through an attempt at more comprehensive analysis of the social states."\(^{10}\)

Clearly then the analyst attends to a smaller number of policies when he only considers those that differ incrementally from the status quo. This limitation is justified on the grounds that non-incremental alternatives are often politically irrelevant and often cannot be rationally explored, as argued previously. In addition, the number of consequences considered for any given policy are restricted. The analyst eliminates the uninteresting, the remote, the imponderable, the intangible, and the poorly understood consequences, no matter how important. This is supported by the assertion that "To omit is often to make manageable, and to aspire to completeness is often to do a bad job of everything attempted."\(^{11}\)

Another major characteristic of the disjointed incrementalist approach is that it has a reciprocal relationship between means and ends. Policy objectives become established

\(^{10}\) Ibid., pp. 85-86.

\(^{11}\) Ibid., p. 91.
in large part from an inspection of the means, rather than policies being sought to attain certain objectives, as in the rational action model.

Because of the fundamental dependence of ends on means, adaptation takes place in the following way: the analyst chooses as relevant objectives only those worth considering in view of the means actually at hand or likely to be available. He automatically incorporates consideration of the costliness of achieving the objective into his marginal comparison. And while he contemplates means, he continues to contemplate objectives, unlike the synoptic analyst who stabilizes objectives and then selects the proper means. 12

A final means-ends distinction is that while in synoptic planning the alternative policies are examined for their suitability to a set of objectives, in disjointed incrementalism the set of objectives are examined for their suitability to the given means. 13

The marginal aspect of the strategy means that analysis and evaluation together follow a series of steps. The analyst returns time and again to approximately the same problems, and he does not "solve" them, but looks for appropriate moves in a series he expects to continue. Another characteristic of incrementalism is that it encourages movement away from certain ills or situations, rather than goals toward which to move. "Even short-term goals are defined largely in terms of reducing some observed ill rather than in terms of a known objective of another sort." 14

12 Ibid., p. 94.
13 Ibid., p. 97.
14 Ibid., p. 102.
ners are less concerned with pursuing a better world than with avoiding a worse one.

While the above discussion has pointed out the characteristics of incrementalism, it has not explained the "disjointed" features of the strategy. Braybrooke and Lindblom assert that analysis and evaluation are socially fragmented, in that they often take place in a large number of places.

"Analysis and evaluation are disjointed in the sense that various aspects of public policy and even various aspects of any one problem or problem area are analyzed at various points, with no apparent coordination and without the articulation of parts that ideally characterize subdivision of topic in synoptic problem solving. Of course, analysis and evaluation are in a secondary sense also disjointed because they focus as heavily as they do on remedial policies that 'happen' to be at hand rather than addressing themselves to a more comprehensive set of goals and alternative policies." 15

With the two models of planning in mind, we shall now look at the planning actually done to create and operate the two mental health centers.

Early History and Planning in the Centers

This section shall begin by giving a summary of the initial planning, (starting with the state plan) for the Lowell and Somerville-Cambridge centers. A short history of the development of each center will point out how from the start, planning tended to deviate from a comprehensive approach. This shall be followed by an analysis of how and why the centers continue to do fragmented planning and the programmatic ramifications of such planning.

15 Ibid., pp. 105-106.
Earlier in this chapter we pointed out how the Planning Project ranked each area according to its overall need (low, medium or high) and its available resources (limited, average or major). It was noted too that the Lowell area fell into the category of medium overall need and limited resources available; and the S-C area had high overall need with major resources available. It is interesting to note that six areas in the state fell into the category of having high overall need and limited available resources. Thus, according to the Planning Project, these six areas had a higher priority for new mental health resources than did the Lowell area, which had the state's first mental health center established there.\footnote{MMHPP, p. 30.}

Previous to the study of the Planning Project, Lowell had already been selected as the site for the state's first community-based facility. Lowell was selected for the project because it was the urban area located furthest from the associated state mental hospital, and also had the least aftercare services available. Clearly then, the initial decision to build the state's first center in Lowell was not based on comprehensive planning; it was based largely on just one factor -- its distance from the state hospital serving that area. The Planning Project did deem a center necessary in order to provide a comprehensive range of services to children and adults in the Lowell area. At that time the only existing resources were the mental health clinics, which
provided limited outpatient care primarily to children, an Alcoholism Clinic at Lowell General Hospital, and a Veterans Administration Clinic, which restricts its services to veterans.

Once Lowell was selected for the center, a site within the area was needed, and the State Commissioner began to consult with the Lowell Mental Health Association on this matter. As soon as the trustees of Lowell General Hospital offered to donate two adjacent acres of land for the center, however, their offer was accepted.\(^{17}\) Again, a major decision was not based on comprehensive planning, which might have included a study to seek the best location in terms of accessibility as well as cost and other factors. Rather a new resource or means presented itself and was seized as the solution.

The center opened in September 1966, with outpatient care and home visiting; the steel strike at that time delayed the delivery of beds, so that the inpatient service was not opened until April 17, 1967. During those interim months, some of the staff worked at Worcester State Hospital, which is the long-term facility serving the Lowell area, and when the beds became available in April some of the patients from Worcester were transferred to the new center along with the staff.

A child guidance clinic had been in operation since 1962 at Lowell General Hospital and it had been arranged that in November 1966, they would move into the mental health center.

\(^{17}\)Interview with J. Sanbourne Bockoven, Superintendent, Solomon Mental Health Center, February 8, 1971.
center with a tenant/landlord arrangement. The legislation, however, called for child psychiatric services to be provided along with adult services in one administration, so in time the two merged. The child guidance center had already developed consultation and education in the community, so services had to be coordinated to avoid duplication and to fill in the gaps. Again we see that a decision -- to actually merge the children's and adults' services into one administration -- was not based on a comprehensive plan for the area, but rather imposed from an outside source. Thus, we have seen that three major decisions: to initially build in Lowell, the selection of a site and the later merger with the child guidance clinic, were based on fragmented planning rather than on a comprehensive plan.

When the Planning Project prepared its study, a number of mental health services were already provided to the residents of the S-C area by local facilities, as well as by the variety of agencies in Boston. The final report, therefore stated, "The development of a comprehensive program in the Cambridge area will require the active coordination of existing facilities as well as the establishment of new ones." This suggestion by the Planning Project did in fact set the stage for the development of a single program. When the S-C Mental Health and Retardation Program was organized in 1969 to offer a coordinated network of services, the Massachu-

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18 Ibid.
19 MMHPP, P. 23.
setts Department of Mental Health, the Cambridge and Somerville Mental Health Associations, Cambridge and Somerville Mental Retardation Associations, the City of Cambridge Department of Health, Hospital and Welfare, and the Children’s Developmental Clinic all conferred in the development of the program.

The primary decision, to apply for a staffing grant rather than a construction grant, was based on political limitations rather than comprehensive planning. The decision was largely a result of the knowledge that the state legislature would have taken six or seven years to authorize construction. Since the legislature is involved in all appropriations for the centers, this is but one example of how the political factors often impinge on the planning process.

In 1968 an application was made to the National Institute of Mental Health for a staffing grant to create a comprehensive community mental health program. In applying for both federal and state funds to expand child and adult services in these two communities, it was decided to build on the existing disconnected services. It was felt that by using these services and filling in the gaps with new program elements, a comprehensive system to provide care from infancy through old age could be established. The plans for the center were drawn up by the three directors of psychiatric services at Cambridge Guidance Center, Somerville Guid-

20 Interview with Robert Reid, Director, Somerville-Cambridge Mental Health Program, April 5, 1971.
ance Center and Cambridge Hospital. The S-C center was seen more as providing extension and better coordination of their services, than as a new overall approach. Policies were based on incremental changes within the existing services, and the goal of the mental health center was not radically different from the goals of the existing services. In this way, with its creation from a number of fairly strong existing services, the entire history of the S-C program almost required that it be more incremental and piecemeal in its planning. The decision was made early to continue functioning in a partnership manner, so that the state and federal funds would pay salaries, while the local sources of funding would continue to pay the operating costs. Since each unit in the S-C program has another source of funding, they tend to operate like semi-autonomous agencies. This results in conditions inimical to comprehensive planning. As Rein points out:

Coordinative planning requires a planning structure that can collect and organize the resources of various agencies to solve the many delivery problems. However, most planning structures have a common constraint, in that they cannot reduce the autonomy of community agencies, nor can they control the base budgets of agencies. As we have demonstrated, this problem is particularly significant in the S-C program, where responsibility has been decentralized to such a degree that the various programs often operate like autonomous community agencies.

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21 Interview with Hilma Unterberger, Associate Area Director, Somerville-Cambridge Mental Health and Mental Retardation Program, December 15, 1970.

Finally, to the extent that the S-C program has more autonomy and decision-making authority delegated to its individual components, it is more inclined to engage in "disjointed" planning than a centralized center, since analysis and evaluation are being carried out in a number of different places (without generally having the articulation of parts that characterizes subdivision of topics in comprehensive problem solving). The parts in the S-C program, as Braybrooke and Lindblom describe in their theory, are in imperfect coordination with each other, and in addition, the individual parts of the program are not always well-defined.\(^\text{23}\) (See Chapter 5 for a discussion of the coordination in the S-C center). Thus, the fragmentation and difficulty in assuring coordination with analysis and evaluation at many different points, makes the decentralized program even more likely to engage in fragmented planning.

To summarize, the history of the S-C center significantly affected the type of planning in several ways. Since there were considerable existing services, it was feasible to apply for a staffing grant rather than a construction grant -- a decision based on political realities rather than on comprehensive planning. More importantly, by building on existing services, policies were based on incremental changes, and a comprehensive consideration of goals was not undertaken. Basically, the existing agencies were allowed to continue

\(^{23}\) Braybrooke and Lindblom, pp: 105-106.
functioning relatively independently, each with its own source of outside funding. This arrangement rendered it virtually impossible to carry out comprehensive planning, since the requisite coordination between the various parts was lacking, as well as the authority to control the overall budgets of the units. The result is that by virtue of its history and organization, the S-C center is particularly suited to carrying out disjointed incrementalist planning.

**Ongoing Planning in the Centers**

The previous section was concerned primarily with the planning during the establishment and early history of each center; in the case of the S-C center we saw how the early history had implications for the planning process to be employed in the future. Now we shall explore three factors that affect the types of planning that both centers undertake: (1) availability of outside resources; (2) evaluation; (3) role of the area board.

First of all, it should be pointed out that the situation in which the center's administration does not have full control over budgets is not limited to the S-C center. In both centers situations of intervention in the planning process arise when "a useful new means come to hand for achieving a variety of ends." For example, when the government appropriated new money for drug programs, the centers immediately diverted attention to this issue rather than others that may

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24 Braybrooke and Lindblom, p. 54.
have been given priority in area planning. Thus by responding to new resources that become available, the centers also diverge from an attempt to carry out comprehensive planning.

Evaluation is a critical item in explaining the type of planning carried out by the centers. Comprehensive planning depends greatly on evaluation and feedback, for without periodic measurement of progress in terms of a program's effectiveness or value, the iterative process of planning, implementation, evaluation, cannot continue.

Both centers engage in little self-examination, probably due to a lack of time and resources, (staff members and administrators alike report that they are too busy with day-to-day operations to have much time for long-range planning or evaluation.) Perhaps also involved are reasons that an education director in another mental health program suggested: "A staff member who insists on evaluation is told: 'There's no time to sit around studying what's past--we've got to forge ahead!' Frankly, I think honest evaluation is too threatening. If we found out what we're really accomplishing, we'd probably all commit hari-kari." At the current time many of the programs are not keeping the types of records and information that are necessary for self-reflection and evaluation.


26 In the S-C program, where the central administration does not demand evaluation information from the various programs, the data are often not collected at all. The Cambridge Court Clinic, for example, does not keep rates of recidivism. While the centralized administration of the Lowell Center does provide for better record-keeping, they are primarily concerned with utilization rates, which do not give a full indication of the effectiveness of the center's programs. In addition,
In this way, the lack of information for evaluation makes it nearly impossible for either center to engage in comprehensive planning. Thus to whatever extent each center initially had some rational planning, such a process cannot continue, and incrementalism replaces it.

Finally, we must turn to the role of the area boards in the planning process. The state legislation had called for the area board system as a part of the comprehensive approach. The area boards were to insure that local representatives were included in evaluating local needs and resources and in the establishment of program priorities. Towards this end, the area boards were delegated the authority of approving the planning and budgetary annual reports.

First of all, it should be noted that there are organizational limitations brought about by the area boards' involvement in the planning process. With a board of twenty-one individuals, it would be difficult to agree upon evaluation criteria, since the members' personal values often differ. Thus, differences in personal values lead some members of a board to be most concerned with school dropouts and offenders, while others are more involved with matters of retardation. Comprehensive planning would require a mechanism for working out such differences.

(26) Professional personnel have no confidence in reports submitted to the State on closed cases, since the clerical personnel (on the basis of therapists' reports) actually make the determination whether the patient's condition improved, worsened, or remained the same.

27 Interview with Mr. Collins, President, Lowell Area Board, April 1, 1971.
In fact, however, the boards generally do not encounter such problems, since they more often tend to leave matters of programming and budgets to the professionals. Although the boards have assumed rather different functions and have pursued different strategies, both have a great deal of confidence in the professionals and feel that the staff members have a better idea about how to run a mental health center. While the boards do approve the budget, the President of the Lowell area board remarked that without an area plan, the board members are not really competent to pass judgment on the budget.28

The one program area in which both area boards have taken an active stand has been in the area of services for the retarded. On both boards the representatives of the Associations for Retarded Children have been active, vocal members. These representatives, parents of retarded children, were prepared to pressure for programs to meet their needs, and they have led to the creation of new services for the retarded in both catchment areas. Similarly, on the S-C board there has been much concern about alcoholics, and this also has led to the establishment of a special program for alcoholics, and the establishment of a corporation to secure a halfway house for alcoholics. Thus, to some extent it appears that the interests of particular members of the area board do effect programs. This type of lobbying, however, is inimical to comprehensive planning unless all possible interests are rep-

28 All of the material in this paragraph is drawn from inter-
views with Mr. Collins and Judge Lawrence Felloney, President, Somerville-Cambridge Area Board, April 3, 1971.
resented. Since the boards are composed predominantly of middle-aged professionals and middle and upper-income individuals, some groups are not represented. (According to a recent study of all area boards in the state, 54% of the 440 members responding have graduate or professional degrees, and 84% have annual family incomes over $10,000 with 14% over $35,000. The average age of Area Board Presidents is 48 years, and only eight board members out of the 440 were under age thirty.\(^\text{29}\)) Thus, unless the ethnic minorities, the aged, the youth, and many other groups were represented, it appears that the area boards also contribute to incremental planning. One President remarked that if a staff member from the center had not taken over responsibility for the area's drug program, nothing ever would have been accomplished. The area board members did not have the time or seem able to deal effectively with the comprehensive planning process.\(^\text{30}\) Thus, we see that the area boards, first of all, have neither the time or the inclination to generally get involved in planning for new programs or budgets. On the occasions when they do, however, there are additional problems in trying to carry out comprehensive planning: (1) the process cannot be comprehensive as long as people on the board serve as lobbyists for different interest groups, with some groups left unrepresented, and (2) to the extent that different interests and values


\(^{30}\)Interview with Mr. Collins.
are represented, the boards generally cannot work out the criteria to do a comprehensive comparative evaluation. Therefore, the functioning of the area boards, along with the center's dearth of evaluation and the occasional availability of new earmarked resources from outside the center, also encourages the centers to engage in incremental planning.

Results of Disjointed Incrementalist Planning

Thus far this chapter has explored how and why the centers have engaged in fragmented planning, even though the legislation had called for a comprehensive approach. The remainder of the chapter shall deal with some of the ramifications of this type of planning. The most noticeable results of the process are due to two features of disjointed incrementalism discussed by Braybrooke and Lindblom: the tendency to move away from certain ills rather than toward positive goals, and the relationship between means and ends.31

Since incrementalism encourages movement away from certain ills or situations, rather than movement toward goals, the mental health professionals' aim is to attend to mental illness, without defining mental health. The result is that while some attention is paid to preventive work, the staff members are more concerned with treatment. This aspect of incrementalism tends to have a conservative influence on the mix of services being offered. While incremental expansion has led to considerable consultation with other agencies,

31 Braybrooke and Lindblom, pp. 94-102.
there is little direct community action work in either center. (Of course, this is also in part attributable to the regulations, as described in Chapter 2). The kind of social action work we are referring to here is directed toward institutional change in the community. Levinson points out that it is a controversial component in the mental health field because it is not clinical in the usual sense and the primary aim of social action is preventive:

"It attempts to modify the features of the social, economic, and institutional environment that are inimical to mental health -- that breed alienating apathy, regressions, and powerlessness of the individual to affect his own destiny. The mental health worker (in this role) functions as a social change agent, facilitating the efforts of community groups to define their own problems and goals and to work more effectively toward improving their lot." 32

We shall see later that there have been isolated examples of such actions in both centers (notably the drug program in Lowell and the effort to organize mothers to provide their own nursery program in S-C). However, in the overall picture it appears that incrementalist planning counteracts such innovative, action-approaches and tends to lead to emphasis on more traditional treatment programs.

There is another reason for this tendency toward traditional forms of action which is related to incrementalist planning: the policy objectives become established in large part from an inspection of the available means. This relates to the centers both in terms of the services they choose to

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offer and the patients they choose to treat. Clearly, professionals already involved in running traditional programs may not feel they are the appropriate ones to handle certain problems, particularly those caused by environmental stress such as poverty. Ryan suggests that upgrading services and personnel in welfare departments, for example, might be more valuable for some clients than increased intervention by mental health professionals.\(^{33}\) In this way, problems are often defined according to the means or resources available, i.e., the competence and interests of the professional staff.

The former case is addressed by Lindemann in his observation that professional agencies prefer for treatment those patients for whom it seems to represent the highest level in diagnosis and treatment, and for whom the prospects for therapeutic success are greatest.\(^{34}\) Indeed some of the most severely disturbed patients, in both areas, rather than being seen at the mental health centers, are still referred to the state hospitals. Secondly, in addition to feelings of competence, the interests of the staff frequently influence treatment patterns in the two centers. At the S-C preschool unit, for example, four children are currently in individual therapy because four trainees at CGC needed cases.\(^{35}\) Similarly, in Lowell staff members have been able to set up therapy

\(^{33}\)Ryan, p. 54.

\(^{34}\)Erich Lindemann, "Introduction," Distress in the City.

\(^{35}\)Interview with Miriam Lasher, Administrative Director and Supervisor in Education, Preschool Unit, Somerville-Cambridge Mental Health Center, January 12, 1971.
groups whenever they wish, according to their own interests. This lack of rational planning became evident and worrisome, however, when no patients showed up for some of the groups.36

Another aspect of how the available resources determines objectives is the situation discussed earlier, when new funding for a specific type of program becomes available. This same situation has arisen with regard to the use of volunteers in the Lowell program. No policy decision was made to have volunteers alone work with most of the children; when the means presented itself (the students volunteered to work with children), the services were expanded.37 In such situations, there is no attempt at rational decision-making, alternatives cannot be weighed, and the disjointed incrementalist process of planning may result in less than the optimal allocation of resources.

Summary

To summarize, we have seen that the federal and state legislation require comprehensive planning, both initially for establishing a community mental health center and continually as the center revises its programs and priorities. There have been many factors, however, that have caused the centers to shift toward incremental planning, including the fact that by engaging in a truly comprehensive process, the

36 Interview with Yasin Balbaky, Director of Outpatient Service, Solomon Center, February 23, 1971.
planners might not ever be able to reach any decisions. More specifically, the uncertainties involved in defining mental health, mental illness, and mental health programs; the multiple objectives arising out of group planning efforts with no clear priorities; the political constraints, particularly specific sources of funding; the autonomy and poor coordination in a decentralized program; the lack of evaluation carried out by the centers' and lack of action on the area boards in terms of actual planning have all been factors encouraging the centers to move away from comprehensive planning. The primary results of the more incremental planning carried out is that it encourages programs concerned with treating mental illness, rather than more preventive measures promoting mental health, and that the goals are often defined according to the means (financing and staff capabilities and interests) available. The results of the latter aspect are therefore twofold: (1) both centers are likely to undertake traditional programs for treating mental illness, since the staff generally were trained for such approaches, rather than for more preventive action programs; and (2) to the extent that there are discernable differences in staff interests between the two centers, this will lead to differences in their programs. This second result shall be explored more in the chapter on the role of ideology in the centers. The first result tends to reinforce the similarity that we expect at the two centers, as a result of the regulations and the common characteristics the areas share.
Chapter 5

ORGANIZATIONAL STRUCTURE

While the three preceding chapters have explored forces that tend to make the centers similar in their programs, this chapter and the following one shall examine factors that lead to differences between the two centers. This chapter, in analyzing the impacts of a centralized and a decentralized structure, shall focus on the effects on (1) coordination and continuity of care, (2) innovation, (3) program mix, and staffing patterns.

As we pointed out in the Introduction, our case studies are not pure models of centralization and decentralization; however, the Solomon Center is clearly more centralized, and the S-C center more decentralized than the norm, so they shall be used to represent such models. In addition, we must recognize that there are some functions, e.g., inpatient treatment and specialized services for alcoholics or the retarded, which are most efficiently run in one location. This argument applies when large overhead costs or a very small clientele with the specialized problem result in economies of scale. Thus, such units are too specialized and costly to be duplicated at lower levels of the organization, and we find that they are centralized in both centers that we

1 Discussion with members of the regional office support this view -- Interview with Natalie Riffen, Coordinator of Program Planning and Arnold Abrams, Mental Health Administrator, Region III, November 17, 1970. Certainly, at a minimum it can be said that the Solomon Center is more centralized than the S-C center.
Coordination and Continuity of Care

Coordination and continuity of care (which depends largely on coordination) are related to the autonomy of individual units within the overall program. Because of the proximity of staff members and increased administrative control, the centralized center finds it easier to have a better flow of communication, which leads to better coordination and continuity of care.

The organizational structure of any group includes the specification of a formal system of communication, including channels for oral and written communication, paper-flow, records, reports, and manuals. In addition, this is supplemented by a network of informal communications based upon the social relationships that develop in the organization. The types of communication can be classified into two broad groups, those that are initiated by individual staff members such as letters, memoranda, or phone calls, and those that they are required to file with particular information, such as records and reports.

It appears that communications, both initiated by individual staff members and "required from above", are easier to achieve in the centralized center. In the centralized Solomon Center the staff members, located in a single building, have more contact with each other than in the dispersed S-C Center; and in addition, it is also easier to have a more complete formal set of communications channels in the cent-
ralized center. Again the reason that it is easier to have a formal reporting system in Lowell is that the various units have less autonomy than in the S-C program. This means that staff members consider their primary responsibility to the overall center and are used to having demands placed upon them from the center's administration.

There is no doubt that the staff members and units experience greater autonomy and authority in the S-C program than in Lowell. At the Solomon Center, for example, a staff member must get the personal permission of the business manager to make xerox copies of any material. In the S-C program, on the other hand, staff members often go out and purchase materials they need and submit vouchers for reimbursement, rather than ordering all materials centrally. Clearly, even if it were desired, due to their dispersion, the S-C program could not have one person granting permission to make copies of documents.

The autonomy resulting from decentralization is also evidenced by the fact that each unit in the S-C system sets its fees for service independently. For a family of two adults and three children, the fees charged, on the basis of selected income levels, are shown in Table 5. It is interesting to note how much variation there is between the three outpatient facilities, and the disparities in the fees are an indication of the degree of autonomy in the S-C decentralized system.

While the inpatient, outpatient, and day care units op-
erate somewhat autonomously in Lowell, they are not nearly as independent as the components of the S-C program in different locations. Achieving coordination in the S-C decentralized system requires more effort since each program is separate and enjoys so much autonomy. The coordination that does take place happens more through the good will of staff members involved than through any formal channels. Since communication and coordination are often lacking in the S-C programs, duplication and overlapping services result in some situations. For example, while the organizational chart indicates that children in Cambridge are seen at CGC and adults at Cambridge Hospital, adults are seen at CGC if their children are seen there first, and children are treated at the hospital if their parents are seen there first. While there may be some advantages to having children's services in both these locations, they have not been defined and coordinated as such. Thus, one result of the lack of coordination caused by the autonomy of the various units in the S-C system is some duplication of effort.

The second reason that coordination is important is that it helps assure continuity of care for patients. We recall from the federal guidelines that two of the criteria to help assure continuity of care relate to the transfer of clinical information about a patient between the various elements in his treatment and that when possible those responsible for a patient's care will continue to care for the patient within other elements. The first criteria seems to be easier for
Table 5

FEES FOR MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Solomon Center</th>
<th>Cambridge Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$40/day</td>
<td>$75-80/day</td>
</tr>
<tr>
<td>Day Care</td>
<td>$21/day</td>
<td>$12/half-day</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$8/visit</td>
<td>see below</td>
</tr>
</tbody>
</table>

Outpatient Weekly Fees for
Family of 2 Adults and 3 Children

<table>
<thead>
<tr>
<th>Gross Family Income</th>
<th>Gross Weekly Income</th>
<th>Net* Weekly Income</th>
<th>Weekly Family Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cambridge</td>
</tr>
<tr>
<td>$4,000</td>
<td>$77.</td>
<td>$73.</td>
<td>.25 1.50 2.00</td>
</tr>
<tr>
<td>$6,000</td>
<td>$115.</td>
<td>$102.</td>
<td>1.75 3.50 5.00</td>
</tr>
<tr>
<td>$10,000</td>
<td>$192.</td>
<td>$163.</td>
<td>6.00 8.50 14.00</td>
</tr>
<tr>
<td>$12,000</td>
<td>$230.</td>
<td>$193.</td>
<td>12.00 11.50 18.00</td>
</tr>
</tbody>
</table>

*Based on tax rates from 1970 Federal Income Tax, Massachusetts Income Tax, and 5% Social Security payments on income up to $7,800.
the centralized facility to fulfill, since the record-keeping and communications among staff members are better handled in one location. Lowell's advantage over S-C is that the staff members tend to have better communication, and it is easier for them to transfer records since they all remain within the central facility. This is in contrast to the situation of a Somerville resident, who must shift from SGC to Cambridge Hospital if he is shifted from outpatient to inpatient status. In addition to the shift in locations, this patient will also have a shift in staff members treating him, even though his records will usually be transferred to the hospital. In addition, to meet the second criteria, the Lowell center is currently instituting the use of treatment coordinators, who will follow patients throughout their treatment regardless of whether they switch from one unit to another. This would be extremely difficult to adopt in S-C, where the various units are located in different parts of the two towns.

Without having coordinators responsible for a patient's overall treatment program, conflicts tend to arise. An example of such problems in continuity of care has arisen in the situation in which staff members have responsibility without authority -- for instance, when a staff member from SGC wants to transfer a patient to the Cambridge Hospital for inpatient care. A staff member of SGC relates some of the problems in such a process as follows: "On several occasions when we have referred SGC outpatients to Cambridge Hospital for in-
patient treatment, hospital staff have refused them admission. This clash between two professionals is extremely disheartening to the confused patient, who no longer knows whom to believe. The reverberations from these types of confrontations often last for a long time." While many issues may be embedded in such conflicts, having a single coordinator responsible for a particular patient's treatment would probably help resolve them in a more agreeable fashion. For the patients it is probably easier also to shift treatments when they are all located within a central facility. The patients know where to call and seek new services. In addition the patient does not have to adjust to new people and resources in different locations. Thus, from all aspects which we have examined. It appears that centralization and less autonomous units helps assure coordination and continuity of care.

Innovation

On the other side of the coin from coordination and continuity of care, we find innovation which appears to be encouraged by decentralization. The argument has been advanced as follows:

"Decentralization has been viewed as giving autonomy to the unit level through which organizational goals can be operationalized, permitting problem solving through prompter and more knowledgeable action; allowing greater organizational flexibility in transactions with the environment; requiring less complicated and precise systems of organizational coordination. . ." 3

2 Interview with Sanford Autor, Chief of Psychology and Associate Director, Somerville Guidance Center, January 18, 1971.

At the local level, then, more appropriate and more prompt solutions should be available for problems that arise. This delegation of authority would seem likely to encourage experimentation, innovation, and greater flexibility. In arguing for decentralization, Schulberg and Baker also write, "Less stultifying and more creative roles can be developed when the degree of responsibility is commensurate with actual functions."\(^4\) According to this argument then, the decentralized system, which allows the staff a broader spectrum for legitimate functioning, should give rise to more innovative services.

Indeed the degree of freedom in the decentralized S-C system does seem to lead to more possibilities for creative innovation or more appropriate solutions to problems. An example of such a situation arose when a number of mothers from a high-rise apartment complex brought their children to the S-C preschool unit (for disturbed and retarded children) within a relatively short span of time. Diagnostic work, however, indicated no abnormal problems. Rather than merely informing the mothers that their children were not eligible for the nursery program, the clinical director of the preschool unit decided to pursue the problem. Other staff members who had made home visits to families in those buildings knew that the children had no place to play and no organized activities. Concomitantly, the clinical director of the program and dir-

\(^4\)Ibid., p. 216.
ector of CGC decided to try to obtain some commitment from the developer of the project and also to hire two part-time special services assistants to work with the mothers. These two workers, hired for a limited period of time by the preschool unit were able to interest the mothers in the buildings in organizing play groups and nursery classes. The developer provided a room in each building for such activities, some of the necessary materials, and undeveloped playground space. There are currently different play groups for different age children meeting on regular schedules with different mothers in charge. As of May 1, 1971, the part-time workers from the preschool unit were transferred from their payroll, and the developer has agreed to pay their salaries through the summer. At the end of that period, their assistance will probably not be needed to sustain this program, and the developer is planning to hire a full-time person to organize recreation programs for children of all ages in the buildings.\footnote{Interview with Miriam Lasher.}

This example seems to support the hypothesis of Schulberg and Baker that staff members develop more innovative roles when the responsibility is shifted to the individual units. It is far more unlikely that such a solution would have arisen in the Lowell center and certainly not without a great deal more time and effort devoted into getting the proper sanctions. When it requires permission to make a xerox copy of a document, certainly more extensive procedures are followed for involving the center in a new problem area.
Generally, staff members write memoranda to communicate their ideas with others in the Lowell Center which is considerably more time-consuming in carrying on a dialogue concerning a suggested new program. (When requesting permission to do this study, I only phoned and had an interview in Cambridge, whereas in Lowell I had to also submit a written outline of my prospectus. Later when I called to make an appointment to see the Superintendent in Lowell, after he had approved my project, I was informed that I had to write a letter to secure an appointment). While more formal channels of communication may aid in coordination, as we suggested earlier, it appears here that it may tend to stultify the adoption of innovative programs. In this regard, it is interesting that one of the most innovative programs in the Lowell area is the drug program. It was established with a great deal of autonomy from the rest of the center staff since it receives separate funding directly from the state. Because the drug program was set up in a decentralized fashion -- including use of three hospitals, a halfway house, a drop-in center, and free school, as well as the mental health center -- the program is far more flexible than one restricted to the center. Thus, in both centers it appears that the most innovative programs are those enjoying the most autonomy, and this is the typical situation more often in the decentralized program than in the centralized one.

Service and Staff Mix

The differences in structure also seem to account for
some differences in the service mix and pattern of staffing in the two centers. First of all, the structure seems to have some impact on the degree to which the centers work with groups and agencies in their communities. It is indeed easier for districted teams to have effective relations with the schools and agencies in their restricted area, than for a centralized center to deal with all such groups within its total area. This is consistent with the ideas put forth by Schulberg and Baker on a decentralized system: staff members can identify with their community more easily, understand its culture and unique problems, and participate with local agencies in the planning and operation of necessary programs. Thus, it is not surprising that the S-C program engages in more consultation with agencies in its communities than the Lowell center does.

While the Solomon Center does have some people working out in the community, in housing projects, for example, and does sponsor meetings for various agencies in the area, not as much energy can be devoted to such activities as in the decentralized center. All mental health professionals may feel some conflict between attending to treatment in the center and doing consultative work out in the community. This conflict is more acute, however, for those in a centralized facility like the Solomon Center, where the needs and demands of the inpatients are obvious to staff. It seems, therefore,

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6 Schulberg and Baker, p. 218.
that having inpatients in the same building with all the staff members is an important factor, particularly when they are free to walk into staff members offices and demand attention, as they do in Lowell. In the decentralized S-C center, on the other hand, most of the staff members never see the inpatients and hence do not feel the same conflict between inpatient and other services.

In addition, by having other groups providing facilities in S-C (e.g., the Mental Health Associations provide the space for the guidance centers, and the City of Cambridge runs the psychiatric department at the hospital), the budget of the mental health center is able to cover more programs. This factor also affects the personnel requirements, as displayed in Table 6. As Lowell operates its own inpatient facility, it requires considerably more hospital-type personnel, as well as people to maintain the buildings and grounds. Since it is an inpatient facility, staff members are required around-the-clock, and this is reflected in the particularly high number of nurses required. The S-C mental health center staffing does not include a number of the people associated with inpatient care, so their staff is weighted more heavily with psychiatrists, social workers, and teachers. In addition, S-C has a large number of speical ser-

7 Interview with J. Sanbourne Bockoven.

8 Caution should be used in interpreting the figures on the chart for two reasons: 1) the positions are not all full-time, so the numbers are not necessarily commensurate, and 2) some of the differences are due to different accounting procedures, particularly for staff who contribute to the mental health program at Cambridge Hospital, but are paid by the hospital.
vices assistants, which includes a wide range of para-professionals, community aides, research assistants, teacher aides, and many others. It appears then that the centralized system supports increased attention to inpatients, at the expense of outpatients and consultation services, which are more heavily emphasized in the decentralized system. Staffing patterns, furthermore, reflect the differences which result in the service mix. In the S-C program, we also noted that it is easier for a decentralized program to utilize resources, particularly space, (such as the facility, owned by the Somerville Mental Health Association, which houses SGC) which are available to it, than for a centralized program.

Summary

This chapter has been concerned with the impact of the centers' organizational structure on coordination and continuity of care; innovation; and program mix and staffing patterns. For each category, we identified the following results. Coordination and continuity of care is more easily achieved in a centralized facility, since such a structure enhances communication, while the autonomy of the various units in a decentralized system tends to impede coordination. In addition to making it more difficult to assure continuity of care, the lack of coordination evidenced in the decentralized system, also leads to some instances of overlap and inefficiency in the overall delivery system.

While autonomy at the unit level is dysfunctional in the quest for coordination and continuity of care, it encour-
Table 6
Distribution of Personnel by Occupational Group

<table>
<thead>
<tr>
<th>Occupational Group</th>
<th>Lowell</th>
<th>Somerville-Cambridge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>22</td>
<td>12</td>
</tr>
<tr>
<td>Hospital Supervisor</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Charge attendant</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Lab technician</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Licensed Practical Nurse</td>
<td>16</td>
<td>-</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Professionals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Psychologist</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Social Workers</td>
<td>24</td>
<td>32</td>
</tr>
<tr>
<td>Teachers</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Recreational Therapists</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Rehabilitation Counselor</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Speech Therapist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Clerical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jr. Clerk Typist</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Principal Clerk</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sr. Clerk Typist</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Sr. Clerk Stenographer</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td><strong>Buildings and Grounds</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carpenter &amp; Electrician</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Cook</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Groundkeeper &amp; Engineer</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Domestic</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>Driver</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Store Keeper</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Telephone Operator</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Protection</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Associate Area Director</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Business Manager</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Administrative Assistant</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Sr. Bookkeeper</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Special Service Assistants</strong></td>
<td>-</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>134</td>
<td>136</td>
</tr>
</tbody>
</table>
ages innovation. We saw that greater freedom at the local levels tends to make possible more prompt, more appropriate, and more innovative solutions to problems. Thus, to the extent that the units in the decentralized system are more autonomous, innovative programs are more likely to emerge than in a centralized system with tighter administrative controls.

Finally, the structures of the two centers also seem to influence their service mix and distribution of personnel. In the centralized facility, in which all staff members have contact with and feel the demands of inpatients, fewer resources are left for other types of programs. The decentralized system, in which most staff members do not feel these conflicts as acutely, also has the advantage of being able to set up consultation programs with agencies more easily since these are generally done on a more localized basis. This difference in service mix, is in turn reflected in the different staffing patterns of the two centers. These differences in service mix and staffing patterns shall be considered again in the next chapter in light of the differing ideologies in the two centers.
Chapter 6

IDEOLOGY

Organizational theory recognizes that complex organizations are the products of the interaction of cultural and value systems, as well as of technological and structural systems. Perrow asserts that organizations are established on the basis of some cultural values and belief systems which determine, within broad limits, what their goals should be. He states that the "influence of cultural definitions on belief systems is particularly apparent in organizations which seek to change people, since the basic material is already in society, and thus encrusted with cultural definitions regarding its nature which predate the change problem."¹ Clearly, the mental health centers fall into this category of organizations, and it is thus particularly important to determine just how the belief systems influence the functioning of the centers. It should be pointed out too that the values of an administrator are most important since he makes some of the broader and more important decisions regarding the context of the organization's work. To mention only one of these decisions, the higher administrator ordinarily has a considerable responsibility for budget decisions -- that is, decisions as to the directions in which the organization's efforts should be applied. Further, he often has the responsi-

sibility, within the limits of his discretion, of "formulating organization objectives -- that is, the values that will guide decisions at all lower levels of the organization." 2

Clearly, there are several types of values, e.g., clinical, organizational, administrative, which influence how a center operates. In this discussion, however, we shall be concerned only with how ideology and philosophy influence the mix of services. Within this context, the most basic role of ideology is in defining the limits of the mental health program. The extremely broad mandate of community mental health seems to encompass the whole universe of human problems:

"The intangibility, tentativeness and subjective nature of psychiatric judgments, are perhaps partially responsible for the tendency of the psychiatric profession to include all human mishaps and vicissitudes within its boundaries. The obligation to prevent mental illness is an added force which fosters extension of this tendency to the point of including all aspects of human behavior. After all, it does not require a great deal of imagination to identify a given bit of behavior as being either an early form of a psychiatric symptom or as injurious to someone else's future mental health -- especially if the someone else is a child." 3

Thus, the mental health center must define its missions, determine the relative weights of treatment and prevention, and establish program priorities (Of course, the federal and state regulations play a large role in the process, as indicated in Chapter 2). Of crucial importance as we shall see, is the role attributed to inpatient treatment in the overall


functioning of the mental health center.

By looking at the differing predominant ideologies in the two centers, therefore, we can account for some of the differences in the centers' program mix. Since the "doctrine" of each center is dependent upon the values of the key individuals involved in the design and operations of their programs, we shall concentrate on the ideologies of the directors.

The Lowell superintendent's personal ideology and background of work in state mental hospitals supports that center's priority for inpatients. From the start the Solomon Center began operations with the policy of giving priority to Worcester State Hospital patients from the Lowell catchment area. In fact, the inpatient service started with patients transferred from Worcester State, and the outpatient service started as an aftercare clinic for patients discharged from there. Despite the fact that there are far more demands for psychiatric service than the center can meet,

"... the center has, however, clung to its policy of giving priority to patients who would be committed to Worcester State Hospital or are former patients of Worcester State Hospital... It would thus appear that there is a lasting need for and a corresponding tendency for the Center to give priority to patients disabled by psychosis and to increase this tendency to a degree which precludes making comparable increases in services for non-psychotic conditions with present staffing. This is, of course, consistent with the original purpose of the Center; namely to provide an alternative to commitment to a State hospital." 4

Thus, it is not surprising that the Lowell center gives priority to the psychotic over the less severely disturbed when we consider the superintendent's concern with providing an alternative to the state hospitals.

The ideologies and backgrounds of the prime movers in the S-C programs are different from those of the Superintendent in Lowell, J. Sanbourne Bockoven, and this is consistent with the observation that the program priorities have developed differently in that center.

The three key leaders in the S-C program -- the Area Director who is also Director of CGC, the Director of SGC, and the Head of the Department of Psychiatry at Cambridge Hospital were all trained as child psychiatrists and analysts, whose experiences are primarily in child guidance centers rather than in state mental hospitals. While state hospital psychiatry has had very little to do with the outside community, child guidance centers have always been involved with the schools, courts, and welfare department. In addition, the guidance centers have always been supported by the local mental health associations, so that these leaders had considerable experience in dealing with community matters. Thus, it is not surprising that while inpatient services were considered essential, the S-C program did not give it the priority that Lowell did. Instead, comparatively more interest was devoted to many types of outpatient services, consultation, and services for children are particularly strong. In addition the values of the S-C leaders led them to place more
emphasis on special programs for emotionally disturbed and retarded youngsters. Both area boards have expressed great desire for increased retardation services; one reason that the S-C program has done more in this area is that the ideologies of the professionals involved has resulted in less emphasis on inpatient services, and a greater receptivity to expanding children's programs than is true in Lowell.

Another ideological difference between the two centers' leaders relates to the provision of mental health services by professional staff members versus setting up local self-help groups. Perhaps due to their backgrounds as analysts, the S-C directors seem to have much greater faith in the skills of mental health professionals than does the Lowell superintendent, and hence have been concerned with expanding the scope of the mental health program, rather than considering outside mechanisms for meeting people's needs.

The Lowell superintendent, on the other hand, has been more concerned with setting boundaries on the problems that mental health professionals should handle. He suggests that

"community mental health being in itself indefinable might profitably be equated with life betterment for everyone. It may be the better part of wisdom for our mental health program leaders to consider the probability that development of community concern for the individual citizen may be more to the point than development of mental health services as such. The art of mental health leadership may well be that art of sensing when timely withdrawal from the social scene is indicated." 5

Indeed this type of thinking is not unrelated to his views of the contribution of the mental health professionals. "There is much to suggest from the experience of Solomon Center that situational conditions may contribute more to a patient's capacity to recover than the advanced academic training his caregivers may have undergone." Since he sees informal personal attention and human concern being just as important, he believes that improving the quality of community life may be more important than expanding the mental health services. This can be accomplished through increased participant citizenship and community development.7

Bockoven argues that community psychiatry is not the sole source of respect for individuality and sensitivity to the individual's right to be a fully participant citizen. In fact he writes:

"Mental health is almost completely translatable as being a matter of citizen morale, and mental illness a matter of individuals who are demoralized by alienation from family and community. It is immediately self-evident that such vital and delicate matters as morale and demoralization which rest at the very focal point of human life and motivation are matters of far too great importance to be placed in the hands of science or medicine or psychiatry." 8

Mental health should not reside in the domain of science, he argues, and the public might be better able to acknowledge


7Bockoven, Psychiatry Digest, XXIX, pp. 52-53.

that mental health is in some sense a simple matter understandable to the public.\textsuperscript{9}

As evidence of how strongly Bockoven believes in a non-medical approach, he has predicted:

The need for direct psychiatric services on a large scale is likely to pass out of the picture, rather rapidly as soon as the socio-political leadership of the community takes active measures to develop social sensitivity to individuality and social attitudes of respect for individuality at the same time that it undertakes programs to extend community services to appropriate levels of quality and quantity.\textsuperscript{10}

In order to help the communities provide such programs, the Solomon Center is now trying to help provide "settings in which citizens and citizen groups can learn helpful attitudes and help one another. . . multi-purpose activity centers for all age groups, and for all conditions of ability and disability. These Centers, to be effective, should be operated by citizens fully representative of all the people of the community -- rather than by professional people."\textsuperscript{11}

The mental health center is currently seeking the funding necessary to set up such self-help centers, in each of the nine towns in the Lowell catchment area. While these centers would be operated by private citizens, the mental health center would provide professional backup services, "A major

\begin{flushleft}
\footnotesize
\textsuperscript{9}Ibid., p. 35.
\textsuperscript{10}Psychiatry Digest, XXIX, p. 60.
\end{flushleft}
consideration underlying this approach is the belief that much can be provided in the way of psychological first aid by citizen groups who seek to familiarize themselves with ways of being helpful in the emotional crisis of fellow citizens."

The organization of such self-help groups would be a radically new development in the Lowell area and would be the first step in Dr. Bockoven's ideological plan. In the long run, he suggests far more investment in appropriately coordinated educational, occupational, recreational, and psychological services, as well as welfare and family service agencies,

"... would be more effective as well as more economical as a first line of recourse immediately available to citizens who have suffered setbacks of whatever kind. The very existence of such recourse would in itself lead to considerable reduction in the number of problem-people presently thought of as requiring the psychiatric services of mental health centers. The mental health center would accordingly receive as patients only those individuals who had not responded to the community's efforts and who are incapacitated by a degree of psychopathology actually requiring study by psychiatric specialists." 13

Through this lengthy review of one director's ideology, we have seen how greatly his personal beliefs and values influence the goals and organization of the center. He believes strongly that only the incapacitated truly require the services of mental health professionals. Therefore the most acutely and chronically ill receive priority attention


13 Bockoven, Psychiatry Digest, XXIX, p. 60.
in the center presently; at the same time he is working to set up community self-help programs to handle some of the less severe problems. In the long run then the state of mental health may be improved through such preventive community ventures, and the demands on the mental health center reduced.

While the ideology of the superintendent of the Lowell center has obviously had a significant impact on the center, it should be pointed out that in the S-C system, the values of one particular individual have not been quite so influential, and this is probably due to its structure, whereby the units are more autonomous in their functioning. Nonetheless, the concern for outpatient services, particularly to meet the needs of children, as well as increased consultation in the community, does pervade the S-C center.

Clearly, this difference in emphasis between the two centers is reflected in their staffing patterns as well. The Lowell center is weighted heavily with nurses, which is consistent with the large amount of attention devoted to inpatients. It is interesting to note that there is not a correspondingly large number of psychiatrists there in comparison with S-C. Again however, this is explained by the superintendent's philosophy -- that affectionate care and respect by staff members for the mentally ill are as important as any psychiatric treatment. On the other hand, the S-C staff has a much smaller number of nurses, reflecting the smaller emphasis devoted to inpatients. Moreover, the number
of social workers, teachers, and psychiatrists is much greater than in the Solomon Center, reflecting the greater attention devoted to outpatient programs and school programs for emotionally disturbed and retarded children. The greater use of psychiatrists, in outpatient programs as well as inpatient programs, is consistent with the ideologies of the S-C leaders, who appear to have a greater faith in psychiatry than does the Lowell superintendent. Finally, this last issue is also reflected in the use of special service assistants; in the S-C program they are used primarily to help professionals in carrying out their programs (as teacher aides, research assistants, community outreach workers for hospital-based alcoholism program, etc.). This is in contrast to the plans in Lowell to hire special services assistants to have the primary responsibility for running the nine local self-help centers. Again this seems to reflect the differences in the administrators' views of the functions to be done by mental health professionals and those to be left to others.

In this chapter we have examined how ideology has influenced the service and personnel mix in the centers. It should be emphasized here that ideology may have even more important ramifications in terms of clinical practices and dynamics of treatment employed by the centers, the styles of administration adopted by the directors, and the composition and roles assumed by the area boards; we have chosen to limit our discussion here, however, to the impact of ideology on the service mix and staffing patterns in the two centers. We
have seen that the overriding concern of the Solomon Center with inpatients is consistent with the superintendent's mental hospital background and ideology relating to the lines of distinction between community psychiatry and active citizen participation in community affairs. As a result of this ideology, the Lowell center is attempting to establish self-help centers in each of the towns in the area. These centers would handle the less severe problems, so that the Mental Health Center would be able to concentrate on the more severely ill patients. The background and ideologies of the S-C leaders have supported greater attention to consultation, services for outpatients, children, and the retarded, although the influence of ideology is somewhat less concentrated in the decentralized system. The chapter demonstrated too how the differences in ideologies have ramifications in staffing patterns, since these reflect the different emphases attributed to various types of programs, as well as views on roles for mental health professionals and nonprofessionals.
Chapter 7

SUMMARY AND CONCLUSIONS

This chapter is intended to review the material presented in the previous chapters and draw together the conclusions about the similarities and differences in the two centers -- in terms of service mix, staffing patterns, coordination and continuity of care, and innovation. In the previous chapters we have explored five determinants in community mental health center programs: regulations, needs of the particular areas, planning processes, structures of the centers, and ideology. In the first part of this chapter, we shall summarize the impact of each of these five explanatory variables. Then we shall draw conclusions concerning the four dimensions of the center's programs (service mix, personnel mix, coordination/continuity of care, and innovation) on the basis of our investigations into the five determining factors. In that section we shall see how the various determinants interact to produce the types of programs that we witness in the two centers.

Summary of Explanatory Variables

1. Regulations

The importance of the federal and state regulations emerges in a comparison with the literature on the community mental health movement. The literature, based on rather amorphous definitions of community mental health, is open-
ended in describing the approaches that centers might adopt. Considerable attention is devoted to preventive services in the literature. The federal regulations, however, emphasized concern for the mentally ill, who were not receiving optimum care in the state hospitals. Thus, the federal guidelines and the state legislation (which complied with and reinforced the federal regulations) enumerated five essential services, of which four were aimed directly at treating the mentally ill. Only the category of consultation and education contained much potential for preventive work in the communities. Inpatient care, partial hospitalization, and emergency coverage were clearly aimed at those already suffering from various forms of mental illness. Outpatient care too, while covering a broad range of clients, is still concerned primarily with treatment. Thus, concern with efforts to engage in community action work to alter some of the detrimental environments in which people live, suggested by the literature was largely ignored in the government regulations. By listing five essential services which the centers must provide before adding other types of programs, the government essentially laid out the broad priorities for the individual centers. Since the centers must comply with the regulations to receive federal and state funding, they clearly place the outlined priorities above those which their area's particular needs or resources might suggest.

2. Area's Needs

There are many problems in attempting to translate char-
acteristics of the areas into programmatic guidelines. When
the Massachusetts Mental Health Planning Project did its
two-year comprehensive study, its output was a rank-ordering
of the areas' overall needs, but did not address the question
of how different problems in the various areas should be
reflected in the programs of their centers. Within this
narrow definition of their task, however, there are still
many problems in interpreting the results. For example, the
most important index used was the rate of first admissions
to mental hospitals in each area. They used a higher admis-
sion rate as indicating a higher need for services in the
area. There are problems however in defining need in terms
of admissions: the more services offered and utilized, the
greater the need reflected by such a definition! In fact,
low rates of admission to state hospitals might indicate a
greater need for resources in the community; the low utiliz-
ation rates may reflect the lack of resources to adequately
serve the area. Given this alternate interpretation, one
is not surprised to see that Lowell, which had lower admis-
sion rates to mental hospitals than S-C, has devoted more
of its attention to inpatient care than S-C. Since Lowell
has a higher rate and number of retarded children, we might
expect it to be stronger in such services. Both areas have
severe problems of alcoholism and drug addiction (although
they are somewhat more serious in S-C), therefore we would
expect them to provide such programs.

Socioeconomic and demographic characteristics are even
more difficult to translate into programmatic terms. To the extent, however, that the two areas in question suffer from similar problems of deteriorating industrial areas -- very high unemployment rates, low incomes, low levels of education, and severe social problems -- it is likely that the centers would adopt similar approaches to the problems. Thus, we expect the differing structures and ideologies in the two centers to take precedence over any differences that might be suggested by differences in the characteristics of the areas.

3. Planning Processes

The tendency for the centers to engage in traditional treatment programs, as a result of the regulations discussed earlier, is reinforced by the type of planning process employed. We noted that while the federal and state legislation both require comprehensive planning, other factors have caused the centers to shift toward incremental planning, including the fact that nothing might ever have been accomplished if the planners had waited until they had completed a truly comprehensive planning process. In addition, the uncertainties involved in defining mental health and appropriate programs, the political constraints, the conflicting priorities arising out of a group process, and the lack of evaluation which is essential for an ongoing comprehensive planning process have all encouraged disjointed incrementalist planning.
The primary results identified with incremental planning are that it encourages more traditional programs concerned with treating mental illness, rather than more preventive measures promoting mental health, and that the goals are often defined according to the means (staff capabilities and interests) for solving the problems. As long as staff members have had traditional training and experiences, therefore, they will probably be less inclined to engage in radically new types of activities. Thus, the planning process adopted by necessity in both centers, tends to have a conservative influence on both centers and thereby undermines, along with the government regulations, some of the potential for innovation suggested in the literature.

4. Structure of the Centers

It appears that neither the centralized nor decentralized structure is inherently superior and that there are gains and losses associated with either form. Thus, it is not surprising that both centers have chosen mixed forms; and with the realization of the problems with their individual structures, both are seeking organizational changes: the S-C program seems to be moving more toward centralization (at least for administration), and the Lowell center is working to set up satellite centers dispersed throughout the towns in the area. It is significant that the main change desired in the S-C center is the addition of a centralized building, and that many of the Lowell staff members would consider themselves better off without the building. This seeming paradox is easily explained
by our findings: coordination and continuity of care are more easily attained in a centralized structure, where the increased communication facilitates coordination. Innovation, on the other hand, is encouraged in the decentralized structure, where the autonomy of individual units -- the very factor which impedes coordination -- makes possible more appropriate and innovative programs.

Structure also appears to affect the service and personal mix of the centers. The decentralized center is more likely to be able to have ongoing consultive relations with more community agencies and groups through its separate units serving distinct geographic areas. The centralized center, on the other hand, tends to be limited to some extent in the scope of its programs by the demands of inpatients, which are very keenly felt when all staff members share the responsibility for the inpatients. This difference in program emphasis is reflected in the staffing patterns: the centralized facility has more hospital-type personnel, while the decentralized center has more social service staff members who are primarily concerned with outpatient and consultation programs.

5. Ideology in the Centers

First of all, we noted that the centralized structure renders the personal philosophy of the director more influential than in the relatively autonomous units of the decentralized structure. In both cases, however, the prominent ideologies do have an impact on the service and personnel mix. The overriding concern of the Solomon Center with in-
patients is consistent with the superintendent's background and concern with mental hospitals. In addition, the move to set up self-help centers in that area, in order to allow the mental health center to focus its resources on the most severely ill is consistent with his ideology relating to the lines of distinction between community psychiatry and active citizen participation in community affairs.

The backgrounds and ideologies of the three S-C leaders, all of whom are child psychiatrists and analysts, have supported greater attention to outpatient programs, particularly for children and the retarded, and to consultation programs. Also, having more faith in psychiatric processes, these doctors have tended to use para-professionals in ancillary roles rather than in situations of prime control, as is planned in the Lowell self-help centers. Finally, the staffing priorities in the two centers also reflect the different emphases given to the various types of programs.

Conclusions

Having summarized the major influences of each of the explanatory variables, we shall now reevaluate them in terms of the four resultant variables: service mix, personnel mix, coordination and continuity of care, and innovation. In this section, therefore, we shall attempt to understand how the five explanatory variables interact to produce the observed outcomes of the dependent variables in the two centers.

1. Service Mix

The two centers engage in the same activities, although
with differing emphases. The fact that they engage in the same roster of programs is striking when viewed within the context of the community mental health literature, which suggested many different models for mental health center programs. The provision of the same services, however, is explained by the government regulations, the incremental planning utilized, and the similarity of the two areas served. Both centers expend most of their resources providing inpatient, outpatient, partial hospitalization, emergency, and consultation and education services -- the five "essential" services outlined in the federal and state regulations. The incrementalist planning serves to reinforce the traditional types of service and emphasis given to treatment, rather than prevention (only one of the five essentials is preventive in nature). The similarities of the two areas served also makes it understandable that they would engage in much the same activities. Finally, another ramification of incrementalist planning is that the centers respond to resources as they become available to them; therefore, they have both instituted alcoholism and drug addiction programs since special funds have been made available for these purposes.

The differences in relative emphasis given to programs in the two centers is explained largely by their differing structures and ideologies. The fact that Lowell has a larger inpatient facility is consistent with the superintendent's ideology. The structure of that center, however, in which all staff members see inpatients, results in more widespread
concern among all the personnel for the inpatients, and thus less attention is devoted to other services. Similarly, the greater attention devoted to outpatient, consultation, and children's programs at S-C is supported by the philosophies of that center's leaders. In addition, in the decentralized structure, most staff members feel no conflicting demands from the hospitalized patients. Their dispersion throughout the communities also makes it easier for them to carry out extensive consultation and education programs throughout their localized areas. In this way, the differences in service mix in the two centers seem to be related to their differing structures and dominant ideologies; the differences, however, are small compared to the radically different centers that might have emerged without the homogenizing influence of the legislation and guidelines and planning.

2. Personnel Mix

The differences in staffing patterns primarily reflect the differences in service mix, which, of course, in turn reflect the differences in structure and ideology. Due to the increased attention devoted to inpatient and day patients, the Lowell staff is much more heavily weighted with nurses, and various types of hospital-support staff, including buildings and grounds personnel, as well as occupational and recreational therapists.\(^1\) The S-C staff is much more heavily

\(^1\)Part of this difference is attributable to differences in accounting procedures; some staff members at Cambridge Hospital who support the psychiatric department do not appear on the S-C budget, since they are paid by the hospital. Of course, this arrangement does leave the mental health center free to use its resources in other positions.
weighted with psychiatrists, social workers, and teachers, the bulk of whom work in various outpatient programs. The larger number of teachers there reflects the greater emphasis given to programs for retarded and disturbed children. The greater use of psychiatrists reflects the belief systems of the S-C administrators, in contrast to that of the Lowell superintendent. The use of special services assistants in S-C also reflects their increased attention to outpatient and community work, since these assistants are not generally employed in the inpatient service. Finally, it should be noted that while personnel are largely recruited to fit the services being provided, to some extent the services (and particularly any change in the service mix) reflect the interests and capabilities of the staff members. Thus, as a result of the centers incrementalist planning, many decisions affecting service mix are a result of the resources at hand for solving the problem. Thus there is a two-way relationship between service mix and staffing patterns.

3. Coordination and Continuity of Care

The federal and state regulations emphasize coordination and continuity of care in mental health programs, and both centers strive to improve these aspects of their services. The centralized center, however, has a more amenable structure for enhancing them. The increased communication and easier transferral and standardization of records in Lowell helps them achieve better coordination and continuity of care, than S-C. In a further attempt to improve the continuity of
care, the Lowell center is currently instituting the use of a treatment coordinator to follow each patient throughout his care. This program for greater continuity could not even be instituted in S-C, where the structure has the various staff members scattered throughout the two cities. The greater autonomy delegated to the various S-C units also impedes some communication and makes it more difficult to transfer information about patients between the various services. From the patient's point of view it is also generally easier to continue care in the same familiar location. Thus, from all considerations, we see that the more centralized structure of the Lowell center aids coordination and continuity in comparison with the decentralized S-C center.

4. Innovation

Again structure and ideology account for the differences in degree of innovation between the two centers; but the legislation and planning efforts tend to minimize possibilities for innovation in both centers. The decentralized S-C center, by giving more autonomy to the individual units, allows for more innovative solutions to problems. The individual units thus enjoy greater organizational flexibility in transactions and need not be burdened with the more complicated and precise systems of organizational coordination required in the more centralized Lowell center. In addition, the amount of freedom granted to the various units, which largely determine the degree of innovation possible, is also a result of the ideologies of the individuals involved.
In both centers, however, the disjointed incrementalist planning employed tends to encourage traditional programs, which mitigates against innovation, although it enables the centers to more readily respond to newly available resources. This influence is further strengthened by the federal and state regulations. By enumerating the types of services that are both essential and desirable, they tend to minimize the search of the centers to create innovative types of services. Therefore, while the structures of the centers do make some difference in relative innovation, this is all within the bounds allowed by the planning and legislation.

A final word of caution must be made in interpreting the above conclusions. The comparison of two centers has provided insights which could not have been derived from a study of a single case. However, since the interpretations are based on only two cases, they can only tentatively test explanatory hypotheses about the influence of given aspects of the organizations. Differences other than those noted may have been responsible for some of the observed differences between the two centers. A comparison of many centers would be required to determine which of many possible institutional characteristics actually has brought about an observed result. This paper has focused only on the roles of structure, legislation, needs, planning, and ideology, and clearly, there are a number of other important organizational influences. In addition, the lines of causation cannot be definitively drawn in a study of this sort.
In spite of the limitations inherent in this type of study, it appears that organizational structure and ideology do have an impact on the different services offered by two community mental health centers. Other factors influencing the centers -- regulations, planning, and the areas' similar profiles -- however, tend to make such differences subordinate to forces rendering the centers more alike. Differences in emphases between the two centers emerged, but their programs are basically similar, considering the radical differences one might have anticipated from reading the literature on community mental health centers.
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