



AN EVALUATION OF THE PLANNING PROCESS FOR
COMMUNITY MENTAL HEALTH CENTERS

by

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Abstract

In a search for relevant issues of urban development, city planning has recently looked to the field of health. This thesis is an evaluation of the planning process of community mental health centers. It attempts to apply the techniques of city planning to a field that has just begun to plan consciously. The focus is on Boston State Hospital, a large mental institution in transition to a community mental health center. Staff meetings at the hospital illustrate the issues of hospital policy - the internal relationships and inter-hospital planning. In addition, the difficulties of the transition to planning both for and with the community are discussed. The major obstacle to planning lies in set ways of thinking about goals and roles among psychiatrists. Community mental health has not been fully adopted as a goal by Freudians; psychiatrists, protective of their status, tend to exclude others from the planning.

Planning at Boston State is compared to planning at several other centers in Massachusetts. Quincy and Concord illustrate the political facets; Boston University, the opportunities for community involvement in an urban setting; and an unnamed center's difficulties underline the conflicts and confusion typical of community mental health center planning.

Local planning is then considered from the perspective of outside interests - the private mental health association, the semi-private Medical Foundation and the state and federal governments. These do not provide significant external

guidance to substitute for the lack of internal guidance that now characterizes the planning. Much of the confusion occurs because planning is not thought of as the gathering of information. To provide a conceptual framework for planning, the thesis proposes a program of elements for mental health and health planning, modeled on city planning's Workable Program for Community Improvement. The program attempts to simulate, to some degree, the best current planning and add to it the previously neglected element of citizen participation. It proposes that through an understandable planning process, participation is possible despite the growth of professionalism and large institutions. The proposed program attempts to conceptualize a planning process that can be evaluated and controlled better than the present uncoordinated mass of health services.

Evaluating a planning process, rather than the product - health - city planners can introduce techniques to the medical field without severely threatening the doctor and his prerogative.

Thesis Supervisor: Bernard J. Frieden

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The personnel of an outside study group, the Program Research Unit of the Laboratory of Community Psychiatry of the Harvard Medical School, headed by H. Charles Schulberg, Ph.D., were also quite helpful. Financed by a National Institute of Mental Health grant to study the development and functioning of community mental health programs, this group is watching the transition of Boston State Hospital from a traditional large mental institution to a community mental health center. Their five-year study has only been in progress for a year and a half, so much of it is still in the conceptualization stage, but members of the staff were quite helpful with their observations: Dr. Frank Baber, Dr. John Hudson, Mrs. Greta Wheler as well as Dr. Schulberg.

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The material presented here is not confidential but it remains confidential in the sense that I may not specifically acknowledge in all cases who told me what. The case studies have been assembled by personal interview, discovering in some, verifying in others. I have tried to report the skein of issues and the manner of their entanglement in a format similar to that used by Edward Banfield in Political Influence and in his effort with Martin Meyerson, Politics Planning, and the Public Interest. I have also been influenced by Robert Dahl's Who Governs?. It is inevitable that a search for a planning process and an evaluation of its elements will find its model in political science writing. It has been said that "planning like any technique is politically neutral....(and that) it may be used by any form of politico-economic organization. When employed by totalitarian states it is dictatorial, militarist, authoritarian..."¹ Our society though is not shaped in such a simple mold.

¹ George B. Galloway, Plan Age, Jan. 1939, quoted in Charles M. Haar, Land-Use Planning, Little, Brown, and Co., Boston and Toronto, p. 717.

Planning in health and other services is intensely "political" in the pluralistic sense that Webster defines the word: "of or pertaining to the organization or action of individuals, parties, or interests that seek to control the appointment or action of those who manage the state."¹ The individuals are psychiatrists, social workers, nurses, and administrative personnel; the parties or interests are the various forms that the bundle of services takes shape as: the hospital, the social agency, the individual doctor; these interests are private, public, or sometimes a mixture of both; they are professional; they are sub-professional; the state is the mental health system and the number of managers to be influenced can make 1400 governments seem, by comparison, a very manageable figure. Order will come out of chaos only by understanding the conflicts.

¹ New Collegiate Dictionary, p. 654.

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INTRODUCTION

Relevance and Techniques

Any field, as it ages, is faced with the problem of remaining relevant, if it is to grow. City planning is no exception. Traditionally, the general advisors on urban development, city planners, concerned themselves with such issues as land use and the movement and growth of population. Today there is a nagging suspicion that this focus is not enough, that it is not at the heart of the real issues of urban development. One such issue is health, and this thesis is an attempt to use city planning knowledge in a study of health planning.¹

The context of the thesis is a Public Health Service grant received by Bernard Frieden of MIT and William Nash of Harvard, city planning professors, to study the contributions that health planning and city planning can make to each other. Nash, in a lecture, pointed out the "possible exchanges of information and services" that might occur between the two fields. He noted the following:

-The city planning agency could contribute population, housing, land use, community, and other data to the health planning agency.

-The health planning agency in turn could make available

¹This is an elaboration of a point made by Bernard Frieden.

to the city planning agency, employment data for traffic generation studies, environmental health standards, and information on birth and death rates for population computations, etc.

-On another level, the city planners could serve as consultants to a health institution or health service network. They could advise on planning procedure and goal formulation, on the designation of service areas as well as on such matters as the physical plant.

-Finally, in the field of research there could be a useful exchange between health and city planners. For example city planning needs a clearer picture of the implications of various development patterns on stress. Health research could be aided with data involving spatially distributive phenomena such as population, employment, land use, public activities and expenditures.¹

In the greater framework then, this paper is a city planning analysis of the planning of one set of health facilities, the community mental health centers, with emphasis on the planning of program more than the actual physical plant. It is hoped that a contribution will be made by this use of city planning techniques on the body of health planning, and that as a result the field of city planning, in the learning, will be infused with more relevance.

¹William Nash, lecture, February 9, 1967.

The political beginnings of the planning process under study here took root two decades ago. Two years after the 1946 National Mental Health Act, which provided for research, training, and service in mental health, the National Institute of Mental Health was set up to "guide the program."¹ The legislative progress took place alongside advances in psychiatry, the move away from the asylum toward community mental health. An indication of this was a 1953 World Health Organization report which was "the first major study concerning the need for increased emphasis on community treatment of the mentally ill....(which) reported that the program to provide more beds in mental hospitals was over-emphasized to the neglect of the development of services that would reduce the need for admission."²

The next step was political. Congress reacted in 1955. The Joint Commission on Mental Illness and Health was set up under the National Mental Health Study Act "to analyze and evaluate the needs and resources of the mentally ill in the United States and make recommendations for a national mental health program,"³ to study the "psych-

¹Schulberg, Herbert C., "State Planning for Community Mental Health Programs: Implication for Psychiatrists," CMHJ, Spring 1965, pp. 37-42.

²Becker, A., Murphy, N. and Greenblatt, M., "Recent Advances in Community Psychiatry", New Eng. J. Med., 621-626, 674-679, 1965.vii

³Joint Commission on Mental Illness and Health, Action for Mental Health, Basic Books, New York, 1964, vii.

iatric scene."¹ The Commission, representing thirty-six national agencies, primarily health ones, had its antecedent in a group formed earlier in 1955 by the American Psychiatric Association and the AMA.²

By 1960 the report was out: Action For Mental Health. Although it lucidly reported the past and present knowledge and preconceptions about mental health and described at length the present resources, the report did not recommend a way to achieve the new community mental health it espoused. The group confessed that "political or legislative action is not our function or forte. We are neither lobbyists nor lawmakers."³

The medical recommendations had to be translated into a legislative program. The Surgeon General's Ad Hoc Committee on Planning Mental Health Facilities laid the groundwork for this in 1961. This study group recommended statewide planning bodies that would determine need, evaluate legislation, make a priority system for the federal funds coming into the states, and consult with local groups about the centers.

¹ Becker, Murphy, Greenblatt, op. cit., p. 621.

² Action For Mental Health, op. cit., xxvii.

³ Ibid., p. 296.

These suggestions were backed in 1962 by a Govern-
or's Conference which also called for appropriations for
state plans. The conference, by the way, had its roots as
far back as a meeting in 1954.¹ The states, as well as
the federal government, were preparing the ground for com-
munity mental health.

Action in history must seem to come from above, so as
the HEW pamphlet The Community Mental Health Center put
it:

"Events began moving in 1963, when President
John F. Kennedy sent a message to Congress
calling for 'a bold new approach' to the
problems of mental illness".

His recommendations for construction, staffing, and planning
money were partially accepted by the Congress. The 1963
act, following the Surgeon General's recommendations, au-
thorized grants to the states for the writing of compre-
hensive mental health plans:

"The designated (state) agency must draw
up a state plan that will include inventories
of existing resources, estimates of need,
and the development of priority systems."²

Money was also given on a matching basis with a sli-
ding scale for the construction of new facilities, but no
money was authorized for staffing. It was not until 1965

¹Becker et al, p. 621

²Cain, Harry P. II, and Ozarin, Lucy D., "Hospitals and Com-
munity Mental Health Centers Program", Hospitals, vol. 38
Dec. 16, 1964, pp. 19-22.p.20.

that Congress amended the original act to pay also for the staffing of the facilities.

The political advance could not have taken place without a scientific advance. This was the development in the 1950's of the tranquilizer. A revolution in mental health care in the United States had its origins overseas. Smith, Kline, and French in 1952 "acquired patent rights to a phenathiazine" of a French company. This became the major tranquilizer, Thorazine.¹ "These drugs proved effective in the control of psychotic symptomology, accelerated the movement of mental hospitals from custodial to therapeutic institutions and made possible the treatment in the community of many seriously disturbed patients."²

The federal legislation and the scientific discoveries were an advance; now it was up to the states to change the system, and, like the Joint Commission's report, the medical recommendations had to be translated into political ones.

Along with the other states, Massachusetts received money for planning, and decided that instead of having the state's Department of Mental Health undertake the task, to assign it to an outside agency, the Medical Foundation, a

¹Jackson, Laura G., Hospital and Community: Studies in the External Relationships of the Administrator, MacMillan, N.Y., 1964. p.555.

²Becker et al, p. 621.

nonprofit research organization. The State Planning Project lasted from 1963 to 1965.

The federal law required that each center serve a "community" of from 75,000 to 200,000 population.¹ To meet this stipulation, Massachusetts was divided into thirty-seven mental health "catchment areas" by the criteria of present utilization, and accessibility. The task force method was used to study the needs and resources of the state in mental health. Fourteen groups were set up in the first year to study different areas: adult mentally ill, emotionally disturbed and psychotic children, mental retardation, alcoholism, drug addiction, adult crime and juvenile delinquency, epilepsy, the aging, manpower, research, training, communications and health education, government structure-legislation and financing, and occupational mental health. Later, with focus on impletation, four more were added. Their work was tied closely in with the community, and

¹ This requirement has been questioned by state planners. Schulberg asked, for instance, of the population areas:

"Has it been arrived at on the basis of national hospitalization rates for psychiatric disorder...on some conception of administrative efficiency in the management of the psychiatric needs of the population.... upon a sociological-political conception of the optimal size of a community with which a mental health program can work most effectively?"

Schulberg, H. C. and Wechsler, Henry, "The Use and Misuses of Data in Assessing Mental Health Needs", Jan. 1967 (paper was accepted for publication in CMHJ), p. 3.

public hearings were held throughout the state to supplement the quantitative socio-economic information with qualitative data. Community groups helped with self-studies. The planning group, in the two years, worked closely also with the Department of Mental Health, professional groups and the Legislative Recess Commission of Mental Health.¹

The plan attempted to show where each area stood in its ability to provide the ten services stipulated by the federal legislation: inpatient, outpatient, 24-hour emergency, partial hospitalization for day and night care, consultation and education with community agencies, diagnostic services, rehabilitation, pre- and after care, personnel training, research and program evaluation studies.

By 1965 the plan was complete. Needs and resources were assessed. Priorities were set, and it was time for the state to proceed beyond the stage of preliminary implementation. To do this a complete reorganization of the state agency that was to receive the federal funds, the Department of Mental Health was necessary. This was accomplished by law at the end of 1966.

The law was an attempt at decentralization of the administration of the Department and, following the recommen-

¹Massachusetts Mental Health Planning Project, Mental Health For Massachusetts.

dations of the Planning Project, participation by local people in area planning. Through the efforts of the Medical Foundation and its allies in the informal mental health system the law was passed over the opposition of the Department itself.

The philosophy behind the local area planning has its analogue in the poverty program. For citizen-establishment communication, a bridge group of people was needed. In each catchment area there will be something called an area board. By law these groups will be composed of twenty-one members, primarily from the voluntary mental health associations and the associations for retarded children plus at least one representative from each town. The boards have been given advisory duties. They are to serve as liason between the community and the staff and are supposed to advise on needs and resources as well as on the recruitment of personnel.¹ Although they were given the power to approve annual plans, they were not given control over the budget, due to the opposition of the Department of Mental Health and the Superintendents of the state hospitals.

The area director, an appointment of the Commissioner of Mental Health, will have the real power to determine a program for each catchment area. But hope still remains of

¹ACTS, Extra Session, 1966, Chapter 735, An Act Establishing a Comprehensive Program of Mental Health and Mental Retardation Services, Advance Copy, Commonwealth of Massachusetts.

of local help in the implementation of much of what is being planned; this is the standard on which community psychiatry chooses to be judged.

The implementation of the two decade-old promise from an idea to a series of studies, from the federal government to the states, is part of the planning. The focus of this thesis is the planning on the local level, where the medical and political conflicts are far from settled.

Method of Study

To do this I was given permission to study Boston State Hospital, a traditional, old mental institution located in Mattapan. A close examination of the planning there will be contrasted with the planning of several other centers in the state. The planning will be viewed from the perspective of the different actors, and it is hoped that the discussion will bring out the issues that are important for an understanding of the internal and external obstacles to the implementation of this legislation and the idea of community mental health. The centers are at different stages of development and I wish to compare their intellectual development in planning, as well as note their physical differences.

Greater Issues

Besides the state of the art of planning and the tech-

niques of health and city planning, broader issues are at the base of this thesis. The general area of concern finds its expression, ironically, in a comment on urban renewal. Erich Lindemann has observed that the "West End population experienced itself as a target of administrative procedures without responsible participation in the planning for their own future."¹ The barriers to participation in our society are a roadblock to the achievement of democratic goals. Some of these barriers lie in the complexity of large institutions, others are represented by professionalism, the exclusion of groups of people who lack specified courses of formal education. The two are particularly prevalent in mental health, with its large state institution and closed medical profession which together tend to shun "outside" planning. In this study I hope to suggest ways in which, through planning, the barriers to participation might be lowered.

In the thesis I will describe and criticize this planning, the dialectic of political components. I will, in the conclusion, try to suggest a planning process that might be followed. The process will be an assembly of planning elements observed at different centers; it will

¹ Lindemann, Erich, "The Health Needs of Communities", in Knowles, John H., (ed.) Hospitals, Doctors, and the Public Interest, Harvard Univ. Press, Cambridge, Mass, 1965. p.288.

take the form of a workable program for social planning.

The list of elements will serve four purposes.

- 1) It will offer standards to guide the planning process, which not lacks internal and external guidance.
- 2) It will make it easier for the planning process to be evaluated. No third party will put a great amount of money into something which cannot be evaluated.
- 3) It will make possible some means of control on the process by a third party.
- 4) Finally, the list will make the process more understandable. With understanding there will be more of an opportunity for citizens' participation.

Thus it will help resolve some of the issues mentioned above, as well as attempt to fulfill the mandate of effecting a union of relevance and techniques.

II. LOCAL PLANNING: BOSTON STATE HOSPITAL

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Problems of Study

The planning for a community mental health center at Boston State Hospital can only be understood in the context of BSH's past and present. This is a large state hospital (1500 inpatients). The planning of the new center will not be taking place in a vacuum but will involve the adapting of an ongoing institution which already has a large budget and a complex program.

To describe and evaluate the present planning and the transition is a formidable task. To do this I will first discuss some of the formal bodies in the hospital that are organized to set policy: the role of the superintendent, the staff meetings, and a "formal" planning group in the hospital. This section will focus mainly on the issues that arise in hospital policy. Next will be a discussion of the "formal" planning bodies that are not part of the hospital establishment: the board of trustees, then in some detail the local area board, whose formation I observed. The hospital's relation with citizens' groups is an important factor, for it tells something about the broader issues of "participation".

After viewing this level of planning, I want to balance against it what I have learned to be the informal planning

in the hospital: the process of program development by individuals. I will do this by examining some cases in detail, and then determining what the dialectic between the two levels has produced, to understand where the substance as well as the shadow of hospital planning lies. I will then comment on the transition from planning for a large custodial hospital to planning for a community mental health center. The analysis will show the clashes of assumptions that occur and the administrative and attitudinal stances that represent the internal and external obstacles to planning.

The Superintendent

In Massachusetts the superintendent alone has the legal responsibility for what goes on in the state mental hospital. By law he is not allowed to delegate any of it, although of course he must do so informally. It has been said that his power derives from four factors.¹ He is administrator over the money and the personnel. He is most likely to have a model or concept of what the hospital should be. He regulates a great deal of the flow of information within and outside the hospital.

¹ Source: Dr. Frederick J. Duhl.

The costs of care are paid for by the Department of Mental Health, which in turn gets its money from the General Court. The superintendent, more than anyone else, deals with the Department and gets involved in the politics of the allocation of money over the state mental health system. It must be pointed out that competition for funds at this level is an important constraint on the individual hospital. The voluntary dollar pays very little of the expenses of the hospital, since people do not see the need to contribute to institutions run by the state. Most of the rest of the money, especially for research and training, an important part of the hospital, comes from grants from private foundations or the federal government. The superintendent's reputation is an important factor in attracting grant money. The grants and the affiliations made with medical and nursing schools must go through him. It has been said that, because of his prestige, no program is started or terminated without discussing it with him.

Because of the good relationships he has had with people, when he became superintendent there were many whom he could call upon to be on the staff of the hospital. These contacts were especially at the important staff level.

The superintendent's control over personnel is a more obvious source of power than the idea of holding a concept

of the hospital. It was apparent, though, after talking with many people working there, that most do not have a very good idea of the part they play in the total framework. Only the superintendent (or those close to him to whom he has informally delegated power) is in a position to see the whole picture. Thus, formally as well as informally, the model of the hospital is his fashioning.

Information

Decisions are made by acting on information, but one cannot study decisions by studying information. It is important to see where information enters the decision-making process in the hospital. There are two points to be made.

1) Where in the system does information come in?

There is a great difference between its going to the superintendent or to one of the residents.

2) Does the information change the decision-making process itself? The information can change, but the same people may continue to make the decisions.¹

The information system was described by one of the doctors. The superintendent is the relevant body. He both receives and disseminates information throughout the system. He is also usually the one who gets information

¹ Source: Dr. Duhl.

from the outside, especially in dealing with the DMH and other bodies.¹ He distributes information through staff meetings, whose agenda he sets. Occassionally he gets feedback. The point is that he seeds the field with information and will let something through if there is staff support for it. I will describe three meetings to illustrate the issues of hospital policy that arise.

Staff Meetings and Some Issues

At one meeting with Dr. Greenblatt in charge, the issues discussed were mainly inpatient concerns, administrative as well as clinical. In the session a doctor asked what the hospital's policy was going to be on the prescribing of birth control devices. A new state law had made it legal for a doctor to give this sort of advice and he wanted to know if the hospital's pharmacy were going to carry the supplies. He admitted that doctors were already doing this informally by sending patients to other places, but he wanted some discussion of it. The problem was that patients were getting pregnant and this was an embarrassment and a hardship to the person and the hospital. What could be done? They agreed that closed wards were ineffective in preventing this, as well as inhumane. One man jokingly suggested sterilization; this was jokingly hissed. The issue was religious, too, a Catholic doctor demanded that

¹ With the hospital in transition this will change.

a gynecologist be added to the staff or consulted before the hospital act. The others saw this as an obstructionist argument but were wary of arguing against caution. Finally nothing was decided. It seemed that the informal system which would allow the doctor to make the choice of referral in secret without a policy statement and the necessary defining of political position would be maintained. This area of policy then was completely decentralized.

A second issue was the State's policy of shifting patients within the system. Apparently in the state hospital system there is a movement of patients, sometimes referred to as "checkers." The long term movement, as far as BSH has been concerned, was a reduction in the number of long-term patients. A few doctors who agreed with the point brought up by one, wanted to ask for two acute patients in return for every three chronics sent elsewhere. The problem was one of personnel and medical practice. Chronic patients, the staff admitted, are not treated with nearly as much time as the acute patients. Often chronics are just stored there. The situation is improving but as late as October 1963 a study showed that one third of the patients were not treated at all.¹ If chronics were replaced

¹ Schulberg, H. C., Notman, Ralph, and Bookin, Edward, "Treatment Service at a Mental Hospital in Transition", unpublished paper, n.d.

one for one by acutes the hospital's load would be intolerable. Some sort of pressure would have to be put on the Department. Greenblatt would be the one to plead. It is interesting that they asked him to phrase it in a political way, to ask for a 2 to 1 ratio at first as a bargaining point, hoping for 3 to 2 in the final compromise.

Other matters discussed were questions of what would happen to utilization of the hospital if the twelve year residency for patients requirement were dropped. Presently, people who have not lived in Boston are "bounced" out to Grafton. In addition they talked about the clinical matter of death reports. A patient had died and it was some time before the rest of the hospital knew. They did not talk about community mental health but it was pointed out to me that they would have if it had been brought up.

Another meeting I went to was interesting because Dr. Greenblatt was away and the assistant superintendent ran the session. Three categories of issues came up: the administrative, the political and the medical.

The records system of the hospital was criticized as medieval, and out of date when it was instituted in the 1920's. There were complaints about records being lost and a long directionless discussion followed about whether authorized people should be given keys to protect confidential-

ity, or whether the records should be more open, but a stricter accounting system set up. A member of the staff had looked into a computer record system in effect at a hospital in Hartford. He lauded it as being as great an invention as the wheel and seemed to think it would not be difficult to set up at BSH. But, it did not seem that any kind of action would be taken on this administrative matter without Dr. Greenblatt's presence.

Again the issue of too many cases came up and a doctor urged that they form some kind of organized opposition to let the Department know of their objection. But nothing came of this besides the plea.

On medical matters though the doctors were more coherent. They discussed the problems of a growing number of cases of toxic psychoses, from drugs like LSD, and how they really did not know how to handle the cases, for often the symptoms were similar to schizophrenia. The doctors did not know if drugs should be administered since the addicts already had drugs in them, and they doubted the other solution of putting people like that in seclusion. They decided to have two of the doctors who specialized in drugs to prepare reports to help the others make this type of medical decision.

It was pointed out to me that without the superintendent there, the doctors tend to get bogged down on detail and

get little done. They look to him for leadership in making administrative decisions.

The meetings of the Psychiatric Executive Committee illustrate several other important issues of hospital policy. Besides discussion of some of the internal responsibilities of the hospital's program, such as the running of the residency program, this group spoke of something of great import to planning: relations with other hospitals.

This is a topic which is now arising with the new federal legislation for community mental health centers. One requirement for federal aid, which makes medical sense as well, is the stipulation that there be "continuity of care." Thus one local center cannot treat a patient for a short time and then send him to the state hospital and thereby lose contact. The patient must be followed through the care system. In Boston, Boston State has been designated in the state plan as the center which will provide the traditional institutional or long-term care. The other centers can make arrangements (contracts) with BSH to provide this component. When Tufts, pressured by the time element of a staffing grant, came to BSH to ask for a building to house their long term patients, the administration was forced to think about "planning." If others were to use the BSH resources BSH would have to get something in return. Thus

"to plan" became an immediate administrative requirement, a day-to-day affair. Discussion of the contract went on in the Psychiatric Executive Committee with the Tufts representative. It seems that what will happen is that the second year Tufts residents who are already at BSH will rotate through the unit of the hospital which receives most of the patients from the Tufts "catchment area" for at least part of their year at BSH. This arrangement will effectively guarantee the continuity of care requirement. In return for the buildings BSH will gain about thirty personnel, nurses, aides, and psychiatrists. This will be an improvement over the past situation in which people from the Tufts area of Boston¹ entered the state hospital and no one but the state hospital staff was responsible for them.

In the series of meetings other types of arrangements were discussed. For example, one unit of the hospital which is being organized to serve West Roxbury, Roslindale, and Hyde Park might, because it has room, also provide a building for the long-term patients from the Massachusetts Mental Health Center. Another could take care of chronics and the rehabilitation needs of the Boston University center. None of this is officially arranged yet, but the goundwork

¹ Parts of the South End, South Boston, and North Dorchester. Source: Mental Health for Massachusetts.

is being laid for planning. The superintendent stated at the regional planning council meeting that he had fifty-three buildings left and he wanted to make contracts for the use of all of them. That day will undoubtedly come.

Planning Meeting

The long-range planning of the hospital seems to take place in meetings like this among the psychiatric staff. A formal group in the hospital doing explicit long-range planning is led by Dr. Duhl. In the multi-goal institution this group (advisory to the curriculum committee) is planning specifically for the training of residents in psychiatry. Duhl has assembled a group of men, all psychiatrists, to meet with him once a week for an hour to discuss what the training program should consist of, considering the "forces that are impinging upon the field of psychiatry...the problems...we face in today's situation...the forces...that will have an impact on us in the near future...the alternative futures and choices..." (mimeo, notes: Feb. 13 meeting). The impetus for this approach comes from the general atmosphere in the U.S. today that planning is necessary. A copy of Andrew Kopkind's "The Future Planners" was given to each participant at one meeting.

This committee is new. A total planning committee could not get the superintendent's sanction last year, but this year he has allowed this partial planning committee to meet. This illustrates again the persuasiveness of the superintendent. He can say who is to plan, and when. It shows again that new information does not necessarily change the decision making process, for the superintendent is still the relevant body to be influenced.

The planning discussed so far has been done by the professional staff of the hospital. Are there any formal planning bodies that involve groups from outside the hospital?

Lay Boards and Planning

There is the board of trustees, at one time a relevant body but now ineffectual. This lay board of the hospital, appointed by the governor, will remain intact with the new act, but does not make policy in any real way. Its meetings consist of the superintendent explaining policy to it. It may be seen as any educational forum in which each week a staff member comes in and explains his work. The fact that it is not a functioning board is illustrated by the difficulty it has in raising a quorum.¹ It is thus

¹ Source: John Hudson.

not worth more than a brief mention.

A planning body, though, that many people place much hope in is the area board, the lay board of the catchment area, created by the new state legislation. The story of the evolution of this level of authority at BSH and its possible role is important to an understanding of the issues of participation involving large institutions and professionals in hospital planning.

The new state legislation provided for the creation of local boards for each of the thirty-seven designated catchment areas. The groups were to consist of twenty-one citizens appointed by the Commissioner to "serve as liason between the local community and the mental health program, the Commissioner and the Advisory Council."¹ As an advisory body, the board is supposed to instruct the area director of the center (whom it helps the Commissioner choose, theoretically) as to the needs and resources in the area. Though not given control of the budget the boards are supposed to review and approve annual plans of the center.

During the debate over the bill the question of how much power the area boards were to have was central. The Medical Foundation task force wanted them to have the power

¹ "The Community Mental Health Act: What it Means to the People of Massachusetts", Mass. Assoc. for Mental Health, 1967. p. 9.

"to exercise the right of prior approval of the Department of Mental Health's nomination for the center's executive director and medical director."¹ This right, and the stipulation that the boards have a technical staff, were not gained. In the end the Department won and the citizens groups lost. Their power is only advisory. The evolution of the area board for the Boston State catchment area illustrates the reluctance of the professionals to give away any power and, shows at the same time, the high hopes held for a new institutional body, any new level of authority that might breathe life into the hospital.

After the bill was passed, the administration of the hospital had no real idea what the area board was supposed to do. They had not thought about how names were to be gathered for the nominating committee. They certainly did not think the new board would do any planning. It was felt that planning was solely up to the professionals, since the hospital was an ongoing large institution and the planning was "technical." The only potential use they saw for the area boards was as leverage for legislative support. It was thought that perhaps in the beginning the area board might make some noise but after a while it would calm down.

¹ Mental Health for Massachusetts, op. cit., p. 53.

Names had to be selected for a nominating committee, however. For this task the administration picked a group of community-minded psychiatrists and social workers who might know some people outside the hospital.¹

It happened that the seemingly simple task of coming up with ten names was fraught with complexities. First, a psychiatrist's training does not prepare him to go into the community and look for people. The insecurity, combined with a surprising ignorance of matters outside the hospital, stalled the deliberations. Other doctors did not fully cooperate, saying they were opposed to the idea of selecting names. But they had to come up with the names or the Commissioner would. The confusion took place amidst theoretical discussions about what type of person should be on the board. One of the community psychiatry oriented people did not want any professionals for this, feeling it would stifle the "people." The group of community-minded psychiatrists thought it would be nice to find people who would work very hard and use the area board as a political outlet. They were told to look for defeated candidates. All this was theory though, because they really did not know many people in the community.

In addition, there was the problem of the catchment

¹ Another doctor at the hospital was asked by someone at the Department of Mental Health to send names in. By coincidence he was on the committee chosen by the superintendent.

area. Geographically, BSH is in the middle of two widely disparate sets of communities. On one side is the lower middle class Dorchester community and on the other, set off by Franklin Park, are middle-class West Roxbury, Roslindale and Hyde Park. The latter area was less known by the staff. Should people from Dorchester on the area board represent only Dorchester or the other area as well? Should the board be modeled on parliament or sectional interests?

Issues like this complicated the plans for a meeting to be held to explain the new law to the community and to get support for the area board. Where should it be held? Should the meeting take place in Dorchester, in Hyde Park or at the hospital? Psychiatrists did not want to give the impression that the whole program was Dorchester-centered, as the hospital was becoming with the vigorous Home Treatment program, but they were also wary of the "nuthouse" association of the BSH complex.

At the meetings of this committee the people earnestly tried to decide who to get for the board, completely unaware of the attitude of the hospital's administration toward the board's function. At all times though they wondered what the administration would allow, for instance in secretarial help, to publicize the meetings.

The resulting list of names was criticized by a doctor

outside the original committee as being a mere power structure list of people with no time to devote to the board. It was doubted if the board included any of the new young leadership in the community or if it would have any more than a ceremonial function. Thus, the growth of the citizens group was squelched almost before the act went into effect. In the study, I found that the seriousness with which the area board is taken is a good indication of the amount of citizen participation in the program development and planning. In BSH there would be none.

Program Planning: Individuals

In an analysis of the planning in a large institution it is shortsighted to stop at the superintendent or even at staff meetings. This level may have the power to encourage or discourage what goes below it, but it is important to see what the individuals at the meetings are doing in planning programs. The next section of the thesis is a look at this middle level. Leading it is a description of the development of a program, the Home Treatment Service, then a series of case studies from interviews with individual doctors and social workers. Each case is an attempt to give a flavor of hospital planning and bring out the issues that are important to an understanding of the obstacles to efficient planning. I hope to point out

here the elements of a planning process that already exist in the hospital without a formal framework.

Home Treatment Service

An example of a well documented and successful program is the Home Treatment Service. This program, which now occupies the time of nine hospital staff members, two psychiatrists plus trainees in nursing, social work, occupational therapy, as well as residents in psychiatry, was not even an official part of the hospital before 1962.

The founders of the service learned from the practice of an Amsterdam municipal psychiatrist whose theory of community psychiatry they shared. This man, Dr. A. Querido, had a philosophy of care which was based on the belief that "any removal of a mentally disturbed patient from his social background implies the side-stepping of the nucleus of the problem."¹ Carried out, this meant the psychiatrist had to leave the hospital and provide first aid, in the home, to intervene in crises, and hopefully avoid hospitalization of the patient with the stigma and the regressiveness that this entails.

Through a process which now seems almost inevitable, but covers the rough spots and long years, BSH acquired a

¹Schwartz, Morris S. and Schwartz, Charlotte Green, Social Approaches to Mental Patient Care, Columbia Univ. Press, N. Y. and London, 1964. p. 37.

service similar to Amsterdam's, though on a more limited scale. In 1956 a pilot study of pathways to hospitalization "revealed that there were vast gaps in community service available for patients suffering from serious mental illness."¹ Under the aegis of the Boston University School of Medicine, and financed by the National Institute of Mental Health and the Maurice Falk Medical Fund, a clinical demonstration grant was received to explore the feasibility of such a service. Thus research was combined with service; and the hospital gained a program, though an undeveloped one.

Over the five years, four clinical programs were tried, each an experiment in getting more referrals. With each the researchers learned something quite useful to the field. For instance, they learned that the process of hospitalization could not be reversed once the patient had arrived at the hospital. From initial failures they learned more about working with caretakers in the community. This led to seminars for general practitioners and clergy, to reduce their fears about mental illness and render consultation. The Service developed new roles for nurses, who acquired more of a responsibility in patient care, by being part of the therapeutic team.

¹ Becker, Alvin, and Weiner, Leonard, "Psychiatric Home Treatment Service: Community Aspects", Current Psychiatric Therapies, vol.vi, Grune and Stratton, 1966. p.281.

Program development depended to a large extent on the cooperation of the hospital the Service was using. This was forthcoming. One problem the service had was getting referrals. The superintendent issued a mandate at one point making it "compulsory that patients from Dorchester be screened by the Home Treatment Service before their admission to the hospital."¹

After the clinical demonstration grant was over, the program became a permanent part of the Boston State Hospital by an act of the Massachusetts legislature. Developing further, it acquired three more goals, one of which was mentioned before: the seminars for caretakers, the development of new roles for mental health professionals in community psychiatry, and the training of residents.²

Hospital planning in this case was allowing talent, outside money, and a good idea have their sway. The institution was big enough to permit a new program to grow in it; it did not feel threatened by it, nor did it try to centralize the decision-making that took place in the growth process. The planning was done by field people; they assessed need and garnered resources. They went

¹ Friedman, T. T., Becker, A., and Weiner, L., "The Psychiatric Home Treatment Service Preliminary Report of The Five Years of Clinical Experience," paper read at the Amer. Psychiatric Assoc., St. Louis, Mo., 1963. p. 7.

² Becker and Weiner, op. cit., p. 281.

through the trial and error development of program, which in time became institutionalized and thus insured of continuance.

One program led to another. The Home Treatment Service is now spawning a Neighborhood Service Center which is depending initially on a federal grant from the Mental Health Center Branch of the NIMH.¹ The theory and practice for the NSC comes from the South Bronx example of Harris Peck and his associates at the Lincoln Hospital.² The Dorchester center, because of the wider experience of the Home Treatment Service people, is being planned with a poverty group in Dorchester, the Dorchester Area Planning Action Council.

It was not always true that the community in Dorchester could do any meaningful planning. The problems that arose with local groups in the poor neighborhood are illustrated by the case of the Dorchester Mental Health Association and the child guidance clinic.

¹ A staffing grant has to get state approval because under it the state agrees to pay an increasing per cent of the cost.

² Alvin Becker and Henry Mirsky, "Proposal: Establishment of a Neighborhood Service Center Under Mental Health Auspices in a Dorchester Poverty Area," Mimeo, no date; "Neighborhood Service Center Program," report to the OEO by Frank Riessman and Emanuel Hallowitz, Lincoln Hospital, New York, mimeo, 1965; "Psychiatry in the Urban Slum," Frontiers of Clinical Psychology, Nov. 15, 1966.

Around 1956 the state was starting to set up mental health centers. Long before the federal legislation, the Mass. Assoc. for Mental Health, a private group, and the Department of Mental Hygiene went around the state trying to interest local citizens. At this time, many mental health associations were formed to get a child guidance clinic. The Dorchester Mental Health Association could not raise the necessary local share of funds. It was handicapped by two conditions. Its citizens were poor and it was only a section of a large city, so it could not go to a town meeting and plea for the funds as had been done in other parts of the state. The legislature waived the local stipulation for Dorchester, and it finally got a clinic which was located not on the hospital's grounds but in the community. Later, a new building was constructed on the institution's grounds, and the clinic moved. By doing so it became in reality, if not law, a part of the state hospital. (It is part of a different section of the Department of Mental Health; with the 1966 state act it will be part of the hospital.) Other mental health associations supplement the salary of the director of the clinic but the Dorchester group did not have the money so state money had to be used. This illustrates the difficulty of local control of policy or planning when the program does not rely

on local money or political support.¹

The community, because of the poverty council, is more organized now and is being consulted on the planning of the Neighborhood Service Center.

The goals of the Neighborhood Service Center, like its parent the Home Treatment Service, are a combination of service and research. Besides helping people with everyday problems, the center will be testing ways which indigenous aides can serve in mental health. It will be part of a training program administered by the Dorchester unit of the hospital.

William McCourt, head of the alcoholism unit at the hospital, will be one of the doctors training these aides. Harris Peck's program at Lincoln Hospital has provided some guidance, but not enough to know how to balance some important concepts. How much psychiatric information should McCourt give the aides? He does not want them to become abortive professionals. He wants them to keep in touch with the problems of the neighborhood and the language used by the people in the neighborhood to describe these problems.

¹ Source: Mrs. Greta Wheeler.

McCourt's work now, as head of the alcoholism unit, is primarily consultation with the community. As an introduction to the planning it is necessary first to say something about alcoholism and psychiatry. It is McCourt's position that in general psychiatrists are hostile to alcoholics. You cannot be admitted to a psychiatric hospital if you are drunk; you must have psychiatric symptoms. In 1956 the AMA declared that alcoholism was a disease, but McCourt doubts that 10% of the doctors believe this, let alone psychiatrists. There will be a large problem, he thinks, in convincing the hospital that a unit such as this should be the concern of a mental institution.

He also feels there will also be problems with the community. People are threatened by excesses, by loss of control. They think that what is wrong with an alcoholic is that he 'isn't trying.' Like doctors, they doubt its classification as a disease.

With this as a message, McCourt consults with caregivers in the community such as welfare, businesses with alcoholism counselors, unions, and the police, with the aim of reducing their anxiety in dealing with alcoholics. It is necessary to educate the policemen, for one half of all arrests in Boston are for alcoholism. The doctors also must be educated, and given help in diagnosing and treating the

disease.

McCourt already is in contact with a great many people and has a good idea of the community and its needs. A doctor whose planning involves acquiring this knowledge and these contacts is John Hart of the Roslindale-West Roxbury-Hyde Park Unit of the hospital. Dr. Hart is in charge of community relations in this area. He views his job as establishing pre-patient contact through doctors and the clergy, continuing community ties, and all along learning what the other agencies have available. Thus, instead of being research-oriented he is very much service-oriented, caring like McCourt, for the caretakers.

Learning about the community in a meaningful way is not easy, but through discussions with people Hart has formulated what the mental health problems of this middle-class section of BS's catchment area are. The West-Roxbury and Hyde Park communities are concerned primarily with the problems of youth. This is opposed to the more lower-class Dorchester's interest in slum conditions, landlords, and civil rights. The different set of needs inevitably leads to a different set of solutions. Where a storefront center might work in densely populated Dorchester it would be less likely to work in Hyde Park, whose people would not go to a storefront for medical care. In

the latter also more people drive to work and thus do not even know their neighborhood.¹

Thus the "mental health" needs of this area are different, or rather there are different reasons people there would make use of a psychiatrist.

Hart has been able to consult with the West Roxbury YMCA, and with the Archdale project of the Boston Housing Authority. He has also started a community luncheon to meet with people and explain what he is trying to do.

Before consultation can take place, the doctor must have a good knowledge of the community. This is what Hart is obtaining with no help from the administration of the hospital. He does not see what he is doing as planned, but it actually is. He has learned about needs and is gradually learning about the resources available and how to use them. Though some would say he is out of the decision-making process of the hospital, it seems that he is making decisions. He is one of few people planning for the community mental health center.

A different sort of issues and problems is illustrated by the planning of adult outpatient services. Since 1950

¹ Source: Dr. John Hart.

Boston State Hospital has had an adult outpatient clinic. A new building on the hospital grounds, it is part of the institution, although few people think of it as such, because for many years it was located in another section of the city.

The program there now is an ongoing one, but its director, Dr. John Snell is currently planning two directions of change. These will revolve around a change in goals. Until now the goal of the clinic has been to teach. To achieve this it wanted particularly a variety of patients (neurotics who can communicate) and turned away the others (the psychotics). Snell asserts now that the clinic is adopting the goal of service to the community and hopes to replace the lack of obligation felt by former directors for the needs of the area as a whole. Secondly, he wants to use the clinic for research, to compare different treatments. He hopes that assessing patients over time will supplement the intuitive approach used by doctors to compare treatments.

Image

To reach these goals he is planning. He admits this program planning is solely internal. He sees his job as getting contact with the community and changing the image of the clinic. In other words, he wants to go into Dorchester,

not to plan with people, but to advertise new services like consultation with the community.

"Image" is a major problem facing mental institutions. The subtlety of image is shown by a remark of a 14 year-old boy about the hospital. He said, "people all over when you say Mattapan think of the nut house but people in Mattapan don't think of Mattapan as the nut house".

To overcome this attitude a seminar has been set up with GP's in the community, and Doctors are being urged to consult with psychiatrists about patients who come to the hospital. The problem is faced in physical planning also. The administration wants to begin to integrate the hospital into the community. Two ideas mentioned, somewhat in fantasy Dr. Duhl pointed out, are to use part of the vast open space for playgrounds and to build a joint housing project for the elderly and the mentally ill on a boundary of the hospital grounds. The administration is fighting the inheritance of architecture and past practice that makes a hospital, especially a mental one, look isolated. "The problem becomes how to weave the hospital into the surrounding urban fabric."¹ The reality and the image must be

¹ Lindheim, Roslyn, "Factors Which Influence Hospital Design", AJPH, vol. 56, No. 10 (Oct., 1966). p. 1671.

woven.

The move to the community brings with it pangs of conscience, though. Snell says the new image may not be suitable, for the hospital falls prey to the accusation that psychiatry is imposing a science made for one class of people, on a different community. McCourt put it this way, that psychiatry until now goes out to seek insight, interpretation, and drugs. Snell does not want to impose psychotherapy as a salve on Dorchester just as McCourt is hesitating to train people this way.

On the other hand Snell points out there are problems about listening to the community about need. Suppose, for example, the community tells him that they consider homosexuality a disease, and he does not agree. Doubting whether to advertize or to ask for advice he still needs certain types of information in order to plan. For one, he knows nothing about the area. He wants to have the health, welfare and nursing agencies surveyed and analyzed. What kinds of service do they give, and to whom? He wants demographic information and sociological data on the location of ghettos. There is a need to know how many have had psychiatric treatment. He suspects that certain groups have received the bulk of it and others none at all.

Some of these questions are being answered by Dr. Price

Kirkpatrick, an epidemiologist who has been given the opportunity by Dr. Greenblatt to create his own job. The hospital and the Boston region are to be his only limits. Using his experience as the former head of a mental health clinic in Waterville, Maine, and as a researcher connected with the Srole Midtown Manhattan study, Dr. Kirkpatrick is studying the utilization patterns of the hospital and their implications.

The question that began to intrigue him more than any other was the underdeviance of the Negro population. A poor group, Negroes make up 11% of the Boston population but only 13% of Boston State's total. Kirkpatrick thinks it should be around 30% (the rate at Grafton) and is investigating the links between social agency utilization, hospital utilization, and police arrests to explain the discrepancies. He believes now that the reason may be a result of the twelve-year residency requirement, which excludes recent migrants to the city from using the hospital. One planning question that arose was what would be the effect on the hospital of the removal of this requirement. Kirkpatrick, if anyone, will throw light on the answer.

Another possible reason for the low Negro utilization was that: lower class people are taken care of by the police

and often charged with nonsupport or drunkenness rather than being mentally ill. To study this he has interviewed policemen in various communities, asking them how they identify alcoholics and mental cases. In the "combat zone" of the South End only one admitted to seeing a mental case as opposed to the Dorchester and Wellesley police who recognized more mental illness. Kirkpatrick considered this a "blind spot in dealing with mental cases in slum areas." Its implications for planning, especially planning for consultation with caretakers in the community such as police, but others as well, are obvious.

Other reasons he gave for low Negro utilization were: Negroes were invisible longer because of transient work and marriage; that they were anti-white hospital; and that there were no GP's to commit them. He is now using Dr. Notman's data to study pathways to the hospital. He has learned that perhaps 50% of the patients are from the "police surgeon," the so-called commitments by "pink slip." Few are from private doctor commitments.

From his work in Maine he learned that utilization of mental facilities by alcoholics and senile people varies as proximity. Does this apply also to the big city?

Kirkpatrick, in his research, will answer many of the questions others have about present utilization and its meaning. His work is defining better the "medical" com-

munity in the Boston State catchment area.

The planning described to this point has been by psychiatrists. Actually a lot of what is going on in Boston State has been planned by another group of professionals, the social workers. A major issue in the planning is just this blindness to what the other group is doing. Perhaps because of the educational difference there is a real status boundary which makes for the two groups planning in the hospital, but taking their ^uconsels separately.

Programs planned by social workers are primarily for the community of patients, mostly those within the hospital but ex-patients as well. Most programs are designed to give the patients some kind of simulated "real world" atmosphere; for instance there is PROP, the Patient Rehabilitation Occupation Program. This started when a staff member of the Rehabilitation department of the hospital became interested in the sheltered workshop, an idea employed by Goodwill Industries to provide sort of half-way place of work where "real" products would be manufactured but the pressures of private enterprise would be lessened. He went out with the aid of the superintendent and recruited businessmen to provide equipment for the project. These businessmen formed a board of directors that would supervise, raise funds

and find work for the shops on a sub-contract basis. This is at no cost to the hospital other than space and utilities and the services of the Rehabilitation department. In January 1967 PROP received a Vocational Rehabilitation Agency grant to expand. It also has contracts pending for service station attendant training with the On-the-Job Training section of the Manpower Redevelopment Act under the Department of Labor.

Another way the patients can make money is through PEP (Patient Employment Program). They are paid 40¢ an hour as secretaries within the hospital out of money earmarked from the profits of the Canteen Fund of all the state institutions. This group is a social club as well.

In all there are 512 working patients. They use their money in activities organized by the social workers. The psychiatrists have little to do with this program. A reason is that rehabilitation is not wholly accepted by psychiatrists who have been trained in the psychodynamic approach.² They have not been taught to work with communities. This is another factor that must be kept in mind when speaking of planning at Boston State Hospital.

¹ Source: Ernest Kraus; Mrs. Greta Wheler.

² Source: Ernest Kraus.

Summary

We have seen some of the elements and issues of planning at the hospital: the evolution of a program from idea to part of the institution, the use of outside money, the learning about the community's needs and resources, and the making of contacts to unite the resources and meet the needs. In this learning we have seen the hesitancy to impose values on a different culture, the problem of image, and the shifting of goals. The gap between the psychiatrist and other personnel, and the problem of working with a community that is poor and badly organized illustrated some of the difficulties of planning.

Overview of the BSH Planning Process

In a seemingly haphazard way, then, the formal and informal systems of planning work their way and programs get established at the hospital. The superintendent allows each person to plan on his own and through whatever informal alliances he may make. Talent has its sway. The system seems to work, not by informal centralization of power as Banfield observed in the political context, but by informal decentralization. To this might be opposed Galbraith's comment:

"As technology becomes increasingly sophisticated and as it leads on to specialization and planning, decisions in the business enterprise cease to come from individuals. They come, necessarily, inescapably, from groups. The groups...contain the men possessed of the information...that bears on the particular decision. They contain also those whose skills consist in extracting and testing this information and obtaining a conclusion... No single person... has more than a fraction of the necessary knowledge."¹

What applies to the new industrial state though, does not yet apply to the planning of health services. What people are doing now in the hospital apparently does not require a lot of money or much power. It requires time, to be free to experiment and make new relationships.²

In the planning of services people can carve a slice for themselves, but there is some criticism nonetheless that the process is inefficient, that it should have more of the qualities of a business. This is true to some extent at BSH. People have little idea what others are doing within the hospital, and at other centers. There is no

¹ Galbraith, J. K., "The New Industrial State", Atlantic, vol. 219, No. 4 (April, 1967), p. 56.

² Dr. Duhl cautioned that the process should not be criticized out-of-hand as haphazard, but that it was using the important research model in which total freedom is allowed. The superintendent intervenes for resolution of conflict. Industry does not exclude this model, but employs it to a lesser degree than hospitals.

mechanism to help other persons plan. The reasons for the haphazardness lie in the set ways of thinking which are really the basis of any planning process. The fragmentation of the planning is due to 1) conflicting goals in the hospital and 2) within these goals, a perception of the role of a psychiatrist that makes for inefficiency in the use of personnel. Both factors constitute the major obstacles to overall rational planning in the hospital.

Goals

First of all it has been pointed out that the hospital is a multi-goal establishment. It cannot be studied like an industry with a simple flow chart. There are doctors who see the goal of the hospital as primarily patient care and others who see BS as a university, a place for teaching and research.

Existing beside this is another dichotomy of goals. This is epitomized by the attitude toward community mental health as a guiding concept. On one end of a wide spectrum of beliefs are the Freudians, and on the other, the new community psychiatry people, who are strongly influenced by the ideas of Gerald Caplan and Erich Lindemann.¹ This

¹ Schulberg and Baker of the Laboratory of Community Psychiatry have devised an ideology scale to test the degree of one's adherence to community mental health.

latter group is the one that pushed the new legislation through the General Court despite the opposition of the Department of Mental Health.

The conflict in psychiatry has its analogue in medicine. The "community" people are the ones who show concern for the greater social and economic context of the patient. They tend to seek patients, and treat in the community, rather than work from the traditional doctor's visit. And it has been pointed out that with the current predominance of chronic, rather than acute illnesses, the social situation and the community will take on more importance. ¹

The second goal conflict, over community mental health, impinges on the first. Even if the goal is to be training, there is disagreement on how to handle it, depending on the degree of acceptance of community mental health ideology. For community mental health, residents must be taught skills of communication with groups. The older medical model was one that emphasized the one-to-one relationship in the office. The new one must include training in how to deal with groups of people in the community. It is

¹ Cherkasky, Martin, "The Hospital as a Social Instrument: Report on Experiences at Montefiore Hospital", in Knowles, op. cit., p. 93.

important that these skills be rewarded with prestige from within the profession.¹

McCourt made a suggestion for a change in the training program that shows a strong allegiance to a non-Freudian approach. Using Goffman's criticism of the mental hospital, that psychiatrists tend to treat patients as children, he would build something into the schooling that would change the way of thinking. Patients often feel persecuted by the doctors. He would have a resident serve as a doctor in one unit and as an ombudsman in another, to represent those patients against the hospital and their doctors. Thus the resident would be forced to play another role. McCourt would also want residents to spend time in the community with different types of people - one day with a drug addict, a skid row alcoholic, a policeman, a doctor, a woman on welfare, etc.

This would increase the number of boundaries that the hospital staff has with the outside. It has been pointed out that formerly it was primarily the superintendent who had such contacts.² With the hospital divided into a unit

¹ Source: Dr. Myron Sharaf.

² Baker, Frank, "An Open-Systems Approach to the Study of Mental Hospitals in Transition", paper presented at annual meeting of American Psychological Assoc., N. Y. 1966.

system, each unit responsible for a separate geographic area (not legally, though; the superintendent is still responsible), other people in the hospital would have contact with the community and this would in turn reinforce community mental health ideology.

Roles

The other set of thinking relevant to an understanding of planning was the question of role. Now, because of training and tradition, the psychiatrist tends to view everyone other than psychiatrists as subprofessionals or subpsychiatrists. Doctors are even viewed in this way. It has been pointed out that while doctors will allow a nonmedical person to be their administrator in a hospital, psychiatrists will allow only a psychiatrist to lead them.¹ The inefficiencies of this way of thinking are obvious. All psychiatrists are not trained as administrators, and with a few gifted exceptions they generally are uncritical in matters not directly dealing with psychiatry.²

As a result of this, and the tradition of autocracy in medicine itself, the psychiatrists tend to exclude other people from their planning and their deliberations about

¹ Source: Dr. Dana Sheldon; confirmed by Frank Baker.

² Robert Emerson, a PhD candidate in sociology at Brandeis, studying a court clinic in Boston, also confirmed this observation.

planning. It was typical that at the Regional Planning Conference of Metropolitan Boston the panel consisted solely of psychiatrists.

The "other people" are psychologists, social workers, nurses, and to the greatest extent, ordinary citizens in the community. They are tainted with one flaw of "not enough education." It is similar in a way to the situation in the South, where Negroes are excluded from the policy bodies, but are assured that they will be told what has been decided, if not how and why. Both examples ignore the lesson that a man must have some responsibility to approach real footing. It is not enough to be given a new school, an equal YMCA, or the results of a meeting. Psychiatrists must get over the tendency of assuming, as Bandler said, that it is "unpsychiatric to share responsibility."¹

What the psychiatrist fears is the loss of the professional identity which is built through his training. A concomitant part though of community mental health is a blurring of roles. Twelve thousand psychiatrists are not enough in the country to meet the medical or legislative mandates.²

¹ Remark made at Regional Planning Conference of Metropolitan Boston, Boston College, March 28, 1967.

² The Joint Commission report suggested one community mental health center for every 50,000 people. In the legislation the number was raised to a range of 75,000 to 200,000. Considering the professional resources available, this may still be too low, especially in declining urban areas like Fall River which will find it difficult to recruit competent personnel.

Other people must be taken into the duties. In Rockford Illinois, there is an example of a more unfettered approach to care. There, groups of people with different professional identities work on a therapeutic team. It is not always the psychiatrist who is primarily responsible for care. Norris Hansell has recruited a large group of returning Peace Corps volunteers, given them a one-year Masters with in-service training, and sent them into the field.¹ If subprofessionals do not share in the task of caring for the patient, it is difficult for them to gain the experience or sanction to share in the planning.

Freezing into roles has happened in Boston State Hospital. When the hospital was decentralized into the unit system the greatest opposition came from the people whose professional identity was being threatened.² Each unit would be headed by a psychiatrist and it was hoped that the other formerly centralized sections of the hospital - the nursing, social workers, and occupational therapy people, would comply. These groups did not want to take orders from a psychiatrist, preferring instead to get their instructions

¹ Dr. Dana Sheldon referred me to this example. Other sources: Charles R. Hurst, "Reducing the Risk", in Mental Health in Illinois, vol. 2., No. 4, (May-June 1965); Rockford Zone Chartpack, Ill., Department of Mental Health (July, 1965).

² Source: Frank Baker.

from the head of nursing, the head social worker and so on. The result has been a number of adjustments. The nurses, for example, want to have a new role description which carries with it a case load.¹

The role factor, along with the unsettled allegiance to goals of community mental health, plus the differences of opinion on what BS's emphasis should be, research or service, make a still picture of the issues clothing the elements of planning at the hospital.

Hospital in Transition

But the hospital is moving. Because it is now in transition, its planning must also be in transition. Dr. Greenblatt "views the institution as...leaving that phase of its history when it functioned primarily as an efficiently operated, self-contained therapeutic entity and becoming a center in which are stressed community adjustment and social adaptation."² As well as moving toward hospital-hospital

¹ Dr. Duhl noted that more than the matter of roles and identity was involved here. It was also a question of systems. Which way should the lines of authority travel? Should the system be decentralized into a team approach (horizontal lines) or centralized into a hierarchy (vertical)? It is complicated by the presence of different groups. Should a nurse report (in the centralized model) to the head nurse or to the head doctor. This is the role question.

² Schulberg, Caplan, and Greenblatt, "Studying the Mental Hospital in Transition", presented at NIMH International Research Seminar on Evaluation of Community Mental Health Programs, Warrenton, Va., 1966. p. 9-10-

planning (the Tufts arrangement), as a large institution with social responsibility, the hospital must move toward community planning. This means more than planning for a wider territory; it means planning with a different group of people.

It is not easy to change because of the set ways of thinking described above. The transition requires at each step of planning a new attitude that will effectively mean some loss of sovereignty. A common market of services is the goal, and the state, hospitals, agencies, and doctors have to cooperate. Contracts between hospitals and memorandums of understanding with community groups have their analogue in tariff agreements reached between nations. In the short run they hurt, but in the long, the pain disappears, hopefully in the general good. In the social services too, there must be a deference to a larger entity. The deferment is difficult, for it means giving up something to another hospital or to an agency. To involve the community as well means that professionals defer to people stigmatized before as subprofessionals.

The first deferment to other hospitals is not as difficult as the second because 1) there are previous examples of it and 2) it does not mean professionals will be giving up anything to a lower status group.

Affiliating with other hospitals is a common way for a

hospital to expand in urban areas. For instance, the Tufts complex used to be three hospitals: the Boston Dispensary, Boston Floating Hospital (child and pediatric), and the New England (which treated adults but not children or maternity cases). Under the pressure of United Community Services they amalgamated the three corporations into the New England Medical Center.¹ The change was effected through a dialogue between professionals and did not mean any radical change in "planning."

The other requirement, that the hospital become community-based with a wider area of tasks, is much more threatening. The hospital in the U.S. has moved from a custodial institution to a doctor's workshop to a center for community health.² These transitions do not have to mean a change in planning; the doctors could still have all the responsibility and make all the decisions. But for the move to community to be really meaningful, the community has to be brought into the decision-making process, the planning. Here for the first time the professionals are forced to speak with the non-professionals, and they fail because they do not know how or what to communicate. To protect themselves, the professionals exclude the com-

¹ Edward Kovar, lecture, March 2, 1967.

² David Rutstein, "At the Turn of the Next Century", in Knowles, op. cit., p. 53.

munity from the planning, and the community either stays away, out of ignorance, or is rebuffed.

III. LOCAL PLANNING: LOCAL ACTORS



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III. LOCAL PLANNING: LOCAL ACTORS

Introduction

Boston State Hospital is not the only institution in the midst of planning for a community mental health center. To get a better idea of the elements of the planning, we must look at what several other centers are doing and the information they are using.

Concord, Quincy, Tufts, B.U. and an unnamed center were used as the field of study.

B.U. provides the best example of the process of learning about the community and working with the community to define its needs. The people of Concord and Quincy had an established program. Each knew the community and had surveyed its needs. The planning discussed in their cases raises an issue just briefly mentioned with Boston State - the political. Concord was involved at a federal level, Quincy at the state and local level. A full reporting of the planning of community mental health centers must include this facet.

It must be remembered also that underlying the planning of all the centers are the same unsettled clinical doubts mentioned in BSH. How Quincy approaches the conflict between psychiatrists and other personnel is noted, and the

doubts of medical versus community psychiatry models is touched on with Tufts.

Finally, in this chapter all the strands are tied together in a discussion of the planning of a more typical local center. The case illustrates the lack of almost all the elements of successful planning, as well as showing the underlying medical issues.

Boston University: Community Involvement in an Urban Setting¹

Boston State Hospital occupies a large tract of land set apart from a medium density development of houses. Boston University's center shares space in a factory in the South End. Boston State is an ongoing mental institution, a long standing state hospital. The BU center, on the other hand, has no such institutional history to surmount and change. Under the direction of the head of psychiatry at BU Medical School, the South End center, growing out of a general hospital, has had the freedom to innovate in plan-

¹ The material for the BU section is primarily from Joseph Devlin, M.S.W., of the center but also from Dr. Bernard Bandler's presentation at the conference of the regional planning committee of metropolitan Boston, Boston College, March 28, 1967; and Dr. Ralph R. Notman and Lester G. Houston's seminar at the Community Mental Health Conference of the Social Work Inter-School Council, Boston College, April 29, 1967; and Prof. Houston's presentation, as a member of a panel at the Legislative Conference on Community Action for Mental Health Services, Boston, January 31, 1967.

ning.

So far, planning has been with the goal of mutual education. The community must learn about the center, and more importantly, the staff must learn about the community. The first step was the formation of a community advisory committee consisting of six people: representatives of the church, ABCD, the settlement houses and the BRA. This was in the quest of local leaders and contact with the politics of the area.¹

To help in this search, the center published a brochure under the name of the advisory committee, "Community Health Planning." The title omits the stigma "mental" in health and implies that mental health will be the first step in the future comprehensive program that will include all health services.

With this as an opening, the center sponsored a series of meetings with the community, to "interpret" the center to the community, to encourage voicing of needs and problems, to develop local leadership, and to reduce the tendency of the staff to apply middle class notions to the perception

¹ In the deprived section of the city it is the poverty-related groups that are considered to be the power structure which must be secured for the success of a program. The formation of an informal community council around the Neighborhood Service Center in Dorchester also involved the OEO group as planners.

of the poor community.

Three meetings were held: 1) with the health and welfare community, social workers, public health nurses, welfare department (both staff and administrative staff were invited); 2) with caretakers such as clergy, school teachers, judges, druggists, police; 3) with residents. At the first meeting about 65 to 75% of those invited came; at the second and third it was down to 20 to 25% but the staff seemed satisfied with the turnout (teachers were the most active group with clergy second), even though no one from business or politics attended.¹

The center is now planning a larger combined meeting to have the groups work together. Preparing for this, they have summarized the meetings and sent a report to people who participated.

Joseph Devlin of the BU Center said that in the meetings the people moved from asking about concrete services to thinking about problems. For instance in one meeting they decried the lack of men involved in the community, a conclusion similar to Daniel Patrick Moynihan's. The community was asked for ideas about services, the use of volunteers, in-service training, planning for careers from high

¹ This may be a sign of where the business men in the "community" live, and an indication of how much power there was to be distributed at the time.

school groups, drug addiction (e.g. a pharmacist spoke of the problems he had with addicts). The health and welfare people complained of the inadequacies of the service system and, along with the teachers, expressed the need for psychiatric consultation.

The problem in planning was how to develop services out of the mass of needs. For instance the community lamented the employment situation, which is usually considered an economic not a mental health problem, but has not been ignored by these mental health practitioners. The psychiatrists have to learn what an employment center implies, what the "milieu" is.

With time the community advisory committee acquired more members, representatives of the Roxbury Multi-Service Center, the Department of Public Welfare, the Roxbury Federation of Neighborhood settlements, some businessmen, residents, and a school teacher. It will hopefully be the area board.

The program of the center now consists of consultation with the community, primarily with caretakers like social workers. BU has no contracts yet. But each week many agencies come to the center and the staff has found that increasingly its function has been to bring people together. To do this more formally the center is assembling a resource file, a handbook of service agencies. Now they

are using a bi-lingual one put out by a group of Wheelock students.

Concord: Creative Federalism

The people who have taken charge of the planning for mental health services in Concord noted that the state plan placed them thirty-fourth out of the thirty-seven areas ranked by need. They said because of this it was necessary to get the grant request to the federal government first.¹ They did this, and it has been approved at the regional level. It has been stated that the reasons which made Concord thirty-fourth are the same reasons that will make it likely for Concord to be the first to receive money - the high education level and income which places them near the top in ability to ask for it.²

At this level of development the short-term objective of planning was primarily to get outside money. The internal coordination was already there. It was the outside obstacles - the indefiniteness of the procedures and the inter-governmental relations which slowed them up. They had a clear idea of what they wanted, for their task was

¹ Source: Mrs. Alice Ames of Central Middlesex Mental Health Association.

² Harvey Newman of the Medical Foundation.

to serve a population which by its homogeneity was easy to understand. There were no middle-lower class "interpretation" problems.

Before applying for the grant, under the leadership of the mental health association a survey was taken of resources and needs in the Concord area. A pamphlet resulted which told people where to go for various types of care (throughout the Boston area). This included the cost and waiting period of each agency.¹ The 1964 questionnaire went to "physicians, clergymen, heads of public and private schools, representatives of local health and welfare agencies, police chiefs, and public health nurses",² a traditional list of caretakers. It led to a definition of need (alcoholic facilities, psychiatric help for adults of "limited means", consultation). Approaching the caretakers, the need was expressed in orthodox psychiatric terms, that is, the problems of mental health in this upper middle class community were seen as those requiring psychiatry, not an employment counselor as decided in the South End.

¹ Directory of Mental Health Resources, Mental Health Association of Central Middlesex, 1965.

² Proposal for a Comprehensive Program of Community Mental Health Services for the Central Middlesex Area", Mental Health Association of Central Middlesex, Inc., n.d.

The survey was groundwork for the formation of a Planning Council for Expanded Mental Health Services.¹ Professional people, the citizens of Concord, will make up the area board. The survey led to the team of the Mental Health Association, the general hospital, and the child guidance clinic applying for a grant with the full cooperation of the group for the mentally retarded, and the school system, which contributed to the program by asking for money under the Elementary and Secondary School Act provision for handicapped children.²

Problems in planning, then, were procedural ones. To qualify for the grant, Concord had to cover an area of at least 75,000 people. It did this by adding some towns (criticized in other quarters as unjust aggrandizement) and by using a 1970 projected population.

¹ NAMH Reporter, Jan.-Feb. 1967

² Source: Mrs. Ames.

Quincy - State and Local Politics

Politics are also central to Quincy's planning. The planning there can best be described as the formation of a number of alliances among private and public groups on a local and a state level of power.

The local facility has a history going back to 1922. It is now an outpatient clinic serving Quincy and seven towns around it, a population of over 250,000 people. The Clinic is primarily the result of cooperation in clinical and fiscal planning between the state and the South Shore Mental Health Association.¹

"Horse-trading will precede launching of projects. When they do something for a town, they will expect the town to do something in return, like sharing the cost."² That was Rockford, Illinois' local planning. Before Quincy could horse-trade there was a political obstacle to overcome. An important element in community mental health is the school system. But for the schools to cooperate with the Clinic they had to have the right for pay outside agencies for services. They could not do this under Mas-

¹ Gershen Rosenblum and Donald Ottenstein, "From Child Guidance Center to Community Mental Health: Problems in Transition," CMHJ, Fall 1965, pp. 276-283.

² Hurst, op. cit., p. 3.

sachusetts law. So the Quincy group lobbied for legislation to get it changed. In 1958 a law was passed making it legal for cities and towns to provide money for services of this kind.

But the Quincy City Council had not paid for services, even though it was legal. The solicitor insisted that it was not. A new solicitor reversed the ruling and now the city pays. To get the money, the entire board of the Clinic had gone down to City Hall. There is a legislative committee of the board which keeps in close contact with the fourteen senators and representatives in the area served by the Clinic. This committee is quite aware of how to get money from the state. They know, for instance, that all mental health bills go to the Public Welfare Committee, where action is usually favorable, since money is not attached yet. It is in Ways and Means that a bill lives or dies. When Quincy had a bill there for the purchase of land for a new clinic, all fourteen of the legislators were brought in by the lobbyists to testify.

Getting the site for the new clinic also involved the Center in politics. Three years ago the legislators from the South Shore managed to make the state transfer land from MDC for the center. The abutters to this land were strongly opposed, so for public relations the board of the clinic

(citizens and state officials) decided to look elsewhere. They could not get the City Council's approval for a site adjacent to the city hospital, but they soon found another possibility. This was an eight-acre plot at the center of population of the area. They wanted the city to acquire it by eminent domain but were rebuffed, so they introduced a bill in the state legislature to buy the land.

The site had access to transportation, was near a project for the aged where a nursing home will be, and there were no objections from the ward. Now the bill is before Ways and Means; the fourteen legislators are in action. The only opposition is from a senator who comes from a town which gave the Department of Mental Health land. He objects to the necessity of the state purchasing it in Quincy.¹

Underlying Medical Issues

Besides the politics underlying the planning of the local centers there are two of same medical issues that were obstacles to planning at BSH.

Were psychiatrists to go out into the community and assume they were the professionals and all the others sub-professionals, or were other people going to be allowed to

¹ The recent history of the clinic was supplied by Mrs. Roberta Manton of the South Shore Mental Health Association.

play a part? In the Quincy Clinic's search for a community of partners it was "Stressed...that jurisdiction and responsibility for cases being diagnosed and treated at the Center were shared jointly with the referring agency.... This involved the agencies in the decision-making process."¹

The second issue is the dichotomy between the psychoanalytic and social approaches. The director of the Tufts center, aware of the obstacle that the classical medical model presents to the community mental health, has a social scientist keeping tabs on the attitudes of the staff. It is as if he were watching for a symptom that might destroy the growing idea, similar to the ideology scale at BSH.

In the midst of this, Tufts is running a residency training program and must make an immediate decision between the two models. How much time should the trainee spend in the community? The decision has been a compromise that allows partial comfort to both parties. For the first two years of the residency the students will take the core psychiatry course, the psychotherapy. In the third they will spend part of their week in the community, working at settlement houses or housing projects or with religious orders.¹

¹ Rosenblum and Ottenstein, op. cit., p. 278.

² Dr. Paul G. Myerson, director of the Tufts University Mental Health Center, at the Conference of the Regional Planning Committee of Metropolitan Boston.

The Quincy, BU, and Concord cases are not typical of planning. The people there have achieved something and are willing to talk and write about it. Most of the other centers, on the other hand, are at various abortive stages. The following is an account of one of them.

The planning in this city is characterized by a clash of private groups, weak state support, and a consequent lack of direction. It currently has a child guidance clinic with very little state money and a staff only consisting of four people. It also has a mental health association and an association for retarded children. The clinic is run by a board partially made up of these people and some medical men. Who is supposed to plan a community mental health center?

The clinic director, like the director of most clinics of this size throughout the state, does not know the ins and outs of politics unlike the superintendents of the state hospitals who became superintendents to some degree because they could play politics. But the state head of the child guidance clinic system, allied with the informal community mental health group in the DMH, had instructed clinic directors to submit names for the selection committees of the area boards.

The local director does not know how to procede. To

make matters worse, he is opposed by the president of the local Mental Health Association who has an office in the clinic. This man, a pediatrician, tends to emphasize the medical approach to mental health. He does not support community mental health and its implications for community involvement in policy. In addition he is the focus of another struggle - between the mental health and the mental retardation groups - a clash of private interests. The Association for Retarded Children is parent-dominated and the more comprehensive mental health associations have accused it of being a limited special interest group ("retarded children"). The conflict between these groups is a major problem in the planning of any health center. The retardation group is said to be politically less sophisticated than the mental health association. It passes bills unanimously in the House and Senate but fails in Ways and Means where money is attached, because it is ineffective in gaining allies.¹

In some places, like Quincy, the two voluntary associations work together, but in others they are not capable of cooperation and there is no one to arbitrate. This is unfortunate because the local body must seek the money - Quincy went to the state and Concord to the federal government.

¹ Source: Harvey Newman.

Cities that are poor or badly organized lose out.¹

This city then has no united form to present to the state or federal government. Its case shows the absence of any element of rational planning. There is no learning

¹ Concord had the technical help to get outside money; Quincy had the political organization. These two factors subvert a "plan" based on a state-wide system of priorities. A proposed theoretical solution is the advocate. The advocate planner represents a particular group and does not try to be comprehensive. The goal is the meeting of needs. Politics is either avoided (through, for example, the authority) or people are given more power. The second is what the advocate does. He gives a group of people technical power so that they may compete. This would work in mental health through financial support for preliminary planning. Perhaps some kind of federal social-planning grant would be the answer. Without it, many communities will not be able to get organized enough to ask for money. In city planning the advocates are usually outside the structure of the formal government, but in mental health planning they need not be.

It is interesting that fields other than city planning are in the midst of a debate similar to the advocacy versus comprehensive arguments. Social work now is emphasizing community organization instead of individual casework. Case work and comprehensive planning both require a long education and "professionalism".

The current interest is part of a cycle. At the turn of the century, Jane Addams practiced community organization at Hull House. Later social workers, perhaps out of insecurity, felt community organization was "unscientific", and that anyone could do it. To protect the "profession" and their status, they adopted the therapeutic stance of concentrating on the individual. But in the last decade with the civil rights struggle, this emphasis on the individual, and not on groups, seemed to lack relevance. Community organization, less "professional", less comprehensive, came back.

Medicine too is now moving away from the model of the individual as the instrument who should be treated. Dr. Duhl noted that community mental health is really a return

about the community, no translating of its needs into a program and no cooperation between the local resources.

¹ (cont. from p. 74) to the "moral treatment" which was practiced by Dorothy Dix in the nineteenth century. This was a humanistic movement which did not rely heavily upon "scientific" knowledge.

Thus all part of a cycle, psychiatrists, social workers and city planners are realizing that the community, with its threats to status and profession, must be more in the focus.

IV: LOCAL PLANNING: OUTSIDE ACTORS

IV. LOCAL PLANNING: OUTSIDE ACTORS

Introduction

A study of the planning process of community mental health centers would be incomplete without a discussion of the outside actors whose interests lead to an involvement in the local process. In three short cases I hope to bring out the varieties of private, public and semi-public interests that complicate the planning of community mental health centers.

Private Interest: Massachusetts Association for Mental Health

In the previous cases, it was noted that when the state hospital or general hospital was not planning, the mental health association was. This happened in Concord, Quincy, and to some extent in Dorchester. These groups were affiliated with the Massachusetts Association for Mental Health, a voluntary health organization affiliated in turn with the National Association for Mental Health. The state organization has only sixteen local associations beneath it, but hopes to establish more. Under the broad goal of reducing mental illness, it is proceeding on several fronts - supporting research, public education about mental illness, volunteers that help in state hospitals doing clinical and

administrative tasks, lobbying for social legislation, and planning-community program development. As a private organization their primary goal - they admit, is to further their organization. Though, in this case, their organization is a social one and inarguably had the public interest at heart, it is still privately funded. It must be considered as an input to the federal-state-local system of health services that is being developed. It sees planning and the development of community programs in community mental health centers as a means toward more associations.

Its community organizers enter the picture with the area board. They talk with mental health citizens' groups to bring people together at the local level. At the present time they are trying to place their people's names on the selection committees of the new boards. A short case history of a state MAMH organizer in Fall River will illustrate where the MHA comes into the local planning picture.

It was not spelled out in the legislation when the area board was to be established. This compromise to the medical and Departmental interests, at the sacrifice of the community, added to the power of the central state body which was already strong enough to prevent change, if not to make change itself. By law, the boards are appointed by the Commissioner with recommendations of the local people. The recommenda-

tions are received indirectly. First, the community must submit ten names for a selection committee. After seven of these are appointed to the committee, the group has thirty days to propose fifty nominations for the twenty-one member board. The Commissioner can appoint anyone, even from outside the fifty, but he is limited to certain categories of people, four from MHA, four from the local association for retarded children and one representative from every city or town in the catchment area.

The process was further diluted in Fall River where the Commissioner sent a letter to each of seven agencies asking for ten names. The task force group, which wrote the state plan, objected to this and called for one letter to the various groups to urge the organizations to hold a joint meeting and agree on ten names. Thus, the task force attempted to centralize the planning on the community level, and prevent further dilution of the intent of the legislation.

Fall River, under the direction of the local Mental Health Association community organizer had its meeting, sent in the names, but meanwhile was opposed from the medical front. Taunton State Hospital now provides service to Fall River. Its director is medically-oriented, not convinced of community mental health and opposed to citizen participation in policy, favoring only a medical level of community

involvement. The director of the new center in Fall River (the state built it with federal funds) is paid for part of his salary through Taunton State so he is not really in control of the resources or the planning.¹

To counter the medical force there is a real need of professional leadership on the area board. First, the board must establish itself and it is here that the MAMH is providing help. The Association is pressuring the Commissioner to recognize the area board (the Department could wait five years); and second, the Association must give the area board some idea of what its job is. Now, the job is unclear. The area board has power to approve or disapprove "annual plans" but it can only advise on the budget that the area director submits. Separated from the budget, the inevitable tendency will be not to take in the plans seriously, or worse, never to make the plans explicit for fear of their being reviewed by the area board. A similar happening occurs in urban renewal.

In addition to "power" of review, the MAMH bases its faith in the area board's power to accept the local dollar. They point to this power in Concord. It is not significant though when there is no local dollar and the only real power or money will come from the federal dollar, which must go through the State Department of Mental Health.

¹ Source: Clark Wilmott.

In any case, the MAMH is encouraging the establishment of the boards, seizing even at hints of institutional change. It is fighting medical and political power. Taunton, too, has two camps of psychiatry and it is apparent to all that the area board can be a lever to oppose the traditional medical model. To whom will the area director report is a political question. If he reports to the Taunton State Hospital, the intent of the law is lost. If he reports directly to the Department, no local political force can counter his moves or feel any responsibility. Now it appears that the former is the more likely, considering the weakness of the Department and the scarcity of local money.

The MAMH sees for the area board, though, a useful function in mental health in this area. Taunton State has no well developed hospital auxiliary like Massachusetts Mental or Boston State. The Fall River board could force this step in mental health, one taken years ago at more progressive institutions.

It is possible that the private group can be an agent of change. The MAMH can be viewed as creative federalism's inadequate adjustment so that towns like Concord do not get all the federal and state resources. The problem is that the state, which should be doing the organizing, has in

past years waited to be called before it enters an area with mental health money.¹ The DMH has been given the responsibility for the Federal legislation, without being injected with the desire to do the community organization that is necessary for true implementation.

The question is "How can this local planning be evaluated, guided or controlled?" The entrance of private groups like the MAMH with their own interest must be considered.

Medical Foundation: A Quasi-Public Interest

Into the vacuum of no planning and the opposition of medical and political (Department of Mental Health) interests, enters another group, the Medical Foundation. A non-profit research and planning organization hired by the State to do the original plan (1963-65), this quasi-public body has become the focus of the informal mental health system in the state. In opposition to the Department, the Medical Foundation represents the group of community psychiatrists. It is one of the ways these psychiatrists hope to politically implement President Kennedy's "bold new approach."²

The Medical Foundation is making an interesting adjustment within our system. It was a defacto legislature during the two years it wrote the plan. In the mental re-

¹ Source: Harvey Newman.

² See introduction.

tardation plan it served an executive function as well, for the third year of its grant was for implementation of the legislation. The mental retardation planning areas will mesh with the mental health ones.

Implementation means the building of local groups, or community organization. Representatives from the foundation are traveling around the state "selling" the law. Within the local communities they have placed their emphasis on the formation of the area boards. Their problem is to persuade the various groups already organized, (the Mental Health Associations and the Associations for Retarded Children) to work together. By the law, eight of the twenty-one members of the board must come from these two groups. The organizers work with legislators in the communities and with welfare people. Because of lack of time they cannot do grass roots organization (their mandate expires June 30, 1967) but must concentrate on the existing groups.¹

The Medical Foundation is filling a gap in the federal system. Not a public body by law, it is a planning group representing the public interest, somewhat analogous to the public authority, not directly responsible to the people, but necessary for action.

Summary

The traditional arbiter of private interests is a public

¹ Source: Harvey Newman.

body. We have seen private groups in conflict: the Mental Health Associations versus the medical opposition, the MHA versus the Association for Retarded Children, etc. On the local level no public body has a real influence. Mental Health is not as central as schools or roads, and the city councils, with little money, are difficult to move, (see Quincy). The state, we have seen, has been opposed to the legislation, and to the reorganization of the Department. It tends to support, if only by inertia, private groups, primarily medical ones, who are not enthusiastic about community health. The Department, medically rather than administratively oriented, is doing next to nothing in local planning. The reorganization has not occurred and the Department is waiting for a new Commissioner.

That leaves the federal government where it all began.

Role of the Federal Government

It is often said that if there is to be any kind of integration of health services the stimulus must come from the federal government. The federal government here is the National Institute of Mental Health.

NIMH can only review the planning of facilities which involve federal funds. So far this has only been in applications for staffing and construction grants. Congress between 1963 and 1965 provided assistance in the formulation of

the state plans which set the priorities for centers but for further implementation, the federal government serves merely as consultant. Community organization, in the federal system, is left to the states.

Thus, for example, the federal consultant meets with a group that wants to apply for funds for the construction of a center. Hesitant to write one proposal for them, the consultant will try to help the group think of what they want. He will suggest staffing patterns, like the doctor-patient ratio, or advise on program development. To accomplish this he will tell the local group about examples of good programs.¹

The consultant will exhort the local group to include as many representatives from the community as feasible. The power behind this exhortation is a form entitled "Checklist for Review of Staffing Application", which consists mostly of technical items, like the listing of dates.² The requirements for cooperation with other agencies include only the formal contracts, not informal alliances which would have to be made to insure a good program.

¹ Source: Jerry Redding.

² Checklist for Review of Staffing Application, NIH -931. e.g. "Has the applicant submitted at least the minimum number of applications?" "Has the applicant submitted all four budget tables...?"

Federal "Plan"

The federal government, in its review, requires a community plan to show how the elements of services (the ten elements) are or will be met. The suggested plan can be roughly outlined as follows:

- a. Description of population: age groupings, economic characteristics; education, marital status, public assistance, housing, recent changes, subgroups.
- b. Extent of mental illness: persons in treatment; persons who would have been referred had service been available; alcoholism; retardation, drugs, juvenile delinquency.
- c. Need for additional mental health services: the existing and proposed services (defined as one of another of the elements) and their relationship to other services.
- d. Factors in delivery of needed services: transportation problems, geographic factors of the service area; location of buildings for the programs; personnel recruitment policies; methods for financing; plans for involvement of mental health and related personnel.
- e. Relationship of program to other efforts: other agencies providing related services; financial assistance from other services; relationship to state wide services and planning.¹

¹Application For Staffing Grant, Community Mental Health Center, NIH-931 4-66, p.2. 2) Optional Worksheet to Accompany Application for Staffing Grant, NIH-931 (Supplement)

The main criticism of this "plan" is that it does not approach the way a planning process works in reality. There is no assembling of a list of resources. The learning about needs is in terms of census data alone.

The plan does not reward the criticism of gaps. It only rewards coordination, which is probably optimistic. Assuming what people want it proposes services before consulting with the community. Like health plans in general, the data collected in the beginning has little relation to what is presented later. For example, "factors in delivery and relationship to other programs" should precede statement of need, not follow it.

No Guidance

The major problems are an inadequate conceptualization of resources, a premature assessment of need, and a development of program that duplicates a mistake of city planning - not consulting the people until the very end, if then.

There is no checklist on the procedure to learn of needs and resources, only a check on the finished product. The process as well as the result should be monitored and guided. The federal consultant is not helping a learning process, but rather helping those with money who have already learned.

It must be concluded that the federal government is a very ineffective agent of change at this time. It does not reach most communities since it delegates proselitization of the legislation to the states. Often, more than one group from the same area will apply for aid. For example, two hospitals may want money. The state is too weak to persuade the hospitals to cooperate.

The federal agency hesitates to give advice, for in this legislation the same agency evaluates and approves the plan. There is fear of being called authoritarian. The lack of confidence is perhaps related to the lack of money. Harold W. Demone pointed out that last year the federal government spent only 5% of the total spent on mental health in Massachusetts. And before, it was nothing, just a "lengthy letter."¹ Unlike HUD, which can withdraw urban renewal or public housing money if there is no planning, the federal government here cannot take away what it is not powerful enough to give. It can only control the planning where staffing and construction grants are involved.² Each state receives a limited share which is one reason why

¹ Personal conversation, March 31, 1967.

² Public Law 88-164, Title II - Community Mental Health Centers Act of 1963; Amendments of 1965 Public Law 89-105 Mental Retardation Facilities and Community Mental Health Centers Construction Act.

Quincy was using state not federal money. The federal allotment had been used up by Lowell and Fall River.¹

What started out as an investigation of the way planning could be controlled led to the realization that guidance was necessary first. There was nothing to control.

Summary

No public body stands out as a strong arbiter of private interests. The political (state) and professional (old medical model) forces vetoing change, are still quite strong. A private group with a public interest like the Mental Health Association, a quasi-public group like the Medical Foundation, and the faction in the profession that espouses community mental health, have tough sledding. The local bodies are moved to the limited extent that they are able, by the Mental Health Association. The federal government, which supports local planning, is still too weak to be a significant influence on the planning.

Thus the outside actors opposing local planning, and opposing change, tend to triumph over those supporting it.

¹ Source: Mrs. Roberta Manton.

V. CONCLUSION AND PROPOSAL

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This concludes the study of the planning process for community mental health centers. We have looked closely at the formal and informal planning of a large state hospital, policy issues that arise in staff meetings and the program development of individual doctors. We have studied other centers as well. The Concord and Quincy cases illustrated the political facet of local planning. BU showed the possibilities for community involvement in an urban setting. Underlying the planning of all the centers were medical issues. What should be the role of the psychiatrist vis-a-vis other personnel? And how strongly held is the belief in community mental health? After examining the case of an unnamed center that typified the conflicts and confusion of the planning, we attempted to complete the picture by viewing the planning from the perspective of outside interests in the state. Thus we saw both the private and public planning that occurs, as well as the quasi-public. How can it all be characterized?

Chaotic Planning: Four Points

The general conclusion is that although the planning is free, it is also chaotic. Though good work is often produced, the manufacturing process is haphazard and

frequently inefficient.

1) The lack of internal guidance or conceptual framework of how to plan is shown by widespread ignorance of what information is needed to begin planning for health services. Most doctors and other health personnel do not realize that the use of information is one of the most necessary facets of planning.

2) External guidance existing does not have the power to compensate for the absence of internal guidance.

3) Because of the chaos and uncoordinated pluralism, the planning cannot be controlled by a third party, particularly a non-medical one. Evaluation of the planning process is impossible for many of the same reasons.

4) Citizen participation in planning new centers is minimal.

Planning as Information Use

The fears of planning are as great as the hopes it brings. Both are laboring under a misconception. Planning in the United States is not the stick of power. Our political system does not work that way. As Banfield points out, we, including planners, are distrustful of any delegation of power to a group that will tell too many other people what to

do. Planners recognize that they do not control events directly. Instead, by providing information for others, the planners enable groups of people to cooperate. Planners assume rational men will use the information reasonably.¹ Thus, for instance, in making a land development plan for a city, the planner gathers data from the civil engineer on the type of housing safe for particular soil types. The planner then places the information in a "plan", for the guidance of the real estate builder and buyer. Compulsion by the city government, not the planner, comes only if it becomes apparent that someone was abusing the public information by malpractice, that is contrary to what is defined in the police power.

I will give two examples how the function of providing information might work in health planning.

The Massachusetts Association for Mental Health, the Department of Mental Health, and United Community Services have organized a regional planning body to include the five catchment areas of Boston. This body, the Mental Health Planning Committee of Metropolitan Boston, has not been designated as a new agency but exists rather as a voluntary group of citizens which will provide guidance in local planning. As such, it will be almost completely useless as a regional planning effort, for its task is vague.

¹ Psychiatrists, Dr. Duhl noted, do not assume this. He argues for a greater use of psychiatrists in policy-making because of their awareness of human process.

and it had no staff to gather and disseminate information.

How could an individual center use a regional health planning body? If each of the five centers contributed toward a full-time planning staff, the group could be provided with some useful data. Dr. Dana Sheldon of Boston State Hospital said that in the Geriatrics Service he will be getting patients from the other four catchment areas in Boston, yet there is no standard form to ensure that data follows these people. Much information remains in the minds of doctors and nurses and is never written down. The unit system within the hospital eliminates some inefficiency, but the hospital must be considered as a unit in the region as well. For quality control there must be good patient data.

Moreover, some agencies serve more than one catchment area. Each center is trying to establish contact with these other services. It would be better if a regional body could help with the negotiations. Resource files of doctors and agencies, compiled by a regional planning staff, would help coordinate the many health systems now in existence.

Regional planning is only one side of the coin. The other is local planning, and this too involves gathering information. The following example from city planning will

also show that the information for local planning can be secured outside the present professional councils of planning.

The city planning commission of Tuskegee, Alabama was receiving planning assistance from the federal government, which paid for 2/3 of the cost. The planning consisted of a report called a Neighborhood Analysis, a study of the physical, social, and economic conditions in the city. Because Tuskegee did not have money for an adequate house-to-house survey of social and economic characteristics, out of the necessities of economics and a belief in democracy, the technical consultant to the city, who normally would have had the work done professionally, decided that he would send the planning commission, an unskilled group, into the field to gather the data. Although this group is "establishment", its members, products of the poor Alabama school system, were no more able than most people in the North who have been through public school. The citizens walked the streets, learned about their city for the first time, and although their work was "unprofessional" and sloppy, it told the story. The technical consultant took their rough data and wrote the report.

Boston State Hospital and the other centers need information about the community - its people and its agencies. This is part of planning and it is logical to use the com-

munity to get this information. The two-way flow of data, into and out of the hospital, would go a long way toward making a community mental health center. But not knowing the information they need, and not even realizing that this is a facet of planning, they cannot ask outside groups like area boards to help them gather it. One purpose of this thesis is to point out the information needed by showing what questions people were asking in the different centers.

Without realizing it, doctors and psychiatrists plan now. They use information in a problem-solving process which is first a perception of the environment. In planning terms it is an inventory of resources, learning what others are doing in order to avoid duplication and achieve cooperation. A determination of need follows analysis of the resources. Next there is a setting of goals and intermediate objectives to meet the need. This involves a set of administrative arrangements for more efficient use of present resources. The "Plan" is usually thought of as these arrangements - the implementation - but it is really the whole process. It must be pointed out that design and testing of alternative courses of action is also built into the problem-solving process and the use of information. The testing takes the form of feedback on implementation.

Individuals working toward community mental health centers are planning; they are using information. They are

learning about the community (Dr. John Hart). The result is sometimes a resource book of one level of sophistication or another (Boston University and Concord). They are seeing where gaps lie in the service network (usually in consultation) and moving to fill them (building contracts and interfaces). Implicitly, they are designing alternatives and relying on feedback to test these alternatives.

The problems is that there is no institutional framework to help them in this process of planning. The doctors at BSH work almost in isolation, as do the local actors at the other centers. Resource books should not be written by different people over and over again; or not written because the doctor does not have time. The lack of time costs him, and it costs other people because they do not benefit from what he has learned. There is no organized way to gather information about what is happening in the community, hospital, or other clinics. If one doctor learns about needs, he has no mechanism by which to feed the information into the system - no seminar, no planning letter.¹

Information should flow easily, within the hospital,

¹ Dr. Victor Sidel in a lecture (February 23, 1967) mentioned the poorly designed channel to bring people together at Massachusetts General Hospital. According to Dr. Sharaf, the same situation exists at Boston State Hospital. Even a lounge would help the process.

between hospitals, to and from agencies, with the aid of local people. Through this information the local actors will find they have allies. The outside actors will be better able to help the local planning efforts. And a system will evolve in which the forces opposing planning will be more and more likely to lose. Information and technical assistance will become translated into political power.

Proposal

Internal guidance can often only come from an outside example of what information to gather and how to do it. External guidance can be an alternative system suggested by another level of authority. The planning of community mental health centers needs a structure equivalent to the Workable Program for Community Improvement used in city planning.

When Washington says that "planning" is required in order to receive federal money, it means the Workable Program. This was instituted in the Housing Act of 1954, which, under Section 701, reimbursed the community for 2/3 the cost of planning. The planning consists of seven elements. Three are written reports with information and analysis. The other four are procedures that must be adhered to and reported. The written reports comprise what is generally

known as city planning. They are:

-Codes and Ordinances. The city must adapt or show it is in the process of adapting: a zoning ordinance, building, plumbing, electrical, and housing codes.

-Neighborhood Analyses. This is a report on the social, economic, and physical conditions of the city which includes recommendations for alleviating blight.

-Comprehensive Plan. A land development and a thoroughfare plan cover this element.

The other elements are:

-Requirement of citizens' participation, which usually takes the form of an advisory committee to the planning commission.

-An administrative organization.

-Financing - Some kind of budgeting must indicate how the rest of the program is being financed.

-Provision for relocation.

Each year, the city submits a report showing the progress in the past year on each of the elements. The Department of Housing and Urban Development (HUD), which administers the Workable Program, does not require that a city have, for example, complete codes and ordinances in one year, but it does require that progress be shown, and that within a

number of years all the elements are completed. If a city fails to fulfill the requirements, HUD can stop the flow of money for urban renewal, public housing, water and sewage grants, etc.

The system is not infallible. For instance, a city not meeting the requirements and foreseeing trouble with HUD, could go to one of its senators who might be on the appropriations committee for HUD. The senator could pressure the bureaucracy, through a top administrator, to pass the city's program that year. But despite politics, the Workable Program does provide an external guide to planning which the city tends to internalize. The idea of it, if not its application in places with entrenched interests and long standing planning programs, would be very useful in community mental health planning, as well as in general health planning. A guide listing the steps for planning (the information and the process) would make the planning easier to understand, evaluate and control.

The elements of a planning program for health services should simulate, as much as possible, the informal planning process of the best centers. From the study of the planning in the various centers I have assembled a list of four elements that could comprise such a program.

- Resources
- Needs
- Interfaces
- Citizens' Participation¹

Resources

This element in social planning corresponds to the "inventory" compiled in city planning. The main purpose of it is to learn who is doing what. Doctors and others do this informally, but in only a few centers has it materialized into a "book" of private and public agencies. Concord has one that lists the hospitals and services, describes the type of care available, the cost, and the conditions, such

¹ Many guides to health planning recommend a planning process and touch on these elements in one form or another. Bertram Brown's Planning, Programming and Design is the best I have seen. It is a case study of San Francisco, which had had a very sophisticated health planning body. Presenting the information graphically whenever possible, the San Francisco group first tried to assess the character of the different parts of the city. This was a social analysis. On maps, the planners showed non-white population, major transportation, land use, urban renewal, income and education levels (the community mental health center went to the tracts in the lowest quartile), employment, juvenile court cases, welfare recipients, population over sixty-five, etc. This is almost identical to city planning's neighborhood analysis. On a map, they showed the mental health resources available: the psychiatric services, hospitals, public health centers. They listed contractual arrangement made by the Department of Health with private hospitals and criticized deficiencies or gaps in service. In an essay

as a waiting list. It also gives the phone numbers of private psychiatrists. A good model of a resource book has also been written by a group of Wheelock students. Called Know Your Neighborhood it was published in English and Spanish for the South End. It underlines the double purpose of a resource book - to educate the staff about the community and the community about the service system.

¹ (cont. from p. 991) they discussed the mental health needs - the problems of lack of standard data and the medical and socio-economic conditions - which affect mental health. The goals of the treatment center...whom are we to treat and how are the services to be organized...were raised as questions. New administrative patterns of delivery were dealt with, specifically the team approach and vertical geographic-based services, similar to a unit system (under this, rather than having e.g. a section for geriatrics there is a unit serving a neighborhood).

The Brown narrative and the others do not make the next step to a workable program, a formal guide to planning with a checklist of elements that can be evaluated and controlled. Harold W. Demone, who is doing the mental health planning in Massachusetts, never heard of the workable program idea and was quite interested to see if it could be carried over from city planning. The problem, he pointed out, is that the federal government does not give money sufficient enough to force people to listen and be monitored.

Needs

The Boston University community meetings, held to start a dialogue between the staff and community, were an implicit attack on the traditional epidemiological approach to determining need. Classic epidemiology is a search for pathology in the population. Besides being inadequate because of conceptual problems,¹ the approach only looks for 'what's wrong with you?' not what's wrong with the delivery mechanism or even the deliverer himself. It is symptomatic of the lack of training psychiatrists receive in assessing the needs of a community, as opposed to those of an individual.²

Some techniques of city planning could be carried over to health planning to study the community. Particularly, the Neighborhood Analyses of the Workable Program and the Community Renewal Program of the urban renewal project illustrate the type of information that has to be gathered, and how it may be used for the most understanding.

Hartford's CRP "The Social Setting for Renewal" (1964) is an excellent example. It begins with a social profile

¹ Cartes notes that epidemiology is plagued by "no systematic typology of need and no parallel typology of services." ("Measurement of Need," in Polansky, N. R. (ed.), Social Work Research, p. 203.).

² Source: Dr. Ralph R. Notman.

which notes demographic trends of the last decade, such as "newcomers" to the city, the "pull of the suburbs," and the people who remain. The report uses standard census data on age composition, family status, level of education, place of work, and income. For each it shows the changes that have occurred in the city as a whole between 1950 and 1960 and notes the impact of the trends. For instance, under age composition there was a decline in the number of people between the ages of 20 and 64. The implication is: "Simply put, fewer wage-earners are supporting more people who are either too young or too old to work."¹ Later in the report there is a breakdown of figures by neighborhoods ("community profiles"), to show what is happening in each part of the city. For this, census data is supplemented by interviews with adults in the area, to learn about the social cohesion of the neighborhood, "common values and expectations", and "attitudes of the residents about the neighborhood." What "social function" does the area serve for the city or the metropolitan area? Is it a "port of entry" or a place to settle? This includes maps of the neighborhood and descriptions of the physical and economic conditions of the land as well as an analysis of the status of the people. Some of the information gathered

¹ The Social Setting for Renewal, op. cit., p. 5.

about this was: housing condition, rents and incomes, crime rate, cases of public assistance, household composition, employment status, and residential mobility.

The city planner, as an agent of urban renewal, will primarily make recommendations concerning the physical environment, after learning about the community. The health planner should react to the new knowledge with ideas for services.¹ Thus, B.U., after its dialogue with community, found a need for employment counseling. An important function of citizens' participation (the process) is to force the professionals to work with local population in defining the needs of the community (gathering information).

¹ Even if this approach were taken, many would demur. They would say, to the extent that social conditions cause mental disturbance, the delivery of services is irrelevant. What is needed, HARYOU in New York decided, is social action not a "cluster of services" (Perlman, Robert and Jones, David, A Report on Neighborhood Service Centers, prepared for the Office of Juvenile Delinquency, Welfare Administration, HEW, Aug., 1966.) p. 42.

This is backed by the evidence of a decline in social pathology during civil rights demonstrations, "protest activity...aimed at mastering their own fate." (Ryan, op. cit., p. 125.)

This step to social action drew opposition to the poverty program. If psychiatrists accept the theory that lack of power is the cause of mental illness as well as of poverty, the premise that mental health can be achieved in the community by the delivery of the ten elements of service (out-patient, inpatient, etc.), is misleading, and the community mental health legislation as it is being planned now, will have to be scrapped.

The element of need must be learned through communication with the people. It is insufficient to box it prematurely into the categories of epidemiology and it is just as insufficient to make a blind use of demographic data without a thorough understanding of the implications of the changes in the numbers.

Interfaces

With the transition of the traditional mental institution to a community mental health center, the number of boundaries the institution has with the outside is greatly increased.¹ We saw this process occurring in all the centers. People within were making contacts with outside agencies such as schools and other hospitals. It is necessary to write down the formal and informal relationships that are being made. An analysis of the effectiveness of existing ties should be undertaken. Criticism of lack of coordination, as well as reward for coordination, must be built into the planning process.

Citizens' Participation

This part of the program is observation and narrative

¹ Frank Baker, "An Open-Systems Approach to the Study of Mental Hospitals in Transition," op. cit., p. 14.

of a process more than compilation of information. The center must show how it is involving outside lay people in its planning.

Citizens' participation would be useful in several ways. The citizens, in the form of a hospital auxiliary in the case of Boston State, could help gather information needed for other elements of planning, especially needs and resources. Citizens' participation would help break down some of the barriers now existing between hospital and community, as well as serve as feedback on implementation.

Faithful use of this provision would increase the number of "subprofessionals" in the health field, achieve the educational function of a community mental health center and counter the argument that the delivery of services is irrelevant. If citizens are able to participate they will gain more power.

Which of the four elements have been fulfilled in the planning of the community mental health centers under study?

Boston State Hospital does not have a resource book, but could compose one from a description of departments within the hospital. An account of the work at the Dorchester Home Treatment Service and that of Dr. Hart in

Roslindale, would help fulfill the second element, concerned with assessing needs. It is in the realm of "interfaces" that research is necessary to learn what the relationships are. Schulberg's study¹, even at its early stage, would provide much of this data. In the area of citizen participation however, BSH would be forced to do more than simply write down what is already occurring. It has to begin to think along lines which it has tended to neglect until now, because of its size and professionalism.

Through a report of its meetings, BU could provide a good method for fulfilling the needs requirement. This center and Quincy are models of citizen participation in an urban area and a middle income suburb, respectively. Concord's use of its citizens is a good model for a higher income neighborhood.

In each, a different form of citizen participation is evolving. In Concord, where the citizens are closest in social class to the professional, the citizens do complicated planning - the lawyers' charting of the intergovernmental course. Quincy uses its organized groups in influencing

¹ See p.ii and the comment in the bibliography for a description of the Laboratory of Community Psychiatry Project.

the state legislature and the City Council, whereas in BU, citizen participation is employed to define the needs of the community.

Boston State Hospital could learn from the examples and use its auxiliaries, or a fully supported area board, in the four-point planning process. The participation requirement is the most important condition of this planning. It is not just a matter of what information is necessary to plan, but also what steps must be taken to gather this information.

With all the centers submitting reports of their planning, a mutual education process will unfold to guide further planning. At this point people do not know what others are doing.

Program...as Evaluation

The first purpose of the program is to guide the planning; the second is to evaluate it. In the evaluation it is necessary to distinguish between intermediate and final goals, evaluation of the clinical and planning processes, and finally, between evaluation of process and evaluation of result.

Planners entering the field of medical services are beset by two obstacles. On the one hand, there is resent-

ment by doctors who feel that non-medical personnel have no right to give advice that may affect clinical practice. The other, related to the first, is the fear held by the planners that they are too ignorant to plan for "health," the final goal of this planning process.

The literature of planning and evaluation of medical services does little to allay these doubts. The writers use the standard terminology of searching for objectives, criteria, and indices that can quantitatively measure the results of one approach or another, but they are usually referring to the evaluation of a clinical process. For instance, Bernard L. Bloom says:

"It goes without saying that some demonstrable results must be postulated by every mental health program....Variables might include incidence, prevalence, severity or distribution of a psychiatric disorder, degree and duration of patient improvement, cost of services or agency recruitment and retention success..."¹

The question is whether it is possible to establish this within the near future. Bloom notes two factors that might make clinical evaluation almost impossible:

"The diagnostic classification system is in need of substantial clarification....Few accepted criteria

¹ Bloom, B. L. op. cit., p. 4.

of improvement are available. There are almost no satisfactory incidence or prevalence measures, and even the concept of a 'mental health program' is unclear."¹

"Highly significant change is taking place in program objectives. The parallel changes required in the system of data collection, analysis, and utilization for purposes of program evaluation have not kept pace. When a mental health program consisted essentially of a centralized State psychiatric hospital which had the primary objective of providing humane but economical residential care, data on the number of admissions, discharges, and readmissions, per capita cost, and staff-patient ratio constituted highly relevant information for assessing goal attainment.... Community-based...programs,...with emphasis on primary prevention, continuity of care, sufficiency of services and restoration and rehabilitation requires a quite different information in order to assess accomplishment."²

The evaluation of a final goal such as health, may not be feasible now. What is needed, is a guide for action to take until it is possible to evaluate health more accurately. Morris and Binstock point out this need: "The absence of explicit, carefully analyzed and developed intermediate goals is characteristic not only of social planning efforts, but of most goal-oriented activity."³

¹ Bloom, B. L., op. cit., p. 7.

² Bloom, B. L., *ibid*, p. 8.

³ Morris and Binstock, R., Feasible Planning For Social Change, Columbia Univ. Press, N. Y., 1966, p. 77.

This approach in clinical as well as other planning, creates some doubts. For instance, MacMahon et al refer to a distinction made in clinical planning by Hutchison, "Between ...two types of evaluation,...'evaluation of intermediate objectives' (the surgical technic) from 'evaluation of ultimate objectives' (the health benefits derived from the procedure)."¹ They note the basic flaw. "Unless it has been shown that the use of a certain technic is followed by beneficial results, what is the use of making sure the technic is being followed?"² They are saying that in the formulation of intermediate goals we must constantly keep the final goals in mind.

Planners though, cannot begin with the evaluation of the "health benefit," as this is a doctor's training and prerogative. Planners can help in the planning of program by seeing if the process followed has feasible intermediate goals. This is their training. This approach is advised for instance, in the Program Guide for Model Neighborhoods in Demonstration Cities. There the intermediate goal of a reduction in infant mortality is suggested

¹ MacMahon, B., Pugh, T. F., and Hutchison, G. B., "Principles in the Evaluation of Community Mental Health Programs", AJPH, vol. 51, 1961, p. 964.

² Ibid.

under the final goal of health.¹

The city planner can construct an intermediate conceptual framework for health planning, evaluating not the goals of health but, the goals of rational planning for health. He can offer his skills of data compilation and working with groups of people to the medical profession. Hopefully, this can eliminate much of the resentment held by doctors and, perhaps in a shorter time, reduce the ignorance of planners. Planners will then be contributing a technique to a relevant field, that of health.

...As Control

With the question of a guide to planning, and the complexities of planning evaluation, there lurks the specter of control. The health service system is an uncoordinated tangle of private and public services and insurance. Because coordination has not been forthcoming from within, another level of authority must enter to achieve efficiency.

Sociological literature is rich in discussion of the power structure and control within the community. James Q.

¹ Program Guide: Model Neighborhoods in Demonstration Cities, HUD, Office of Demonstrations and Intergovernmental Relations, U.S. Gov't Printing Office, p. 4.

Wilson reviews the issues that arise among community sociologists. One group (Floyd Hunter, the Lynds) believes there is a power structure in the community, while another, (Banfield, Dahl et al) refutes this contention. They see the community not as an oligarchy, but as a pluralism of interests which wheel and deal on decisions. Wilson rejects this either/or analysis. He notes that "recent studies have attempted to combine the reputational and behavioral approaches."¹ He does not view power as springing solely from an elite nor explainable only through observation of the resolution of an issue through its pluralism. But in his analysis he is speaking only of power within the community. For this thesis there is a need of a conceptual framework of power within the nation, especially as exerted by a federal governmental body on a local private body like the health network. This unfortunately seems to lie in the interstices between sociology and political science. In the former, only C. Wright Mills writes of national power and he speaks specifically of elites- a professional class - not the relations of governments. Political science deals with governments, but not in the sociological sense necessary

¹ Wilson, James Q., "An Overview of Theories of Planned Change", in Morris, Robert (ed.) Centrally Planned Change, National Assoc. of Social Workers, N. Y. 1964, p. 17.

to explain control over the activities, private agencies, or individuals. It only does this in a general way, e.g. Paul Goodman's social criticism.

The purpose of a planning program would be to exert control from a higher level of authority on the current uncoordinated mass of planning. The tool of control would not be persuasion, which health councils have unsuccessfully relied upon in the past, or "lengthy letters". It would be coercion, supported by money, and the attending power of economic reward or punishment. If a city does not have a satisfactory workable program the agency that administers the program can withhold funds. HUD does not have to ask another agency to wield the instrument of discipline. So too, in health planning, for the system of planning to be adapted, the amount of money behind it must be sufficient to make fear of loss and hope of gain a real factor in local decision-making.

Control is as important in the planning of community mental health centers and health services as guidance and evaluation, for without control there would be little incentive to be guided and no desire to be evaluated.

The final point is understanding. Without an understandable planning process, guidance, evaluation, and control

are impossible.

Robert Dahl, in his study of the politics of New Haven, noted the trend toward the growth of "noncumulative inequalities." How does a democratic system, whose strength, Toqueville observed to be its feeling of equality, work with the inequality of resources in the United States? Dahl's conclusion for New Haven was that with pluralism, groups make alliances, and generally the few rich people are not in agreement on a broad enough range of issues to control the populace. Besides this, there is a general democratic ethos, noted by Myrdal, that prevents an elite from exercising dictatorial power. In addition, most people just do not care. "Most citizens", as Dahl says, "use their political resources scarcely at all."¹ They have no time; they let the professionals do it; they feel themselves incompetent to handle the issues.

This feeling of incompetence is due, in part, to the absence of an understandable planning process. Two forces mitigate against understanding: the growth of professional expertise and the growth of institutions. Both trends occur inevitably with urbanization, and make democracy almost a function of density.

¹ Dahl, R. A., op. cit., p. 280.

Community organizers have stayed out of Boston because of the great number of professionals able to do the planning.¹ Professionals, by their status, awe the amateurs. The BU center has been involving nonprofessionals, but the large fees and the long education that accompany the status produce a system that makes it difficult for men to be "good."

The trend in health and city planning is toward larger and larger units that are difficult for the "common man" to manipulate. It cannot be denied that much knowledge and training beyond common sense is required to run a hospital or a system of health services, or a city.

The second point is the management of money. Can a group of people with sophistication to oversee the operation be assembled from Dorchester? The people in Dorchester and Concord are citizens but Concord has the lawyers; Dorchester does not. Will citizens' participation only take place where it can be "lawyer's participation"? Past a certain point in money invested, it becomes difficult for local groups to have a voice. Boston State has become too big for experimentation based on citizens' ideas. Even with professional leadership it took five years of experimentation to institutionalize the Home Treatment Service.

¹ Source: Harvey Newman.

It may be that the forces leading to efficiency, cost saving, and large institutions carry with them the seeds of destruction for citizen participation in urban areas.

Some of the inevitability of these trends in urban growth can be removed by education. An understandable planning process, with a built-in requirement of citizen-involvement, could partially reaffirm the democratic ethos.¹ Hoggart has written about the uses of literacy. His contention, in a study of the working-class of England, is that education has spawned a popular culture that taught people to read but not to think. He does not exclude other uses of literacy though. So too, there might be more uses for planning than we are accustomed to thinking of. One use might be a greater participation by more members of society. Faithfully followed, I have no doubt that this would create greater efficiency in the allocation of our resources, the traditional use of city and social planning.

¹ It seems to me that the mere conception of a vigorous and genuine democracy...depends on a capacity for faith in human beings so strong that on its basis one can dare to assume that goodness and intelligence will generally prevail over stupidity and evil." James Agee, Agee on Film Beacon Press, p. 285.

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Most of the literature in the field of mental health that pretends to be about planning is actually very poor. Vaguely written, the pieces call for the goals of planning to be such things as a "salubrious mesh" and often just conclude with exhortations for comprehensiveness. There are few guides that do anything to help change the system's present uncoordinated state.

I have noted where I found some item which was worth particular attention or caution.

Books:

The Brown piece is a beautifully illustrated and clearly written guide to planning. It uses the case of San Francisco and with the technique of a neighborhood analysis graphically and intelligently presents material on needs and resources. There is also a long section on the inputs of the design process.

Goffman's work is good for an understanding of the type of treatment the community mental health people were opposed to. The Joint Commission's report is an excellent background of psychiatric if not planning education. Ryan's booklet is the working document of the Boston regional mental health planning body. It is an honest discussion of the present utilization of services, handling class factors particularly well. The book by the Schwartz's is a clear nontechnical summary and analysis of recent trends in the mental health movement.

Articles and Papers:

Andrew's "Uses of Data in Planning Community Psychiatric Services" is mistitled. It only talks of a psychiatric case register, a very limited part of planning. Baker's paper is a concise conceptualization of the Laboratory of Community Psychiatry study of Boston State Hospital. It analyzes the method used: examining inputs, the processing by the hospital, and the outputs. For political reasons that made the study possible it has had to neglect the important role of the Department of Mental Health as an input. The articles by Becker, Murphy, and Greenblatt are a good summary of the community mental health movement. Bloom's paper is the finest discussion I have seen of the attempts to analyze the planning of clinical programs in mental health. Kramer's article on the hospital and community is one of several quite relevant pieces that have appeared in a new periodical: the Community Mental Health Journal. Schulberg and Wechler's piece is a good analysis of planning on a state level but not very instructive for local planning.

Miscellaneous:

Becker and Mirsky's proposal is an example of the meaningless statistical data that is required by the federal government to show need. The Local Guide to Comprehensive...Planning put out by the Retardation Project is a how-to-do what-to-expect pamphlet. It suffers from the lack of any outside support (money) or framework (program) for the planning they suggest. The Central Middlesex Proposal is an admittedly poor plan but the best that the federal government has received from this area. The Rockford Zone Chartpack is a clinical planning guide and is interesting for its didactic use of national mental health statistics.