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CENTER FOR COORDINATING COMMUNITY HELP©

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I. INTRODUCTION

The project proposed here is a relatively new approach to "mental health" (social and emotional problems, individual and social crises) and in fact involves a redefinition of "mental health" to include practically all the problems of the community members. It has been tried by the Range Mental Health Center in Virginia, 'Minnesota (see the papers of Muhich, Hunter, et al),

The coordination of the fragmented helping professions is a much needed job. The Center would employ some regular mental health specialists, such as clinical and counseling psychologists and psychiatrists. However, these people would not be oriented toward the medical model of "Treatment" of "Mental Illness" (See Szasz, 1961) but instead would implement a social-psychological community development approach to the problem areas. In addition, other members of the helping professions would be utilized in a more effective manner by the Center along with an extensive complement of para-professionals. The problems which the usual Mental Health Clinics attempt to solve exist first in the community. However, the typical mental health approach tends to encourage irresponsibility, passivity or rejection of the problems which arise or are produced. by the community (this is an ironic result of the availability of clinics and mental hospitals). The community model produces the opposite effect in that it raises the competence of the community, especially the key contact personnel, to deal with social-emotional problems of its members on the spot and prevents them from becoming major crises and social problems. A community which can handle most of its social problems, instead of shutting them up in the most convenient institution, is healthier than the present typical community which is never forced to face the problems it creates.

II. RATIONALE

The Center for Coordinating Community Help for individual and social crises would be based primarily on consultation and prevention activities. The program assumes that the problems of individual and social disorder and the stimulation of positive emotional and social health require a broad program based on strengthening and coordinating community resources. The program carries a sociological and public health orientation. The intent is not merely the diagnosis and treatment of mental disorders, nor is the goal limited to prevention and

educational endeavors. Rather, the goal is the conservation, development, and full utilization of human resources for the betterment of the individual and the society.

As a child of necessity, mental health energies have been directed increasingly toward groups, families and communities. The Center described here makes an effort to use mental health specialists and para-professionals in a unique way realizing that there will never be enough mental health specialists to meet the needs of the acute and chronically distressed. (Albee, 1959)

Along with continuing manpower shortages has come the discovery that. one need not be a mental health specialist to deal effectively with disordered behavior. In fact, mothers, teachers, clergymen, physicians, attorneys,, nurses, police, welfare personnel, all deal with people in emotional crises daily.

Thus, the basic philosophy underlying the program is the conviction that assisting people in emotional distress is not a skill restricted to personnel trained in psychiatry, psychology, or psychiatric social work, but rather it is a human skill which all people possess. Recognizing, however, that individuals vary in their interest and ability to use themselves in this manner, the Center views its central role as a stimulant to the uninvolved or the timid and an educator to those currently performing mental health functions. (Guerney, 1969)

Gurin's study indicated that 42 per cent of seriously distressed people in the United States first turn to their clergyman for help. Another 29 per cent first contact a family physician. Only 10 percent go to a mental health agency when it is available. There is little reason to suppose that such community helpers will be sought less frequently in the future. Thus, the contact made during this crisis period is seen as the natural site for early intervention.

Recently institutions of all types are redefining their roles and increasing their efforts to integrate themselves more intimately with the communities they serve. To assist families and communities in this endeavor requires approaches other than the traditional use of mental health manpower. To help a community and its key contact personnel in the job of learning about, preventing, and handling emotional and social disorders a different approach from that of ordinary dyadic or group psychotherapy is demanded.

Some of the assumptions contained in the program are these:

(a) The events happening during emotional crises within the real life-space of the person are more important than what might happen weeks or months later in a mental health facility.

(b) The interaction with the person who is spontaneously sought out for help is the crucial interaction for the troubled person.

(c) All human beings have some urge and some ability to help others in emotional distress, although some individuals are more interested or more adept in this helping relationship than others.

(d) The people who are spontaneously used for help can increase their effectiveness through consultation with and minimal training by mental health specialists.

The major contributions of the mental health specialist should therefore be in the education, stimulation and encouragement of the community key contact personnel; that is, the

school personnel, courts and probation officers, police, clergy, public welfare departments and the medical establishment including physicians, hospitals and nurses. A representative from at least one of these groups is present during practically every life crisis - birth, death, unemployment, marriage, school-dropout, unwed motherhood, etc. These are the "helping professions" that are on the scene, and the manner in which they handle a crisis can enable an individual to move toward or away from better emotional and social health.

What the physician says to his patient or what the school teacher does during a "crisis" on the playground is much more important than what may transpire two weeks later in the mental health specialist's office. It is felt that in making the resources of the Center available to the individual physician, teacher, or clergyman that the total impact on the community will be much greater. The goal of the Center should be to help these key people handle the emotional and social problems presented to them and to handle their own interpersonal relationships in a way that will lead to strengthening the distressed person. Mental health specialists can offer more to an area by working with other key personnel than by devoting the same time to direct therapy. Techniques gained by a key contact person (teacher, for example) are passed on to his other clients immediately and in the future.

Besides consultation there are other jobs to be done. We have a duty to interact with and to attempt to educate the general Public on pertinent, everyday-mental health matters. There is a need for data-collecting procedures which will not only assess direct efforts and aspects of the community but also which will attempt to provide acceptable data on community changes in. relationship to a mental health teams input.

Thus, most of the effort of the Center will be spent consulting with existing community caretakers, stimulating and coordinating agency efforts, providing in-service training, working regularly through all media for public education, offering direct service in acute or preventative type situations only when nobody else is willing or able to do so, and evaluating these inputs into the several communities and into the area as a unit. In the program here outlined about 75 per cent of staff time would be expended in consultation and in-service training activities.

Through all this, the major effort is towards the on site helping of a distressed person if at all possible, toward strengthening, rather than breaking, family and community ties, and toward developing the entire community in its therapeutic and preventive mental health role.

III. PROGRAM

There has never been an epidemiological survey of most target areas, and the incidence of emotional and social crisis and breakdown has not been measured. One can safely say, however, that social and individual problems are frequently encountered, and the key contact groups register concern over the number of people with problems who confront them.

Using surveys that have been done in other populations, (Leighton, et al, 1963; Pasamanick, 1959; Srole, et al, 1962) an estimate of the number of individuals in the area served by the Center who could benefit from some form of mental health service would be a minimum of one person out of five. Direct service as an approach to the problem is an impractical solution, and so a public health and sociologically oriented center is proposed. This decision is made even though there will probably be a demand from some portions of the community for a direct treatment facility.

In attempting to develop the total community into a therapeutic device, there are six specific areas to which the center would direct its energies. They are: consultation, in-service training, direct clinical service, public education and information, stimulation and development of helping resources, and specific preventive programs.

A. Consultation

There are five groups of key contact personnel - schools; the medical establishment; clergy; social welfare agencies; and the legal profession, courts, probation officers, and police.

The goal of consultation is to increase the skill of the key contact personnel so that they can deal more effectively with increasingly complex cases of emotional disturbance. The staff of the Center will not "give advise" in the usual sense, but try to furnish means whereby the consultee can develop his own way of dealing with the problem m a continuing basis in accordance with his own needs and style.

Each of the professional staff members will assume responsibility for one of these areas to develop a consultative relationship between that portion of the community and the Center. The division of responsibility will be accomplished primarily on the basis of the staff members prior professional experience and interest. It should not be assumed that the staff members work in isolation because all staff members work with all agencies. Out of this will evolve an ongoing consultation program so that everyone in the area who is in a care taking position to an individual in emotional distress will be seen in ongoing consultation in his own office at least once every four weeks.

Consultations will be held on a regularly scheduled basis. For instance, clergyman might be visited at least once during each. two month period with many clergy being visited monthly. All other consultees might be seen on a monthly schedule. In addition a staff member will respond at any time assistance is requested outside of the regularly scheduled contacts. Consultees will never be asked to come to the Center for the consultation. The Center staff will in each case offer to go to the office of the consultee.

It is not proposed that the consultative method will supersede or supplant any function now being carried in the community, but rather will supplement the existing facilities.

The members of the staff will travel individually or as a team (depending upon the manpower needs in each area) to the office of the consultee, where an effort will be made to increase the therapeutic skills of the individual consultee and to stimulate his interest in using himself in a therapeutic manner. In addition to consultation, occasionally a staff member will participate in a joint interview with the consultee and his client.

A typical consultation day may find one staff member calling on physicians, another staff person meeting with individual clergymen, while a third staff member is consulting with police officers. The two remaining staff members would likely be visiting at one of the school districts in the area to discuss general and specific problems with individuals and groups of administrators, teachers and counselors. At some agencies several activities may be underway simultaneously,. For example, in a school system, one staff member may be engaged in consultation with an individual teacher, a second staff person may be leading a seminar for a small group of primary teachers, and still a third member may be participating in a joint interview with a counselor and a child or his parents. The list of consultees will include all of the

teachers, clergymen, physicians, chiropractors, nurses, police, judges, employment agencies, rehabilitative agencies, welfare workers, etc.

This consultative function will also place the staff in a position to serve as a liaison between various community agencies. Typically a number of key contact personnel are involved with the same family, but are unaware of each other and do not communicate with each other. The center would serve to coordinate these efforts.

B. In-Service Training

Another important aspect of the program will be to provide a more formal kind of training for these "front line" key people. Each of the key groups will have needs that would be best met in different ways. For example, a monthly in-service training session might be held for the welfare, probation and veterans service officers. A series of evening seminars might be offered to the area physicians and nurses. Day-long workshops could be held for the clergy, public health nurses, school nurses and police officers.

The training program would emphasize practical information on human growth and development, interviewing techniques, psycho-pharmaceutical medications, types of therapeutic interactions, family interviewing, etc. Again, the needs of each of the five groups would vary and the program will be tailored to meet the needs as the individual groups see them, with a general attempt to make the family the basic unit of inquiry, understanding, and interaction. (see Thomas)

C. Education and Information

In order to encourage public support and assistance in the development of the Center and other programs, all news media will be used in public information work. The Center could run a weekly column in local papers, taped interviews might be played over the local radio stations, and an occasional television program on mental health topics might be sponsored by the Center. The Center could operate a booth at the fair to distribute information, run public educational meetings directed to special problems, and the Center staff should spend considerable time speaking to a variety of social clubs and service organizations.

The Center should develop a mental health library which is catalogued in each of the local libraries in the area, although the books would reside in the Center offices. All of this would be directed at public education and also at developing support for the center. In establishing a center such as this, one must be painfully aware of some of the experiences of community mental health centers such as that in Onondaga, New York. (Stepanek and Willie, 1969) The active support of the community is essential and it is necessary to conduct a program to enlist this support.

D. Stimulation And Development Of Helping Resources

The Center staff, in assessing the needs of this area, will attempt to stimulate and develop needed mental health resources such as adequate school psychology programs, continued growth of special classes, development of day-night facilities, and adequate schools for the physically handicapped (such as cerebral palsied, deaf and blind) on a regional basis, and a number of other programs.

E. Direct Clinical Service

The matter of direct clinical service is an important consideration to any mental health facility, but it is especially important to a center such as this. A closed intake system is proposed, in that a case will be accepted only through consultation, and will be accepted for only one of six reasons. The priorities will be: consultative value, preventive value, psychiatric reasons, staff development value, community coordination or public relations. Direct clinical service might occupy about 25 per cent of professional time. All referrals for direct service will generate from and be an integral part of the consultative process. Direct self-referrals will not be accepted but will be referred to one of the key contact groups for initial evaluation and discussion with Center personnel. In some instances the evaluation process will involve an interview conducted jointly by a Center staff person and the consultee. Cases which are accepted are evaluated and, if needed, short term family oriented psychotherapy will be initiated. The case will then be transferred back to the key contact individual for further treatment with continuing consultation with the Center.

No prolonged psychotherapy will be available at the Center. A family or individual will not be seen continuously for months or years. Rather, patients will be on a highly active status for a brief period and wherever possible the family will be considered as a unit for both diagnosis and therapy. In each case, an attempt will be made to return the family to the consultee for continued treatment as soon as possible or perhaps to refer them to some other community agent who is in a more strategic position to continue therapy.

The proposed 25% of professional time spent in direct clinical service (utilizing the medical model of coping with "mental health" problems) may be too much and in fact, if there are facilities for out-patient therapy in existent institutions then, I would propose that the Center not become involved in this area at all. Instead all of the resources should be put into the task of creating a healthier community which is in line with The Active Society orientation (Etzioni, 1968). The problems of the "economically disadvantaged" are so great and the usual helping models are so inadequate or ineffective that any time spent in the typical approach must be examined with the greatest care to see that there exist no other methods to handle the problems more efficiently.

Thus, the only practical approach to problems which are typically displayed by the mental health clinic's clientele would be the one proposed here of mobilizing the community as the therapeutic agency and not confining this function to a very localized and specialized entity such as a Mental Health Clinic.

F. Prevention

Although the preventive value of working with community key contact personnel and their involvement in early therapeutic interventions with clients is recognized, a more direct kind of preventive program will also be necessary. The primary vehicle for this program will be the school systems. It is necessary to develop adequate data collection systems within the school systems to allow identification of deviant populations in the first three grades. Subsequent controlled preventive programs will be developed from that data.

G. Programmatic Inquiry and Evaluation

It is the responsibility of any community agency to examine its own operation, particularly a program such as this, which has some novel features. It is important to assess the work and the effect of the project. To meet this end, a four phase inquiry system is proposed.

Phase I will concern itself with the detailed examination of where the Center puts time and energy into the community, at what locations, with what individuals, and concerning what ends. This will allow the staff to record the amount of effort and the process involved in working with key community people and groups.

Phase II will describe the individuals and families dealt with purely through consultation. It will describe where they work, where they live, and size and kinds of families that they exist in, etc.

Phase III will perform the sane task for those cases which are seen in direct clinical service by the Center personnel. Thus, Phases II and III will allow the Center staff to compare the cases dealt with through consultation with the cases seen directly.

Phase IV will assess the changes in behavior, techniques and attitudes of the consultees. This will enable the staff to assess the influences of the Center on the community. The development and modification of the program will rest directly on this series of data collection systems built into a feedback circuit.

H. Program Summary

Each of the areas, Consultation, In-Service Training, Public Education and Information, Direct Clinical Service, Program Stimulation and Development of Helping Resources, and Programmatic Inquiry and Evaluation will be in a constant state of change and development as keyed to the data in the inquiry system. The Center, in sum, will not be primarily a treatment agency but rather it will be an agency which is attempting to develop the entire community into a therapeutic device. It is to this long-range goal that the Center will be dedicated.

IV. DEVELOPMENTAL PHASES OF THE PROGRAM

The initial difficulty facing the community program herein described will probably be that of obtaining sufficient time for initial planning and organization. During this period a major problem will be withstanding the pressures for direct-service from the community faced with immediate problems. If the community program does not involve the coordinated development of both professional staff and board, (i.e. the representatives of the community) this planning time will not be obtained.

Due to the community pressures upon the Center, organizational time will probably be shorter than optimum when the staff is the sole determinants of the Center program. The initial time spent becoming acquainted with the community and attempting to communicate some of the ideas within this program to the community will be the chief task of the first phase of development.

Overlapping with this initial phase it will be the procurement of "sanctions." (Caplan, 1959) This process of obtaining permission to work with a number of individuals within a variety of social systems and subsystems must occur at somewhat the same time as the original organization. However, the procurement of sanctions is a constant, never ending, and ever changing operation.

What. for example, a school superintendent will sanction within his school system may vary from month to month, although the overriding sanction of your consultation with his school in a general way may be maintained. The procurement of these sanctions and the maintenance of them is an inter-personal issue of great complexity and of great difficulty. This is the second major problem in development of such a Center.

The third phase will probably be a cycle of development similar to what Erikson, (1959) has described for the individual in the Epigenesis of the Ego. The initial problem at the beginning time is the establishment of Trust. This to be sure, begins with the first day of the Center's existence, carried through with the establishment of sanctions. It will become the "phase specific task" of the Center when the consultative and training relationship with the various groups has begun.

This is also a never-ending task and it is an issue to which one must address oneself with each consultative contact. However, the first contacts will be by far the most important. This will be a period of consultee wariness and defensiveness, a period when many of the projections that others place upon mental health specialists can be identified and sometimes partially dealt with, and a period of consultant discomfort. With the gradual establishment of trust, there follows the development and maturation of an ongoing consultative relationship.

V. AN ILLUSTRATION OF THE CONSULTATIVE RELATIONSHIP BETWEEN THE SCHOOLS AND THE CENTER

In implementing the consultative role with schools, a team consisting of, for instance, a psychiatrist, a psychologist and a social worker visit the schools on a regular monthly basis. They must be invited by these schools to assist with problems of emotional disturbance in children. An effort will be made to familiarize themselves with the prevailing philosophy and staff of that particular school. In a less intensive fashion, they will come to know the children and something of the classroom atmosphere.

The Consultants will seek to help teachers and administrators by demonstrating ways in which they can observe, understand, and manage more successfully the problems that confront them. The consultative method differs from supervision, discipline, use of school counselors, or school psychologists in that members of the Center team will rarely deal directly with the child in question.

One of the goals will be to indicate what can be done to provide school personnel with practical and useful tools for dealing with the myriad difficulties confronting them. It is not proposed that this method will supersede or supplant any present function in the school but will supplement the existing facilities.

The consultative method is specifically non-judgmental and has no strings attached. It has nothing to do with a schools internal policies, employment, tenure, advancement, or increase in salary.

As the teacher discusses the problem with a person trained in human behavior, she will develop new ways of observing the situation, of coping with and understanding a child's difficulties. Through analysis of these human experiences will come greater professional competency for the teaching staff. (See Moustakas' The Authentic Teacher, 1966, for example)

The Consultants do not "give advice" in the usual sense, but try to furnish means whereby a teacher can develop his own ways of dealing with the problem on a continuing basis in accordance with his own needs, style and abilities.

Considering the number and variety of disturbed children in the schools and the amount of anxiety and frustration among teachers and principals who have to deal with these children along with the normal group, it is felt that the consultative method will help a teacher survive and grow, and at the same time help children. This approach, advocated by the National Institute of Mental Health, will be the chief method of implementing the basic philosophy of the Center.

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