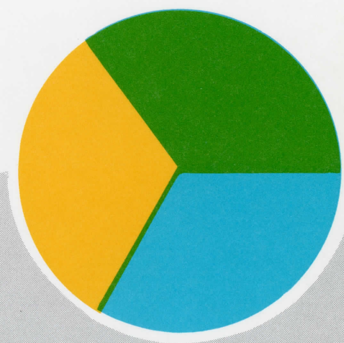
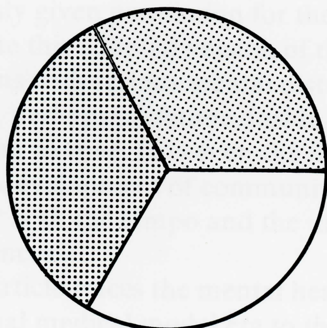


Delivery of Mental Health Services: Social, Cultural, and Family Factors

Delivery of Mental Health Services: Social, Cultural, and Family Factors

by Wayne H. Holtzman



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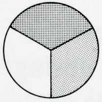

Introduction

Individual responsibility for maintenance and furtherance of the community mental health movement becomes the challenge in this article delineating issues in the continuation of mental health services. Dr. Wayne H. Holtzman, president of the Hogg Foundation for Mental Health, offered this overview originally at the 17th Annual International Meeting of the Association of Psychiatric Outpatient Centers of America, where he was recipient of the annual award in 1978. The Association has graciously given permission for the Foundation to publish and distribute this adapted version of the speech.

Persons with serious mental disturbances once were consigned to years, perhaps a lifetime, inside institutions. Custodial care kept them passive. However, the discovery of tranquilizing drugs and the development of community mental health services have changed both the tempo and the methods of treating emotional disturbances.

This article traces the mental health movement through the traditional medical model era to the types of community intervention. It looks at the ultimate goal of preventative measures maximizing positive health. The interplay of family relations, the influences of cultural philosophy and patterns of behavior, and the efforts of one foundation to facilitate positive activities in Texas are delineated. Most important, perhaps, the challenge is given to each individual to take initiative for furthering positive mental health.

BERT KRUGER SMITH

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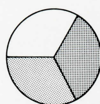


Notable changes in the amount and variety of services for people with mental and emotional problems have occurred during the past thirty years. Some differences have come in the type of care given, others in the location of such services. As scientific studies continue to reveal still other possibilities in preventative and curative modes of treatment, patterns of service alter accordingly.

The establishment of the National Institute of Mental Health in 1948 marked the beginning of a new era. Robert H. Felix, the first director of NIMH, started with a budget of only $4 million and several offices from the U.S. Public Health Service.

Twenty-five years and $4.3 billion later, one of his successors, Bertram S. Brown (1973), pointed to a number of remarkable changes in state mental hospitals, community mental health centers, the kinds of mental health services offered, and the great increase in numbers of mental health professionals who offer services. The number of residents in state mental hospitals dropped from a high of a half-million in 1955 to 275,000 in 1972. The expenditure per patient day increased from only $1.81 in 1948 to $20.68 over this same 17-year period.

Thirty years ago there were five resident-patients for each full-time staff member in contrast to the current ratio in which the number of staff members is almost equal to the number of patients. More important has been the sharp drop in length of hospitalization from an average of more than six months to a median length of stay of just 41 days for 1972 admissions.

A dramatic shift in the locus and type of care during the past quarter-century has also occurred. In 1955 one-half of the nearly two million episodes of care were provided by traditional public mental hospitals. Twenty years later only nine percent of the 6.4 million episodes were accounted for by state and county mental hospitals. Nearly one-half of today's therapy is provided by outpatient psychiatric services, while almost another one-third takes place in community mental health centers.

As the President's Commission on Mental Health pointed out recently (1978), the greatest changes have been the increase of the elderly in nursing homes, the marked shift from mental institutions to community care facilities, and the rise in treatment of alcohol-related disorders in mental institutions. Many factors are responsible for these changes, and several stand out as particularly noteworthy.

Gerald L. Klerman, head of the Alcohol, Drug Abuse, and Mental Health Administration, has described two professional developments that occurred almost simultaneously in the mid-1950s, revolutionizing the treatment of schizophrenia and other mental illnesses (1977). The first of the so-called tranquilizers, rauwolfia and the phenothiazines, contributed to improved treatment of many acutely psychotic patients. The second major development involved new psychosocial and behavioral methods of treatment in the mental hospital, leading to new social reform.

These quite different developments—the biomedical and the psychosocial—continue to stimulate debate and controversy concerning the ultimate answers to the still-baffling problems of diagnosis and treatment of the mentally ill.

Whether one is conducting work on the new frontiers of neurohormones and behavior in a search for better medical treatment or whether one is engaged in new experiments with social organization and the technologies of behavior modification, the delivery of mental health services must be pressed forward vigorously without waiting for future developments.

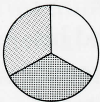
Several models of care demonstrate changing philosophies. In the first pattern, emphasis is upon the professional expert's engaging in diagnosis and treatment of a mental illness. This is the medical model. Here the clinical skills of the professional and his assistants are of paramount importance in providing effective services for the person in need of help. Close attention must be paid to environmental-behavioral interactions within the family as well as in the cultural milieu in order to be effective, in most cases.

A second approach grows out of the preventative model championed by public health. Here the strategy is one of locating the focal points in society where high risk of emotional breakdown can be determined and then developing social practices that are aimed at minimizing the degree of mental illness that occurs. A primary focus is upon illness and its prevention.

The third point of view has sometimes been called the positive mental health approach. Its emphasis is on large-scale educational and social intervention in order to overcome cultural and environmental factors that prevent the full development of an individual's potential.

The community movement places strong emphasis upon a combination of preventative health measures and social intervention aimed at promoting greater mental health. Clinical services tend to be short-term for crisis intervention. The professional devotes more of his time to preparing others (such as parents and teachers) to deal with the problems themselves rather than offering to deal directly with the problems of others. All the models represent valid approaches. Each pattern also has serious limitations that are overlooked all too often.

The Community Mental Health Movement



A broad consensus was reached across the land following the reports of the Joint Commission on Mental Illness and Health in 1961. The Commission's final report placed strong emphasis on community-based services, leading to the Mental Retardation

Facilities and Community Mental Health Centers Construction Act of 1963. The Association of Psychiatric Outpatient Centers of America was formed at this same time. Swept up in the ambitious federal program of Kennedy's New Frontier and Johnson's Great Society, the community mental health movement was born in a climate of enthusiasm and hope for the future.

Today some 726 community mental health centers throughout the country receive federal funding totaling more than a quarter-billion dollars per year. The $1.5 billion in categorical federal funding during the first 15 years of the community mental health center program has attracted nearly $5 billion of additional support from non-federal sources. Useful mental health projects have been introduced in hundreds of communities where there would be few or no services if the federal program had not produced them.

In spite of these great gains, serious problems remain throughout the country with regard to delivering mental health services. As the President's Commission on Mental Health (1978) noted, many areas still have virtually no mental health programs while others suffer from major deficiencies for large segments of the population. Even where well-established centers exist, a distressing lack of service is too often evident for the after-care of mental patients who are returning to the community.

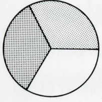
Additional federal legislation passed by Congress in 1975 revised substantially the original Community Mental Health Centers Act. The 1975 legislation defined for the first time what comprehensive mental health services must be provided by a community mental health center in order to qualify for federal assistance. The five core services essential to a comprehensive center are emergency care, both out-patient and in-patient care, partial hospitalization, and some form of consultation and educational activity for others in the community. Seven additional services are also recommended to deal with children, the elderly, court-screening, follow-up care for ex-patients, transitional living facilities, and the treatment of alcoholism and drug abuse.

In only a few mental health centers are all of these services effectively rendered in a comprehensive manner for the entire community. All too frequently limited funds and lack of direction preclude the continuum of services from crisis intervention to aftercare support originally envisioned 15 years ago. As the President's Commission stated, many people with chronic mental illness have no choice but to live in cheap rooming houses or nursing homes ill equipped to serve them. Many persons would be better off remaining under institutional care where, at least, humane treatment would be offered.

A point noted by the 1975 federal legislation and repeatedly stressed by the Commission is the extent to which large segments of our population continue to be underserved. Populations especially at risk were recognized in this most recent legislation—children and youth, the elderly, and substance abusers. It was also apparent to anyone who closely examined the uneven distribution of services that programs aimed at helping minorities and the poor had fallen far short of their initial goals.

When services are available, all too frequently they conflict with the cultural or linguistic traditions of ethnic minorities and the urban poor. It is worth noting that fewer than two percent of all psychiatrists in America are black, while the percentage of Spanish-speaking psychiatrists is even lower. Among the traditional professions, only social work and nursing show any appreciable increase in minorities over the past ten years.

For these reasons, the newly proposed Mental Health Systems Act has been given high priority by President Carter's administration. This new program would shift emphasis from large comprehensive service centers to discrete services most urgently needed to serve especially vulnerable populations. This new look within community mental health requires close attention to social and cultural factors underlying delivery of mental health services in the country. Among the many such factors are several that tend to be underplayed in spite of their importance. The first of these is the family.



Family Environment and Mental Health

The critical importance of a family for the developing child is universally recognized. Family interactions of mother, father, and young child leave an indelible impression upon the child's personality. Down through the ages and across the many cultures of man, the family in some form or other has been the most durable of our social institutions.

Too often the family is taken for granted because of its pervasive influence. One only has to experience a disruption of the family or the loss of a loved one to realize its fundamental importance. Families differ markedly in their lifestyle, social interaction, cohesiveness, size, and the degree to which grandparents, aunts, uncles, and others are thought of as part of the extended family.

Family patterns are changing in ways that spell trouble for the children of our society and their parents. The National Academy of Sciences recently published a major report by the National Research Council (1976) aimed at establishing a new national policy for children and families. Among the disturbing statistical trends noted in this report are the following:

1. One out of every six children under the age of 18 lives in a family with only one parent—double the percentage of single-parent families in 1950. In single-parent families, the absent member is usually the father. The effect of father's absence depends largely upon why he is absent and the attitudes that remain after his departure. Children can develop normally in a single-parent home but such development is often difficult. Adequate alternative supervision of the child must be provided while the parent works; there must be adequate contact with the child when the parent is at home; and the absent parent should not be denigrated in the eyes of the child.

2. Adult family members are less available to children today than they were a generation ago. The number of working mothers

with preschool children has tripled since 1950, while the proportion of mothers with school-age children has doubled. More children than ever are left to fend for themselves. The passive viewing of television after school hours has substituted for parent-child interaction in all too many homes.

3. The number of illegitimate births, mostly to teenage mothers, has increased sharply in the past 15 years. Today one out of every eight births is illegitimate. About 10 percent of American teenagers get pregnant, and six percent give birth each year.

The Alan Guttmacher Institute (1976) reports that more than half the twenty-one million teenagers in the United States are sexually active. Only 28 percent of babies conceived by the 600,000 teenagers who gave birth in 1974 followed marriage. Although fertility in general has declined since 1960, birthrates among young girls have actually risen. This epidemic of adolescent pregnancies contributes significantly to the number of infants and young children who receive inadequate care. U.S. teenage childbearing rates are among the world's highest. The frequent lack of prenatal care and the young age of these mothers produce an unusually high percentage of babies who are underweight and frail.

4. Child abuse, infanticide, teenage suicide, school dropouts, drug use, and juvenile delinquency have increased concurrently with these other major social changes in the family. Youngsters growing up in low-income families are at a specially high risk of damage physically, intellectually, emotionally, and socially.

5. The middle-class American family of today increasingly resembles the low-income family of the early 1960s on most of the indices of social disorder. Quite clearly, the children of so-called traditional families are also in serious trouble to a higher degree than our society can tolerate.

A child's cultural milieu and family environment have a more profound impact on mental health and illness than upon any other aspect of individual well being because of the interpersonal and behavioral nature of mental health.

Early intervention with infants and preschool children has proven promising as a preventative approach, provided certain general guidelines are carefully followed. In a review of large-scale experiments in the United States, Urie Bronfenbrenner (1974) has formulated some principles of early intervention that are worth noting.

Foremost among these principles is the development of family-centered intervention. Evidence to date indicates that the family is the most effective and economical means for fostering development of the child. Active participation of family members is critical to the success of any intervention program. Ideally, intervention begins in preparation for parenthood and in providing an adequate cultural milieu for nurturing the newborn infant.

Large-scale parent-child development centers established as national experiments have demonstrated the value of parental training during the child's first years of life followed by preschool group experiences in which parent and child continue to work closely together. Highly significant results have been obtained not only for disadvantaged black minorities but also for middle-class white families, Spanish-speaking Mexican-Americans, and other ethnic groups. A closer look at a representative parent-child development center for Spanish-speaking Mexican-American children in Houston, Texas illustrates the way in which this type of educational-social intervention improves the mental health of children and their families.

In the Houston model program, social intervention consists of working closely with both the mothers and fathers of very young children. Beginning when a child reaches the age of 12 months, a bilingual worker makes frequent home visits to introduce the mother to a number of techniques for intellectual stimulation of the child. The mother is coached in her communication with the child in order to promote cognitive and personality growth while maintaining strong affectional bonds with her child. Parents meet regularly several evenings a month to discuss their family prob-

lems, to share their ideas, and to seek advice. The family is dealt with as a whole and the techniques are carefully adapted to the cultural milieu in which the family lives. Consequently, the parents are uniformly enthusiastic.

When the child is two years old, mother and child attend a special nursery school four mornings a week. Parent-child relations continue to be stressed at the nursery at the same time that the child is introduced to social interactions with other children in a controlled and stimulating but playful environment. Videotape recordings of mother-child interactions are played back for the mother in order that she can see where she is facilitating or inhibiting desired behavior in the child. Periodic contacts with the family are maintained after the child is three years old in preparation for the youngster's entering school.

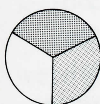
A model program of this type incorporating all of the best techniques from earlier experiments is expensive, particularly when carried out with a great deal of accompanying research and evaluation. Most of the essentials of such a preschool program, however, can be applied without a great financial investment by use of volunteers and the heavy involvement of parents. Still, one can rightly ask whether or not the benefits from such a model program are worth the costs. The final answers to this important question are not yet available. Nevertheless, early returns from evaluative research in the Houston project indicate the following important findings when the experimental families in the program are compared to similar families who do not participate:

1. As compared to controls, the program mothers grew significantly more affectionate, encouraged more child verbalization, showed more praise, and had children who were more verbally responsive.

2. Home observation scales revealed greater maternal involvement with the child, greater emotional and verbal responsiveness of the mother, avoidance of restriction and punishment, and more provision of appropriate play materials on the part of the program mothers.

3. Children in the experiment maintained a nearly constant level of mental ability over time, as measured by the Bayley Scales and Stanford-Binet, while the control children fell steadily behind the norm.

A grant from the Hogg Foundation for Mental Health* to the University of Houston has made possible a follow-up study of both experimental and control group children in the Houston Parent-Child Development Center in order to determine the extent to which these early experiences and parental training have an ongoing helpful influence upon the child's later mental and emotional development. Preliminary results indicate that the program does indeed have lasting effects of a positive nature. The elegant simplicity of this parent-child development center approach takes advantage of informal support systems and is readily adaptable to other ethnic and cultural groups.



Cultural and Social Change

A second and often underplayed factor in understanding mental health components influencing people today is the alteration of societal makeup. Acceptable family patterns and child-rearing practices undergo continuous refinement as society changes. Transmitting the primary values, skills, and other personality characteristics from one generation to the next is the key to survival as a society. Granted that biological as well as social factors enter into the development of an individual personality, certain shared attitudes, beliefs, and values within the culture provide a common basis for socialization of the child.

*The Hogg Foundation, an endowment within The University of Texas System, functions as a granting foundation to support demonstration projects in mental health. See pages 18 to 21 following.

These implicit attitudes, beliefs, and values constitute sociocultural premises that are fundamental determinants of shared personality characteristics within a given culture. For these reasons, studies of families and their children within different cultures can shed considerable light upon the significance of both psychological and cultural factors as they influence the mental health and development of the individual.

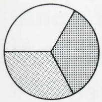
A six-year longitudinal study of more than 800 children and their families in Mexico and the United States illustrates the importance of cultural factors in child development (Holtzman, et al, 1975). A large staff of research associates in Mexico City and Austin, Texas, gave an extensive battery of psychological tests to each child once a year for six years. The children were originally drawn from the first, fourth, and seventh grades so that a complete developmental continuum from age six to seventeen could be covered in the six years of repeated testing.

Pairs of cases were closely matched across the two cultures in order to control for socioeconomic status, age, and sex of the child. Midway through the study, intensive interviews were conducted with the mothers in their homes in order to obtain information about the family lifestyle, home environment, parental aspirations for the child, child-rearing practices, and other factors believed to be important influences upon the child's development.

Most of the differences in personality discovered between Mexican and Anglo-American children can be attributed to the differing sociocultural premises underlying the two cultures. The majority of adolescent Americans subscribe to active self-assertion as a sociocultural premise while their Mexican counterparts prefer affiliative obedience. Mexicans tend to be more family-centered and cooperative in interpersonal activities while Americans are more individual-centered and competitive.

Similar findings concerning the importance of informal social support systems in sustaining an individual's mental health have been reported by Gary (1979) in promoting mental health in

black communities. Focusing on the strengths of black people and the positive aspects of their mental health, Gary and his colleagues singled out the black churches and the extended family network as vital social support systems that have been ignored too long by professional mental health workers.



Hispanic Culture

The fastest growing minority population in the United States consists of Hispanic Americans, particularly those of Mexican descent. Competition, ethnocentrism, and conflict among the ethnic populations of the Southwest have taken their toll upon the Mexican-American for more than a century. One would expect that as a result of the stresses and frustrations suffered by the Mexican-American, a greater incidence of mental illness and severe emotional disturbances would be present among the Mexican-Americans than among the Anglos.

The first systematic data collected on this important question were gathered over twenty-five years ago by E. Gartley Jaco in a major study supported by the Hogg Foundation.* Jaco surveyed all inhabitants of the state of Texas who sought psychiatric treatment for a psychosis for the first time in their lives during the two-year period of 1951–1952 (Jaco, 1959). Information was compiled from every psychiatrist in private practice as well as from all the hospitals and clinics in Texas and surrounding states.

The results showed only six percent of the new psychotic cases during this two-year period were Mexican-American; 85 percent were Anglo-Americans; and the remainder were primarily black. When the data were standardized for age and sex composition, the average annual incidence rate per 100,000 population was only 42 for the Mexican-Americans. The same incidence rate for Anglos was 80, while that for Blacks was 56.

*See pages 18 to 21 following.

Additional checking by Jaco convinced him that the markedly lower incidence rate for psychosis among Mexican-Americans was not a function of accessibility of treatment. Could the lower incidence rate for Mexican-Americans result from different ways of coping with stress? Could the smaller number be due to more cohesive family patterns and different lifestyles? Or is the rate, at least in part, only illusory because the Mexican-American seeks out *curanderos* rather than psychiatrists when mental illness is present?

In 1957, with Hogg Foundation* support, William Madsen, Antonieta Espejo, Octavio Romano, and Arthur Rubel embarked upon a three-year anthropological project dealing with differential culture change and mental health in South Texas (Rubel, 1966). After intensive ethnographic studies of three variations of Mexican-American folk culture in which the referral networks for curing illness were carefully traced, Madsen and his colleagues concluded that the different world views and ways of coping with illness that characterized the Mexican folk culture and urban Anglo society are sufficient to account for a large part of Jaco's findings.

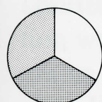
Madsen proposed that stress situations among Mexican-Americans are less likely to produce mental illness because they are shared by the family group (Madsen, 1969). He hypothesized that anxiety-producing stress seldom precipitates mental illness when the anxiety is shared and relieved by a tightly knit, primary group like the Mexican family.

Later studies by M. Karno and R. B. Edgerton (1969) indicate that mental illness is also greatly underrepresented among the Mexican-Americans of Los Angeles, a large metropolitan population rather far removed from the folk culture of rural South Texas. Edgerton found that folk-psychiatry had greatly diminished in influence among Los Angeles Mexican-Americans

*See pages 18 to 21 following.

and that the great majority of Mexican-Americans would not hesitate to seek help from a psychiatrist or mental health clinic (Edgerton, Karno, and Fernandez, 1970), a finding confirmed more recently by J. M. Casas, S. E. Keefe, A Padilla, and others (1978) at the Spanish Speaking Mental Health Research Center in Los Angeles.

Whatever the reasons for the lower incidence of mental illness among Mexican-Americans, it is clear that recognition of mental illness is largely a social process. Rather than primarily a problem in medical diagnosis, the recognition of mental illness is a social transaction that often takes the form of a negotiation. The symptomatic content and prevalence of mental illness in various populations are dependent to a large extent upon how this negotiable social transaction is carried out.



Specific Needs

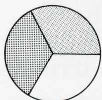
Severe mental illnesses such as schizophrenia or depressive psychoses are only one aspect of mental health problems requiring community services tailored to specific cultures. Chronic alcoholism, drug addiction, social alienation, child abuse, crime and delinquency, some forms of interpersonal aggression, dehumanizing and degrading social practices, family disintegration, neurotic behavior, and a host of other common psychological and social problems are of even greater importance in a society that is searching for better ways to promote mental and emotional health for all of its people.

Absence of mental illness is not synonymous with the presence of mental health. Everyone is faced at some time in life with identity crises, severe emotional stress, frustration, and failure. At one time or another each person desperately needs help. A mentally healthy person is not only one who has learned to cope with most life stresses but also one who understands when help is needed.

While every culture has some way of coping with psychological and social problems, complex industrialized societies create for their members unusual stresses that require professionally trained persons to provide a wide range of services to people in need of help. For each highly trained professional in the mental health field, a team of paraprofessionals, technicians, and volunteer workers is needed in order for services to be effective. A major problem for the disadvantaged and culturally different has been the severe lack of adequately trained personnel indigenous to the people served. Most professionals come from middle-class Anglo-American backgrounds, creating acute shortages of service delivery personnel who can be most effective for the large number of relatively uneducated, lower-class families who desperately need help.

Since global services always translate into personal ones, some of the historical developments and specific concerns may be traced with examples from the vantage point of one organization.

Texas and the Hogg Foundation for Mental Health



Unlike the older states of the Midwest and East, Texas has only recently become a predominantly urban society with both the opportunities and problems characteristic of large cities. Thirty years ago few psychiatrists and almost no psychologists or psychiatric social workers practiced in public service. A major state hospital boasted of only one board-certified psychiatrist for several thousand patients. Ancient buildings and archaic practices characterized the state hospitals, and almost no public out-patient facilities were available.

The newly established Hogg Foundation for Mental Hygiene, made possible by the estate of Will Hogg and the wisdom of his

surviving sister, Ima, offered hope for significant change. Miss Hogg had gained her early understanding of emotional needs and social problems from her father, Governor James Stephen Hogg. Robert L. Sutherland, a sociologist who served as the first director of the Hogg Foundation, devoted his energies in the early years to educating the people of Texas about mental health. From its beginning, the Hogg Foundation adopted a pluralistic concept of mental health encompassing social and cultural factors as well as psychological and medical concerns in its program of public education, consultation, and support of mental health programs throughout the state.

By 1954, the income of the Foundation doubled, making possible the launching of new programs. Additional emphasis was given to research in the social and behavioral sciences where there were promising young investigators whose reputations were not sufficiently well-established to interest sources of federal grants. Investment of only $80,000 of private funds by the Hogg Foundation was largely responsible for attracting more than $1 million in grants over the next three years. A number of these projects were aimed at gaining a better understanding of how to provide more effective mental health services for Mexican-Americans, Blacks, small-town residents, and the rural poor, as well as inner city dwellers. An increased concern for the underlying problems of society characterized the Foundation's work in the 1960s.

The major thrust of the Hogg Foundation has shifted from one emphasis to another, with each change dictated by the critical needs and opportunities of the time.

Fifteen years ago Texas received its first planning grant from the federal government to develop a comprehensive mental health plan for the entire state. Officers of the Hogg Foundation joined with other citizens in a number of task forces appointed by the governor, from which a new Texas Department of Mental Health and Mental Retardation emerged two years later. Within the first three years of the new department's operation, 24 community

mental health and mental retardation centers were established. In addition, state hospitals began an outreach network that provided public services in areas beyond the bounds of the new mental health centers. With the shift of emphasis to local services, the resident population of state mental hospitals dropped to one-third over the past 13 years. At the same time, appropriations for the community services rose from $600,000 to more than $41 million. In spite of this progress, however, many citizens throughout the state strongly believed that further changes were urgently needed in order to provide more effective services for all the people of Texas.

Sensing an opportunity to bring many organizations and leaders together in a new reform movement, the Hogg Foundation organized the first Robert Lee Sutherland Seminar on Mental Health as a tribute to its late president in May 1978. The central theme of the conference, "Mental Health for the People of Texas," used the just-published report of the President's Commission on Mental Health as a catalyst to bring together nearly a thousand citizens from all areas of life. Out of the workshops, lectures, and seminars highlighted by Rosalynn Carter's keynote address, a new organization was launched—Citizens for Human Development. To carry out a massive public education program funded by private as well as public monies, this citizens' movement is aimed at new legislation and greatly increased support at the local level for community health services (DeMoll and Andrade, 1978).

Both private and public funds are seen as essential to the success of mental health services at the community level. While the principal source of funds must remain public appropriations from the federal and state levels, delivery of human services will prove truly effective only if private and local funds are assured, together with the enthusiastic voluntary contributions of local citizens.

The American tradition of private giving for public purposes preserves the essential elements of freedom and flexibility that are

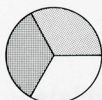
critical for local success. How all the needs of a community relate to one another and ways to define the nature of mental health services in terms of local tradition, local resources, and local motivations are beyond the reach of both federal and state governments.

The non-profit private sector of our society has a vital role to play in the seeking of new solutions to human problems at the local level. As John Gardner, former Secretary of Health, Education, and Welfare and founder of Common Cause, has stated in the creation of a new organization aimed at strengthening the private pursuit of public purpose, "Thanks to the institutions of the non-profit sector, not only can citizens participate in the concerns of American life, they can do so at the grass roots level—and in doing so contribute importantly to the preservation of vital communities" (1979).

Among the most important aspects of our communities that are an essential part of a healthy private sector is the web of personal, familial, and neighborly relations. These ties are essential as informal support systems in the resolution of family and personal crises. All too frequently the categorical funding and federal or state regulations accompanying mental health service programs lead to tragic disruption, rather than facilitation, of these indigenous forces at the local level.

The Hogg Foundation for Mental Health is but one small illustration of a privately endowed organization striving to nourish the indigenous resources latent in all of our communities. While only a tiny number of the 26,000 private foundations in the United States have mental health as a specific focus, many are concerned with more effective human services at the local level. Churches, the United Way, civic clubs, and other private organizations are equally concerned with the preservation of the informal support systems that can restore our sense of community. Citizen participation at the grass roots level clearly provides the best opportunity for sympathetic personal attention to human problems.

Summary



In this presentation of some ideas concerning social and cultural influences upon the delivery of mental health services, a few key points can be highlighted. The report of the President's Commission on Mental Health and other recent studies all indicate an urgent need for strengthening the grass roots involvement of local citizens in the development of more effective mental health services. A focus upon the underserved and the sociocultural factors that must be taken into account has been neglected too long in our efforts to mount large comprehensive systems of mental health.

Important issues can be summarized in a set of principles, as follows:

First, the definition of mental illness is a social contract subject to wide variations of interpretation depending upon the cultural context and social norms of the community.

Second, the degree to which services are used is directly related to their accessibility and appropriateness as defined in sociocultural terms by the individuals constituting the community.

Third, indigenous systems of support, both social and family, are hidden assets that must be recognized and strengthened rather than thoughtlessly destroyed.

Fourth, the farther removed the source of funding and control from the community being served, the more unresponsive and irrelevant the agency's response to community needs is likely to be.

And finally, it must be remembered that the organization and delivery of services as seen from the consumers' point of view is often markedly different from the viewpoint of the service providers.

The community mental health center movement is at a crossroad where it can either recede back into more traditional, narrowly-defined psychiatric services closely associated with mental hospitals, or it can go through further transformation in becoming a more responsive, highly flexible system of services under local control and direction. Whether or not the new Mental Health Systems Act can accomplish this transformation remains to be seen. That plan has its strongest chances to succeed if everyone within the community mental health movement takes seriously the major issues raised.

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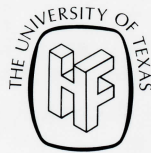
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