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City University of New York PH.D. 1983

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UTILIZATION PATTERNS IN A
COMMUNITY MENTAL HEALTH CENTER

by

Tsila Zalcman

A dissertation submitted to the Graduate
Faculty in Sociology in partial fulfillment of the requirements for the degree
of Doctor of Philosophy, The City
University of New York.

1983

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TSILA ZALCMAN

1983

This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

January 21, 1983
date

Samuel W. Bloom
Chairman of Examining Committee

1/25/83
date

Bogdan Denitch
Executive Officer

William Kornblum, Ph.D.
Judith Lorber, Ph.D.
Mary Louise Skovron, Dr. P.H.

Supervisory Committee

The City University of New York

Abstract

UTILIZATION PATTERNS IN A COMMUNITY MENTAL HEALTH CENTER

by

Tsila Zalcman

Adviser: Professor Samuel W. Bloom

The primary aims of this study have been to chart how a predominantly minority client population utilizes the services of a community mental health center (CMHC) and to account for variations occurring in patterns of utilization. The data used in the study were derived from two sources--a survey conducted among former patients of an urban CMHC, fictitiously referred to as "City," and patient charts.

The growing complexity of mental health service delivery and the fact that the CMHC movement has greatly enlarged and diversified its potential clientele required that we rethink the issue of utilization behavior. We, therefore, began by discerning four prototypes of users at City-CMHC: low, sporadic, intensive, and high. The

typology of low and high represents the traditional dichotomy which views use of mental health services on a linear continuum. In contrast, we believe that the sporadic and intensive patterns of use offer useful alternatives to the dominant middle-class and professional model of long-term insight therapy, with special reference to the poor and minorities.

Our data reflect the grinding effects of poverty among users of City-CMHC. The most consistent finding points to an association between unemployment and high use of mental health services. Moreover, clients who are recipients of welfare checks also constitute the "highest" utilizers of City services. Another important, yet serendipitous finding, uncovered the high use of medication as either a supplement to or as the sole mode of treatment for emotional and mental problems. Other noteworthy results point to the predisposing implication of sociodemographic factors upon utilization behavior, and to the importance of accessibility--geographical, financial and psychological.

Finally, we feel that the major determinants of utilization in the type of population we have studied are beyond the policy-maker's short-term attainments. If the CMHC is to be successful, it should get away from the medical model and embrace more fully the social model.

ACKNOWLEDGMENTS

I am grateful to the community mental health center for giving me access to the data needed for this study. Special thanks are due to my thesis committee members, Samuel Bloom, William Kornblum, Judith Lorber, and Mary Louise Skovron who helped me achieve my perspectives and crystallize my theme. George Rothbart was invaluable in providing intellectual stimulation. The women of my study group--Phyllis, Joan, and Sue--have encouraged me throughout the research and writing process. The patience and sense of humor of Caroline Helmuth have been most helpful. Michael's friendship has helped sustain the energy required for the completion of my work.

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CHAPTER 1

COMMUNITY MENTAL HEALTH CENTERS AND UTILIZATION OF SERVICES

Mental health is regarded today as a fundamental concern for the American society. Yet, it is only in the past century that definitions of deviance have been transformed from "badness" to "madness" to "illness." This gradual transformation has created the need for medical treatment and increased the demand for equitable distribution of mental health services.

By 1963 the Community Mental Health Center Act was legislated with the intended purpose of making such services available to all segments of the population. At the core of the newly legislated act, however, was a concern for certain "target" populations, such as poor minorities and the elderly. Thus, issues of utilization of mental health services, especially by poor minorities, are appropriate at this time.

The objectives of this research are twofold. First, we explore the patterns of utilization which emerge in a community mental health center (CMHC). Second, we attempt to identify the factors which shape these utilization patterns.

The pursuit of our research objectives has been guided by three central tenets: (1) to develop indicators of utilization which adequately reflect the complexities of the actual patterns produced and experienced by the research subject; (2) to include in the analysis of utilization factors linked to the clients' perspective and subjective experiences; and (3) to understand how external forces--social, political, economic, and technological--help to shape utilization patterns.

We begin, therefore, with the macro issues discussed in both Chapter 1--the historical overview--and Chapter 3--dimensions of utilization: a review of the literature. We then describe the research design in Chapter 4. The historical evolution and organizational structure of our research site are presented in Chapter 2, which is intended to provide the reader with the more "objective" facts about the organization--a center we call City-CMHC located in a large urban city--within which utilization patterns occur. The next three chapters (5, 6, and 7) present our findings, which are based on a survey sample with 327 former clients of City-CMHC, gathered between late 1980 and mid-1981. Chapter 8 will conclude with a summary of our principal findings and a general discussion.

Mental Health Policy in the United States: A Historical Overview

The nineteenth century marks an era in which the most pivotal changes in the conceptions and the treatment of mental illness had occurred. Around the beginning of the 1800s, the vast majority of psychiatric patients were cared for in their local communities. Not always distinguished from common criminals and vagabonds, they were often lodged in prisons or poorhouses, usually deprived of any form of treatment and subjected to a great deal of suffering under intolerable conditions.

In 1841, the State Mental Hospital Movement emerged, partly as a protest against the inadequacies of these community programs. Inspired by the energy and commitment of one person--Dorothea Dix, a Sunday School teacher in a Massachusetts jail who was shocked to discover mentally disturbed patients among the inmates--the movement advocated states' intervention and participation in the care of the mentally ill. By 1881, thirty-two state mental hospitals had been inaugurated as a result of her efforts and "mental illness" became the dominant definition of insanity.[1]

This shift of responsibility for the care of the mentally ill from local communities to the state took part during a period of growing public concern for the protection of the general health and welfare of the population; a concern which was expressed in the provision of public health departments and services throughout the country.

During its early days, the state mental hospital came to epitomize everything that was noble and humane about the treatment of the mentally ill. Charles Dickens, who in 1882 had visited what is now Boston State Hospital, wrote about it: "The state hospital for the insane is admirably conducted on those enlightened principles of conciliation and kindness."[2] Indeed, the state hospital was founded on principles of the Moral Treatment Movement which believed in the cultivation of the human capacity through the process of education. This was quite a departure from earlier methods of treating insanity with chains, purging, and bloodletting.[3]

The situation, however, began to change by the late nineteenth century. Increase in the general population due to waves of immigration, mass production, rapid industrialization and urbanization produced a concomitant rise in admission rates to the state mental hospital. Beginning in the 1880s, the number of patients admitted into the hospital began to increase annually; simultaneously, the average length of hospitalization climbed as well. In addition, and as a consequence of the waves of immigration into the United States, the foreign-born and the poor were heavily over-represented among the mentally ill.

Unable to expand because of a dire lack in financial and manpower resources, the state hospitals were no longer capable of providing adequate care to their patients. As the buildings had begun to deteriorate, the institutions reverted to custodial care, becoming vast warehouses for a burgeoning mental health population. Thus, what had started out to be a model of care for the mentally ill had gradually been transformed into a "snake-pit" asylum.[4]

Around the beginning of the twentieth century, and in the spirit of reform prevailing during the Progressive Era, the National Committee for Mental Hygiene was formed and gained momentum. Its predominant concern was to open the state hospital to the view of the public in order to awaken its conscience and bring about innovations in treatment modalities. The goals of the committee included improving the standards of treatment and care in state mental hospitals and educating for prevention of mental illness.

The committee, which grew side by side with the movement for promoting the health of mothers and children, was reflective of the Progressive Era which had already brought about more direct forms of health protection through increased federal involvement. A public health approach, emphasizing prevention, education, and early detection, was thus proposed. However, these early attempts to involve the federal government met with strong opposition by the American Medical Association.[5]

Meanwhile, the mental health professions were developing as specialties and organizing into societies. Yet, their successful claim to legitimacy depended largely, like that of any occupational group, upon the public's belief in their competence and professed skills. Indeed, beginning in World War I, the psychiatric profession gained acceptance through its successful treatment of shell-shock and other war-related symptoms. Different forms of treatment, such as insulin and electric shock, were also invented by the 1930s. In addition, new ideas and concepts were emerging, most notable among them, Freudian theories, pushing toward even greater specialization. Thus, for example, psychoanalysis took root and with it yet another claim for professional expertise.

Technological developments and an increase in scientific knowledge have continued to aid the mental health professions. By World War II--both during the draft when an estimated 1,875,000 of men (of 15 millions) were rejected from serving in the Armed Forces because of mental problems,[6] and in the aftermath of the war as thousands of veterans were suffering from war-related mental disabilities

--demand for mental health professionals increased. By then, the psychiatric professions had gained the public's endorsement; they were highly regarded and viewed as the vehicle to a quick wartime recovery.

The success of the psychiatric professions in conjunction with the ferment created by the mental health reform movement and the rapid growth of professional organizations have laid the foundation for the federal government's involvement in mental health policy. Thus, in 1946 the National Mental Health Act (PL 79-487) was legislated. Its intended purpose was "the improvement of the mental health of the people of the United States through the conducting of research, experiments and demonstrations relating to the cause, diagnosis and treatment of psychiatric disorders."[7] The legislation of this act paved the way for the creation of the National Institute of Mental Health (NIMH) which was established that same year, and ultimately to the creation of the Community Mental Health Centers (CMHC) program in 1963.

Traditional explanations for the genesis of the CMHC Act usually focus upon the widespread critique of state hospitals' custodial care and the growing concern for patients' rights. The benefits of psychotropic drugs in tandem with the development of new concepts of community-based treatment modalities are also regarded as significant. While each of these factors had probably contributed to the promotion of the community mental health program, it is their convergence in a particular time, when the political climate was ripe, that made the program a reality.

The Development of Community Mental Health Centers

Mental health policies are part of an intricate matrix which comprise the broader and the constantly changing social and political context. It is important, therefore, to understand the forces which shape these policies in order to have a better grasp not only of the complexities of CMHCs but also of the ways in which they are being utilized.

The general parameters of these forces were already described as the increase in scientific and technological knowledge and, perhaps more importantly, the rise of the mental health professions. These have consequently resulted in the medicalization of many forms and definitions of behavior removing them once and for all from the domain of "deviance" or "insanity" and into the medical sphere. Before we discuss the impact of this process upon utilization behavior, let us review briefly the emergence of the CMHC.

After the establishment of NIMH, various developments which had begun several decades earlier accelerated rapidly. The professionals, well organized by now, united around the early 1950s to form what has been labeled the mental health lobby. Joined by an array of foundations, congressional leaders, and environmental groups dedicated to change, the movement protested against the state hospital system. They pledged to end custodial care, stressing prevention and rehabiliation. In addition, they publicized ideas such as "mental illness is an illness like any other illness" and "mental health is everybody's business."[8]

Simultaneously with the mental health lobby, a patients' rights movement was also forcefully denouncing the state mental system. Their attack, fought vehemently through the courts, centered on the right to treatment issue. In case after case, they described and documented the lack of treatment and the total neglect of the state mental hospitals.[9] Their legal attack combined with the protest of the mental health lobby produced a burst of media exposes which gave the situation a sense of urgency.

Advances in the field of scientific knowledge also lent support to changing the system. Epidemiological studies documented a surprisingly high prevalence of mental disorder among all segments of the population, however, especially notable among the poor and the lower classes.[10] These findings pointed out the need for professional services and, in part, contributed to the decision to make such services available on a mass scale.

Progress in related technology produced the field of psychopharmocology. The advent of psychotropic drugs, especially, presented an alternative to institutionalization since symptoms of many mental disorders were now arrested or altogether erradicated. Indeed, the result was a sharp decrease in the daily census of the mental hospital population and the facilitation of what later became largely known as the "Deinstitutionalization Program." Concepts of the therapeutic community, formulated just around that time, also lent support and eventually the necessary justification to discharging patients from the state mental hospitals and supposedly into community-based programs.[11]

The various strands of development schematically described above have converged to make mental health a national issue of major importance. Thus, in 1959, the surgeon general appointed a committee of state health authorities to work with the public health service in recommending guidelines for state mental health planning. In 1961, the Joint Commission Report was submitted to Congress, followed two years later by a special presidential message transmitted to Congress by President Kennedy. In his message, Kennedy asserted that: "Mental illness and mental retardation are among our most crucial health problems. They occur more frequently, affect more people, require more prolonged treatment, and cause more suffering...."[12]

The President, therefore, proposed "a bold new approach" to the problem of mental illness. This approach would require an increased role for the federal government in legislating and implementing a national mental health program. He recommended that the Congress authorize grants to the states for the construction of comprehensive community mental health centers, authorize short-term grants for their initial staffing cost, and appropriate money for planning grants under the supervision of NIMH.

The Community Mental Health Center Act

The key to the proposed national mental health program, according to Kennedy, was "the new knowledge and new drugs acquired and developed in recent years which make it possible for most of the mentally ill to be successfully and quickly treated in their own communities." He continued to state that "these breakthroughs have rendered obsolete the traditional methods of treatment which imposed upon the mentally ill a social quarantine, a prolonged or permanent confinement in huge, unhappy mental hospitals where they were out of sight and forgotten."[13]

The promise implicit in Kennedy's message was that state mental hospitals would be phased out. In their place, CMHCs would be established throughout the country. These centers would use community resources and facilities to provide better care for all aspects of mental problems. The concept behind the CMHC program was comprehensiveness. Each center would offer diagnostic and evaluation services, emergency psychiatric units, outpatient and inpatient services, day and night care, consultative services to other community agencies, and mental health information and education.

These services would be provided within the patient's own community, thus making it possible for professionals to better understand his problems and the environmental factors which play a part in them. The centers would be well coordinated to facilitate the movement of patients from one service to another as their needs change without necessity to transfer them to different facilities located in different communities.

On a broader, long-range plane, the President focused on three objectives: First, he said, "we must seek out the causes of mental illness and of mental retardation and eradicate them." Thus, prevention became a key concept and a stated goal of the new act. It was also emphasized by the President that prevention would require a concerted effort to improve the fundamental conditions in our society. Such conditions as, for example, poverty, racism, and drug abuse, often associated with mental illness, were identified as crucial targets warranting amelioration and change. Therefore, the need for social welfare and educational programs to correct harsh social and environmental conditions was stressed.

Second, the President called for the expansion of research efforts into the causes and prevention of mental illness, and for an increase in the number of professional and paraprofessional personnel who work in the field of mental health. This, he said, could be accomplished through launching new training programs. Third, emphasis should be placed upon "timely and intensive diagnosis, treatment, training, and rehabilitation" in community-based facilities which will also provide a range of services to meet community needs.[14]

The presidential message to Congress in 1963 thus laid the foundation for the CMHC Act, its goals and objectives. These objectives may be summarized as follows: A broader understanding of environmental or community factors which play a part in the patient's emotional disturbances must be sought out; greater emphasis should be placed on the interrelations between the individual and the community; comprehensive services for the mentally ill should be established in a broad range of community-based agencies; greater stress should be given to preventive measures, methods of coping, community organization, and styles of behavior in groups; special attention to the needs of children and youth, the elderly, minorities, the chronically ill, and other underserved populations.

Operationally, the CMHC Act promised to establish centers all over the country. These centers were to provide short-term inpatient care, outpatient and transitional care, emergency care, and consultation and educational services within the community. In order to realize these goals, almost 2,000 centers would have been needed to service a nation of over 200 million people. In effect, this plan was not realized. In 1967, 286 CMHCs had been in existence; by 1970, their number went up to 450, and by 1973 to 493. During the period between 1965 and 1973, Congress had authorized almost 600 million dollars for the construction of CMHCs; however, only 245 million (41 percent) had been appropriated.[15]

The discrepancy, which grew over time, was a result of a series of decisions made by the Nixon administration. These decisions, reflective of a new ideology which came into existence, opposed the involvement of the federal government in the support of health and mental health services. Thus, in the changing social and political climate, brought about with the change in administration, the CMHCs were gradually mandated to take on more responsibilities for social disorder with far less support than necessary. A series of amendments were legislated between 1965 and 1974 intending to expand the required services the CMHCs were to offer, demanding, among others, evaluation and documentation on the effectiveness of these programs.

CMHC: Issues and Problems

One of the main thrusts of the CMHC program was to supplement and ultimately replace custodial care of the state asylums. Indeed, the Community Mental Health Movement grew out, in part, of the conviction that the state hospitals were not providing adequate care to people with psychiatric disorders; on the contrary, they were seen as the cause of chronicity and dependency among patients. Accordingly, the CMH movement advocated the discharge of patients from state mental hospitals and their treatment in the community.

The question becomes: did the CMHC program succeed in achieving this objective? Firstly, did CMHCs become a replacement for state hospitals, and secondly, did they indeed offer a better alternative for treating the mentally disabled? The task of evaluating the success of the CMHC program is a very complicated matter and research studies designed to answer these questions yield contradictory and inconclusive findings.

Yet evidence exists from which some inferences can be drawn. An examination of the nationwide state mental hospitals census reveals a staggering decline in population --from a peak of nearly 600,000 in 1955 to a low of 216,000 in 1974. While the process of deinstitutionalization had actually started before CMHCs were established, with the advent of psychotropic drugs, it accelerated rapidly after the enactment of the CMHC Act. Stricter admission criteria with rapid discharge policies have combined to reduce the state mental hospital population by over 60 percent in less than two decades. In New York State, the inpatient population fell from 85,000 in 1965 to 25,000 to date, with a projected plan of a further reduction to 18,000 by 1983.[16]

Yet the sharp drop in state mental health population, while unequivocally a goal of the CMHC program, does not necessarily signify its success. For one thing, evidence suggests that most discharged patients have not been treated in community facilities and, in effect, have failed to make it in the community.[17] This evidence is quite startling since the early justification for the CMHC Act was precisely the provision of after-care treatment to discharged patients. However, the rapid process of emptying the state mental hospitals was not matched by an equally fast establishment of sufficient numbers of community facilities. Thus lack of resources--for financing construction of CMHCs and for training and hiring competent personnel--account, in part, for the CMHC program's inability to meet the demand for outpatient care.

Second, while CMHCs were supposed to offer an alternative for treatment, no one planned for an alternative place to live, for a home. Therefore, the key problem for discharged patients became the almost impossible task of finding an affordable place to live. As a result, substantial numbers of patients found their way into dilapidated and dangerous single room occupancies (SROs), while others had to resort to equally perilous men's and women's shelters, and still others had learned to survive as best they could on the streets of big cities.[18]

The difficult search for housing was exacerbated by community residents' protest at the clustering of "deviant" single people in specific buildings. These patients, who sometimes looked differently and exhibited peculiar mannerisms, were regarded as an undesirable element in the community. Ironically, the drugs which stabilized them sufficiently to be discharged into the community in the first place often produced those formidable side effects which at times contributed to their peculiar behavior.[19]

The lack of coordination between the deinstitutionalization program and the CMHC program resulted in the rise of a new kind of facility--the Private Proprietary House for Adults (PPHA). These homes proliferated, rapidly becoming the single largest care takers for the mentally disabled population. In fact, for lack of other options, patients were increasingly being discharged directly to these facilities. It is estimated that around 900,000 mentally disabled people live in these homes, usually deprived of any kind of therapeutic or rehabilitative programs. Moreover, they live under terrible physical conditions, mistreated and often abused.[20]

The consequences of deinstitutionalization, often referred to as "dumping," have been attracting the attention of many local politicians as well as the media. In a curious and paradoxical way, the plight of mental patients in the community today is being described in the same way as it was several decades earlier when they were housed in the state mental hospitals. "Old walls are torn down and new, less visible ones are erected. Someone had called it moving from 'back wards to back alleys.' Whatever it is called, it still adds up to ghettoizing the mentally disabled."[21]

Thus, the intentions of planners and the early belief that discharged patients receive care in the community seems to have had little basis in fact. This is verified by demographic statistics. For example, of the total deinstitutionalized population, 60 percent was aged fifty-five and above; in contrast, only 5 percent of the patients seen in the community were in that age group. Also, within a relatively short period of time, readmission rates for former mental patients began to climb markedly. Between 1967 and 1971, the number of patients admitted to state mental hospitals increased steadily, until 1971, when more than 402,000 patients were readmitted. Thus, a "revolving door" phenomenon began to take shape and deinstitutionalization has gradually become reinstitutionalization.[22]

The effectiveness of the CMHC program had been clouded by the program's inability to reintegrate and provide continuing care to patients discharged into the community. More serious, however, were the allegations that CMHCs did not succeed in developing needed innovations in their programs. Some asserted that the CMHCs have failed to achieve therapeutic results with the bona fide psychotic and therefore, have widened the psychiatric net to include those people with only minor disturbances who are more responsive to existing treatment techniques. In this connection, critics have accused the CMHCs for concentrating their resources on "the same old services," that is to say, traditional individual psychotherapy with receptive individuals, dissociating themselves from those patients who needed help the most--the deinstitutionalized, the poor, the uneducated, and the aged.[23]

These assertions raise very important questions regarding another major stated goal of the CMHC movement--the provision of quality mental health services to "target" groups, especially the poor minorities and the elderly who by and large have been inadequately served by traditional services. A critical question, therefore, continues to be whether or not these populations have taken advantage of the CMHCs and in what ways.

While this question is at the core of our research endeavor, we were also interested in how the ideological tenets of the CMHC movement were transformed into an organizational reality. Thus far, the historical overview of the changing mental health field has demonstrated that various forces converged to shape mental health policies. But how were these policies implemented in reality?

While it is beyond the scope of this study to deal with this issue in depth, it is worth discussing a few of the more salient problems which were incurred in the transition from a stated ideology to a concrete reality.

Community mental health, as an ideology,[24] was accompanied by several proposals for desirable treatment modalities. First and foremost, it stressed treatment in the community as opposed to an institutional setting. Also, it emphasized the need for direct and indirect services designed to address both preventative and therapeutic issues.

Yet despite these specifications, it quickly became apparent that the meaning of a "comprehensive community mental health center" is far from self-evident. More explicit guidelines were necessary in order to implement the innovative program. While the various amendments legislated between 1963 and 1976 denoted some specific guidelines, the meaning of the CMHC Act remained elusive and vague. This led to severe criticism about the nature of the program.[25] In fact, only a short time after the implementation of the

CMHC Act had begun, disillusioned critics proceeded to denounce the program as a failure. At that early stage, the criticisms were not based on evaluation of existing centers and their performance. Rather, they stemmed from divergent ideologies and the actual disagreement among proponents of the program about the fundamental nature of CMHCs--their role and domain of responsibilities.

If one holds the conviction that social problems are contributing factors in the development of mental illness, what then is the CMHC's responsibility vis-a-vis these problems? The community mental health movement did espouse a philosophy which regarded emotional disorders as a part of the larger social context. As stated by Smith (1968:21):

> We are not dealing with isolated disease processes, but with vicious circles of human misery and ineffectiveness, with patterns of self-defeated behavior that are hard to break because they are imbedded in the very texture of people's lives. We need to invest more in working on the social contexts in which troubled people are involved, and to count less upon the effectiveness of the isolated therapeutic hour.

The ideological underpinnings of these debates are embodied in two fundamentally different models: the so-called "medical model" and the so-called "social model."[26] The social model asserts that deviant behavior emanates from a social context, therefore, only attention to that social context offers a possible resolution of the problem.

According to the medical model, however, psychopathology is viewed as a disease and, therefore, by implication, people suffering from mental disorders are seen as sick and in need of treatment.

It was already pointed out that the social model acted as a dominant force in shaping CMHC ideology. But how, if at all, was it incorporated into CMHC reality? Once more, this question is too broad and cannot be answered here adequately. However, the following three aspects of the CMHC represent what we believe to be influences, if not conscious attempts, of the social model. Each one has, invariably, effected utilization of services and, therefore, should be briefly mentioned.

Modification in the Definitions of Mental Disorders

In 1974, the American Psychiatric Association appointed a task force to prepare new classifications "which would reflect the current state of knowledge regarding mental disorders." In May of 1979, the final draft of the Diagnostic Statistical Manual III (DSM-III) was formally approved.[27]

It is enlightening to compare DSM-III with its predecessor, DSM-II. The new manual clearly expanded the boundary of professional responsibility to include those situations which are not necessarily in the realm of mental problems. As stated clearly on page six of DSM-III:

> It is recognized that a behavioral or psychological problem may appropriately be a focus of professional attention or treatment _even though it is not attributable to a mental disorder_. (Author's emphasis)

Thus, a whole new category was added entitled "V-codes for conditions not attributable to a mental disorder that are a focus of attention or treatment" (p. 331). This category includes, for example, such codes as V62.20--"occupational problem (job dissatisfaction, or un ertainty about career choice)" and V62.89--"phase of life problem or other life circumstance problem (starting a new career, marriage, divorce, and retirement).

Whether this new addition was self-serving or whether it stemmed from other motives is a debatable question. But, it is clear that the expansion of the psychiatric definitions made it "appropriate" for a large number of individuals to utilize mental health services without necessarily being labeled as "mentally sick." This widening of the psychiatric net has, perhaps, destigmatized mental health services, and to a large extent made them more approachable. It also, inadvertently, blurred even further the border line between mentally sick and socially needy. Thus, to put it simply, there are more reasons now to use mental health services than ever before.

The Interdisciplinary Setting of the CMHC

The CMHC was staffed by several professional and paraprofessional groups which were intended to work as teams. These teams, comprised of psychiatrists, psychologists, social workers, nurses, and aides, were trained to deal not only with the client's emotional or mental problems but also with their social needs. Social workers, especially, who are more adept at providing concrete services, served that function.

The literature is replete with discussions of the hierarchical problems besetting CMHCs' professional teams.[28] However, regardless of the ensuing conflicts, the presence of social workers and paraprofessionals attracted a type of clientele seeking social rather than "psychotherapeutic" help. This point will be elaborated and substantiated with our own data in another chapter.

Community Control

NIMH Policy and Standards Manual required CMHCs to involve the community in the planning, development, and operation of the program; however, it did not specify the exact form such involvement should take. On the contrary, NIMH left this important mandate flexible and to the discretion of the particular center. Thus, different interpretations of the concept "community"--which has at least two apparent meanings, a geographical one and a sociological one--began to appear in the literature, and by extension, also a different interpretation of the meaning of community control. This latter concept was often distorted by interchanging it with concepts of community participation and community involvement.[29]

There seems to be a consensus that community control never did become a reality; and that community boards are generally elitist--comprised of the wealthy who are unaware of the real problems besetting their communities.

In summary, many critics claimed that despite the rhetoric about a community mental health revolution, the mental health field has yet to undergo significant changes. This sentiment was summarized succinctly in the Nader Report[30] which asserted that:

> While many of the motives behind the program are commendable, the program itself was hastily conceived and has fallen sadly awry in implementation.

The Report concluded:

> Community Mental Health Centers have largely failed to fulfill any of their major stated goals. They have not supplanted state hospitals; they are not usually accessible--geographically, financially, or psychologically; they have continued the two-class rich and poor system of care by frequent exclusion of indigent patients as well as those with the most severe problems; citizen

> involvement in administration and decision-making is more a goal than a reality in most cases; and centers are not held accountable to NIMH goals.

Whether the above criticism is justified remains to be conclusively demonstrated by future researchers. It is a fact, however, that the CMHC program did fall short of the initial hopes of many of its proponents. Yet, it is also our contention that the CMHC program has changed the patterns of mental health service utilization.

In this chapter we examined the history of the CMHC program from a national perspective. In the next, we turn our attention to one particular community mental health center--called by the fictitious name of City-CMHC (or City). We feel that the story of the center's evolution will elucidate the process through which CMHCs get established. Furthermore, since this center served as our research site, a description of its organizational structure will provide the context within which utilization patterns occurred.

Notes

[1] For a comprehensive discussion of the gradual transformation of deviant behavior from "badness" to "illness" see Conrad and Schneider, 1980. For a more detailed history of the state mental hospital movement and, in general, the history of psychiatry see, Goshen, 1967; Ackerknecht, 1968.

[2] Quoted in Bloom, 1975, page 11.

[3] For additional historical perspective see, Foucault, 1965; Bockoven, 1963.

[4] David Rothman (1971) provides a good history of the asylum, placing it within the context of the turbulent Jacksonian era. Grob's book (1970) adds an analysis of the decline of the asylum.

[5] For a historical account of the role of the American Medical Association in American medicine see Stevens, 1971.

[6] See Mechanic, 1969, page 55; also, in Ridenour's (1961) Mental Health in the United States.

[7] Quoted in Bloom, 1975, p. 21. For the original law see U.S. Congress, 1946.

[8] See Conrad and Schneider, 1980, p. 56.

[9] For an overview of the rights to treatment legislation fight see, Stone, 1975.

[10] The best known studies which have started a whole new area of research are Hollingshead and Redlich, 1958 and Srole, et al., 1962.

[11] Maxwell Jones is most prominently associated with this movement, see Jones, 1968.

[12] Kennedy's message is included in Appendix A, Bloom, 1975, pp. 263-276.

[13] Ibid., p. 265.

[14] Ibid., p. 264.

[15] See Bloom, 1975, p. 51.

[16] Bloom, 1975, p. 14; also see Baxter and Hopper, 1980, p. 5.

[17] Baxter and Hopper, 1980, p. 5.

[18] Ibid.

[19] Scheff (1976) argues that the short and long-term effects of psychoactive drugs have not been demostrated. Thus, he claims the enthusiasm for chemotherapy is premature.

[20] Hynes, C., 1979.

[21] Baxter and Hopper, 1980, p. 2.

[22] Bloom, 1975, p. 24.

[23] There are many critics whose names may be cited; however, their views are well expressed in the Nader Report, (Chu, 1974; also, Chu and Trotter, 1974).

[24] Community psychiatry served as a base for the community mental health movement. Gerald Caplan's (1964) Principles of Preventive Psychiatry, which draws from a public health model, became the gospel of the movement.

[25] A few good examples of these criticisms can be found in: Lego, 1975; Feldman, 1978; Sharfsteen, 1979.

[26] A discussion of the two models can be found in Bloom, 1975, pp. 211-214. A more critical analysis, especially of the social model can be found in Reiff, 1968.

[27] It should be noted that besides the American Psychiatric Association, the following organizations participated in the process of drafting the DSM-III: the Academy of Psychiatry and Law, the American Academy of Child Psychiatry, the American Academy of Psychoanalysis,

the American Association of Chairmen of Departments of Psychiatry, the American College Health Association, the American Orthopsychiatric Association, the American Psychoanalytic Association, and the American Psychological Association. These professional organizations formed a liaison committee in 1976.

[28] See, for example, Northman, 1977 and Kuramoto, 1977.

[29] Nassi (1978) analyzes the forces--professional and political--which impede community control. Brown (1978) extends her argument. His claim is that professionalism and capitalism coincide in their efforts to prevent community control.

[30] Chu, 1974, p. 775.

CHAPTER 2

CITY - CHMC: HISTORY AND STRUCTURE

Historical Overview

The idea to establish the City CMHC was conceived as early as 1961, before the enactment of the federal legislation, by the department of psychiatry of a medical college, an affiliate of a large municipal hospital. After the passage by Congress of the CMHC Act of 1963, plans were advanced for the development of a comprehensive CMHC to be part of and adjacent to the Municipal Hospital.[1]

In 1965, the City of New York recommended that the New York Community Mental Health Board request funds under the CMHC Act. The City Department of Hospitals then submitted an official grant application to the National Institute of Mental Health (NIMH) proposing to build a fourteen-story addition to the hospital. The building was to provide the necessary space for an array of mental health treatment programs; and, in addition, contain resources for training, research, and consultation and education. Of the total construction cost, estimated at $11,500,000, the City of New

York was going to assume the major portion of the expense, with the State contributing at least $3,612,000, and the federal government the sum of $1,950,000.[2]

This became the first construction project application from the State of New York under Public Law 88-164 (the CMHC Act). It marked the start of a new concept of co-responsibility in the care of the mentally ill to be shared between city, state, and the federal government. Thus, a new type of organizational structure--the Community Mental Health Center--came into being.

Federal legislation mandates through specific regulations a set of structural boundaries within which all community mental health centers must be organized.[3] Therefore, a certain degree of similarity exists in the comparison among CMHCs. However, the communities which are host to these centers differ from each other in their geographical, demographic, and socioeconomic characteristics. This introduces important variations in organizational structures, authority patterns, and types of treatment programs.[4]

As we examine one community mental health center and its response to the statutory act, it is, therefore, important to keep in mind the sources of both its uniqueness and typicality.

The process of establishing the City CMHC began with intensive studies of the community in an attempt to determine the need for mental health services and the boundaries of the catchment area. The estimated number of people residing in the area covered by the outpatient services of the Municipal Hospital was about 650,000. About 373,000 are served in a smaller area given inpatient services.[5]

This population is heterogeneous, however, with a heavy concentration of underprivileged minorities. Included within the total area, a sizable proportion of the population has an income of less than $4,000. Also, there is a high percentage of substandard housing, the highest crime and delinquency rates in the city, as well as a high drug addiction rate and a high unemployment rate. This area's rate of admission to state mental hospitals is one of the highest in the state.[6]

A letter of intent, submitted to the State of New York Department of Mental Hygiene, asserted the need for an additional mental health facility which was claimed to be seriously needed at that time and which would continue to be required in the foreseeable future. It was further emphasized in the letter that the six municipal hospitals serving the larger metropolitan area were overcrowded. In 1963, for example, the six hospitals providing psychiatric inpatient services admitted 34,675 patients compared to 2,610 for the eleven voluntary hospitals.[7]

Therefore, and in accordance with the recommendation of the New York Regional Mental Health Planning Committee that municipal hospitals be given prime consideration, a request was made to expand the mental health facility affiliated with the municipal hospital and establish alongside it a CMHC on the same premises. The proposed mental health center, to be administered by the Department of Hospitals and affiliated with the Medical College, would offer, besides mental services, a wide range of other services including general care, and general out-patient and emergency services.

The applicant had also provided assurance that all of the mental health services constituting the elements of comprehensive mental health care would be included: an inpatient ward, outpatient services, day care, a 24-hour emergency service, and consultation and education services. In addition to these five mandatory services, the plan included provisions for diagnostic, rehabilitative, precare and aftercare services, and for training, research and evaluation.

The project also proposed to establish "battalion aid stations" located in the community and staffed by professionals from the center. These battalion aid stations would serve as neighborhood first-line mental health services, as well as the baseline operation for consultation within related neighborhoods.

In November, 1965, the Regional Mental Health Director recommended approval of the project. However, the Review Board of NIMH deferred the proposal with advice to resubmit with revisions.[8]

Problematic Issues

Several issues were raised in the review of the grant. The first issue dealt with the population size of the catchment area. The applicant proposed a catchment area of 650,000 people which, in effect, was the designated catchment area for the Municipal Hospital. This grossly exceeded the 200,000 limitation stipulated in the federal regulations.

In line with the federal requirements, the applicant was urged to redefine its service area so it would meet the criteria of the regulation. It was pointed out by the Review Board that the magnitude of the social, health, and mental health problems reflected in a high proportion of the population covered would require very intensive services. Thus, the Review Board recommended to reduce the catchment area population to nearer the 200,000 federal stipulation.

The second issue, related to the question of the catchment area, was the provision of continuity of patient care. The Board expressed concern over the fact that there were no clear definitions of either the manner in which continuity of care would be managed once the catchment area is specified, or the relationship of the Municipal Hospital staff to the neighborhood and to the service agencies located in it.

The reader should keep in mind that while the proposed CMHC was going to be integrated into the Municipal Hospital so that together with the existing department of psychiatry all five necessary types of services could be provided, the federal government did insist on a distinction between the CMHC and the department of psychiatry. It mandated that the CMHC specify its own catchment area and treat its own patients.

The third issue referred to the use of the facility. More specifically, two objections were raised. One pertained to the proposed number of inpatient beds--200--which, according to the Review Board, exceeded the inpatient bed needs for a defined catchment area of 200,000 people. The other point of contention centered on the planned shock therapy unit. Since many facilities were no longer providing for this type of treatment, it was felt that the construction of the unit should be of such design that it could easily be converted to other use.

Lastly, the Board expressed its dissatisfaction with the design of the CMHC entrance and the fact that it was not directly open to the street. A memorandum to the New York City Regional Mental Health Director from the architectural consultant of NIMH states this concern very effectively:

> It is very important that the CMHC facility encourage the people in the community to seek mental health care. If the entrance is difficult, the person seeking help will be discouraged. A person arriving at a CMHC facility should easily be able to find his way to the appropriate entrance. A person initially seeking help should immediately feel that he is being taken care of.[9]

In March 1966, a CMHC construction grant was finally awarded to the New York City Department of Mental Health and Mental Retardation Services under the jurisdiction of NIMH, and on July 1966 the groundbreaking ceremony occurred. During the ceremony, John Lindsay, the then mayor of New York City, expressed his desire to see the new facility available "as soon as possible." He, therefore, urged the Public Works Commission to expedite construction of the center and promised that "this would be one project that would be opened on time--by 1969." Despite the mayor's optimism, the City-CMHC did not open until October of 1973.

The construction process had been plagued by architectural, structural, fiscal, and labor problems. Although the building was completed in 1971, two years after the mayor's projected date for completion, numerous violations made it unacceptable to the Hospital and Health Corporation

(HHC), and therefore continued to delay the opening of the CMHC until 1973.

It seems that the central problem was the fuzziness surrounding accountability between the HHC, the New York City Department of Mental Health and Mental Retardation Services, and the medical college, with regard to construction as well as the programs to be implemented.

In 1970, concerned over the delay in the opening of the facility, various representatives of community organizations joined forces and established an advisory body to the department of psychiatry of the medical college (the psychiatric affiliate for the Municipal Hospital). In 1972, the advisory body formed a Community Board of Directors for the CMHC.

Their primary stated goal was to open the center. Another goal was to achieve strong community participation, and to provide community outreach programs. In order to accomplish these goals, the Community Board made three demands: 1) that staff should be under the directorship of the department of psychiatry; 2) that the CMHC have its own community board, separate from the Board of the Municipal Hospital, to insure that the programs of the center meet the needs of the community; 3) lastly, that the center open without further delay. The Board expressed its grave concern over the building's condition. They stated: "We feel that after seven years of construction (1966-1972) this is a disgrace and that the city must be held accountable and pressed to remedy this situation."[10]

In response to the Community Board's action, the Regional Office of Mental Health began to exert pressure and to provide help in an attempt to solve the bottlenecks. Following extensive negotiations and voluminous reports, the City-CMHC was finally open in its new site on October 1973.

The Organizational Structure

While City, in its present form, did not begin to function until 1973, implementation of expanding programs had started with governmental staffing grants in 1968. At that time, the existing department of psychiatry had already been offering outpatient, inpatient, and emergency services. These comprised three out of the mandatory five services deemed essential by the CMHC Act for qualification as a community mental health center. (See Figure I)

In 1968, the two remaining services--a partial hospitalization program and a brief hospitalization ward--were added as a result of the newly available federal money. These two new services were funded as a partial CMHC, yet, with the understanding that the department of psychiatry would manage and oversee these two programs and in addition would supplement them so that all five "essential" services would be provided. (See Figure II)

From 1968 until 1973, while the building was being constructed with the intended purpose of housing all the mental health services, the two additional services were integrated into the existing ones and began to function under the same directorship, without distinctions in staff or catchment area affiliation. This practice resulted in a serious problem for the center.

The National Institute of Mental Health view the center as in violation of federal law which insisted on a reduced catchment area, on separate staff for the CMHC, and eventually on a separate director. Thus the same points of contention which were raised as objections to the original grant proposal, continued to plague City, bringing the imminent threat of legal suits.

A significant change took place in 1973 following the hiring of the incumbent director, a prominent black child psychiatrist. Her dynamic direction, as well as the force of her personality, has helped in molding City into a strong, decidedly autonomous organization.

The organizational structure of City-CMHC is intricate and complex. Its two components--the department of psychiatry with its Chief of Services, and the CMHC with its Director--are interwoven with parallel lines of authority. Cooperation between these two administrators is essential if the overall undertaking of service delivery is to function smoothly. The current directors stated in an interview that in general cooperation has been maintained and that conflicts have been minimized in order to facilitate the provision of well-coordinated and smoothly operated services.

Some problems are, however, being experienced in attempting to operate under various governmental requirements, particularly at a local level. This CMHC, as well as others in New York City, is often caught on the horns of a dilemma. For example, federal regulation mandates CMHCs to provide at least five basic services including consultation and education. The City of New York, however, has, as a matter of policy, withdrawn financial support for indirect services (such as consultation and education) for all city assisted and/or sponsored CMHCs. This places the city in direct conflict with federal requirements, a conflict which as of now has not been resolved.

Another problem often encountered in this particular case is that occasionally the hospital and the department of psychiatry's assignments and functions blur the specific concentration of the CMHC on its own designated catchment area.

At the state level, written agreements with the state hospitals are often lacking, or at best ineffective, for both adults and youth care. This interferes with the flow of patients from one facility to another and, therefore, hinders the continuity of care.

The preceding discussion served to illustrate the dynamic process involved in the creation of a CMHC. It, particularly, reflects the nature of the negotiation between the federal government, local authorities, and the community, each acting to protect its own needs and demands. In this case, the outcome of the negotiation resulted in a hybrid organization comprised of two distinct facilities: the more traditional hospital psychiatric department, which predated the CMHC Act, covering a large catchment area; and the second, the CMHC, covering a somewhat more restricted catchment area. In the remaining sections of this chapter, a brief description of City's catchment area will be followed by a general description of the CMHC.

The Catchment Area

The catchment area of City-CMHC is approximately one mile wide and two miles long. Yet, it is one of the most densely populated areas in New York City, estimated at over

200,000 people in 1980.[11] In general, the area may be described as urban-residential in nature. It has a few concentrations of stores and shops which serve the local residents, but very little industry and no manufacturing or office districts.

The southern boundary of the catchment area had remained very much the same for almost a century. Traditionally the home of the well-to-do, it is characterized by elegantly restored brownstones and apartment buildings, and by clean, well-maintained streets, providing an overall impression of affluence. The high rents may have accounted for the fact that the lower income population has not expanded to the south.

As one moves from the southern end up north, the appearance changes radically and with it changes also the composition of the population. The northern section of the catchment area was developed as a home for the working classes. It is visibly deteriorating, with houses that range from tenements to urban renewal buildings, to an ever-increasing number of abandoned buildings and empty lots.

Thus, the catchment area is comprised of diametrically opposed sections. On the southern end, the population is predominantly white and affluent. The northern end is comprised of a predominantly black and Puerto Rican population, generally found to be "disadvantaged," living in substandard housing and experiencing a great deal of social problems. This part of the catchment area also experiences a great deal of population turnover and accounts for the vast majority of those receiving mental health services at Municipal Hospital CMHC.[12]

The area is well served by public transportation. Buses run at frequent intervals on six of the seven north-south avenues and they run east-west on every tenth street. The subway also provides rapid transit service.

Population Characteristics

Many different ethnic groups inhabit the catchment area. The composition seems to change from one block to the next. However, there are relatively large concentrations of Hispanic--mostly people from Puerto Rico--and blacks in the northern half, and a greater proportion of whites in the southern half.

The differences between the two halves are pronounced also in terms of age, income, density of living condition, and education. These characteristics have been found consistently to be associated with the degree to which various types of mental health facilities are used.

Of the total population in the area, over 50 percent live in the northern half, with relatively high proportions of children ranging from 36.3 to 41.0 percent population under 18 years of age (as compared to 32.0 for the state as a whole and 21.5 for the borough of Manhattan as a whole), high proportions of blacks and Puerto Ricans--69.3 percent to 87.2 percent (compared to 17.5 percent for the state as a whole, and 40.0 percent for the borough), low levels of formal education (under 30 percent of those over 24 years of age were high-school graduates, while oever half of the comparable statewide and boroughwide population had graduated from high school). In addition, there are very high percentages of unemployed and individuals living under poverty level, and about 40 percent of the entire population is receiving welfare.[13]

In marked contrast, the southern portion of the catchment area had relatively high percentages over age 64, low percentages nonwhite and Puerto Rican, very high median incomes, low percentages of individuals under poverty level, and high educational levels.

City-CMHC--Provision of Service

City Community Mental Health Center derives its financial support via the quasi-public, quasi-private New York City Health and Hospitals Corporation, from the New

York City Department of Mental Health, Mental Retardation and Alcoholism Services, and the New York State Department of Mental Health. The funding for the center's operation is given in two separate allotments by New York City and H.H.C. to the Municipal Hospital for all personnel except physicians and certain selected administrative staff and to the medical college for physicians' services.

City had originally been funded as a partial CMHC consisting of a Brief Hospitalization Ward and a Partial Hospitalization Program. Other essential services for catchment area residents (24-hour Emergency Services, Outpatient Clinic, additional inpatient beds) were provided, also at City and within the CMHC Pavilion. The CMHC grant was administered by the medical college, which also provided attending psychiatric coverage for the department of psychiatry of the Municipal Hospital, under a separate affiliation contract with the City of New York and the Health and Hospitals Corporation.

The following services were included for the calendar year of 1979:[14]

(1) Outpatient Department (OPD)

(2) Child and Adolescent Clinic

(3) Drug Abuse Clinic

(4) Adult Partial Hospitalization Day Program

(5) Adolescent Partial Hospitalization Program

(6) Community Out-Reach Program

(7) Therapeutic Nursery Service

(8) Consultation andLiaison Service

(9) Emergency Room Service

(10) Ward After Care Service

(11) OBS/GYN Psychosomatic Clinic

(12) General Adult In-Patient Services (Wards 6S, 6W, 8S, 8W, 9W)

(13) Adolescent In-Patient Service (Ward 7S)

(14) Detoxification Unit (Ward 9S)

The main CMHC building is a fourteen-story structure adjacent to and attached to the rest of the Municipal Hospital. These floors resemble traditional mental hospitals in design. They contain several four-bed rooms, a few two-bed rooms, a nursing station, seclusion rooms, a day room, and several interviewing rooms or offices.

The building was constructed to contain both the CMHC and the psychiatric facility for the Municipal Hospital. However, there is no clear designation of space for the CMHC and, therefore, it is not identifiable as a separate and autonomous entity. This problem, which was regarded as a stumbling block in the approval of the original grant proposal, has not been corrected. As a result, the

CMHC and the department of psychiatry are viewed by patients as one clinic which provides a variety of services.

Services at City-CMHC

The total yearly outpatient visits were 69,665 (an average of 5,805 per month) for Calendar Year 1979. The distribution of outpatient visits is as follows:

SERVICE	VISITS	PERCENT OF TOTAL
Adult OPD Clinic	35,252	50.6%
Partial Hospitalization Program	7,195	10.3
Drug Abuse Clinic	6,797	9.8
Child and Adolescent Clinic	5,701	8.2
Community Out-Reach Service	4,595	6.6
Emergency Room Service	3,159	4.5
Therapeutic Nursery Service	2,628	3.8
Adolescent Partial Hosp. Program	1,835	2.6
Consultation and Liaison Service	1,384	2.0
Adult Partial Hosp.--Evening Program*	761	1.1
Ward After Care Service	265	.4
OBS/GYN Psychosomatic Clinic	93	.1
TOTAL	69,665	100.0%

*Service was closed in April, 1979.

The sample used as data base for this study was drawn from three key services of City: the Outpatient Department, the Partial Hospitalization Program and the Community Out Reach Service (underlined above). These services represent the major adult services responsible for 67.5 percent of the total yearly outpatient visits at City.

They are each described briefly below.

Outpatient Department (OPD)

The Outpatient Department, located within the new building, has been in existence since before the establishment of the CMHC. As part of the department of psychiatry it has an active caseload of approximately two thousand, eight hundred of whom are chronically ill and participate in socialization groups.[15] There are three treatment teams providing a broad range of treatment modalities. A special intensive treatment unit sees about seventy patients in individual and group treatment.

A "lounge program"[16] provides service three days per week from 1:00 P.M. to 4:00 P.M. for twenty-five patients who require more than weekly outpatient care but less than partial hospitalization. The emphasis is on social and vocational rehabilitation in preparation for more intensive treatment or training.

Most patients seen at City enter through the OPD which is generally responsible for their "intake." The intake procedure usually includes two interviews: the first is conducted by a social worker who obtains background information (such as demographic, financial and social data) on the patient. The second interview is with a psychiatrist who writes the official diagnosis[17] and recommends the course of treatment. On certain occasions, an additional interview will be arranged, usually by the department or service to which the patient is referred for treatment.

At OPD, patients are generally assigned to one therapist, although sometimes, depending on the diagnosis, two or even three therapists may be assigned to the case. Treatment modalities employed are fairly traditional, including individual and/or group therapy. There are no set rules for appointment procedures. This is negotiated between the patient and his or her therapist.

Community Out-Reach Service (COS)

This service is located at a neighborhood settlement house about one mile north of the main Municipal Hospital. Here, outpatient service is provided to a predominantly Spanish-speaking population who may be treated either at this facility or be referred to the Municipal Hospital for services, depending on the patient's needs. Current active caseload is two hundred, which represents approximately four hundred adult patient visits per month.

The COS has developed and implemented a program for the training of bilingual social work students. This program has been described as quite successful, yet, those who are trained at the CMHC and wish to remain as paid staff are unable to do so because of city budgetary constraints.

At COS, patient intake procedure is comprised of three interviews--one is a general intake evaluation, the second, a psychiatric evaluation. In addition, however, each case is presented before a team for a general evaluation in which short-term and long-term treatment goals are decided. A third interview will then be scheduled for the patient in which the original "intake" person will explain the treatment plan.

At COS, emphasis is placed on concrete social services. Most patients are assessed by a vocational rehabilitation counselor. This assessment, according to the director of the service, is a very important component of the program. In fact, the director stressed that successful termination of patients is achieved when they are placed on a job. "Many people leave us," she added, "when they find a job. Others often stay because they don't want to lose their welfare."[18]

In addition to treatment, COS is actively involved in outreach efforts with staff of various agencies as well as with consumers. Considerable consultation and education

(C & E)[19] is provided from this location, primarily by a C & E coordinator, however, with other staff members participating on their own time. The program maintains liaison with all community groups which deal with the health and social problems within the catchment area in a mental health context. Unfortunately, as we stated elsewhere, severe limitations are imposed upon the CMHC by the grantee (City of New York) as a result of budgetary constraints and policy determinations. These limitations often place the CMHC in conflict with state and federal requirements, especially in relationship to thie service.

Partial Hospitalization Program (PHP)

The PHP is a program which is designed to be an alternative to the inpatient service, as well as a transition type of program when a patient can be maintained in the community for at least eight hours, i.e., sleeping at home. The goal of the program is to establish the patient's independence of the Community Mental Health Center as quickly as possible. From the PHP, a patient could be referred to the Outpatient Department or to the Out Reach Program if individual therapy, family therapy, group therapy, etc., on a less intensive basis, were indicated. It is the goal of the CMHC to treat patients as close to their natural environment as possible. Therefore, patients who require ongoing outpatient treatment would have this treatment in the CMHC location that is most convenient for them and which offers the type of treatment that is indicated for the individual patient.

The decisions about the patient flow are made in the Liaison Committee of the CMHC staff. The Committee is made up of the program directors, chief of Ambulatory Care, and the director of the CMHC. In those instances where there is a question about the appropriate next step for a patient, the decision is made in the Liaison Committee. The Liaison Committee meets twice daily to discuss the patients.

This program adopts the therapeutic community concepts as a guide. The "people's community" format (PHP also standing for "people helping people") is supportive and enhancing and allows members (patients) to be involved in their evaluation, planning, and treatment. The group approach to therapy is emphasized as is vocational rehabilitation to a population which is rapidly becoming identified as chronically unemployed.

The major difficulty in this program is a lack of bilingual personnel. As a result, Hispanic patients experience difficulties in communicating with and relating to program participants of other ethnic and linguistic background.

More serious, however, is the lack of connection between the program's so-called vocational rehabilitation and labor force realities, which reduces that program to a mere occupational, or recreational therapy. Patients, therefore, are kept busy playing games, or learning how to make such items as ashtrays, doilies, or necklaces.

At COS, despite the fact that the vocational counselors are more active in terms of vocational training, actual job placements are also overwhelmingly difficult. Thus, at both treatment units, there is a "Catch-22" situation where patients acquire skills for which there is no employment.

In comparing the three services that were just described, COS, more than the other two, has made an attempt to deal with community problems. It has taken advantage of many services available in the community, whatever they may be--church, school, neighborhood health centers, and other types of counseling facilities. Its professional team works in a coordinated effort to diagnose a case and make the appropriate treatment plan. Moreover, COS is very small in size and does not resemble a "traditional" medical clinic. Rather, it has the appearance of a community center. The OPD, on the other hand, is a very large department which resembles, both in appearance and ways of functioning, a more conventional clinic. It is also less active in the community.

For these reasons, we anticipate different patterns of utilization to occur at COS. This will be discussed in further detail in Chapter 7, which examines the organizational determinants of utilization and uses the type of service as a test factor. We now turn, once more, to a general perspective which highlights some of the social indicators of mental health utilization found in the literature.

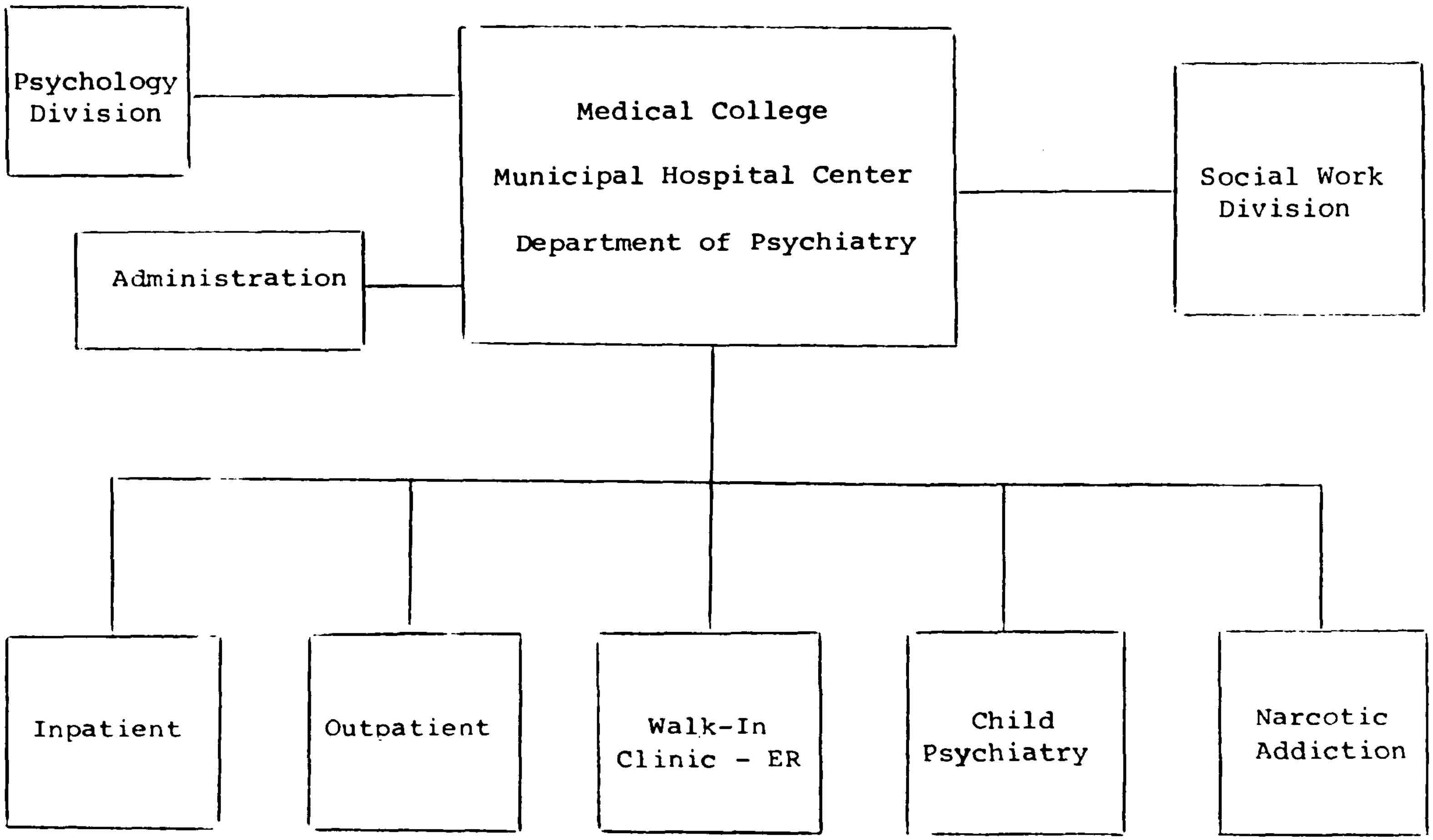


Figure I - CMHC Structure

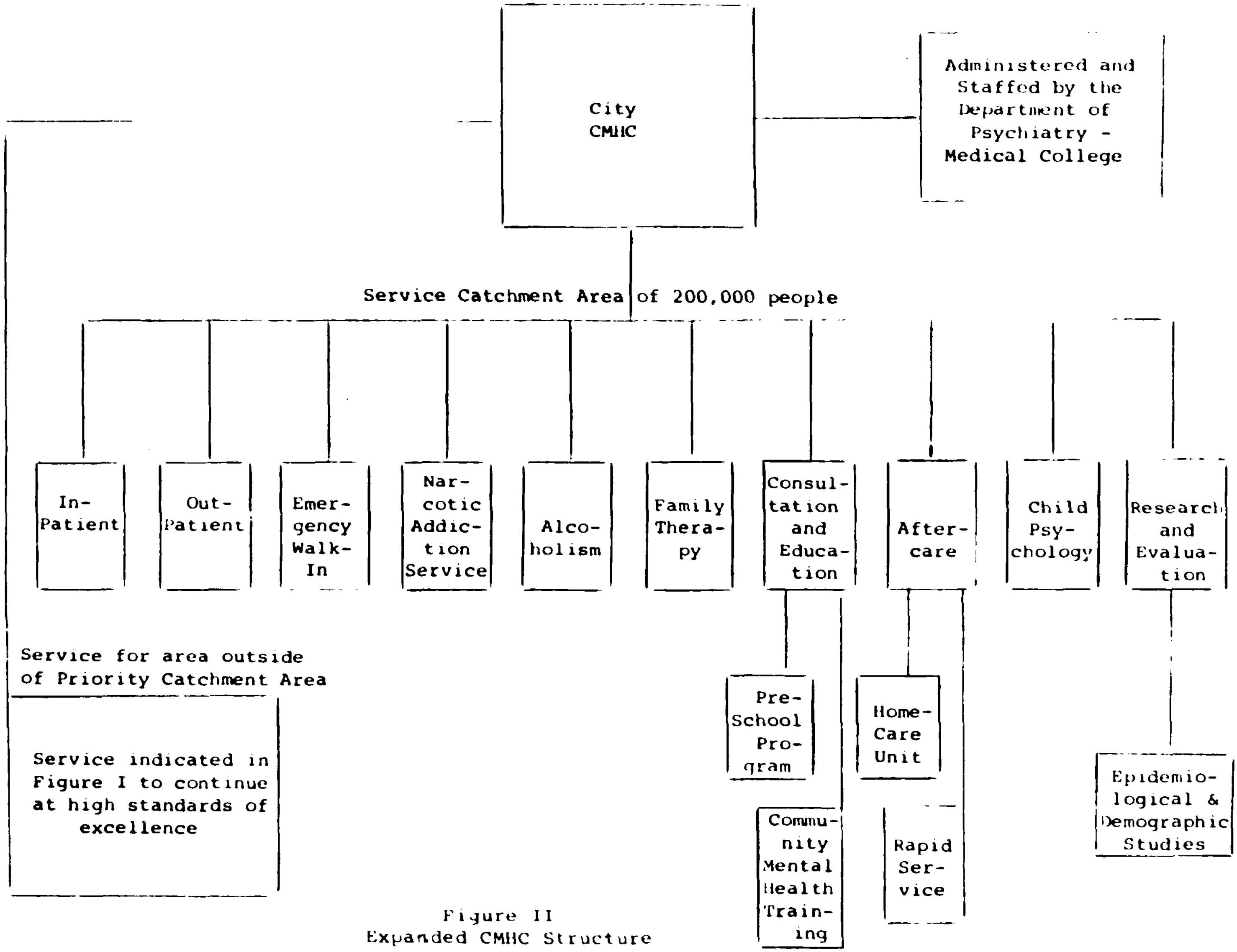


Figure II
Expanded CMHC Structure

Notes

[1] Throughout the thesis, we refer to the main hospital as the Municipal Hospital and to the CMHC as either City or City-CMHC. Their real names have been substituted in order to protect their identity.

The information for this chapter was drawn, in a large part, from archive material available at the regional mental health office. The information is public and contained in a special file available upon request.

[2] The grant application--a privileged communication.

[3] Bloom (1975) has a detailed discussion of these boundaries. See, especially, pp. 31-65.

[4] Firestone (1973) describes a wide range of CMHCs in New York City. The various organizational structures, however, can be found elsewhere.

[5] The numbers were obtained from a letter sent by the New York City Community Mental Health Board to the Commissioner of the State of New York Department of Mental Hygiene, dated March 10, 1965.

[6] Department of Health, Education and Welfare Publication No. (ADM) 76-373, printed 1976.

[7] The "letter of intent" was submitted by the commissioner of mental health services and director of community mental health services to the Department of Mental Hygiene of the State of New York on March 8, 1965.

[8] Response to grant application--a privileged communication.

[9] Ibid.

[10] A letter prepared by the Community Board of Directors on January 9, 1973.

[11] East Harlem Health Data Handbook. Department of Community Medicine, The Mount Sinai School of Medicine, May 1982.

[12] DHEW. Op. cit.

[13] Ibid.

[14] Annual Statistical Report, City-CMHC, 1979.

[15] The socialization groups constitute intensified group therapies in which the individual is socialized to function better in his or her environment.

[16] The lounge program is similar to the Partial Hospitalization Program, except, it is much less intense.

[17] The official diagnosis is a numerical category based on DSM-III. It is necessary to include in the patient's chart in order to get federal reimbursement.

[18] It is worthy of note that for many of City's clients, the official diagnosis and continued attendance at the CMHC serve to legitimize receipt of welfare checks.

[19] For a conceptual overview of consultation models see, Dworkin and Dworkin, 1975.

CHAPTER 3

SOCIAL INDICATORS OF UTILIZATION: A REVIEW OF THE LITERATURE

This chapter aims to provide a general framework for the discussion of minority utilization of mental health services. We do not intend to present a comprehensive evaluation of all the pertinent literature; rather, we highlight pivotal studies to point out the different approaches to utilization and the significant contribution of each.

In overview, several general observations can be made about the existing literature: First, studies vary significantly in the way they generate their key data. Most use official records or charts (e.g., physician, hospital, clinic or insurer records). A few rely on questionnaire data gathered from patient surveys. When official, allegedly "objective," data are used, the conclusions run a risk of being determined by organizational imperatives. Moreover, the viewpoints of consumers are systematically excluded from the findings. On the other hand, studies which rely totally on surveys tend to tilt the potential bias in the direction of consumers. This suggests the need to combine both "objective" and "subjective" data sources, a strategy employed by few researchers.

Second, and even more serious, vast disparities exist in the definition and measurement of utilization behavior. The importance of accurately defining what is being measured or evaluated cannot be stressed enough, and therefore will be discussed in greater detail in the following chapter. However, it is important to point out that some of the findings we report here were collected in studies designed to address issues not directly related to utilization behavior. Nevertheless, we chose to include these data because of their implications about seeking help for mental illness or emotional problems.

Last, historical and political changes transform social reality and therefore preclude the stability of research data over time. In studying mental health utilization, the advent of the CMHC Act followed by the legislation and implementation of Medicare and Medicaid have radically diminished the effect of some factors (particularly economic) upon utilization of services. For this reason, we drew mostly, although not exclusively, from research published after 1965.

There is a wealth of data, but they lack comparability and consistent theoretical bases. With the purpose of providing a more logical and comprehensible ordering of the published data, we have grouped selected studies into thematic categories.

The Socio-Demographic Approach

The utilization of mental health services is regarded to be related to population characteristics or, more specifically, such demographic factors as sex, age, education, religion, race, and ethnicity (McKinlay, 1972; D'Arcy, 1979; Williams, et al, 1979). It is generally agreed that women use mental health services more than men; that utilization increases with age; and that whites take advantage of available services more than other racial or ethnic groups. Yet, with the exception of sex, studies of sociodemographic factors do not explain in any depth why variations exist. All, however, provide a helpful account of utilization behavior by various social groups based on routinely collected and easily available data.

Sex, more than any of the other demographic factors, has been found to be a significant predictor of mental health utilization (D'Arcy, 1979). General consensus exists among observers that women report more mental distress symptoms than do men and use services with greater frequency (Verbrugge, 1979). Yet, the reasons given vary depending on the theoretical frameworks used for analysis.

The use of services by different minority groups has been of special concern for community mental health center (CMHC) researchers. One of the major goals of the CMHC movement has been to serve poor minorities, traditionally underserved by the medical system. Thus, with increased governmental attention on this issue, some of the emphasis in utilization studies began to shift in this direction. For example, Hooker (1979) compared Mexican-Americans to Anglo-Americans in terms of both need and utilization of mental health services. He reports that while the Mexican-Americans experience more stress and presumably need more services, they are, in fact, underrepresented in mental health centers. Similarly, Williams (1979) provides evidence for significant racial differences, with whites using more services than blacks, and black males using strikingly fewer services than white males or black women.

The Sociocultural Approach

The 1960s marked an upsurge of group consciousness and ethnic identification. The civil rights movement which heightened black identity also awakened the ethnic pride of other groups who increasingly became more sensitized to their own special needs (Hamilton, 1976; Giordano, 1976). The emergence of this "new pluralism" (Feinstein, 1974) created an expectation that society's institutions, particularly service-oriented programs, be sensitive to and accepting of cultural group differences. The CMHC movement, which came into being in this spirit of ethnic pluralism, indeed purported to make mental health services psychologically more accessible and culturally more relevant to American ethnic minorities.

Mental health research had also been affected by this new wave. A number of researchers, chiefly from the United States, focused more intensive attention on the study of norms, values, attitudes and life styles of various ethnic groups (McKinlay, 1972). More than any other, the concept of "subculture" provided these researchers with a conceptual framework from which to formulate their questions. This concept focused attention on the fact that attitudes and behavior are patterned and systematically linked to particular social structures. The central question was how various social groups perceive and respond to mental illness, and how these perceptions effect the utilization of mental health services. Although the type of inquiry was not new, it assumed new intensity and depth.

Perception of Mental Illness and Utilization of Services

Since utilization is, at least in part, a function of how individuals perceive, define and respond to existing symptoms, the utilization of mental health services would, therefore, be contingent upon the recognition and definition of certain types of hebavior (or symptoms) as "mental illness." In other words, the degree of acceptance of the medical/psychiatric model[1] and the ability to construe certain behavioral patterns as pathological can be expected to affect the rate of utilization.

It has been shown that in general and regardless of ethnic roots, the acceptance of the medical model is not widespread (Starr, 1955; Cummings and Cummings, 1957; Lemkau and Crocetti, 1962; Meyer, 1964; Dohrenwend and Dohrenwend, 1974). A number of vignettes were employed in a series of surveys. The vignettes illustrated psychiatric categories (i.e., paranoid schizophrenia, simple schizophrenia, anxiety neurosis, alcoholism, compulsive-phobic behavior, and juvenile character disorder. While psychiatrists unanimously agreed that the vignettes represent mental disorders, a number of studies conducted at various points in time concluded that the public was much less amenable to psychiatric definitions (Dohrenwend and Chin-Shong, 1967). Instead, they tended to label the behavior as socially inappropriate, and, by extension, not in need of mental health services.

The readiness to attribute mental illness to certain types of behavioral patterns varies among subcultures. In a multiethnic cross-sectional study of New York City, Dohrenwend and Chin-Shong (1967) compared the degree to which Jews, Irish, blacks, and Puerto Ricans accept the medical model, namely, view certain behavioral manifestations from an illness perspective. The Puerto Rican, more than the other three groups, departed furthest from the medical model regarding the behavior in question as "madness" rather than "sickness." The difference between these two categories is clarified by Garrison (1977), who contributes an added dimension to our understanding of the meaning of mental illness among Puerto Ricans. He emphasized a distinction which Puerto Ricans often make between "crazy" or "mad" and "nervous." The "nervous" state--sometimes manifested in the <u>Ataque</u>[2]--is regarded as a temporary medical problem not requiring any psychiatric help; the "crazy" or "mad" state, while requiring help, is not considered treatable by the medical system but, rather, by spiritualists or folk healers.

The culturally accepted belief in spiritualism and folk healers has greatly influenced Hispanic groups, providing them with traditional alternatives to modern medical care (Lubchansky, Egri, and Stokes, 1970; Garrison, 1972; Scott, 1974, 1975; Bestman, et al, 1976; Rabkin and Struening, 1976; Harwood, 1976). Garrison (1977) explained that espiritismo--an equivalent to a folk system of psychotherapy--is a widespread phenomenon, used by men and women alike. He estimated that at least 80 percent of the Puerto Ricans living in New York City use spiritualists at least once for crisis intervention purposes.

Gil (1980), who studied Puerto Rican women in New York City, indicated that spiritualism or "folk psychiatry" is an important source of support to the women who otherwise perceive mental health services as impersonal, insensitive and unkind. Espinoza (1977), who explored underutilization of mental health services by Mexican-American males, also found that many of the men preferred to see "curanderos" or other kind of folk spiritualists to seeing mental health professionals.

Other ethnic groups utilize alternatives to orthodox medicine as well. Bestman (1976) summarized the health practices of Miami's diverse groups:

> Ethnic groups utilize a wide range of therapeutic systems which are alternatives to orthodox medicine. Psychic healing, rolfing, chiropractice and Christian Science are examples of those therapeutic systems characterized by white Anglo clients. Obeah, Santeria, Vodum, Espiritismo and Orrtwork are those which are indigenous to the Bahamian, Cuban, Haitian, Puerto Rican and southern U.S. Black communities respectively.

While the spiritualists serve a very important function among many ethnic groups, it is not always clear from the studies whether they impede utilization of "established" mental health services. In fact, Garrison (1977), who studied the use of mental health services by Puerto Ricans, suggests that there are multiple patterns of utilization which involve the use of spiritualists, physicians, and mental health professionals simultaneously. Thus, the use of spiritualists may not be a good predictor of utilization (or, more appropriately, of underutilization) as many researchers have tended to assume. Yet, it expands our understanding of the complexities involved in the use of mental health services by particular ethnic groups.

The main thrust of the sociocultural orientation was to document different ethnic perceptions of mental illness and their use of mental health services. Instead, the literature reveals a strong common theme which reflects an avoidance of professional health services.

As an example, Fandetti (1974), in a study of working-class Italians and Poles, found similarities between the two groups, in that both preferred to rely on traditional institutions--the family and the church--in dealing with personal problems. Respondents of both groups failed to identify mental health professionals as a potential source of help. Mostwin (1976) focused in her study on the differential values and attitudes among Eastern and Central European families. Only subtle differences existed in the way those groups reacted to mental health services, but the general and persistent attitude was that of mistrust and reluctance to depend on professionals for help with what was perceived to be a personal or familial problem. The above studies constitute exceptions insofar as "ethnic groups" in most studies refer only to black, Hispanic, Asian-American, and native Americans. European ethnic groups have generally been classified under the category of "white" (Giordano, 1977).

Researchers who concentrated on Hispanic groups report similar findings to those summarized above (Edgerton and Karno, 1971; Newton, 1978; Keefe, 1978; Acosta, 1979). Padilla (1971) found that older and less acculturated Chicanos believe in the inheritance of mental illness, and adopt a fatalistic orientation toward the mentally ill, maintaining that they will recover by remaining at home. Alternatively, Padilla and Ruiz (1973) state that a Puerto Rican or Mexican would, in times of stress, return to his old neighborhood to chat with friends and seek companionship in the barrio. At times, he would even return to Mexico or Puerto Rico to be with his family. The common theme discerned from these findings points to an attitude which views emotional problems as a weakness, to a pride which compels individuals to deny symptoms, and to a reluctance to use mental health services, often opting instead to struggle alone or with the help of the family. Gaviria and Wintrob (1979) use this theme as their key variable in explaining underutilization of mental health services by Hispanic groups.

Before concluding this section, it is worthy of note that earlier studies like that of Hollingshead and Redlich in New Haven (1958) and Srole's Midtown study in New York City (Srole, et al, 1962) tended to stress the socioeconomic factors rather than ethnoculutral, pointing to the uneven distribution and reverse relationship of mental illness with social class. In contrast, others (Mechanic, 1969) asserted that ethnicity exerts a more powerful effect than socioeconomic status on illness behavior.

Researchers have continued to debate the relative importance of socioeconomic versus cultural factors in determining the prevalence of mental illness and the utilization of services. The debate, although redundant, was by no means trivial. It reflected two perspectives with radically different policy implications. The one which focused on socioeconomics implicitly defined any variation from middle class behavior as deviant and, therefore, undesirable. This implied the need to change the behavior through the intervention of the mental health system. In a critique of this "middle class" bias, it was proffered by some that what is labeled mental illness often represents cogent attempts at accommodating social stress produced by conditions of poverty (Billingsley, 1972).

Focusing on ethnocultural factors, on the other hand, shifted the emphasis from "universalistic" definitions of mental illness to a "particularistic" understanding of the unique cultural patterns of definition and response to emotional problems. This implied the need to change service institutions in order to make them more relevant to ethnic needs.

In summary, the sociocultural approach has the advantage of regarding behavior as patterned and systematically linked to social structures and community cultures. This enables one to view certain manifestations of so-called "pathologic" or "deviant" behavior from a relativistic perspective. It points out the fallacy of applying universalistic definitions of mental illness indiscriminantly. Moreover, it sensitizes mental health professionals to cultural variability and relativity. Far from being "deviant," the practices of different social groups can thus be viewed as the emergence of subcultural formulations. Furthermore, the knowledge, attitudes, and practices of the lower working class can be understood as adaptive responses to problems directly related to social structural positions and their associated life chances.

Yet the sociocultural approach has one major limitation. Such macrocosmic concepts as values, norms, ethnicity and subculture are too general and therefore do not constitute sufficient explanation of utilization behavior. Some researchers have shifted attention from these macro issues to employ a more symbolic interactional[3] perspective. Through this perspective, they attempt to describe health-seeking behavior on the basis of the "definition of the situation." Such situations as the relationship between the client and the professional, and the client's confrontation with a bureaucratic structure have, in particular, attracted social researchers. Studies of this type represent what we call here the delivery system approach.

The "Delivery System" Approach

Increased knowledge about organizations coupled with a heightened sensitivity about "blaming the victim" has led many researchers to focus on the mental health delivery system and the inherent structural barriers to utilization.

Karno and Edgerton (1969), for example, contend that Mexican-Americans' perceptions of mental illness do not differ significantly from those of Anglo-Americans. Rather, they attempt to explain variations in utilization according to obstacles to utilization inherent within the delivery system. Thus, the authors point to language difficulties, lack of respect, and the actual deficiency in psychiatric facilities as barriers preventing utilization of mental health services by Mexican-Americans. Indeed, Karno and Morales (1976) argue, when efforts are made to recruit Spanish-speaking personnel and to plan services more effectively, utilization rates for Hispanics seem to increase. This particular viewpoint has received widespread popularity recently. Particularly, evidence is accumulating that points to the absence of bilingual and bicultural staff, a fact which supposedly discourages Hispanic groups from using mental health services (Ghali, 1977; Mizio, 1979; Abad and Boyce, 1979; Gaviria and Wintrob, 1979).

A somewhat different approach which also focuses on the delivery system concentrates on the manner in which bureaucratic rules and regulations affect utilization. Here, intake procedures and emergency treatment are especially noted as creating obstacles for use (Gordon, 1965; Wolkon et al, 1974; Brandon, 1975). Torrey (1970) asserts that mental health services are, in effect, structured for the middle class, in that middle-class individuals are more adept at dealing with bureaucratic procedures and, in general, at finding their way through the bureaucratic maze.

One of the most persistent strategies in the study of utilization focuses on the sociocultural discrepancies between mental health professionals and the patients (Abad, Ramos and Boyce, 1974; Yamamoto, James and Palley, 1968; Lorrion, 1974, 1976). Acosta (1979), who examines underutilization of mental health services by Mexican-Americans, concludes that stereotypes and generalizations about Spanish-speaking patients are pervasive among professionals, and often discourage use of services. Trevino (1979) related the therapist's professional and ethnic status to utilization behavior by Mexican-Americans. His findings reveal that in those centers with low proportions of Mexican-American staff, utilization by this ethnic group tends to be lower than in those centers in which a higher proportion of Mexican-American staff is visible. A different conception of this problem is offered by Gaviria and Wintrob (1979). They suggest that the underutilization of mental health services by Puerto Ricans stems essentially from a cultural misunderstanding, namely, a discrepancy between the patient's presentation of symptoms and the provider's interpretaion of them. An illustration of this can be found in Fitzpatrick and Gould's study (1970). Exploring the high incidence of classified schizophrenia among Puerto Ricans in New York City, they conclude that the high rate is probably due to intercultural misunderstandings, where the practitioner diagnoses incorrectly because of a cultural bias.

Differential Treatment

The relationship between the patient's socioeconomic background and the assignment of therapists has been explored extensively. For the most part, the findings are consistent, showing that the higher the socioeconomic status of the therapist, the higher the status of the patient seen by him or her (Cobb, 1972). However, the interpretations of the finding have been contradictory. Some contend that a match in therapist-patient socioeconomic background results in better utilization of services and more effective treatment outcome (Cobb, 1972). Others argue that such congruity in background characteristics is not necessarily helpful, indeed, sometimes harmful.

A study by Daniel (1969) supports the first contention. Based on interviews with professionals, paraprofessionals, and poor patients, he emphasized the importance of the similarities between the patient and the therapist if the patient is to become a "good" user and the treatment goal is to be achieved. Especially important, according to Daniel, are the similarities in life experience and the use of common language. A rapport between the patient and the therapist is clearly desirable and perhaps even necessary for encouraging people to stay in treatment. But it is questioned by some whether it can only be achieved in a situation where therapists and patients are matched on SES and cultural characteristics. For example, Satow and Lorber (1975), who also conducted interviews with professionals and paraprofessionals at a community mental health center, point to a danger inherent in the concept of cultural congruity. The authors fear that a practice of matching patient and therapist on background characteristics may result in a kind of ghettoization of workers and clients. In the conclusion to their study, they state:

> . . . those clients considered least desirable may be relegated to service workers with social characteristics <u>also</u> considered undesirable in the guise of benefit to each, but resulting in a stratification of service workers <u>and</u> clients. . . . If that happens, it may be more beneficial to mix clients and service workers with different social characteristics as is now being recommended for the public school systems in New York City and Chicago.

Regardless of organizational policy, the "YAWVIS Syndrome"--the preference for Young, Attractive, White, Verbal, Intelligent, and Sophisticated patients--has been observed among mental health professionals, especially psychiatrists. It is maintained that psychiatrists tend to favor patients with whom they share normative values and expectations. Thus, they often view the lower-class patient as a less suitable candidate for psychotherapy, referring him or her to other modes of treatment.

Success in psychotherapy is usually attributed to the possession of such traits as the ability to explore interpersonal relations, the capacity for introspection, psychological insight, and a facility at verbalization.

These traits are almost always associated with the middle class. The lower-class person, on the other hand, is frequently perceived as a "poor" patient, and on that basis is denied traditional long-term psychotherapy.

The relationship between social class and the assignment to a treatment modality has similarly been explored by many researchers. The CMHCs are especially suitable for such an inquiry since, in addition to traditional psychotherapy, they also provide an array of other treatment options. Yet, here as well as in the other areas of research, the findings are contradictory and inconsistent.

Stern (1977), in a study of forty CMHCs, found that "overall, clients are given treatment with little or no regard to social class" (p. 323). Sue, et al (1974), in a study of seventeen CMHCs, found no evidence of preferential treatment for white patients. According to him, blacks were just as likely as whites to receive psychotherapy. In contrast, Shader, et al (1969), Lubin, et al (1973), and Mayo (1974) found that social class and ethnicity have a strong impact upon the treatment assignment, with middle-class and white patients being assigned to psychotherapy more often than lower-class and black patients.

Many researchers have argued that low socioeconomic status groups have a much lower rate of acceptance to individual-insight therapy than middle-class patients (Robinson, Redlich and Myers, 1954; Myers and Schaffer, 1954; Hollingshead and Redlich, 1958; Cole, Branch and Allison, 1962; Harrison, 1965; Shader, 1970; Brandon, 1975; Lorrion, 1974, 1976). Yamamoto and Goin (1966), for example, showed that one fourth of all employed patients were referred to individual long-term therapy, whereas only one in thirty of the chronically unemployed was offered such therapy. Instead, they were assigned to groups or brief treatments. Lief, et al (1961), consistent with the above example, reported that 62 percent of the patients accepted for treatment at mental health clinics were college graduates. In comparison, only 18 percent of those rejected had completed college.

The fact of differential assignment to treatment, in and of itself, is not a sufficient indication of discrimination. Yamamoto and Goin (1965), for instance, argue that lower socioeconomic patients require special kinds of psychiatric treatment, designed to be short-term, active, flexible and reality-oriented.

A number of studies have also examined the role of patient expectation in determining the nature of the treatment modality. Overall and Aronson (1963, 1966) found that low socioeconomic status patients expected the therapist to adapt a supportive, active and directive role. Those patients whose initial expectations differed from the therapist's were less likely to return. In another study, Klein (1967) reported that lower socioeconomic patients preferred counseling over reflective insight-oriented therapy. And Goin, Yamamoto and Silverman (1965) claim that even when lower-class patients do seek reflection and self-understanding through insight psychotherapy, they expect to get it within ten sessions or less. In summary, it is important to understand the processes which determine patients' assignment to a particular treatment modality. These processes, which include professionals' as well as patients' expectations, affect the way in which mental health services are being used.

The Social-Psychological Approach

The so-called "Social-Psychological Approach" has proliferated an abundant body of literature, too bulky for this review to consider. In general, however, this approach views health and mental health problems, as well as the utilization of services, as related to psychological and/or social-psychological mechanisms such as stress.

Consequently, many studies attempt to distinguish between users and non-users of mental health services on the basis of such mechanisms.

A vast area of research, which rapidly has been gaining attention, has concentrated on stress as it is related to mental health (Dohrenwend, 1974). It is often argued that "unhealthy" environments and life styles produce stressful reactions which may result in a mental breakdown. Thus, researchers have devised measures of positive and negative events by which to test and predict mental health and well-being, and similarly, to predict who will use services and who will not.

For example, using such a measure in a household survey of 454 people, Zautra, et al (1979) report that those individuals who reported more negative events also reported more psychological distress and less positive adjustment. On the other hand, positive events were associated with reports of positive adjustments. In the same study, it was also found that the basence of positive life events was related to higher utilization of community mental health centers.

Personality, as well as life-style measures, have been used extensively to study variations in utilization behavior. For example, Dawkins, et al (1980) looked for such differences among users and non-users of a mental health facility in an inner-city black community in Chicago. Significant differences between the two groups were found only for four out of fifteen personality measures and for two out of four life-style measures. Users were described as more dependent, unmotivated and socially withdrawn than the group of non-users.

Finally, the role of social support and its impact on health and mental health as well as use of services has also received a great deal of attention. This type of research, regardless of its focus, tends to emphasize the importance of support networks for coping with mental distress. Social support systems are also critical determinants in fostering successful use of mental health services (Dimsdale, et al, 1979).

Poverty, Racism and Mental Health

The role of poverty in the epidemiology of mental illness (particularly schizophrenia) was documented by H. W. Dunham (1935, 1939), Hollingshead and Redlich (1958), and again by Srole and his colleagues (1962). Since then, numerous studies have generated similar findings confirming that an inverse relationship exists between social class and mental illness and likewise between social class and utilization of mental health services. In fact, the association between poverty and a disproportionately high rate of mental disorder seems to be a transnational phenomenon (Dohrenwend and Dohrenwend, 1974).

Common sense alone tells us that poverty has myriad adverse effects. It is self-perpetuating, creating a vicious cycle which often leaves people not only poor, but also feeling helpless and hopeless. It therefore stands to reason that those conditions which are usually associated with poverty would be conducive to mental disorder. It has also been observed that even the utilization of health and social welfare services is hindered by poverty. Indeed, a sense of hope is necessary for people to seek any help at all (Davis, 1979).

Poverty in the United States is further confounded by the pervasive effects of racism and discrimination. Two major perspectives dominate the relevant literature on this question. The first focuses on the effects of racism on the mental health of victimized groups, especially blacks (Willie, et al, 1973). Here, the emphasis is primarily on the psychological damage to one's self-image and sense of security. The second perspective shifts attention to the manifestations of racism in the profession of psychiatry and psychology (Thomas and Sillen, 1972). The premise inherent in this orientation is that mental health professionals are not immune from racial biases. These biases, in turn, affect the ways in which they diagnose and treat their patients, and, therefore, inadvertently affect utilization patterns.

A very large body of literature thus exists which documents differential diagnoses of minority groups, particularly of blacks (Shapiro, 1974, 1975; Bell and Mehta, 1980). In addition, studies have also shown that blacks are often assigned different treatment modalities; they are hospitalized more frequently or assigned to short-term therapies (Maas, 1976; Rabkin and Struening, 1976).

Class and racial biases continue to affect the field of mental health--in theory and in practice (Brown, 1973, 1974). This is also manifested in the CMHC, despite its early intentions to eradicate racism and other forms of discrimination. We therefore believe that an understanding of these structural determinants is crucial for any study of health-seeking behavior. While it is difficult to completely unravel the intricate patterns of utilization, it is, at least, necessary to be aware of those factors inherent in the delivery system and pervasive throughout society which help determine whether and how people use mental health services.

In summary, there is evidence to indicate that many psychosocial factors contribute to the utilization of mental health services. They can be grouped according to three major categories: 1) factors intrinsic to the individual--i.e., mental health needs, perceptions and responses to those needs, and sociodemographic attributes, particularly, sex, race, and age; 2) factors intrinsic to the social group--i.e., cultural definitions, perspective on mental health professionals, support networks; 3) factors intrinsic to the organization of mental health services--i.e., availability and accessibility of facilities, staff characteristics and attitudes, and bureaucratic procedures.

Researchers who use any one (or all) of these factors in their explanation of utilization behavior often do so within varying theoretical frameworks and methodologies. In addition, the findings are often contradictory and confusing. There are also several assumptions inherent in much of the research which add complexity to the issue. First, in scanning the literature on mental health utilization, it quickly becomes apparent that more use (or longer use) is often equated with better use. This assumption should be carefully studied, especially in light of the expanded nature of CMHC services and the types of people they are supposed to attract. Second, it is assumed that those people who need services the most use them the least. This assertion is supported by mental health rates which show a greater degree of "pathology" among the lower classes on the one hand, and by utilization rates which point to a higher volume of service utilization among the middle and upper middle class on the other. However, these rates do not always reflect the whole situation and, therefore, should be carefully examined. For instance, the higher degree of pathology may be the result of overdiagnosis (attributing a more severe diagnosis than is warranted because of cultural misconceptions or biases), and not because of more mental illness. Similarly, low utilization rates may be the result of structural barriers and professional prejudice and not of the user's lack of motivation.

Finally, researchers often take for granted that people who come to mental health clinics do so because of mental illness. It is important to raise the question of what patients define as their problem and what kind of help they hope to get for it.

With these questions in mind, we turn now to the design of this study.

Notes

[1] In the literature, the psychiatric model and medical model are often used interchangeably. However, the traditional medical model was somewhat modified for the purposes of psychiatry. The ramification of this has been the broadening of the concept "illness" so that hardly anyone can escape the label. For a discussion of specific problems with the psychiatric model see Reiff (1968).

[2] *Ataque*, often diagnosed as schizophrenia (Freedman, Kaplan and Sadok, 1975) is a culturally accepted occurrence. It is described by Ghali (1977, p. 463) as an acute response to severe anxiety, characterized by hysteria and seizures.

[3] This approach attempts to understand, in detail, the ways utilization is effected by the interactions between clients and agencies or clients and therapists and the symbolic meanings attached to these interactions.

CHAPTER 4

RESEARCH DESIGN

The review of the literature in the previous chapter has served to demonstrate that utilization of mental health services is a multidimensional phenomenon and that many factors confound its explanation. While the primary focus of this study is on individual determinants of utilization, we feel, nevertheless, that such determinants can only be understood within the larger context (i.e., social, political, economic, technological and organizational); Chapters 1, 2, and 3 draw attention to these contexts.

Within these contexts, interpretation of the findings are influenced by the labeling-interactionist approach to deviance. Therefore, special emphasis is given to the clients' subjective assessment of their experience. Our concern with the subjective factors shaping utilization resulted in a study which stressed sample survey techniques with secondary reliance on organizational records.

Problems of Measuring Utilization

As mental health care grows more complex, the need to reconceptualize and redesign measures which reflect the reality of utilization more fully becomes more and more necessary. The fact that the CMHC movement has greatly enlarged and diversified the potential population of mental health service users makes the task all the more imperative and difficult. Yet, a review of the relevant literature reveals that most utilization studies continue to be couched in simplistic terms, representing utilization in terms of extensiveness of use or duration of time in treatment.[1]

These are unidimensional measures usually obtained either by counting visits to a facility or by computing the total period of time spent in treatment. Such an approach may have advantages, especially for administrators, insofar as it provides easily derived and apparently "hard" measures of the volume of services being used. However, the approach neglects crucial dimensions of utilization.

Most current researchers on utilization still rely implicitly on a conception of utilization which stems from psychoanalytic tradition. Consequently, long-term insight therapy is regarded as the ideal and other patterns of use are seen as less valuable and perhaps counter-productive.

It is no surprise that this limited frame of reference fails to capture the magnitude of the changed realities in mental health delivery.

A small number of studies have tried to expand their definitions to include divergent styles of use. One study, for example, divides patients into "good" and "poor" users (Otto and Moos, 1974). The good users were those who participated regularly in the treatment program, rarely missing an appointment, while the poor users were frequently absent and made minimal use of the treatment program. In another study, degree of staff approval for discharging patients was the key concern. Patients who consistently failed to keep appointments or left treatment against the advice of the therapist were designated as "dropouts." Those who were discharged with some degree of staff approval and who had discharge dispositions of "substantial benefits" were placed in the comparison group (Kennedy, 1949).

Udell and Hornstra (1977) made a more sophisticated distinction among utilizers. They discerned three distinct styles: the "intensive" user, exemplified by the patient using long-term, insight psychotherapy; the "casual" user, who comes to the clinic only for the purpose of receiving medication; and the "pseudo" user, e.g., the alcoholic who attends a detoxification clinic whenever necessary.

In another study, Fiester, et al (1974) delineated three similar categories of users: patients who try out a facility for one or two sessions and then drop out without trying any other; individuals who use mental health resources frequently and consistently; and people for whom a mental health clinic offers another contact in a maze of health-related agencies.

Solon, et al (1967) attempted to give meaning to a utilization career by introducing the notion of episodic users. They employed the "episode" as a framework for clustering discrete units of services in cohesive entities. Thus, a utilization career may be distinguished by varied number and lengths of discrete episodes. While Solon and his associates were referring to health care in general, the notion of episodes is also relevant and applicable to mental health care, particularly of minority and poor clients. Lorber and Satow (1975) also emphasize this point in their research of a CMHC. They demonstrated that lower-class individuals tend to use mental health centers on a short-term basis (usually three to four visits) for the immediate alleviation of acute symptoms or for crisis management.

Dropout Rates

Closely related to utilization styles is the question of dropouts. The "premature" termination by large numbers of clients from mental health facilities is regarded by many as an acute problem. The dropout rate is especially high among lower-class patients (Garfield, 1971; Dohrenwend and Dohrenwend, 1974). This led some to argue that those most in need of mental health services have the least access to the available resources (Hoppe, 1977).

Attempts to account for the alleged high dropout rate among lower-class patients have generated many explanations. Some researchers have pointed to the cultural barriers between the therapists who are predominantly middle-class and the lower-class patient. Difficulties with communication due to class, race/ethnicity, language barriers, and conflicting value orientations, are among the most frequently discussed problems (Hunt, 1960; Haas, 1963; Kline and King, 1973; Wilkinson, 1973). Allowing for the feasibility of such explanations, questions persist. What, one can ask, is the statistical basis for designating someone as a "dropout"? Since most utilization measures count the number of visits or compute the amount of time (whether in days, weeks, or months) in treatment, dropouts are often identified on the basis of measures of central tendency, i.e., a median, mode, or a mean. Cases falling at or above the differentiating criterion are labeled "stayers" or "remainers," while those falling below it are designated "terminators" or "dropouts" (Siegel and Blum, 1981).

This operational definition reflects an implicit assumption about utilization of mental health services. For one thing, it assumes that traditional treatment (i.e., long-term, insight therapy) was going on; that there was an explicit agreement between the patient and the therapist; and that the patient at some point, and presumably against the therapist's advice, quit. Yet, as others have noted, a consensus between patient and therapist rarely exists (particularly when the patient is from a lower socioeconomic stratum) about the desired length of the therapeutic relationship, nor its rules and goals (Goin, 1965; Lorber and Satow, 1975).

In the final analysis, this mode of measurement rests on agreement with the universal acceptability of traditional psychotherapy. Some observers, however, regard this model as suitable mainly for middle-class patients. The model neglects the expanding definitions and boundaries of mental health services. These changes, most visible perhaps in CMHCs, have radically enlarged the domain of mental health providers as well as expanded the definition of who is in need of services. Moreover, most operational definitions of "dropout" continue to associate length of stay in treatment with accrued benefits, and only a few investigators have questioned this presupposition (Hoppe, 1977).

Regardless of the particular operationalization of dropout, this usage "blames the victim," i.e., it assumes that the client has somehow failed or "dropped" out. Thus, the approach incorporates the notion that everything rests on the clients' decisions, and it ignores what the therapist has done or failed to do (Brandt, 1965). The "dropout" approach to utilization also assumes that the therapist's position is the objectively correct assessment. Yet, evidence exists which shows that many patients who leave treatment (even without the approval of their therapists) often feel nevertheless that they have "gotten what they wanted" out of the program. For example, one study reports that over 60 percent of the patients studied who sought dynamically oriented psychotherapy were satisfied with the program, but nevertheless, expected it to last only ten sessions or less (Goin, 1965).

There is also evidence (Kline and King, 1973) that some patients are "eased out" (i.e., discouraged from continuing by the therapist) from treatment because they are more difficult or less interesting to treat and less treatable by the methods most therapists prefer to use (i.e., long-term verbal insight therapy). In these cases the label of "dropout" obscures the deeper social dynamics which are operating.

An Alternative Measure of Utilization

After careful review of previous measures of utilization it is our judgement that they fall short of representing the complex nature of this type of behavior. Excessive focus on duration of use (expressed in either number of visits or amount of time) has tended to obfuscate the real content of a utilization career. While questions about who uses which kind of services and for what purpose are important issues, they rarely find their way into existing definitions and measures. As a result, summary statistical data have come to be the conventional indicators for utilization of mental health services. Although such measures have administrative value, the reality behind the figures is obscured and is much more complicated.

Consider the following example from our study.

Two patients are registered at a clinic on the same day and both are terminated a year later. When duration is used as a measure, both persons obtain the same score. However, a more careful look at their usage of services reveals very different patterns. For example, the first patient came consistently once a week for the duration of the whole year; the second came to the clinic only sporadically. A further examination reveals that they are not necessarily "good" or "bad" users. Rather, the first patient was committed to verbal, insight therapy, while the second needed help with concrete social services. Consequently, each developed a "unique" utilization career based on individual needs or personal desires.

This example shows that a measure of duration by itself can be misleading, and may indeed distort the "true nature of utilization. Moreover, as the CMHC offers numerous services, it is inevitable that modes of utilization will be come more and more variegated.

Our own efforts at measuring utilization began with the assumption that it was a multidimensional phenomenon which requires more than one indicator. As a minimum, we believed that the length of time a person is registered as a patient at the clinic (reflected in extensiveness or duration of use) and the actual pattern of utilization (reflected in regularity of use) are both critical factors and that one could not--on a priori grounds--be collapsed into the other. We, therefore, decided to employ both factors in our utilization measure.

The first indicator--extensiveness of CMHC use--was measured simply by counting the number of months between the first intake interview and the last visit kept by the patient. For our second indicator--regularity of use--we considered as a potential measure the frequency of visits to the CMHC over the course of the utilization career. However, since the frequency of visits (per week or per month) is largely a function of diagnosis, determined primarily by the provider, and since we wished to emphasize the patient's point of view, we felt that there was a need for a different measure, one which could better reflect the behavioral patterns of patients.

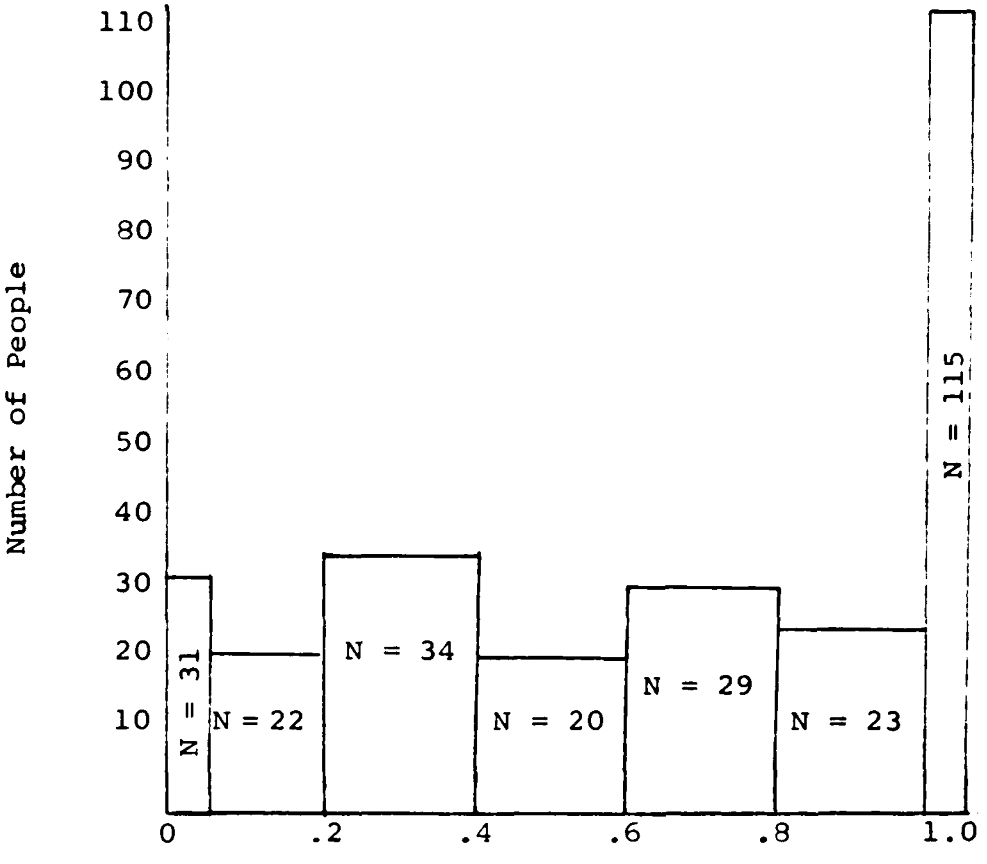
We, therefore, chose to focus upon continuity of service over the course of the utilization career. For instance, given a utilization career of twelve months, did the patient come to the clinic every month regardless of the frequency of his visits? Or did s/he, over the course of the utilization career, come to the clinic for a few months, then stop for a while and then resume coming again? We, then, ended up measuring regularity of service use in terms of the actual number of months a patient was in contact with the CMHC.

In the final step of constructing our second indicator--regularity of use--we computed a ratio of the contact time (measured in months) divided by the total duration (months) of the utilization career. The ratio--labeled the Raw Regularity Ratio--has values ranging from zero to one. The value "zero" reflects a situation in which the patient had registered at the center, had undergone an intake interview but never actually started treatment. On the other hand, the value of "one" represents a situation in which the entire utilization career includes monthly contacts for treatment--in other words, regular use of services. All the other values (any score between zero and one) were collapsed to mean irregular use of CMHC services (see Figure III).

For operational purposes, we dichotomozed both indicators--extensiveness or duration and regularity--into High/Low categories. For duration, High equals a year or longer of utilization; Low equals less than a year of CMHC use. For Regularity, High refers to a score of "one," which means regular visits (at least once a month), Low refers to a score between zero and one, which means irregular pattern of service use.

Figure III

Histogram Reflecting the Distribution of Scores for Regularity of Service Use



Total N = 274

The combination of duration and regularity dimensions yields four analytical types of utilization (Table 4.1). Types 1 (high users) and 4 (low users) represent patterns of utilization in which duration is parallelled by regularity (Low, Low--High, High). Most the the literature on utilization presupposes that these combinations are the only theoretically important ones. We, on the other hand, assume that incongruent combinations may occur empirically and are, potentially, of great substantive significance. The typology in Table 4.1 identifies two such patterns: The Sporadic user (type 2), which refers to clients who are "on the books" of the CMHC for a considerable time but who actually avail themselves of the facility only intermittently; and the intensive user (type 3), which refers to clients who use the services regularly and continuously for short periods of time.

CMHCs which cater primarily to populations for whom the conventional middle-class intensive talk therapy model seems inappropriate are likely to encounter appreciable numbers of Sporadic and Intensive users.

Plan of Analysis

Since we expanded the definition of utilization to include patterns of use, a reexamination of those

Table 4.1

A Typology of CMHC Utilization Based on Extensiveness of Use and Regularity of Use

		Regularity of Use (Contact)	
		High (monthly or more)	Low (less than monthly)
Extensiveness of Use (Duration)	High (1 year or more)	(1) High Users 19.3% (N = 47)	(2) Sporadic Users 43.2% (N = 105)
	Low (less than 1 year)	(3) Intensive Users 28.0% (N = 68)	(4) Low Users 9.5% (N = 23)

Total N = 243

explanatory factors (i.e.: sociodemographic, sociocultural, etc.) of utilization of mental health services is in order. It is our hypothesis, therefore, that different sets of factors will be associated with different types of users.

This study employs three classes of explanatory variables: (1) preceding events and social networks, (2) sociodemographic characteristics of utilization and (3) psychological and organizational factors. This classification of variables into distinct groups provides a heuristic device to facilitate analysis of the data and their organization into theoretically relevant concepts. Each major class of variables was then thematically subdivided into separate categories. In class (1), we examined the events which focus on key life experiences immediately preceding the most recent use of center services. Especially, we inquired why our respondents came to City-CMHC. Also, we tapped the potential impact of referral sources and of familial and associational relations upon utilization patterns.

In class (2) we focused upon sociodemographic characteristics as potential explanatory variables of utilization. Here, we were concerned with the general propensity of members of different demographic groups to use mental health services. Such factors as sex, race, age and educational background were considered. We especially zeroed in on the role employment status and source of income play in affecting use of mental health services.

In addition to the above "objective" variables which exert an indirect influence upon utilization, we were interested in the clients' expectations or goals in coming to City. We felt that the "subjective" variables; tapping "psychological accessibility" might be more decisive in determining how individuals use CMHC services. Specifically, therefore, in class (3) we have focused on the clients' degree of satisfaction with CMHC staff, the therapist-patient relationship, their overall CMHC experineces, as well as their values regarding mental health ideology. This kind of approach is in keeping with the central tenet of our research which aims at an understanding of the clients' subjective experiences with the CMHC and their general orientation to mental health.

Of course, we do not rule out the possibility that organizational traits may also be of importance. Thus, among organizational factors we study are (1) bureaucratic, financial, and geographic barriers to accessibility; and (2) staff characteristics. We felt it was important to include such variables, for an enlarging body of evidence suggests that organizational and staff factors can be strongly related to utilization. This is part of our attempt to go beyond considerations of personal characteristics of clients to a consideration of sociological characteristics of the services which they utilize. Yet, here too, our predominant concern was with clients' subjective experience of organizational factors. Thus, we used "surrogate" measures[2]--clients' perceptions--to assess organizational traits.

Method of Analysis

We used tabular analysis, employing an elaboration model design, as the strategy for analyzing the data. This particular method was chosen because of the nominal and ordinal level of the data. In each of the three "findings" chapters (5, 6 and 7) we begin with an examination of the main associations between the measure of utilization--our dependent variable--and the independent variables under consideration. We then go on to elaborate those associations where significant relationships are found.

This elaborative process--using control tables--often results in diminishing sample size, which makes it difficult to discern stable patterns. Where this situation occurs, Discriminant Function analysis is employed to examine the relationships among several variables simultaneously.

The Data Base

The data used in this study are derived from two sources--a survey of former patients and patient charts. The survey was carried out between late 1980 and mid-1981. During that time 327 former patients, who had terminated treatment at City-CMHC between 1978 and 1980, were administered an extensive, in-depth interview. The interview, which took approximately one hour to complete, was conducted in either English or Spanish by three people from the community who were hired and trained especially for that purpose. The interview schedule contained both closed and open ended questions tapping an array of issues, feelings, and attitudes pertaining to the patients' experiences at the center. The survey generated the bulk of the data except for the dependent variable--utilization patterns; this was derived from patients' charts provided by City-CMHC. From among 327 who were interviewed, the CMHC was able to provide usable records on 294 cases. However, sufficient information for both indicators--duration and regularity--was obtained for only 274 patients.

Of those, 31 people were dropouts--had only registered but never started treatment. Thus, we ended up with 243 cases for whom we have data on both independent and dependent variables. We use this number--243--as the base for our analysis. However, for descriptive purposes we include all 327 surveyed cases.

Since the information we use in this study is largely self-reported and retrospective, it is subject to general recall error by respondents. In addition, such common problems as a misunderstanding of a question, or a possible unwillingness to answer a question correctly, invariably result in some anticipated bias. Yet, despite the constraints inherent in this type of methodology, we feel that the views of the respondents are of great importance. This is especially the case here, since this kind of population, comprised of former mental health patients, is rarely interviewed by social scientists.

In order to minimize the possibilities of recall error regarding actual utilization of services--our dependent variable--we used the more "objective" patient charts. We felt that these records would be especially useful when used in conjunction with the other method, the more subjective questionnaire.

Sampling

The sample was drawn from three key services of City-CMHC: The Outpatient Department (OPD), the Partial Hospitalization Program (PHP), and the Community Outreach Service (COS). These services represent the major adult services which deal with most of the mental health problems, except for problems directly related to alcohol and drug abuse. We believe that children and alcohol and drug abusers incorporate enough significantly different problems to warrant a separate study.

We began the sampling procedure by examining hospital records in order to best determine the sources from which we could select a sample. This investigation resulted in the "discovery" of termination lists which are kept for each service separately and are tallied on a monthly basis. We culled names of all former patients,[3] eighteen years and older, beginning with the most recently terminated and working our way two years back in time.

The names of these patients and their addresses were entered onto a special index file designed for monitoring and follow-up purposes. These people constituted our list of potential respondents. Each person received a letter briefly describing the research project and requesting his or her participation in an interview for which the sum of $10.00 was to be paid. In addition to the letters, telephone numbers, whenever possible, were also used to initiate contact.

As we anticipated, the response rate was very low. Unlike most ordinary field surveys which randomly sample by areas and then by household in which any adult may be eligible, we were faced with the problem of having to locate a specific set of individuals. In addition, certain characteristics related to the nature of this population--high degree of residential and geographical mobility, and the stigma of mental illness--made an already difficult task even harder.

This problem is, indeed, reflected in the response rate throughout the sample selection and interviewing process. Although the results of the initial contact and all the succeeding follow-up contacts were monitored carefully, it was difficult to assess exactly how many of the respondents actually received and read the letters. About 30 percent of the letters mailed were returned by the post office, usually marked "unknown" or "moved--no forwarding address." From 10 to 20 percent responded positively to the letter, but were not qualified for participation according to our criteria (i.e., former CMHC patients, eighteen years or older). Only from 5 to 10 percent of the original mailing was scheduled for an interview; however, here again, some resulted in "no-shows."

Given the enormous difficulties we encountered in locating, contacting and gaining the cooperation of former patients whose names had been culled from the hospital records, we were forced to resort to "opportunistic" methods to get people to participate in the study. The following procedures were implemented with varying degrees of success:

1. Local agencies were used extensively for the referral of former patients of City-CMHC who were familiar to them.

2. A poster advertising the project and requesting volunteers was placed at various community sites.

3. Therapists affiliated with the three services were approached and asked to refer eligible former patients.

4. Respondents were asked to inform friends and relatives about the research project and refer potential respondents to us.

Approximately 40 percent (or 143 people) of the sample are from the hospital termination lists; the rest, 60 percent (or 184) were derived through the other strategies: 22 percent were referred by therapists or the service department, 18 percent came through agencies, and 12 percent through snowball, i.e., via others who were interviewed.

While we cannot claim that this sampling procedure produced a representative distribution of users of the center's services, we have been able to identify the most characteristic patterns of utilization manifested by our respondents. We are confident that we have tapped the major types of utilization although we are less certain whether they appear in our sample in the same proportions as in the population.

Sample Characteristics

The two fundamental characteristics of the sample are its predominantly minority composition and its poverty: 92.9 percent are black or Hispanic; 76.2 percent has a total household income of $6500 or less. The greater numbers are unemployed (69.1 percent), on welfare (66.1 percent), receiving Medicaid (78.6 percent), and have less than a twelfth-grade education (58.9 percent). Thus, in terms of conventional SES indicators, our sample population may be described as predominantly lower class, rather than working class.

In view of the nature of our sampling strategies, which relied heavily on referrals, it is understandable that our sample is so heavily represented by poor minorities. Data from City's statistical reports reflect that the City-CMHC, although heavily tipped in the same direction, has a larger number of white clientele than appears in our sample (see Table 4.2).

Nevertheless, the data base from such a sample, heavily weighted to minorities and the poor, has particular advantages for our research objectives. It allows us to examine the utilization patterns of individuals who belong to a social group which in the past was, by and large, inadequately served by traditional mental health providers. In this light, the presence of a significant number of white and middle-class respondents might indeed have been a disadvantage. They might have actually acted as a potential source of confounding variables and thus hindered the analyses.

Therefore, factors which are usually seen as pivotal in explaining utilization of mental health services across SES categories can be anticipated, in all probability, not to serve such a major role in the explanation of CMHC utilization in our research. Rather, our study strives to identify variables which account for variation within this highly homogenous sample.

A further look at the demographic characteristics of our sample reveals that it is predominantly middle-aged or younger (82.7 percent 50 years of age or under), female (58.1 percent), Hispanic, 60.4 percent (as compared to 32.5 percent blacks and 6.7 percent whites), and reared as Catholic, 62.9 percent (as compared to 26.1 percent Protestant, 2.8 percent Jewish, and 4.6 percent "Other"). Only 3.6 percent of our sample were raised with no religious affiliation.

When we examine the marital status, we find that nearly one-half (46.5 percent) are single, one-third are currently divorced, widowed, or separated (33.5 percent), and one-fifth (20.0 percent) are married. Thus, married individuals comprise the minority of this sample population.

Households tend to be relatively small: 91.1 percent of the total sample live with four others or less, and 32.3 percent live alone. Moreover, while 61.3 percent report having children, 43.7 percent of this number have no children living with them.

The vast majority (87.1 percent) live in apartments. Rents are generally below $300.00 per month. Respondents have relatively stable residential patterns: 74.1 percent have lived in their present residence for a year or more; 18.4 percent have lived in their present residence for over ten years. The most transient segments of our potential respondent pool are probably the least likely to have participated in our survey.

Notes

[1] Both extensiveness of use of services and duration in treatment are usually obtained by either counting visits to a facility or by computing the total period of time spent in treatment from the first intake interview to the last recorded visit (Siegel and Blum, 1981).

[2] For a discussion on surrogate measures and, in general, the dangers involved in applying "valid" social measurements, see Etzioni and Lehman, 1967.

[3] The decision to interview former patients was based, in part, on clinical advice of therapists concerned that a lengthy interview may jeopardize the on-going treatment. In addition, it was felt that former patients will be more forthright about answering questions regarding the quality of care received at the CMHC.

CHAPTER 5

PRECEDING EVENTS AND SOCIAL NETWORKS

It was the original, general goal of the CMHC to expand the realm of psychiatric services to include, in addition to long-term psychotherapy, also short-term crisis intervention, vocational rehabilitation, counseling, and help with concrete services. Professionals working in teams--usually comprised of psychiatrists, psychologists, social workers and paraprofessionals--were intended to complement each other to insure the satisfactory need fulfillment of different population groups. With reference to such purpose, several questions become important: What are the needs of people who come to the CMHC? What types of problems do they present and what kind of treatment do they expect? Finally, are the various needs and treatment expectations related to different patterns of utilization?

In the first part of this chapter, we attempt to answer these questions through the examination of our data. Then, in the second part, we will focus upon the role played by social networks in effecting users of services and utilization patterns. Before we begin, a few general comments on the "sociology of presenting problems" are in order.[1]

Sociologists generally agree that social structures create disparate problems for their members by subjecting them to different pressures. Furthermore, given the same social pressures, there are various culturally defined ways of reacting to them. Consequently, people's verbal expression of their problems is reflective of their social positions. Data show, for instance, that working-class persons would, more frequently, complain to a psychiatrist about physical rather than psychological symptoms. The middle-class person, on the other hand, who is supposedly more able to articulate his or her underlying emotional state, would more frequently present psychological symptoms.[2]

In addition to observed class differences in presenting problems, there are also observed class differences in one's expectation of the treatment modality. Lower-class people often come to a psychiatric clinic expecting to receive concrete help with social problems rather than long-term, insight "talk" therapy.[3]

Given these findings, we formulated our own hypotheses. First, we expected our respondents, who are predominantly lower-class, to present more concrete problems than psychological ones. Second, we also hypothesized that our respondents would expect their treatment to be more oriented towards resolving those concrete social problems. Last, we anticipated that both the "presentation of the problem" and the expectation of the treatment would be related to utilization patterns in the following way: patients who present social or physical symptoms and/or expect concrete help would more likely be low or sporadic users. They would come to the clinic for a specific identifiable problem and would leave when the problem was resolved. In contrast, patients presenting psychological symptoms, and/or expecting "talk" therapy would more likely be either high or intensive users. They would be more committed to long-term insight therapy.

Before we present a categorical analysis of our data, it may be enlightening to regard the ways in which our respondents describe the events preceding their coming to City-CMHC.

Preceding Events

The general theme that emerges from our examination of the impact of previous life experiences on utilization is of the disabling and corrosive role of poverty.

Regardless of the particular problem presented, or the symptoms for which the patient sought help, what many share is the fundamental fact that they are poor. While poverty may be relative, the people in this sample are poor by any American standard; their reported annual income varies from $3,500 or less to a little over $6,500. This common experience seems to color every dimension of their lives, contributing to their worries:

> I had problems, worries about my family. They were having personal problems themselves--household bills, arguments constantly.

and their tensions:

> I was having money problems, I was borrowing too much and I couldn't pay back. I had too much tension.

and to their sense of despair:

> I was fed up with my life. I had no money and no friends. I couldn't get the things I needed.

Beneath the surface of this unifying theme, we find many differences. Each person has a unique story to tell:

> I came to New York from Puerto Rico after I lost my brother. . . . I was living here with my sister and she asked me to move because her apartment was too small and she had no money. She was on welfare.

Yet, what seems to be emphasized time and time again is the presence of anxiety, of feelings of nervousness and depression. As the same young man continued:

> I was unemployed. I was nervous and I had problems with money. I was depressed, very unhappy.

The personal worries over money and a job, the bad housing, and the general poor health, are compounded with concern for children and their future. Fear is an ever-present strong feeling, especially since the streets are perceived as a threat and a constant source of danger. Thus, many are afraid that their children will easily stray and get into trouble.

Some of the patients interviewed, indeed, focused all their anxieties on their children. For example, one woman claimed:

> My only problem was the children. They were acting up, the school was writing to me about their bad behavior. There was no man in the house, I just got depressed.

And another mother stated:

> I came here because I was having a lot of problems with my children and I wanted to know how to deal with them. My children were using drugs.

On a manifest level, the issues are obvious--economic deprivation with its myriad effects and manifestations. One forty-six-year-old woman summarized it succintly:

> Well, we had lots of problems--money, housing, my husband's poor health, my son used to run away from home. People were talking about drugs in the streets and that worried me. I became very anxious.

Overwhelmingly, the complaints reflect a sense of helplessness:

> I lost my job and my girlfriend and I was also about to lose my apartment. I was out of work, I couldn't find work and couldn't keep up with the rent. I took an overdose of drugs and I was brought here to the hospital.

On a deeper level, the issues are more complex. Sociologists have discussed some of the more subtle, perhaps psychological, "hidden injuries"[4] of poverty in America. Among these injuries, they especially emphasize the sense of worthlessness and the deep-rooted shame many poor people feel. Feelings such as these are generated in a system which purports to provide opportunities and open channels of mobility for all its members.

These adverse effects of poverty include shame:

> I had job-related health problems and became very depressed. I was emotionally upset most of the time and at times I could not sleep. I had lost my job because of health problems. I was out of work for a while. I was having financial problems to the point where I had to apply for public assistance. I had worked all my life and felt ashamed to receive welfare.

The above quote was by a fifty-five-year-old woman. Yet, many of the men in the sample acutely felt that lack of a job or the loss of one damages self-esteem:

> I had lost my job and had money problems. I was very depressed and I needed to talk to somebody to sort out my difficulties. I developed a low self-image and started to avoid people.

This particular respondent is somewhat unusual in our sample in his perceptive ability to conceptualize some of the more subtle implications of being poor and unemployed in more abstract terms. Yet, there is no doubt that what he conceptualized many others felt deeply. Another woman, in her fifties, expressed it more concretely:

> I always had hard jobs and low pay. Everyone wants to live good and be respected and accepted.

A few of the patients actually came to the CMHC seeking help in finding means for livelihood:

> I wanted some kind of job training, I really wanted to get off welfare.

For others, the CMHC is seen as able to help by providing them with a letter which could certify their disability and allow them to receive governmental funds:

> I had no problem. I just wanted to get a job. . . . To tell you the truth, I wanted to get SSI.

The constant worries about unpaid bills, the fear of crime and illness, the anxiety about the future, and the inner conflicts are bound to produce an overwhelming strain which is inimical to family life and marriage. Our respondents often complained about interpersonal relationships:

> I had lost my job and had money problems and family problems . . . my wife became very nervous, my mother was giving me a hard time, life was getting heavy on me.

A considerable body of both psychological and sociological literature documents the adverse effects of poverty on family life and marital relationships.[5] Such painful consequences as drinking, drug abuse, and violence are often discussed as common reactions of men and women to their plight. These reactions were also frequently mentioned by the respondents in our sample. For example, one man said:

> I had a lot of problems with my wife. She ran away with my daughter. That made me feel very depressed and I started drinking.

A woman complained about a violent husband:

> I had problems with my husband. He was beating me almost every day. I wanted to get a divorce and start a new life. . . .

And a mother was concerned about her daughter:

> My daughter was on drugs at that time and had a husband who abused her a lot. I was very depressed about that.

When the strain and strife build up, escape may become one way of dealing with the situation. Indeed, as the following quotes reveal, some people resort to alcohol and drugs.

> I was drinking, I was frustrated because of lack of employment and I was not satisfied with the kinds of jobs I've had. Also, my son and daughter were on drugs, that bothered me a great deal.

> I smoked pot, and also took angel dust. Then I began to feel paranoid and to hear voices. Then, my mother

> took me to the hospital, that's where they gave me all this medication to tranquilize my nerves.

A few of the patients came to the CMHC complaining about physical, rather than psychological, symptoms:

> My health was not too good. I was going back and forth to clinics. My husband had died a few years before.
>
> I was very anxious regarding my health. They couldn't find anything wrong with me and they said that I should see a psychiatrist.

It is not uncommon to psychosomatize, and to focus on one's physical state; in fact, very few patients articulated their problems in psychological terms as did this twenty-eight-year-old woman:

> I wanted to be able to cope with problems of everyday life, to control myself because I am too fast. I was always under pressure, always confined to the house, always criticized and I was never praised, I was always told that I would never be able to do something for myself.

Finally, patients frequently come to the CMHC requesting assistance in their dealings with various welfare and other public agencies. For example, this thirty-four-year-old woman:

> The Bureau of Child Welfare had a court case against me. I had nowhere to turn to for help. People sent anonymous letters to the bureau telling lies about me. My eldest daughter was put in placement and they were taking action to take both my daughters and also my eldest son away from me.

Others request the CMHC to intervene with welfare:

> I was having money problems, the welfare did not want to open my case.
>
> I needed help to get on welfare.
>
> I have seven children, and at that time I was having problems with the welfare checks.

All of these quotes from the interviews yield a richness of texture that the aggregation of individual statistics rarely provide. Nevertheless, our survey research strategy adds to the qualitative data, allowing a clearer portrait of the dimensions of such problems. (See Table 5.1.)

The members of our sample tend to associate a clear precipitating event with their coming to the CMHC for help. Fewer than one in seven of the sample do not link their symptoms with particular preceding events. The vast majority of patients (84 percent) have a clear notion of why they came to the clinic and what experiences or problems led to the onset of their symptoms.

This fact is significant since it suggests that these types of people seek help mainly in a crisis situation, or when there is an acute precipitating event. The literature on utilization of mental health services by the poor suggests that many enter treatment for short-term intervention rather than to relieve long-standing mental health problems. Despite the uniformities in this regard, some differences by sex and ethnicity do appear in our study.

Twice as many men as women cite events pertaining to financial or employment situations. For women the dominant source of crises derives from interpersonal relationships. In fact, as many as 60 percent of all women interviewed locate their problems in some kind of interpersonal difficulty--usually with a spouse or a child--in comparison with 31 percent of the men. This finding, of course, reflects institutionalized gender-role differences in our society. (See Table 5.2.)

When a husband, for example, is unable to provide for his family, he is perceived as a failure by himself and by others. The result is frequently a loss of self-esteem and a sense of worthlessness, which, in turn, may explain why more men than women come to the CMHC with complaints about unemployment and financial problems. Although many women now work outside the home, the primary identification for most is still with the role of wife and mother. In addition, women have traditionally been perceived as more immersed in life's socio-emotional aspects and, therefore, more concerned with interpersonal relationships. This focus of women's gender roles is reflected in what women respondents regard as precipitating events.

Table 5.3 indicates that race and ethnic differences in presenting preceding events are not so pronounced as the sex differences. Yet, a recognizable pattern does emerge. White patients are more likely to present problems pertaining to employment and financial difficulties than either black or Hispanic patients (31 percent, 18 percent, and 10 percent respectively). On the other hand, Hispanics are more likely to cite interpersonal problems as preceding events than either blacks or whites (54 percent, 40 percent, and 37 percent respectively). These patterns remain stable when we crosstabulate "preceding events" by race and sex. (See Table 5.4. Whites are omitted because of their small number.)

However, our expectations that the presentation of the symptom and the preceding event would be related to utilization patterns was not supported by the data (see Table 5.5). Therefore we conclude that the type of problem brought to City-CMHC does not appear to be associated with the way people utilize the services. We can, however, speculate here that since our data are retrospective, patients' perceptions and recollections of their problems might have been altered. This could be especially true for those patients who were "converted" to talk therapy and learned, through the therapeutic process, to explain certain somatic complaints in psychological terms.

Treatment Expectation

Contrary to our hypothesis--based on research findings which suggest that lower-class patients do not expect to receive "talk" therapy--many of our respondents (48 percent) said they wanted someone to talk to or expected to get "talk" therapy. An additional 21 percent came to City specifically for medication ("I wanted something to calm me down" was the most common answer in this category). Only 13 percent expected concrete services--i.e., help in finding a job, housing, etc. In contrast to the 72 percent who came to the CMHC with specific treatment expectations, 18 percent said they did not know what to expect. (See Table 5.6.)

Once again our expectation rests predominantly on the fact of the retrospective implications of our data. To summarize, our main findings suggest that utilizers cannot be distinguished on the basis of their presented problems or their treatment expectation. (See Table 5.7.)

Social Networks and Utilization

In recent years, the concepts "networks" and "support systems" have been used extensively in a variety of research fields. Yet, they have been largely neglected in the study of utilization of health services. Our data enable us to examine the extent of the respondents' involvement in social networks. Moreover, we include a brief analysis on the relative influence of both family and friends in the decision to use CMHC services.

A study of social networks has one additional benefit in the present circumstance. We have noted previously the extremely homogenous character of the respondents particularly in socioeconomic matters. Higher socioeconomic rank is critical in society for a number of reasons, one key aspect being that it points to access to material and nonmaterial resources. When populations are seen as homogenous in socioeconomic traits they are normally treated as roughly equal in their control of these resources. One pivotal nonmaterial resource is the ability to gain access to and use social networks. The following discussion makes clear that however homogenous the respondents are in occupational and income factors, they vary considerably in their immersion in social networks. Thus, these networks--and their differential use by minority and poor populations--may play an important role in varying degrees of CMHC utilization among persons who otherwise look very much like one another in gross social attributes.

Religious Affiliation

The factor of religious denomination does not seem to be related to patterns of utilization independently of race-ethnicity (note that many in our sample are Hispanic who identify themselves as Catholic). However, a distinction still remains between those patients who identified themselves as belonging to a religious group and those who claimed no such ties. This suggests the importance of an affiliation, regardless of denomination. Our primary concern here is, then, with extent of participation in voluntary associational ties. We therefore asked our respondents to indicate how many times they attended church within the previous two months.

When we crosstabulated church attendance (coded as "no attendance," "low attendance," and "high attendance") with utilization patterns a significant relationship emerges in which churchgoers seem more likely to be high users and patients who do not attend are more likely to be low users (Table 5.8). It is, however, difficult to be sure how valid this finding is. Our sample is comprised of more women, especially Hispanic women, who professed to have a high attendance in church. Since a four-way contingency table (utilization patterns crosstabulated by church attendance and controlled for race and sex) becomes statistically meaningless, we can only say that the issue of religious affiliation requires more data and cannot be meaningfully discussed here.

Family and Friendship Involvement and Utilization

In the absence of abundant voluntary associations, it is all the more important to ask whether the presence or absence of family life impinges on utilization patterns. When we queried whether the composition of the respondent's household (i.e., living alone or with others) affected utilization, no systematic relationship was found. Yet while this purely objective characteristic of family life may have no effect, some family processes seem to be important for the respondent's utilization careers.

When asked about their families' reactions to their coming to and then leaving the Center, respondents could answer (1) that the family agreed with the decision or (2) that they disagreed with the decision. A large percentage --56.6 percent--of the respondents indicated that their families agreed, 4.8 percent said that they disagreed, and 3.5 percent, that their families were neutral or had no reaction. The remainder indicated that their family did not know that they had come (26.3 percent) or that they did not have family (4.8 percent).

Once more, we found no significant relationship between utilization pattern and family involvement. Similar analyses were performed for the role of friends. In this instance, again, no association exists between the level of friends' involvement in mental health decisions and utilization patterns.

To summarize, while networks were reported to be highly associated with decisions to seek mental health services, they do not appear to be related to the way in which those services are being used by the consumers.

The examination of the "preceding events" gave us some clue that sociodemographic factors might play an important role in shaping utilization patterns. We turn, now, to examine these factors and the interrelationships among them.

Table 5.1

Preceding Events

	Absolute Frequency	% Frequency
Interpersonal	126	48.6
Health	56	21.7
Employment/Financial	35	13.5
None	42	16.2
TOTAL	259	100.0

Table 5.2

Preceding Events by Sex

	Men	Women
Interpersonal	31.4	59.9
Health	19.6	22.9
Employment/Financial	20.6	8.9
None	28.4	8.3
TOTAL	100.0%	100.0%
	(N = 102)	(N = 157)

Table 5.3

Preceding Events by Race/Ethnicity

	White	Black	Hispanic
Interpersonal	37.5	39.8	54.1
Health	18.8	20.5	22.3
Employment/Financial	31.3	18.1	9.6
None	12.5	21.7	14.0
TOTAL	100.0%	100.0%	100.0%
	(N = 16)	(N = 83)	(N = 157)

Table 5.4

Preceding Events by Sex and Race

	Men		Women	
	Black	Hispanic	Black	Hispanic
Interpersonal	23.7	35.1	53.3	65.0
Health	18.4	21.1	22.2	23.0
Employment/Financial	23.7	19.3	13.3	4.0
None	34.2	24.6	11.1	8.0
TOTAL	100.0%	100.0%	100.0%	100.0%
	(N = 38)	(N = 57)	(N = 45)	(N = 100)

Table 5.5

Utilization Patterns by Preceding Events

	Low	Sporadic	Intensive	High
Interpersonal	35.3	50.6	39.3	65.0
Health	23.5	20.3	30.4	12.5
Employment/Financial	29.4	11.4	12.5	10.0
None	11.8	17.7	17.9	12.5
TOTAL	100.0%	100.0%	100.0%	100.0%
	(N = 17)	(N = 79)	(N = 56)	(N = 40)

Table 5.6

Treatment Expectations

	Absolute Frequency	% Frequency
Talk Therapy	15	48.0
Medication	65	21.0
Concrete Social Service	42	13.0
No Expectations	56	18.0
TOTAL	314	100.0%

Table 5.7

Utilization Patterns by Treatment Expectations

	Low	Sporadic	Intensive	High
Talk Therapy	62.5	56.5	55.1	56.1
Medication	6.3	27.0	28.5	26.8
Concrete Social Service	31.2	16.5	16.4	17.1
TOTAL	100.0%	100.0%	100.0%	100.0%
	(N = 16)	(N = 85)	(N = 49)	(N = 41)

Table 5.8

Utilization Patterns by Church Attendance

	Low	Sporadic	Intensive	High
No Attendance	66.6	48.9	55.6	36.6
Low Attendance	28.6	23.9	28.6	29.3
High Attendance	4.8	27.2	15.9	34.1
TOTAL	100.0%	100.0%	100.0%	100.0%
	(N = 21)	(N = 92)	(N = 63)	(N = 41)

Notes

[1] For a discussion on the subject of presenting problems see Kadushin, 1969, p. 89.

[2] See, B. Dohrenwend and D. Crandell, "Some Relations Among Psychiatric Symptoms, Organic Illness and Social Class," American Journal of Psychiatry 123 (1967): 1527-1537.

[3] *Ibid.*

[4] In their book: The Hidden Injuries of Class, Sennet and Cobb (1973) uncover the internal conflicts of the working class men and women. They vividly describe the injuries incurred by being poor in America. The book includes a good bibliography on related writings (pp. 272-275).

[5] A good recent book that deals with the subject is Coles and Coles (1978), Women of Crisis: Lives of Struggle and Hope; another is Lillian B. Rubin's Worlds of Pain (1976). This book also includes a comprehensive reference list of literature on this and related subjects (pp. 239-260).

CHAPTER 6

SOCIODEMOGRAPHIC FACTORS OF UTILIZATION

In this chapter we explore the relationships between sociodemographic factors and utilization patterns. We divide the chapter into three parts: the first examines the predisposing impact of ascribed characteristics upon types of users; the second looks at the "achieved" status, and the third discusses the effect of economic variation on utilization of City-Services. All of these factors have been regarded (by one study or another) as significant predictors of mental health service use. The aim here, however, is to determine whether they are associated with different patterns of utilization.

Ascribed Characteristics

Sex, race/ethnicity, and age are special factors in that they are biologically ascribed and, except for age, invariant. While all three factors are associated with complex modes of social behavior, sex (or gender) roles appear to be particularly prone to effect mental health service utilization. As was indicated in the review of the literature, women generally use mental health services more than men. Most explanations of this phenomenon are couched in terms of role theory. They describe the woman's role in contemporary society as more amenable to emotional expressions and admissions of distress. Consequently, sex is regarded as a fairly good predictor of mental health service utilization.

We have already discussed at length the fact that various racial and ethnic groups perceive and respond differently to mental symptoms. We can only reiterate that whites are said to take fuller advantage of mental health services than either blacks or Hispanics. This is often explained by pointing to varying cultural norms and social structures.

Age, the third ascribed factor to be considered, is the most puzzling one. While evidence suggests that, in general, utilization of health services increases with age (probably due to the "wearing" effect of aging and onset of illness), the reverse has been observed in reference to mental health utilization. That is, utilization of mental health services decreases with age. The CMHC Act, which regarded the elderly as one of its primary "target" populations, was supposed to make a special effort to attract old people to the centers. Whether it did or not is still a debated question. The issue of utilization by various age groups needs further clarification through research specifically designed for that purpose. Hence, based on both empirical findings and theoretical grounding, we examine whether these three demographic factors are also associated with different patterns of utilization.

Sex

A very significant relationship was revealed when utilization patterns were compared in terms of sex. Fully three quarters of the high users are women compared to 39 percent of the low users. The low user category is comprised mostly of men (61 percent) who make up only 25 percent of the high user group. (See Table 6.1.)

This finding seems to confirm the strongly held contention that women use more mental health services than do men. A new dimension is added, however, by focusing on the other two patterns. As Table 6.1 indicates, intensive users are slightly more likely to be women (60 percent) than sporadic users (50 percent). This finding suggests that even when men and women use CMHC services for a similar duration of time (less than one year), the women tend to use them more regularly than the men.

When we examine the data to discern whether race is a determining factor--namely, whether black men and women would have the same pattern of use as Hispanic men and women--only minor specifications can be added. (See Tables 6.2 and 6.3.) While the general tendency remains the same in three patterns of utilization, the gap between Hispanic men and women has diminished in the low category from a 20 percent to slightly over 10 percent difference. Thus, black men tend to be low users more often than Hispanic' men.

Race/Ethnicity

A strong association appears also to exist between utilization patterns and race/ethnicity. There are almost 20 percent more blacks than Hispanics among the low users (see Table 6.4). This is especially significant since, in general, there are almost twice as many Hispanics as blacks in our sample. These proportions change radically in the high users category, which is comprised of 90 percent Hispanics. Table 6.4 also suggests that Hispanics are more likely to be found in the sporadic pattern of use and only slightly more likely to be intensive users.

These patterns remain unchanged when we control the relationship between race/ethnicity by sex (see Tables 6.5 and 6.6).

Age

Looking at the mean age of our various types of utilizers (see Table 6.7), we observe that the high users are significantly younger than the low users, thirty-eight as compared with fifty-two. The ages of the sporadic and the intensive users are intermediate and do not differ substantially from one another (forty-five and forty-eight).

Since the relationship between sex and utilization patterns stays the same for blacks and Hispanics and, similarly, the relationship between race/ethnicity and utilization remains (more or less) stable for men and women we can, therefore, conclude that the roles of sex and race/ethnicity are independent from one another in the way they are associated with patterns of service use. Furthermore, since age also seems to be a significant factor in affecting type of use, we end up with three demographic variables each of which may have an independent effect on patterns of utilization.

In this type of situation, contingency-table-analysis is not an adequate procedure for assessing whether age is independently related to patterns of use because the introduction of multiple control variables acts to reduce sample size to the point where statistical interpretations become meaningless. For this reason, we chose an alternative method called discriminant function analysis. This method can assess whether or not the relationships reported between sex, race, age and utilization are independent from one another.

Results of Discriminant Function Analysis

Variable	F-value	Level of Significance
Race	8.04	$p < .0001$
Age	4.56	$p < .05$
Sex	3.68	not significant

As the table above indicates, race/ethnicity, followed by age, are the strongest discriminators among types of utilizers of City-Services. Sex is diminished, in effect, when race and age are introduced as control variables.

To summarize, the notion that patterns of use of mental health services are dependent upon the social/cultural context of the consumer is supported by our data analysis. This relationship appears to be the most important of the sociodemographic issues addressed thus far. Since the factor race/ethnicity seems to have the most significant impact on utilization patterns, we will continue to introduce it as a control factor as the analysis proceeds.

Achieved Characteristics

Whereas in the previous section we examined the predisposing implications of ascribed characteristics upon utilization, here we focus on the "achieved" status.

In particular, we turn our attention to such factors as educational, occupational and marital statuses. These represent "achievements" which are ground for self-evaluation and may, in some instances, represent the crises which precipitated the coming to the CMHC.

Occupation

As we expected, no relationship is found between occupational status and patterns of utilization. One obvious reason lies in the fact that little variation exists in occupational levels among our respondents. At best, some distinctions exist between service workers and operatives. However, these distinctions do not represent significant differences in occupational tensions and satisfactions.

Education

Here too, we did not expect, and indeed did not find any relationships (see Table 6.8). Our sample is very homogeneous, with 82 percent having no college education at all and 18 percent having only some college.

Furthermore, education is usually used as one indicator (among several) to measure SES and we have already emphasized the homogeneity of our sample in terms of SES indicators. Interestingly, while neither education nor occupation seem to be related to utilization of mental health services, employment status emerged as an important discriminator among the four patterns. We will discuss this in detail below.

Marital Status

We expected to find some relationship between marital status (coded currently married versus currently not married) and utilization patterns. However, no relationship was found (see Table 6.9). Upon reflection we can speculate that our expectations--based on the notion that single people are more alienated and therefore more likely to be high and intensive users--was erroneous. Marital status, by itself, is probably not a good measure of alienation. It tells us nothing at all about the quality of life individuals are leading.

To conclude, occupation, education and marital status, which in the past were regarded as pivotal sociodemographic factors affecting utilization of mental health services, were found to bear no relationships to patterns of utilization at City-CMHC.

Socioeconomic Characteristics

Researchers have repeatedly suggested that economic factors are important determinants of use of medical and mental health services. A vast literature exists linking occupation and income to utilization in the United States. A general consensus prevails that people who are on high occupational ranks and who have more money take fuller advantage of health and mental health services. This finding not only held to be true empirically but made sense logically. Higher occupational ranks are commensurate with a higher standard of living which, in turn, enables a person to purchase more (and perhaps better) health care.

As already indicated elsewhere, the advent of the CMHC, followed by the introduction of Medicare and Medicaid, made financial resources available for the use of health and mental health services by the poor. Therefore, the mere economic factor of utilization behavior can no longer be regarded as sufficient explanation. Indeed, as we have shown above, no relationship exists between occupational status and utilization. Unemployment, on the other hand, still remains an important factor in predicting use of mental health services. A great deal of evidence continuously generated since the Great Depression points to the negative consequences of unemployment, especially for men. Symptoms resulting from unemployment have been identified, specifically such feelings as nervousness, tiredness, anger, and depression (Work in America, 1973). The loss of a job and a prolonged state of unemployment carry profound negative meanings for the worker as well as for his or her family. For these reasons, we decided to examine the effect of work (or the lack of it) on utilization behavior.

Our sample of predominantly poor and unemployed persons affords a unique opportunity. It permits us to zero in on economic factors which will better explain differential use of services within the least privileged segments of our society. We focus especially on two such factors: the respondents' current employment status--whether they are working or unemployed--and their main source of income.

Employment Status

We begin by distinguishing three groups, set off from one another by their relationship to the labor market. The largest of these groups are those "out of work," who comprise 69 percent of our sample (or 208 people). The second group represents homemakers, students, and retired persons. These people, who are not currently seeking employment, hold legitimate social roles and therefore define themselves out of the labor force. This group, labeled the "not employed," numbers 59 people, or 20 percent of the total sample. The third group, and by far the smallest, constitutes the "employed," with only 33 people, or 11 percent of the respondents. The proportional representations of the unemployed among blacks and Hispanics is virtually the same (70 percent and 69 percent respectively). However, the Hispanics are more likely to be not employed, while the blacks are more likely to be employed (see Table 6.10). This is partly explained by the fact that there are more Hispanic women--homemakers who define themselves as not employed--in our sample.

Table 6.11 presents the association between utilization patterns and employment status. As the data indicate, those "out of work" are less than half (43 percent) of the low users, whereas they comprise more than two thirds of the other patterns. They especially seem to cluster among the sporadic users, of whom 76 percent are "out of work." Contrarily, the percentage of employed patients is the highest among the low users (35 percent as compared with an average of only 11 percent for the other three patterns).

It appears, then, that the sporadic, intensive and high users of City-Services are most likely to be out of work, whereas the low users are more likely to be employed. This general trend persists when we separate the data by sex, despite some observed differences between men and women (see Tables 6.12 and 6.13).

Among blacks, the low users are more often employed than among other types of utilizers. However, among Hispanics the employment rates are comparable across all patterns of utilization (see Tables 6.14 and 6.15). Thus, we canconclude that the original relationship holds only among blacks.

Since those out of work overwhelm our sample (208 people, or 69 percent), factors within this group are important to gauge as well. We thus created an additional employment variable which is (1) not simply dichotomous but has several ordinal values; and (2) ordered by degree of <u>social stigma</u> society normally attaches to the person's employment situation. This new work-stigma variable has five values ranging from most to least socially approved (see Table 6.16): (1) currently employed (13.3 percent of the 271 persons for whom the data necessary to contruct the variable are available); (2) not employed--not in the labor force, i.e., housewives, students, etc. (22.5 percent); (3) underemployed--has had a job in the last year but not now (8.9 percent); (4) our of work--not working but looking for a job (17.3 percent) and (5) chronically unemployed (38.0 percent).

When we crosstabulate this "work" variable with utilization patterns (see Table 6.17), the most striking relationships which appear are between low users and the employed on one hand, and high and sporadic users and the chronically unemployed on the other. It might be speculated that the employed have less time available to use the services with the same intensity as the unemployed. The issue of how employment and use of mental health services are related is a very important one and much neglected in the field of utilization research.

Source of Income

An additional method of tapping variation in economic status in a sample which is so heavily poor is to examine how they obtain the money they need to conduct their daily lives, i.e., their main source of income.

First, however, we felt it appropriate to study actual level of income as well. We obtained annual income information for all respondents regardless of whether or not they were heads of households, working full-time, part-time, or receiving governmental funds. Then we inquired about the income of all other household members. We subsequently added the two reported sums, arriving at a total annual household income. The range reported proved to be a very small one: from $3,500 per household per year to just over $6,500. This narrow range probably explains why we found no relationship between annual income and our various dimensions of utilization.

The not-expected absence of differences in utilization by income level heightened our interest in source of income as a potential explanatory variable. Our original principal source of income measure had a number of values, but ultimately we reduced the variable to three categories: (1) Wages or Salaries (15.6 percent); (2) Public Assistance, i.e., welfare and SSI (63.8 percent); and (3) Work Compensation, i.e., pensions and unemployment insurance (20.6 percent). Welfare and SSI constitute the single largest source of income. Low users are least likely to be receiving welfare or other governmental funds relative to the other types of users, the majority of whom receive welfare (see Table 6.18).

Thus, our data suggest that the key difference with regard to source of income is between those on public assistance and those gainfully employed. One obvious reason for such a differential is that chronic welfare populations tend to be in greater need of mental health services than those who are functioning in the labor market. However, various City personnel whom we had interviewed called our attention to the fact that welfare recipients often use CMHC services in order to document disability and thus legitimize their claim for compensations. Our data can neither confirm nor deny this contention. Further research is necessary, designed specifically to address this issue. The higher utilization of services by welfare clients probably also indicates the greater availability of resources, primarily Medicaid, which facilitate utilization.

Table 6.1

Utilization Patterns by Sex (N = 243)

	Low	Sporadic	Intensive	High
Men	60.9	49.5	39.7	25.5
Women	39.1	50.5	60.3	74.5
TOTAL	100.0% (N = 23)	100.0% (N = 105)	100.0% (N = 68)	100.0% (N = 47)

Table 6.2

Utilization Patterns by Sex:
Blacks Only (N = 76)

	Low	Sporadic	Intensive	High
Men	69.2	46.7	41.4	25.0
Women	30.8	53.3	58.6	75.0
TOTAL	100.0% (N = 13)	100.0% (N = 30)	100.0% (N = 29)	100.0% (N = 4)

Table 6.3

Utilization Patterns by Sex: Hispanics Only (N = 147)

	Low	Sporadic	Intensive	High
Men	55.6	50.0	40.0	27.0
Women	44.4	50.0	60.0	73.0
TOTAL	100.0% (N = 9)	100.0% (N = 66)	100.0% (N = 35)	100.0% (N = 37)

Table 6.4

Utilization Patterns by Race/Ethnicity (N = 223)

	Low	Sporadic	Intensive	High
Black	59.1	31.3	45.3	9.8
Hispanic	40.9	68.8	54.7	90.2
TOTAL	100.0% (N = 22)	100.0% (N = 96)	100.0% (N = 64)	100.0% (N = 41)

Table 6.5

Utilization Patterns by Race/Ethnicity: Women Only (N = 125)

	Low	Sporadic	Intensive	High
Black	50.0	32.7	44.7	10.0
Hispanic	50.0	67.3	55.3	90.0
TOTAL	100.0% (N = 8)	100.0% (N = 49)	100.0% (N = 38)	100.0% (N = 30)

Table 6.6

Utilization Patterns by Race/Ethnicity:
Men Only (N = 98)

	Low	Sporadic	Intensive	High
Black	64.3	29.8	46.2	9.1
Hispanic	35.7	70.2	53.8	90.9
TOTAL	100.0% (N = 14)	100.0% (N = 47)	100.0% (N - 26)	100.0% (N = 11)

Table 6.7

Distribution of Mean Age Among Utilizers

	Count	Mean Age	Standard Deviation	Standard Error
Low	22	52.2273	6.5460	1.3956
Sporadic	101	45.2871	10.58404	1.0528
Intensive	62	48.4516	11.0136	1.3987
High	46	37.6087	12.2065	1.7997
TOTAL	231	45.2684	11.5328	0.7588

Table 6.8

Utilization Patterns by Education (N = 243)

	Low	Sporadic	Intensive	High
No College	82.6	80.0	79.4	89.4
Some College	17.4	20.0	20.6	10.6
TOTAL	100.0% (N = 23)	100.0% (N = 105)	100.0% (N = 68)	100.0% (N = 47)

Table 6.9

Utilization Patterns by Marital Status (N = 240)

	Low	Sporadic	Intensive	High
Currently Married	13.0	13.5	17.9	26.1
Currently Not Married	87.0	86.5	82.1	73.9
TOTAL	100.0% (N = 23)	100.0% (N = 104)	100.0% (N - 67)	100.0% (N = 46)

Table 6.10

Employment Status by Race/Ethnicity (N = 300)

	Employed	Not Employed	Out of Work	Total
Black	17.9	12.3	69.8	100.0% (N = 106)
Hispanic	7.6	23.7	69.1	100.0% (N = 194)

Table 6.11

Utilization Patterns by Employment Status (N = 241)

	Low	Sporadic	Intensive	High
Employed	34.8	11.4	13.4	8.7
Not Employed	21.7	12.4	19.4	19.6
Out of Work	43.5	76.2	67.2	71.7
TOTAL	100.0% (N = 23)	100.0% (N = 105)	100.0% (N = 67)	100.0% (N = 46)

Table 6.12

Utilization Patterns by Employment Status:
Men Only (N = 97)

	Low	Sporadic	Intensive	High
Employed	35.7	10.6	11.5	10.0
Not Employed	7.1	2.1	11.5	-
Out of Work	57.1	87.2	76.9	90.0
	100.0% (N = 14)	100.0% (N = 47)	100.0% (N = 26)	100.0% (N = 10)

Table 6.13

Utilization Patterns by Employment Status: Women Only (N = 126)

	Low	Sporadic	Intensive	High
Employed	37.5	8.2	13.2	9.7
Not Employed	50.0	24.5	26.3	22.6
Out of Work	12.5	67.3	60.5	67.7
TOTAL	100.0% (N = 8)	100.0% (N = 49)	100.0% (N = 38)	100.0% (N = 31)

Table 6.14

Utilization Patterns by Employment Status:
Blacks Only (N = 76)

	Low	Sporadic	Intensive	High
Employed	53.8	13.3	20.7	25.0
Not Employed	15.4	13.3	13.8	25.0
Out of Work	30.8	73.3	65.5	50.0
TOTAL	100.0% (N = 13)	100.0% (N = 30)	100.0% (N = 29)	100.0% (N = 4)

Table 6.15

Utilization Patterns by Employment Status: Hispanic Only (N = 145)

	Low	Sporadic	Intensive	High
Employed	11.1	7.6	5.9	8.3
Not Employed	33.3	13.6	26.5	16.7
Out of Work	55.6	78.8	67.6	75.0
TOTAL	100.0% (N = 9)	100.0% (N = 66)	100.0% (N = 34)	100.0% (N = 36)

Table 6.16

Work Status in Last Year (N = 271)

Work Status	Absolute Frequency	Adjusted Frequency
Employed	36	13.3%
Not Employed	61	22.5%
Underemployed	24	8.9%
Out of Work	47	17.3%
Chronically Unemployed	103	38.0%
TOTAL	271	100.0%

Table 6.17

Utilization Patterns by Work Status (N = 185)

	Low	Sporadic	Intensive	High
Employed	44.4	10.1	12.7	12.1
Not Employed	27.8	15.2	23.6	21.2
Underemployed		7.6	9.1	6.1
Out of Work		19.0	21.8	15.2
Chronically Unemployed	11.1	48.1	32.7	45.5
TOTAL	100.0% (N = 18)	100.0% (N = 79)	100.0% (N = 55)	100.0% (N = 33)

Table 6.18

Utilization Patterns by Source of Income (N = 243)

	Low	Sporadic	Intensive	High
Earnings	34.8	15.2	14.7	8.5
Welfare/SSI	43.5	66.7	63.2	68.1
Work Compensation	21.7	18.1	22.1	23.4
TOTAL	100.0% (N = 23)	100.0% (N = 105)	100.0% (N = 68)	100.0% (N = 47)

CHAPTER 7

PSYCHOLOGICAL AND ORGANIZATIONAL FACTORS OF UTILIZATION

Psychological Accessibility

It has been stated already that a particular concern of our research has been to incorporate into the analysis the clients' subjective assessment of their experience with CMHC services. Previous studies have stressed the importance of accessibility as a determinant of service use. Yet they have mostly treated accessibility in physical terms--i.e., proximity of home to CMHC and availability of transportation. We began this study with the assumption that, in a crowded urban setting such as our catchment area, physical accessibility is a secondary issue. Instead, we felt, our main focus should be on subjective or psychological accessibility.

A review of previous research indicates that there has been little detailed discussion of patients' psychological accessibility to treatment and the utilization process (McKinlay, 1972). This is especially true of poor minorities who are rarely surveyed. Our questionnaire permitted us to focus attention upon this type of accessibility. This, in turn, led us to ask about the satisfaction and contentment of minority clientele with City-CMHC. We can discern what problems <u>they</u> identify as the most vital ones in their encounter with the center, and to what degree <u>they</u> feel alienated from it. This approach allows us to move beyond formalistic and bureaucratic criteria of utilization by making clients' perceptions a significant part of our analyses.

In this section, we examine two types of information on psychological accessibility: (1) clients' satisfaction with various aspects of the CMHC experience, especially their satisfaction with the doctor-patient relationship, and (2) clients' attitude toward mental health professionals in general.

While one's general attitude toward mental health professionals may affect the decision to seek treatment in the first place, the concrete satisfaction with one's therapist or treatment will undoubtedly impact more directly upon utilization behavior. We therefore hypothesized that satisfaction, more than a general positive attitude, will result in longer, and perhaps more intense, use of CMHC services.

Client Satisfaction

We have created two indices of client satisfaction: (a) general satisfaction with the CMHC and (b) satisfaction with the doctor-patient relationship.

The first index--clients' general satisfaction with the CMHC experience--was constructed by combining responses to six statements about the clinic.[1] The index was dichotomized into High and Low categories, where High indicates at least four positive statements and Low reflects two or more negative statements regarding the experience in the CMHC.

In general, we find a strong relationship between degree of satisfaction and degree of use. As indicated in Table 7.1, the High users are also more likely to be the highly satisfied. It is interesting, however, that a large majority of the Sporadic users are also highly satisfied clients (see Table 7.1). Since sporadic users by definition enter treatment at an on-again-off-again manner, this finding suggests that a high degree of satisfaction with the services rendered may influence the duration of treatment but not necessarily the regularity with which services are being used.

When we introduce race/ethnicity as a control variable, the original relationship between satisfaction and utilization remains the same only for black patients. It completely disappears for Hispanics (see Tables 7.2 and 7.3). We, therefore, conclude that for blacks, satisfaction with the CMHC appears to influence patterns of use while for Hispanics it does not.

Our second index--satisfaction with doctor-patient relationship--was built from eight statements.[2] A positive score of five or more was labeled High satisfaction and a negative score of three or more was labeled Low satisfaction.

A relationship appears to exist between degree of satisfaction with physician and patterns of use (Table 7.4). Low users are also likely to be Low on satisfaction. Once again, upon the introduction of race/ethnicity as a control variable, the original relationship holds only for blacks and not for Hispanics (see Tables 7.5, 7.6).

Satisfaction also appears to be related to service: On each of the two indices, patients who attended Community Outreach Services (COS) expressed more satisfaction (Tables 7.7, 7.8). Indeed, it seems that COS patients are more often represented among the Intensive users and less often among the Low users (see Table 7.9).

Despite this apparent association, we cannot, within the context of this study, discern whether satisfaction leads to longer use or whether longer use results in more satisfaction. Hence, the precise direction of this relationship requires further attention.

In the previous section we dealt with general satisfaction indices. Here, we turn our attention to specific likes, dislikes and recommendations made by our sample in response to the following questions: What were the things you liked best about City? What did you like least? And what would you recommend that would improve City's services? By asking these questions, we were hoping to identify the source of the generally high level of satisfaction with City-CMHC.

The three most frequently cited things the respondents claimed to have liked best encompassed 65.4 percent of all responses. They are the following: 28.1 percent--staff attitude or behavior; 21.3 percent--doctor's attitude or behavior; and 16.0 percent--treatment in general or treatment outcome. Other categories of patients' responses drop off dramatically in frequency. For example, the next category (5.2 percent) is specific mentioning of group therapy; then, 4.9 percent--food, and 4.0 percent--recreational activities. The remaining categories of answers received fewer than 4.0 percent of the responses.

It appears then that satisfaction with the quality of interaction with staff and with physicians is at the top of the list of what respondents liked best about City.

Further indications of the generally satisfied state of our sample emerge when we ask respondents to recommend improvements. The two most frequently mentioned recommendations involve staffing patterns of the City-CMHC. Despite the high level of satisfaction with CMHC servides, a third of the patients would like to see more staff available, and a quarter of the patients specify that they would particularly like to see the size of minority staff grow.

Mental Health Attitudes

Of course, the issue of psychological accessibility also includes more long-term subjective factors which are not tied to a specific context but which might impinge on the character of utilization careers. In particular, how receptive respondents are to the mental health establishment and its ideology may be important in this regard. Thus, we paid close attention to our respondents' attitudes regarding the efficacy of the practice and practitioners of services apart from the specifics of the City-CMHC context.

The major focus here is the relationship between general attitudes toward mental health and mental health providers, and utilization behavior. An index of general attitudes toward the efficacy of mental health services and providers was built out of three general statements.[3] Scores on the index have been divided into positive views of efficacy; mixed views; and negative views. In our sample, 37.6 percent have positive views; 58.2 percent mixed views; and 4.2 percent negative views. The low proportion of negative attitudes regarding efficacy provides a continuity from the earlier findings on largely positive assessment of the mental health experience and suggests this mind set extends to mental health services generally.

Generally, high users are more likely to be those clients who express positive attitudes regarding efficacy of mental health practitioners (see Table 7.10). This relationship persists where we control for race and ethnicity.

Yet, while these findings point to a general positive relationship between a sense of efficacy and utilization behavior, we cannot determine the precise direction of this relationship. We cannot, with in the framework of this study, state whether one's positive attitudes have, in fact, impacted upon one's utilization behavior; or conversely, whether prolonged use of services accounts for the expression of more positive attitude; or if there is an interaction effect.

Indeed, a dearth of good empirical research exists in this area. Theoretically, it appears that there are at least three possible approaches to this problem within the area of medical health service use. One, which emphasizes motivation, assumes a strong personal motivation to use services. Thus, people's utilization of medical and mental health services will be motivated by a strong need, rather than attitudes and views. The second approach dwells on perceptions, and assumes a rational connection between the way people perceive their world and their behavior. The third theoretical approach focuses on learning and its impact upon behavior.

These three approaches are, in fact, interdependent. But even if we were, for the sake of simplicity, to rely on one of the three theories, let us say, attitudes, it is unclear to what extent attitudes--whether positive or negative--influence utilization behavior, as stated clearly by McKinlay (1972:124):

> The hypothesis that behavior is determined by a particular constellation of beliefs and can be tested adequately only after it has been established that the beliefs existed prior to the observed behavior that they were supposed to determine.

In summary, we find that psychological access to the various facets of the CMHC is quite high along all three dimensions we studied. Yet, despite these high levels and the low variation they entail in our sample, different degrees of psychological access still impact on utilization patterns.

Access

Our focus on psychological accessibility as a potential lever in fostering utilization should not make us oblivious to material aspects of accessibility. When help is too far away, or waiting time too long, or treatment too costly, the motivation to use services may drop sharply. It has been argued that access--geographical and financial as well as psychological--is of special concern to community mental health centers primarily because of their ideal of fast and efficient service offered in response to crises. Thus, delays in offering treatment and long waiting periods may result in missed appointments and in a high rate of attrition. Wolkon (1972), for example, examined appointment-keeping behavior in several mental health facilities. He found that when potential patients had problems scheduling appointments or when there was a long waiting time, people were less likely to show up again at the clinic.

In the following section we focus on material access, particularly on geographical and financial barriers and on bureaucratic impediments, such as waiting time at the clinic, and troubles in making or keeping appointments. We also examine the potential effects of cultural barriers between therapist and client in utilization, and the impact of a drug regime on type of use. The relevant information was obtained directly from the respondents and focuses on their reports and feelings regarding services rendered at City-CMHC.

Mode and Cost of Travel

It appears that the majority of the sample live within easy reach of the CMHC. About 48 percent (156 people) walk to and from the center, an additional 34 percent (111 people) travel by bus, 14 percent (46 people) reach the center by subway, and the rest (4 percent) either drive a car or take a taxi to come to City-CMHC. The majority of patients interviewed reach the center within fifteen minutes (53 percent or 172 individuals). For 37 percent of the sample it takes anywhere from fifteen minutes to a half hour to reach the center.

It is not surprising, therefore, that the overwhelming majority of the respondents (88 percent or 289 people) do not regard the travel time as a problem. While 9 percent claim it was somewhat of a problem for them to travel to the center, only three individuals (less than 1 percent) regard the traveling time as a serious problem.

Of those patients who do use some means of public transportation to and from the center, 43 percent receive reimbursement of travel cost, while the rest of the patients (57 percent) have to pay their own traveling expenses. Yet, despite encountering such cost, 66 percent stated that "it was no problem," 15 percent said it was somewhat of a problem, and 19 percent of those who paid their own travel expense proclaimed the cost of travel as a problem.

Cost of Services

We were interested in probing the patient's awareness regarding the actual amount charged by the CMHC for its services, the extent to which the patients participate in payment for visits to the center, and their feelings about the charge.

In general, the majority of our respondents (86 percent) have no idea how much a visit to the CMHC costs. They are not billed directly for the service, and, therefore, are not aware of the actual charge for treatment. Of the remaining 14 percent, most people know the actual charge per visit, despite the fact they do not pay for the treatment.

Almost 92 percent (or 300 people) of the sample do not themselves pay for services. The primary source of payment is Medicaid, covering 79 percent of the clients interviewed. Hence, it is understandable that for the majority of the respondents, the cost of services is of no concern. We can conclude that City-CMHC is easily accessible in a material sense--both geographically and financially--to the population it attempts to serve. Yet, since most of the people served by this CMHC rely heavily on insurance coverage, any major changes in Medicaid or Medicare policies may seriously hinder accessibility in the future.

Bureaucratic Factors

As indicated above, a long waiting time to see a therapist, or problems experienced in making or keeping appointments may deter some people from using the services. We, therefore, sought to find out whether such bureaucratic factors have indeed influenced utilization behavior and, if so, in what ways.

Waiting Time

According to the respondents, over a third (35 percent) waited only fifteen minutes or less during their first visit to the center. An additional 25 percent was kept waiting up to 30 minutes, another 17 percent waited up to one hour when they first came to City-CMHC, and 23 percent of the sample was kept waiting for one hour or more on their first visit.

When asked whether they were bothered by the first visit waiting time, 78 percent of the respondents said that they were not bothered at all. Despite the fact that almost one quarter (22 percent) of the sample did express negative feelings about waiting time, these feelings do not appear to have any influence on their utilization behavior.

In general, there is no difference in the distribution of utilization patterns between those who were bothered by the waiting time and those who were not. This finding is not surprising since having to wait an hour or even more in a doctor's office is customary for many Americans regardless of class or race. This is especially true in public clinics or public agencies in which a long waiting period is even more the norm.

Making and Keeping Appointments

Respondents were asked whether they had experienced any problems making appointments to return to the CMHC. The overwhelming majority of patients interviewed say no, they did not experience any problems in this area (94 percent, or 307 people). However, about 20 percent did report problems in keeping their pointment (regardless of reasons which were varied).

When we examine this group, we note that they are just about as evenly distributed among the services, and they are as likely to be men as women. It appears from our data that these factors--problems in making or keeping appointments--regardless of the feelings expressed, are not significant explanatory factors in utilization patterns.

Such issues as geographical distance, traveling time, and cost of services, much discussed in the literature of utilization, do not pose any problems and do not hinder utilization of services in this study. The same applies to potential bureaucratic impediments. Such problems as making or keeping appointments and waiting time at the center, if and when experienced, do not seem to have a strong influence on utilization patterns.

Staff Characteristics

One of the major goals of the CMHC Act was to attract indigenous population why by and large have been inadequately served by traditional services. An attempt was therefore made by many CMHCs to employ paraprofessionals from the community who could bridge the gap (both culturally and in terms of language barriers) between the all-too-often middle-class professional and the lower-class patient (Reiff and Reisman, 1965).

The underlying assumption was that a shared experiential base can result in a better rapport between patient and therapist and, therefore, in a greater benefit to the patient. According to the sociologist Robert Merton (1972), this notion reflects the concept of "insiders" versus "outsiders":

> . . . the doctrine of extreme insiderism represents a new credentialism. This is the credentialism of ascribed status, in which understanding becomes accessible only to the fortunate few or many who are to the manner born. . . . The insider doctrine can be put in the vernacular with no great loss of meaning: You have to be one in order to understand one. In somewhat less idiomatic language, the doctrine holds that one had monopolistic or privileged access to knowledge, or is wholly excluded from it, by virtue of one's group membership or social position. . . . Insider as Insighter, one endowed with special insight into matters necessarily obscure to others, thus possessed of penetrating discernment.

In this study, we are not evaluating the validity of Merton's concept, nor the merits of CMHCs' attempt to employ more indigenous workers; neither are we evaluating City-CMHC's actions in this area. Rather, we are interested in examining the ways in which staff characteristics are perceived by the clients, and the effects of these perceptions on utilization.

On a general descriptive level, a little over half the sample population (52 percent) reported that they are seeing two staff members on a regular basis. About a third (31 percent) was seen by one professional at a time, and 15 percent stated that they have contact with three staff members simultaneously.

When asked to specify the professional rank of the person seen, the majority of patients (71 percent) reported contact with a doctor/psychiatrist as their primary therapist. The rest of the population was almost evenly distributed among all other professional groups.

For those who were seen regularly by two staff members, the most common combination was that of a doctor/psychiatrist and one other professional, usually a social worker. It should be pointed out here that neither the number nor the rank of the professionals seen at the CMHC seem to be related to utilization patterns.

Race/Ethnicity of Patients and Therapists

To the question: "Was your primary therapist of the same race/ethnicity?", most of the respondents (64 percent) answered no. When we compare the response distribution by service, we note that patients attending OPD are less likely to be seen by a therapist of the same racial/

ethnic background than patients attending either PHP or COS (80 percent, 53 percent, and 52 percent, respectively).

Since 52 percent of our sample are seen by more than one of CMHC's staff on a regular basis, we inquired about the racial/ethnic background of the second person seen. Here, again, it appears that attending either PHP or COS increases the likelihood of being seen by someone of similar racial or ethnic origin.

Does the congruity between the patient's and the therapist's background increase utilization? The answer is no. In general, there are no significant differences between those patients seen by a therapist of the same racial/ethnic background and those who were not in terms of utilization patterns. Thus, for most of the respondents, utilization behavior does not seem to be affected by matching patients and therapists by race or ethnicity.

In summary, while the concept of cultural congruity (or racial/ethnic similarity) has theoretical validity, it does not appear to have a strong influence on utilization behavior. Indeed, 61 percent of our respondents said they had no preference in terms of seeing someone from a similar background. Despite the fact that over a third of the sample (36 percent) did have a preference for an "insider," claiming that such a therapist would, indeed, have more "insight," overall behavior does not seem to be affected by such preferences.

Medication

Does the dispensing of medication affect utilization? In other words, did the patient who received medication use the center for a longer period of time or in a different manner?

First, we would like to point out that the majority of the interviewed patients (78 percent) had received medication while in attendance at City-CMHC. Those patients attending OPD and PHP were more likely to get medication prescribed for them than those at COS (82 percent, 84 percent, and 67 percent, respectively).

Men were just as likely to receive medication as women (77 percent and 78 percent respectively). Likewise, patients in the 31 to 50 age group were more likely to get medication than both the younger (18 to 30) and the older (50 plus) groups (84 percent, 71 percent, and 77 percent, respectively).

When we asked the patients in our sample whether or not their doctor had explained carefully the use of the medication and its potential benefits and possible harm, 85 percent responded yes. When specific inquiries were made in order to ascertain the nature of the explanations given by the doctor, varied kinds of information was prevalent among the patients.

For example, while 96 percent of the respondents knew some things about the type of help they can anticipate from taking the medication (i.e., calming effect, allow the patient to sleep, eliminate symptoms, and reduce anxiety), 55 percent were told by their doctor how long it would take before the medication starts to have an effect. Only 30 percent were informed about the possible side effects which could result from taking the medication.

Medication Treatment and Utilization

It is evident from our data that those patients who were treated with medication (either medication alone, or a combination of medication and a therapeutic program) are more likely to be high users (64 percent as compared with 34 percent of those who did not receive any medication).

When we examined more closely the regularity of use, the following trends were revealed. Patients who were "on medication" were more likely to be higher users in terms of duration, yet, their regularity of attendance was lower. They tend to concentrate in the sporadic group, namely, their style seems to be that of a long utilization career, albeit a sporadic use of services. In contrast, patients who do not receive medication as part of their treatment (or as their whole treatment) tend to comprise the intense user group. While their utilization career is shorter, they use the services more intensely and consistently.

When we control the above relationship by sex, race/ethnicity, and age, it holds consisteltly with the same result.

Thus, in conclusion, it appears that those clients who get medication have a higher duration of use but are more likely to be sporadic users while those who do not get medication are more likely to be more intensive users.

Table 7.1

Utilization Patterns by Patient's Satisfaction
with CMHC Experience (N = 198)

Satisfaction	Low	Sporadic	Intensive	High
Low	50.0	18.4	32.0	18.6
High	50.0	81.6	68.0	81.4
TOTAL	100.0% (N = 18)	100.0% (N = 87)	100.0% (N = 50)	100.0% (N = 43)

Table 7.2

Utilization Patterns by Patient's Satisfaction with CMHC Experience: Black Only (N = 59)

Satisfaction	Low	Sporadic	Intensive	High
Low	60.0	12.5	31.8	0.0
High	40.0	87.5	68.2	100.0
TOTAL	100.0% (N = 10)	100.0% (N = 24)	100.0% (N = 22)	100.0% (N = 3)

Table 7.3

Utilization Patterns by Patient's Satisfaction with CMHC Experience: Hispanic Only (N = 126)

Satisfaction	Low	Sporadic	Intensive	High
Low	28.6	19.0	30.8	22.9
High	71.4	81.0	69.2	77.1
TOTAL	100.0% (N = 7)	100.0% (N = 58)	100.0% (N = 26)	100.0% (N = 35)

Table 7.4

Utilization Patterns by Patient's Satisfaction with Doctor-Patient Relationship (N = 187)

Satisfaction	Low	Sporadic	Intensive	High
Low	53.8	47.6	28.8	18.4
High	46.2	52.4	71.2	81.6
TOTAL	100.0% (N = 13)	100.0% (N = 84)	100.0% (N = 52)	100.0% (N = 38)

Table 7.5

Utilization Patterns by Patient's Satisfaction with Doctor-Patient Relationship: Black Only (N = 53)

Satisfaction	Low	Sporadic	Intensive	High
Low	71.4	30.0	33.3	50.0
High	28.6	70.0	66.7	50.0
TOTAL	100.0% (N = 7)	100.0% (N = 20)	100.0% (N = 24)	100.0% (N = 2)

Table 7.6

Utilization Patterns by Patient's Satisfaction with Doctor-Patient Relationship: Hispanic Only (N = 123)

Satisfaction	Low	Sporadic	Intensive	High
Low	33.3	51.7	24.0	15.6
High	66.7	48.3	76.0	84.4
TOTAL	100.0% (N = 6)	100.0% (N = 60)	100.0% (N = 25)	100.0% (N = 32)

Table 7.7

Patient Satisfaction with Doctor-Patient Relationship by Service (N = 266)

Degree of Satisfaction	Service			
	OPD	PHP	COS	Total Sample
Low	50.5	43.9	23.7	39.5
High	49.5	56.1	76.3	60.5
TOTAL	100.0% (N = 107)	100.0% (N = 66)	100.0% (N = 93)	100.0% (N = 266)

Table 7.8

Patient Satisfaction with the Organizational Experience by Service (N = 316)

Degree of Satisfaction		Service		
	OPD	PHP	COS	Total Sample
Low	28.0	16.4	10.9	19.3
High	72.0	83.3	39.1	80.7
TOTAL	100.0% (N = 125)	100.0% (N = 90)	100.0% (N = 101)	100.0% (N = 316)

Table 7.9

Utilization Patterns by Service (N = 234)

Service	Low	Sporadic	Intensive	High
OPD	45.5	34.3	26.6	45.7
PHP	27.3	41.2	29.6	23.9
COS	27.2	24.5	43.8	30.4
TOTAL	100.0% (N = 22)	100.0% (N = 102)	100.0% (N = 64)	100.0% (N = 46)

Table 7.10

Utilization Patterns by Patients' General Attitudes Toward Mental Health

Attitudes	Low	Sporadic	Intensive	High
Positive	29.4	37.3	31.6	53.1
Mixed	70.6	55.4	66.7	43.8
Negative	-	7.3	1.8	3.1
TOTAL	100.0% (N = 17)	100.0% (N = 83)	100.0% (N = 57)	100.0% (N = 32)

Notes

The indices of clients' satisfaction with various aspects of CMHC experience were developed by Dr. Carol Kunzel.

[1] Questions upon which this index is based inquire about the CMHC's safety, cleanliness, desire for future use, importance of services, quality of care and satisfaction with help received.

[2] Questions upon which this index is based are as follows: Did you feel at ease with people who treated you? Do you desire the same or another therapist in the future? Was the person who helped you well qualified? Did the therapist ask you to come often enough? Were questions important to your problem? Were you able to explain your problems? When discussing problems with staff, did you have sufficient privacy? Did staff listen to your problem?

[3] Statements upon which this index is based are as follows: (a) A sympathetic or understanding friend can help you just as much as a psychiatrist with emotional problems. (b) Most people who go to psychiatrists for help with their personal problems are satisfied or pleased with the help they get. (c) To feel better, you have to come to the CMHC regularly.

CHAPTER 8

SUMMARY AND CONCLUSIONS

In this final chapter our primary aim will be to summarize and interpret the research findings. Our major goals have been to chart how a predominantly minority client population utilizes the services of a community mental health center and to account for variations occurring in patterns of utilization. The pursuit of our research objectives has been guided by three central tenets: (1) we attempted to develop an alternative conception and measure of utilization behavior; (2) we were committed to include in the analysis of utilization factors the clients' own perspective and experience; and (3) we wished to understand our "micro" analysis of utilization of community mental health services within the larger contextual structure of the mental health field.

To put things in perspective, let us review some of our findings. We have argued that the growing complexities of mental health service delivery requires rethinking the issue of utilization behavior. The fact that the CMHC movement has greatly enlarged and diversified the potential population of mental health service users makes the task all the more imperative and difficult. We discerned four prototypes of utilizers at City-CMHC: low, sporadic, intensive, and high.

The typology of low and high represents the traditional dichotomy which views use of mental health services on a linear continuum. In contrast, we believe that the sporadic and intensive users are not merely idiosyncratic departures from this dominant linear pattern. Rather, the way these clients use City-CMHC services reflects the exigencies of their particular needs or situations. Thus, the sporadic use of services over a long duration (the sporadic user) and the intensive use over a shorter time period (the intensive user) should be regarded as common patterns of utilization. These categories offer useful alternatives to the dominant middle-class and professional model of long-term insight therapy, with special reference to the poor and minorities.

In looking over the principal findings, the overriding picture which emerges is of the grinding effects of poverty. The descriptive part of our findings reflects, in the clients' own words, the ubiquitous problems prevalent among the people we surveyed. Our respondents can probably trace much of their distress to such conditions as unemployment, inadequate welfare payments, powerlessness, and a general barren and impoverished community.

Without question, our most consistent finding is the unemployment status which is strongly associated with high use of services. For men and women of both black and Hispanic origin, a chronic state of unemployment appears to result in more use of services. Moreover, clients who are recipients of welfare checks also constitute the "highest" utilizers of City services. One possible explanation for this finding may be that the chronically unemployed are more mentally disabled and therefore appear in greater numbers in the high-use category. This explanation, however, presupposes a positive correlation between degree of social functioning (reflected in employment status), mental disability, and extent of service use. In other words, it is assumed that persons who are chronically unproductive (i.e., unemployed) are likely to be more disabled. It is further assumed that these persons are more likely to seek mental treatment. While these assumptions may be plausible, we believe they are incorrect. Therefore, we offer an alternative explanation which views mental health utilization as a critical mechanism used by people to cope with the social injuries incurred in being poor. Before we attempt to justify and elaborate this contention, let us review our other major findings.

We noted earlier our expectations that the patients' perceptions of their problems and their expressed desire for a particular treatment modality would be related to utilization patterns. Despite the rationale inherent in these expectations, we discovered, to the contrary, no relationships at all. The lack of a relationship between why patients came to the clinic, what they came for and the way they utilized the services may be methodological, the result of errors of subject recall. However, it is also possible that undetermined intervening factors intercede to mask such a relationship. These so-called intervening factors have been widely discussed in the review of the literature on utilization. They refer to: (1) the exclusionary effect of professional bias; (2) the reinforcement of alienation through the use of traditional techniques of psychotherapeutic treatment; (3) the cultural discrepancies between therapists and patients due to language barriers or a differential value system; (4) the discrepancy between the patient's expectations of the treatment and the therapist's judgements; and (5) the inequities embedded in the system which unevenly distributes both the type of diagnosis and the quality of the treatment modality.

These factors have been cited as surreptitious causes which essentially perpetuate the two-class system of care. While undoubtedly they must operate to some extent within City-CMHC, we did not succeed in uncovering them. On the contrary, when asked about their satisfaction with the general CMHC experience and with some particular aspects of it, our respondents, on the whole, expressed a high degree of satisfaction. In general, they did not articulate any feelings of disappointment in the treatment they received. Yet, we uncovered a very important serendipitous finding which may raise a question about the reliability of the patients' responses. This finding reflects that while only 20 percent of our respondents expected medication as a form of treatment, 80 percent got it. Moreover, while 80 percent stated that they came for "talk therapy," only 20 percent actually received talk therapy.

This finding may reflect the log jams in such mental health facilities and the lack of sufficient personnel to treat patients on a one-to-one basis. The New York State Department of Mental Hygiene (1964) took note of this problem in the following statement:

> The ratio of manpower in the mental health field to persons in need of care and treatment virtually eliminates as a significant element of treatment traditional

> one-to-one psychotherapeutic modalities--at least in publicly supported programs. Major reliance must be placed on psychopharmacological, somatic, and therapeutic community efforts.

Clearly such practices have profound implications, particularly in maintaining the two-class system.

Our other noteworthy results point to the predisposing implication of sociodemographic factors upon utilization behavior. We showed that women, as previous researchers had also found, use services more than men. Yet we added a new dimension to this generally held knowledge by highlighting the fact that women are also more intensive users of mental health services. In other words, we have shown that the main distinction between the way in which the men and women of our sample use services is that men tend to be sporadic users while women are intensive users. In addition, we have confirmed the finding which points to greater use of services among younger people. Also, in comparing blacks and Hispanics, it appears that Hispanics take more advantage of mental health services than do blacks. This finding, once again, has already been observed by previous researchers in the field. It is possible that for Hispanics, mental health services, far from constituting an effective alternative to spiritualists and other types of "folk psychiatry," serve as an additional support system. It may act as an acculturating institution to which Hispanics bring the same kind of problems they would bring to the spiritualist. Garrison (1977) already observed that "established" mental health services are used by Hispanics simultaneously with other forms of help. This should be examined more carefully along with what potential structural barriers impede use of services by black patients.

Other findings revolve around accessibility. Generally, our respondents found City-CMHC highly accessible--not only geographically, financially, and bureaucratically, but psychologically as well. Physical access to City-CMHC is sufficiently high that it accounts for only minor variations in utilization patterns. The importance of governmental subsidies, mostly through such vehicles as Medicare and Medicaid, should not be ignored since they probably maintain financial access to the CMHC and therefore account for a high degree of use.

Psychological accessibility appears to be important. Differences occur in the sample desipte a generally high degree of psychological accessibility. Greater satisfaction with one's experience with the CMHC as well as with one's therapist is linked to three patterns of utilization: intensive, sporadic and high, whereas low satisfaction is associated only with low use. Similarly, positive values regarding the efficacy of mental health services appear to enhance higher utilization among City clientele.

Finally, the last finding we would like to emphasize here relates to structural factors. Patients at Community Outreach Services are, on the whole, more intensive and higher users than patients at the Partial Hospitalization Program and the Outpatient Department. We have already indicated elsewhere the differences between these services. We can only speculate here that COS, situated in a neighborhood settlement house and having the appearance of a neighborhood club rather than a medical clinic, may be more appealing to potential clients.

In looking over the major findings we have just summarized, we feel dissatisfied, particularly, because of the dearth of malleable factors which can suggest policy recommendations. We feel that the major determinants of utilization in the type of population we have studied are beyond the policy-maker's short-term attainments. We come back now to the point made earlier that mental health utilization serves as a critical mechanism used by people to cope with the ramifications of poverty. In order to convincingly argue this point, let us remind the reader of the earlier goals and stated ideology of the CMHC movement.

The justification for the establishment of CMHCs came largely from a philosophical stance which advocated the eradication of those environmental conditions associated with mental distress and disability. Thus, "community mental health" and its tangible organizational structure --the CMHC--were both condemned to failure because of overcommitment. Yet, despite the somewhat grandiose ideology, in reality a new type of service-oriented organization has been established. This organization--with its five structural cornerstones--outpatient, inpatient, emergency, day hospital and consultation and education services--is unique only in that those five services are now mandated as a "package" serving a wider range of people.

However, these services, for the most part, continue to regard the clients' problems as medical illnesses. The "medical" model assumes (a) that physicians can correctly diagnose mental illness as if it was a distinct entity, and (b) that those who come to a CMHC are by necessity sick and require mental health services. Both of these assumptions are, at best, erroneous. With regard to the first, Glasscote and others (1964) have observed that what is missing is "a consensus about the cutoff points that differentiate the 'mentally ill' from the 'mentally well' since otherwise all those who seek help presumably

BIBLIOGRAPHY

Abad, U., and Boyce, E. "Issues in Psychiatric Evaluation of Puerto Ricans: A Socio-cultural Perspective." Journal of Operational Psychiatry 10:1 (1979):28-39.

Abad, U., Ramos, J., and Boyce, E. "A Model for Delivery of Mental Health Services to Spanish-Speaking minorities." American Journal of Orthopsychiatry 44:4 (July 1974):584-95.

Ackerknecht, E.H. A Short History of Psychiatry. New York: Hafner Press, 1968.

Acosta, Frank. "Barriers Between Mental Health Services and Mexican Americans: An Examination of a Paradox." American Journal of Community Psychology 7(5) (1979): 503-20.

Baxter, E., and Hopper, K. "Pathologies of Place and Disorders of Mind: Community Living for Ex-Mental Patients in New York City." Health Policy Advisory Center 11:4 (March/April 1980):1-32.

Bell, C.C., and Mehta, H. "The Misdiagnosis of Black Patients with Manic Depressive Illness." Journal of the National Medical Association 72 (1980):141-45.

Bestman, E. et al. "Culturally Appropriate Interventions: Paradigms and Pitfalls." Paper presented at 53rd Annual Meeting of the American Orthopsychiatric Association, Atlanta, Georgia, March 1976.

Billingsley, A. "The Struggle for Mental Health." In Mental Health Issues and the Urban Poor, edited by D.A. Evans and W.L. Claiborn New York: Pergamon Press, 1974.

Billingsley, A. "Black Families and National Policy." Journal of Sociology and Social Welfare 2 (Spring 1975).

Billingsley, A. "The Family and Cultural Pluralism." Address at Baltimore Conference on Ethnicity and Social Welfare. New York: Institute on Pluralism and Group Identity, January 1976.

Block, W.E. "The Study of Attitudes About Mental Health in the Community Mental Health Center." Community Mental Health Journal 10(2)(1974):216-20.

Bloom, B.L. Community Mental Health: A General Introduction. Monterey, California: Brooks/Cole, 1975.

Bloom, B.L. and Padan, H.J. "Values of Community Mental Health Center Staff." Professional Psychology 8(1) (1977):33-47.

Bockoven, J.S. Moral Treatment in American Psychiatry. New York: Springer, 1963.

Brandon, R. "Differential Use of Mental Health Services: Social Pathology or Class Victimization?" In Handbook of Evaluation Research, edited by M. Guttentag and E. Struening. Beverly Hills, California: Sage Publications, 1975.

Brandt, L. "Studies of 'Dropout' Patients in Psychotherapy: A Review of Findings." Psychotherapy: Theory, Research and Practice 2 (1965):6-12.

Brown, P. Radical Psychology. New York: Harper and Row, 1973.

Brown, P. Toward a Marxist Psychology. New York: Harper and Row, 1974.

Brown, P. "Political-Economic and Professionalistic Barriers to Community Control of Mental Health Services: A Commentary to Nassi." Journal of Community Psychology 6 (1978):381-92.

Brown, P. "The Transfer of Care: U.S. Mental Health Policy Since World War II." International Journal of Health Services 9(4) (1979):645-62.

Brown, P. "The Mental Health Patients' Rights Movement and Mental Health Institutional Change." International Journal of Health Services II(4) (1981):523-40.

Caplan, G. Principles of Preventive Psychiatry. New York: Basic Books, 1964.

Chu, F.D. "The Nader Report: One Author's Perspective." American Journal of Psychiatry 131 (1974):775-79.

Chu, F.D. and Trotter, S. The Madness Establishment: Ralph Nader's Study Group Report on the National Institute of Mental Health. New York: Grossman, 1974.

Cobb, C. "Community Mental Health Services and the Lower Socioeconomic Classes: A Summary of Research Literature on Outpatient Treatment (1963-1969)." American Journal of Crthopsychiatry 42(3) (April 1972):404-14.

Cole, V., Branch, C., and Allison, R. "Some Relationships Between Social Class and the Practice of Dynamic Psychotherapy." American Journal of Psychiatry 118 (1962):1004-12.

Coles, R. and Coles, J.H. Women of Crisis: Lives of Struggle and Hope. Redcliff Biography Series. New York: Delacorte Press, 1978.

Conrad, P. and J.W. Schneider. Deviance and Medicalization: From Badness to Sickness. St. Louis: C.V. Mosby Company, 1980.

Cumming, E. and Cumming, J. Closed Ranks. Cambridge, Massachusetts: Harvard University Press, 1957.

Daniel, J. "Factors in Effective Communication Between Professionals, Non-Professionals and Poor People." Dissertation Abstract 29(11-A) (1969):4126.

D'Arcy, Carl and Schmitz, J.A. "Sex Differences in the Utilization of Health Services for Psychiatric Problems in Saskatchewan." Canadian Journal of Psychiatry 24(1) (1979):19-27.

Davis, E.B. "Mental Illness in Blacks: An Overview and Treatment Approaches." Journal of the National Medical Association 71(10) (1979):1022-24.

Dawkins, Marvin et al. "Personality and Life Style Factors in Utilization of Mental Health Services." Psychological Reports 46(2) (1980):383-86.

Department of Mental Hygiene. "Statement on Long-Range Plans in Mental Health." June 15, 1964, p. 11.

Dimsdale, J.E. et al. "The Role of Social Support in Medical Care." Social Psychiatry 14(4) (1979):175-80.

Dohrenwend, B.B. Stressful Life Events--Their Nature and Effects. New York: John Wiley and Sons, 1974.

Dohrenwend, B.B. and Dohrenwend, B.P. "Social and Cultural Influences on Psychpathology." In Annual Review of Psychology 25 (1974):417-52, edited by M.R. Rosenzweig and L.W. Porter.

Dohrenwend, B.P. and Chin-Shong, E. "Social Status and Attitudes Toward Psychological Disorder: The Problem of Tolerance of Deviance." American Sociological Review 32 (1967):417-33.

Dunham, H.W. "A Study of the Distribution of Six Major Psychoses in the Local Community Areas of Chicago" (Master's dissertation, University of Chicago, 1935).

Dunham, H.W. Mental Disorders in Urban Areas. Chicago: University of Chicago Press, 1939.

Dunham, H.W. "Theories and Hypotheses in Social Psychiatry: An Analysis of the Evidence." In Social Psychiatry, Proceedings of the 57th Annual Meeting of the American Psychiatric Association, edited by J. Zubin and F. Freyham. New York: Grune and Stratton, 1968, pp. 220-45.

Dworkin, A.L. and Dworkin, E.P.A. "A Conceptual Overview of Selected Consultation Models." American Journal of Community Psychology 3 (1975):151-59.

Edgerton, R.E. and Karno, M. "Mexican American Bilingualism and the Perception of Mental Illness." Archives of General Psychiatry 24 (March 1971).

Espinoza, Jorge A. "The Underutilization of Mental Health Services by Mexican American Males." Ann Arbor, Michigan: University Microfilms (No. 7906819), 1977.

Etzioni, A. and Lehman, E.W. "Some Dangers in 'Valid' Social Measurement." *The Annals of the American Academy of Political and Social Science* 373 (September 1967):1-15.

Fabrega, H. "Psychiatric Illness in a Small Latino Community." *Psychiatry* 31 (1968):339-51.

Fandetti, D. "Sources of Assistance in a White Working Class Ethnic Neighborhood" (Ph.D. dissertation, Columbia University Graduate School of Social Work, 1974).

Feinstein, O. "Why Ethnicity." In *Immigrants and Migrants: The Detroit Ethnic Experience,* edited by D. Hartman. Detroit: Center for Urban Studies and Southeast Michigan Regional Heritage Study Center, Wayne State University, 1974.

Feister, A.R. et al. "Shaping a Clinic Population: The Dropout Problem Reconsidered." *Community Mental Health Journal* 10(2) (1974):173-79.

Feldman, Saul. "Community Mental Health Centers: A Decade Later." *International Journal of Mental Health* 3 (2-3) (1974):19-34.

Feldman, S. "Promises, Promises or Community Mental Health Services and Training: Ships That Pass in the Night." *Community Mental Health Journal* 14(2) (Summer 1978): 83-91.

Finestone, S. "Community Mental Health Services in New York City." New York: The Center for New York City Affairs, New School for Social Research, 1973.

Fitzpatrick, J.P. and Gould, R.E. "Mental Illness Among Puerto Ricans in New York: Cultural Conditions or Intercultural Misunderstanding." *American Journal of Orthopsychiatry* XL (1970):238-39.

Foucault, M. *Madness and Civilization*. New York: Random House, 1965.

Freedman, A.M., Kaplan, H.I., and Sadok, B. A Comprehensive Textbook on Psychiatry. Baltimore: Williams and Wilins, 1975.

Garfield, S.L. "Research on Client Variables in Psychotherapy." In Handbook of Psychotherapy and Behavior Change, edited by A.E. Bergin and S.L. Garfield. New York: Wiley, 1971.

Garrison, V. "Espiritismo: Implications for Provision of Mental Health Services to Puerto Rican Populations," paper presented at the Eighth Annual Meeting of the Southern Anthropology Society, Columbus, Missouri, February 1972.

Garrison, V. "The Puerto Rican Syndrome." In Psychiatry and Espiritismo, edited by V. Crapanzano and V. Garrison. New York: Wiley, 1977.

Gaviria, M. and Wintrob, R. "Spiritist or Psychiatrist: Treatment of Mental Illness Among Puerto Ricans in Two Connecticut Towns." Journal of Operational Psychiatry 10(1) (1979):40-46.

Ghali, S.B. "Cultural Sensitivity and the Puerto Rican Client." Social Casework 58(8) (October 1977):459-68.

Gil, Rosa Maria. "Cultural Attitudes Toward Mental Illness Among Puerto Rican Migrant Women and Their Relationship to the Utilization of Outpatient Mental Health Services." Dissertation Abstracts International 41 (7) (1980):2557-B. Ann Arbor, Michigan: University Microfilms No. 8101467.

Girodano, J. Ethnicity and Mental Health: Research and Recommendations. New York: Institute on Pluralism and Group Identity, 1973.

Girodano, J. "Community Mental Health in a Pluralistic Society." International Journal of Mental Health 5 (Summer 1976).

Girodano, J. and Girodano, G.P. The Ethno-Cultural Factor in Mental Health. New York: Institute on Pluralism and Group Identity, 1977.

Goin, M.K., Yamamoto, J. and Silverman, J. "Therapy Congruent with Class-Linked Expectations." Archives of General Psychiatry 13 (1965):133-37.

Good Tracks, J. "Native American Non-Interference." Social Work 18 (November 1973).

Gordon, S. "Are We Seeing the Right Patient? Child Guidance Intake: The Sacred Cow." American Journal of Orthopsychiatry 35 (1965):131-37.

Goshen, C.E. Documentary History of Psychiatry: A Source Book on Historical Principles. New York: Philosophical Library, 1967.

Grob, G.N. "The State Hospital in Mid-Nineteenth-Century America: A Social Analysis." In Social Psychology and Mental Health, edited by H. Wechsler, L. Solomon, and B.M. Kramer. New York: Holt, Rinehart and Winston, 1970.

Haas, K. "The Middle-Class Professional and the Lower-Class Patient." Mental Hygiene 47 (July 1963):408-10.

Hamilton, C. "Introduction." In Moving Up: Ethnic Succession in America, edited by D. Elazer and M. Friedman. New York: Institute on Pluralism and Group Identity, 1976.

Harrison, E. "Social Class and Mental Illness in Children: Choice of Treatment." Archives of General Psychiatry 13 (1965):411-16.

Harwood, A. Rx: Spiritualist as Needed: A Study of a Puerto Rican Community Mental Health Resource. New York: John Wiley and Sons, 1976.

Hill, R. "The Strength of Black Families." New York: National Urban League, Research Department, 1971.

Hollingshead, A.B., and Redlich, F.C. Social Class and Mental Illness. New York: John Wiley and Sons, 1958.

Hooker, W.D. "Characteristics of Clients Utilizing Mental Health Centers in the Lower Rio Grande Valley: Implications for Programs and for Continuing Education for Mental Health Workers." Dissertations Abstract International (1979), Ann Arbor, Michigan: University Microfilms No. 8010730.

Hoppe, E. "Treatment Dropouts in Hindsight: A Follow-Up Study." Community Mental Health Journal 14(4) (1977):304-13.

Hunt, R. "Social Class and Mental Illness: Some Implications for Clinical Theory and Practice." American Journal of Psychiatry 116 (June 1960):1065-69.

Hynes, C. "Private Proprietary Homes for Adults." New York: Office of the Deputy Attorney General, March 1979.

Jacobs, E.P. "Whither Community Mental Health?" International Journal of Mental Health 3 (2-3) (1974):35-43.

Jones, M. Social Psychiatry in Practice: The Idea of a Therapeutic Community. New York: Penguin, 1968.

Kadushin, C. Why People Go to Psychiatrists. New York: Atherton Press, 1969.

Karno, M. and Edgerton, R. "Perception of Mental Illness in a Mexican-American Community." Archives of General Psychiatry 20 (1969):233-238.

Karno, M. and Morales, A. "A Community Mental Health Service for Mexican Americans in a Metropolis." In Chicanos: Social and Psychological Perspectives (2nd ed.), edited by C.A. Hernandez, M.J. Hang and N.N. Wagner. St. Louis: C.V. Mosby Company, 1976.

Keefe, S.E. "Why Mexican Americans Under-Utilize Mental Illness: An Exploratory Study." In Family and Mental Health in the Mexican American Community, edited by J.M. Casas and S.E. Keefe. Los Angeles, California: Spanish Speaking Mental Health Research Center, 1978.

Kennedy, J. "Factors Relating to Breaking Treatment" (M.S.W. thesis, Smith College School of Social Work, 1949).

Klein, D. "Parental Preference for Counseling Approaches as a Function of Social Class." Dissertation Abstract 28-2141-B (1967).

Kline, J. and N. King. "Treatment Dropouts from a Community Mental Health Center." Community Mental Health Journal 9 (Winter 1973):354-360.

Kuramoto, F.H. "Community Mental Health Center at the Turning Point." Social Casework 58(7) (January 1977): 395-400.

Larsen, D.L. "Enhancing Client Utilization of Community Mental Health Outpatient Services." Ann Arbor, Michigan: University Microfilms No. 7904220 (1978).

Lego, S. "The Community Mental Health System: Is It an Improvement Over the Old System?" Perspective in Psychiatric Care 13(3) (1975):105-12.

Lemkau, P.V. and Crocetti, G.M. "An Urban Population Opinion and Knowledge about Mental Illness." American Journal of Psychiatry 118 (1962):692-700.

Liebow, E. Tally's Corner. Boston: Little, Brown, 1957.

Lief, H., et al. "Low Dropout Rate in a Psychiatric Clinic, Special Reference to Psychotherapy and Social Class." Archives of General Psychiatry 15 (1961): 264-78.

Lorber, J. and Satow, R. "Dropout Rates in Mental Health Centers." Social Work 20(4) (July 1975):308-12.

Lorber, J. and Satow, R. "Creating a Company of Unequals: Sources of Occupational Stratification in a Ghetto Community Mental Health Center." Sociology of Work and Occupations 4 (August 1977):281-302.

Lorion, R. "Patient and Therapist Variables in the Treatment of Low-Income Patients." Psychological Bulletin 18(6) (1974):344-54.

Lorion, R. "Ethnicity and Mental Health: An Empirical Obstacle Course." International Journal of Mental Health 5 (1976):16-25.

Lubchansky, I., Engri, G., and Stokes, J. "Puerto Rican Spiritualists View Mental Illness: The Faith Healer as a Paraprofessional." American Journal of Psychiatry 127(3) (September 1970).

Lubin, B., et al. "Correlates of Initial Treatment Assignment in a Community Mental Health Center." Archives of General Psychiatry 29 (1973):497-500.

Maas, A. "Asians as Individuals: The Japanese Community." Social Casework 57(3) (March 1976).

Mayo, J.A. "Utilization of a Community Mental Health Center by Blacks: Admission to Inpatient Status." Journal of Nervous and Mental Disease 158 (1974): 202-207.

Mechanic, D. Mental Health and Social Policy. Englewood Cliffs, New Jersey: Prentice-Hall, 1969.

Mechanic, D. "Sociocultural and Social-Psychological Factors Affecting Personal Responses to Psychological Disorder." Journal of Health and Social Behavior 16(4) (1975):393-404.

Merton, R. "Insiders and Outside: A Chapter in the Sociology of Knowledge." American Journal of Sociology 78 (July 1972):9-47.

Meyer, J.K. "Attitudes Toward Mental Illness in a Maryland Community." Public Health Reports 79 (1964):769-72.

Meyers, J.K. and Beau, L.L.A. A Decade Later: A Follow Up of Social Class and Mental Illness. New York: John Wiley and Sons, 1964.

Miranda, N. and Kitano, H. "Mental Health Services in Third World Communities." International Journal of Mental Health 5 (Summer 1976).

Mizio, E. Puerto Rican Task Force Report: Project on Ethnicity. New York: Family Service Association of America, 1979.

Mostwin, D. "Differential Values and Attitudes Among Families of Eastern and Central European Background: Implications for Mental Health and Social Services." Paper presented at Baltimore Conference on Ethnicity and Social Welfare. New York: Institute on Pluralism and Group Identity, January 1976.

Myers, J. and Schaffer, L. "Social Stratification and Psychiatric Practice: A Study of an Out-Patient Clinic." American Sociological Review 19 (June 1954):307-10.

McKinlay, J.B. "Some Approaches and Problems in the Study of the Use of Services--An Overview." Journal of Health and Social Behavior 13 (1972):121-52.

Nassi, A. "Community Control or Control of the Community? The Case of the Community Mental Health Center." Journal of Community Psychology 6 (1978):3-15.

Newton, F. "The Mexican American EMIC System of Mental Illness: An Exploratory Study." In Family and Mental Health in the Mexican American Community, edited by J.M. Casas and S.E. Keefe. Los Angeles, California: Spanish Speaking Mental Health Research Center, 1978.

Northman, J.E. "The Interfacing of Constituencies." Psychiatric Quarterly 49(2) (Summer 1977):110-17.

Opler, M., "Schizophrenia and Culture." Scientific American 197 (August 1957).

Opler, M. (ed.) Culture and Mental Health. New York: Macmillan, 1959.

Opler, M. Culture and Social Psychiatry. New York: Atherton Press, 1967(a).

Opler, M. "Social and Cultural Influences on Psychopathology of Family Groups." In Family Therapy and Disturbed Families, edited by G. Zuk and I. Boszormeniji-Nagy. Palo Alto, California: Science and Behavior Books, 1967(b).

Opler, M. and Singer, J. "Ethnic Differences in Behavior and Psychopathology: Italian and Irish." International Journal of Social Psychiatry 2 (Summer 1956).

Otto, J. and Moos, R. "Patient Expectations and Attendance in Community Treatment Programs." Community Mental Health Journal 10(1) (Spring 1974):9-15.

Overall, B. and Aronson, H. "Expectations of Psychotherapy in Patients of Low Socioeconomic Class." American Journal of Orthopsychiatry 33 (1963):421-30.

Overall, B. and Aronson, H. "Treatment Expectations of Patients in Two Social Classes." Social Work 11(1) (1966):35-42.

Padilla, A. "Psychological Research and the Mexican American." In La Causa Chicana: The Movement for Justice, edited by M. Mangold. New York: Family Service Association of America, 1971.

Padilla, A. and Ruiz, R. Latino Mental Health: A Review of the Literature. Rockville, Maryland: National Institute of Mental Health, 1973.

Pasamanick, B. et al. "A Survey of Mental Disease in an Urban Population: Prevalence by Race and Income." Reprinted from Epidemiology of Mental Disorder. Washington, D.C.: American Association for the Advancement of Science, 1959.

Rabkin, J. and Struening, E. "Ethnicity, Social Class and Mental Illness in New York City: A Social Area Analysis of Five Ethnic Groups." Working Paper No. 17. New York: Institute on Pluralism and Group Identity, 1976.

Reiff, R. "Social Intervention and the Problem of Psychological Analysis." American Psychologist 23 (1968): 524-531.

Reiff, R. and Reisman. "The Indigenous Nonprofessional: A strategy of Change in Community Action and Community Mental Health Programs." Community Mental Health Monograph No. 1, 1965.

Ridenour, N. Mental Health in the United States. Cambridge, Massachusetts: Harvard University Press, 1961.

Robinson, H.A., Redlich, F.C., and Meyer, J.K. "Social Structure and Psychiatric Treatment." American Journal of Orthopsychiatry 24 (1954):307-16.

Rogler, L.H. and Hollingshead, A.B. "The Puerto Rican Spiritualist as Psychiatrist." American Journal of Sociology 67 (1961):17-22.

Rogler, L.H. and Hollingshead, A.B. Trapped: Families and Schizophrenia. New York: Wiley and Sons, 1965.

Rothman, D. The Discovery of the Asylum. Boston: Little, Brown, 1971.

Rubin, L.B. Worlds of Pain: Lives in the Working Class Family. New York: Basic Books, 1976.

Satow, R. and Lorber, J. "Using Paraprofessionals in Community Mental Health Work." Paper presented at the Annual Meeting of the American Association for the Advancement of Science, New York, N.Y., January 1975.

Satow, R. and Lorber, J. "Cultural Congruity and the use of Paraprofessionals in Community Mental Health Work." Sociological Symposium 23 (1978):17-26.

Scheff, T.J. "Medical Dominance: Psychoactive Drugs and Mental Health Policy." American Behavioral Scientist 19(3) (January/February 1976):290-317.

Scott, C. "Health and Healing Practices Among Five Ethnic Groups in Miami, Florida." Public Health Reports 89 (1974):524-32.

Scott, C. "Puerto Rican Health Concerns: Cultural Focus versus the Orthodox Medical Pattern." Paper presented at the Annual Meeting of the American Anthropological Association, San Francisco, California, December 1975.

Sennet, R. and Cobb, J. The Hidden Injuries of Class. New York: Vintage Books, 1973.

Shader, R.I. et al. "Biasing Factors in Diagnosis and Disposition." Comprehensive Psychiatry 10 (1969):81-89.

Shader, R.I. "The Walk-In Service: An Experience in Community Care." In Changing Patterns in Psychiatric Care, edited by T. Rothman. New York: Wiley, 1970.

Shapiro, R. "Racism and Community Mental Health." Paper presented at the East Arkansas Regional Mental Health Center, Helena, Arkansas, October 1974.

Shapiro, R. "Discrimination and Community Mental Health." Civil Rights Digest 8(1) (Fall 1975).

Sharfstein, S. "Community Mental Health Centers: Returning to Basics." American Journal of Psychiatry 136(8) (August 1979):1077-79.

Siegel, K. and T. Blum. "Continuities in the Measurement of Utilization." New York: Center for Policy Research, 1981. (Mimeographed.)

Smith, M.B. "The Revolution in Mental Health Care--A 'Bold New Approach'?" Transaction 5 (1968):19-23.

Solon, J.A. et al. "Delineating Episodes of Medical Care." American Journal of Public Health 57(3) (March 1967): 401-408.

Srole, L. et al. Mental Health in the Metropolis: The Midtown Manhattan Study. New York: McGraw-Hill, 1962.

Starr, S. "The Public's Idea About Mental Illness." Chicago: University of Chicago National Opinion Research Center, 1955. (Mimeographed.)

Stein, H. "An Ethno-Historic Study of Slovak-American Identity" (Ph.D. dissertation, University of Pittsburgh, 1972).

Stein, H. "Cultural Specificity in Patterns of Mental Illness and Health: A Slovak-American Case Study." Family Process 12(1) (March 1973).

Stein, H. "A Dialectical Model of Health and Illness Attitudes and Behavior Among Slovak-Americans." International Journal of Mental Health 5 (Summer 1976).

Stern, M.S. "Social Class and Psychiatric Treatment of Adults in the Mental Health Center." Journal of Health and Social Behavior 18 (1977):317-25.

Stevens, R. American Medicine and the Public Interest. New Haven: Yale University Press, 1971.

Stone, A. "Overview: The Right to Treatment--Comments on the Law and Its Impact." American Journal of Psychiatry 132(11) (November 1975):1125-134.

Suchman, E. "Sociomedical Variations Among Ethnic Groups." Journal of Sociology 70 (November 1964).

Suchman, E.A. "Stages of Illness and Medical Care." Journal of Health and Human Behavior 6 (Fall 1965): 128-44.

Suchman, E.A. "Ethnic and Social Factors in Medical Care Orientation." The Milbank Memorial Fund Quarterly XLVII: 1 part 2 (January 1969):1525-1733.

Sue, S. et al. "Delivery of Community Mental Health Services to Black and White Clients." Journal Consult. Clinical Psychology 42 (1974):794-801.

Szapocznik, Jose et al. "Outreach in the Delivery of Mental Health Service to Hispanic Elders." Hispanic Journal of Behavioral Sciences 1(1) (1979):21-40.

Thomas, A. and Sillen, S. Racism and Psychiatry. New York: Brunner/Hazel, 1972.

Tischler, G.L. "Catchmenting and the Use of Mental Health Services." Archives of General Psychiatry 27 (1972): 389-92.

Torrey, E.F. "The Irrelevancy of Traditional Mental Health Services for Urban Mexican-Americans." Paper presented at the American Orthopsychiatry Association Meeting, San Francisco, March 1970.

Trevino, F.M. "The Utilization of Community Mental Health Services by Mexican Americans as a Function of Institutional Staffing Characteristics." Ann Arbor: University Microfilms No. 8011095 (1979).

Udell, B. and Hornstra, R. "Three Utilization Styles at an Urban Mental Health Center." Hospital and Community Psychiatry 28(9) (September 1977):700-702.

U.S. Congress. The National Mental Health Act. P.L. 79-487. Washington, D.C.: U.S. Government Printing Office, 1946.

Verburgger, Lois M. "Female Illness Rates and Illness Behavior: Testing Hypotheses About Sex Differences in Health." Women and Health 4(1) (1979):61-79.

Warshaw, L.J. Managing Stress. Addison-Wesley Series on Occupational Stress. Reading, Massachusetts: Addison-Wesley, 1979.

Wilkinson, G. "Patient-Audience, Social Class and the Social Construction of Psychiatric Disorders." Paper presented at a meeting of the American Sociological Association, New York, 1973.

Williams, S.J. et al. "Mental Health Services: Utilization by Low Income Enrollees in a Prepaid Group Practice Plan and in an Independent Practice Plan." Medical Care 17(2) (1979):139-51.

Willie, C. et al., (eds.). Racism and Mental Health. Pittsburgh: University of Pittsburgh, 1973.

Wolkon, G.H. "Crisis Theory, the Application for Treatment, and Dependency." Comprehensive Psychiatry 13 (1972):459-64.

Wolkon, G. et al. "Ethnicity and Social Class in the Delivery of Services: Analysis of a Child Guidance Clinic." American Journal of Public Health 64 (1974):709-12.

Work in America. Cambridge, Massachusetts: MIT Press, 1973.

Yamamoto, J. and Goin, M. "On the Treatment of the Poor." American Journal of Psychiatry 122 (1965):267-71.

Yamamoto, J. and Goin, M. "Social Class Factors Relevant for Psychiatric Treatment." Journal of Nervous Mental Disease 142 (1966):332-39.

Yamamoto, J., James, G., and Palley, N. "Cultural Problems in Psychiatric Therapy." Archives of General Psychiatry 19 (1968):45-49.

Zautra, Alex and Simons, Lynn Stanley. "Some Effects of Positive Life Events on Community Mental Health." American Journal of Community Psychology 7(4) (1979):441-51.

Zola, I.K. "Culture and Symptoms--An Analysis of Patients Presenting Complaints." American Sociological Review 3 (October 1966).

Zusman, Jack. "What Is Community Mental Health?" International Journal of Mental Health 3(2-3) (Summer-Fall 1974):5-18.