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Jack Zusman

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WHAT IS COMMUNITY MENTAL HEALTH?

JACK ZUSMAN

Community mental health, like most new and rapidly developing disciplines, cannot be accurately defined. As new techniques are developed and new discoveries made, and as interest in older techniques fades, the boundaries change. Perhaps the best definition of community mental health is that it is whatever community mental health professionals do. From a practical point of view, any attempt to fix the boundaries of community mental health more precisely requires a great deal of effort; and expenditure of such effort seems to be wasteful of time and energy in the face of pressing service demands.

The most important definitional question is what work needs to be done or what work is the responsibility of particular individuals and agencies. Once that is settled, the second issue is what kind of training best prepares people to carry out that work. This training should be provided regardless of what professional area it seems to fall into or who has traditionally carried it out in the past. One of the major problems in providing services to those in need has been that professional training programs are designed on the basis of tradition rather than of an examination of the job to be done. Consequently, clients and patients are often forced to meet the expectations of the professionals and to present their problems in a way that meets the professionals' needs rather than being able to obtain help for a problem as it appears to them.

In addition to discussions of the boundaries of public mental

Jack Zusman, M.D., is Professor of Psychiatry, State University of New York at Buffalo, 462 Grider St., Buffalo, N.Y. 14215.

health, there has been a good deal of attention devoted to distinctions among social psychiatry, community psychiatry, community psychology, and community mental health. None of these terms is particularly descriptive of what the proponents of their use have in mind, and the arguments over the terms contribute nothing to the advancement of knowledge. In the present discussion community mental health will be the term used to encompass the entire operation.

Also of somewhat more than passing interest is the whole problem of mental health as a subject of study separate from mental illness. This question is, of course, much larger than the community aspects. Suffice it to say here that when most mental health practitioners refer to mental health or mental health services they are talking about mental illness or services for the mentally ill. Mental health and mental illness are certainly related to each other, but a program designed to deal with the one does not necessarily have any effect on the other. Most mental health professionals and mental health programs are focused on mental illness; relatively little has been specifically expended on the promotion or study of mental health.

The Historical Origins of Community Mental Health

Community mental health has arisen out of the coming together of developments and interests in a number of disparate disciplines. This accounts, in part, for the vague definition of what it is: people coming into it with one kind of background or another will see it from completely different vantage points.

Sociology has been a major influence in developing our present concepts. Durkheim's classic study of suicide was a major step in relating deviant behavior to social conditions. There have subsequently been countless studies of the relationship between deviance and environment. Specialties of sociology (e.g., deviance and labeling theory) have developed that are particularly relevant to the study of mental illness. Sociologists have also been concerned with the sociology of the mental health service system itself and with the sociology of psychiatry as a profession.

Social therapy has been a major building block of community

mental health. Application of the idea that the treatment environment can influence the course of mental illness is centuries old. One of the first major "modern" practitioners of sociotherapy was Pinel, who removed the chains from his patients in 1798. However, after spreading all across Europe, sociotherapy gradually lost popularity during the 19th century; and it was not until shortly after World War II that it once again was rediscovered and widely put into practice. Its application has expanded so rapidly that it is not even possible to list all of the forms of social therapy. Indeed, the potential number of therapies of this type would seem to be infinite, since the principle can be applied in all sorts of settings. Some of the major forms of social therapy include compensated work, patient government, milieu therapy, and remotivation.

A concern with the development of optimum mental health and happiness as one of the responsibilities of mental health professionals became important in the early part of the 20th century. The mental hygiene or orthopsychiatric movement propounded the philosophy that the best preventive for mental illness was good mental health. This was coupled with the belief that early treatment of mental illness would prevent the development of serious illness later on. These are untested hypotheses that seem to be based on an analogy with physical health and certain forms of physical illness. However, despite the lack of proof, this philosophic approach has stimulated extensive efforts to organize service facilities and promote mental health.

Of more recent origin is concern for providing services to groups of people who have not had access to them previously. The poverty-stricken, in particular, cannot purchase medical care privately; and the public facilities open to them are often inadequate or uninviting. The development of various antipoverty programs has led to efforts to find new ways of increasing utilization of services. Such approaches as use of local ("indigenous") nonprofessionals or the establishment of service facilities in small units serving individual neighborhoods have been tried.

Administrative psychiatry has come to be recognized as an important and legitimate specialty. When, previously, psychi-

atric treatment was considered mainly an issue between an individual patient and an individual physician, there was little need for skilled administration as part of psychiatry. With the recognition that a good treatment program is built of many elements, all of which must be designed, purchased, and coordinated, the administrator has become one of the most important members of the therapeutic team.

Finally, the development of public health and its application to mental illness have been a major element. Public health has traditionally been concerned with efficient provision of services to large numbers of people, with prevention of illness, and with the study of epidemiologic questions such as how many cases of untreated illness exist in a population. The development of public mental health has led to significant advances in care of the mentally ill.

Is Community Mental Health a Medical Specialty?

A significant debate seems to center on the relationship of community mental health to community psychiatry and the relationship of both of them to medical training and practice. For the most part, community psychiatrists seem to be psychiatrists — that is, they are M.D.s. On the other hand, those calling themselves community mental health professionals often are members of other professions, particularly those of psychology, social work, and sociology. The concerns and techniques of community mental health certainly have much in common with those of medicine. However, the question "Is it necessary to be an M.D. in order to do good community mental health work?" must be answered with a resounding No. Unquestionably, certain functions that often are carried out by community mental health professionals require an M.D. because of tradition and training. Prescription of drugs, administration of somatic treatments, and enforcement of involuntary admission to mental hospitals are some examples. On the other hand, there are other tasks that may be done poorly by those with medical training or be a waste of the very expensive time of a trained physician. These range from group therapy to vocational rehabilitation.

It seems logical that, whenever possible, both job specifications and job applicants be considered on an individual basis in terms of suitability rather than that any blanket rules be applied regarding professional background. There are some things to be said, however, for setting minimum educational or professional standards without making a fetish of professional requirements. Specifying that a community mental health applicant have a particular degree or be an accredited member of a particular profession simplifies screening for suitability and maintaining a minimal standard for applicants. Although there will be some exceptions, it seems reasonable to assume that those who have completed a professional training program are generally able to function and carry out assignments at a fairly high level of abstraction and organization. To open a position to all applicants regardless of training would require a great deal more effort in screening. However, professional requirements can keep out those few imaginative individuals whose innovativeness is expressed in part by their refusal to take formal professional training. The gain in ease of screening must be weighed against the loss of unusual applicants and a decision made regarding which is more important in a particular case.

Although from a practical point of view much of the work in community mental health need not, or should not, be done by physicians, how much of a tie, theoretically, is there between community mental health and medicine? The answer to this (a point enlarged upon below) is, not very much.

First, many of the issues of community mental health ought to revolve around health, not the treatment of illness. Physicians, though they often are inclined to forget this, are trained to deal with illness, not to promote health. There is an important distinction.

Second, many of the present techniques of community mental health involve skills in which physicians are not trained. These include the areas of administration, community organization, and social analysis. Other professions are far better equipped in these areas.

Third, medicine is traditionally concerned with the welfare of the individual, not the group. Physicians are, with few, carefully limited exceptions, required to work only for the interests

of the patients they see, not for populations. To change this tradition may be not only difficult but even dangerous.

Thus despite the facts that community mental health has evolved in relation to a medical specialty, that many of its practitioners are physicians, and that many of its techniques and tasks are medical, it is not simply a medical specialty or subspecialty.

Hallmarks of Community Mental Health

Community mental health seems to be distinguished from other forms of mental health practice by its concerns in four particular areas. These are (1) theory, (2) the special target groups for which services are designed, (3) research, and (4) clinical approaches. (In a discussion of the ideal it is easy to contrast the community approach with other approaches. However, it must be kept in mind that the ideal is rarely found in practice and that in deciding whether or not something is community mental health, no single factor is decisive; rather, a whole complex of factors must be examined.)

Theory

Community mental health emphasizes the importance of an individual's current environment in the onset of mental illness. Such factors as social disorganization, occupational stress, "culture shock," and "transition state" have been among the major interests of community theoreticians. This is in contrast to other views of the etiology of mental illness, which may emphasize such factors as biochemical imbalance or stresses during early stages of life, long before the illness became manifest.

The environment is also seen as very influential in shaping the course of the illness and, particularly, its symptoms. Thus, even though many community mental health professionals are of the opinion that schizophrenia, for example, is always accompanied by some biochemical change, they are likely to think that the severity of the symptoms and the particular symptoms that appear are influenced, if not determined, by the interaction

between the ill person and his environment. Interest in the syndrome that has been variously described as institutional neurosis, the hospitalization syndrome, the social breakdown syndrome, and the back-ward syndrome is a manifestation of this. Some of the most serious symptoms, which others have felt to be essential aspects of schizophrenia, are attributed to confinement of the patient in a very special type of institution.

Many community mental health professionals look upon many mental illnesses as a form of social deviance rather than anything analogous to physical illness. Even when these professionals do not talk in these terms, their treatment approaches are often based on this idea. Thus, the mental hospital may be seen as an educational institution rather than a place of "treatment." The patient may be viewed as someone with bad habits who needs to learn new ones rather than as someone who is suffering from an illness he must passively accept and who must then passively cooperate with his physician's prescription.

Mental illness (i.e., social deviance) is likely to be regarded as inherent in the process of social groups rather than as a mysterious and unpleasant phenomenon that someday may be wiped out when we learn all its secrets. This is because both norms and deviance are always established by a group as part of the mechanism of ensuring group integrity. Unless a group reinforces those who adhere to its norms and punishes those who deviate from them, the group cannot remain a group. Yet innovations in group behavior and responses to new situations cannot take place without deviation. It is today's deviant who may be tomorrow's group leader. It is essential for group survival to tolerate some deviants since the group's only method of adjusting to changing environmental conditions is to change norms. Those group members in whose behavior the new norms are first expressed may be seen at the time as mentally ill.

Finally, the basic sciences of community mental health are social psychology, sociology, and epidemiology. In contrast, the basic sciences that principally underlie other types of mental health work include biochemistry, neurophysiology, and psychoanalytic psychology.

Target Groups

It should not be surprising that the targets of community mental health practice are indeed groups rather than particular kinds of individuals. Community mental health professionals have evinced concern for groups that seem to have been rather neglected in previous years. Perhaps this is in part because as participants in a newly developing area, community mental health professionals were looking for groups with which they could work without being in danger of competing with more traditional professionals. In any case, community mental health workers have been very much involved with providing service for people who live in poverty and who are culturally deprived. These are, in particular, groups such as slum-dwellers, American Negroes, American Indians, and other minority groups.

Community mental health professionals have also been concerned with groups that, for one reason or another, have not been easily accessible to traditional mental health services. These include state mental hospital patients, prisoners, soldiers, juvenile delinquents, and groups with special problems, such as narcotic addicts and alcoholics.

Finally, community mental health workers have been interested in providing support to the group known as "caretakers," or "gatekeepers." These are individuals in key service occupations in which they come into regular contact with many people who are in distress and in need of mental health services. The caretaker group includes, for example, policemen, schoolteachers, bartenders, barbers, pharmacists, and probation officers. Because of the shortage of mental health services and the reluctance of many people to seek help, caretakers often have to deal with problems that might better be referred to a mental health professional. Since it is simply not feasible for all these referrals to be made, the community mental health approach has been to train and consult with the caretakers so that their attempts at helping their clients may be more effective.

Research

Community mental health research tends to be modeled after

work carried out by researchers trained in public health — that is, it emphasizes such approaches as epidemiology, program evaluation, and operations research. The research generally has a practical goal, such as determining whether a particular treatment program is of value or is worth the amount it costs to carry it out. Epidemiology is a useful method for testing theories of disease etiology; it is also very important in providing data for planning health services. Operations research is concerned with the techniques by which programs are carried out and with studies of the efficiency and effectiveness of programs. Community mental health research thus tends not to be basic research, but to deal more with prevention and treatment and to be focused on operating programs.

Clinical Concerns

Community mental health workers have been concerned with assuring that services be available to all who need them. Whereas one of the overriding considerations in the provision of traditional services is that the highest treatment standards be maintained and the maximum possible benefit for each patient be the aim, this is not the case in community mental health. Community mental health workers recognize that to aim for the maximum possible benefit for each patient means that many patients who are equally in need of service will have to do without. Therefore, rather than provide a very high level of service for some and no service for others, they try to provide an acceptable level for all in need. They tend to have little interest in long-term, continuous treatment approaches or in methods that involve reconstruction of personality and require years of treatment. Rather, interest is in what has been called the first-aid approach, or crisis intervention. In this the goal is to restore the patient to the level at which he was functioning before he became ill. Treatment must work rapidly and demand a minimum of professional time. It must be relatively inexpensive, since treatment cost is a limiting factor in treating large numbers of people.

Because of interest in reaching large numbers of people and the emphasis on the environment's influencing the course of

mental illness, community mental health workers tend to make great use of what has been called "social therapy." This therapy uses social pressures to shape patients' behavior and attributes great importance to relationships, not just the relationship of the patient with his primary therapist but his relationships with all those around him, including other patients. Specific examples of this treatment approach include group therapy, remotivation, compensated work, patient government, and milieu therapy. Many social therapies go on outside the hospital — indeed are often more effective outside the hospital. Therefore, community mental health workers are concerned with operating alternative institutions to the hospital, such as halfway houses, day and night hospitals, and suicide or crisis intervention centers.

Because of its relationship to public health and its concern for the overwhelming, unmet needs for service, community mental health focuses also on the prevention of mental illness. If mental illness can be prevented, then the need for service will be decreased, and care of all those in need may become more feasible. Thus, programs in mental health education and in mental health consultation have been developed. Mental health education is intended to help people avoid situations damaging for themselves and for those around them and to promote healthful environments. Mental health consultation is intended to help caretakers deal with potential illness or the early stages of illness so that the disorder will not become severe enough to require intervention by a mental health professional.

Community mental health workers view administration as an important part of treatment and as a particular skill of the professional. Since much of community psychiatric treatment takes place in and around institutions, the operation of those institutions becomes very important. Whereas the traditional psychotherapist needs only an office and a desk (and possibly a secretary) to work effectively, the community mental health worker may use a multi-million-dollar building and a large budget and staff in order to work effectively. The design and construction of such a building, the recruiting and organizing of the staff, and the maintenance of effective working condi-

tions require someone highly trained in administration and all of the related skills.

The community mental health administrator is highly respected within his profession. This is quite different from earlier views of the administrator (e.g., in a state hospital), in which he was often looked down upon as someone who could not make good in the more respected role of therapist.

The community mental health worker is concerned with delivery systems. He recognizes that excellent mental health services are not really helpful if somehow they never get to the consumer. He also recognizes that good services provided in an unsatisfactory setting may become unsatisfactory. Finally, he recognizes that in a time of inflation and public rebellion against tax burdens, the cost and efficiency of services have become major issues. For all of these reasons, the means by which services are delivered are of great importance. Much of the effort of community mental health workers is devoted to studies in this area and to efforts at improvement.

Finally, the community mental health worker is interested in community change. He recognizes that social disorganization quite likely increases the occurrence of mental illness and that the most effective method for preventing or treating mental illness may be to bring about change in the community. He also recognizes that conditions in the community may interfere with his being able to treat his patients adequately. For example, although he knows that regular employment may be very important for the recovery of his patients, if his community has a high unemployment rate for healthy people, there is little likelihood that he will be able to find jobs for his patients. Therefore, he must try to deal with the general employment problem before he can hope to be able to help patients find work.

Purposes of Clinical Community Mental Health

Community mental health service, like mental health service in general, has many purposes and fulfills a number of social functions. Some of these are in conflict with each other. Thus, there is no single dominant theme in community mental health, and programs can be found that emphasize one or another aspect.

Perhaps the major purpose of community mental health services, as of psychiatry and of medicine in general, is to relieve suffering. The worker deals with patients who are in pain and who have requested his help in obtaining relief. For some, this might seem to be the only purpose; but, as will be seen, this is clearly not so. Although all physicians are dedicated to the relief of suffering, psychiatrists and other mental health workers face a much more complex task in carrying out this function. For physicians dealing with physical illness, pain is usually an indication of pathology, and the relief of pain is almost always good. However, this is not always true with respect to mental illness. Some mental suffering seems to be a normal part of growing up, at least in Western culture; and a person relieved of all pain is relieved of the opportunity to grow and to prepare himself to function in the world. Thus, the worker sometimes must not attempt to relieve pain, or must even urge his patient-client to go into a situation in which he knows in advance there will be pain.

A second complicating factor is that mental patients are sometimes disorganized to the point where it seems as if they are not aware of what is going on around them or of their own suffering. In these cases an inference may be made that the patient is suffering from pain, or would suffer from pain if he were aware of it. The worker then takes it upon himself to institute treatment, perhaps even against the patient's expressed will. This puts the worker in an authoritarian position that is foreign to the mental health tradition and that is rarely encountered by other helping persons. In physical illness, for example, it is usually fairly clear what is an illness and what is within the physician's jurisdiction; and the final word as to whether or not an illness will be treated remains with the patient.

Another important function of community mental health is to act as an agent of social control. Every social group has mechanisms through which the norms of the group are maintained, and those who violate the norms beyond a certain degree are discouraged by, or even ejected from, the group. In Western society many complex methods of maintaining control and enforcing norms have been developed. One of these methods is the mental health service system and, particularly, psychiatry.

The details of social control systems and the ways in which the various systems interact and overlap will be discussed later. Suffice it to say that social life could not go on without some form of social control. Traditionally, medical personnel have been involved in a very limited way in the enforcement of social controls, and only where these impinge on medical concerns (e.g., sanitation, immunization, etc.). The social control issue is particularly relevant for psychiatrists. Although there has been some unhappiness in the psychiatric community and among those who are concerned with psychiatry that the profession should be involved in social control, this is an essential and highly valued function. Psychiatrists, other physicians, and most categories of helping persons cannot be, and never have been, neutral regarding certain fundamental moral principles. For example, the helping professionals are dedicated to the beliefs that pleasure is better than pain, life better than death, and health better than disease. Any professional who does not adhere to these principles is likely to suffer the disapproval of his colleagues, except under most unusual circumstances.

Community mental health, in particular, has been concerned with maintaining social harmony, whereas other mental health workers have traditionally focused on the interests of their individual patients or clients. When these individual interests are at variance with those of the group, community mental health workers have tended to be concerned about the group as a whole. This can be seen clearly in the approach to treatment. An individually oriented worker often concentrates on improving the mental health of his patient regardless of the cost to the patient or to society. His objective is to provide the best possible service for that patient, and his ideal is likely to be to cure the patient. The community mental health worker recognizes that in devoting the time and effort to one patient necessary to effect a cure or at least to attain maximum possible benefit he may be neglecting the needs of many other patients who could also benefit from his treatment. He balances the needs of one patient against the needs of society, and may decide to release the patient well before maximum benefits are achieved in order to make way for someone else in need.

Some community mental health workers have been involved

in efforts to dampen the fires of social conflict, for example, when riots have occurred. Others have been on the other side, stirring up conflict. It is possible to view such conflicts either as a form of political and social pressure or as a manifestation of social disorganization. Those who have chosen the latter point of view have then proceeded to intervene to see if they could channel the conflict into what they considered less pathological forms.

A final example of the community mental health worker's concern with social harmony rather than the welfare of individual patients is in his involvement with the court and correctional system. Here he acts directly as an instrument of society, and may advise judges or probation officers regarding the proper disposition of defendants or persons found guilty. Although a possibly secondary objective in his work is to make the situation pleasanter or healthier for the individual involved, clearly his primary objective is to make the court and correctional system more effective.

The Future of Community Mental Health

Community mental health is now maturing from a fad into a recognized subspecialty. In both psychiatry and psychology there are special training programs and professional groups devoted to the field. Most schools of public health have faculty members or academic units specializing in public health aspects of mental health. The establishment of formal professional credentials to indicate competence in the discipline does not seem far off.

As community mental health ages, it is to be expected that there will be some narrowing of scope together with, it is to be hoped, some increase in depth. A firmer foundation in theory and completed research should leave us more secure in knowing what we can and cannot do.

Community mental health is here to stay. Its concerns are real; its skills, though far from perfected, have begun to make an impact. Confidently, its practitioners look to the future.