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ABSTRACT

The focus of this study is on the relationship between community support programs and the provision of mental health services to urban Hispanic populations, and the impact of existing public policies and future policy options on the chronically mentally ill in Puerto Rican neighborhoods in New York City. This policy analysis uses five steps. (1) The problem is reviewed and analyzed in light of available knowledge; major issues discussed are the underutilization of mental health services by Hispanics, deinstitutionalization and the development of community health centers, and the nature of community support systems. (2) Existing policies at the Federal, New York State, and New York City levels are reviewed, as are relevant judicial decisions. (3) Three public policy options--a managerial fiscal model, a community development model, and an ethnic model--are examined in terms of administrative control of programs, source of funding, nature of services delivered, forms of support, and program specificity. (4) The most promising policy options for improving mental health services in Hispanic neighborhoods (the ethnic and community development models) are discussed in terms of economic costs, values represented, public acceptability, political feasibility, ease of implementation, and unintended consequences. (5) A strategy for the implementation and evaluation of the preferred solution is considered. (CMG)

SOCIAL AND COMMUNITY SUPPORT SYSTEMS IN HISPANIC NEIGHBORHOODS IN NEW YORK CITY: A PUBLIC POLICY ANALYSIS

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Needless to say, I bear full responsibility for the final product.

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ACRONYMS APPEARING FREQUENTLY IN MONOGRAPH

CMHC	Community Mental Health Center
CSS	Community Support Systems
GAO	General Accounting Office
ICF	Intermediate Care Facilities
NIMH	National Institute of Mental Health
NYCDMH	New York City Department of Mental Health, Mental Retardation and Alcoholism Services
NYSDMH	New York State Department of Mental Hygiene
PPHA	Private Proprietary Homes for Adults (Aged)
SNF	Skilled Nursing Facility
SRO	Single Residence Occupancy (Hotels)

CHAPTER I

INTRODUCTION

> To be connected to others, to belong, to receive social support when it is needed and to be able to give it in return is an important part of mental health...utilization of social and community support systems can provide for constructive innovation and systematic change in the mental health system, moving toward a comprehensive human services system with a holistic orientation that would remedy some of the defects of our present fragmented and uncoordinated efforts.
>
> --Task Panel on Community Support Systems
> President's Commission on Mental Health, 1978.

These introductory remarks in the Report of the President's Task Panel on Community Support Systems reflect a new strategy being considered by federal, state, and local governments to improve the quality of life in the United States. In this study I focus on the relationship between community support programs and the provision of mental health services to urban Hispanic populations. More specifically, I am interested in the impact of existing public policies and future policy options on the chronically mentally ill in Puerto Rican neighborhoods in New York City.

There are several sources for the recent interest in the social and community support systems for the mentally ill in Hispanic neighborhoods. Since the early 1960's federal and state agencies have actively promoted deinstitutionalization, a mental health policy aimed at transferring the greater part of care for the mentally ill from large, crowded state hospitals to small-scale community settings. From the beginning, mental health agencies have given priority to managerial/organizational and

fiscal issues. Also, during and since the 1960's, ethnic minority interest groups have increased demands that public policies more adequately meet the needs of the populations they represent. Coalitions of urban Hispanic groups are now organizing mental health programs for their barrios (neighborhoods). Public sentiments favor a new sense of community, the decentralization of an entire range of social welfare services, and the encouragement of grass-roots organizations to meet local demands. Will the interests of federal and state mental health agencies in community mental health, Hispanic American demands for mental health programs, and the return-to-communities movement combine in a constructive or conflictive manner? In a five-step process of policy analysis, I address the issues of social and community supports for the chronically mentally ill in Hispanic neighborhoods in New York City. This policy analysis process was developed by the Center for the Study of Families and Children at Vanderbilt University.

1. Definition of the problem in light of available knowledge. This first step is a review and analysis of what is currently known about the problem. This review covers the main issues in the delivery of mental health services to urban Hispanic populations. Demographic and epidemiological studies outline the state of Hispanic mental health, with special reference to New York City. A central issue concerns the underutilization of mental health services by Hispanic groups. A second main issue is the dilemma of deinstitutionalization and the development of community mental health centers (CMHC's). A review of the general process of deinstitutionalization is necessary to understand the current structure of the community mental health movement. Third, the basic

issue of the nature of community support systems is of central importance. I use the concept of social networks throughout the review of the community support systems literature. The social network perspective ties together main elements of social supports--neighborhood or community, the family and non-kinship networks (friends and neighbors, co-workers, etc.).

2. Review of existing policies. This step entails an analysis of existing policies relevant to social and community supports for the chronically mentally ill in urban Hispanic populations. The review of current policies includes federal legislation: the Community Mental Health Centers Act of 1963 and Amendment of 1975; appropriate sections of Medicaid, Medicare, Supplementary Security Income Program; and special programs in Vocational Rehabilitation, Department of Labor, Department of Housing and Urban Development, and others. Also, Judicial decisions are briefly reviewed in terms of responsibility to use least harmful forms of care, right of non-dangerous individuals to freedom, and right to treatment in least restrictive alternatives.

Existing policies for community supports are sponsored by the National Institute of Mental Health (NIMH) Community Support Program, the State of New York plan for deinstitutionalization, and the New York City Community Support System Program. Moreover, current urban renewal policies in inner city areas are important for the successful implementation of social and community supports programs.

3. Analysis of knowledge and policy and the identification of policy options. A synthesis of the available knowledge and of existing policies produces two outcomes: (a) a decision concerning the adequacy

of the knowledge base for policy formulation and (b) an identification of the most positive policy options for the provision of social and community supports in Hispanic neighborhoods. I consider three main policy options for social and community support programs: (1) a managerial-fiscal model, (2) a community development model, and (3) an ethnic model.

Current public policies relating to community support programs are considered according to several criteria: administrative control of programs, source of funding, nature of services delivered, forms of support, and program specificity. The administrative control of programs raises the issue of local consumer control compared to centralized, professional medical control. Funding sources vary, for the most part, among federal, state, city, and third-party groups. The nature of services delivered may emphasize out-patient care or generic services like housing, jobs, and educational opportunities. Policies may focus on support for the individual, family, neighborhood, or the entire network of social relationships. Programs also vary in their specificity. These include programs targeted for only the chronically mentally ill; programs for CMHC's in poverty areas; programs made available to all residents of a catchment area; and programs for CMHC's serving a wide range of socioeconomic classes.

4. The analysis of policy options. I consider the most promising policy options for improving mental health services in Hispanic neighborhoods. Their relative advantages and disadvantages are analyzed in terms of the following criteria: economic costs, values represented, public acceptability, political feasibility, ease of implementation, and unintended consequences.

5. Implementation and evaluation. The final task of this study is the development of a strategy for the implementation and evaluation of the preferred solution. A well-constructed program for the development of social and community supports for the chronically mentally ill in New York City's Hispanic neighborhoods is of limited value without a plan for its implementation and subsequent monitoring of degree of success. Moreover, effective implementation of community support programs depends upon the actions of both federal administration and local street-level deliveries of services. These problems are discussed in terms of the implementation of a social community support program for the chronically mentally ill in Hispanic neighborhoods in New York City. Finally, I discuss the issue of evaluation of social and community support programs.

CHAPTER II

COMMUNITY SUPPORTS AND DEINSTITUTIONALIZATION: IMPLICATIONS FOR URBAN HISPANIC MENTAL HEALTH

Characteristics of Urban Hispanic Populations

According to the latest national U.S. Census (1970), some 9.6 million persons of Spanish origin are living in the United States. By 1975, the Current Population Reports estimated the number of Hispanics to be 11 million. Other calculations, including estimates of undocumented workers, suggest that more than 23 million Hispanics are presently living in the United States. The Hispanic popul[illegible] is the fastest growing ethnic group in the United States. Hispanics will soon become the largest ethnic minority (Macias, 1977).

The Hispanic population is unevenly distributed throughout the U.S. About 59% are of Mexican origin and live in the five Western States--Arizona, California, Colorado, New Mexico, and Texas. Puerto Ricans live mostly in the New York area and comprise 16% of the U.S. Hispanic population. The rest of the Hispanics include Cuban Americans (6%), Central and South American (7%) and others (12%). These data from the 1975 Current Population Reports do not include the estimated 7 million undocumented Hispanic immigrants. Hispanic Americans are essentially urban dwellers. Some 84% live in the metropolitan areas of Los Angeles, New York, and Chicago (President's Commission on Mental Health, 1978b:2). Moreover, 50% of the Hispanic families live in the central city area compared to 25% of the families in the general U.S. population (U.S. Bureau of Census, 1976).

Hispanic families in the United States are urban, young, and found in the poorest socioeconomic groups. In 1975, about 32% of Puerto Rican families were below the government poverty line, lower than all other minority groups in the U.S. (see Table 1). Unemployment rates in 1976 were also the highest of any U.S. ethnic group for males (16%) and females (22%).

The largest proportion of the Puerto Rican population living on the mainland is located in New York City. In 1970, Puerto Ricans made up 10% (811,843) of the total New York City population. They include about two-thirds of the Hispanic population in New York City. The borough with the highest percentage of its population Puerto Rican, in 1970, was the Bronx (39%). The City's other boroughs holding substantial Puerto Rican groups were Brooklyn (33%) and Manhattan (23%). The Puerto Rican population is relatively young compared to the rest of the population. In 1970, only 3% of Puerto Ricans were over 65, compared to 12% for the total population (Alers, 1978:2). These demographic data suggest that the Hispanic population and, more particularly, Puerto Rican families in New York City, compose a substantial part of the City's inhabitants and that their distinct characteristics (age, income, and occupation) represent needs for health and welfare services different from other ethnic groups and from the total population.

Table 1

Poverty Rates

	Raw Measure[a]	
	1969	1975
Families and Unrelated Individuals		
Amer. Ind./Alask. Nat.	36	26
Blacks	33	28
Mexican Americans	28	24
Japanese Americans	12	7
Chinese Americans	16	17
Filipino Americans	19	6
Puerto Ricans	28	32
Majority	13	9
Female-Headed Families and Female Unrelated Individuals		
Amer. Ind./Alask. Nat.	54	49
Blacks	53	46
Mexican Americans	53	46
Japanese Americans	32	22
Chinese Americans	29	19
Filipino Americans	39	20
Puerto Ricans	52	49
Majority	28	22

[a]The percent of families and unrelated individuals that are below the poverty line.

Source: Social Indicators of Equality for Minorities and Women--A Report of the United States Commission on Civil Rights, 1978; p. 62.

Because of the youth of the Puerto Rican population, their mortality rates are much lower compared to the total white and non-white populations. However, cirrhosis of the liver and homicide have a greater incidence among Puerto Ricans than the total population (Alers, 1978:2). In fact, for 1970, homicide and drug dependence accounted for 10% of all deaths among Puerto Ricans born in New York City. Considering causes of mortality by age groups, death rates for Puerto Rican children (under 15 years) are significantly higher compared to the total population (79.5 to 55.5/100,000). Mortality rates from accidents, influenza and pneumonia, and homicide are double the rates found among children in the total population (Alers, 1978:8). Within the adult population (ages 14-44), death rates are also considerably higher for Puerto Ricans compared to the total populations (308.1 to 253.2/100,000). In this age group, homicide, drug dependency, and cirrhosis of the liver were the main causes of the higher mortality rates. Homicide accounted for almost 20% of the deaths in this age category--more than twice the rate for the total New York City population from 1969 to 1971 (Alers, 1978:8). A general indicator of community health is the maternal mortality rate. The Puerto Rican-born maternal mortality rate for 1970-76 is greater than that for whites but not as high as for non-whites (mainly blacks). However, maternal mortality rates for Puerto Ricans have been declining rapidly since 1963 through 1976, narrowing the difference with whites (Alers, 1978:13). Similarly, the gap between Puerto Rican and white infant mortality rates has also been decreasing over the past 14 years (Alers, 1978:13). In short, the physical health of Puerto Ricans in New York City for some age categories is poorer than the health of the rest of the population.

Mental Health Services

The literature indicates that Hispanic populations underutilize mental health services even though they are in greater need of these services than the total population (Padilla et al., 1975). Earlier studies suggested that Hispanic populations in general experience lower frequencies and severity of mental illness (Jaco, 1960; Madsen, 1964). Certain aspects of Hispanic culture were said to protect its members against mental disorders. Traditional family organization was thought to provide social supports to prevent mental breakdowns. Yet these arguments that Hispanic families are better prepared to tolerate stress and require fewer formal mental health services were not fully supported by empirical evidence.

Ethnic and class differences make it difficult to measure the incidence of mental illness in Puerto Rican populations. Dohrenwend's study (1966) in New York City showed that, compared to other subgroups, Puerto Ricans evidenced a greater prevalence of psychiatric symptoms with a greater degree of severity. Yet Dohrenwend holds serious reservations concerning these findings. Are Puerto Ricans, with their language and cultural differences showing, according to Dohrenwend (1966:33), "differences not in the amount of disorder, but rather in culturally patterned modes of expressing distress and/or culturally patterned willingness to express distress?" In a later study Dohrenwend and Dohrenwend (1969:170) concluded that for Puerto Ricans:

> this ethnic difference indicates more about subcultural contrast in modes of expressing distress than about differences in underlying psychological disorder. We are forced to conclude that the consistently high rates of symptoms among Puerto Ricans on the measures we used could not validly be interpreted as evidence of higher rates of psychological disorder.

Data from the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services show that total admission rates per 100,000 population to community mental health and mental retardation facilities for Puerto Ricans and blacks were about twice that for the white population in 1978 (Alers, 1978:16). However, it is difficult to interpret high admission for treatment rates as the sole definition of disorder. Treatment rates are known to vary with the availability of these facilities and with attitudes toward the use of public facilities. Moreover, Alers (1978:16), in reporting these findings, admitted that the differences were biased since blacks and Hispanics made greater use of community mental health centers while higher income whites were more likely to use the private sector facilities.

The assumed high incidence of mental illness in Hispanic populations is based, in large part, on the findings for a general non-Hispanic population of a negative relationship between socioeconomic status and mental illness (Srole et al., 1962; Dohrenwend and Dohrenwend, 1969:165). However, the inverse relationship is specific to certain mental illnesses (brain and schizophrenia disorders) but not to others (neuroses and manic depression) (Rushing & Ortega, 1979). It is unclear whether there is an inverse relationship between socioeconomic status and personality disorder. Rushing & Ortega (1979:1190) developed a sociomedical model to account for higher incidence of brain disorder and schizophrenia in low-income populations. They argue that:

> lower-status individuals may be more apt to be exposed to etiological factors (e.g. infectious disease) of both disorders. Second, socioeconomic factors may mediate the effect of biological factors (e.g. infectious diseases, neurological deficits).

Many of the factors associated with brain and schizophrenia disorders may be modified by appropriate health-relevant attitudes and behavior (e.g. preventive care) and medical attention, which may vary by socioeconomic status.

However, there is little empirical evidence that lower-status individuals are troubled by more situationally induced stress compared to higher socioeconomic groups (Dohrenwend and Dohrenwend, 1973). Although there is evidence to show a relationship between life event changes and the onset of schizophrenia (Rogler and Hollingshead, 1965; Myers et al., 1974, 1975), support for the stress argument is less convincing (Mechanic, 1972). Using ecological aggregate data analysis, Brenner (1973) shows that economically induced stress influences psychological disorders. Although Brenner's study did not use a measure of socioeconomic status, it verified the impact of economic change or unemployment on psychological disorders.

In all, the findings support the argument that certain mental disorders are inversely related to socioeconomic status. We should expect greater need for services related to schizophrenia and brain disorder among low-income Hispanic populations. Aler's review of the poor public health conditions of Puerto Ricans supports this view. However, findings of higher incidence of other psychological disorders in Hispanic populations using standard indices (i.e., the Midtown scale) are confounded by cultural biases.

As recipients of mental health services, Hispanics are significantly underrepresented (President's Commision of Mental Health, 1978b:3). For example, Abad et al., (1974) found that admissions and readmissions of Puerto Ricans to the Connecticut Mental Health Center from 1971 to 1972 were over three times lower than blacks of a comparably low socioeconomic status. In a

California study, Karno and Edgerton estimated that although Chicanos constituted ten percent of the population in 1963, they represented only 3 percent of the clients of mental health facilities (Padilla et al., 1975). In general, the existing case studies agree that Puerto Ricans and other Hispanic groups underutilize mental health services.

The Hispanic mental health literature (Padilla et al., 1975; President's Commission on Mental Health, 1978b) finds that institutional policies and organizational problems are primarily responsible for the low utilization patterns of mental health facilities by Hispanics. Language barriers exist in CMHC's since few professional mental health staff members are bilingual. Hispanics are underrepresented at all levels of professional employment--psychiatry, psychology, psychiatric nursing, and social work (President's Commission on Mental Health, 1978b:5). On the other hand, Puerto Ricans and blacks are overrepresented within the lower skilled health jobs (Alers, 1978). Moreover, class and culture bound values limit the usefulness of mental health facilities for low-income Hispanic clients. Therapists are found to conduct treatment according to middle-class values. Lorion (1974) suggests that "Psychiatrists refer to therapy persons most like themselves." Karno (1966) found that in the Los Angeles General Hospital Outpatient Clinic, Mexican Americans accepted for treatment receive less and shorter psychotherapy than non-ethnics of the same class.

Puerto Ricans have other means for dealing with health problems. Espiritismo and santeria are folk health systems that provide alternative and/or complementary services to Hispanic populations in the treatment

of physical and mental difficulties. Espiritismo represents the traditional healing practices among Puerto Ricans which embodies the beliefs of Alan Kardec, a 19th century Mesmerist and engineer. Santeria is an Afro-American syncretic cult with an African world view different from espiritismo (Garrison, 1977b). Surveys of Puerto Ricans in San Juan and in New York show that between 33 and 90%, respectively, of these populations seek the assistance of spiritist healers at some point in their lives (Thomas & Garrison, 1975:281). Accounts of espiritismo in New York City show that, as a form of folk psychiatry, it retains its utility for a substantial part of the Hispanic community (Garrison, 1977a, 1977b, and 1979a, 1979b; Harwood, 1977; Koss, 1977).

In summary, there is not sufficient evidence to show whether Puerto Ricans, and Hispanics in general, experience higher rates of psychological disorder than other minorities or the general population. Moreover, it is difficult to separate the independent effects of ethnicity and social class on the incidence of mental illness (Rabkin and Struening, 1976). Certainly, the underutilization of existing community mental health services by Puerto Ricans and other poor minorities strongly suggests that non-traditional mental health programs are needed. One major policy option, social and community supports, is the topic of this monograph.

The Dilemma of Deinstitutionalization and Community Mental Health Centers

By 1955, the number of persons in public mental hospitals peaked at 559,000. Twenty years later a census of resident patients in state mental hospitals shows a reduction of 65 percent to a population of 93,000 individuals (Bassuk & Gerson, 1978:45). New York's state mental insti-

tutions declined from a population of 107,000 in 1967 to 45,000 in 1976 (NYC DMH, 1978d:1). In 1963, the federal government began its program of deinstitutionalization with the intentions of:

(1) preventing both unnecesaary admission to and retention in institutions;
(2) finding and developing appropriate alternatives in the community for housing, treatment, training, education and rehabilitation of mentally disabled who do not need to be in institutions; and
(3) improving conditions, care and treatment of those who do need institutional care. (GAO, 1977:1).

The deinstitutionalization process is based, in part, on the principle that "mentally disabled persons are entitled to live in the least restrictive environment necessary and to lead their lives as normally and independently as they can" (GAO, 1977:1). Moreover, it was hoped that the deinstitutionalization program would also be less expensive to operate and more effective in treating mental illnesses.

With the sharp decline in the resident population in state mental hospital, the process of deinstitutionalization has created considerable discontent among mental health professionals, mental patients and their families, and the communities where the former patients are placed.* Federal efforts to implement plans for deinstitutionalization centered on the Community Mental Health Centers Act of 1963. This legislation intended to establish 1,500 community mental health centers by 1980. In 1978, only 650 CMHC's were functioning (President's Commission on Mental Health, 1978b, viii). The diversion of funds away from the field of mental health

*For an account of the problems encountered by deinstitutionalization, see Bassuk & Gerson (1978), Arnhoff (1975), Brandon (1977), P. Brown (1978), Brown & Goldstein (1978), Cameron (1978), Chu & Trotter (1971), Roman & Trice (1974), Rumer (1978).

due to the War in Vietnam and organizational difficulties slowed the optimistic projections for the development of the CMHC's.

Community mental health centers are experiencing difficulty providing services for the residents of their catchment areas and reintegrating former mental patients into communities.* Although the resident population in state hospitals was declining, admissions increased from 178,000 in 1955 to 390,000 in 1972, declining to 375,000 by 1974. (Bassuk & Gerson, 1978:49). This trend reflects a new strategy of short-term hospitalization. However, a growing percentage of admissions were readmissions--64 percent in 1972. About one-half of the released inpatients were readmitted within a year of their discharge (Bassuk & Gerson, 1978:49). Arnoff (1975:1277), one of the harsher critics, concluded that:

> a compelling body of systematic evidence now exists to suggest not only that the actual cost benefits of community treatment (using costs in its broadest social sense) are far less than its advocates proclaim, but that the consequences of indiscriminate community treatment may often have profound iatrogenic effects; in short, we may be producing more psychological and social disturbances than we correct.

The community mental health centers are being criticized for not achieving their goals. Kirk and Therrien (1975) concluded that CMHC's have not accomplished four main goals: (1) to rehabilitate former patients; (2) to enhance continuity of care; (3) to save money; (4) to reintegrate the mentally ill into society. A main criticism by mental health professionals is that the community mental health

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*Explanations of these difficulties are diverse. They include the following: lack of funding, organizational problems linking the state hospitals to CMHC's failure to develop community services, barriers of professions, and the very nature of capitalist society's medical-industrial complex (B. Brown & Goldstein, 1978; P. Brown, 1978).

movement has failed to improve significantly the welfare of the severely mentally ill (Arnoff, 1975; Kirk and Therrien, 1975; Reich and Siegal, 1973). There is a need to provide a wide range of social and community supports for former patients who are better but not well (Klerman, 1977),

In a review of proprietary extended care facilities for the chronically mentally ill, Kohen and Paul (1976:576) discovered that:

> aggressive placement of long-stay mental patients in facilities, for example, foster homes, nursing homes, sheltered-care homes, etc., accounts for nearly all of the reduction in the chronic population of public hospitals over the past 15 years.

Some of the surveys mentioned concluded that these extended-care facilities had not improved the rehabilitation programs for the well-being of the chronically ill mental patients. Recently, a U.S. Senate Sub-committee Report condemned conditions in propriety nursing and boarding homes because of numerous incidents of serious neglect and abuse (U.S. Senate, Speicial Committee on Aging, Subcommittee on Long-Term Care, 1976). Often the chronically ill individuals living in "community" homes are socially excluded from active social participation by strategies that encourage docility (drugs and the caretaker's economic incentives to maintain a stable resident population) and isolation (zoning laws and local municipal regulations that foster ghettoization) (Aviram and Segal, 1973).

Despite the decrease in resident populations in public mental institutions, many persons who could be treated in communities still enter or remain in these institutions. New York's "level of care survey," developed by Arthur Arnold in 1975, shows that about 28 percent of the mentally ill in state hospitals do not need to be there. Some 10 percent

could be cared for adequately in nursing homes while 17 percent are capable of living independently or in sheltered situations (NYSDMH, 1978). A study by the State Department of Mental Health Massachusetts in 1973 indicated that between 50 and 75 percent of the admissions to state mental hospitals could have been avoided with the existence of adequate community services--housing, social supports, educational programs, etc. (GAO, 1977:21). A HEW study of 1,800 patients in Texas mental institutions concluded that only 35.5 percent needed continued psychiatric care and the other 65.5 percent could have been placed in sheltered homes or independently in the community. A GAO study (1977:19) concluded that the primary reason for patients remaining in the state hospitals was the lack of community facilities and services or the lack of access to them.

At the state and local levels of government, community services compete for funds with the traditional state hospital system. Between 1968 and 1974, the cost of state institutions increased from $1.7 to $2.8 billion (Bassuk & Gerson, 1978). Inflation, federal demands for improvements in institutional care, and the political power of the state hospital system as patronage contributed to their rising costs. Although state institutions in New York declined in resident population from 107,000 in 1967 to 45,000 in 1976, that part of the State Mental Hygiene budget did not decline (NYC DMH, 1978d:1). Some 90 percent of the mental hygiene funds appropriated in 1977 were allocated for state facilities and their administration. Only 10 percent of these funds went to local counties and New York City for local assistance purposes

(NYC DMH, 1978:1). In all, massive reduction in population of state mental institutions freed little money for local community support programs. However, the transfer of the mentally ill from state institutions to privately-run nursing and proprietary homes has shifted a substantial burden of support from the state to the federal government's MEDICAID programs.

The evidence from cost effectiveness studies is still unclear. The GAO deinstitutionalization report (1977) reviewed seven studies which compared institutional costs to community care costs. Five of the studies concluded that community care is less expensive than institutional care. Two others found little difference. A three-year HEW study concluded that it is cost-beneficial to the states to maintain the mentally disabled persons in the community since the burden of costs is shifted from the state to federally supported programs. In New York State, care in state institutions averages $20,000 per person per year compared to $2,500 for comprehensive community care programs (NYC DMH, 1978d:13). However, superseding the interest in cost comparison between institutional and community care, the GAO (1977:6) concluded:

> In view of Federal legislation and court decisions....the most important question appears to be how to most cost effectively serve mentally disabled persons in the least restrictive environment appropriate to their needs.

It is difficult to quantify the costs of community support programs in comparison to hospital-based programs. One study (Sharfstein & Nafziger, 1976) found that the cost of community care was 2½ times less expensive than the cost of hospital care. Weisbrod, Test, and Stein (1976) estimated the costs and benefits of a Total Community Living clinical research program

compared to a hospital-based traditional aftercare program for one year. They found the total costs per patient for both hospital and community based programs were high. In all, they point out that unless costs are defined and measured comprehensively, it is difficult to determine whether an apparent cost difference between community and institutional treatment is only a shift in costs that is still unmeasured (Sharfstein & Clark, 1978:407). Finally, Zeckhauser (1975) concluded that: "The disadvantage inherent in cost effectiveness analysis is that it leaves unresolved the final question of how much should be spent."

In general, the criteria of cost effectiveness does not directly address the issue of who benefits. Most frequently, the options are limited to the provision of traditional mental health services in a communtiy by state, federal, or private agencies. However, the difficulty of reaching appropriate policy decisions through this kind of cost-benefit analysis is increased when one considers the interests of the family of a mentally ill person, the neighbors, and the use of non-traditional community services. The variables economists are able to quantify traditionally lend themselves to decisions about whether state or federal agencies bear the costs of providing conventional community mental health services.

Community Treatment

Community treatment can be broadly defined as any treatment that takes place in the community as an alternative to hospitalization, following early discharge, or after hospitalization (Test and Stein, 1978:351). Several studies (Langsley and Kaplan, 1968; Pasamanick, Scarpitti, and Dinitz, 1967; and Rittenhouse, 1970) showed that it was possible to treat chronically mentally ill persons at home rather than in the hospital.* Other studies demonstrated that patients could be treated in non-family residential environments when the family situation was not sufficiently stable. Former patients were successfully treated in halfway houses (Rutman, 1971), crisis homes (Polak, 1978), day hospitals (Herz et al., 1971), and in separate apartments and rooms in the community (Test and Stein, 1978; Stein, Test, and Marx, 1975).

Test and Stein (1978:353) discussed several indicators for measuring the effectiveness of community alternatives relative to institutional treatment: time out of the hospital and readmission rates; psychiatric symptomatology; psychosocial functioning (role performance, employment, and social functioning); and client satisfaction. Test and Stein (1978:360) concluded, from an extensive review of the literature, that adjustment and functioning of patients treated in the community are no worse compared to patients treated in hospitals. A small number of studies (Polak, 1978; Test and Stein, 1978; Wilder, Levin, and Zweling, 1966) reported consumer satisfaction higher in community programs than in institutional treatment. Finally, those studies that involved direct,

*In all three of these studies, only patients whose families agreed to keep the patient at home and to participate in the treatment process were included.

long-term intervention in specific daily activities (i.e., housing, jobs) demonstrated definite gains in the persons' psychosocial functioning in the community as long as the treatment continued. (Fairweather et al., 1969; Test and Stein, 1978; Weinman and Kleiner, 1978).

An issue not frequently raised during discussions about the efficacy of deinstitutionalization concerns the consequences of community treatment for the community and family of the ex-patient. In a very blunt manner, Arnoff (1975:1279) remarked that:

> the potential detriment to the family members resulting from the presence of a psychotic person in their midst has not received the careful scientific scrutiny it deserves. As the traffic between home and hospital multiplies, a point may be reached when the mental health needs of the community as a whole conflict with the mental health needs of individual patients.

The argument that home or community residence of mental patients substantially disrupts family and community life makes decisions concerning social and community support for the chronically mentally ill more complex. Certainly the range of factors to be considered when evaluating the effects of community treatment must be wider than the individual patient concerned. In a holistic context, the patient, family, friends, neighbors, and related community institutions need to be included in any analysis of the impact of community treatment programs.

Community Support Systems

Previously I indicated that the urban poor, and especially the Hispanic American population, are underutilizing mental health services. Moreover, in certain mental disorders, low socioeconomic status groups

show a higher incidence than higher socioeconomic status groups. The studies of the process of deinstitutionalization indicate a failure on the part of federal, state, and local programs to direct their efforts toward strengthening social and community supports for the chronically mentally ill. In this section, I focus on the nature and utility of these social supports in the form of community, kinship, and non-kinship social networks. A considerable amount of literature on social networks now exists. Much less information is available relating to urban Puerto Rican or Hispanic populations. We will have to rely on the social networks studies of non-Hispanic communities to provide a general basis for policy analysis.

My analysis of social and community supports centers on the concept of social network. A social network can be simply defined as "a specified set of links among social actors" (Fischer et al., 1977:33). Kapferer (1969:182) defined an individual network as: "the direct links radiating from a particular Ego to other individuals, and the links which connect those individuals who are directly tied to Ego, to one another." The network, as a particular unit of analysis based on role and exchange theory, links individual and societal models of social life. The President's Commission on Mental Health (1978d:152-53) summarized the main functions other researchers attributed to social networks as the following:

--maintenance of social identity
--provision of emotional support
--provision of mutual aid and services
--access of information
--access to new social contacts and social roles.

While social networks provide these supports, they also create demands on individuals within these networks for time, instrumental and emotional support of others.

The Family

There is very little empirical research on the organization of the Puerto Rican family on the mainland, although a major study is underway in New York City (Rogler, 1978).

Studies of Puerto Rican culture suggest a strong sense of traditionalism and belief in the family (Fitzpatrick, 1971). An important role is attributed to the Puerto Rican family in easing the transition from agrarian to industrial society (Tumin & Feldman, 1961). The traditional fictive kinship system of compadrazgo (godparent relationships) expands the social support network of the Puerto Rican family (Mintz, 1955). Despite the rapid social change occurring in Puerto Rican society, Rogler (1978:250) maintains that the family plays a stronger role in the functioning of Puerto Rican Society than it does in the U.S..

In the mid-1960's, Rogler and Hollingshead (1965) studied poor urban Puerto Rican families living in the shantytown and public housing projects in San Juan. They investigated how families coped with problems associated with schizophrenia when either the husband or wife or both suffered from this disorder. These families were not linked to any professional mental health care. Rogler and Hollingshead found that sex roles of the spouses intervened between the illness and its impact on the family. When both spouses or the wife alone experienced schizophrenic conditions, the nuclear family experienced serious disorganization. How-

ever, when only the husband was schizophrenic, the wife organized the family's resources to cope with the illness. The wife accepted the role of economic provider for the family in addition to providing emotional support for the husband. The Rogler and Hollingshead study also demonstrated how nuclear families are tied into the extended family network. According to Rogler (1978:249): "Mutual help, in fact, has the force of a sacred, obligatory norm: it is sustained by the double edge of guilt and gratitude." Moreover, kinship assistance is probably sustained by the rational choice of individuals who realize their dependency on the extended family networks for their own welfare. This study in San Juan found that 88 percent of the nuclear families were either giving or receiving material goods from ties with relatives. Again, the nature of help provided was sex-linked. While the women exchanged family centered social and emotional support, the men acted in instrumental roles linking the families to external, formal institutions, i.e., job market, welfare organizations.

Social change in Puerto Rico may be weakening the traditional mutual assistance bonds within family networks and among friends and neighbors (Steward et al., 1956; Rogler, 1967). It is unclear to what extent Puerto Rican families in New York City have moved away from the present family structure in Puerto Rico. There are sharp differences in terms of the strengths of family supports between first and second generation Puerto Rican women on the mainland. Second generation women are much more likely to develop dependencies on the formal public welfare system than women who migrated to the U.S. as adults (Personal communication with a representative of the Puerto Rican Family Institute, Fall, 1978).

For the non-Puerto Rican population, kinship and friendship networks have been studied as sources of aid to individuals and their nuclear families (Litwak and Szelenyi, 1969; Bott, 1957). Litwak and Szelenyi (1969), for one, show that kin provide long-term assistance, friends generate the affective relationships, and neighbors offer help in short-term emergency situations. For the most part, each type of relationship provides a different kind of service.

Few studies link psychiatric help-seeking to the structure of kinship and friendship networks. A recent study of 120 outpatient and short-term inpatients at a New Haven CMHC (Horowitz, 1978) does investigate the responses of social networks to mental illness. Horowitz's sample included working and middle-class married whites. The study categorizes husband-wife relationships as uninvolved, mutual conflict, and separate. Excluding the "separated" group, Horowitz (1978:299) found that only 21 percent of the persons currently living with their spouses received affective support from them. In all, Horowitz (1978:299) concluded that: "spouses are far more commonly hostile than a source of positive support to patients." This New Haven study found that help-seeking is mainly a female phenomenon. Men seek assistance from an average of one person outside their nuclear family while women mobilize more than four individuals searching for assistance. Horowitz's study (1978:300) encountered a definite link between the type of marital relationship and the nature of informal help-seeking. As one might expect, in the mutual reciprocal relationship, patients receive active support from spouses and have lower rates of utilization of kin and friends (some 60 percent seek help from kin and 50 percent from friends). In the other marital relationships

where there is substantial conflict, these individuals are the most active help-seekers (92 percent turn to kin and 73 percent to friends). So, the degree of supportiveness of nuclear family interactions is inversely related to help-seeking from friendship networks.

Non-Kin Social Networks

Non-kin networks as social supports are now receiving wider attention by policy analysts as resources to strengthen families or to act as alternatives to institutional placement for reintegrating chronic schizophrenics into communities. Garrison (1978) studied the non-kin support systems for first generation migrant Puerto Rican women in the South Bronx borough of New York City. In this analysis, supportive relationships are defined as those that provide either instrumental (e.g., financial assistance, help with household tasks, child care, etc.) or affective help (seeking advice and emotional nurturance in times of crisis).

Garrison drew a sample of 29 nonschizophrenic and 26 schizophrenic women from a local neighborhood, the Lincoln Hospital Mental Health Service outpatient clinic, a spiritist center, and the Tremont Crisis Center (Bronx Psychiatric Center). Garrison located seven basic patterns of social support associated with different types of nuclear family organization. The schizophrenic women who successfully adapted to their neighborhoods showed greater dependence upon neighbors, kin, and other non-kin groups than upon their families. These non-kin groups included neighbors, friends, Pentecostal groups, Jehovah's Witnesses, block organizations and political organizations, quasi-groups or action sets, self-help and spiritist groups. Generally, the process of social withdrawal for schizophrenics takes place progressively, beginning with more

peripheral social contacts, then personal but not intimate relationships; finally the disturbed individual withdraws even from immediate nuclear family relationships. Garrison observed that social withdrawal for schizophrenic Puerto Rican women occurred in a reverse order from a disintegration of conjugal bonds first, followed by weakening of the less personal relationships. Garrison concluded the following:

> Instead of looking to the family to find support for chronic schizophrenic patients in relationships that frequently have not been supportive in the past, the clinician might seek to halt or reverse the process of withdrawal by emphasizing, reinforcing, or supplying transient non-kin support relationships, involvement in voluntary associations of non-kin within the natural community that are tolerant and accepting of schizophrenic persons, and development of future kinship relationships with agencies.

Eventually these non-kin relationships may act to restore more functional kinship relations.

Patterns of informal mutual aid extend beyond the kinship groups to include neighbors, friends, and acquaintances. Horowitz's study of the social networks of clients of a New Haven CMHC showed that, excluding the nuclear family, persons are more likely to approach friends for help than kin or other kinds of networks members. When parents and siblings are available they are about as common a source of help as friends (Horowitz, 1978:301). It is apparently the physical isolation of individuals from their kin, not choice, which explains the importance of friends providing greater amounts of aid.

Several studies have shown that kin, friends, and neighbors provide specialized kinds of help (Adams, 1967; Litwak and Szelenyi, 1969). Generally, all members of a social network provide advice to help-seekers. However, in-kind services are usually exchanged among kin. Horowitz

found that concrete services (money, childcare, housing, etc.) unlike advice, are not interchangeable. When kin are not available to provide these services, they are not provided by friends (1978:302). Finally, friends are more likely than kin to suggest referrals to mental health agencies for assistance. Non-kin members of social networks are mobilized for emergencies and for obtaining resources not available to the kin network.

Other studies of urban families indicate more generalized exchange relationships (Stack, 1974). Carol Stack's detailed analysis of kinship and friendship networks within a poor urban black community expresses the importance for survival of sharing goods among local networks of "personal kindreds." Stack found stable domestic networks of cooperating kinsmen within the poorest black communities. These friends who became involved in reciprocal generalized gift exchanges are defined as kin, similar to the Hispanic ritual coparent concept of compadrazgo. Ruby Banks, one of Stack's close informants put the nature of gift exchange this way: "You ain't really giving nothing away because everything that goes round comes round in my book" (1974:42).

The "extended psychosocial kinship system" (Pattison, et al., 1975) is another concept suggested as a basic social support for the chronically mentally ill when the individual's family is not intact. The concept actually refers more to a network of neighbors and friends than to a person's kin. Nevertheless, the psychosocial network provides affective and instrumental supports. Pattison and others (Budson & Jolley, 1978: 610) argue that normal, healthy people maintain 20 to 30 people in an intimate psychosocial network, including five to six persons in each of

the following groups: family, relatives, friends neighbors, co-workers or social contacts. Neurotic individuals have 10-12 people in their networks, and psychotics even fewer. The goal of community support programs is to repopulate the weak psychosocial networks with individuals holding resources valuable for reconnecting the mentally disabled person to the neighborhood.

Budson and Jolley (1978:611) concluded that common to all successful community programs is the psychosocial kinship system that was either introduced when it was absent after a long period of hospitalization (Budson, Grob and Singer, 1977), supported when it was weak (Polak and Kerby, 1976), or reinvigorated when a person arrived with an intact but weak network (Stein, Test & Marx, 1975). In all, the non-kin social network appears as a strong, useful image in the literature on social and community supports for the chronically mentally ill.

Espiritistas

In San Juan, Puerto Rico, Rogler and Hollingshead's studies (1961, 1965) of schizophrenic families found the institution of spiritualism to be the most common form of help sought outside the family when individuals experience emotional stress and mental illness. Studies of folk healers in Puerto Rican communities in the U.S. showed spiritists to be a main community resource in the health, mental health, and welfare system (Garrison, 1977a, 1977b, 1979a, 1979b; Thomas and Garrison, 1975; Harwood, 1977, Koss, 1977). There is an informal referral network among emergency services, medical clinics, spiritists, and mental health professions that often bypasses the psychiatric services except for the most severe mental disorders.

In Thomas and Garrison's work with Hispanics in New York City (1975:292) almost half (24) of the 50 spiritist clients interviewed visited physicians, without successful treatment, before contacting the spiritists. Some 20 of the 50 respondents claimed to go to doctors with somatic complaints they considered "material" and take other somatic problems they define as "spiritual" in origin to the spiritists. Almost all of the 34 consecutive Hispanic admissions to an outpatient clinic in the same neighborhood had been to spiritists concerning the same problems. In this latter group some 75 percent held beliefs in "spiritual causation" of the psychiatric difficulties. Half of the persons interviewed finally arrived at the mental health clinic after failing to locate a spiritist that could help. One-third continued to visit spiritists while attending the clinic. Comparing spiritists and psychiatrists, Garrison (1977d:441) concluded:

> that the two types of healers (the folk and the professional) interpret the same feelings and behaviors in similar ways, that they have similar treatment goals and, to some extent, similar treatment techniques; but they talk about what they see and do within very different systems of conceptualization of the self and world. The conceptual systems are, in fact, diametrically opposed in that the locus of the illness is inside the self in one system and outside the self in the other.

Garrison interprets these different systems of interpretation of the self and world as reflections of different cultures (Puerto Ricans vs. Anglo-American) and socioeconomic status (lower class vs. upper-middle class). Professional mental health workers now recognize that spiritists are an important group that provides services for Hispanic clients not available through the community mental health centers and other formal institutions.

A Sense of Community--Does it Matter?

How does the concept of community fit with the Federally defined geographical "catchment areas" with 75,000 to 200,000 inhabitants? Smith and Hobbs (1966:9), concerned with the issue of community and community mental health centers, make the point that "the community is not just a catchment area from which patients are drawn; the task of a community mental health center goes far beyond that of purveying professional services to disordered people on a local basis." Yet how the policy maker perceives a sense of community influences the kinds of policies established to foster social and community support programs.

Essentially, community studies tend to divide into three main perspectives: one view concludes that we have lost our sense of community; a second view maintains that neighborhood kinship ties continue to thrive in modern society; and a third view considers the value of social networks not related to local geographical origins (Wellman, 1979). According to the decline-of-community perspective, primary relations are now "impersonal, transitory, and segmented" (Wirth, 1938:12). Urban residents are not considered as members of a single, closely-knit community but as participants in multiple, sparsely knit and weakly bounded social networks. The loose, disorganized social ties of urban dwellers provide few help-giving services for individuals experiencing mental disorders. Services are thought to be delivered only through secondary affiliation and formal institutions. Basically, this perspective assumes that strong primary ties occur only in densely knit, self-contained solidarities that are no longer present in industrial-bureaucratic society.

The second view finds that communal solidarities have continued to exist in industrial-urban society because of their usefulness in providing social support, meeting basic human needs and exerting fundamental social control in populations (Gans, 1962; Jacobs, 1961; Keller, 1968; Suttles, 1972). While recognizing that the division of labor in urban society produces membership in more narrowly-based social networks, the continuity-of-community argument holds that these networks develop solidary features. Urbanites are, in fact, urban villagers (Gans, 1962). Neighborhood and local friendship networks provide important supports mediating between the family and formal bureaucratic structures (Young & Wilmott, 1957; Gans, 1962; Liebow, 1967; Stack, 1974). Numerous field studies show the maintenance of strong urban primary ties even with the advance of industrial-bureaucratic society. During the early 1960's, the continuity-of-community perspective became the new orthodoxy.

Followers of the continuity-of-community perspective of urban social organization focused their research on the persistence of communal solidarities in kinship systems and in neighborhoods. Generally, these ties were not considered within an overall view of social networks. More recently, community studies have focused on the external linkages of communities and the extension of primary social networks outside the local neighborhood (Suttles, 1972; Fischer, 1977; Wellman, 1979). Suttles (1972:13) argued that communities and neighborhoods acquire a corporate identity because they are held jointly responsible for certain issues by external organizations. According to Suttles (1972:46), "There is no unique urban community, but instead a pyramid of residential collectivities

which receive their recognition by common consent and whose expansion depends on the expansion of a hierarchy external to the community itself."

The newer, third perspective of community recognizes the importance of primary ties but asserts that these ties are no longer structured by densely knit and tightly bounded solidarities (Wellman, 1979). These "communities of limited liability" (Janowitz, 1952) result from: a separation of residence, workplace and kinship groups; high rates of residential mobility; inexpensive, effective means of communication and transportation making it easier to maintain dispersed primary ties; and the heterogeneity ofurban populations. This view of the "liberated" community abandons the use of the local area for investigating community structure, focusing directly on the structure of primary ties (Wellman, 1979:1207). Primary ties are now seen as forming sparsely knit,* spatially dispersed structures instead of densely organized solidarities (Granovetter, 1973; Fischer, 1977; Laumann, 1973; Wellman, 1979). Instead of the institutionally complete (Breton, 1964) networks or the self-contained urban village structure, primary ties are seen as dispersed among multiple, weakly connected social networks. Primary relationships are organized as differentiated networks, not as solidarities. Wellman's (1979) study of a Toronto neighborhood found that even kinship obligations function as dyadic relationships instead of densely-knit networks.

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*Whether neighborhood friends are considered more intimate than those living outside the neighborhood varies by class (Fischer, 1977:171). Low income respondents in a Detroit survey considered their neighborhood friends more intimate than those friends living outside the neighborhood.

Weakly-knit but extensive primary networks provide a wide range of direct and indirect ties to dispersed and differentiated resources in modern urban society. Obtaining resources through these new social networks is no longer dependent on moral obligations of the natural community but on the quality of dyadic ties, ease of maintaining contacts, and the ability of members to provide indirect connections to additional resources (Wellman, 1979; Boissevain, 1974; Boissevain & Mitchell, 1973). While tending to create less locally focused, communal solidarity, these differentiated social networks provide bases for access to a wider variety of services than the closed, dense network cluster identified with the traditional sense of community.

Current neighborhood and community supports for mental health programs still rely on the traditional sense of neighborhood. Studies (e.g., Naparstek, 1978) interpret community supports as local, neighborhood-based programs where neighborhoods enclose the social networks that help individuals cope with their problems. However, the more recent findings from the perspective of a liberated community suggest that policies should focus more on supporting differentiated social networks instead of just locally based solidary networks inside neighborhoods. Neighborhood cohesion will develop when residents discover social relations in their localities more rewarding than contacts outside the neighborhoods.

The recent resurgence of neighborhood associations deals with problems that residents feel city, state, federal governments do not handle well. Some neighborhoods have been forced to concern themselves with the problems of deinstitutionalization as a community issue when former

state hospital patients were channeled into their areas. Other neighborhoods prefer to exclude community mental health issues as high priority topics until city agencies target their neighborhoods to receive former patients.

Housing

The issue of housing for the mentally ill has gained importance recently in federal, state, and city policies. Federal court decisions have ruled that the mentally ill have a constitutional right to live in the least restrictive, most appropriate environment. The General Accounting Office (GAO, 1977) reported that a major barrier to adequate community placement for patients leaving the state hospitals is the unavailability of decent, affordable housing. Most recently the President's Commission on Mental Health (1978a) stressed the importance of living arrangements for the chronically mentally ill in their own communities. The New York Office of Mental Health has declared community residences a top priority issue. At the city level, the Department of Mental Health, Mental Retardation, and Alcoholism Services has increased the importance of community residences among its Community Social Supports goals.

I could not locate studies focusing on the experiences of Puerto Ricans or other Hispanic American groups in housing programs. The State of New York does not break down by ethnic categories its follow-up of ex-patients in community residence programs. Even city programs targeted specifically for single residence occupancy (SRO's) hotels have not analyzed findings according to ethnicity.

While in New York State the majority (54 percent) of patients coming out of mental institutions return to their families, there is a substantial number of individuals who do not return to families or relatives (Carpenter, 1978:385). Different types of transitional residences have developed to meet the housing needs of individuals unable to live with their families: foster care homes, halfway houses, post-halfway houses, satellite housing programs, and cooperative apartments and hostels (see Carpenter, 1978 for a review of the literature on housing for the mentally ill).

There is a diversity of housing programs. The main differences can be accounted for by their acceptance of the medical model of drug therapy, independence from the CMHC's or other mental health institutions, permanence of residence, amount of professional staffing, and number of residents (Carpenter, 1978). More structured programs like the halfway houses provide services to strengthen the social and kin networks of residents. In many cases small groups of halfway house residents leave the halfway house together to locate apartments on their own (Fairweather et al., 1969). These groups give patients the additional support which might not be available if they were on their own (Bowen & Fry, 1971).

Other research suggests that transitional residences need to be closely linked to comprehensive vocational rehabilitation services (Wilder, Kessel & Caulfield, 1968). For example, the staffer at El Camino House in California found that immediate placement of chronic patients in vocational rehabilitation programs was more useful for their adaptation to the neighborhood than social skills programs which delayed their leaving (Richmond, 1969-70). However, all chronic patients cannot manage quick

entry into the labor force or even vocational rehabilitation programs. Recognizing the difficulty of vocational placement for the chronically ill, the Fountain House in New York City established over the past 30 years a transitional employment program where members work in some 44 businesses in the metropolitan area (Beard, 1976). Jobs are rotated among members every four to six months. If necessary a series of transitional jobs can be arranged. Evidence as far back as the centuries old housing and work arrangements of Geel, Belgium, supports the need to closely tie together the community residence programs with work experiences.

The recent focus on housing for the mentally ill raises other issues concerning the acceptability to neighborhood residents of group homes or other types of residence. For the success of community residence programs, mental health agencies must extend their concerns beyond the location of suitable residences to the problems encountered in gaining neighborhood acceptance of these programs and integration into community life. These new issues have not been studied systematically. A major problem from the local residents' perspective concerns the stability of the neighborhood affected by changes in zoning ordinances, change in property values, and the introduction of atypical home living arrangements. Other residents are offended by the intrusion of the state into what they define as a local planning issue. So, proposals for the development of community residences for the mentally ill, while gaining recognition as instrumental for the success of the deinstitutionalization policy, have raised the complex issue of community acceptance and support for these programs.

Summary

An assessment of the available knowledge concerning Puerto Rican and other Hispanic American mental health community support programs for the chronically ill shows considerable room for research in this area. The existing studies point out methodological problems and gaps in current information.

There is a demonstrated need for improvements in the delivery of mental health services to the large Hispanic American population in the United States. Moreover, the value of social and community supports is evident. However, the available information suggests that the domain of social and community supports for the chronically mentally ill is not as policy responsive as policy analysts would like it to be. Social and community networks are less manipulative and more resilient to change than many public agencies expect. Still, the delivery of mental health services to Hispanic Americans can be improved. Particularly for ethnic minorities, social and community supports can significantly contribute to this improvement.

Epidemiological studies clearly show the precarious physical living conditions of the Puerto Rican population in New York City. Yet, it has not been shown that Puerto Ricans experience higher incidences of mental illness than other populations. High rates of symptoms among Puerto Ricans cannot be understood as meaning high rates of psychological disorder. These symptoms may be due to cultural differences. The inverse relationship between certain forms of mental illness (schizophrenia and organic brain disorders) and socioeconomic status holds for the general

population. Various explanations for the higher rate of mental illness within the lower class included: physical conditions, socioeconomic stress, social selection, and labeling. However, these relationships may be confounded by ethnicity. The data emphasize that the recognition of mental illness is mostly a social process (Holtzman, 1979).

In the improvement of epidemiological studies, agencies must standardize a definition of the Hispanic or Puerto Rican category. While some public agencies define Puerto Rican as those persons of Puerto Rican parentage, others include only those born in Puerto Rico.* The U.S. Census Bureau defines as Puerto Rican those persons born in Puerto Rico and of Puerto Rican parentage. Other agencies use only "Spanish-Surnamed" or "Spanish-Speaking" categories. Third generation and subsequent generations who identify themselves as Puerto Rican are not included in the federal or state definitions for Hispanic groups. In short, changing categorizations of ethnicity further complicates the collection of health statistics.

Most studies indicate that Hispanic populations are underrepresented in the utilization of health facilities. Hispanics experience problems of access, lack of mental health information of available services, institutional "hostility," and other difficulties with formal community mental health services. The available information does not include longitudinal studies of user rates by ethnic minority status for the

*Alers (1978:1) found the New York City Health Department uses each of the above definitions for different kinds of statistical information.

community mental health centers. Representative sampling and time-series studies are necessary to more carefully investigate the utilization of public and private mental health services by Hispanic populations.

The concept of social networks as developed recently by anthropologists and sociologists provides a useful framework for analyzing social and community supports for the chronically mentally ill. Certainly the relationships among the structures of nuclear families, extended families, friendship and neighborhood networks are complex and need further study, particularly among Hispanics. Detailed social network studies of Puerto Rican families and social networks similar to Carol Stack's work with poor urban blacks are needed. The available information does suggest that differentiated, widespread social networks are vital for individuals to cope with the contingencies of urban life. Federal, state, or city funds cannot by themselves improve weak social networks. Further work is needed to indicate exactly what resources that strengthen social networks can be supported by public policy.

Because of the absence of longitudinal analysis and difficulties of quantifying exchanges in social network relationships, policy intervention is problematic. Healthy individuals are associated with complete social networks; individuals experiencing mental disorders are associated with sparsely populated, weak networks. However, available studies do not clearly support the argument that strong social networks will cause significant improvement in persons already mentally ill. Further investigations are necessary to establish these causal connections.

Finally, recent community studies suggest that strong social networks need not be physically limited by local neighborhoods. Community supports have previously attracted attention to more narrowly defined social structures located within neighborhoods. Although neighborhood supports are important, especially for the poor and minority groups, their social networks should not be limited to these local environments. Total dependency upon local social supports in areas of New York City, like the South Bronx, would severely hamper the usefulness of residents' social networks. A sense of community need not be constricted by traditional neighborhood units but, instead, can include the differentiated social networks extending beyond these limits to include external sources of support. Federal grants alone will not reconstruct a sense of community. Community studies must determine what resources are needed to do so and which of these are policy responsive.

CHAPTER III

CURRENT POLICIES FOR SOCIAL AND COMMUNITY SUPPORT PROGRAMS

In this chapter I review the existing policies related to social and community support for the chronically mentally ill in urban areas. The discussion includes federal, state, and local policies. I also discuss the federal judicial decisions that have influenced mental health policies concerning social and community supports.

Federal Policies

According to a recent GAO report (1977:5) there are at least 135 federal programs, managed by eleven major departments or agencies, that have a direct or indirect impact on the mentally disabled. The Department of Health, Education, and Welfare alone operates some 89 programs. The federal programs and agencies particularly related to social and community supports include the following: Community Mental Health Centers Act of 1963, Community Mental Health Centers Amendments of 1975, the proposed Mental Health Systems Act, Medicaid, Medicare, Supplemental Security Income Program, Department of Labor, Vocational Rehabilitation, Department of Housing and Urban Development, and the NIMH Community Support Program.

Community Mental Health Center Legislation

As a result of broad national discontent with the state mental hospital systems, the Joint Commission on Mental Illness and Health was established by Congress under the Mental Health Study Act of 1955. Although the Joint Commission did not propose the community mental health center concept, it carefully documented the need to abandon the large state mental hospital program and to treat the mentally ill in their own

communities. In response to the Joint Commission's study, NIMH's director Robert Felix proposed the concept of the community mental health center.

In February, 1963, in a special message to Congress, President Kennedy proposed the idea of a national system of community mental health centers.* Kennedy's proposal became the Community Mental Health Centers Act of 1963. Each federally funded community mental health center is required to provide at least five essential services: (1) inpatient care for persons needing intensive or full-time care; (2) outpatient care for the entire population in their catchment area; (3) partial hospitalization for those needing day or night care but able to function the rest of the time in the neighborhood; (4) emergency care for a 24-hour basis by one of the above three services; (5) consultation and education for community groups, professional and non-professional. The CMHC's are organized around the traditional medical model of inpatient/outpatient services. However, the consultation and public education services extend the scope of the CMHC beyond the clinical setting to the organization of neighborhood groups and institutions. The consultation and public education services provide the opportunity for CMHC's to support existing social networks and neighborhood organizations which strengthen individual and family resources.

The newer Community Mental Health Centers Amendments of 1975 (42 USC 2689) mandated CMHC's to provide the following services: (1) inpatient/outpatient services and day care/partial hospitalization;

*For an analysis of the politics of the process resulting in the Community Mental Health Centers Act, see Bloom (1977), Foley (1975), and Reichenbach (1978).

(2) specialized services for children; (3) specialized services for the elderly; (4) consultation and education services; (5) assistance to courts and public agencies in referral of clients to state mental health facilities; (6) follow-up care for residents of catchment area released from mental health facilities; (7) transitional halfway house services; (8) alcoholism and drug abuse programs.

A GAO (1974:67) report that reviewed the policies of the CMHC's found that CMHC's had increased the accessibility, quantity, type of community services available and the responsiveness of mental health services to individual needs. The same study also indicated that CMHC's had not been fully effective in the prevention of unnecessary admissions to public mental hospitals, the provision of treatment and care of individuals released from these institutions, or the development of a coordinated system of care for the mentally ill. The GAO (1974:67) concluded:

> It appears that, in some cases, psychotropic drugs and other Federal programs, such as Medicare and other public assistance programs, have had more of a direct impact on the reduction of mental hospitals than the CMHC program.

Recognizing the need for improvements in community mental health center practices, Congress passed two pieces of legislation: the Special Health Revenue Sharing Act of 1975 and the Community Mental Health Centers Amendments of 1975 (Public Law 94-63). The Special Health Revenue Sharing Act works to eliminate inappropriate placement of the mentally ill in institutions and to insure the availability of the right noninstitutional services for these individuals. The legislation assists the courts and other public and private agencies in the provision of follow-up care by CMHC's for persons released from state hospitals. The Act

provides that at least 15 percent of each state's allotment for comprehensive public health services be used only for mental health services and that at least 70 percent of these funds be provided for community services. During 1975 fiscal year, $90 million was appropriated for comprehensive public health services. At least $13.5 million was to be allocated to mental health programs and $9.5 for community-based mental health services.

The 1975 Community Mental Health Amendments Act added four new required services for CMHC's: (1) assistance to courts and other public agencies in screening whether residents of the center's catchment area should be referred to a state mental hospital or to treatment at the CMHC facilities; (2) provision of follow-up care for residents of the centers catchment area who have been discharged from mental institutions; (3) a program of transitional halfway houses for the mentally ill residents of their catchment area; (4) provision of governing boards of the CMHC. The governing boards are intended to represent residents of the center's catchment area, reflect the demographic characteristics of the area, meet regularly to set general policies for the CMHC, and assure that at least one-half of its members are not professional health providers. However, with the Community Mental Health Centers Extension Act of 1978, (42 USC 2689) CMHC's operated by hospitals or government agencies gained a loophole to community control efforts. Advisory boards might be substituted for governing boards.

By July, 1975, NIMH allocated construction and staffing grants of $1.2 billion to 603 CMHC's serving 41% of the U.S. population (GAO, 1977: 68). Construction grants included up to 66% of the costs in nonpoverty

areas and up to 90% in poverty areas. Staffing grants are awarded on a declining basis over an eight-year period. They range from 30-75% in nonpoverty areas to 70-90% in poverty areas (GAO, 1977:68).

Despite the formal goals of CMHC legislation only minor attention has been paid to community support systems. The weakest links in the CMHC system are between the centers and the surrounding community. A review of CMHC activities suggests that the consultation and education services for community groups has been one of the least active services. Federal support has remained focused on the more traditional professional services delivered within a community context.

Community Mental Health Systems Act

Currently, the Carter administration supports legislation aimed at the development of a comprehensive national mental health policy.

The administration's draft of the Community Mental Health Systems Act includes the following objectives: the more effective use of federal, state, local, and private mental health and human resources through improved State management; the development of community-based services for special populations including children and youth, the aged, the chronically mentally ill, racial and ethnic minorities, the poor, and rural groups; the minimization of unnecessary institutionalization and assurance of long-term residential care in the least restrictive environment; the integration of general health and mental health services; renewed emphasis on preventive programs; and the encouragement of mental health professionals to work in the unserved and underserved areas.

This legislation, in response to the President's Commission on Mental Health, strongly backs the concept of community support systems. Core service agencies are to be funded for the development of social support systems within their communities. Funding for the community based mental health services will be provided through several new categories of awards for: the assessment of community needs and operational plans; initiation awards to target populations (i.e., ethnic minorities, children and youth, etc.); flexible plans to include services as the neighborhoods need them until finally reaching a comprehensive mental health service system for the entire population; the linkage of mental health services to primary health care facilities; and continued support for the nonrevenue-producing services of CMHC's whose development grants have ended.

Medicaid

Medicaid is the most important federally supported program influencing the process of deinstitutionalization.* The Medicaid program has contributed to the welfare of the mentally ill by the imposition of minimum requirements on the quality of institutional care in mental hospitals, nursing, and intermediate care facilities. However, without

*Medicare and Medicaid are regarded as two of the most important pieces of social welfare legislation since the New Deal. "Medicare provided for insurance to cover hospital and related care for persons aged 65 and over. The program was to be administered by the federal government and financed by an addition to the mandatory employer-employee contributory payroll tax that already financed retirement pensions. Title XIX-Medicaid-provided federal grants to match state programs of hospital and medical services for welfare recipients and the medically indigent." (National Association of Social Workers, 1977:527).

available alternative community placement, Medicaid funding for nursing homes has contributed to the tremendous growth of nursing home facilities. Moreover, nursing homes often cannot provide for the special needs of the mentally ill (GAO, 1977:85).

Day care services for the mentally disabled are not available or available only to a very limited extent under Medicaid. Coverage of outpatient services in mental health clinics is also quite limited.

Home health care, usually for physical disabilities, comes under Medicaid and Medicare coverage. However, the mentally ill not confined to their homes are not entitled to home health services.

Federal legislation and HEW regulations prohibit the use of Medicaid funds for those under 65 in mental hospitals, except for individuals under 21 years in accredited psychiatric facilities. The mentally ill under 65 living in halfway houses would not be entitled to Medicaid reimbursements according to HEW regulations. The same persons living in nursing homes would qualify for Medicaid.

Medicaid expenditures for mental health services for 1977 are shown in Table 2. Nursing homes received over 53 percent of the Medicaid budget compared to 2.4 percent for community mental health centers. In 1974 Medicaid contributed nationally about 60 percent of the cost of nursing homes. Medicare paid some seven percent of the bill (National Association of Social Workers, 1977:1011). Federal funding through Medicaid makes nursing homes the primary destination of patients leaving public mental institutions.

Table 2

Medicaid Expenditures for Mental Health Services[a]

FY 1977

Type of Care or Service	Estimated Expenditures (millions of dollars)	Percentage
State, County and Private Mental Institutions and Psychiatric Hospitals	$ 558	13.6
General Hospital, Inpatient, Outpatient and Emergency Care, Related to Mental Health	$ 185	4.5
Community Mental Health Centers	$ 100	2.4
Private Free-Standing Clinics	$ 25	0.6
Physicians and other Practitioners	$ 82	2.0
Nursing Homes	$2,189	53.5
ICF/MRs	$ 702	17.2
Residential Treatment Facilities, Rehabilitation and Children's Programs	$ 110	2.2
Drugs	$ 110	2.2
TOTAL	$4,091	100.0%

[a]Estimates include direct costs to Medicaid for mental illness and retardation. Source: President's Commission on Mental Health, 1978, Vol. II, p. 520.

Medicare

Medicare is a federal health insurance program available for the aged, individuals entitled to Social Security Disability Insurance for at least 24 consecutive months, and for a few others. Medicare coverage of outpatient mental health care is limited to one-half the cost or $250/yr., whichever is less. The dollar limit has not increased since 1965. NIMH recognizes that these limitations on outpatient coverage are contrary to their deinstitutionalization policies (GAO, 1977:119). Medicare provides limited inpatient care in state mental hospitals (190 days for life) and more extensive coverage in general hospitals. Medicare also provides funds to nursing homes that are licensed as extended care facilities. Funds are limited for post-hospital care for specific periods of time (National Association of Social Workers, 1977:1011).

Supplemental Security Income Program

Administered by the Social Security Administration, the Supplemental Security Income Program (SSI) provides a uniform national minimum cash income for the aged, blind, and disabled. Under this program, individuals could receive up to $167.80 a month in July, 1976. A large number of mentally disabled persons who have been placed in substandard facilities or have not been provided necessary services have been receiving SSI payments (GAO, 1977:125). A 1975 HEW study found that 75 percent of the individuals in residential care facilities in six of seven states had not received rehabilitative services (GAO, 1977:125). Except for alcoholics, drug addicts, and disabled recipients, federal policies do not demand that SSI clients have treatment plans or specified services.

According to a GAO (1977:126) report, operators of nursing homes have abused SSI benefits by crowding individuals into substandard facilities to increase their profits.

The Social Security Act prohibits payments of SSI to persons in public institutions. In November, 1975, 47 percent of the 603 CMHC's were publicly sponsored. Residents of these sheltered homes, halfway houses or hotels could not receive SSI funds. Similarly, residents of housing programs run by state or local governments were not eligible for SSI payments. The GAO report (1977:128) concluded that:

> by authorizing Medicaid reimbursements for the care of persons in large publicly run institutions and in nursing homes, but not in smaller, publicly run community-based facilities like group homes or hotels under SSI, the Federal government is providing financial disincentives to care in least restrictive environments.

SSI payments to persons are reduced when support is provided by public agencies. To maximize federal funding sources, these reductions encourage states to place individuals in private nursing homes or intermediate care facilities.

More recently, changes in the federal law have favored publicly-run facilities. The Unemployment Compensation Amendment of 1976 (PL94-566) excludes publicly operated community residences for 16 or less from the definition of public institutions (GAO, 1977:132). Consequently, residents are now eligible for SSI payments. Other new legislation provides that state and local government subsidies to SSI recipients will not reduce their SSI benefits.

Department of Labor and Vocational Rehabilitation

Local opportunities for work offer strong community supports for the mentally ill. With the new Rehabilitation Act of 1973, vocational

rehabilitation programs are required for the chronically mentally ill. Previously, programs focused on individuals only slightly disadvantaged. However, the Rehabilitation Services Administration has not focused clearly on deinstitutionalization as a main goal of its programs (GAO, 1977: 152). Vocational rehabilitation for the chronically mentally ill has not been a high priority interest of states.

A 1975 HEW report showed that nationally there are more than 3,000 sheltered workshops. The Department of Labor allows 2,700 to pay less than minimum Federal wages. The programs serve 410,000 clients yearly, of which 72 percent are mentally disabled (53 percent mentally retarded and 19 percent mentally ill) (GAO, 1977:166). The workshops are successful in reducing the number and severity of problems of the mentally disabled. However, their achievements have been limited insofar as placing clients in competitive, long-term employment in the neighborhood. In the past, workshops placed only 10 percent of their clients yearly in competitive employment, usually low-paying, service jobs.

Section 503 of the amended Rehabilitation Act of 1973 and Department of Labor regulations requires Federal contractors with more than $2,500 work to take affirmative action to employ handicapped persons. Yet, the Labor Department has conducted little monitoring of the implementation of this regulation (GAO, 1977:169).

The Comprehensive Employment and Training Act (CETA) requires programs for the mentally disabled. However, there has been little Federal effort to systematically utilize CETA programs for supporting the process of deinstitutionalization.

Department of Housing and Urban Development

Housing is a critical element in any program intended to foster social and community supports for the mentally ill. Although HUD officials agree that the Department's programs could be used to further Federal deinstitutionalization programs, HUD has not developed strong policies for housing the mentally disabled. Still, there are some efforts to serve the mentally ill's housing needs in HUD's more recent programs.

The Housing and Community Development Act of 1974 changed the definition of handicapped to include non-physical impairments and specifically included the developmentally disabled in the new definition. Moreover, in Section 8 of the 1974 Act, the Federal government supports the New York City Housing Authority to "make monthly payments to a landlord on behalf of an eligible tenant that will constitute the difference between the rent that the tenant can afford to pay for the apartment....and the full rent for the apartment." (New York City Housing Authority, 1979). These rent subsidies are important for helping low-income households to obtain affordable apartments.

In January, 1976, HUD amended its community development grant program to exclude group homes, halfway houses, sheltered workshops and central social service facilities from funding under that program. However, in August, 1976, the Housing Authorization Act of 1976 added centers for the handicapped as facilities included in the Community Development Program. Moreover, under this act (PL 94-375), the value of housing assistance provided by HUD may not be counted as income for the determination of eligibility for SSI.

HUD's Urban Homesteading Division focuses on community supports of potential use for housing mentally ill persons. In an attempt to revitalize or stabilize neighborhoods, HUD transfers the title of houses abandoned or foreclosed to the municipality. The city leases the dwelling to a homesteader for a nominal fee (i.e., $1). The homesteader may obtain a low interest loan for renovation of the dwelling. After living in the house for three years, the homesteader receives the title. At present, only a small number of HUD foreclosed homes have been set aside for the homesteading programs. In addition, municipalities hold the bulk of inner city abandoned homes. They are unwilling to give them away to homesteaders, preferring instead to auction off the housing. Finally, HUD programs have involved mainly one-and two-family dwellings. Multi-family dwellings, particularly suited for apartments for the mentally ill or halfway houses, are not included in their programs (Hanley, 1979).

Federal efforts focusing on the larger issue of community development have been less successful. From the early HUD sponsored "new towns in town" projects (Derthick, 1972) to the stalled Charlotte Street project in the heart of the South Bronx, the federal government has failed to coordinate its programs with local governments. Particularly, the New York City Board of Estimates' rejection of the Charlotte Street housing project showed publicly the devisiveness of borough politics in competition for federally funded urban renewal projects (New York Times, Feb. 25, 1979). In the end, individual housing projects, like the homesteading program, depend upon the larger community development projects for their continued success.

NIMH Community Support Program

In 1978, NIMH began its pilot Community Support Program. So far, 19 state mental health agencies have been awarded contracts with NIMH amounting to $3.5 million. The NIMH Community Support Program Guidelines of 1977 focus on "severely mentally disabled adults whose primary disability is emotional and for whom long-term 24-hour nursing care is inappropriate." It is estimated that this population nationally is more than 1.5 million (Turner & TenHoor, 1978). The NIMH guidelines for the Community Support Program define the community support system as:

> a network of caring and responsible people committed to assisting a vulnerable population to meet their needs and to develop their potential without being unnecessarily isolated or excluded from the community (Turner & TenHoor, 1978:329).

The Community Support Program provides two types of contracts: (1) a strategy-development contract for state planning; and (2) a community support system demonstration and replication contract to implement pilot projects in local areas. The program specifies ten guidelines (see Turner & TenHoor, 1978:329-330) which include a range of services from the prevention of secondary disabilities to rehabilitation, and long-term support for persons who will never gain independence. Within these guidelines, NIMH mentions the need for back up support to families, friends, and community members, and the need for job and housing assistance for the chronically mentally ill. The Community Support System is similar to the Balanced Service System concept used by the Joint Commission on Accreditation of Hospitals as a basis for the accreditation of CMHC's (Turner & TenHoor, 1978:330). Both guidelines encourage service planners to foster natural support systems in communities.

The NIMH Community Support Program policy directly calls for "a system of opportunities, not just a system of services" for the chronically mentally ill (Turner & TenHoor, 1978:332). The psychosocial rehabilitation program emphasizes the value of the social and community supports in providing clients with choices and the opportunity to make significant contributions in their neighborhoods. The NIMH policy explicitly tries to avoid the passive patient role within the institutional or the community context. Although self-help forms of assistance are not directly mentioned, NIMH guidelines appear compatible with this form of social support.

Finally, the NIMH community support policies are designed for flexibility through an organization that is functionally specific rather than facility specific (Turner & TenHoor, 1978:333). Indicative of this approach is their interest in the avoidance of dichotomized planning between institutional and community projects. One of the core agencies selected for the Community Support Program was the Harlem Valley Psychiatric Center which serves a three county area north of New York City.

Policies of the State of New York

The State of New York is using the basic NIMH Community Support System framework for the first stage of its five-year plan. According to Turner & TenHoor (1978:336) New York is one of the states that has taken the strongest leadership in program development for Community Support Systems (NYSDMH, 1978). The main focus of the five-year plan for deinstitutionalization developed under Governor Carey's administration is non-traditional mental health services for the chronically mentally ill. Arthur

Arnold, the chief architect of the State plan conceived the State's mental health policy as the following: "The long range prospect is to get dollars out of mental health and into the generic services that former patients need most" (Herbert, 1978).

Arnold's plan is to link the mental health services agencies with external agencies providing social welfare services (i.e., job training, housing, nutrition programs, etc.). Only a little more than $1 million of the $13.7 million budget for 1978 was appropriated for strictly mental health services. The larger part of the funds was targeted for housing, transportation, sheltered workshops, case managers and other generic services.

The five-year plan intends to enlist substantial aid from the voluntary sector for its community supports program. However, State policies are also committed to assisting the State's mental health employees affected by the deinstitutionalization plans. The State Office of Mental Health is committing itself to state-run programs within the community programs and to retrain by 1981 at least 6,000 state employees for community jobs.

In 1975 the Task Force for Development of Community Residential and Rehabilitation Programs of the New York State Department of Mental Hygiene emphasized the primary importance of the home as a social support in the development of community programs for the mentally ill. In New York City the Pibly Fund sponsored the Group Apartment Living Program whose aim is the administration of housing programs for patients. The Pibly Fund is supported by New York State Office of Mental Health Community Residence grants and individual residents. An average of 60 former patients have been living in 15 apartments located throughout the Bronx and in three

apartments in Manhattan. Since the program began in 1967, about 160 patients have lived in this housing program (Futter, 1978:32). The principal objective of the apartment program is to increase the former patients' resources for community life by strengthening their social networks, including families, kin, friends and staff members who visit the apartments.

New York City Policies

In response to the State's policies on deinstitutionalization, New York City's Department of Mental Health developed its Plan for Community Support Systems. In its first phase of operation, the City was allocated $3.1 million from a State budget of $13.7 million to contract for services from September 1978 through March 1979. The City Department of Mental Health estimated some 40,000 eligible clients in 44 catchment areas. After two successive three month contracts, the City Department of Mental Health has now annualized its planning for CSS programs. In the 1979-80 fiscal year, the city will receive $5.8 million to fund 15 CSS Projects.

The main efforts for New York City CSS programs concentrate on the establishment of professional groups to work with the chronically mentally ill in private proprietary homes for adults (PPHA's) and single room occupancy hotels (SRO's). Staff members will work to improve the quality of life of residents by:

> (1) increased outreach and socialization activities
> (2) arrangement for the provision of psychiatric services.... and arrangements for medical care
> (3) the provision of day, evening and weekend programs as well as links with other community programs
> (4) work with the residence staff and landlords
> (5) work with other city agencies to maximize the resources for the residents. (NYC DMH, 1978b:11)

Assuming that the existing community based services will have a low utilization rate by residents of the nursing homes and SRO's, the core agencies are mandated to:

> (1) provide on-site competency training and coping skill programs... take responsibility for evaluating what additional services are needed for impacted areas....proceed to develop programs or subcontract to fill the gaps....
> (3) develop a plan which will link the existing discharge planning in the State Psychiatric Centers, as well as that of the municipal and voluntary hospitals, to the program.
> (4) maximize other payment/reimbursement sources for services and clients....
> (5) begin with an overall encompassing plan for the needs of designated impact and target areas....there will be a phase-in of PPHA's and SRO's in an incremental fashion to eventually include all homes in a given impacted area. (NYC DMH, 1978b:12)

The CSS program within the largest Hispanic population in the city is located in the South Bronx. It is managed by the Lincoln Community Mental Health Center and affiliated with Misericordia Hospital Medical Center. The Lincoln CMHC is responsible for the delivery of comprehensive mental health services to a population within its catchment area of 148,000 residents. The ethnic composition of the area is 65 percent Puerto Rican and 35 percent black. Although the CSS program began only in March of 1979, the Lincoln CMHC has been operating for ten years. Originally started with federal, CMHC, state, and city funds, federal funding ended two years ago. Currently the CMHC is supported by matching funds from the New York Department of Mental Health, Mental Retardation, and Alcoholism Services and the New York State Office of Mental Health. Third party payments (i.e., Medicaid) are included within the City's share of the budget.

The Lincoln CSS program intends to provide comprehensive community support services to 70 CSS eligible residents of the South Bronx and Hunts Point

areas of the Bronx. By the end of fiscal year 1980 the program anticipates 140 clients. Because of recent difficulties in locating clients eligible for the program, the staff has increased its outreach efforts. Case managers are responsible for insuring the implementation of each client's service plan developed cooperatively by the staff and client. The main elements of the Community Support System program include the following: (1) mental health services/outreach; (2) medical care; (3) day treatment; (4) competency/surrogate landlord; (5) homemaker services; (6) sheltered workshop; (7) transportation; (8) case management (NYCDMH, 1979b Lincoln CMHC, March, 1979).

Originally, staff at the Lincoln CMHC perceived priorities for the CSS program differently from those established by the State. Their priorities were ranked in this order: (1) a housing/apartment program, (2) mental health services; (3) day treatment; (4) competency skills program; (5) coping skills program; (6) homemaker services; (7) housekeeping services; (8) sheltered workshop; (9) transportation (NYCDMH, 1978b; Appendix 2:3). The main difference is the importance residents and staff of the South Bronx attach to need for more housing programs. The Lincoln staff requested a budget for ten independent apartments for ex-mental patients during the first year of CSS funding. The Lincoln CMHC also intended to establish a halfway house and supportive community residences. The CMHC advisory board later rejected the halfway house plan. Despite strong petitions for an increased housing budget for the CSS program, the State Office of Mental Health did not accept these changes. Some effort was made to recognize the problem through the Surrogate Landlord program. Although no more than 10 percent of administrative time will be reimbursable for locating and securing apartments, staff are directed to find

five apartments suitable for ten clients. However, state funds are very limited for meeting the costs of establishing their clients in the apartments. The SSI checks former mental patients receive will hardly cover the moving-in costs. The housing problem for former mental patients is particularly pressing since the Bronx Psychiatric Center now has 100 patients from the Bronx who remain hospitalized because of the lack of local community residences for them.

The staff of the Lincoln CSS Program are mostly bilingual. Yet the program is not especially designed to locate and utilize culturally relevant social and community support. In large part, the design of the State's CSS programs has not been responsive to the pressing need for housing in South Bronx neighborhoods. The availability of folk healers and the resilience of Puerto Rican families are some of the main social supports the CSS program does not address.

Although the Hunts Point Multi-Service Center does not hold a state CSS contract, its organization and programs provide a strong example of social and community support efforts. Since 1967, the Hunts Point Multi-Service Center has operated as a non-profit community organization servicing 50 - 60,000 residents of South Bronx. It is funded by federal, state and city sources. Some 76 percent of the residents in the area are Hispanic (90 percent of these Puerto Rican) and 13 percent are black. Hunts Point operates the Mental Health Unit under a contract with the City Department of Mental Health.

The Hunts Point Center is a front-runner in developing the concept of a multi-service center. One centralized administration oversees the following

programs: comprehensive ambulatory health center, mental health services, manpower and training, a parent and child center, family day care, alcoholism, ambulatory detoxification unit, methadone maintenance treatment. The essence of the programs is the belief in promoting a holistic sense of health, combining mental, physical and social well-being. Clients are encouraged not to sharply distinguish among the services they receive. One may receive services from the Multi-Service Center without being identified as a mental patient or an alcoholic. The combination of services increases accessibility for Hispanic families (particularly males) who are reluctant to admit emotional difficulties.

In addition to the concept of a multi-service center, Hunts Point has maintained from its beginning one of the strongest examples of community control in the delivery of health services. In 1967, residents of the Hunts Point area elected a 22 member Board of Directors. The Board, acting as the main policy-making group for the Multi-Service Center, reflects the local population's demographic characteristics. Members serve for four year terms which may be renewed only after a two year absence. The Hunts Point Multi-Service Center is one of the few organizations where a community elected board determines the allocation of funding and evaluation of programs managed by the Center.

The New York City Federation of Mental Health, Mental Retardation and Alcoholism Services is a program planning and review organization consisting of representatives of provider agenices and consumer. These groups are mandated to play an advisory role to the Department of Mental Health, Mental Retardation and Alcoholism Services on mental health service issues. The re-

organization of the Federation's structure includes the creation of Mental Health Councils for each borough. One of the special committees within this Council, the Patient Care Committee, will be established to identify problems encountered by individuals seeking mental health services. The Committee will represent consumers and service provider agencies at city and state levels (NYCDMH, 1979a).

Judicial Decisions

Recently federal court decisions have imposed Constitutional standards on states concerning the rights of the mentally ill. The most significant court decisions include: the right of involuntary patients to procedural safeguards (Lessard v. Schmidt, 1972); the right to treatment (Rouse v. Cameron, 1966, and Wyatt v. Stickney, 1972); the responsibility to use the least drastic form of care (Lessard v. Schmidt, 1972); the right of non-dangerous individuals to freedom (O'Connor v. Donaldson, 1975); and the right to treatment in the least restrictive alternative (Dixon v. Weinberger, 1975). On the whole, the decisions have increased pressures for deinstitutionalization.

The O'Connor v. Donaldson decision is one of the most important ones for the community support programs. The Court concluded the following: "A State cannot constitutionally confine...a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." In a second decision, Dixon v. Weinberger, a class action suit against St. Elizabeth's Hospital, the Court ruled that mental patients were guaranteed "suitable care and treatment under

the least restrictive conditions including placement of patients in community-based care.

Summary

Certainly the main direction of current mental health policies supports the funding of communtiy-based services. However, a number of policies mandated by federal legislation (i.e. Medicaid) have encouraged the growth of nursing homes and other intermediate care facilities to the exclusion of other forms of social support (i.e., self-help groups, family and friendship networks). Some policies (i.e., Medicare) clearly encourage states to reinstitutionalize its patients for fiscal purposes.

The community mental health legislation, from the Kennedy administration through the Carter administration, has promoted community-based mental health services varying from emphases on traditional mental health services like clinical outpatient services to generic services like housing, welfare and job training. The client populations for these services have also changed in priority from all residents of the catchment areas (CMHC Act of 1963) to special segments such as the chronically mentally ill, ethnic minorities, the poor children and youth, etc. (Proposed Community Mental Health Systems Act of 1979). The NIMH Community Support Program provides states with further incentives to develop community support organizations.

State and city mental health policies follow the major guidelines established by federal legislation and sources of funding. Yet special social and political environments change state and city policies. As will be discussed later, powerful unions of state mental health workers limit the funds available for the promotion of local self-help and neighborhood voluntary

associations. The particular urban context for New York City's mental health services encourages the development of policies related to single room occupancy hotels, high density poverty areas, and ethnic minorities.

In all, current federal, state and city policies affect community mental health programs in diverse ways. Most legislation promotes the development of conventional community-based services like nursing homes. Government policies attribute little importance to the strengthening of families, friendship networks, self-help groups or other non-professional neighborhood organizations. Several Federal agencies such as HUD, NIMH, and the Department of Labor hold the financial resources to encourage social and community support programs. However, they have yet to organize a comprehensive policy directed toward this goal.

CHAPTER IV

PUBLIC POLICY OPTIONS

I have grouped the main policy options for social and community support programs to Hispanic populations into three basic categories: (1) a managerial-fiscal model, (2) a community development model, and (3) an ethnic model. A managerial-fiscal model focuses on strengthening the weak linkages among social support programs, delivering services through traditional, federally reimbursable programs, and expressing concern for fiscal accountability. A community development model emphasizes non-traditional, non-professional kinds of mental health services, lower concern for fiscal accountability, greater interest in the community control of these programs, and greater interest in the economic and environmental causes of stress. The ethnic model focuses on culturally relevant mental health programs and the delivery of non-traditional services to minority ethnic populations. These three models of policy options are not mutually exclusive. They do, however, tend to emphasize different concerns and strategies for the delivery of mental health services.

The Mangerial-Fiscal Model

Recent federal government reports on community mental health policies reflected the managerial-fiscal model (GAO, 1977). The GAO (1977) attributed the major problems associated with deinstitutionalization to the following factors:

(1) "the absence of an effective management system for clearly defining objectives, roles, and responsibility for monitoring and evaluation to be done by various agencies;

(2) a lack of systematic ways to finance deinstitutionalization which assures that persons be placed in the least restrictive environment most appropriate to their needs;

(3) a lack of criteria for defining acceptable or adequate community placement." (GAO, 1977:173).

The last three GAO reports on the issue of deinstitutionalization (GAO, 1977, 1974, 1971) emphasized fiscal planning and accounting systems, information systems to determine community needs, and program coordination and evaluation.

Focus of Services

The importance of managerial expertise can be appreciated knowing that 11 major Federal departments and agencies administer over 135 programs for the mentally disabled (GAO, 1977:28). The OMB, Federal regional councils, HUD, the Department of Labor, and even HEW have failed to develop adequate planning policies for the implementation of community support systems. Within the Department of Health, Education and Welfare, the deinstitutionalization strategy faltered because:

> the agency primarily concerned with the mentally ill--NIMH-- (1) provides only a small portion of the funds needed and used for deinstitutionalization (and development of community support services); (2) exerts only a limited influence and no authority over other agencies, and (3) does not have authority or responsibility for monitoring, evaluating, and enforcing standards and requirements under other programs serving the mentally disabled (GAO, 1977:36).

Summarizing the NIMH Community Support Program, Turner and TenHoor (1978:323) concluded that similar conditions prevail at state and local levels:

> No one agency at any level has been clearly charged with responsibility for comprehensive assessments of mental health and community support needs of the mentally disabled, planning and implementating a system to assure the needs are met, and monitoring the quality of both institutional and community programs.

Responsibilities for management of the deinstitutionalization process are fragmented across three levels of government, and among numerous health, mental health, and human service agencies.

Resource Base

The managerial-fiscal model focuses on strengthening linkages among the more conventional mental health service providers. In New York City, the Interagency Task Force on Problems of Deinstitutionalization and the Chronically Mentally Ill (NYC DMH, 1978d) recommended the establishment of an official executive level city interagency mechanism to coordinate administrative policies related to the provision of services to the chronically mentally ill. This Commission places the responsibility for financial support for deinstitutionalization services on the state as opposed to the federal government. Proposals were made for a single integrated system of mental health services. Similarly, the GAO (1977:183) recommends the consolidation of the Special Health Revenue Sharing program administered by the states and CMHC grants which are made directly to local organizations by the federal government.

The Task Panel Report on Community Support (President's Commisssion on Mental Health, 1978a) emphasized improving linkages between natural helping networks and professional source help. The President's Commission (1978a) recommended the use of case managers to integrate the fragmented mental health services available to their clients. The liaison role of the case manager serves an enabling function for a person's problems by mapping out the key resources in a person's environment and developing an intervention strategy (Dokecki, 1977; Hobbs, 1979). The managerial concerns of liaison workers should be with the delivery of services to clients (New-

brough, 1977). Ideally, the case manager develops programs where the agency and the client benefit from the relationship. The New York State Five Year Mental Health Plan (1978) and the proposed federal Mental Health Systems Act place considerable emphasis on the role of case managers to coordinate clients' needs with services of provider agencies.

In part, the managerial-fiscal approach attempts to deal with a dilemma that has long troubled the welfare state--the interface between primary groups and large-scale bureaucratic organizations. Primary groups, like the family or block associations, best perform non-routine tasks while bureaucratic organizations perform routine or uniform tasks (Litwak, 1978: 62). The dilemma arises when organizations must deal with uniform and non-uniform tasks. Ideally, the structures of both the primary groups and bureaucracies are needed. For example, a mental health agency handles the uniform tasks of service delivery in institutions while families and neighborhood groups concern themselves with the special and different needs of former patients in communities. Too close a relationship between bureaucratic and primary groups may lead to the destruction of one or the other (Litwak, 1978:68). Families may lose their unique emotional supportive service or bureaucracies can become too personalistic to function effectively. The managerial policy focuses on the linkages between the formal organizations and local primary groups. These linkages may take the form of decentralized, store front services, case managers, voluntary associations, etc. A more conservative managerial-fiscal policy will concentrate on inter-organizational ties among formal organizations instead of strengthening the links between these organizations and primary groups in the community.

Fiscal Accountability

The managerial-fiscal model emphasizes program accountability. Although federal legislation does not require it, the CMHC's have conducted to an unprecedented extent the monitoring and evaluation of their programs (Brown & Goldstein, 1978:1047). NIMH established review procedures for CMHC's which included an initial site visit as early as 90 days after receipt of a staffing/constructing grant. Annual visits continue until the end of the grant support. Grantee accountability stands as a main goal of this model for the delivery of mental health services.

The managerial-fiscal model places great emphasis on financing professional community-based services. Although the population of public mental hospitals has declined dramatically from 559,000 in 1955 to almost 150,000 in 1979, (Klerman, 1979) the budgets supporting these institutions have not decreased accordingly. Stricter accreditation criteria, strong union opposition to staff cuts in institutions, and other factors prevented the release of funds from public hospital to community service supports. Supplemental security income and Medicaid provide major fiscal incentives to states to move mental patients in their institutions into nursing homes and other federally supported facilities.

State and local governments encounter problems funding CMHC and other community-based mental health services. First, there is considerable uncertainty concerning funding as federal staffing grants decline over the years. Second, the state's ability to provide sufficient funding for community-based services is limited by the increased costs of state-operated mental health hospital care. Third, out-patient services are not federally

reimbursable when provided by mental health workers individually or in group sessions, without direct supervision by a physician or psychiatrist. Reimbursements to CMHC's and other agencies are very limited for non-traditional mental health services. In all, innovative programs are difficult to fund.

A managerial-fiscal model focuses on mechanisms for the reimbursement of social and community supports with the intention of making them formally recognized parts of the mental health and health delivery system. However, it is uncertain to what extent non-professional organizations can be tied into the administrative structure involved with these funding mechanisms without losing their original reason for existence. For example, spiritists consider that their powers for resolving problems derive from supernatural sources. To consider direct government funding for these services would be an insult to the folk healers. Similarly, many self-help groups are defensive about accepting financial support from external sources. However, other organizations, block associations, for example, may readily accept government funding.

Time Horizon

A managerial-fiscal model holds a shorter time perspective than the community development and ethnic models. Tied to the high priority on fiscal accountability is the view that social and community support programs ought to provide concrete evidence of improvement within a six-month period. The demand for fast results limits the nature of the social support programs this perspective considers.

Political Concern

The managerial-fiscal model avoids politicizing its policy options. For instance, one GAO study (1974) showed the scarcity of non-federal funding for community mental health centers. Moreover, the alternative sources of funding available (self-pay, third-party, state funding, etc.) promote the more institutional services in opposition to the community support systems approach. Funds are provided under Medicaid for skilled nursing facilities (SNF) and for intermediate care facilities (ICF). However, little money is available for non-traditional services. The GAO study demonstrated that the CMHC grant requirements for matching funds and other federal policies are biased against CMHC programs in low-income areas. Nevertheless, the GAO (1974:22) proceeded to support the development of CMHC's plans for self-sufficient financing and to expand the services available through third-party payments for non-physician services (Siegal and Doty, 1979:61). The GAO ignored the political implications of their earlier findings since they were unwilling to challenge strong interest groups supporting the alternative funding.

Community Development Model

From the community development perspective, the issue prior to the integration of mental health and health services or to the development of culturally relevant programs is the construction of policies which strengthen the neighborhood or the larger community (Breton, 1964; Naparstek & Haskell, 1978; Warren & Warren, 1977). A belief in the viability of the neighborhood as the basis for the delivery of mental health services

to ethnic minorities or other groups is strongly held by proponents of this model. This approach argues that neighborhoods should define their own needs and build upon their own strengths. The model begins with the local social networks rather than the professional agency networks as possible supports for the delivery of mental health services. The community development model focuses on building linkages between neighborhood organizations and professional agencies without coopting the grass-roots organizations. These linkages may be forged by community advocates. The advocacy role is played by professionals or local residents. The community controls mental health programs. Housing and neighborhood revitalizations are important issues in the community development model. Although the neighborhood is also a focus for the ethnic model, the community development model does not require an ethnic component. Fiscal constraints are not a high priority.

Scale and Focus of Services

From the point of view of a community development model, small-scale organization is vital. Mental health services should be localized in small neighborhood areas so that the mental health center staff can become familiar with the formal and informal social supports of specific neighborhoods. The community development model particularly rejects the administrative units (catchment areas) used to develop the geographical limits of the community mental health centers. Residents themselves should be allowed to define their own community boundaries. Generally, natural communities are assumed to exist.

Unlike the management perspective which tends to regard the indivi-

dual as a focus of integrated agency services or the ethnic model which looks more at ethnic groups or individuals, the community development model expresses direct concern for the community or neighborhood. This view is clearly expressed by Smith and Hobbs (1966:9):

> It is not just an individual who has faltered; the social systems in which he is embedded through family, a school or job, through religious affiliation or through friendship, have failed to sustain him as an effective participant. From this view of mental disorder as rooted in the social systems in which the troubled person participates, it follows that the objective of the center staff should be to help the various social systems of which the community is composed to function in ways that develop and sustain the effectiveness of the individuals who take part in them, and to help these community systems regroup their forces to support the person who runs into trouble.

A healthy community is prior to individual mental health.

Resource Base

The community development model considers that the federal and state mental health programs fail to use the existing resources in neighborhoods. The informal social and community supports are particularly neglected. For the community development model, block associations, voluntary church groups, social clubs, and other neighborhood based organizations are considered important social supports.

The decentralization of services, in itself, will not provide the resources needed for community based mental health programs. This model attempts to strengthen the links between neighborhood supports and the professional supports needed to create a comprehensive social support system. Current community development models recognize that structural obstacles in the large federal, state and city context create disincentives for neigh-

borhood revitalization. For instance, unequal distribution of municipal services weakens the local resources for building and maintaining informal neighborhood social supports for the mentally ill. Consequently, advocates of the community development model realize the need to strengthen ties between neighborhood organizations and outside agencies.

Housing, in all respects, plays a major role for community development programs. In this case, the housing interests of the mentally ill are particularly important. Alternative living arrangements for deinstitutionalized patients include foster family care, halfway houses, community residences, cooperative apartments and lodges. Goldmeier (1978:159) reviews three different program styles for housing: a managerial model, a medical model, and a family/vocational model. For the medical model, housing agencies are closely linked to hospitals and CMHC's. In the family/vocational model, there is more concern for extended-family type apartments (i.e., Fountain House in New York City). Whatever the arrangements, housing is one of the highest priority items in the community development model.

A central issue concerns the acceptance of housing for the mentally ill by neighborhood residents. Because of the stigma attached to mental illness, problems of zoning, property values and other factors, most communities are reluctant if not hostile to proposals for establishing community residences in their areas. Cooperative apartments are more acceptable to local residents when there are fewer (generally no more than four) persons per apartment and these apartments are dispersed across the community. Other strategies to remain inconspicuous include the use of

only one apartment in a building (Carpenter, 1978:386).

Community Participation

In the community development model, community control of the mental health center's policies is essential. Nassi (1978) outlined three basic modes of citizen participation in community mental health. In the first model, the elitist type, community representatives sit on mental health boards for the purpose of public relations. These boards are not intended to reflect the interests of local consumers. In the advisory model, the second type, the boards are powerless in the face of budget and policy decisions of the administration. However, local consumers participate in board activities. With the third type, the consumer control model, community representatives not only participate in board activities but actually hold decision-making power. In this last model, local consumers are involved in program selection, budget decisions and actual policy making. In general, the community development model emphasizes the devolution of power to local consumers at the neighborhood level.

Fiscal Concerns

Proponents of neighborhood enablement argue that "Money or cost saving is not and should not be the prime rationale for alteration in the ways in which services are delivered" (Naparstek and Haskell, 1978:32). Neighborhood groups should be given funds to use as they desire. For example, the Consultation and Education Program monies from the CMHC legislation should be reworked to allow funds to go to all communities regardless of whether they hold federally funded CMHC's (Naparstek, 1978:

32). Currently, non-profit organizations like churches, ethnic clubs, or block associations cannot receive Federal CMHC funding. Other studies have recommended that the maintenance of networks of natural associations (informal social networks) can be achieved with no greater cost or expenditures of professional time than is now spent supporting the same group of patients in a traditional medical model setting (Garrison, 1978:593).

Time Horizon

From the community development perspective, accountability for social support programs should be a long-term consideration. The kinds of grassroots organization and community support programs implemented will show meaningful results only after long periods of time. Community development programs are seen as entailing time commitments of three to five years if not longer.

Political Concern

The roots of community development programs are highly politicized Community development programs often depend on their ability to demand resources from outside agencies. Successful demand-making involves the political organization of the community through block associations or other neighborhood groups.

Ethnic Model

The ethnic policy options coincide closely with the community development model. Moreover, both models prefer not to focus on the management and fiscal constraints placed on the mental health programs by federal, state and local regulations.

Focus of Services

An ethnic model emphasizes the need to train more Hispanic American professionals in the areas of psychiatry, psychology, psychiatric nursing and social work. Olmedo and Lopez (1977) demonstrated the serious underrepresentation of Hispanics in the main mental health professions. In 1971 only 0.54 percent of the American Psychiatric Association were Spanish-surnamed U.S. residents. There were only 0.5 percent Hispanic Psychologists in 1973. From 1969 to 1974, 4 percent of the Masters in Social Work graduates were of Hispanic origin. A study of public health staffing in New York City found that Puerto Ricans comprised only 2 percent of the professional employees of the Health and Hospital Corporation in 1971 (Alers, 1978:59). Puerto Ricans were disproportionately represented in the lower-level occupations: operatives (23 percent) and paraprofessionals (27 percent). The proportion of Spanish-surnamed persons in professional and office/clerical occupations has remained the same from 1974 through 1977 (Alers, 1978:65).

Within the ethnic model, there is some tension between professionals and paraprofessionals in the delivery of mental health services. As consumers, ethnic minorities are wary of programs which, under the guise of culturally-relevant services, substitute less expensive, non-professional workers where professionals are really needed. However, sensitivity to this problem has also led to unnecessary reliance on professional personnel and to the acceptance of the general medical model. For many services the ethnic model considers non-professional and non-traditional cultural supports more appropriate. Presently, the ethnic model appears to be taking the direction of increased professional training.

Most ethnic models recommend that mental health services be provided along with health, social welfare, educational, economic and legal services in multi-purpose neighborhood centers (Padilla, Ruiz, and Alverez, 1975; Presidents Commission on Mental Health, 1978b; Alverez, 1974; Garrison, 1978). The Hispanic Panel recommended that Centros Familiares (Family Centers) provide these services. Other recommendations include store front agencies similar to the older OEO antipoverty neighborhood organizations. Particular emphasis is placed on providing mental health services within the context of primary health care programs (President's Commission on Mental Health, 1978b;593).

Usually, the local mental health services are available through community mental health centers. The Miami Health Ecology Project (Garrison, 1979a:1) was organized to provide for the special needs of several subcultural areas within its catchment area. The CMHC developed seven miniclinics in the neighborhoods, staffing them with paraprofessionals from the community. Professional mental health services are provided on a part-time basis. Each miniclinic is directed by a "culture broker,"* a social scientist who does not play the role of a mental health specialist. The culture broker/miniclinic director mediates between the community agency and the traditional psychiatric facilities.

Another project in Newark, New Jersey, adapted the Miami project to a different environment (Garrison, 1979a). The Inner-City Support Systems project works within the constraints of a centralized which prevents the establishment of dispersed miniclinics. In addition, the Newark

*It is the culture broker's job to be well versed in both the professional health care system and the folk health culture of the area served by the miniclinic (Weidman, 1975:19).

project must operate within the boundaries of a catchment area which has little similarity to the residents' perceptions of the boundaries of their ethnic neighborhoods. Finally, the Newark area has a greater ethnic diversity than the Miami area. Garrison found it necessary to expand this cultural brokerage to that of a cultural specialist role dealing with several subcultural areas. That role may be performed as an extra function by all clinical staff or as another specialist on a mental health team.

Resource Base

Mental health workers should be trained to deliver culture-specific services to Hispanic Americans by the integration of traditional values and support systems with more conventional treatment. From a more orthodox perspective, the family adaptation model (Padille, Ruiz and Alvarez, 1975) is a varient of group psychotherapy for Hispanic clients. Simulating Puerto Rican family structure, the therapists attempt to resolve their clients', intrapsychic problems (Maldonado-Sierra and Trent, 1960). Hispanic cultural themes underlying Hispanic family organizations (machismo, respeto, compadrazgo-comadrazgo, sex-roles, personalismo, etc.) are brought into the therapy sessions.

Mental health services for ethnic minorities would be used more readily and experience fewer drop outs if the times and attendance of programs were more flexible. Garrison (1978:593) suggests that agencies serving Hispanic populations restructure their programs to provide walk-in services without fixed appointments and group activities without established memberships.

Most ethnic mental health policies provide services within the context of the extended family. The nuclear family traditionally has been the focus

of public policies. More recently, the ethnic model has conveyed to professionals the importance of the extended family to their Hispanic clients. Extended family members are brought into traditional therapy sessions. Social services are aimed at strengthening extended families and encouraging them to provide home care for mentally ill members of their kin group.

In addition to kinship supports, the ethnic model directs attention to special non-kin forms of help. Garrison (1978:594) suggested that schizophrenic Puerto Rican women who cope relatively successfully in their communities depend more on their neighbors, friends and other non-kin than on their families. Apparently non-kin social supports appear to be as helpful as one's family for maintaining chronic schizophrenic women in Puerto Rican neighborhoods.

A lower incidence of mental illness within a migrant ethnic minority population appears to be related to the presence of a significantly larger receiving community of the same ethnicity (Thomas and Garrison, 1975). The ethnic community acts as a buffer between the first generation migrants and the dominant culture. This raises the issue of whether community mental health workers should attempt to change the life-styles and culture of minority clients toward the patterns of the larger society or to build institutionally complete ethnic neighborhoods. Breton (1964) found that churches, welfare organizations, newspapers and periodicals had the greatest influence in keeping immigrants' personal social networks within the boundaries of the ethnic community. Brenton concluded that for a community to control its social integration with the larger society what is

important is the presence of only some of the community organizations mentioned.

The ethnic model suggests that mental health policies be oriented toward stabilizing pluralism, at least for first or second generations minority groups. The President's Panel on Hispanic American Mental Health (1978:35) proposed the development of Hispanic cultural centers, ethnic education programs, and Hispanic mental health education programs.

In addition to general institution building, there are specific groups the ethnic model recommends be incorporated into social and community supports policy. Folk healers represent a mental health resource that a significant number of Hispanics utilize whether or not they are part of public programs. Within Hispanic communities, folk healers include botanicas (folk medicinal store owners), espiritistas (spiritists) and santeros (Afro-cuban practitioners). The services they provide vary greatly in competence and skills within the folk tradition.

Community Representation

The ethnic model focuses on the issue of underrepresentation of ethnic minorities as professionals in mental health agencies and on CMHC governing/advisory boards. The issue of community control of community mental health programs plays a secondary role. Similarly, the distinction between provider and consumer views of mental health services are not clearly made when efforts focus primarily on ethnic group participation.

Fiscal Controls

In addition to the management-fiscal approach, some advocates of the ethnic model have also expressed particular interest in fiscal controls.

The President's Commission Panel on Hispanic Mental Health (1978b) made the point that instead of increased spending "What is called for instead is the rationale and enlightened planning needed for an equitable allocation of existing resources, the elimination of inefficient approaches, and the maximizing of benefits relative to costs." The Panel calls for Hispanic American participation in the formulation of national mental health policies without exceeding current expenditures.

Time Perspective

The concerns of the ethnic model are medium and long-range. Unlike the managerial-fiscal model there is little interest in immediate, quantifiable returns for funds invested in community support programs. Medium range interests focus on the training of minority members as psychiatrists and social workers in addition to participation of minority members in the mental health programs. The longer term perspective considers the general welfare of cultural community supports for families and non-kin associations. The cultivation of ethnic support groups requires a longer time frame for evaluation than traditionally used in the field of mental health.

Ethnic [illegible]

For the ethnic model, social and community support programs maintain a political base. Ethnic mental health programs are assumed to be political issues just as other social concerns of minority groups. Minority group concerns for social support programs do not always coincide with community boundaries. Multi-ethnic neighborhoods further politicize community support issues. Blacks and Hispanic-Americans compete for social support programs that best suit each minority. Moreover, in areas like New York City, Puerto Ricans, Dominicans, Cubans, and Colombians divide into separate interest

groups.

Summary

In this chapter I have discussed three main models for social and community support programs. Each model results in a series of generally cohesive policy options. The main issues raised by the three models are outlined in Table 3. In the following chapter I consider the most promising policy options, and their relative advantages and disadvantages for building social and community supports in Puerto Rican neighborhoods in New York City. I discuss the more promising policy options in relation to the Community Support Systems programs currently being implemented by the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services.

Table 3

Public Policy Options for Social Support Programs

Issue	Managerial-Fiscal Model	Community Development Model	Ethnic Model
Unit	Administrative boundaries	Natural community	Ethnic community
Focus of services	Interorganizational and agency-client linkages	Neighborhood	Family and social network/professions
Resource base	Formal institutions and agencies (some ties with primary groups); professional services; housing not important	Grass-roots organizations (i.e. block associations); non-professional services; housing important	Cultural social supports (i.e. compadrazgo, extended family, neighborhood centers); non-professional services; housing important
Program coordination	Case manager role	Liaison-advocacy role	Advocacy role
Community representation	Elitist function	Community control	Community participation or control
Fiscal accountability	High concern	Little attention	Moderate attention
Time horizon	Short-term	Long-term	Medium/long-term
Political concern	Avoid political issues	High politicalization	Ethnic politics

CHAPTER V

SUGGESTED POLICY OPTIONS FOR A SOCIAL AND COMMUNITY SUPPORT SYSTEMS PROGRAM

The ethnic and community development models discussed in the last chapter are the policy options I consider to be most promising for improving the delivery of mental health services in Puerto Rican neighborhoods in New York City. These policy options focus on strengthening the primary group network (kin and non-kin attachments) of mentally ill persons, or improving the services available from non-professional community mental health workers and folk healers, and on providing housing for individuals without other feasible alternatives for community support. The success of these policy options depends on several factors: economic cost, values enforced or diminished, public acceptability, political feasibility, unintended consequences, and ease of implementation.

Economic Costs

The economic costs of mental health programs are certain to come under attack as federal, state and municipal governments cut public spending. Most social and community support programs developed as part of the federal community mental health legislation from 1963 and 1975. The 1975 Public Law (94-63), in particular, focused on community supports by providing for community residence programs and local control through community governing boards. Newbrough (1978) indicated three distinct alternatives for financing community mental health services: (1) no more federal funding; (2) continued federal funding of mental health services connected to community mental health centers and (3) federal support for a wider variety

of services to meet the needs as defined by the local population. On the whole, Newbrough found the third alternative (federal monies for locally determined programs) the more adequate for strengthening the family and responding to client needs. Moreover, the advocacy and liaison functions provided respectively by residents and professionals may be able to deliver these services at lower costs than present.

The Community Support System Projects in New York City are 100 percent State-funded. However, the State is pressuring the City Department of Mental Health to incorporate federally reimbursable programs into their CSS projects. At the beginning of the CSS program, funds were to include community services outside the medical model. Now, those more non-traditional mental health services which are not federally reimbursable by Medicaid/Medicare to SSI are not likely to be included as part of the CSS project.* Apparently, the State considers private proprietary homes for adults (PPHA's) the main target of CSS monies. These homes provide ready access to large numbers of CSS eligible clients with Medicaid reimbursable programs.

Another difficulty created by the budgetary constraints on the CSS project is that the target population is very narrowly defined as:

> those individuals 18 years of age or older--with over 6 months total consecutive hospitalization and whose primary diagnosis is not developmental disability, or--who within the past two years have had 3 or more admissions of two weeks or more duration, or who have had 3 or more months of cummulative psychiatric hospitalization (public or private).

*However, some non-traditional mental health services will continue to be funded under CSS contracts. These services include case management, transportation, homemaking and surrogate landlord programs.

CSS eligible persons must be considered to be functionally disabled because of mental illness. Since the State has a very limited budget, it significantly reduces its client population in the neighborhoods served to the segment of the chronically disabled persons placed there by deinstitutionalization programs. Individuals who do not meet these criteria but need services must find them outside the CSS program.

Besides limiting the impact of a community support program, the rigid client definitions create considerable discontent for street-level mental health workers. They must turn down clearly needy cases located in their population surveys because these individuals do not meet the CSS program criteria. Consequently, social workers spend considerable time locating appropriate service programs for these people. Alcoholics and drug addicts located in the single-room occupancy hotels are not CSS eligible but certainly prime candidates for mental health services.

The incorporation of traditional Puerto Rican folk healers into a comprehensive mental health program would increase costs only minimally. Espiritistas charge little if anything for their services. Curanderos' services cost more. However, because of the wide variations in the adequacy of services provided by folk healers, and other factors discussed here, no attempt should be made at this time to establish policies for third-party reimbursements.

The development of culturally relevant mental health services might include a new mental health position, that of the cultural specialist. The role played by a cultural specialist could be included among the functions of the case manager whose job is defined in President Carter's new Health Systems Act.

The NIMH Community Support Systems programs are not intended to be more costly than the more traditional approaches (Turner and TenHoor, 1978:339). In fact, it is hoped that CSS programs will provide more appropriate services at lower costs compared to the present custodial nursing homes and individual psychotherapy.

New Medicaid regulations will allow socialization/competency skills programs to become Medicaid reimbursable. These regulations will encourage states to use CSS funds as seed money to start a program and to maintain the socialization/competency part until it becomes Medicaid reimbursable. Then state CSS funds will be transferred to another program to repeat the same process. Eventually, the federal government may pay high costs through increased Medicaid expenditures for programs that were originally intended to cost no more than previous programs or to reduce expenditures by encouraging local social and community supports. As Medicaid becomes the major source of reimbursement, both the federal government and city government will end up paying for the formerly 100 percent state CCS funded program. In New York City the city share of Medicaid is one-fourth and the federal share is one-half.

Whenever federal, state or city funding for mental health programs is reduced, the non-professional community mental health workers (paraprofessionals) are one of the earliest categories cut. Professionals' positions generally remain untouched. To qualify for federal assistance, programs must have a certain number of psychiatrists in residence or consulting with them. Although administrators recognize the value of community mental health workers in linking local residents to formal services (psychiatric and social work services, food stamp programs, etc.), these positions

are the first to suffer from program funding cuts.

Reliance on unit costs as a major indicator for evaluation of mental health programs limits the innovative potential of social and community support programs. More traditional programs can be evaluated in terms of the number of hours of psychotherapy provided by psychiatrists or the number of clients seen by social workers. Social and community support programs will require different kinds of measurement for evaluation of their economic costs. The evaluation of progress in the construction of friendship networks and strengthening families will require new criteria not presently available. Evaluation procedures are discussed more fully in Chapter 6.

Housing programs are, most likely, the costliest component of the community supports programs. Community residences are also one of the highest priority needs of residents of low-income neighborhoods in any city. Residents of the South Bronx place the development of adequate low-income housing among the most pressing needs of the area. The Lincoln CMHS ranked community housing as its first priority to be met by the community support system project. However, the state allocated only minimal funding in its CSS projects, doing little to satisfy the demands of the South Bronx for adequate housing for the mentally ill and the population in general.

Values

The Family and the Individual

While the U.S. Congress consistently affirms its commitment to the family, it continues to oppose programs not consistent with an individualistic-pluralistic tradition. With regard to the history of legislation in

the U.S., Kamerman and Kahn (1978:453) argue that:

> There is little that is specifically targeted at the enhancement of the family as an organic unity or which encourages integration around the family at the point of personal social service delivery.

Social and community supports could strengthen the caring function of the family rather than substitute for it. This approach encourages the delivery of mental health services through the family. Moreover, the relationship between families and professionals should empower the family rather than weaken it.

The community development model encourages the strengthening of families through improvements in neighborhood housing. Similarly, the ethnic model values the family as a source of stability and identity for the mentally ill. Hispanic culture places greater emphasis on responsibilities to one's family than on individual rights. The management-fiscal model simply does not raise the family vs. individual issue at all.

Often programs consider families as negative influences on the patients' mental health. Other social groups (e.g. friends, neighbors, church associations, folk-healing cults) are considered more appropriate natural support groups than the family. Garrison (1978) recreated support for schizophrenic Puerto Rican women by providing transient non-kin relationships using neighbors, good friends, Pentecostal groups, building superintendents ("supers") and others. Her intention was eventually to reestablish the patient with relatives.

Least Restrictive Environment

The concept of community residences, a central issue in the community development model, raises important value issues. Certainly one value

highlighted by recent court decisions is the right of the mentally disabled to live in the least restrictive setting. The New York City Advisory Board on Deinstitutionalization and the Community pointed out that the goal of all community support programs should be to provide the mentally disabled with as many choices in the least restrictive environment possible.

With reference to community residences, Goldmeier (1978:176) argued that: "those who are suffering from mental disabilities have the same right as anyone else to live in the type of environment which affords a quality of life conducive to self-realization and growth." Cooperative apartments are one way to avoid the stigma of the more conspicuous halfway houses. Yet efforts to establish halfway houses, group homes or other community residences for the mentally ill often meet strong resistence from local residents. The assertion of individual rights regarding community residences for the mentally ill is perceived by local residents to be in conflict with their own rights to surround themselves in their neighborhoods with other traditional nuclear families.

A Sense of Community

The success of social and community support models depends on local residents' sense of community. If the process of deinstitutionalization is to work at the local level, residents must be willing to accept a greater amount of deviant behavior in their community. The integration of chronically mentally ill individuals with a community necessitates the acceptance by residents of people who behave differently than they do. To the extent to which communities are more tolerant of deviant but not

harmful behavior, extended families, kin networks, neighborhood social groups, churches, and other voluntary associations will be better able to mediate between families and the professional social service bureaucracy. The issue is one of individual interest versus community welfare.

Ethnic minority neighborhoods are thought to place greater value in a social contract than other areas. Yet it is not safe to assume that all Puerto Rican neighborhoods will opt for community welfare over individual interests. Even within Puerto Rican neighborhoods in New York City, there is considerable variation in social cohesiveness and political mobilization. Spanish Harlem (El Barrio) is known as possessing a much greater sense of community than the more highly transient areas of the South Bronx.

Ethnic Pluralism and Social Class

The selection of policy options depends on the extent of commitment to ethnic pluralism. Most federal, state and city policies favor pluralism in principle, just as they do participatory democracy. However, there are public misgivings toward the direction pluralistic policies might lead. Not far beneath the surface lie fears that ethnic pluralism will create divisiveness and societal instability. Discussing the problems of bilingual education for Japanese-Americans, S. I. Hayakawa is quoted as saying:

> If you push the bilingualism process too far, especially in the states with a heavy Mexican population like Texas or California, you could someday find yourself in a situation with the problems of Quebec" (The Tennessean, April, 1979).

Support for pluralism has also been viewed as a guise for unequal and dis-

criminatory services for minority groups.

A more recent argument questioning the desirability of a pluralistic model holds that it obscures the basic class nature of social services. Class conflicts, not insensitivity to ethnic differences, are said to be responsible for the inequality in the provision of mental health services. What is needed are not better culturally relevant mental health services for Puerto Ricans but the same quality services across classes. Thus, class conflict is believed to be at the bottom of inadequate service delivery to Puerto Ricans, not cultural discrimination or inappropriate services. On the other hand, it may be unrealistic to try to separate class from ethnic minority issues since they are so highly related.

Local surveys show that residents place the lack of public services as a higher neighborhood priority than mental health services. Neighborhood associations perceive the absence of public services as contributing to mental illness. Consequently, it will be more difficult to organize neighborhood groups around issues concerning traditional mental health services unless they are grouped with a more general community development model. So, for many neighborhood groups, urban services are given a higher priority than mental health services for improving the general quality of life.

Public Acceptability

At the same time that the courts are pressing for the constitutional rights of former mental patients to life in the least restrictive environment, there is growing local resentment toward the establishment of community residences in neighborhoods. Generally, the more desirable and stable

a neighborhood, the less likely are its residents to accept a halfway house for the mentally ill. However, it is difficult to determine whether local residents reject the concept of community residents or the strategies CMHC's and other mental health agencies have used to install them. Often residents are not consulted about plans to locate a community residence until they are finalized by state and city government. Only then is the community approached about the plans. In one case in the South Bronx, the CMHC advisory board was not consulted about plans to establish a community residence until the CMHC staff had finalized the project with local and state agencies. When notified of the project, the CMHC advisory board turned it down.

Certain areas of cities attract groups of people dependent on social services. For example, in New York City, the Lower East Side is known for its extensive network of welfare services. Similarly, city welfare agencies have been sending large numbers of former mental patients to the single room occupancy hotels on the Upper West Side. Local residents express concern that community residences will attract large numbers of mentally disabled persons to their neighborhood, turning it into a dumping group for society's deviants.

Perhaps, neighborhood residents do not reject the concept of community residences as much as the strategies of professional mental health workers and their agencies for imposing policies on them without initial community involvement. Moreover, previous models for community residences have crowded mental patients into highly visible settings: SRO's and large nursing homes. Recent policies suggest that whenever possible, distributing cooperative apartments throughout several neighborhoods and only maintaining a

couple apartments in each building reduce community fears of being inundated by former mental patients.

Innovative programs require time to be effectively implemented and to produce measurable results. Both provider agencies and residents often create unrealistic time periods for the evaluation of new programs. Provider agencies feel accountable to state legislatures and city governments to show immediate results for programs considered experimental from the beginning. Local advisory boards are anxious to see that their tax dollars are spent efficiently and that their program goals are effective. Moreover, over-zealous community control advocates may create unrealistic demands on mental health agencies for effectiveness in experimental programs. One community planning board wanted to approve funding for a CSS project in New York City on a monthly basis or for a maximum of three months. The development of non-traditional mental health services could suffer from the unwillingness of provider agencies and community groups to allow sufficient time for these programs to organize and produce results.

Political Feasibility

Union Labor

The first social and community support programs were intended to rely strongly on voluntary associations, neighborhood social groups, extended family and friendship networks, and self-help groups. However, the community mental health movement had to confront the issue of employment for employees of state and mental hospitals. As the process of deinstitutionalization continued, wards in the state mental institutions were emptied and

in many cases, closed down. Consequently, state hospitals no longer need ed to employ as many individuals at their facilities.

Since the state hospital workers are strongly unionized, they represent a powerful political force at the city, state, and federal levels of government. Moreover, the state mental hospital association workers, particularly in lower-skilled jobs, are disproportionately represented by blacks and Hispanic minorities. Their unions are demanding that the community mental health clinics find jobs and retrain them if they are released by the hospitals. The CSS projects in New York City and the new Mental Health Systems Act proposed by the Carter administration have been influenced by these union pressures for worker re[illegible]tion.

The entrance of state mental health workers into the CMHC programs raises costs considerably more than expected. Also, their presence encourages continuity with more traditional programs rather than those depending on grass-roots groups, self-help and the voluntary sector. Yet, the earlier CMHC legislation was unrealistic to have assumed that a strongly unionized labor force like the state hospital workers would not have resisted their displacement by federal deinstitutionalization policies.

Hospital Control

Community mental health centers that are associated with a hospital find their community advisory boards severely limited. In addition to the CMHC executive boards, community advisory groups must contend with the hospital boards. Hospital boards of directors do not intend to allow equal participation of non-professional local residents on a board which affects hospital budget decisions. The earlier concept of community mental health

center governing boards was not politically feasible because of CMHC's need for a hospital affiliations. Generally, the federal government will not give control of funding to a CMHC without a hospital affiliation.

The Hunts Point Multi-Service Center in the Bronx is a good case of a mental health clinic goverened by a community board. Its mental health clinic is not directly affiliated with any hospital although it has back-up ties with the Lincoln CMHC and Misericordia Hospital.

The social and community support programs are strongly attacked when professionals perceive these programs as alternatives or substitutes for their services. When self-help programs or folk healers are presented as replacements for professional mental health services, innovative programs are most vulnerable to the attacks of professional associations. On the other hand, when non-traditional mental health services are organized as supportive or complementary to existing services they encounter less professional resistance.

Community Control

The issue of community control is particularly important with respect to social and community support programs. Among the main barriers to community control, Nassi (1978) emphasized three: (1) the role of the professional in determining service goals and ultimate accountability; (2) the mental health ideology which encourages individuals to focus on internal sources of psychological stress; (3) the conservative nature of the mental health special interest groups acting to maintain their existing power structures. Nassi (1978:10) concluded that: "Without institutional changes in funding, the service aspects of community psychology will never

be truly accountable to the community." In addition to these micro-limits to community control there are macro-structural limitations supporting centralized control of mental health programs. Brown (1978) claimed that community control of mental health care is impossible as long as U.S. society maintains its class structure with its racial and sex biases.

The private sector is absorbing large amounts of federal funds provided to foster community-based institutions. For example, nursing homes have expanded their psychiatric wards to gain third-party payments, (Brown, 1978:389) showing increases of 72 percent from 1964 to 1970 compared to 2 percent in public hospitals. From this perspective, deinstitutionalization is used as a policy for states to successfully transfer mental health costs to federal and city governments as welfare costs. The federal government has picked up most of these costs through its Medicaid, SSI, and Medicare programs focusing more on private in-patient care rather than public, out-patient services.

The federal government indicated a declining interest in community control when community mental health center legislation downgraded community governing boards to advisory boards. In addition, HEW rarely allocated CMHC funds to centers that are not directly associated with hospitals. The hospital boards continue to hold the budgetary power over the CMHC. Moreover, the CMHC executive directors also dominate community mental health policies.

Yet within the advisory role, community organizations have firmly established themselves in New York City. The Borough Federations for Mental Health, Mental Retardation and Alcoholism Services and the city community planning boards advise the Department of Mental Health and the City government and make planning recommendations concerning the programs operating

within their neighborhoods.

The federation mental health councils are composed of providers, (representing mental health agencies) and consumers (representing the various sub-regions of the borough). The federation guidelines mandate a consumer majority on the borough mental health councils. However, the definition of consumer allows for the possible domination of the councils by two groups: representatives of area voluntary associations; or, other designated representatives of human service agencies not related to the mental health provider agencies. While professional mental health workers attend these meetings as part of their regular work, local consumers must arrange to meet with the council at their own expense. Time and transportation costs can be considerable. Consumer representatives who are not responsible to local voluntary associations are often relatives of mentally ill persons, not former mental patients themselves. In general the Federation structure is dominated by providers or consumers who think like providers. Similar to other community organizations, true representation of local residents is difficult to obtain.

The City community boards are also represented on the borough federation board. However, in some areas of the city, community boards have their own mental health subcommittees. In particular areas, community boards have delegated sub-committees to oversee the community support system program. These subcommittees reflect a professional human services orientation similar to the managerial and fiscal model discussed in the previous chapter. Members of the committee who are not associated with the professional mental health and social services agencies present other problems for community planning. Frustration with the complex human service

bureaucracy leads local consumers to make demands for program performance and evaluation which are unreasonable from the provider's point of view. For example, at one community board meeting local residents urged that the community support programs be funded for three-month periods and evaluated for program effectiveness after that period. Representatives of the Department of Mental Health and provider agencies pointed out the difficulty of measuring the effectiveness of a new program after as short a period as three months. In this instance, the city agency's criteria for evaluation prevailed. Moreover, monitoring program effectiveness is more problematic than usual when dealing with the new community support projects whose efforts are more difficult to quantify than traditional programs.

Centralization of the CMHC

The cultural pluralism of many catchment areas in New York City creates special problems for the delivery of mental health services by community mental health centers. Organizationally it is difficult for adminstratively centralized CMHC's to provide services to minority populations within their catchment area. For example, the South Bronx CMHC catchment areas include Black and Hispanic populations.

One option is to redefine catchment areas to conform more directly to ethnic and class neighborhood boundaries. A culturally homogeneous catchment area facilitates the delivery of services by centralized CMHC's.

If the catchment areas are not redefined, then political conflicts will most likely be heightened as CMHC's attempt to deliver services to dominant and minority ethnic populations. Under these conditions the

case manager must learn to link his/her clients with services from a variety of subcultures and cultures.

Unintended Consequences

Outcomes other than those planned result from all policy options. Recognition of possible unintended consequences will, at least, make it easier to deal with them once they occur.

When primary groups like block associations, social clubs, and friendship networks become the policy tools of the government and the professional welfare agencies, they become vulnerable to cooptation and to changes from their original purposes. Indigenous leaders can lose their effectiveness with their neighborhood groups if they become too closely identified with a formal social service agency. Spiritualists who assume clinical roles within CMHC's may lose their original effectiveness. Once federal, state, or city funding becomes available to assist neighborhood organizations, local leaders are more readily coopted by government agencies. The current, popular self-help groups modeled on middle-class white organizations cannot be assumed to function equally effectively for low-income ethnic minorities. In general, a public policy focus on particular non-traditional social supports has a way of quickly converting these organizations into traditional, less effective deliverers of mental health services.

The development of apartment housing programs for the mentally disabled can weaken the stability of neighborhoods, reducing the very desirability of the area for former mental patients. Halfway houses often establish themselves in neighborhoods that are declining in real estate value

and experiencing less residential stability. Without careful planning, the stigma attached to halfway houses will contribute to the flight of local residents.

A policy focus on culturally relevant mental health services can lead to two unintended consequences: (1) the over emphasis on folk healers as the principal deliverers of mental health services to ethnic minorities; and (2) the continuation of a two class system of mental health services for the poor, ethnic minorities.

For one, professional mental health workers in accepting an ethnic model for the delivery of mental health services may indiscriminantly accept all categories of folk healers as equally beneficial to their clients. However, folk healers vary significantly in terms of the quality of care they provide. Instead of accepting folk healers as supportive to their work, professionals may relinquish their expertise in providing any kind of mental health services. In addition, once culturally relevant mental health services are incorporated by policy-makers, there may be a tendency to incorrectly assume that all Puerto Rican or Hispanic clients must be treated by folk healers. Although spiritism is a common culture trait found in Puerto Rican communities, few individuals (probably no more than 9 percent) regularly use these folk services (Garrison, 1977a:162).

A second unintended consequence that may result from the acceptance of culturally relevant mental health services is the development of a discriminatory two class system. Hispanic communities may have their CMHC's loaded with paraprofessionals while white middle class CMHC's receive the professionally trained mental health workers. To emphasize the importance of paraprofessionals in linking professional service to

clients is not to suggest that local residency is a sufficient criterion for working with ethnic minorities in community mental health programs. Moreover, a policy directed toward paraprofessional training for mental health programs might lead to cuts in general funding since professional services are no longer the main budget items.

CHAPTER VI

IMPLEMENTATION AND EVALUATION

Implementation: The Weak Link in the Policymaking Process

The process of implementation of mental health policies will always contain uncertainties and unpredictable events. Berman (1978:179) summarized three reasons why federal (or state) policymakers should never expect a context-free theory of implementation:

(1) macro-implementation inevitably involves politics;
(2) the federal government typically has limited leverage to influence the behavior of local implementors, who have the effective power in the system;
(3) micro-implementation cannot be effective unless local delivery organizations undergo an adaptive process that can neither be predicted accurately nor controlled from the outside.

Often, the failure of programs results from not considering the problems of implementation in the original formulation of policy. According to Pressman and Wildavsky (1974:143): "Implementation must not be conceived as a process that takes place after, and independent of, the design of policy." Generally contradictory legislative goals, administrative conflicts among federal, state and city agencies, and local exigencies account for the difficulties of implementing programs. Studies of implementation differ in the weight placed upon federal policymaking versus the uncertainties of local action in contributing to program failures (Attewell & Gerstein, 1979; Pressman & Wildavsky, 1974; Berman, 1978; Elmore, 1978).

Macro-implementation involves the ways in which the federal (or state) government policy influences local service deliverers. Responding to these actions, the city devises and executes its own internal policies creating problems of micro-implementation (Berman, 1978). Difficulties in the implementation of CSS policies in New York City occurred at both the macro and micro levels.

Macro-Implementation

Major difficulties for the state's implementation of social and community support programs involve their use of a systems management model of organizations. The systems management model views organizations as value-maximizing and implementation as an ordered, goal-directed activity (Elmore, 1978). The systems management approach "assumes that the totality of an organization's resources can be directed at a single, coherent set of purposes--that organizations can be programmed to respond to changes in policy." (Elmore, 1978:20).* In all, policymakers will have to also recognize the options available from the ethnic minority and community development models if community support systems programs are to develop beyond the delivery of conventional mental health services in community contexts.

Decisions about the population to be served by a social and community supports program must be developed by both the state and city agencies in collaboration with the local communities targeted for these programs. Experiences from the early stages of implementation of Community Supports System programs in New York City showed that the criteria for defining the target population were too limited. State level decisions influenced the selection of only SRO's and PPHA's as the target population for the community social supports program. The City Department of Mental Health,

*Elmore (1978) discusses three other models where each provides a different explanation for implementation failures--bureaucratic process model, organizational development model, conflict and bargaining model. Elmore concludes that: "every implementing agency probably has a set of management controls, a firmly entrenched collection of operating routines, some process for eliciting the involvement of implementors, and a set of internal and external bargaining relationships. The important question is not whether these elements exist or not, but how they affect the implementation process." (1978:227).

its local contracting agencies, and neighborhood residents became increasingly concerned that the original criteria were not adapted to meet community needs for non-traditional and culturally appropriate mental health services. The Borough Federation Boards established by the City Department of Mental Health and the Community Boards should be more closely incorporated into the CSS projects from the initial planning stages. The local residents and agencies could play a major role in defining the populations targeted for CSS programs within their neighborhoods.

Yet, macro-implementation approaches are also amenable to community social support programs. Title IV of the proposed Mental Health Systems Act will provide increased assistance to the community support systems approach. This section of the Act recognizes the close relationship between mental health and other supportive services. Moreover, it specifically supports the maintenance of existing non-revenue producing functions (i.e., not Medicaid reimbursable) once basic support has terminated. If there is sufficient funding for this section of the Act, it will directly assist efforts to build social and community support for Puerto Rican and other minority populations.

Micro-Implementation

Community support systems are different from the traditional model of professional treatment for the mentally ill. Their usefulness for the mentally ill requires an ecological perspective where professional and non-professional workers, traditional and non-traditional services facilitate the reintegration of mentally ill persons into a community or some

form of supportive social network. The micro-implementation approach is important in dealing with these ecological issues.

Housing is a very significant element in the ecological context. Housing programs, like group residences or separate apartments, are critical factors for the adjustment of the mentally ill to life outside the institutions. In the South Bronx, adequate housing is a serious problem even for those not labeled as mentally ill. The City Department of Mental Health might encourage its case managers or other staff to act as advocates for their clients to obtain housing through the Community Tenant Management Contract Program. In this program, residents of the South Bronx buy abandoned buildings from the City for a minimal cost. The costs of restoration are deducted from the rent paid to the City. In this way, housing improvements are encouraged outside the expensive public housing programs. The City Department of Mental Health might develop programs to increase the incentives for providing community residences and apartments for the mentally ill through similar urban housing programs.

Unless housing projects are associated with large scale efforts for local economic recovery, there is little chance for neighborhood revitalization. For example, the Charlotte Street project in the South Bronx did not offer the assurances of a comprehensive community development plan based on the economic revitalization of the area. In fact, the project was initially designed to provide only a cooperative housing project located in a small part of a large devastated area of the city. Projects of this nature do not encourage the development of social and community supports in Puerto Rican neighborhoods.

The City Department of Mental Health and local providers need more discretionary funding to be able to develop community support type programs. Discretionary funding would allow communities to reorder the priorities of community support programs to meet their specific needs, whether they are housing in the South Bronx or SRO's on the Upper West Side.

More flexible state funding increases the problem of accountability. Certainly the importance of accountability is foremost in the managerial-fiscal model for the delivery of mental health services. However, from the point of view of the ethnic or community development models, funding should be more flexible.

Program Evaluation

The evaluation of social and community support projects is a very difficult process. Reliance solely on the managerial-fiscal tools such as unit costs for patient care is adequate only for orthodox programs within the medical model of treatment. It is difficult to conduct experimental research within a clinical setting without additional staff (Carpenter & Black, 1979). Moreover, it cannot be assumed that clinical staff will correctly interpret a researcher's intentions in the collection of data for non-traditional programs. Clinical staff are trained in research evaluation in which standard interviews are unlikely to capture unconventional beliefs.

Instead of the older, easily quantifiable, short-term criteria, new criteria for evaluation of the community support programs must be developed. For example, these programs have no precedents for measuring the time it should take to locate clients for their porgrams. Greater flexibility must be allowed in innovative programs attempting to strengthen or rebuild social networks. These criteria should be developed in an ongoing dialogue among state and city agencies and local residents. Evaluation procedures should not be delegated only to outside private consulting research groups. It is important that evaluation criteria be meaningful to a community's residents. This can only occur if residents play a part in their formulation. For example, as the Borough Federations in New York City develop, they are scheduled to organize Patient Care Committees to evaluate the problems patients encounter while seeking services in the community (NYC-DMH, 1978b). Direct consumer participation

in the creation of program evaluation criteria will improve the implementation process at the local level.

It is unrealistic to assume that there can presently be a meaningful uniform evaluation of community support systems programs for purposes of statewide comparisons. Standardized evaluations will reflect little more than criteria from a managerial-fiscal perspective. I have argued that the managerial-fiscal model alone is inappropriate for developing and evaluating community support systems.

From the perspective of the community development model, program evaluation would focus criteria on the measurements of neighborhood solidarity. This point of view considers change within a long-term perspective. Moreover, the community development model designs criteria for program evaluation that would be comprehensible to a neighborhood's nonprofessional residents. In all, program evaluation is recognized in the end as being a highly political process regardless of the clinical aura attached to the evaluation procedures.

The ethnic model could focus its program evaluation criteria on the measurement of cultural community supports. Similar to the community development model, changes are considered within a medium to a long term perspective. Criteria for program evaluation would be designed to reflect changes in family and social network organization. In addition, these criteria would indicate the extent of increased minority representation within the mainstream mental health agencies. The program evaluation process is recognized as political. The ethnic model considers political conflict a central factor in building ethnic interest groups.

To some extent there are similarities in the program evaluation criteria developed by each of the social support models: clarity of goals, general accountability, efficiency and others. Yet, each model focuses on other criteria which are mutually exclusive. Unless the community development and ethnic models establish sources of funding independent of federal, state or city government, they must deal with program evaluation criteria which are acceptable to their funding organizations. At the same time, these models must maintain evaluation criteria which make sense to their particular constituencies or clientele. Without losing sight of the neighborhood or the family as the main focus of services, community development and ethnic models must recognize the concern of the managerial-fiscal model for its goals (i.e., interagency linkages and short-term fiscal accountability). A program evaluation specialist could act to make evaluation criteria more compatible to these various interest groups. This liaison role fits within the more general policy liaison strategy discussed in the following section.

Policy Liaison Strategy

The implementation of the policy options proposed here depends upon the transfer of knowledge from researchers to policymakers. However, it cannot be assumed that this process will occur automatically. The gap between researchers and policymakers is described in a report by the National Research Council (1975:155).

> The lack of communication about R&D (Research and Development) is caused by differences in the cognitive worlds of government officials and researchers as well as their time priorities. The researcher isolates and examines one small piece of reality while the official lives in a realm of buzzing confusion where variables scramble together and decisions must be made in the face of uncertainty. Mutual education is often necessary for government executive and researchers to understand each other, but time for this interchange does not seem to be available. The pressure of daily business weighs upon officials, driving out long-range planning, problem anticipation, and efforts to call R&D results for policy and program decisions.

To bridge the gap between social scientist and policymakers, city agencies like the Department of Mental Health need individuals to take on the roles of policy liaison specialists (Dokecki, 1977). Whether as advocates or mediator/broker, policy liaison specialists help translate research information into a form readily useable by policymakers.

The role of policy liaison specialists is particularly important where we are concerned with the implementation of policies for Puerto Rican communities based on social and cultural supports foreign to the traditional medical model. This role might be incorporated as part of the cultural specialist's work in community support systems projects.

A critical dimension of the implementation process involves the development of program evaluation criteria acceptable to Puerto Rican

clients, local residents and the mental health bureaucracies at federal, state and city levels. With a broker or liaison specialist whose role is to adjust expectations, demands and evaluation criteria, there are more opportunities for the successful development of a social supports program for chronically mentally ill Puerto Ricans in New York City.

The new role of case managers adopted by the community supports systems projects in New York City and the President's new Mental Health Systems Act, if not coopted by the managerial-fiscal groups, can play an important part in linking culturally significant social supports to the array of professional social services. Garrison's Inner-City Support Systems Project argued the need to institutionalize the culture specialist as a separate staff position (Podell & Campos, 1979) with its own state civil budget line. However, it is unlikely that staff training programs, although valuable in themselves, will be sufficient to establish the legitimacy of a cultural liaison specialist role within the mental health field. Such programs face strong professional resistance and bureaucratic intransigencies. If the community development and ethnic models gain greater acceptance among professional mental health organizations or these models are forced upon them by grass roots political action, then the efficacy of cultural liaison specialists will increase dramatically. The liaison strategy remains a promising new direction for policy formation and implementation very applicable for meeting the needs of the mentally ill within a community setting.

CHAPTER VII
CONCLUSION

For the past twenty-five years, the deinstitutionalization movement has developed at a rapid pace. The promotion of social and community supports for the mentally ill has met substantial resistance. The absence of information concerning the effectiveness of social supports for mentally ill individuals in Puerto Rican neighborhoods hinders efforts to document the impact of this approach. Moreover, the existing studies suggest that social and community networks are not as easily manipulated as public policymakers would like them to be. While the philosophy of the current deinstitutionalization movement supports the funding of community-based services, some federal policies have forced states to focus on more conventional community-based services (i.e., nursing homes). Other federal guidelines, like the NIMH Community Support Program, emphasize less conventional grass-roots local social services for the chronically mentally ill. The federal government has not developed a comprehensive policy with regard to social and community support programs. The federal, state and city programs have moved in the direction of the managerial-fiscal model to the neglect of the community development or ethnic models. The deinstitutionalization process shows that there are no simple policies that can adequately deal with complex problems.

Via NIMH guidelines and state deinstitutionalization policies, New York City's Department of Mental Health, Mental Retardation and Alcoholism Services is implementing a Community Supports System Program. I consider the ethnic and community development models as the preferable options for the New York City program. These models focus on strengthening the primary group networks

(i.e., kin and non-kin attachments) of mentally ill persons, on improving the services available from non-professional community mental health workers and folk healers, and on providing housing for individuals without other alternatives for community support.

The City Department of Mental Health is under pressure from the State to orient its Community Support Systems Program along the lines of the fiscal-managerial model. The State focuses on the City's need to build their Community Support Systems program on the basis of federally reimbursable programs. However, a reliance on federally reimbursable programs prevents the City from meeting the most pressing needs of Puerto Rican neighborhoods for housing and non-traditional mental health services. The ethnic and community development models are more supportive of values found within the Puerto Rican neighborhoods than the managerial-fiscal perspective of the State.

Public acceptance of Community Support Systems programs is problematic. The establishment of local services and community residences for the mentally ill is as difficult in Puerto Rican neighborhoods as it is in other areas of the city. Union labor, hospital corporations and centralized community mental health centers have acted as politically conservative forces limiting the implementation of the ethnic and community development models. Representatives of the Puerto Rican community are concerned that the Community Support Systems programs may unintentionally lead to an overemphasis on folk healers in their neighborhoods and to the continuation of a two-class system of mental health services.

A policy liaison person who mediates between the community's views and the perspectives of the state or city can assist in the implementation of social and community support programs in Puerto Rican neighborhoods. It is

important that program evaluation be meaningful for both the funding agencies and their clients. A program evaluation specialist could also play a significant liaison role.

Finally, the managerial-fiscal model will loom even more forebodingly over the City's Community Support Systems programs as federal welfare programs are affected by growing government austerity. The actions taken in Washington will demonstrate once more the increasing interdependence of contemporary organizational life.

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