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On the threshold of community mental health

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ON THE THRESHOLD OF
COMMUNITY MENTAL HEALTH

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Submitted for Honors Work
In the Department of Sociology
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1968

Elizabeth Ann Glosser

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Accepted by the Department of Sociology
of Illinois Wesleyan University
in fulfillment of requirements
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Project Advisor

PREFACE

In the midst of whirlwind social change, the United States finds its mobility and standard of living rising along with its crime rate and mental illness statistics. Though voluntary social welfare has historically undertaken the treatment of such social problems as emotional disturbance and marital discord, services seem unable to keep pace with the demands of modern living.

Careful community planning must organize the nation's many specialized social agencies to avoid overlapping and fragmentation of services in the face of growing needs. In McLean County, Illinois, as in every community, public goals and individual agency goals for mental health provisions must be predicated, above all, on service to the people.

Neil D. Michaud, Executive Director of Child and Family Services, Lewiston, Maine, told the 1966 National Seminar on Social Welfare and Community Mental Health that "thousands of small towns and cities stand on the threshold of making a significant contribution toward implementing the concept of community mental health care."¹

This study proposes a plan by which the McLean County Mental Health Center and Family Service of McLean County can draw the community across that threshold and wedge it firmly in the door.

¹Neil D. Michaud, "Planning for a Small City and Its Environs," in National Health Council and National Social Welfare Assembly, Proceedings: Seminar on Social Welfare and Community Mental Health (New York: National Social Welfare Assembly, 1966), p. 40.

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INTRODUCTION

Planners and practitioners in social welfare join sociologists, economists and political scientists in looking anxiously and deliberately to the future. Changes are emerging and continuing in American population make-up and distribution; education, occupation and income distribution; and marriages and families.

Population growth is the most obvious factor affecting the American economic and social future. The United States Census Bureau has estimated that the population will reach from 216 to 228 million by 1975, an increase of between 11 and 17 per cent compared with 1965.¹

While the total population of the U.S. increased about two and one half times during the first 60 years of the century, urban population multiplied nearly fourfold, metropolitan area population more than fourfold and large metropolitan area population fivefold. From 1950 to 1960, growth in the urban population accounted for more than 100 per cent of the total population increase of the country. That is, rural population declined (for the first time)

¹U.S. Department of Commerce, Current Population Reports, Series P-25, Numbers 311,321 and 359, cited by United Fund Raising, Projections for the Seventies (New York: United Community Funds and Councils of America, 1967), p. 5.

during the decade.²

Already, 70 per cent of all United States citizens are residents of communities over 100,000.³ If urbanization continues at the present rate, the percentage will climb even higher.

The population is growing younger, with the rate of increase sharpest for young adults. Projected increase of the total adult population between 1965 and 1975 is nearly 18 per cent. The number of individuals between 18 and 34, however, is expected to grow at twice that rate, while the number between 35 and 54 will remain nearly static. Increase in the number of persons over 55 will be close to the total average.⁴

At the same time that adult population is becoming concentrated in the "minimum" age bracket, the teen-age population is growing. Between 1965 and 1975 the proportion of youths between 13 and 17 in the population is expected to increase by 18 per cent. The number of youngsters from 6 to 12 will decrease slightly, as a result of the decline in births during the early Sixties, but children under six will be slightly more numerous by 1975.⁵

Today, approximately 19 million American adults have had some college education; by 1975 it is estimated that number will

²Philip M. Hauser and Leo F. Schnore, eds., The Study of Urbanization (New York: John Wiley & Sons, Inc., 1966), p. 8.

³Gerard Piel, et al., eds., Cities (New York: Alfred A. Knopf for Scientific American, 1965), p. v.

⁴United Fund Raising, Projections, p. 6.

⁵Ibid.

reach 27 million, or about 40 per cent more.⁶ This educational trend is responsible for the fact that U.S. society is increasingly white-collar. The growth of technical and scientific industries, computerization and the increased complexity of modern business will continue to expand white-collar employment. "Since World War II, white-collar employment has been growing three times as fast as industrial employment; this trend is expected to continue into the Seventies."⁷

With increased white-collar experience, the American income distribution curve is rising impressively.⁸ An important factor contributing to this rise is the number of working wives. Today more than one of every three wives is in the labor force; 15 million wives were working in 1967, two-fifths more than in 1957.⁹

Rising population of young adults means a concomitant upsurge in marriages. The marriage rate began to rise in 1963 and should continue to do so into the late 1970's. At the same time, the pace of new family formation is accelerating. During the first half of the Sixties, the number of families increased by an average 545,000 each year. The second half of the decade will see an annual increase of 865,000 families.¹⁰ By 1975, young families will account for almost one-third of the total population compared with about one-quarter in 1965.¹¹

⁶Ibid., p. 7. ⁷Ibid., p. 8. ⁸See Figure 1.

⁹United Fund Raising, Projections, p. 8.

¹⁰See Figure 2.

¹¹See Figure 3.

FIGURE I
 DISTRIBUTION OF FAMILIES AND INCOME (BEFORE TAXES)
 BY INCOME LEVEL, 1963 AND PROJECTIONS TO 1975*
 Per Cent Distribution

Income Class	1950	1963	1975	
			In 1963 Dollars	In 1975 Dollars
Distribution of Families				
Under \$3,000	31.0%	18.5%	12.0%	10.5%
\$3,000 - 5,000	31.0	17.5	13.0	11.0
5,000 - 7,000	19.0	21.5	13.5	11.5
7,000 - 10,000	12.0	22.5	22.5	20.5
10,000 - 15,000	5.0	14.5	23.5	26.0
15,000 and over	2.0	5.5	15.5	20.5
All families	100.0	100.0	100.0	100.0
Distribution of Total Income				
Under \$ 3,000	11.5%	5.0%	2.0%	1.5%
\$ 3,000 - 5,000	24.5	10.0	5.0	4.0
5,000 - 7,000	22.5	18.0	8.0	5.0
7,000 - 10,000	20.5	26.5	18.5	14.5
10,000 - 15,000	12.0	24.0	27.0	25.5
15,000 and over	9.0	16.5	39.5	49.5
All income	100.0	100.0	100.0	100.0

*Projection to 1975 is tentative, and subject to significant revision in a final report now in preparation.

Sources: 1950 and 1963 - U.S. Bureau of Census, 1975 - The Conference Board.

FIGURE 2
MARRIAGES AND FAMILIES
(millions)

	Marriages	Families
1960	1.5	45.1
1965	1.8	47.8
1970	2.0	52.2
1975	2.3	57.1

FIGURE 3
FAMILIES BY AGE OF HEAD

	Distribution		Growth 1965-1975	
	1965	1975	Millions	%
All Families	100.0%	100.0%	9.3	19.4%
Under 35	25.5	32.3	6.3	51.6
35-54	44.9	38.3	0.4	1.9
55 and over	29.6	29.4	2.6	18.3

United Fund Raising, Projections for the Seventies, p. 7.

While the aforementioned changes in the American scene can be catalogued dispassionately, some trends are not so easily dealt with. Among these is the abundant evidence that mental health problems are on the rise in the United States. Statistics on admission rates to state and county mental hospitals show an increase of 50 per cent in 1963 as compared with 1950.¹² Consultants suggest that "while this increase may reflect growing public recognition of psychological disorders as a form of illness and an increased willingness to seek treatment, it also indicates the number of persons who require intensive assistance in coping with their problems."¹³

Many individuals have problems of mental health which do not require hospitalization, but which do require some outside assistance to overcome. The social groups in the greatest state of flux in our society appear to be those most prone to be under stress.¹⁴ For example, the youth and children of the nation, mentioned before as an increasing group, have specialized problems that become more acute with social change. Note a similar proliferation of needs in the expanding age group over 65.

Meanwhile, as the composition of the basic institution of society, the family, changes, the unit comes under growing stress.

¹²See Figure 4.

¹³Booz, Allen and Hamilton, Inc., Report of Management Consultants, Study of Philosophy and Objectives, Programs, Organization, Planning and Financing (New York: Family Service Association of America, 1967), p. 14.

¹⁴See Figure 5.

FIGURE 4
TRENDS IN ADMISSION RATES
TO STATE AND COUNTY
MENTAL HOSPITALS
1950 - 1963

Year	Admission Rate per 100,000 Population
1950	101.0
1955	109.2
1960	131.8
1963	152.9

Booz, Allen and Hamilton, Inc., Study of Philosophy
and Objectives, p. 14.

Family Service Association of America

PROBLEMS AND NEEDS OF
SELECTED SOCIAL GROUPS

FIGURE 5

Social Group Prone To Be Under Stress	Characteristics of and Trends Affecting the Group	Nature of Problem	Group Needs
Individual Family Unit	<ul style="list-style-type: none"> • Family size is decreasing • Children are leaving home at an earlier age because of marriage, education, and employment opportunities elsewhere • Greater number of single parent families • More mothers are working • Fathers spend more time working away from home • Families tend to move more often 	<ul style="list-style-type: none"> • Individual family members lose contact with traditional sources of support and counsel • Increasing stress on families results in high divorce rates • Parent-child relationships may become strained in single parent families • Children lack family environment • Families must adjust to new environments • Limited income 	<ul style="list-style-type: none"> • Guidance and counseling services • Premarital education • Marital counseling • Parent--child adjustment • Recreation and guidance centers for children • Income maintenance • Companionship and social contact • Guidance and assistance in adapting to new environment
Aged (65 and older)	<ul style="list-style-type: none"> • Comprises an increased proportion of the population • Isolated by single-family way of life • Isolated by increased mobility of population • Extended life beyond productive years • 2.1 million are on public assistance, .5 million have incomes below poverty level 	<ul style="list-style-type: none"> • Require more housing and medical care • Lack of resource for advice and counsel • Lack of companionship with family and friends • More economic dependency on others • More prone to need medical care • Unoccupied leisure time • Lack of sufficient income without prospect of increasing income 	<ul style="list-style-type: none"> • Housing for elderly • Adequate medical care • Income maintenance • Recreation and leisure time activities • Companionship and social contact • Homemaker service • Protective care

Social Group Prone To Be Under Stress	Characteristics of and Trends Affecting the Group	Nature of Problem	Group Needs
Youth and Children (18 and under)	<ul style="list-style-type: none"> • Comprise an increased proportion of the population • Almost one million youths a year are school drop-outs with diminishing employability • An increasing number come from broken homes due to rising separation and divorce rates • An increasing number come from single-parent families due to illegitimate birth, parental divorce, or separation • Juvenile delinquency rates among youth are increasing • An increasing percentage of children are from families receiving AFDC public assistance • Lengthening educational years 	<ul style="list-style-type: none"> • Will require more recreational facilities • Need training programs to promote skills for employability • Lack of traditional sources for supervision, guidance, advice and counsel • Increase in unwed mothers at an early age • Family likely to have inadequate economic resources • Children likely to have no home or unsatisfactory home • Opportunities likely to be limited for many children • Economically dependent on others for longer time 	<ul style="list-style-type: none"> • Recreation facilities • Training and education for jobs • Parent--child adjustment • Preventive education • Family planning • Income maintenance • Child placement, foster homes, adoption • Juvenile delinquency prevention • Protective care • Psychiatric care for mentally disturbed children
Married	<ul style="list-style-type: none"> • Marriage is occurring at an earlier average age • A larger percentage of the population is getting married • Tend to live more in a single-family unit rather than with relations • A larger percentage of marriages are broken up by separation and divorce 	<ul style="list-style-type: none"> • Tend to have marital immaturity • Continued economic dependency on parents • Less availability of traditional family sources of advice, counsel, and guidance • Increase in marital stress and strife • More dismembered families and family disorganization • Isolation of one parent from children 	<ul style="list-style-type: none"> • Sex education • Premarital guidance and counseling • Marital counseling • Marital advice and guidance

Social Group Prone To Be Under Stress	Characteristics of and Trends Affecting the Group	Nature of Problem	Group Needs
Poor	<ul style="list-style-type: none"> • Increasing percentage are in urban areas--55% now • 15 million children under 18 are from poverty families as are 5 million persons 65 or older • Unemployment rate twice that of non-poor • 73% of male family heads were employed • Diminishing in number and percentage of population 	<ul style="list-style-type: none"> • Need housing, food, income, and medical assistance from others • Limited opportunities for children to rise above poverty • Older person dependent on others economically • Need training and skills for employment and better jobs • Reducing to hard-core without means to become self-sufficient 	<ul style="list-style-type: none"> • Housing assistance • Medical care financing • Income maintenance • Special education for children • Training and education for employability • Special opportunities for economic advancement
Minority Groups	<ul style="list-style-type: none"> • High illegitimacy rate • Percent of Negroes who are poor is three times that of whites • Income level and education level below national average • Slightly increasing in percentage of population • High incidence of relocation from rural to urban areas 	<ul style="list-style-type: none"> • Continued discrimination in jobs, education and housing • Need for education and training • Need for better employment • More unwed mothers • Breaking of family ties 	<ul style="list-style-type: none"> • Education in race relations • Special education opportunities • Training and education for jobs • Preventive education • Guidance and assistance in adapting to new environment
Unemployed	<ul style="list-style-type: none"> • Related increasingly to education level achieved • Caused by increased demand for more skilled workers 	<ul style="list-style-type: none"> • Undereducated, illiterate, and unskilled for today's labor market • Unable to qualify for technological training • Need income maintenance 	<ul style="list-style-type: none"> • Retraining and education for jobs • Income maintenance • Unemployment insurance

Social Group Prone To Be Under Stress	Characteristics of and Trends Affecting the Group	Nature of Problem	Group Needs
Urban	<ul style="list-style-type: none"> • Comprises increasing percentage of population • More likely to be separated from other family relations • More likely to come from other locations, either rural or urban • More likely to be in strange environment 	<ul style="list-style-type: none"> • Living in more crowded conditions • Increasing social contact • Limited recreation facilities • Isolation from traditional elements of security • Problem of education, training, housing, acculturation, and unemployment 	<ul style="list-style-type: none"> • Urban renewal, slum clearance, rehabilitation of cities • Recreation facilities • Adjustment

The size of the family is decreasing, and elderly persons are living apart from their offspring. Children leave home earlier than ever before, and single-parent families appear more often. These factors, along with growing urbanization and an increasingly complex society are disturbing relationships among family members.

In particular, the causes of increased family stress include the assumption of family leadership by more mothers; fathers spending longer hours away from the home earning a living; more mothers working outside the home; children being exposed to wider influence by their peers and their general environment; youths, without parental guidance, becoming involved in a wider range of problems; and grandparents and other relatives living isolated from the nuclear family.

Experts observe that "each of these factors tends to diminish the ability of the family to support its members effectively in coping with their problems. Individuals are thus forced to seek counsel and assistance in other ways."¹⁵ Figure Five suggests the types of problems and needs which must be dealt with outside the family structure.

In the broad spectrum of intrapersonal and interpersonal difficulties is a focus which defines them as mental health problems: man caught in the midst of change and personally threatened by it. What kinds of services are provided for these persons, and in what way is provision made?

¹⁵Ibid., p. 17.

There are many agencies designed to help meet the emotional needs of individuals and groups in the United States. Such services have proliferated with the industrial age. While this boom has increased the effectiveness and availability of services, it has also caused problems in social welfare function.

Today, "the potential client may still have severe difficulty in getting to 'the right person in the right agency' without a discouraging experience with vague or misdirected referrals and dead ends."¹⁶ Each agency and discipline, in the conviction that its way is the right one for solving problems, seems to have created an island in the community, oblivious of other helping agents.

There is a lack of knowledge among disciplines, agencies and groups of agencies of the values and uses of the othersWe often lack administrative courage to tackle interdisciplinary and interprogram issues. This...results in competitive activity and fuzzy programming.¹⁷

America's increasingly white-collar population does not need this kind of confusion, and, indeed, will not support it. Greater knowledge and information contribute to expanded public awareness of social and economic problems. Concurrently, public pressure on governmental and private welfare agencies to assume an aggressive role in the prevention and solution of these problems increases.

"Recent events have demonstrated forcibly that failure to take

¹⁶Vaughn P. Manley and Allen C. Jensen, "Equalizing Access to Social Services through Area Inter-Agency Approaches," Iowa Business Digest, XXXVII (October, 1966), 30.

¹⁷Norman V. Lourie, "Impact of Social Change on the Tasks of the Mental Health Professions," American Journal of Orthopsychiatry, XXXV, No. 1 (1965), 46.

effective steps to alleviate the causes of many of these problems can only result in increasing social tensions."¹⁸

"When citizens see societal needs not being met and a proliferation of agencies and organizations which claim to meet them, the usual response is that programs need co-ordinating."¹⁹ The need is for uniform definitions of problems to account for the broad spectrum of disorders dealt with by various units of the social welfare system. The goal is to span the gap between single agency and community plans, achieving dynamic and flexible application and assignment of manpower to multiplying problems.

¹⁸Booz, Allen and Hamilton, Inc., Study of Philosophy and Objectives, p. 15.

¹⁹Manley and Jensen, "Equalizing Access," p. 30.

CHAPTER I
COMMUNITY ORGANIZATION

The impact of social change requires the clarification of certain issues in the social welfare field:

1. The need for uniform definitions of the problems families and persons have that are universally understandable and can be operationally applied.
2. The testing of the concept of problem solving as contrasted with the open-end provision of services.
3. A workable and uniformly applied definition of the concepts of prevention.
4. A framework for comprehensive diagnosis as a basis for differential treatment.
5. The development of criteria for the community-wide allocation of responsibility and services.
6. Development and use of systems for constant evaluation and accountability.
7. Creating and allowing real leadership to operate.¹

Responsibility for examination of such issues rests in the community organization of services, usually a fund-raising coalition of voluntary agencies. Individualism, religious freedom, a relatively free market economy, noidelological unionism and industrial wealth are the traditional American values that lie behind voluntarism; that is, "Every Community Chest campaign is sold to corporate and individual givers partly on the gospel of preserving the private interest in welfare; if you do not give voluntarily, the warning

¹Lourie, "Impact of Social Change," p. 45.

runs, it will shortly be added to your income tax."²

Voluntary agencies traditionally espouse program emphases on leisure time, counseling and specialized services, while "public agencies undertake to meet, . . . basic economic, health and educational needs."³ The Seventies will see more public funds being spent through the media of private agencies, but individual and family problems other than those pertaining to education and income maintenance will likely continue to be served by voluntary agencies, because such difficulties are local in nature and require flexibility in program.⁴

United Fund Raising predicts that as public spending increases in the area of health and welfare, United Fund expenditures will also grow but will represent a smaller percentage share of the total cost of services. This does not mean that Fund agency services will decline as a proportion of the total health and welfare function, but that more of the financing will come from government grants and fees, with United Funds underwriting a smaller fraction of enlarged agency programs. "United Funds will therefore strive toward more quality as opposed to quantity in agency services."⁵

²Harold L. Wilensky and Charles N. Lebeaux, Industrial Society and Social Welfare (New York: Free Press of the Macmillan Company, 1965), p. 161.

³Emerson F. Andrews, Philanthropic Giving (New York: Russell Sage Foundation, 1950), p. 112, quoted in Wilensky and Lebeaux, Industrial Society, p. 166.

⁴United Fund Raising, Projections, p. 12.

⁵Ibid.

Six conscious acts constitute the social improvement process:

1. Defining and describing current social conditions and problems.
2. Formulating, promoting and adopting higher goals and standards of social welfare being.
3. Developing community and organizational policies and strategies.
4. Concerted action that results in assembling or producing, focusing and activating the necessary human, material and monetary standards and policies.
5. Assessing and reassessing the program and its consequences.
6. Developing community leaders and officials, voluntary and professional.⁶

Community organizations seeking provision of quality services must first know the make-up and unique needs of their constituency. Overviews of national trends and situations are helpful and should be used as models for local research and description. Information thus provided leads to the formulation of local goals.

The national organization of United Funds outlines a program for strengthening agency programs which places first the functional clarification of agency service goals and establishment of service priorities. The obvious next step is evaluation of program accomplishment.⁷

Questions to be asked in the assessment of agency programs include: 1) What needs should the agency seek to meet? 2) What services should the agency provide? 3) To whom should these serv-

⁶Jack Stumpf, "Community Planning and Development," in Harry L. Lurie, ed., Encyclopedia of Social Work (New York: National Association of Social Workers, 1965), p. 192, cited in Joe R. Hoffer, "The Large Forum in the Social Welfare System-- Planning and Action," The Social Welfare Forum, 1967 (New York: Columbia University Press for the National Conference on Social Welfare, 1967), pp. 97-98.

⁷United Fund Raising, Projections, p. 26.

ices be provided? 4) What should the services seek to accomplish? 5) Where should the services be provided? 6) Who should provide the services? 7) What external relationships should be maintained? 8) How should the agency be organized? and 9) How should the agency be financed?⁸

In light of theoretical appraisals of agency program, realistic evaluation of the existing content of agency services must be made. Solender cautions:

It is in program that some of the most acute resistance to change is encountered. The familiar and the known are judged to be better than, and certainly preferable to, the new and strange. Vested interests of participants, staff, or board cluster around particular programs. Unawareness or lack of conviction about the need for change combine with the resistance of traditional constituencies to new people. The classical misreading of the need for program change often takes the form of: "All we need is more money; give us larger budgets and everything will be all right."⁹

The essential question is not one of finance nor even of social welfare techniques, but of how to devise creative methods of strengthening programs and, thus, professional services to meet emerging needs in the community. Having generated fresh insight and knowledge about changing social phenomena, the community service agencies must apply that knowledge to practice. New methodology and program can be projected, implemented, tested and evaluated to enrich service. New agency structures and functional

⁸See Figure 6.

⁹Sanford Solender, "Implications of Change for Social Agencies," The Social Welfare Forum, 1967, p. 130.

FIGURE 6

1. What Needs Should the Agency Seek To Meet?

- . What are the outstanding needs of families and individuals in the community?
- . What needs of families and individuals is the agency competent to meet?
- . What needs is it best equipped to meet? What needs is it most important to meet?
- . What other community services exist or are planned to meet these needs?
- . What is the magnitude of the needs to be met? Is this likely to change?
- . What does the community see as the most important needs to be met?

2. What Services Should the Agency Provide?

- . What services are required to meet the needs identified?
- . What services is the agency presently equipped to conduct? What are its staff capabilities and interests? What new capabilities do these services require? What can be done by volunteers?
- . What costs are involved and what sources of financing are available?
- . How effective are the services?
- . Will these services eventually be taken over by the community?
- . How long is the service likely to be needed?
- . Where is the service to be provided? In the home? At the agency?
- . What is the relationship of the benefits to be derived in terms of the cost of providing the service?

3. To Whom Should These Services Be Provided?

- . To a cross-section of the community?
- . To those where the need is most acute?
- . Where the service is most likely to be effective?
- . To those who seek the service?
- . To those referred by others?

4. What Should the Services Seek to Accomplish?

- . To solve client problems?
- . To help clients solve their own problems?
- . To help clients identify and cope with emerging problems before they need outside help?
- . To prevent problems or needs from occurring?
- . To refer clients to other appropriate community sources?
- . To assist other community services in developing more effective programs?
- . To inform the community of unmet needs and to persuade it to provide appropriate services?

5. Where Should the Services Be Provided?

- . What facilities are required?
- . Are clients able to come to the agency? Do agency staff need to go to the client in his home?
- . Are the services to be provided in conjunction with other community services?
- . What are the costs of providing services in alternative places?

6. Who Should Provide the Services?

- . Volunteers?
- . Nonprofessional staff?
- . Professional staff?
- . Part-time staff?

7. What External Relationships Should Be Maintained?

- . With other local private community services?
- . With local public officials and programs?
- . With the family service association?
- . With other family service agencies?
- . With local community and volunteer groups and associations?

8. How Should the Agency Be Organized?

- Who should be involved in leadership and decision-making? Volunteers and/or professional staff?
- Who should be represented on the local agency board?
- How should board members be involved?
- How should it be administered?
- How should it be staffed?

9. How Should the Agency Be Financed?

- By local community chests, sectarian federations?
- How much income should be realized from fees-for-service? Who should pay and what rates should be established?
- How much income should be accepted from public sources, for what purposes, and under what conditions?
- How much income should come from private contributions?

relationships can be tried and appraised.

United Fund Raising says that "experimentation and innovation, . . . must be the basic ingredients in voluntary programs in the Seventies if voluntarism is to be relevant and responsive to the needs of the future and assume significance in the eyes of both the contributor and the volunteer."¹⁰ Solender declares, "The measure of the readiness of leaders to alter agency purposes, functions, programs, and structures is the extent of their confidence in the vigor and efficacy of their institutions."¹¹

Strengthening agency program involves such innovations as functional financial accounting; more precise service accounting; unit cost analysis; use of job study methodology and effective personnel administration; and management consultation directed toward the development of sound agency structures and their proper administration. The complexity of emerging social patterns will provide that only an organization which possesses high level professional skills and managerial competence can produce effective services. Development of community leaders both professional and voluntary depends upon development of strong managerial capability. At the same time, organizational structure must adapt as the focus and direction of the agency are altered.

Developing community organizational policies is perhaps the most important move for effective social services. Organization

¹⁰United Fund Raising, Projections, p. 12.

¹¹Solender, "Implications of Change," p. 141.

must be considered in terms of structures to facilitate creative relationships between disciplines and services which now operate discretely. Solender notes, "Too often people and communities are the victims of overspecialization and inflexible separations between functional programs."¹² Lourie recognizes the need "to move vigorously to coordinate and integrate multi-professional, economic, social welfare, health, mental health and political elements."¹³

Projections for social welfare in the coming decade include consolidation of services for greater efficiency and flexibility as well as higher quality and more individualized services to all segments of the community. So strong is the emphasis on coordination that a well-known lecturer states without reservation, "If you're not interested in coordination, you'd better fold up your tents and go home."¹⁴

The community organization or association is the agent of change in the field. It has the preparation and the means to encourage individual agencies to join in the necessary coordination of services. The plan will look considerably bold to some agencies:

The new preventive and other programs developed will often involve a variety of disciplines in addition to social work. Agencies will be dealing with larger numbers of people and working cooperatively with a variety of other agencies on

¹²Ibid., p. 134.

¹³Lourie, "Impact of Social Change," p. 47.

¹⁴Oscar Shade, speech given at "Institute on Coordination," McLean County Social Service Council, Normal, Illinois, May 28, 1968.

community based programs. Those developments may generate the need of members for national assistance in organizing and staffing agencies in different forms to accomodate new program needs.¹⁵

In reaction to both the specific and general threat to agency autonomy posed by coordination and consolidation of services, it is reasonable to assume that some organizations will attempt to maintain integrity and to increase their scope. Given this assumption, "the integration and coordination of agency policies and programs depends on the enlightened self-interest of the independent agencies."¹⁶ Coordination, facilities sharing and integration are likely to occur only when the autonomous agencies stand to gain.

While the defensiveness of an agency must be weighed carefully, the community association may have to act strongly. Bernard Coughlin reflects on this matter:

I strongly recognize the right of the voluntary agency to establish its own program and policies, to limit its service, and to specialize....At the same time, I recognize the right of the community welfare council to assign a low funding priority to such an agency if, in the judgment of the council, the agency's program is not directed to high-priority community problems. And I would say that an agency that refuses to modify its policies in the face of social change is assigning itself to a small corner of the welfare field.¹⁷

¹⁵Booz, Allen and Hamilton, Inc., Study of Philosophy and Objectives, p. 41.

¹⁶Mayer N. Zald, "Sociology and Community Organization Practice," in Mayer N. Zald, ed., Organizing for Community Welfare (New York: Quadrangle Books, 1967), p. 55.

¹⁷Bernard J. Coughlin, "Interrelationships of Governmental and Voluntary Welfare Services," The Social Welfare Forum, 1966 (New York: Columbia University Press for the National Conference on Social Welfare, 1966), p. 97.

Organization of only voluntary services in the community is not adequate for meeting the welfare responsibilities of the nation. Partially because of the increase of public monies spent through private agencies and partially because the welfare of the people is a common goal of both types of services, the future of voluntary programs can be secure only "if it is predicated on the compatibility of voluntary and public programs and the obligation of each to strengthen the other and to work cooperatively."¹⁸

To carry out this kind of joint planning, the community organization of voluntary agencies gathered behind one fund-raising drive may give way to coordinating bodies established legally. Wisconsin, for instance, has such groups, which include government and private agencies, combining federal, state and local resources in the planning and coordination of services.

Whatever the method of organizing services, "much remains to be done to help free large sectors of agencies and agency leadership from institution-bound attitudes and practices and toward a community-oriented philosophy of services."¹⁹

¹⁸Booz, Allen and Hamilton, Inc., Study of Philosophy and Objectives, p. 139.

¹⁹Benjamin B. Rosenberg, "Where We Are: What Shall We Do Back Home?" in Proceedings: Seminar on Social Welfare and Community Mental Health, p. 77.

CHAPTER II

ORGANIZATION OF McLEAN COUNTY SERVICES

McLean County is a midwestern community whose economy is a combination of industry, business and agriculture. It faces most of the social changes discussed in the Introduction, particularly the alteration of population in terms of age distribution.

The increase in population of McLean County is predominantly in the extreme age groups--over 65 and under 20 years.¹ Junior and senior high school enrollment figures confirm the national trend of growing teen-age population. Inferred by this growth is an increased marriage rate. Referring again to Figure Five, note the special problems and needs of the very groups on the rise in McLean County.

At the same time that dependent groups increase in the community, proportionately fewer wage earners are present to support growing service needs. Careful planning and effective organization is essential to the provision of needed social services under these circumstances.

United Community Services of McLean County is the agency which undertakes these responsibilities. Under the leadership of

¹Ralph W. Metz, "Central Services Operations," in Institute of Community Services, Survey of Health, Welfare and Recreation Services in McLean County (Bloomington, Illinois: Citizens Community Survey Committee of McLean County, 1962), p. 77.

a professionally-trained social worker as executive director and an influential and ambitious voluntary board of directors, U.C.S. strives "to coordinate, offer guidance to, and financially support the services of non-profit McLean County health and welfare organizations."² The organization currently funds twenty agencies and had a budget of \$421,231.00 in 1967.³

Although at present U.C.S. consists of only those agencies receiving support from the United Fund Campaign, the organization does not limit its planning efforts to those services. It intentionally functions with government and other voluntary agencies to evaluate the social, health and welfare needs of the community and to assist in providing services to meet them.

Recommendation was made by the Institute of Community Services in 1962 that U.C.S. give consideration to the expansion of its membership to all those agencies and organizations providing direct service to the people of McLean County:

The concept of a United Community Service organization indicates that all organizations and agencies providing services to the people should be members, whether these organizations are tax supported public agencies, voluntary fund supported, or voluntary non-fund supported.⁴

²"McLean County United Community Services," Directory of Social Welfare Services for McLean County, Illinois (McLean County Social Service Council, Association for Mental Health and United Community Services: Bloomington, Illinois, May, 1967), p. 56.

³James Mack, "Treasurer's Report," in United Community Services, Eighth Annual Report (Bloomington, Illinois, January 30, 1968).

⁴Metz, "Central Services Operations," p. 77.

The leadership of United Community Services recognizes the necessity of being more than a fund-raising organization. President James Mack, in his formal acceptance speech, emphasized the need for change in the social service structure of McLean County and the determination of U.C.S. as a planning body to deal with community problems:

Times and conditions do change, and as a result, the needs of our community in terms of social welfare agencies also change. Each individual serving with a specific agency should obviously be interested in the well-being and service performed of that agency. At the same time, and of equal importance, is the realization that the best interests of the community must also be considered. In the final analysis, we only serve the community and we must not lose sight of what is best for the total community needs.⁵

A pressing community need that has received much attention through the recent referendum is the problem of mental health in McLean County. The National Committee Against Mental Illness estimates that one person in ten suffers from some form of mental illness. This figure indicates that nearly 9,000 residents of McLean County have mental hygiene problems.⁶ Yet the combined efforts of the community agencies which deal with such problems⁷ served only 1,388 persons in 1967 and will serve an estimated 2,768 in

⁵James Mack, President's acceptance speech presented at United Community Services Annual Meeting, Bloomington, Illinois, January 30, 1968.

⁶"Mental Health and Mental Retardation in McLean County: Facts You Should Know," Bloomington, Illinois, 1968. (Offset.)

⁷Family Service of McLean County, McLean County Mental Health Center and McLean County Association for Retarded Children, with McLean County Sheltered Workshop becoming operational in 1968.

1968.⁸ These figures do not delete multi-agency experiences of individuals.

Bertram S. Brown states quite accurately that "mental health is more than mental illness."⁹ Mental health problems include the lack of traditional sources for guidance and counsel for youth and children. Unwed motherhood, delinquency and underachievement in school are mental hygiene problems. The aged, isolated from families and friends, are subjects for concern by mental health practitioners as are the immature young married couple or the middle-aged parents pressed by tension and strife.

The groups in which these problems are found are just those portions of the population in flux in McLean County. Those individuals are the targets of social change which has as a by-product increased social service need.

Provision of needed services will soon become an even more specific problem in view of the provisions of House Bill 1407, the Mandatory Special Education Law. This statute requires that all public schools meet educational needs of handicapped students by July 1, 1969. Definition of "handicapped" pertinent to this law is set forth in Section 14-1 of the School Code of Illinois:

⁸"Agency Budget Sheet," Mental Health Referendum, Bloomington, Illinois, 1968. (Mimeographed.)

⁹Bertram S. Brown, "Concepts Underlying the Development of New Patterns of Community Mental Health Services," in Proceedings: Seminar on Social Welfare and Community Mental Health, p. 20.

1. Physically handicapped - ages 3 to 21.
2. Maladjusted children - ages 5 to 21.
3. Educable mentally handicapped - ages 5 to 21.
4. Trainable mentally handicapped - ages 5 to 21.
5. Speech defective - ages 5 to 21.
6. Multiple handicapped - ages 2 to 21.

The Office of the Superintendent of Public Instruction has determined that emotionally disturbed students must be diagnosed, including psychiatric diagnosis, in order to be eligible for services. After placement in the program, child and teacher are to have continued consultation, while the child is in treatment at the local agency. The mentally retarded likewise must be diagnosed for mental ability, social and emotional adjustments for placement in Trainable or Educable Mentally Handicapped programs. Monies are not provided for mental health services through H.B. 1407.¹⁰

Requirement of these services leaves uncouneted the needs for programs aimed at children and adults having less than one-third normal ability; treatment or counseling for the families of these children; follow-up services for persons over 21 years; and services for children younger than five years except for physically and multiply handicapped. The need for full-time mental health services in McLean County is critical in view of the July 1, 1969, deadline posed by H.B. 1407.

The United States Public Health Service lists five requisites for mental health services in every community:

¹⁰"Rebuttal," Speech Guidelines for Mental Health Referendum, Bloomington, Illinois, 1968. (Mimeographed.)

1. Twenty-four hour in-patient care.
2. Part-time hospitalization (day or night in-patient care).
3. Twenty-four hour emergency care, such as crisis intervention and suicide prevention programs.
4. Consultation and educational services.
5. Out-patient treatment and counseling.¹¹

McLean County is supplied with only the final type of service, through the combined efforts of the staffs of four agencies: McLean County Association for Retarded Children, McLean County Sheltered Workshop, Family Service of McLean County and McLean County Mental Health Center.

The Association for Retarded Children operates from September to June, serving approximately fifteen children who are not eligible to attend public school classes and whose parents belong to the Association. Its annual budget approximates \$15,000, which is gained from U.C.S., tuition and bake and rummage sales.¹²

The Sheltered Workshop was organized in 1967 and became operational in 1968, with a budget of approximately \$38,000. In 1968 it will serve an estimated 75 persons who have physical or mental handicaps which inhibit gainful employment. The aim is to provide a work-oriented rehabilitation facility with a controlled working environment.¹³

Family Service of McLean County provides marriage, family

¹¹"Speech Guidelines: Mental Health Referendum," Bloomington, Illinois, 1968, p. 2. (Mimeographed.)

¹²"Agency Budget Sheet."

¹³"McLean County Sheltered Workshop," Directory of Social Welfare Services for McLean County, Illinois, p. 46.

and personal counseling services. With the aid of a part-time consulting psychologist, the agency will serve approximately 673 persons (238 direct contact clients) in 1968, with a budget of \$37,900.

Serving an estimated 2,000 persons in 1968, McLean County Mental Health Center provides evaluation, treatment and consultation. With a staff of psychiatrists, clinical psychologists and psychiatric social workers, the agency also offers follow-up care to residents of McLean County who are conditionally discharged from state mental hospitals. Its 1968 budget is approximately \$125,000.

Family Service and the Mental Health Center obviously provide the bulk of mental health services in McLean County. In 1967 the two agencies served 97% of persons receiving mental health care, and the figure will be approximately identical for 1968.

In light of the mental health needs and resources of McLean County, what should be the organizational plan of these two agencies? Dealing with common problems, straining to fit expanded programs into tight budgets and scouring the horizon for dedicated professional personnel, are these two agencies necessarily integral? More particularly, is their individual autonomy practical and desirable for meeting mental health needs in McLean County?

CHAPTER III

THE FAMILY SERVICE AGENCY

The central purposes of the family service agency, says the Family Service Association of America, are "to contribute to harmonious family interrelationships, to strengthen the positive values in family life, and to promote healthy personality development and satisfactory social functioning of various family members."¹

Family Service of McLean County has interpreted these purposes for itself and for the community in Article Two of the agency constitution:

The Agency is dedicated to the preservation of family life. the casework method is utilized to enable individuals and families to seek and maintain harmonious relationships with themselves, their families and their community and to seek and maintain a level of life and livelihood that will enable families to enjoy life and contribute to the society in which they live.

The Agency resolves that it will be ever alert to the needs of its clients and the community; will participate in constructive activities designed to improve conditions within the community; will participate in research and studies with the aim to increase and expand technical and social competence; will encourage social work education and will constantly seek to improve the quality of service to individuals, families, and the community.²

¹Committee on the Range and Emphases of a Family Service Program, Report of the Committee, Range and Emphases of a Family Service Program (New York: Family Service Association of America, 1963), p. 11.

²Constitution of the Family Service of McLean County, Incorporated, Article II (1964).

The business of Family Service of McLean County is carried out by a Board of Directors made up of interested lay persons from the community. The Board appoints an Executive Director, who has "general charge, oversight and direction of the affairs of the Agency" and who is its managing head.³ The Executive Director's task falls primarily into three categories: technical administration--budget, research and statistics, office management; personnel administration--recruitment, employment, evaluation, promotion, determination of salary, discharging, classification, salary scales, assignment, supervision when necessary; and program administration--analysis and evaluation of agency program, study and proposal of new projects.⁴

Qualifications for the position of Executive Director of Family Service of McLean County are:

1. Master of Social Work degree from an accredited school of social work and a minimum of 6 years experience, two years of which would be supervisory experience.
2. Capacity to accept the obligation of authority, to make assignments to others, and to delegate appropriate responsibility.
3. Ability to enlist the full and willing participation of all individuals and groups involved in agency program.
4. Ability to contribute to the advancement of understanding of the family service field and to contribute to the general field of social welfare.⁵

³Constitution of the Family Service of McLean County, Incorporated, Article VII (1964).

⁴Family Service of McLean County, "Administration: Respective Functions of Board and Executive Director of Family Service Agency," Bloomington, Illinois, n.d. (Mimeographed.)

⁵Family Service of McLean County, "Administration: The Executive Director," Bloomington, Illinois, n.d. (Mimeographed.)

The purposes of the family agency are to be carried out through two major functions and three related ones listed by F.S.A.A. Major functions are: 1) providing casework services and 2) participating in community planning. Related activities include 1) conducting group education activities; 2) contributing to professional education; and 3) engaging in research.⁶

Family Service of McLean County, in provision of casework services, begins with the comprehensive intake interview. The worker collects a social history of the client and a description of the stimulus of his immediate request for help. After a broad understanding of the situation and the client are obtained, evaluation of the case is made by supervisor and intake worker to determine whether the case should be dismissed, referred to another resource or assigned for ongoing service in the family agency. Cases are closed with supervisory approval.

The agency carries out its second major function, participation in community planning, through its ties with United Community Services. The Board of Directors holds itself responsible "to relate the services of the agency to the work of other agencies and to concentrate upon improved community conditions."⁷

Activities listed as related to the central purposes of the family agency are effected in McLean County through group educa-

⁶Range and Emphases of a Family Service Program, p. 12.

⁷Family Service of McLean County, "Functions and Responsibilities of the Board," Bloomington, Illinois, n.d. (Mimeographed.)

tion (sixteen talks were presented in the community during the first eleven months of 1967) and through contribution to professional education (two graduate and two undergraduate students of social work gained experience with Family Service of McLean County during 1967.)

The agency's performance of the third related function--engaging in research--is interpreted in the Executive Director's task. Responsibility of the Board of Directors is clear in this respect: "The Board must know how to receive and analyze factual material as the basis for the making of decisions."⁸

The Family Service Association of America recognizes that the programs of member agencies will vary considerably and that some agencies will give greater emphasis than others to certain activities. "Such variation is to be encouraged in the interests both of meeting community needs and of advancing knowledge and skill."⁹ At the same time, however, F.S.A.A. does provide certain guidelines for program planning.

The first specification is that the casework program have the central place in agency operation. "The provision of skilled counseling services to families is the special and unique contribution of the family agency."¹⁰ In addition to the essential provision of casework services, the agency should increase its par-

⁸Ibid.

⁹Range and Emphases of a Family Service Program, p. 36.

¹⁰Ibid.

ticipation in community planning and in social issues; take some responsibility for secondary activities; allot time and funds to administrative aspects such as public relations, recruitment, salaries, agency housing and equipment; engage in long- and short-range planning; and increase financial resources.

That Family Service of McLean County adheres closely to F.S.A.A. program planning guidelines, with special attention to local needs, is demonstrated in the goals set for the agency for 1968:

- Increase staff.
- Increase services to incoming clients.
- Increase preventive services to the community.
- Participate in joint-agency and community projects.
- Participate more in joint Board and Staff undertakings.
- Promote Staff and Board training through F.S.A.A. and other important conferences and seminars.
- Promote optimum public relations to the community.¹¹

The question of whom an agency serves is of first importance in program planning. F.S.A.A. figures show that more than 45 per cent of the cases served by member agencies involve marital problems, with most clients facing more than one problem.¹² Comparable statistics for Family Service of McLean County show that marital counseling is the agency's most frequent task, also with many multi-problem cases.¹³ The problems that clients bring to family agencies are in comparable rank order on the national and local

¹¹Family Service of McLean County, Annual Report: 1967.
Bloomington, Illinois, January 4, 1968, p. 3. (Mimeographed.)

¹²See Figure 7.

¹³See Figure 8.

ANALYSIS OF CLIENT PROBLEMS

FIGURE 7

PROBLEMS CLIENTS BRING TO FAMILY SERVICE AGENCIES
(1960)

	<u>Family Relationship Problem</u>	<u>Individual Personality Adjustment</u>	<u>Other</u>
Marital	45.2%		
Economic			38.6%
Parent--child	31.5		
Personality adjustment of adult		27.4%	
Physical illness or handicap			18.4
Employment			18.0
Educational or vocational problems			11.1
Personality adjustment of an adolescent		10.9	
Mental illness			10.4
Planning substitute care for children			9.9
Housing			9.9
Personality problem of children under 13		9.2	
Unmarried parenthood	5.4		
Old age			5.0
Recreation	-----	-----	<u>3.5</u>
Total	<u>82.1%</u>	<u>42.5%</u>	<u>124.8%</u>

FIGURE 8

STATISTICS THROUGH NOVEMBER, 1967
FAMILY SERVICE OF McLEAN COUNTY

Categories of Service	Number of Cases
Marital Counseling	71
Child Treatment	26
Family Counseling	25
Individual Counseling	18
Parent-Child Conflict	17
Mental Illness	14
Unmarried Parenthood	9
Collateral Cooperation	86
Referrals	29
Contacts without Service	25
Community Talks	16
Children Served	720
Adults Served	371

Family Service of McLean County, Bloomington, Illinois,
January 4, 1968

level, with heavy emphasis on child adjustment in McLean County.

Mental health services are provided by family service agencies on a national scale in at least 42.5 per cent of all cases-- those categorized in Figure Seven as Individual Personality Adjustment. When the percentage of cases classed as Mental Illness are added to the adjustment sector, more than one-half of all cases deal in mental health. In McLean County's family agency, the second greatest category of service, child treatment, is a mental health function.

The Director of Mental Health Activities for F.S.A.A. has described the mental health services performed by family service agencies:

1. Identification and referral (professional assessment task.)
2. Treatment of stress situations and neurotic disturbances on reality ego-centered level.
3. Casework treatment of character disorders amenable to ego-supportive methods.
4. Family life education.
5. Supportive services.¹⁴

This listing shows a clearly limited ability on the part of the family agency to deal with more than 50 per cent of all problems brought to it. Limitations of staff training and technique narrow the choice of treatment patterns. Family Service of McLean County is limited in its offering of services by the presence of only one part-time clinical psychologist as consultant.

¹⁴Mildred K. Wagle, Director of Mental Health Activities, Family Service Association of America, Memo No. 66/5-320, "Mental Health Clinics and Family Agencies," New York, May, 1966. (Mimeographed.)

The Institute of Community Services survey conducted in McLean County in 1962 stated, "If a community is to have an adequately functioning social welfare program it is axiomatic that it must first have a strong family care program."¹⁵ Recommendations of that report designated for immediate attention included the employment of two trained caseworkers in addition to an executive director for Family Service of McLean County. The agency, in 1968, still has not filled this minimum complement for a basic family service agency.

Among suggestions by the Institute for long range emphasis in the Family Service program were the provision of homemaker service, foster home service, counseling to the aging and family life education. The strongest recommendation was in reference to the desperate need for homemaker service in McLean County. This service may be offered by an agency when parents' ability to provide home care and guidance for children has been impaired by some crisis:

Its goal is to strengthen, support, supplement and/or restore parental capacity to care for children and to prevent the unnecessary and/or precipitous removal of children from their own homes....When adequately staffed, homemaker service reduces the number of foster home placements and costs of child care in a community.¹⁶

The survey suggests that without a county-wide public welfare department, Family Service of McLean County would be the appropriate agency to provide homemaker service in the community. Such a program, in 1968, is not available through any agency in McLean County

¹⁵Earl J. Beatt, "Voluntary Welfare Services," in Institute of Community Services, Survey of Services, p. 31.

¹⁶Ibid., p. 32.

on a dependable, routine basis.

Provision by Family Service of a foster care program for the voluntary placement of children who require separation from their own home during a period of rehabilitation, while casework is in progress, was also highly recommended. Since the service is not currently available, families who require foster home care must submit to court commitment which declares the child "dependent" or "neglected."

In reference to services to assist aging persons and adult children of aging parents, the Institute cited a 1960 Bloomington Association of Commerce survey that indicated that one of four women in the city of Bloomington is over sixty years of age.¹⁷ The statistic emphasizes a need in McLean County which was further pinpointed by an extensive project conducted for Family Service in 1967 by a group of Illinois Wesleyan University students. No tangible planning has been the result of this work.

The Institute recommendation regarding family life education was broadly aimed at preventive work in the community.

The purpose of such a program is to bring to community civic organizations, i.e., P.T.A., church groups, service clubs, the expert guidance and skill of family counselors to discuss the problems inevitable in family life and to suggest preventive means and guidelines by which families may avoid family maladjustment.¹⁸

The agency has taken this project quite seriously, as noted in

¹⁷Jerry Mayer Survey, 1960, cited in Beatt, "Voluntary Welfare Services," p. 32.

¹⁸Beatt, "Voluntary Welfare Services," p. 32.

Figure Seven by the number of community talks delivered in 1967. This series was carried out in spite of staff shortage and unmanageable caseloads.

It is clear that Family Service of McLean County, which must supply vital service, has achieved limited success in meeting the needs of the community. Staff shortage and turnover have prevented planning outside the skeleton program of casework services. Competence of the staff in dealing with personality adjustment and mental illness is hampered by the use of a single, part-time consultant. Yet, the community needs endure and must be met.

The Family Service Association of America describes the chief characteristic of the family service agency as its fluidity: "Historically, it has always been responsive to changing social conditions and to advances in methods of dealing with social problems."¹⁹ Indeed, the Board of Directors of Family Service of McLean County reminds itself that "the Board must have a flexibility and willingness to change to meet new conditions as they arise."²⁰

It must also meet old conditions as they persist.

¹⁹Range and Emphases of a Family Service Program, p. 11.

²⁰Family Service of McLean County, "Functions and Responsibilities of the Board."

CHAPTER IV

THE MENTAL HEALTH CENTER

The stated purposes of the Mental Health Center of McLean County are:

1. To promote and conserve mental health for the people of McLean County.
2. To offer to and to secure for those who seek the help of our Corporation the facilities for prevention and care of nervous, emotional and mental disorders.
3. To offer consultation to social agencies or professional persons such as physicians, clergy, social workers, counsellors, psychologists, who regularly practice their professions in McLean County.
4. To receive, use, hold, and apply funds, gifts, bequests, and endowments or proceeds thereof in order to give effect to and carry out the purposes herein stated.
5. To coordinate the activities of the Center with other established agencies in the community engaged in planning for mental health and social welfare.¹

The Center carries out these purposes by various means.

The effort to promote and conserve mental health in the community was exemplified in the recent referendum campaign. Members of the Board of Directors and professional staff gathered data, produced printed materials and addressed local groups in support of the mill-tax proposal for mental health services in McLean County. The Center office was headquarters for the Steering Committee and Speakers Bureau of the project.

¹Bylaws of the McLean County Mental Health Center, Incorporated, Article II (1959).

The second purpose is the central philosophy of a voluntary agency--the offering and securing of service for those who seek help. The Mental Health Center endeavors to interview each person asking for aid. An integral part of the agency program is immediate intake for "walk-in" clients.

The effort outlined in the role of the Center as a source of consultation in the community is for spreading adequate mental health services across McLean County. If several hours each month can be devoted to general sessions for teachers, clergymen and others who have frequent contact with emotional disturbances, the quantity of mental health services offered in the community is increased geometrically.

In coordinating activities with other agencies engaged in mental health and social welfare planning, the Center holds membership in the United Community Services, with representation from its own Board. In addition, the staff is active in the McLean County Social Service Council, of which the Executive Director of the Center is president. This organization brings together staff members from the social agencies in the community for informative programs and discussion. The Social Service Council sponsored a recent institute on coordination of services.

In practice, the Mental Health Center provides two kinds of direct services: diagnostic evaluation and treatment of emotionally disturbed children and adults, and follow-up care for residents of McLean County who are conditionally discharged from

the state mental hospitals. The Public Health Service of the Department of Health, Education and Welfare, however, enumerates five essential services for a community mental health center:

1. Inpatient Care--This unit offers treatment to patients needing 24-hour care.
2. Outpatient Care--This unit offers treatment programs for adults, children and families.
3. Partial Hospitalization--This unit offers, at least, day care and treatment for patients able to return home evenings and weekends. Night care may also be provided for patients able to work, but in need of further care or without suitable home arrangements.
4. Emergency Care--Twenty-four hour emergency service is available in one of the three units named above.
5. Consultation and Education--The Center staff offers consultation and education to community agencies and professional personnel.²

Outpatient care is the only one of the "essential" services available in McLean County. None of the local hospitals has a psychiatric unit, and emergency attention is available only in the jail. Consultation and education, due to personnel shortage, has been limited in practice to Center staff meetings. This service can be expanded, hopefully, with the addition of a resident psychiatrist to the staff.

Five more services complete the full comprehensive community mental health program. These activities, in addition to the five essentials, can draw special attention to an application for Federal support under the Community Mental Health Centers Act of 1963:

²U.S. Department of Health, Education and Welfare, Public Health Service, "Fact Sheet: The Comprehensive Community Mental Health Centers Program," p. 2. (Mimeographed.)

6. Diagnostic Service--This service provides diagnostic evaluation and may include recommendations for appropriate care.
7. Rehabilitative Service--This service includes both social and vocational rehabilitation. It offers for those who need them services such as pre-vocational testing, guidance counselling and sometimes job placement.
8. Precare and Aftercare--This service provides screening of patients prior to hospital admission and home visiting before and after hospitalization. Follow-up services for patients are available in outpatient clinics or in foster homes or halfway houses.
9. Training--This program provides training for all types of mental health personnel.
10. Research and Evaluation--The Center may establish methods for evaluating the effectiveness of its program. It may also carry out research into mental illness, or cooperate with other agencies in research.³

The program of the Mental Health Center of McLean County fails to measure up to comprehensive community mental health care. The reasons for this are not in the planning of intention of the agency--surely the stated purposes encompass such an offering of services. The factors that keep the McLean County mental health program narrow in scope are staff and, more basically, finance.

The American Psychiatric Association recommends that a mental health clinic be staffed with the following minimum full-time staff complement: Administrator (psychiatric social worker or psychiatrist); Psychiatrist (assuming medical responsibility for each patient); four Psychiatric Social Workers; and two Clinical Psychologists.⁴ Until the introduction into the Center of a full-time resident psychiatrist July 1, 1968, psychiatric consultation

³Ibid., p.3

⁴Beatt, "Voluntary Welfare Services," p. 34.

was available part-time only. Except for one full-time psychiatric social worker and the Executive Director, the rest of the staff was made up of persons "moonlighting" on positions with other agencies or institutions or on private practices.

This kind of staff is hard-pressed to meet treatment demands of a walk-in outpatient nature. Even with exceptional organization, it would be difficult to build the cohesive unit of staff necessary to provide any other types of services.

The main reason for the patchwork staff of the Center was finance. Support of the agency is predominantly from voluntary contributions through United Community Services and from state grant-in-aid programs. The 1968 estimated budget of \$125,000 will be made up of \$27,000 from U.C.S., \$75,000 from state grant-in-aid and \$23,000 from fees and contractual services.⁵ In this situation, "requently members of the Mental Health Center Board must sign 30 day notes for loans to the Center until monies are made available."⁶ The resulting limitation on recruitment of professional staff is serious. Inability to attract practitioners competitively results in limited services.

The agency budget for 1967, when approximately 700 people were served, was \$109,700. About 2,000 will be served in 1968 with an income of \$125,000. This estimate reflects a cut in the price of services, made possible through the addition of full-time staff

⁵"Agency Budget Sheet."

⁶"Speech Guidelines," p. 2.

and the introduction of group therapy programs. A projected budget for 1972 is approximately \$400,000, indicating a further drive into preventive programming and service for 4,000 to 5,000 persons.⁷

The scope of this program is still far from service to the estimated 9,000 residents of McLean County who suffer from some form of mental illness.

The organization of the Mental Health Center of McLean County is much like that of other voluntary agencies like Family Service. A lay Board of Directors, made up of interested businessmen, professionals, educators and service-minded persons in the community, conducts the business of the Center. The Executive and Associate Directors of the agency are also members of the Board.

The Executive Director is employed by the Board and is "directly responsible to the Board of Directors for the administration of the Center in all its purposes, functions and services."⁸ He may be either a full-time psychiatrist or psychiatric social worker. He must meet the current minimum qualifications recommended for the position by the American Psychiatric Association and/or the National Institute of Mental, "including experience in the interdisciplinary teamwork approach to the diagnosis and treatment of mental and emotional illnesses."⁹ Therefore, the Center program remains interdisciplinary, with joint use of the insights of psychi-

⁷"Agency Budget Sheet."

⁸McLean County Mental Health Center, Inc., "Personnel Policies," Bloomington, Illinois, December 23, 1958. (Mimeographed.)

⁹Ibid.

atry, psychology and social casework.

Treatment at the Mental Health Center begins with an intake interview similar to that in the family service agency. The client's immediate presenting problem is set in the broader context of his current and past environment. A detailed social history is eventually prepared by the psychiatric social worker. Psychological and psychiatric evaluation follow, before staffing and assignment of the case for ongoing treatment.

The procedure becomes more flexible with the availability of casework and medical supervision. Supervisors and caseworkers, in estimating the needs of clients, may be able to eliminate the costly psychological or psychiatric diagnosis or both. Professional hours and agency dollars can be redirected to increase the number of persons served by the agency.

Even with careful administration, financial limitations remain to block expansion of the program. Again, McLean County suffers insufficient mental health services.

CHAPTER V
THE ALTERNATIVES

June 11, 1968, the voters of McLean County decided whether to levy an annual tax "not to exceed .1% upon all of the taxable property in the governmental unit at the full, fair cash value thereof,"¹ for the purpose of providing community mental health facilities and services. The referendum was made possible by the Community Mental Health Facilities and Services Act, approved by the Illinois General Assembly in 1963 and amended in 1965.

The Act provides for the establishment of a seven member community mental health board to administer the program. The board, to be representative of such interested groups in the community as local health departments, medical societies, local welfare boards, hospital boards, school boards and lay associations, would have the power to:

1. Review and evaluate community mental health services and facilities.
2. Submit to the appointing officer and governing body a program of community mental health services and facilities.
3. Within amounts appropriated therefor, execute such program and maintain such services and facilities as may be authorized under such appropriations, including amounts appropriated under bond issues, if any.
4. Enter into contracts for rendition or operation of services and facilities on a per capita basis or otherwise.

¹Community Mental Health Facilities and Services Act, State of Illinois, sec. 4, (1965).

5. Arrange for the rendition of services and operation of facilities by other agencies of the governmental unit or county in which the governmental unit is located with the approval of the governing body.
6. Make rules and regulations concerning the rendition or operation of services and facilities under its direction or supervision.
7. Employ such personnel as may be necessary to carry out the purposes of this Act and prescribe the duties of such personnel.
8. Perform such other acts as may be necessary or proper to carry out the purposes of this Act, consistent with the regulations of the Director of the Department of Mental Health.²

The four agencies in McLean County eligible for participation in the program resultant from the passage of such a referendum are the McLean County Association for Retarded Children, McLean County Sheltered Workshop, McLean County Mental Health Center and Family Service of McLean County.

The referendum was defeated at the polls with 5,402 ballots favoring the mill-tax and 7,101 opposed.³ What reasons had the public for rejecting the proposal?

The Daily Pantagraph claimed its chief objection to the issue was the responsibility of the state, rather than the county, to provide mental health services. An editorial on June 1, 1968, expressed the conviction that if the state fully staffs the tax-supported zone centers, the need for local mental health centers will be reduced if not eliminated. This line of reasoning is softened, however, by the admission that "an additional burden on

²Ibid., sec. 3(e).

³"Two Issues Both Lose," Daily Pantagraph (Bloomington, Illinois), June 12, 1968, p. 3.

property may be the only immediate way to get the services the county wants, but it is not the best way.⁴

This tentative recognition of the value of a county tax for mental health services elicits the doubt that state responsibility is the chief reason for non-support of the proposal. Perhaps the real key to the Pantagraph position is in the following paragraph:

In addition, the organizational structure of county mental health and family service organizations is too far shattered. Reorganization to bring about greater centralization and better utilization of personnel should precede, not follow, a change in financial structure.⁵

The population that supports voluntary social services must be sold on the programs. A better-educated, white-collar society with higher earning power puts a premium on quality service sold on its merits. Possibly the mental health services of McLean County fail to meet such a demand for quality and efficiency. And the public seeks expression of willingness on the parts of the agencies to fulfill the challenge. The editorial continues:

A Mental Health Board, which would be appointed by the Board of Supervisors, could insist on reorganization of local organizations as a prerequisite of funding. But voluntary efforts to avoid overlap and competition for professional services is preferable.⁶

Detailed examination of Family Service of McLean County and the McLean County Mental Health Center has shown several common characteristics. Both agencies exist under the auspices of a lay

⁴Editorial, Daily Pantagraph (Bloomington, Illinois), June 1, 1968, p. 4.

⁵Ibid.

⁶Ibid.

board of directors. Professional leadership in each agency is held by a Master of Social Work with several years' experience. Funding of both agencies is predominantly through voluntary contributions to the United Community Services. Nationally, the percentage of public funds is increasing in the programs of both types of agency. Evaluation of certain theoretical differences between the family service agency and the mental health clinic will emphasize other actual similarities.

The public seems to regard the mental health clinic as a place where one brings symptoms of all kinds, somatic or psychological in description. People approach the family agency, on the other hand, presenting problems in terms of situations or relationships. Comparison of the records of 270 consecutive and concurrent clinic applicants and family agency applicants nearly obliterates these differences:

On the whole, it may be said that people with very much the same kind of problems come to the attention of both agencies. They are people with long histories of chronic maladaptation, with rather poorly developed psychological coping capacities, and with relatively little expectation that they are likely to receive the help they need or are looking for. They are hungry for the meaningful and satisfying relationships of which, in their own estimation, they seem to be grossly deprived in their usual life experiences. Their security foundations appear to be constructed and unreliable both from an emotional and an economic standpoint. They suffer from feelings of isolation and often alienation from whatever intimate groups might be available to them.⁷

The distinction between classification of problems in the

⁷Jules V. Coleman, et al., "A Comparative Study of a Psychiatric Clinic and a Family Agency: Part II," Social Casework, XXXXVIII, No. 2 (1957), p. 79.

two kinds of agencies is sometimes made in this way: the clinic sees the client as an individual with intrapersonal conflicts while the family agency views the person within the framework of his interpersonal or psychosocial relationship problems. The Director of Mental Health Activities of the Family Service Association of America recognizes that there is a question as to whether family agencies are actually now focused on the family or on the individual as a member of the family group to a greater extent than are the clinics.⁸

Actual operation of the clinics, too, makes questionable the distinction. Dr. Bertram Brown states,

In modern psychiatry, we have seen the initial Freudian emphasis on the individual and his intrapsychic mechanisms proved no panacea. From the individual or clinical frame of reference, we then moved into an emphasis on the concept of interpersonal relations.⁹

In a study of new directions in community mental health programs, Ozarin and Brown found a significant increase in the use of conjoint family therapy with the patient and his family because "research has shown that a psychiatrically disordered patient often is found in a family where pathologic relationships exist."¹⁰

⁸Mildred K. Wagle, "Mental Health Clinics and Family Agencies."

⁹Bertram Brown, "Prevention--The Holy Grail of Mental Health," The Imperative of Prevention, Proceedings of Fifth Annual Conference on Family Life (St. Louis, Missouri: Family and Children's Service of Greater St. Louis, 1967), p. 5.

¹⁰Lucy D. Ozarin and Bertram S. Brown, "New Directions in Community Mental Health Programs," American Journal of Orthopsychiatry, XXXV, No. 1 (1965), p. 14.

A major conjectural difference between the mental health center and the family agency is in the treatment plan and approach. Such assumption claims that in the clinic, after complicated intake and evaluation procedures, the treatment plan is determined by a psychiatrist and always supervised by a psychiatrist, while the family service plan is primarily up to the caseworker. This difference is minimal, if existant, in McLean County and is decreasing nationwide. In their survey, Ozarin and Brown observed:

Lengthy intake procedures and examinations which included interviews with social worker, psychiatrist and psychologist and a time consuming case conference were giving way increasingly to an intake performed by one qualified professional who saw the patient and the family, assessed the problem and directed them to a therapist who started treatment.¹¹

Both clinics and family agencies use basically the same treatment methods of ego support, clarification and reality testing. The process in both cases is based upon therapeutic professional relationship and psychosocial diagnosis.

Clinics and family service agencies share the elusive goal of prevention implemented by early diagnosis and treatment of problems. But, in reality, both types of agency "most often get cases after problems have become quite severe and it is too late for preventive work; thus both are dealing equally with the results of problems of long standing."¹² As a result, the agencies must emphasize the setting of attainable goals in the hope that clients

¹¹Ibid.

¹²Mildred K. Wagle, "Mental Health Clinics and Family Agencies."

can be kept functioning at whatever level is possible for them.

The similarities in makeup and function of the McLean County Mental Health Center and Family Service of McLean County are quite clear and bring to the fore the question of why they are separate agencies. What would be the advantages of closer coordination of their services or even integration of their organizations?

The desirability of centralized intake is a primary reason for agency coordination or combination. Particularly in periods of staff shortage, less waste is made of professional time where there is one intake worker or intake department from which clients can be referred to the service that seems most appropriate. It is further suggested that such a setup is more assuring to the client, who experiences less fear of "coming to the wrong place" when a broad scope of services is available through a single center.

Referral, too, is eased when two services combine:

If, after either service has seen the client, it then appears that a referral to the sister service is indicated, it is much easier both for client and agency to arrange an appointment; this can be done within the agency without formality and loss of time. Also, the client-patient does not have to face the anxiety of the unknown or the confusion of getting to a new place, or of having the feeling of being rejected or 'pushed around.' Then, too, there is not as much necessity to repeat the same material again and again to different people for information can easily be shared within the same agency.¹³

Current duplication of records between Family Service and the Mental Health Center testify to the desirability of this characteristic.

¹³Mildred K. Wagle, Memo No. 67/1-4, "Suggestions for Guidelines re: Family Service Agencies and Mental Health Clinics," New York, [January, 1967]. (Mimeographed.)

For efficient intake and referral, the agencies need to analyze their caseloads together. Each case should be considered for reasons why it was accepted and treated in the service in which it is now active and what is being done that could not just as well be done by the sister service. Planners need to attempt to tabulate the type of problem or the degree of illness that is handled by either service.

Another reasons for combining the two agencies is the need for a larger unit in order to provide stimulation to staff and to enable clients to be referred to the person most appropriate for their particular situation. In such small agencies as those in McLean County, it is impossible to employ staff members equally competent to work with all age groups, both sexes and all types of problems and disturbances.

Vacancies in the staffs of both the family and the clinic are factors for integration of services because shared efforts in recruitment bring better results. Salaries can be pooled and thus raised, and combined agencies are more attractive to potential staff than small one-function agencies.¹⁴

Combination of the agencies eliminated the red-tape of consultation requiring payment for services exchanged and simple booking complications. Record keeping is consolidated and simplified; the integration process itself will demand review of antiquated and duplicated filing systems.

¹⁴Ibid.

Finally, the housing of the two agencies, already shared informally, would provide better office accommodations and increased interview space. Scheduling of rooms for use would be uniform.

In summary, close cooperation or consolidation of the McLean County Mental Health Center and Family Service of McLean County would provide better services for more people in the community.

APPENDIX I
F.S.A.A. GUIDELINES FOR COMBINED
MENTAL HEALTH CLINICS AND
FAMILY SERVICE AGENCIES

A combined agency is most desirable in small or middle-sized communities where the structure of social services is not complex, where the size and nature of the population make it impractical to support specialized services and where manpower in the helping professions is in short supply.

Criteria for Continuing F.S.A.A. Membership

1. The service must function under a lay board of directors with the authority to employ an executive director and medical director (psychiatrist), and to plan program, establish policies, determine budgeting and appoint appropriate committees.
2. The board must centralize authority in one person, i.e., executive director, who should have at least an M.S.W. degree and five years of experience, preferably in a family service agency. Some experience in a mental health setting is also to be desired.
3. The committees of this combined service should include those usually found in a family service agency, plus a medical advisory committee. There should be a policy or service committee to replace the usual "Casework Policy Committee."
4. A psychiatrist should staff the medical advisory committee, which would be made up of both board and non-board members. The agency executive should sit in on meetings of this committee. The psychiatrist should also attend meetings of the board. He should carry the medical responsibility for clients referred to his department through intake and should

be responsible for after-care of conditionally discharged patients and for all patients receiving medication. He should act as consultant and advisor to the casework staff and should supervise any medical assistants in his department.

5. Sources of funds for this agency may be from both public and private sources, as well as from third party payments. The source of funds should not be the final criteria as to whether or not the agency meets F.S.A.A. membership standards.
6. Whereas the basic activity of F.S.A.A. Member Agencies in the past has been casework focused on serving the family and the individual members of the family, a combined agency might have as its basic activity both family casework and psychiatric diagnosis and treatment.
7. The following present membership requirements of F.S.A.A. need then to be amended:
 - "E. Major source of support of voluntary agency must be private funds."
 - "G. Agency staff must be composed of at least an executive director, caseworker and secretary."

All other membership requirements now established would still be appropriate for a combined agency.

APPENDIX II

F.S.A.A. MEMBER AGENCIES COMBINED

California

Family Service of Berkeley--Agency does intake for state-supported mental health clinic housed in agency building.

Connecticut

Family Service of New Haven merged with Family Counseling Association of Milford--Combined agency and clinic receives mental health funds.

Illinois

Family Service and Mental Health Center of South Cook County, Chicago Heights--Combined agency grew out of the need for psychiatric services in a geographical area where a family agency had recently been organized.

Kansas

Family Service and Guidance Center, Topeka--Result of a merger of two autonomous agencies. Both were in search of staff at the same time. A psychiatrist directed the clinic and a social worker the family agency when the merger went through. Both resigned and a new executive, a social worker, was employed to direct the combined agency. The merger was pushed by the United Fund rather than the Boards initially. At first the Boards were divided but eventually they cooperated.

Kentucky

Family Counseling Service, Lexington--Affiliated with the Central Kentucky Regional Mental Health Board.

Maine

Family and Child Services, Bangor--Joint board-committee of family service and guidance center, working out details of merger. Currently sharing case supervisor, with joint staff meetings.

Maryland

Family Service of Prince George's County, Hyattsville-- Agency program includes a clinic financed by Central Base Fund of Andrews Air Force Base; contract provides clinic service for children and families on the base.

Michigan

Family Service of Oakland County, Berkley--Contractual agreement provides Family Service casework time for intake at mental health clinic. Other agreements in development.

Missouri

Family Guidance Center, St. Joseph--Result of merger of family agency and guidance center.

New Jersey

Jewish Counseling and Service Agency, Newark--Family agency with clinic integrated into total program.

New York

Family Service League, Huntington--Under contract with County Mental Health Board, agency obtains funds to employ caseworkers called mental health associates. These associates are responsible for joint intake of family agency and County clinics. The agencies also carry cases jointly.

Jewish Family Service, New York--Psychiatric clinics in each of four district offices funded by New York Mental Health Board. In central office there is a mental health center for family and group treatment.

Pennsylvania

Family and Children's Service, Pittsburgh (Allegheny County) East Suburban Counseling Center, Monroeville--District offices of large agencies receiving State mental health funds.

Family and Children's Service of Lycoming County, Williamsport-- Agency carries clinic program that receives state funds.

Pennsylvania, continued

Family Guidance Center of Berks County, Reading--Recent merger of family service agency, guidance clinic and children's aid. Guidance Center receives state mental health funds and local United Funds. This agency is also in process of working out its relationship with comprehensive mental health center.

Family agencies with a clinic as a department:

Jewish Family Service of Buffalo, New York.
 Jewish Family Service of Washington, D.C.
 Jewish Family Service of Pittsburgh, Pennsylvania.

Topeka, Chicago Heights and Seattle are all involved in planning to be the nucleus of a comprehensive mental health center.

Conferences

"Cooperation Toward Mental Health: Community Psychiatric Clinics and Family Service Agencies," A Conference sponsored by New Jersey Department of Institutions and Agencies, New Jersey Association of Mental Hygiene Clinics, New Jersey Council of Family Service Agencies and United States Public Health Service, Trenton, New Jersey.

"Meeting Mental Health Needs in California: Family Service and the Long Range Plan," Report of a conference sponsored by California State Department of Mental Hygiene, Family Service Agencies of California affiliated with the F.S.A.A. and National Institute of Mental Health, Lake Tahoe, California, 1965.

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CONCLUSION

The mental health needs of McLean County are reflected in the estimate of 9,000 persons in the community suffering from some degree of mental illness. Rising numbers of applicants to the family agency and the mental health center intensify the staff and financial needs of the two services. Still, the public, unconvinced of the extent of mental health problems in the community, also doubts the ability of existing agencies to meet the needs.

In such a setting, "social services...cannot remain institution-centered, but must be community oriented..., so must social welfare agencies adjust their thinking, their structures, their programs to the demands of community needs."¹ Agencies are obligated to consider the feasibility and desirability of combining their services, asking such questions about the small community as:

Are its institutional structures sufficiently flexible to allow consideration of new ideas and new ways of providing services?

Recognizing that even the small city has for many years developed certain means of coping with mental ill health, what are these systems like today?

Have they become fixed with tradition-bound concepts to such a degree that they could be considered closed systems?

If so, can they be reopened for reassessment at an Ecumenical-Council-like level?²

¹Benjamin B. Rosenberg, "Where We Are," p. 77.

²Neil D. Michaud, "Planning for a Small City," p. 40

Recognizing that combination of the family service agency and the mental health center can take place without jeopardy of professional recognition or accreditation of either service, the advantages of such a plan are obvious in staff, program, finance and facilities.

We must conclude, with U.C.S. President James Mack, that "change just for the sake of change is irresponsible. We also recognize that failure to change when changes are demanded by the people we serve is just as irresponsible."³

³James Mack, President's Acceptance Speech.

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