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Community Mental Health: Why the Benign Neglect?
The Community Mental Health Centers Act of 1963 was the culmination of decades of effort to achieve equity in the provision of mental health care by developing a comprehensive and coordinated network of service within the community. The statute projected the mental health profession beyond the confines of the clinical establishment into the fabric of community life. The challenge given the new mental health centers was to aid people, "... too fearful, too angry, too alienated, too hopeless to seek any kind to help."¹

The community mental health movement is hardly "revolutionary". What it has really offered is an extension of mental health services to those who had previously been denied them, without any clear transfer of control over the provision of those services to the communities involved. It is true that the 1963 Act defined responsibility in terms of the health needs of a population rather than the illness needs of individuals; it stressed prevention as well as treatment; and it structured programs within geo-political boundaries. By insisting upon the inclusion of citizen groups in the planning process (although only at the state level), the Act focused mental health services on local communities in a dramatic and innovative manner. Yet as the mental health profession struggled to maintain a sense of identity and purpose within this new context, what had been viewed as a progressive movement toward accessible treatment, rehabilitative and preventive service was frequently perceived by consumers as but another palliative. As a result, what the architects of the community mental health movement heralded as "mental health's third revolution" was to be used by militant mental health professionals and their community allies as a vehicle for revolt against the mental health establishment itself.

The focal issue was community participation. By the mid-1960's good will was no longer enough. Many consumers, deeply suspicious of the establishment's willingness to change itself, demanded a redistribution of decision making power. Some professionals agreed.

The reasons for which professionals endorse the goal of community participation, we will set out shortly. What must be emphasized first, by way of introduction, is the lack of preparation or guidance which the mental health establishment itself brought to the often confusing problems created by an operational emphasis on community participation programs. Neither the movement's activist professionals nor the institutions tacitly supporting the thrust into the community nor even the language and legislative history of the original 1963 statute were able to guide the evolution of participatory models.

Professionals discovered that effective and representative community participation may suffer when a participatory group takes a stand on a politically controversial social issue. Universities and state and federal governments, rather than setting guidelines for participatory programs, have adopted, in effect, a policy of benign neglect toward community involvement. They have tended to underplay the fundamental divergence between their own political and social views and those of community groups participating in the delivery of mental health services. The 1963 Community Mental Health Centers Act fails to specify what role, if any, local community participation is to play in controlling the provision of services, indicating only that the centers should focus on providing comprehensive services that meet the needs of their particular communities. What was on the legislators' minds was a shift in responsibility for the provision of mental health care from the states to the localities, a shift which would be initially aided by federal funding. Radically improving the preventive and outpatient care available in communities would reduce the burden on state-supported facilities for the long-term hospitalization of the mentally ill.²

A commitment undertaken by mental health professionals to community participation was, in this context, very much a commitment to an excursion into the unanticipated and the unknown. This article is really a chronicle of that excursion as it took place in New Haven, with reflections offered on the lessons learned and questions raised along the way.
The rationale for including participation as a core element in a program of mental health service to community is threefold: empirical, sociological and psychological. A considerable body of current data indicates that mental health services are not only organized inefficiently and distributed inequitably, but that the inter-relations between various agencies are characterized more by insularity and rivalry than by collaboration. These empirical realities seem related to the prerogatives and roles historically assigned by society to the clinician-healer. Surrounded by the aura of omniscience with which societies so frequently endow their healers and bulwarked by a “special competence” gained through professional training and validated by licensure, the healer is cast as a beneficent authority. His authority is often used to justify his drawing of the boundaries of the mental health domain; hence it becomes possible to limit psycho-social problem solving to areas which the mental health professional himself deems of primary import. The resultant institutional self-definition can and has led to the emergence of major service gaps which discriminate against the more disadvantaged sectors of the population, for instance, in the consignment to state mental hospitals of certain types of chronic psychotic patients. The empiricist argues that the sharing of responsibility and authority with community would build a set of checks and balances into the mental health delivery system which would militate against the emergence of major service gaps, while simultaneously placing the citizen-participant in a stronger position to insist upon inter-agency collaboration.

The sociological justification for participation is derived from a Mills-ian concern over the transformation of America into a society where individuals lose any effective means of criticizing or influencing the world in which they live. As impersonal and automatic mechanisms of control and coordination supplant visible and personal authority and leadership, human responsibility and freedom are reduced and society’s institutions are increasingly dehumanized. Participation is seen as a vehicle for mitigating the anonymity of man by giving him a modicum of control over his immediate life-space.

"If one cause of disruption in our society is alienation from the immediacy of life on many levels—in education, in employment, in sensuality, in responsibility for political decision-making—then participation is certainly the first step towards cure." Participation is seen as a vehicle for mitigating the anonymity of man by giving him a modicum of control over his immediate life-space.

The psychological rational for participation stems from data indicating that the incidence of severe emotional disorder and social pathology is highly correlated with socio-demographic variables frequently referred to as the handmaidens of poverty—unemployment, family disorganization, under-education, poor housing and social disequilibriu, to name but a few. While the data are not so conclusive as to demonstrate a causal relationship between poverty and mental illness, various psychological mechanisms have been posited as intervening variables that help explain the observations. Of these, powerlessness and lowered self-esteem have received the greatest attention. W. Ryan formulates this rationale:

"To a significant extent and in a significant number of cases, emotional disorder is based on lowered self-esteem. Self-esteem is largely dependent upon the exercise of a minimum quantity of power in relation to one's environment, as well as a perception of oneself as a minimally powerful person. Powerlessness is a major characteristic of low income neighborhoods and of the residents of these neighborhoods, which in turn leads to significantly higher levels of emotional disorder and other forms of social pathology. A program of mental health enhancement and emotional disorder prevention, therefore, can meaningfully address itself to the issue of personal and community power."
Now let us examine the vicissitudes in both community and institutional relations encountered by one mental health facility, the Hill-West Haven Division in New Haven, as it attempted to realize both this goal of community participation and the service mandate dictated by the 1963 legislation. The dilemmas encountered, the issues raised, have been paralleled in Model Cities programs, Legal Aid offices, and “community” schools across the nation.

The Hill-West Haven Division is an integral part of the Connecticut Mental Health Center. A collaborative effort of the State of Connecticut and Yale University, the Center was organized in a unit system in order to facilitate the testing out of divergent models of care. The Hill-West Haven Division, the sole portion of the institution which is a federally funded Mental Health Center under the 1963 legislation, was one of its original units. The Division’s service area covers the Hill neighborhood of New Haven, population 25,000, and the City of West Haven, population 50,000. West Haven is a predominantly white, lower middle-class working town that is heavily dependent upon New Haven-based agencies for social and health care services. The Hill, the last major inner city area in New Haven to undergo urban redevelopment, is currently in the throes of marked social transition. Poor income, unemployment, low educational level, substandard housing and overcrowding characterize the neighborhood.

Nonetheless, citizen involvement with the Hill-West Haven Division was initially informal and unstructured. Counsel was sought from community members and numerous grass root groups around program goals and priorities; however, neither the authority of community in relation to Division, nor the accountability of the Division and its staff to community were made explicit. This was, in large part, due to the nature of the catchment. There were no neighborhood mechanisms for either coordinating or regulating social or health care services. Thus in concert with various community groups and other agencies, the Division staff’s initial energy was devoted to community development. The goal was the evolution of mechanisms to assure maximal participation of consumers and potential consumers in all aspects of health planning and programming and a facilitate the emergence of an integrated health and social service delivery system.

In the Hill, the first effort involved bringing together representatives of essentially every public and private agency, church and civic group serving the community. The body that evolved (The Hill Inter-agency Council), in concert with an elected coordinating unit, participated in the formation of another citizen group, the Hill Health Committee, which served as a forum for dealing with issue-oriented problems related to health and health services and as an adviser to various health and mental health agencies in the community.

From its inception in 1966, the staff of the Division saw itself as implementing a particular model of service to the community. This model holds that such service represents a working alliance between citizens and staff to seek out and modify vectors harmful to mental health through social action, consultation, education and research; to support individuals in their efforts at dealing with life stresses, whether they be internal or external through the provision of a full complement of clinical services which assure ease of access and continuity of care to catchment residents; and, to develop an effective community mental health manpower base through training program for neighborhood residents. The model thus necessarily includes participation and social action as well as emergency and outpatient treatment, twenty-four hour and partial hospitalization, rehabilitation and resocialization, child care, consultation, education, research and training.

In West Haven, the Division’s staff participated with other agencies in the formation of a Community Services Committee, to develop comprehensive plans not only for mental health services but for all human services in the community. The committee’s membership was drawn primarily from community welfare and health agencies, civic and religious organizations, public and parochial schools, the Chamber of Commerce, the Police Department and representatives of major employers.

By the spring of 1969, then, these organized structures designated as the Community Boards for the Hill-West Haven Division, existed in both communities. These Boards had clearly defined responsibilities in the area of program development, personnel practices, and the establishment of service and research priorities.

In this process of developing an alliance with the consumer, the Division’s relations with the community occasionally became strained. The enthusiasm and optimism that characterized the Kennedy era and the social programs instituted at that time was shared by the staff of The Hill-West Haven division. They were
committed to the Division’s preventive and curative mission, particularly the social action and consumer participatory elements. Conflict between these elements of their program seemed unlikely—but it has occurred.

For instance, in the fall of 1967, the Division was asked to conduct a series of seminars on sex education by a racially mixed neighborhood group consisting of parents of children attending the one predominantly black public school in the city of West Haven. Growing anxiety over inter-racial sexuality was the latent reason for the request. Considerable effort went into the program, which was considered helpful. Two years later, the Division was again asked to present the series. By this time, however, the city’s de facto segregation had become a public issue. The parents’ group with whom the Division was working consisted of several leaders pressing for an integrated school system. As articles on racial imbalance appeared in the press and a racial fight occurred at one of the city schools, staff members were requested by the parents’ group to speak out on the deleterious effects of de facto school segregation. Several did.

At the same time, the issue was presented to the Division’s West Haven participatory group, the West Haven Consumer Board. After considerable debate, and partly as a result of staff lobbying, the Board took a position in favor of integrating the local schools. Before that position became public, however, the President of the Board resigned, and others opposing school integration followed suit. In the ensuing political fracas, attacks were received from both ends of the political spectrum. Conservative critics accused staff members of being “Ivy League puppets” and “ruffling the calm waters of the community,” while from the other end Consumer Board members were accused of being “hard Hats” and of “whitewashing” the real problems of the city. Association with the group came to be considered “radical” by a small but vocal segment of the community. The base of support which the board itself could generate was diminished, and some staff were reluctant to view the Board as ‘really representing the community.’

This episode suggests a paradox that the “hip professional” has difficulty in facing: What if community participation or consumer control bodies lose their representative legitimacy in the political controversy resulting from the professionals’ advocacy of social change? What obligations exist not to work for social change, to hide may place in jeopardy the benefits of community participation in structuring therapeutic programs. There is a marked tendency to avoid the painful reality that, at times, social change and community participation will not be synonymous.

Another pitfall awaits the unwary professional; the well-meant oversell. In taking its preventive and curative mission to the Hill neighborhood, the Division staff, a cadre of less than fifty people, was presented as being able to contribute meaningfully to virtually every aspect of community life. Despite the exuberance and tirelessness of staff members, however, the promises could not be met. While understandable in retrospect, the failure created a “credibility gap” that subsequently gave the community cause to question both the intent and ability of the Division to “deliver”. Now, in almost every major interchange between community and the Division—discussing a proposed grant, altering the staffing pattern of a component, instituting a new training program for catchment residents—a neighborhood person rises up and recalls the unfulfilled promises and dashed hopes of the past. The professional reduces his usefulness as much by exaggerating his ability to produce change as by refusing to recognize the need for change.

Experience with both professional social activism and the professional oversell give rise to the suspicion in both blue-collar white and ghetto black communities that community participation, today’s royal road to romance, is really just an updated primrose path. That suspicion is reasonable. The opportunity to participate and the act of participation are merely preconditions for the acquisition of power. Power itself is another matter. In reality, consumers and a community-oriented staff must either wrest power and authority from their supporting institutions or acquire them through the legitimizing function of those same supporting institutions. The political impact of the community participation ideology cannot be fully assessed without looking to the role of those supporting institutions.

As noted previously, the supporting institutions of the Hill-West Haven Division include the Federal government, the State of Connecticut, and Yale University. A lengthy Memorandum of Agreement, apportions responsibility and authority between Medical School Dean and Mental Health Commissioner. Both Commissioner and Dean are free to delegate their authority to the Director of the Connecticut Mental Health Center. They are also free to revoke that authority at any time. The Division, despite its federal funding under the 1963 Statute as an integral part of the Connecticut Mental Health Center, officially exists, as it were, at the sufferance of these two institutions.
“Community participation, today’s royal road to romance, is really just an updated primrose path.”

Aware of the staff’s zeal and ideological commitment, fully apprised of the program’s social as well as clinical goals, and knowledgeable about the steps contemplated for implementing these goals, the state and university have tolerated the Division’s activities, while clearly not ascribing to its philosophy. Almost from the inception of the Division, that tolerance has been severely tested. During the 1967 “summer disturbances” which occurred in the Hill neighborhood, for instance, the Division was used both as a refuge for burned-out and frightened neighborhood people and as a meeting place for community groups attempting to be helpful to residents. As fear of further trouble grew, community representatives approached Division staff members and asked that they arrange for residents, particularly frightened mothers and children, to be bussed out of the area. The staff agreed to the request, contacted the local bus company and negotiated the donation of two buses to help evacuate people into the suburbs. This act was not well received by local government officials who charged the staff with spreading terror in the community. While this was going on, ironically, another part of the parent institution, an area in the Connecticut Mental Health Center, was being used for a short time as a communication center and staging area for state police—a symbolic testimony to the schism within. In the aftermath of the “disturbances,” the existence of the schism was made quite explicit. The stance of the Division was labeled too partisan, too involved, and far beyond the limits of the staff’s professional competence.

Despite the resulting friction in their relations with the Division, and numerous subsequent incidents exacerbating that friction, neither of the two local sponsoring institutions has developed clear guidelines around the issues of participation and social action, an omission shared by the Division’s third sponsor, the federal government. For instance, while the National Institute of Mental Health, the funding channel for the centers, has consistently encouraged citizen involvement in community mental health centers, the regulations issued by the Secretary of Health, Education and Welfare under the 1963 statute are ambiguous as to the nature and level of that involvement. One might contend that such ambiguity is politic, since the political liabilities of community participation are more likely to be felt at the local rather than the federal level.

The University has similarly failed to define clear guidelines regarding social action or participation for the community programs with which it is involved. President Brewster, of Yale, has spoken to the issue of the constraints upon a private university’s assumption of a major role in community:

“No matter how useful it is for the training of students or for the problem it offers for study and research, the management of a community service activity involves obligations which are at least different from, and may on occasion be adverse to, the interests of the academy;

“In the case of private universities at least, there is a basic misfit between community needs and the sources of our principle support. ... Political pressure from the ghetto neighborhoods in New Haven upon my institution, however, is likely to fall on politically deaf ears in Hartford, which is not in the habit of supporting Yale. The same neighborhood pressure will also fall on financially deaf ears among my out-of-town alumni, who are not in the habit of supporting New Haven...”

“... society, too, will be better served if we continue to limit our proprietary responsibility to our principal task of discovery, conservation and transmission of knowledge.”

In the absence of a clearly defined institutional position regarding community participation, the sponsoring institutions have adopted a policy of benign neglect: government and university have never formally acknowledged the existence or prerogatives of the Division’s community boards; yet neither have they repudiated them. Does this reflect an awareness of the contradictions of their role in publically supporting an institution promoting social change which leads to a diminution in their own authority? Several explanations of the pattern of benign neglect suggest themselves: turmoil and expedience; pragmatism and the hedged bet.

The health care system in our nation, and the university medical centers that intermesh with it, are not only in a precarious fiscal situation as a result of financial cutbacks, but they are also racked by internal conflict and are in the process of fundamental change. Under such circumstances, it is altogether possible that our particular federal-state-university minotaur views the activities of a small segment such as the Hill-West Haven Division as vexatious, but inconsequential—a gadfly not worthy of attention.

Another possible reason for a policy of benign neglect by state and university is expediency. It is one thing to rap the hand that feeds you, but quite another to cut it off. For many years universities as well as state and local governments have complained about the cost and conditions of federal support. But they have not refused it. While it is true that Federal support for the establishment of community mental health centers can be viewed as an attempt to get long-run program development with short-run funding, we can calculate that the state of Connecticut receives considerable federal funding during the eight-year period that the Hill-West Haven Division’s grants are in effect. The declining nature of these federal funds means that provision must ultimately be made for state support. Nonetheless, the federal monies allow the
development and expansion of human services at minimal initial cost at a time of fiscal crises and in a manner that enables state and local planners to schedule their expenditures along a predictable time table. For the university, such government funding, while not the sauce bordelaise which they prefer, is still gravy; furthermore, a university medical school, to support its primary missions of research and training, requires room for expansion and diversification and can ill afford to estrange itself from a community to which it contributes, within which it exists and upon which it is dependent.

A further possibility is that entities like the Division, with its apparatus of community control, its community selected staff, indigenous paraprofessionals and social action commitment, are no more than tethered bears that serve to keep the community “cool” and the supporting institutions “relevant”. Indeed, some see “community medicine” as a sop to divert attention so that medical institutions can carry out their self-defined missions in relative peace.

Another view is more positive—Brandeisian almost—and ascribes the benign neglect to a societal pragmatism, an institutional hedged bet. It holds that when society is in transition; when old solutions appear inadequate, decentralization permits experiments aimed at new solutions. Over time, those solutions that work become more widely adopted; others are eliminated. Thus, institutions survive. Governments and universities, with a stake in survival, permit experimentation as a part of this process.

Participatory models are being tried in areas other than mental health, and frequently with parentage as unlikely as that of Yale and the State of Connecticut. It may be that the deviant child will produce an exceptional offspring. It may be that if we are going to offer mental health service to the poor, only an alliance with them will produce the preventive, clinical and rehabilitative service envisioned in the 1963 law.

The Hill-West Haven Division felt that to accomplish this statutory aim successfully, the community had to be brought into the mental health system as more than the recipients of bountiful clinical largesse. Implicit was a transfer of power and authority from entrenched institutions to new structural forms rooted in the life of the community. Such a transfer is radical in a “democratic egalitarian society” only insofar as it dares suggest that authority ought to be shared by the servant with the served.

What the community mental health movement has frequently labeled a “revolution,” appears to be revisionism or, at best, reformation.

If the societal pragmatists are right and continue to advocate benign neglect, participatory models such as ours should, allowed sufficient time, lead to structural forms where power is shared between established institutions and communities. This benign neglect, whatever the motivation, will not undermine, as open criticism would, the legitimacy which the supporting institutions bring to community organizations. These forms, when stabilized, will permit a new allocation of resources leading to a more resilient and responsive mental health care system. If the pragmatists are wrong, if they are overruled, or if community-based institutions are in fact being exploited as “cooling off” mechanisms, still these structural forms may nonetheless, be transformed into political base camps from which even more massive assaults upon entrenched institutions can be launched.

Perhaps my son, the doctor, is not in fact drowning. He may just be out there learning to swim.

“In the absence of a clearly defined... position regarding community participation, the sponsoring institutions have adopted a policy of benign neglect.”
The House Report suggested that community participation would be the process used for ascertaining community needs:

"Each community would have a major voice in determining the basic pattern of services to be offered through its own mental health center."

But the Act itself nowhere refers to a process of local community participation. Neither the 1965 Mental Health Amendments, providing for staffing grants, nor the 1967 Mental Health Amendments gave any more guidance.

These minimum service standards were determined in Washington. The Regulations did not set out anywhere any mechanism for supplementing them with standards derived from community assessments of their specific, local needs.

This community focus takes the form in the Act itself of one of the criteria for approval by the Secretary of Health, Education and Welfare of application for federal financing of community mental health constructive projects:

"that the services to be provided by the center, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, will be part of a program providing, principally for persons residing in a particular community or communities in or near which such center is to be situated, at least those essential elements of comprehensive mental health services for mentally ill persons which are prescribed by the Secretary in accordance with regulations."


8. When the Hill was designated as the Model Cities neighborhood for New Haven, the Hill Health Committee became the health task force of the Model Cities Program with responsibility for health planning under Model cities funding.


10. See Note 2, supra.

11. Indeed, one supporter of the community mental health center movement, who is also the director of a county mental health department, has commented:

"The federal agency has continued to seem more interested in building a political constituency than in working with local government which, nevertheless, is apparently expected to pick up the financing of the mental health center when federal funds are withdrawn."
