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Social work practice in community mental health

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The authors analyze social work's role in community mental health and describe practice models that enable practitioners to contribute to the improvement of an individual's mental status while maintaining a view of the person in the environment and a commitment to the improvement of social life.

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DURING the past twenty years, the mental health field has become increasingly cognizant of the interaction between social life and mental status —a relationship that is the basis of traditional social work practice. Social work is committed to improving the interaction among individuals, among institutions, and between people and institutions to enhance the general quality of life. However, in mental health, the major concern (the "dependent variable" in research jargon) is mental status. This article is concerned with social work's role in community mental health: the activities that enable the social worker to contribute to the improvement of an individual's mental status while maintaining a commitment to viewing the person in the environment and to improving the overall quality of social life.

BOUNDARIES

As a profession, social work is concerned with all spheres of interaction between people and their environments. Social workers practice in the realm of formal organizations of care and control; are concerned with the social, psychological, and jural dimensions of the family; and have become increasingly interested in the everyday support systems that function among friends and acquaintances. All these concerns have been identified, in one way or another, with the treatment of mental disorders or the promotion of mental health.

To the consternation of many traditional mental health professionals, the field of community mental health has become so elastic that it now includes almost all kinds of ameliorative activity. This expanded purview derives from the association of a myriad of social factors with the development of mental disorders and from the concomitant tendency to equate social well-being with mental well-being. For instance, the relationship between social class and mental illness and the relationship between social stress and mental illness clearly indicate that poor people are at the greatest risk of developing mental disorders.

Because of these relationships, it is tempting to conclude that full employment, better housing for the poor, national health insurance, and an array of poverty programs might be the best means to reduce mental disorders in a society. Unfortunately, there is little evidence to support this conclusion. Such policies and programs are laudable in their own right, but their impact on the mental status of the individual is subject to question.[1] The equation of social well-being and mental well-being is like the Calvinist equation of wealth with salvation: both are nice, but not necessarily related.

What does it mean, then, to "contribute to the improvement of individual mental status" while "maintaining a commitment to improving the overall quality of social life"? The answer depends largely on how a mental health "problem" and a mental health "service" are construed.

INAPPROPRIATE LABELS

As one moves farther from the traditional concerns of mental health (with psychoses, for example), the reliability of the assessment of mental status becomes poorer and the risk of inappropriately labeling "problems of living" as "mental disorders" becomes greater. Similarly, when one approaches human problems whose relationship to discernible mental disorders is ambiguous or distant, the definition of a "mental health service" becomes problematic.

Current empirical understanding does not permit a more elegant solution in either case. Mental disorders are variously defined and diagnosed either in narrow or broad terms. And a mental health service is often what Congress, the National Institute of Mental Health, state legislatures, or local citizens' advisory boards are willing to pay for.

The clinical risks associated with inappropriate labels make it incumbent on mental health practitioners to be specific and judicious in the use of labels. Further, the treatment of individuals in mental health settings, as opposed to social service or "generic" settings, may discourage potential clients who "know" that only "crazy people" (or members of any devalued

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group for that matter) go there for help. For this reason, it is often necessary for mental health agencies to assume names that disguise their purpose or spoof the severity of their clients' problems. (In the past, the authors have been aware of such examples as the Daily Planet in Richmond, Virginia, and the Cabin Fever Clinic in Anchorage, Alaska.) Similarly, in many cases practitioners must allow clients to treat a meaningful diagnosis as a euphemism for problems of living. This obviates the often needless semantic battles over the clinician's specific meaning and right to pass judgment. Admittedly, these are expedient methods of relieving the dilemma of its horns, but they appear unavoidable in many circumstances and are therefore widely practiced.

Following the same logic of expediency, the authors regard a "mental health service" as whatever service is necessary to improve what clients (except those who are a danger to themselves or others) regard as a less-than-desirable mental status, regardless of the diagnostic description. Although this definition permits a broad interpretation, priorities pertaining to the more reliably assessed mental health problems and to the expenditure of limited funds justifiably narrow the field. That is, mental health services must pay more attention to problems which are derivative of chronic schizophrenia than to those that are only marginally related to mental status.

The following is an example of how broadly the term "mental health service" can be interpreted:

> The executive director of a community mental health center (a psychiatrist) was annoyed with the director of the children's service (a social worker) because she had allowed her staff to provide day care to children of single working mothers whom she believed to be an at-risk population. The executive director informed the children's service director that no further funds could be expended on this program because it was not a mental health service. She replied that a day care service for children of single mothers who were under stress was a mental health service. Authority prevailed, but the issue was never resolved.

Therefore, the day care service ceased to be a mental health service; it became an "educational supplement." However, emergency housing was considered an important contribution to mental health and thus became a mental health service. These distinctions came about because the local school district had funds for day care, whereas the mental health system had money for emergency shelter. Subsequently, when the mental health system had fewer funds, shelter became a "social service" and received support from elsewhere.

These are the political concerns that govern the organization and subsidy of mental health care. Such distinctions are authoritative and they are usually arbitrary. Fortunately, the activities of social work transcend their settings. The profession is bigger than the organization of care. The social worker in community mental health is not only concerned with duly sanctioned mental health services but is committed to the application of whatever services can reasonably be expected to improve the mental status of a client over time or to prevent the predictable deterioration of mental status. In the broadest and most important sense, this is what differentiates casework from psychotherapy. If a single mother needs day care for her children to alleviate her anxiety, the case plan should include such services—within the mental health system if they are provided there or within the school system if that is where they are to be found.

Traditional mental health settings are not the only ones that provide mental health services. Family service agencies, youth service bureaus, and many other general social service agencies provide services that are legitimately within the realm of mental health. Many of these agencies provide better services than the traditional agencies. However, in this article, the authors have chosen to focus on the activities of the traditional agencies because these agencies have brought mental health services to the general population, especially to those with discernible mental disorders.

In the past twenty years, two practice models have developed as a result of the community care and community mental health movements. The community care movement has spawned a practice model based primarily on legal and administrative mandates designed to minimize the violation of the patient's civil rights and to maximize the patient's right to "fail." The community mental health movement is based on the epidemiological model. The remainder of this article will be devoted to a discussion of the two models (including their history and problems and the role of the social worker) and to the relationship between the objectives of social work and the practice of community mental health.

COMMUNITY CARE

According to the U.S. General Accounting Office, community care seeks to

> (1) Prevent both unnecessary admission to and retention in institutions; (2) Find and develop appropriate alternatives in the community for housing, treatment, training, education, and rehabilitation of the mentally disabled who do not need to be in institutions; (3) Improve conditions, care, and treatment for those who need institutional care . . .; [(4) Entitle] mentally disabled persons to live in the least restrictive environment necessary and to lead their lives as normally and independently as they can.[2]

These principles have been given teeth by administrative codes, state and federal law, and judicial decisions that have formed what amounts to a judicial and statutory model for practice. The U.S. General Accounting Office goes on to say:

> Judicially imposed standards in New York and Alabama provide that those states shall make every attempt to move residents of the designated institutions from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual resi-

dences; (5) places segregated from the community to places integrated with community living and programming; (6) dependent to independent living.[3]

The Lanterman-Petris-Short Act, passed in California in 1969, is tantamount to a patient's bill of rights. The act guarantees patients in California the right to a judicial hearing with respect to involuntary confinement and imposes hard evidentiary standards for involuntary admissions. The act also allows patients to refuse certain types of treatment, such as shock treatment and lobotomy. An October 1979 decision in Boston (*Rogers et al.* v. *Okin*, U.S. Court, District of Massachusetts, 75–1610–T) allows patients to refuse antipsychotic medication and seclusion unless they are dangerous to themselves or others. Furthermore, the 1972 *Wyatt* v. *Stickney* decision in Alabama confirmed that involuntary patients have a right to treatment, not merely custodial care. And there have been other efforts to extend the right-to-treatment principle to community care.[4]

Traditionally, social workers have been responsible for managing the patient's transition from hospital to community. In California, from 1946 until the early 1970s, social workers in the Bureau of Social Work had primary responsibility for community placement and supervision. Although the treatment of psychological disturbance remained within the purview of the medical profession, social workers supervised former patients and, except in acute cases, dealt with the ex-patients' various psychosocial needs. Ex-patients in family care homes were often on probationary leave from the hospital and could be moved from one family care setting to another or back to the hospital at the discretion of the social worker in charge. To the extent that placements were in good supply, this discretionary power was believed to be an important factor in maintaining high-quality care.

With the growing recognition of patients' rights, placement workers lost much of the power previously attached to their role. Statutory, judicial, and administrative decisions placed substantial limits on professional discretion and clearly indicated that judgment must err on the side of liberty. Thus, as criteria for involuntary admissions became more stringent, the population of potential clients whose need for institutional care was ambiguous—that group for which the error rate of clinical judgment would be high—was no longer permitted to be admitted involuntarily to mental hospitals. The rationale for this decision was that the benefits of institutional treatment of this group as a whole could not be expected to exceed the therapeutic liabilities of forced treatment or to justify the abrogation of a citizen's right to liberty.[5]

RIGHT TO FAIL

The growing emphasis on the civil rights of patients did more than remove power from placement workers. Mandates for treatment in the least restrictive environment, for the right to treatment rather than mere custodial care, and for the right to refuse treatment have molded the placement worker's role, providing a framework or model for decision-making and practice. These mandates stimulated the development of a new logic of decision-making, based on the overt consideration of statistical risk. The placement worker must now continually weigh the client's ability to cope with minimally restrictive environments against the repercussions of failure. This is certainly not a new dilemma in social work practice. However, now the client's right to fail—and perhaps even his or her right to fail repeatedly—is mandated by law.

Optimally, a placement worker encourages constructive risk-taking while minimizing the impact of failure. To achieve this, systematic attention must be paid to each case, and individualized social support for clients must be developed. Stein, Test, and Marx defined such support as the set of relationships adequate to assure that a client's needs are addressed without discouraging self-sufficiency.[6] Individualized social support requires a thorough assessment of the client's current problem-solving capabilities and the existing set of effective and affective relationships, that is, an assessment of the relationship between the client's mental status and the social context in which the client functions.

Mental status must be assessed in terms of the client's tolerance of social relationships and the impact of the client's mental status on those relationships. This assessment ought to include attention to a client's ability to function within a set of reciprocal relations rather than in a dependent manner. With such an assessment in mind and by monitoring each case, the worker may develop necessary buttresses and change them as necessary to provide either more support or less support, depending on the client's social situation and mental status.

FOUR ISSUES

In the future, social workers in community care must attend to four salient issues within a minimum treatment or confinement/right-to-fail framework: (1) the burden on the community of a concentrated number of ex-mental patients, (2) matching clients to optimal environments, (3) case management, and (4) medication.

Burden on the Community Many urban communities have been overwhelmed by an influx of ex-mental patients. Their courts are clogged with disordered petty offenders and their subway stations and doorways are haunted by disheveled, vaguely menacing individuals whose "community care" has been negligible. Although sheltered-care residents pose some burden to local communities, it is the free-living ex-patients that are the most troublesome and threatening.

Elsewhere, the authors have made some specific recommendations for policy and programs with respect to this population that will not be repeated here.[7] The central point, however, is worth repeating: social support must become more than a casework catchphrase. Social workers must define in more specific operational ways the meaning of social support systems, especially when networks of kin cannot

be activated. Developing effective networks of indigenous helpers is crucial to multiply the effect of such helpers and creates a first line of acceptable response to the periodic crises of ex-patients in the community.

It is not enough to define social support systems the way an anthropologist would limn the structure of mutual aid as it naturally occurs. Social workers must learn how to use and develop natural or surrogate helping networks, and this requires more practice-based research designed to yield practice materials. Although much attention has been focused on support systems, on outreach, and on community-building, little has been accomplished.[8] Nor has the profession oriented curricula in schools of social work to reflect interest in these areas. Thus, a commitment to defining, implementing, and teaching methods of social support is an immediate challenge to the profession.

Matching People to Optimal Environments To date, the placement of former patients in the community has involved a largely unspecified process of finding the best fit between the client and available environmental options. Researchers and practitioners have emphasized that diverse types of individuals fare differently in treatment environments that present various physical and cultural barriers to adjustment and demand either much or little emotional involvement by residents.[9] Little research has been done on the placement process itself, however. Segal and Aviram described the goal of "best available fit" and the political contingencies associated with its achievement, but research on testable placement models is needed.[10] To this end, practitioners must document the placement-decision process in much greater detail.

Much more also needs to be known about the methods by which social workers monitor the progress of ex-patients in community care. To some extent, this is a matter of understanding the impact of mental disorders on social life to achieve greater benefits for clients from programs. However, "burnout" among practitioners may also be reduced through the study of activities constituting the monitoring role and through adjustments to lessen the tedium of routine and the discouragement that results when clients do not improve.

Case Management By defining and developing the case management role, social work can build a strong base for its future practice in community care. Because there are as yet no specified methods, case management is little more than a goal of coordinated care. Of particular importance is the question of the role of case management in casework settings: Are case managers to be considered specialists who concentrate on coordinating resources and on continuity of care, or should case management be a general activity of casework to be performed by all workers? Further, can difficult problems of case management, such as the tracking of transient clients, be solved without infringing on the rights of ex-patients?

Surber described five functions of the case manager: assessment, planning, linkage, monitoring, and advocacy.[11] Empirical investigation of such procedures and their relationship to established casework methods, the organization of care, and civil rights issues is the next logical step in the development of an effective case management program.

Consequences of Medication To the degree that the major tranquilizers measure up to their promised performance—inhibiting the symptoms of psychosis without affecting social functioning—they are not the concern of social welfare. Unfortunately, the drugs fail to perform well for some individuals and produce undesired side effects. Moreover, their administration is abused, and there is a notable lack of adequate supervision and follow-up of patients who receive the drugs.

The consequences of medication—its impact on social functioning—are within the purview of social work practice. The authors do not advocate the prescription of drugs by social workers but emphasize that the behavior and side effects associated with medication should be a part of every mental health social worker's education. Graduate social work curricula are sorely lacking in this area; consequently, many practitioners are not adequately prepared to understand the important role of medication in their clients' lives.

In a similar vein, social workers must also be able to intervene in the process of self-medication in which many ex-patients are engaged. It is common to find ex-patients medicating themselves with their own or collectively created concoctions of major tranquilizers, opiates, barbiturates, alcohol, marijuana, cocaine, and even LSD.[12] If mental health social workers are to understand the behavior of these clients, they must have some education about the effects of these substances, used alone or in combination.

EPIDEMIOLOGICAL MODEL

To some extent, the community mental health movement grew out of the community care movement and its conflict with advocates of improved care in state mental hospitals. Its emergence is usually traced to the passage of the Community Mental Health Centers Act of 1963 (P.L. 88-164) that provided for the establishment of community mental health centers in "catchment areas" with at least 75,000 but no more than 200,000 residents.

These centers were to be concerned with the mental health of everyone in their designated areas and, to be eligible for construction funds, were required to provide five services: inpatient, outpatient, partial hospitalization, emergency, and consultation and education. The 1975 amendments to the act (P.L. 94-63) increased the number of required services by seven: diagnostic, rehabilitative, precare and aftercare, training, research and evaluation, screening, and provision for community living arrangements. The legislation also required that the full range of twelve services be provided to children, the elderly, drug abusers or addicts, and alcohol abusers or alcoholics.

The community mental health movement's focus on community-based treatment and its emphasis on the impact of social life on mental status places it squarely within the domain of

social welfare. Indeed, despite the greater authority accorded the medical profession, social workers staff more full-time positions and provide more services than any other professional group in community mental health centers.[13]

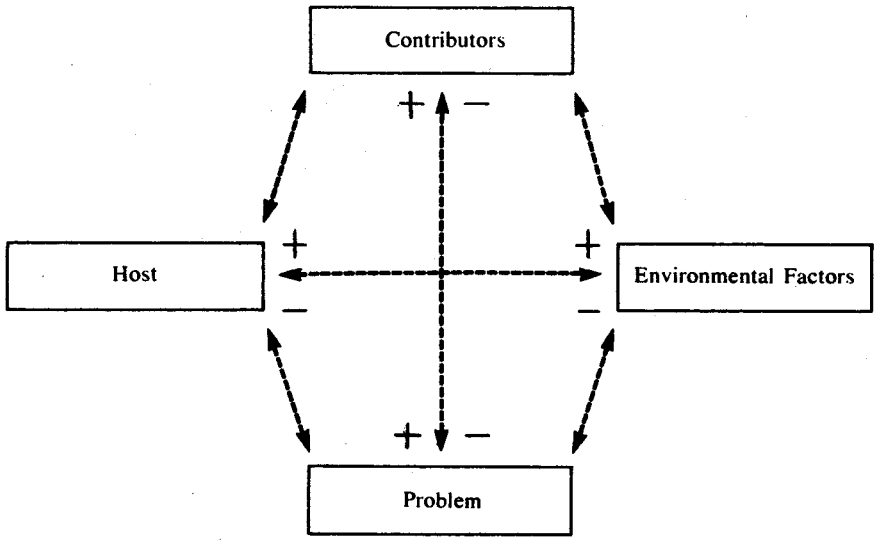
The comprehensive nature of a good community mental health center complements the traditional versatility of social work and offers many roles for practitioners. Social workers may become involved in every dimension of operation—from administration to emergency services. Theoretically, the community mental health center offers social workers the opportunity to address the needs of the "total" individual, rather than administer treatment geared solely to the improvement of mental status.

The traditional role of the epidemiologist has been to discover the causes of a disorder's appearance in a population. Usually, epidemiologists specify the causal mechanism and public health practitioners then develop the method of attack on the causal chain.

Figure 1 represents a slightly modified epidemiological model derived from the study of infectious diseases. Although the authors do not mean to imply that mental ill-health is infectious or that the problem confronted necessarily has to be a disease, they believe that this model offers a framework for social work practice in community mental health. It is a framework not only for the delivery of direct services, but also for the planning and evaluation of community mental health services.

At the direct-service level, the model suggests an investigative, empirical approach to ferreting out and detailing material that enables the worker to understand and have an effect on each component: the host, the contributors, the environmental factors, and the problem itself. (The term "contributors" has been substituted for the epidemiological term "agents," since, unlike diseases, the causes of most mental disorders are not known.) Figure 1 depicts the interrelations among the four components of the model. As illustrated by the plus and minus poles of each component, influences are variable. Since all components interact,

FIG. 1 EPIDEMIOLOGICAL FRAMEWORK



the process described by the model can, in combination with variable influences, be complex.

All models of this sort are liable to appear simple and mechanistic. It is, therefore, important to keep in mind that the purpose of such a model is to illustrate how a case can be analyzed and evaluated. The model does not provide a formula for clinical judgment; nor is it a graphic representation of wisdom. It is simply a useful way of viewing a human dilemma in its proper context. It is a framework for bringing to bear the most complete and complex information possible.

The social worker's role is that of a detective working with a client to develop the best understanding of each component. Unlike practice models based exclusively on clinical theory, assumptions about discrete "facts" or about the interaction between components of this model must, whenever possible, be validated or tested. The social worker must use the principles of scientific case study (single-subject designs) to assess changes in clients over time. The worker applies the validation and hypothesis-testing techniques of the field researcher, who uses corroboration, multiple observations, and experimental manipulations to achieve a significant degree of empiricism.[14]

Perhaps the best way to understand the validation process is by way of example. Let us take the case of an individual with terminal cancer who tells his social worker that he really wishes that someone would tell him what he suffers from. In this situation the social worker seeks to keep the family functioning as a unit while coming to terms with the imminent death of a member and tries to help the dying person cope with the approach of death.

As a first step, the worker speaks to the physician to confirm the patient's report. The physician may inform the worker that he has communicated the information to the patient several times. The *problem* thus appears to be denial in the *host*. Or the physician may indicate that he has not responded to the patient's questions. The problem thus appears to be avoidance by the physician, a *contributor* to the host's anxiety. The worker must also assess the relationship between the patient and his family to determine the strength of *environmental factors* contributing to denial, for instance. Following such validation, the worker is prepared to

plan a strategy that will enable the physician to communicate the information or the patient to hear and understand what is said. The worker must then check the outcomes during the course of the service relationship and after the designated service period has come to an end.

The epidemiological problem-solving framework accommodates various theoretical approaches and, given the assessment of all four components and their interaction, requires the selection of the most useful alternative interventions. The framework accommodates not only a medical model but also a deviance perspective in that the problem, located with the host, is interactive with environmental contingencies. There is always an emphasis on the environmental context and the constraints applied or degrees of freedom allowed by specified components. Problems that appear similar may be treated differently based on the intransigence or tractability of environmental factors.

PREVENTION

With respect to planning and evaluation, the epidemiological framework is founded on a preventive model that is concerned with the maximum utility of mental health services for the social group. Outcome is evaluated in relation to changes in rates of occurrence of specific problems within the group and activities are differentiated by the state of the problem in the host. Activities consist of primary, secondary, and tertiary prevention.

Primary Prevention Primary prevention activities are directed toward populations at risk, that is, those individuals with the highest probability of developing a specific problem but who do not as yet have it. They are evaluated in relation to their efficacy in reducing the incidence or number of new cases of a problem. Although all social work skills are used to implement primary-prevention activities, three (consultation and education, crisis intervention, and community organization) have become the major techniques of primary prevention.

Education and consultation programs of community mental health centers have been the focal point of primary prevention. Such programs have involved family life education and lectures on the impact of stress, retirement, and the benefits of social support. In addition to educating the public, the purpose of consultation and education is to develop further the existing helping systems of lay people in a community. For example, self-help organizations or service programs run by church groups may need consultation from professionals to screen participants with serious psychological problems that require the attention of experts. Bartenders may be trained to provide referrals to problem drinkers, or cab drivers may be taught to refer people in crisis to appropriate programs.

Crisis intervention is usually considered to be a technique of primary prevention when applied to persons in crises caused by such events as a natural disaster or the loss of a spouse. However, it is usually associated with secondary prevention when applied to persons with diagnosable conditions. In these cases the crisis is likely to be the precursor of another acute episode of the condition, for example, schizophrenia.

When no clear point of onset of a mental disorder exists, it is difficult to make a distinction between primary and secondary prevention. For example, when considering services to "troubled youths," whose problems are invariably diffuse and involve them in several systems of care and control, the distinction between primary and secondary prevention has mostly heuristic value. However they are classed, the activities involved in crisis intervention implement the epidemiological approach through aggressive casework and group work efforts to develop resources, muster social support, and increase the ego strength of clients to facilitate coping.

As a technique of primary prevention, community organization emphasizes local and democratic control of social institutions as a means of buttressing the individual's sense of personal control through participation and strengthening social bonds by virtue of reciprocal commitments among participants. Thus, participation is seen to be both health promoting and politically effective, contributing to the well-being of individuals and their communities.

Community mental health centers have sponsored such community-organization activities and have also been the targets of mobilized residents, especially in minority-group communities. Community organization has also been used to foster the development of self-help groups, such as extended "nonfamily" networks capable of lending continuous support to the individual and family in stress.

Secondary Prevention Secondary prevention activities, such as short-term treatment and crisis intervention, are associated with shortening the duration of a specific problem or treating it before it becomes severe. They are assessed with regard to their effectiveness in decreasing the prevalence of a mental disorder in a community or reducing the total number of cases already suffering from that disorder.

It is in the implementation of secondary prevention activities that the community mental health center has been identified with the less disturbed and more privileged members of a community, and it is in this role that social workers come to be therapists in the narrowest sense of the term. The mandate that community mental health centers serve the total population of a catchment area—and their patent inability to do so—has resulted in the application of resources according to potential demand rather than to severity of need.

Thus, community mental health centers gear their services to middle-class people, whose only previous resource was the mental hospital if they could not afford private psychiatric care. This is an important achievement, but frequently it has come at the expense of the chronically ill, the poor, and ethnic and sexual minorities, who often need different services in alternative settings. This problem is especially important in view of the virtual monopoly that community health cen-

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ters have on federal mental health funds.

To a great extent, community mental health centers have been the victims of incompatible demands. All the people cannot be pleased all the time—and certainly not under one roof or by one agency. Thus, the last decade has seen the growth of private, usually small, mental health agencies serving groups underserved by community mental health centers. Social workers have been important participants in these alternative efforts as administrators, caseworkers, therapists, and advocates. They have also emerged as the professional links between these agencies and established centers. Thus if a rapprochement is forthcoming, it is likely that social workers will negotiate its terms.

Tertiary Prevention Tertiary prevention activities are concerned with the reduction of disorder-related problems in a population. They have been largely associated with the care and rehabilitation of the chronically mentally ill and with the deinstitutionalization movement. It appears that shorter hospital stays have reduced the occurrence of the iatrogenic effects of institutional care. However, assumptions that community mental health centers would provide the care necessary to prevent the postinstitutional deterioration of ex-patients have not proved true. Community mental health centers and the social workers practicing in them have been severely criticized for their inattention to the chronically disordered, and statistics have supported these criticisms.[15]

Following these criticisms, and in response to the mandates of the 1975 amendments to the Community Mental Health Centers Act, community mental health centers have begun to provide more appropriate services to the chronically mentally ill. Social workers have been outposted or detached to work with ex-patients in single-room occupancy hotels, sheltered-care homes, and private residences.[16] They have also become advocates of patients' rights. Still, these efforts are far short of what is necessary to prevent the grave consequences of chronic disorders.

SOCIAL WORK OBJECTIVES

The role of social workers in community mental health is embedded in the broader relationship of people to social institutions. Social work's concern with the quality of life is sanctioned by the social system and involves, of necessity, some commitment to the institutions that organize and govern secular life. This responsibility does not preclude activities directed toward social change. Indeed, to be fully responsible in any society requires a commitment to social change.

However, social workers are creatures of society's mandate and must keep in mind that the needs of the individual arise in a given social context and must be weighed against the claims of the social group. Social work educators, in particular, must confront the last decade's fashionable narcissism. Social work's commitment to equity, social responsibility, relatedness, and sacrifice should be a source of pride for practitioners and should not be dismissed on the road to the practice of psychotherapy.

Social work's efforts to define and develop its practice in community mental health must address specific and difficult problems currently facing the field, such as violence in families. The profession must also respond to the needs of underserved population groups. In considering the individual's relationship to the social group, social work must balance primary prevention efforts against services to the chronically ill. The former is an efficient approach to the social group, the latter is a commitment to serving the individual. One should keep in mind these issues and the practice frameworks described in this article in reading the following summary of their relationships to the basic objectives of social work.

Help people enlarge their competence and increase their problem-solving and coping abilities. The legal/administrative model of community care stresses the first objective of social work practice: to help people enlarge their competence and increase their problem-solving and coping abilities. Emphasis in community care is placed on intervention that provides necessary support without discouraging self-sufficiency. Error in treatment is calculated to occur on the side of the individual's right to risk failure. Thus the individual is to be served in the least restrictive environment possible and always encouraged to do for himself or herself.

The epidemiological model of community mental health places an emphasis on the host, beginning where he or she is and encouraging the use and development of problem-solving and coping abilities necessary to affect environmental contingencies, contributors to the problem, and the problem itself.

Facilitate interaction between individuals and others in their environment. The community approach in community care and in community mental health emphasizes the individual's formal and informal association with groups. It is the "functional community" that most directly affects the individual's ability to live as an integrated member of society and to achieve a satisfactory state of mental well-being. In describing the individual's functional community, Caplan referred to the social support system.[17] This system consists of others in the environment who provide help in three

ways: (1) They help the individual mobilize psychological resources and master emotional burdens. (2) They share tasks. (3) They provide extra supplies of money, material, tools and cognitive guidance to improve the individual's situation.

Help people obtain resources. Segal, Baumohl, and Johnson, drawing on Wiseman, view the function of social support as providing the individual with "social margin"—that leeway for error or disreputability which facilitates survival even in the meanest circumstances.[18] Social margin consists of the relationships, possessions, skills, and personal attributes that can be mortgaged, used, sold, or bartered in return for necessary assistance in prospering or surviving in society. It derives from the interaction among individuals and between individuals and institutions. When the social work profession seeks to improve such interactions, it is trying to increase the social margin of its clients.

Clearly, this improvement may be brought about in numerous ways, including those related to the three remaining objectives of social work: *make organizations responsive to people, influence interaction between organizations and institutions,* and *influence social and environmental policy.* In the community mental health field, virtually every activity, from individual casework to community organization, is an attempt to develop the relatedness required to prevent the stresses that seem to forecast the occurrence of a mental disorder or to relieve those which prolong its duration or make its chronic presence more agonizing.

The evaluative component of the epidemiological model emphasizes benefits to the social group, defined in practice as the residents of a particular catchment area. The policies, formal and informal, that govern the organization of care in any area have a substantial impact on the lives of individuals and consequently on the rates of incidence and prevalence of a mental disorder. Criteria for eligibility and barriers to comprehensive or continuous care are, among others, elements of policy and organizational behavior that should be of great concern to social workers in community mental health. These are not simply problems for mental health administrators or for politicians concerned with the formulation of social welfare policy and program. They are issues that affect almost every case.

Aside from organized political activity, which the authors recommend, and in addition to the promotion of more social workers to administrative and policy making positions, the responsiveness of institutions is most affected by the profession through case management, especially through the activities of brokerage and advocacy. As was observed previously in the article, the mental health field is not always or even usually organized in a manner that permits a comprehensive response to those in need. Short of the creation of a mammoth mental health empire, this will always be true. From case management specifically and from good casework generally comes the simultaneous concern for mental and social well-being that forms disparate helping activities into a coherent whole in the service of each client. To see the person in environment obliges social workers to see the person in relation to the organization of care.

CONCLUSION

The mental health field has moved increasingly into the realm of social welfare, focusing its interventions on the relationship between individuals and institutions. As a result, social work has become the mainstay of mental health's community-based efforts.

In the future, mental health social workers must develop additional skills to cope with the compound human problems they face daily. They must become adept intervenors in crises, develop a greater awareness of the impact of drugs on social functioning, better define and implement methods of social support and case management, and better describe and evaluate the discrete methods of their profession.

What is most important, though, is that social workers in the mental health field must maintain their commitment to social well-being, even when called on to attend narrowly to the improvement of mental status. In this commitment to the quality of social life—to equity, social responsibility, and relatedness—lies the unique and noble purpose of the profession.

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