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Crisis Intervention and the State Comprehensive Mental Health Service Plan Act of 1986 (P.L. 99-660): An Historical Analysis

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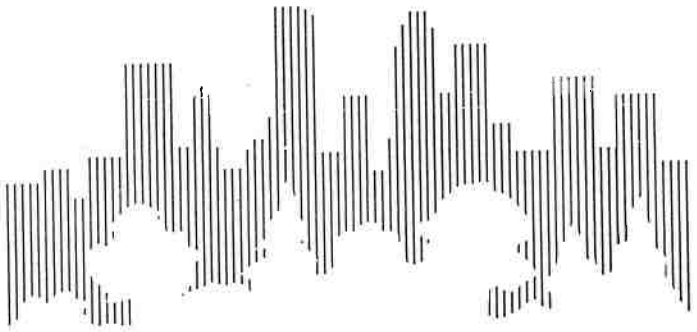

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MASTERS IN SOCIAL WORK THESIS

Thomas J. Barron

Crisis Intervention and the State Comprehensive Mental Health Service Plan Act of 1986 (P.L. 99-660): An Historical Policy Analysis

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CRISIS INTERVENTION AND THE STATE COMPREHENSIVE MENTAL HEALTH SERVICE PLAN ACT OF 1986 (P.L. 99-660): AN HISTORICAL POLICY ANALYSIS

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This work has been inspired by Mom, Dad, Joe, Rich, Sara, and Jane, whose words of encouragement and humor-filled insights have not only enhanced the experience of its writing, but of Life itself. I am also grateful for my friends who motivated me along the way.

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CERTIFICATE OF APPROVAL

This is to certify that the Master's thesis of:

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Abstract of Thesis

Crisis Intervention and the State Comprehensive Mental Health Service Plan Act of 1986 (P.L. 99-660): An Historical Policy Analysis

Thomas J. Barron
May, 1998

Despite numerous contributions by theorists and crisis service providers in the field of crisis intervention, few reports have examined underlying legislation. This study reviews policy trends in past mental health legislation and crisis programs between 1840 to1996. It focuses on the State Comprehensive Mental Health Plan Act of 1986 (Public Law 99-660) and describes the response to such legislation in Minnesota. An incremental policy process illustrates how crisis intervention services have evolved to be part of the array of comprehensive mental health services.

TABLE OF CONTENTS

Chapter I

INTRODUCTION

The majority of relevant literature encountered in this study focuses not on the efficacy of crisis intervention services, but rather on the emergence of crisis intervention theories and the range of the literature related to the field. Lukton posits that the growth of crisis intervention services has coincided with the repudiation by mental health workers of the medical model of intervention. The notion that a situation contains the seeds of dysfunction, rather than the individual's psyche, has met with wide acceptance (Lukton, 1982). In large part, a crisis intervention service delivery model is one of the responses to the legal, social, and political mandates that individuals must have the right to treatment in the least restrictive environment, and that service models should exist to meet the actual needs of patients (Paradis, 1987).

Responding to mental health needs of clients at the community level has gained more focus by mental health policy makers rather than institutional placement in recent years. The State Comprehensive Mental Health Services Plan Act of 1986 (P.L. 99-660) was to make available a model plan for a community-based system of care for mental health services. Its passage mandated additional mental health services to focus on the needs of the homeless mentally ill.

The law's priorities were: a) to develop and utilize community-based, non-institutional services, while reducing reliance, to the extent appropriate to the client needs, on the more costly and restrictive inpatient or residential treatment; b) to establish and implement a program of outreach to, and services for, chronically mentally ill individuals, with an emphasis on homeless mentally ill individuals, and c) to develop plans in consultation with State mental health

directors, providers of mental health services, chronically mentally ill individuals, advocates for such individuals, and other interested parties. The advantage of including this wide range of consultation was the natural link it provided between actual policy and the mental health system by linking providers, consumers, and family members.

Purpose of the Study

This thesis examined the origins and the historical development of crisis intervention services and their inclusion in the array of mental health services. The overall purpose of this study was to explore how the crisis intervention movement evolved during the late 1800's to the present. The study traced a number of public policies prior to and after the passage of the State Comprehensive Mental Health Services Plan Act of 1986 (P.L. 99-660). The overall intent of the study is to increase our understanding of the process by which theory and practice are formulated. Implications for social workers are addressed in Chapter Six.

Research Questions

What were some of the changes in the design of mental health services that led to the development of crisis intervention theory and services? What impact have legislative policies and provisions had upon crisis intervention theory and services?

Chapter II

THEORETICAL/CONCEPTUAL FRAMEWORK

The conceptual framework for this thesis incorporated an historical review of major legislation initiatives upon the development and evaluation of crisis intervention services. To aid in comprehending this analysis, major mental health legislation and trends in the treatment of mental illness will be reviewed to consider what gaps in services created the field of crisis intervention.

A review of social policy definitions, historical research definitions, and a definition of crisis intervention will be discussed to acquaint the reader with the framework for this study.

Social Policy Definitions

This section presents a limited review of relevant social policy models and definitions as they have been posited over the years. The "rational" and "incremental" models of policy-making will be featured as their relevance to the social policy literature is well established.

The rational model of policy-making requires several elements to be included in a decision: a) definition of the problem in objective terms; b) a needs assessment to add information regarding the dimensions of a problem or population; c) alternative courses of action and their consequences; d) calculation of the alternative outcomes in terms of their meaning for the various values inherent in the policy; e) a set of agreed upon values on the basis of which to select goals and to judge the consequences of alternative courses of action; and f), an exhaustive survey of all relevant alternatives, since an unstudied alternative may be the optimal one (Etzioni, 1968). The author states "the optimal alternative may not be a "good" one but only the best

alternative among a set of "bad" ones. Its relative merits may be established only if it is systematically compared to other alternatives" (p.264). Values are subjective and difficult to be agreed upon in policy making.

The political scientist Charles Lindblom (1959) presented an incremental model of policy-making in his critique of the rational model. In the incremental model, policy-makers do not attempt a comprehensive survey and evaluation of existing policies nor do they investigate all the benefits and costs of proposed alternative policies, but only those which differ to a limited degree from the existing policies. They, therefore, do not make selections on the basis of all relevant information as suggested by the rational model. Rather, a series of small decisions are made which eventually produce an outcome, often quite different from what was intended. Incrementalism is a more conservative and practical model which is more able to adapt to time-limits, uncertainty, and conflicting values inherent in policy decisions.

Dobelstein (1996) believes a public policy "undertaken to achieve one objective may in fact achieve the opposite because of the way resources are provided" (p. 30). Through the allocation of resources, such as financial, environmental, political, and human resources, public policies change patterns of resource distribution. Policy analysis includes a review of those who gain from the redistribution and those who lose. The deinstitutionalization of the mentally ill has had mixed results, improving the quality of life for some while having negative, often unintended consequences for others. Once discharged, the need for continued psychiatric services and for affordable housing identified a whole new dimension of problems (Bachrach, 1982).

Wildavsky (1979) stated that:

"policy problems are man-made in that we choose among infinite

> possibilities to attack one sort of difficulty rather than another. Problems are defined by hypothetical solutions; the problem's formulation and the proposed solution are part of the same hypothesis in which thought and action are fused. Problems, then, are difficulties or dilemmas about which we think we might do something so as to create a new problem that is more worthy of trying to solve. Problems are not so much solved as superseded" (p. 83).

In terms of successes and failures in American social policy, Widavsky (1979) commented that "...when citizens, acting through government, have tried to alter basic patterns of individual behavior involving large numbers of people, have failed; but when citizens have sought to get government to reallocate resources, they have often succeeded" (p.23).

DiNitto (1991) recognizes the political context of policy-making which places additional limits on the rational model. The political context refers to the conflicting values, costs, and the prediction of consequences of various policy alternatives. DiNitto believed the first obstacle to rationalism underlying mental health policy is a lack of consensus about how to define mental health problems and how to determine the number of persons in need. While the public generally agrees that mental health services and treatment should be provided, the political dimension of policy-making includes disagreements about where and how this treatment should be provided. Under an incremental approach, policy makers continue past policies or programs whether they have been proven effective or not; this approach reduces conflict and involves less dramatic shifts in policy. Only in a crisis do political decision makers begin to consider new and untried policies as preferable to existing ones.

Etzioni (1968) stated democracies must accept a relatively high degree of incrementalism because of their greater need to gain support for new decisions from many and conflicting sub-societies, a need which reduces their capacity to follow a long-run plan. He stated:

> Decisions are to be made by the actors who pursue their interests...but this, we suggest, may well not include representation of the values and interests of the poor, ethnic, minorities, untouchables, and so forth, since it is not the amount of protest or discontent which determines the adjustments made but rather the relative power of the actors, which is precisely what these groupings lack when decisions are made in the course of a political free-for-all (p. 272).

For the purpose of this study, the incremental model proposed by Lindblom will be referenced to support the premise that crisis intervention services, under mental health policy, emerged in an incremental fashion as one of the solutions to the problem of treating those in need of mental health services.

Historical Research Definitions

The historical research method was used to document, clarify, and illuminate concepts, issues, policies, and practices in mental health services that have developed over time. Verbal, (non-mathematical) definitions of scientific concepts have little scientific content when considered by themselves.

It follows that such concepts can scarcely be invented independent of context (Kuhn, 1962) They are not full logical specifications of meaning, but more nearly pedagogic aids. For example, "deinstitutionalization" refers to the removal of someone or something from an institution. Only after an explanation of the historical events and social issues regarding the treatment of people with mental illness over time, and deinstitutionalization in the mental health treatment field, does the concept acquire relevant meaning.

Gordon Leff (1969) states:

> " there can be no generalization without comparison and no meaningful social comparison without history. The social, or the human studies are concerned with diversity and irregularity, with the interplay of individuals with distinctive and often conflicting attitudes and interests. Since the forms that this takes are not reducible to universal laws, they can only be grasped through the sequences and contexts in which they occurred historically" (p. 5).

In seeking to interpret or contextualize moments or trends in history, Skocpol (1984) believed it is important that careful attention is paid to the "culturally embedded intentions of individual or group actors in the given historical settings under investigation" (p. 368). Furthermore, the author stated "... both the topic chosen for historical study and the kinds of arguments developed about it should be culturally or politically 'significant' in the present; that is, significant to the audiences, always larger than specialized academic audiences..." (p. 368). Historical research aims to disclose relationships that were important for those then living and the significance of their outcome on subsequent events.

In this study, the reconstruction of the past is in relation to historical events important in the development of crisis intervention services in the years up to and including the passage of P.L. 99-660.

Definition of Crisis Intervention

Parad's (1977) definition of crisis intervention was used in this study for its succinctness and applicability across various settings and range of clients: "crisis intervention is utilized to cushion the impact of the stressful event by offering immediate emotional first aid and by strengthening the client's coping through on-the-spot therapeutic clarification and guidance" (p. 366).

The term crisis has been applied to both sudden, unplanned events such as the death of a loved one or natural disasters as well as developmental and transitional events such as termination of a relationship or life changes such as retirement.

Definition of Systems Theory

This study also recognized the contributions of systems theory as it relates to the influence of the continuous exchanges of human interaction across boundaries to shape or alter the environment. Shifting social values, along with the socio-economic and political forces associated with them, influenced the character of social work's interventive strategies at any one moment in time (Franklin, 1990).

Methodology

An inductive analysis of historical information with the application of retrospective policy analysis was employed to carry out this study.
The historical research method was used to review past legislation and trends associated with crisis theory and the provision of crisis services. A policy analysis will be another means of investigation. An interpretation of trends

also examines which kinds of problems have been important in its development.

It is through a historical review that we are able to assess a system's successes and failures. If we are to avoid the errors of the past, future attempts must take into account past efforts. To provide insight into the factors that influenced crisis intervention services, two major procedures for data collection will be used.

Procedures for Data Analysis

Primary data collection sources for this research included congressional records, legislative history reports, House and Senate reports, and State and County reports. Secondary data sources include books, research studies, social work and other professional journals. These events will be arranged in chronological order which displays an overall developmental image and sequence of events. The display reveals a context of sociocultural factors in relation to the progression of crisis intervention services, which will allow a retrospective image of crisis intervention services in an historical context.

Chapter III

LITERATURE REVIEW

Theory of Crisis Intervention

Crisis intervention theory in human service delivery is based largely on the concept of a psychosocial crisis that, through intervention, can be restructured so that resolution produces growth and avoids damaging repercussions. The evolution of crisis intervention as a discipline has been influenced further by the various theories of psychology and its practitioners. Freud stressed the importance of keeping the id, ego, and superego in "balance" or "equilibrium." Ego psychologists emphasize the person's ability to grow throughout life. Rather than regard a response to a crisis as a static phenomena, a crisis situation creates a disequilibrium which is an occasion for change.

Two general service categories have emerged in crisis intervention theory labeled as generic or individual (Jacobson, Strickler, and Morley, 1968). The generic approach focuses on the course of the crisis rather than on the psychodynamics of each individual in crisis. Treatment under this approach is assumed to be effective across a range of individuals, rather than a specific treatment geared to the unique differences of one individual. A leading theorist under the generic approach (Caplan, 1964) stated that a crisis is characteristically self-limiting, one that lasts from four to six weeks, and progresses through three universal stages or phases. The first stage begins with an emotionally-hazardous event that may be perceived as threatening and anxiety-arousing, setting in play well-developed coping behaviors and problem-solving tactics. The second stage includes efforts of an individual to reduce the stress. With continued stress, and when efforts to reduce the stress

have been unsuccessful, more extreme maladaptive reactions emerge including repression, denial, avoidance, projection of blame, or substance use. It is at this point that the individual may be most amenable to intervention. Without intervention at this stage, the crisis progresses to a third stage--withdrawal. As withdrawal worsens, agitation, confusion, depression, and even suicidal behavior may manifest. Caplan also was the first theorist who applied a "homeostasis" concept to crisis intervention. Caplan used the homeostasis concept to illustrate the constant state of balance human organisms mediate between external threats and maintaining an internal sense of stability. A crisis may be perceived as an external threat to one's sense of equilibrium.

Another generic practitioner (Erich Lindeman, who is considered the "father of crisis intervention") observed that people experiencing acute grief usually have five related reactions: somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, and loss of patterns of conduct (Lindemann, 1944). He worked with bereaved families in the aftermath of the Coconut Grove nightclub fire in Boston in 1943 in which hundreds of servicemen and others died. In subsequent work with the survivors of the incident, Lindemann found that the duration and severity of the bereavement process depended on the extent to which each survivor or relative could carry out his or her grief work successfully. The extent to which people were able to emancipate themselves from their bondage to the deceased, to readjust to an environment in which the deceased was missing, and to form new relationships over time was critical in the bereavement process.

The individual approach as a service delivery category in crisis intervention theory differs from the generic approach in its emphasis on professional assessment of the interpersonal and intrapsychic processes of the

person in crisis. Emphasis is placed on the psychological, social, and cognitive aspects of the individual's experience to offer insight into the dynamics and contexts of the crisis, on the individual unlearning of old, unsuccessful patterns of interaction, and the learning by the individual of new constructive behaviors to adjust to or prevent future crisis. Intervention is planned to meet the unique needs of the individual in crisis and to reach a solution for the particular situation and circumstances that precipitated the crisis (Aguilera and Messick, 1974). The authors predicted that the model of crisis intervention services represented an important change in therapeutic emphasis since it is a model based on mental health and adjustment in the present rather than being oriented to psychopathology and the past.

Expansion of Crisis Intervention Techniques

A proliferation of studies over the last forty years seeks to apply crisis intervention techniques across various practice settings. For example, suicide prevention programs proliferated across the country during the 1960s. The use of trained volunteers to assist in the staffing of all-night suicide prevention centers was first documented in the 1960's. A study of 60 suicide attempt cases helped suicide prevention center staff determine the seriousness of suicidal potential and suggested that a suicidal crisis has special features and significance which set it apart from traditional psychoanalysis of the day, especially in terms of the heightened personal emergency between life and death in suicidal intent (Farberow, 1961). Specific features of suicide prevention centers included the use of a 24-hour telephone service, immediate mobilization of community resources, incorporation of volunteers into the core staff, and an approach that featured the use of authority, extensive activity, and the involvement of 'significant others' to avert further harm.

Another application of crisis intervention is to minimize or reduce the risks of mental health emergencies (psychiatric decompensation, suicide attempts) in the community or in the hospital. Benensohn and Resnik (1973) described the "suicide-proofing" of a hospital psychiatric unit as a way to avert suicide attempts by including patients in setting their own behavioral limits and in defining the unit security. The authors believed that patients were reassured by their involvement in designing external limits and more able to control their suicidal impulses . This behavior by care givers portrays a sense of respect and caring for the suicidal patient.

Crisis intervention techniques emphasize offering immediate, accessible, short-term services, both in program structure and in the treatment philosophy of the social worker or care giver. However, the routine translation of crisis theory and principles into standard treatment steps (intake, assessment, goal formulation, etc.) may not be sufficient in all cases. Specific knowledge of core values and the structure of a population's helping networks are critical to the development of skill in implementing an effective helping strategy. For example, in rural farm communities, external factors such as the economic stressors may interfere with the success of treatment. Some of the stressors may include a high number of farm bankruptcies, the collapse of real estate and retail markets in small dying towns, and the subsequent fiscal stresses on rural governments to maintain sufficient public works resources.

The rural context presents challenges to the social worker practicing in these areas, including the integration of crisis intervention strategies. The controlling aspects of rural culture are embodied in three value constructs which permeate the rural community: self-help, self-sufficiency, and traditional morality (Sundet and Mermelstein, 1984). Understanding the helping networks in rural

areas includes more than recognition of the formal helping services of human services. For example, an informal network of assistance emerges in a rural area in response to a perceived need that no agency or institution is meeting. This informal network may include organizations that have a different primary purpose but which incorporate social services as a subsidiary function. Counseling activities of the rural church and school are examples of this type of function.

More recently, social service agencies are basing services on models that include rapid assessments and brief crisis interventions with their clients (Mattaini and Kirk,1991). Recent innovations in assessments have suggested methods to collect data through a computerized assessment system (Franklin, et al, 1993). The authors developed an integrative computerized assessment and database system that is consistent with and mirrors the tasks that a clinical practitioner would use to develop a thorough assessment of a client and/ or family. It can also be used as a database that can provide data for funding sources and to help guide decisions concerning practice activities. In addition to computerized assessments, recent market changes have also impacted the provision of mental health services.

Managed care has increased scrutiny of the costs of mental health and substance abuse services. Utilization review between managed care case managers and mental health service providers occurs in which insurance reimbursement may be denied to providers for services deemed unnecessary or too numerous. These review processes tend to emphasize the most cost-efficient treatments, not always the ones practitioners would choose to address the long-term special needs of clients (Dorwart, et al., 1993). Managed care has focused services on resolving the crisis at hand. Quick, immediate responses

to emergencies and to acute, sudden onset of problems, often resulting from some unforeseen outside agent (for example, a job termination) offer additional application of crisis intervention techniques in such crises.

Limitations of Crisis Intervention Theory

Smith (1978) stated crisis intervention theorists had not at that time developed models of crisis intervention that could be rigorously tested. He believed all helping professions were facing an evaluation crisis in reference to their inability or unwillingness to assess the effectiveness of their interventions. Most had not demonstrated through sound empirical research that crisis intervention techniques were successful.

In addition to the criticisms offered by Smith, Strean (1981) also alluded to other weaknesses of crisis theory at the time:

> Short-term therapy, which is extremely popular is quite congruent with contemporary man's and woman's resistance to intensively explore their inner lives. The yearning of so many people for instant gratification without too much self-reflection can make therapies like "Quick Response," "Task-Oriented Casework," or "Crisis Intervention" very attractive" (p. 158).

Strean also criticized the use of self-reports of patients and therapists that are gathered from questionnaires or from one interview, as basically "short-term research" with a myriad of transference, defense, and wish variables operating to invalidate the report. He believed the only accurate form of outcomes research on the efficacy of therapy [crisis interventions or long-term analysis] was to observe clients over time.

Although Strean stated that short-term interventions helped individuals to cope better with situational distress and offered some support to individuals too frightened or unwilling to enter long-term treatment, he was overly critical in stating that brief treatment has never increased a patient's maturity, or substantially enriched one's ego strengths. Strean believed the models were too abbreviated and were unable to clearly conceptualize the distinguishing characteristics of crisis intervention as a treatment method opposed to other treatment models.

Chapter IV

CRISIS INTERVENTION SERVICES IN AN HISTORICAL CONTEXT

Between 1840 and 1986, two areas of the past were reviewed: a) policies and provisions of care for the mentally ill and, b) the trends and responses of government and private agencies to the issue of caring for those in crisis. The chapter does not attempt to include all relevant events before or after the passage of P.L. 99-660, but describes key events that had an impact on the development of crisis theory and crisis intervention mental health services.

1840 - 1900: The Institutional Years

America was in the midst of major demographic change as the country's population began to shift from rural to urban areas; the extent of poverty, mental deviancy, and crime became more concentrated in urban areas as the number of people living in urban areas increased. Mental health policy and services remained the responsibility of the states. Increases in travel and mobility raised the issue that caring for the needy was no longer an issue of caring for one's neighbors, but necessitated greater assistance for more nonresidents. Poorhouses, also referred to as almhouses, were erected as the predominant institution to house the poor, insane, feeble-minded, alcoholics, delinquents, the blind, and the sick, often with little regard for safety and sanitation involved in large institutions (Trattner, 1994). Overcrowding in the poorhouses, and neglect in caring for the increasing number of mentally ill lead to action to remove the mentally ill from the large poorhouses of the day.

The asylum in this period sought to insulate institutional residents from the pressures of community life. A home-like atmosphere was often sought, but

rarely achieved. These asylums were viewed as a controlled environment where humane and individualized treatment was attempted to rehabilitate the patients (Rochefort, 1993). The prevailing attitude toward the mentally ill was that mental illness was often caused by emotional and environmental factors; therefore, it was believed that offering such an environment could help in rehabilitating the patients. However, the growing number of chronic patients, (those who failed to recover or the severely mentally ill,) raised the questions for states about the role of the U.S. Government in sharing the burden of support for the growing numbers of the mentally ill.

The Minnesota Territory was established in 1849. Concern for mental health services in Minnesota dates to 1851 when the first territorial legislature passed a law making probate judges responsible for the interests of mentally incompetent persons. Minnesota became a state in 1858, but it was not until 1866 that Minnesota opened its first mental institution in the town of St. Peter with the admission of 30 mental patients who had formerly been "boarded out" to other states. There was an agreement between neighboring states about which state would accept mental patients in their facilities until adequate facilities had been built in the referring state (Minnesota Department of Public Welfare, 1964).

In 1890, New York State passed the State Care Act that mandated insane persons were to be wards of the state. A subsequent New York law mandated a state property tax with proceeds to be used for the care of the mentally ill (Grob, 1995). Most states developed a vast public hospital system that provided care and treatment for all mentally ill persons regardless of their ability to pay.

1900-1940: Mental Hygiene Movement

The emergence of the mental "hygiene" movement in the early 1900's corresponded with the belief that the social environment of patients discharged from state institutions could contribute to the prevention and cure of mental problems. The National Committee for Mental Hygiene was founded in 1909, and aimed criticism at the inhumane treatment existing in the state hospitals. The impetus to change the system was based on the experiences of the movement's founder, Clifford Beers, author of "A Mind That Found Itself," (1953) an account of his mental collapse, the inhumane treatment he received in the state hospital, and his eventual recovery. The notion of intervening early in the onset of mental illness symptoms took hold in the mental hygiene movement. The development of after-care work was the formal recognition of the medical value of a constructive intellectual and emotional environment in the treatment of many mental conditions.

It was the beginning of a national movement (in conjunction with state and local groups, physicians, social workers, and other concerned citizens), which focused on educating the public in terms of increasing knowledge related to the causes, early diagnosis, prevention, and treatment of mental illness. The mental hygiene movement included many volunteer organizations that provided temporary financial assistance, employment, and counsel for needy persons discharged from mental institutions (Trattner, 1994). However, there existed a population of patients who were admitted, treated, and discharged after relatively brief stays in private mental hospitals.

In 1906, the National Save-a-Life League was established in New York under the direction of its founder (Reverend Harry N. Warren) who had

consoled a young woman who had recently recovered from a drug overdose. She stated that if she had someone to talk to she never would have tried to kill herself (Fisher, 1973). The National Save-a-Life League operated with trained volunteers who worked overnight and with trained professionals who worked during the day; professional psychologists and psychiatrists provided face-to-face psychotherapy during the day. However, despite these new attitudes, the states' custodial care of high numbers of chronically ill patients was maintained as the dominant tradition in the treatment of mental illnesses.

1940-1986: The Federal Government's Impact on Crisis Intervention

The nation's wars created additional demands in the provision of mental health services. Wartime experience in World War II, Korea, Vietnam, the Arab-Israeli, and other wars offered military psychiatrists ample opportunities to experiment with new techniques related to the prevention and treatment of mental health and stress disorders. Military service brought additional stresses on soldiers during combat which carried over into civilian life at the end of military service. Stress, sleep disorders, and depression were common among the returning soldiers.

The wartime role of the psychiatrist was to advise military commanders of the methods for the prevention of stress casualties, to screen out the unsuitable, and to assure that over stressed soldiers were rested and returned to duty whenever possible. During World War II, the condition known as "war neurosis" was officially labeled "combat exhaustion." There were "exhaustion centers" in the regimental or combat team trains area, monitored by the regimental surgeon. Mental health personnel found that rest, food, and returning soldiers to their units helped them to deal with their emotional and

physical problems related to combat. There were also neuropsychiatric centers (clearing units with psychiatric supervisors and specially trained staff) behind the divisions (Department of the Army, 1994).

It was believed that prior screening could identify and exclude most of the soldiers who would be prone to psychological breakdown in combat. The need for recruiting large numbers of draftees left little time for thorough assessments and adequate psychosocial histories to minimize errors in selection. During World War II, those judged fit to enter the armed services, but subsequently given medical discharges, about 40 percent, were dismissed for psychiatric disorders.

There was also a large number of men who were rejected for military service for mental health reasons. Some 1,100,000 out of 4,800,000 men (almost 25 percent) were rejected for military duty because of mental or neurological disorders (Trattner, 1994). This high number of men returning to their communities changed the postwar image of psychiatric problems. Concurrently, these large numbers of men who were rejected for military service for mental health reasons applied an increasing strain on local and state mental health services.

The National Mental Health Act of 1946, conceived by Robert H. Felix, incorporated four distinct goals: 1) to provide federal support for research on the cause, diagnosis, and treatment of psychiatric disorders; 2) to train mental health personnel by providing federal fellowships and institutional grants; 3) to award federal grants to the states to assist in establishing clinics and treatment centers; and 4) to fund demonstration studies dealing with prevention, diagnosis, and treatment of mental illness. The Act of 1946 created a framework for the emergence of a mental health lobby that helped to redirect priorities

away from reliance on state mental hospitals and to replace them with a network of community initiatives that were financed by the federal government.

The National Institute of Mental Health (NIMH) was created by this legislation and the prestige of this agency helped persuade state officials and the general public that new community-oriented policies would be more effective than the existing state mental-hospital system in preventing and treating mental disorders and psychological problems (Grob, 1991). The concept of prevention, taken from the medical model and promoted through the mental hygiene movement , became part of a community mental health care system.

In Minnesota, the Minnesota Mental Health Policy Act of 1949 (Chapter 246, Minn. Statutes, 1949) provided funds for the diagnosis, treatment, and care of those with mental disorders. Governor Luther W. Youngdahl appointed a Governor's Advisory Council on Mental Health in 1949. Recommendations from this council included an adequate program for treatment of the mentally ill and retarded. Personnel training centers were established. Provisions were made for facilities and equipment for research and study in the field of modern hospital management, the causes of mental illness and retardation, and the diagnosis, treatment and care of those with mental disorders. In addition, the Act established a program for detection, diagnosis, and treatment of mentally ill persons and established a commissioner of mental health and mental hospitals in the Division of Public Institutions.

Grants from the federal government continued flowing into Minnesota and other states' programs for treatment programs in state hospitals; however, there were no provisions for emergency or crisis services in this federal legislation.

In 1955, the Mental Health Study Act passed by Congress called for a Joint Commission on Mental Illness and Health, which completed a nationwide evaluation of the human and economic problems of mental illness and included recommendations regarding a national program (Joint Commission, 1961). In the report were renewed criticisms of the overcrowded conditions of the large state mental hospitals as well as the re-emphasis on preventative measures to reduce the number of persons needing hospitalization.

The passing of the federal Community Mental Health Act in 1963 built upon several themes in programs for the treatment of the mentally ill. First, President John F. Kennedy articulated his preferences to move away from state mental hospitals, which continued to be understaffed and overcrowded. Second, Kennedy stressed that knowledge of new therapeutic techniques and the advent of psychotropic drugs enabled new directions in community care and social reintegration, and reinforced the importance of prevention as well as emerging treatments of mental illness in a national health program.

The CMHC act authorized three years of federal grant support for the construction of a network of local community mental health facilities. The facilities were to be responsive to community priorities encountered frequently within the community: marital and family difficulties, emotional problems of children and delinquency, and substance abuse. Kennedy promised the development of community-based care, but only obligated the government to pay for five to seven years of start-up costs. The CMHC Mental Health Amendments of 1967 authorized additional federal funding for additional programming and construction grants, as well as establishing 300 more centers (Rochefort, 1993). Amendments to the act came under several veto attempts during the Nixon and Ford administrations, but with Congress and mental health

lobbyists affirming their support, the vetoes were overturned (Rochefort, 1993). A 1975 amendment to the act required each of the local community mental health facilities to provide twelve specific program services in addition to the construction of community mental health centers. Specifically, each center was required to provide services for the elderly and children, transitional services and follow-up care for recently discharged mental patients, screening of persons being considered for admission into a public mental hospital, and services for alcohol abusers and drug abusers. However, CMHCs were no longer required to provide all the essential services in order to qualify for federal funding.

At the end of these funding cycles mandated by the previously mentioned amendments, state officials were often blamed for not adequately funding the program services to be provided by the CMHCs. President Jimmy Carter established a commission, in 1977, to review the mental health needs of the nation and to make recommendations on meeting those needs.

The commission's studies resulted in a four-volume report to the President in April, 1978, which served as a blueprint for Carter's Mental Health Systems Act proposal. The concept of mental illness was broadened to include less morbid emotional disturbances. The report stated: "America's mental health problem is not limited to those individuals with disabling mental illness and identified psychiatric disorders. It also includes those people who suffer the effects of a variety of societal ills which directly affect their everyday lives." Its focus on prevention and lowering the incidence of emotional disorders by reducing stress and promoting conditions that increase personal competence and coping skills represented an important paradigm shift in the treatment of mental illness (Congress and the Nation, 1985).

The Mental Health Systems Act of 1980 would have put more emphasis on the prevention, as well as treatment, of mental illness. However, instead of requiring states to protect the rights of mental health patients as a condition for receiving federal funds, the programs became voluntary, with no penalties attached for failure to establish them. Although signed into law in 1980, the funding to implement the Mental Health Systems Act was never completed because President Reagan effectively halted implementation with the passage of his Omnibus Budget Reconciliation Act (OBRA) of 1981.

Additionally, when Reagan took office, he collapsed funding for alcoholism, drug abuse, and mental health services under the Alcohol, Drug Abuse, and Mental Health Block Grant (ADM). The block grant reduced the amount of funds available to states to provide these services. Critics believe such fiscal austerity has contributed to an increase in homelessness among mentally ill individuals and drug abusers and in the ability of others to obtain services. It also increased pressure on CMHCs to focus services on the needs of those with serious mental illness to the detriment of others with less serious conditions (DiNitto, 1991).

CHAPTER V

FEDERAL AND STATE LEGISLATIVE INITIATIVES

This chapter will examine legislation related to crisis intervention through four points of inquiry. They are: 1) an examination of the federal State Comprehensive Mental Health Services Plan Act of 1986 (P.L. 99-660), 2) some of the historical antecedents to the policy, 3) the focus of crisis services, and 4) the response to the problem of crisis intervention in Minnesota.

State Comprehensive Mental Health Services Plan Act of 1986: (P.L. 99-660)

The impetus for the State Comprehensive Mental Health Services Plan Act of 1986 centered around concerns of being able to treat the increasing number of mentally ill patients with fewer public resources. Federal efforts at reducing dependence upon institutional care and replacing it with community-based care began with the Community Mental Health Centers legislation in 1963. As previously stated, the long-running federal appropriations of financial support to construct, staff, and maintain services within the community mental health centers was changed by Congress in 1981 under pressure from the Reagan administration. Also, deinstitutionalization left many mentally ill without the physical structure and protection of the state mental health institutions and prone to the stresses of life in the community.

A federal report funded by the NIMH entitled "Notable Solutions to Problems in Mental Health Services Delivery (1985) stated:

> "...that budgetary constraints, the reduced Federal role coupled with the need for CMHCs to strengthen or establish relationships

with State mental health authorities, and the changing economic climate would no doubt create new challenges. Since many CMHCs are struggling with the same or similar problems, it is critical to share ideas and experience. Reinventing the wheel is a luxury that cannot be afforded, particularly in this era of increasing service demands and declining budgets" (p. 1).

The report listed successful outreach programs of the day that provided crisis intervention services and other solutions to problems in mental health service delivery in light of budget constraints.

The goal of the Act was to develop and make available a model plan for a community-based system of care for chronically mentally ill individuals. Among the provisions in P.L. 99-660:

1. A plan shall be developed in consultation with State mental health directors, providers of mental health services, chronically mentally ill individuals, advocates for such individuals and other interested parties.

2. The plan shall provide for the establishment and implementation of a program of outreach to, and services for, chronically mentally ill individuals who are homeless.

3. States are mandated to produce a count of their chronically mentally ill as part of their mental health plan.

4. Each state must establish a planning council to advocate for children and adults with serious mental illnesses. At least half of the council members may not be state employees or providers of services; these members of the council should include a balanced representation of consumers and family members (P.L. 99-660).

P.L. 99-660 increased the expected responsibility of the state administrators, managers, supervisors, and staff in the mental health system for issues directly related to housing, employment, and social supports for persons with mental illness. In order to receive Federal Block Grant Funds, states were compelled to prioritize services for people with persistent mental illnesses and children with severe mental disorders. Instead of directly funding the community mental health centers and their efforts in treating the mentally ill, the block grants under P.L. 99-660 gave state governments greater responsibility in planning, coordinating, and funding their own mental health systems. Also, a planning partnership between state mental health agency staff, inpatient and community mental health providers, and consumers--those defined as persons who experience or have experienced a serious mental illness, and parents of children with serious emotional disorders was required for continued funding. As consumers, family members, and advocates gain power, a shift in state mental health policy agendas was thought to be probable. Recruitment plans to hire consumers and family members as case managers as well as consumer coalitions were important ramifications of P.L. 99-660 (Hudson, et al, 1991).

Under P.L. 99-660, each state was forced to formulate its priorities and create its unique mix of mental health service priorities. Likewise, communities were to develop programs tailored to local needs, but also within the parameters of the state-developed service objectives under the

federal mandates. For example, focusing on case management services for the severely mentally ill or providing services for the severely mentally ill who are homeless.

Historical Antecedents

The impetus for policy changes under P.L. 99-660 was formulated to address the national problem of treating the increasing numbers of the homeless mentally ill in America. The numbers of people with serious mental illnesses and co-occurring substance abuse problems as well as chronic homelessness among the mentally ill became more apparent in the years following deinstitutionalization.

Deinstitutionalization, the movement of mentally ill patients from state hospitals into local communities had been underway in response to the CMHC Act of 1963. This effort also impacted the provision of mental health services as more people with chronic mental illness began living in the community. Little attention was paid to the unintended consequences of the effects of deinstitutionalization.

Many advocates of deinstitutionalization assumed that when patients were removed from the regimentation of the large state mental hospitals they would be better off. When the more burdensome elements of institutionalization are removed, the supportive positive elements are removed as well, which results in a "mixed blessing" phenomena (Morris, 1995). For example, emerging issues of people with dual diagnosis of serious mental illness and substance abuse problems, and a recognition that many persons who were mentally ill were also homeless or not wanted by their families or their communities increased demands upon community health professionals and services. There was considerable concern that the chronically mentally ill were

not receiving adequate aftercare services following hospital discharge.

During the late 1970's and early 1980's, rampant inflation, oil shortages, and unemployment changed the mood of the country from one of optimism to one of insecurity, financial worries, and future uncertainty. But of all the symptoms of a troubled economy, it was inflation that affected Americans the most. Consumer debt rose to 83% of after tax income (Zimmerman, 1995). Although unemployment was not a serious matter in all community mental health center catchment areas surveyed, when the unemployment rate did exceed the national average, there appeared to be a more significant increase in mental health admission rate and workload (Kopolow, 1975). A study revealed that since World War II, an increase in admissions to State and private hospitals increased whenever economic conditions worsened (Brenner, 1973). The researcher predicted that such findings would enable mental health program administrators to someday be able to predict changes in total demands for mental health services and the socioeconomic characteristics of clients as a result of the interrelationship between economic change and anticipated demands for theses services.

It was becoming apparent that the network of community health centers and outpatient mental health services were unable to take care of the increasing numbers of persons needing mental health services. There was inadequate preparation in the community to receive those looking for mental health services. Additionally, 1982 was the last year for CMHC categorical grants and simultaneously the CMHCs faced steadily increasing service requests.

Focus of Services

The shift of patients from inpatient psychiatric care settings to home and community services did not eliminate the need to deliver comprehensive

services, but called for an array of treatment settings and different levels of supervision and mental health outreach. Prior to P.L. 99-660, (apart from congressional testimony given by consumers or their families during legislative hearings), primary consumers and family members were excluded from mental health planning. In P.L. 99-660, the inclusion of consumers and family members on state mental health planning committees was mandated. The inclusion of consumers and family members counteracted the paternalism that had been overly involved in the planning and care for the seriously mentally ill (Morris, 1995).

Clearly, obtaining family involvement in the care of members and client empowerment in representing their needs to practitioners parallels the National Association of Social Workers code of ethics. Consumer involvement in the design and implementation of their own care provides some assurance that services will be culturally appropriate.

In Minnesota, mental health program administrators began to address the inadequate preparation of the community to receive the numbers of mentally ill patients transferred from state hospitals. Zigfrids Stelmachers of Hennepin County Medical Center stated " the climate for establishing crisis centers is favorable. Shorter and shorter treatment modalities are gaining popularity with the mental health establishment. Crisis intervention is no longer the stepchild of mental health, which traditionally emphasized long-term personality reconstruction" (Stelmachers, 1978). The author stated the ideal place for the center would be hospital-based, with outreach crisis intervention services. A recommendation of the Mental Health Task Force to the Commissioner of Public Welfare (cited in Stelmachers, 1978) stressed the need for crisis intervention services to allow for early identification and treatment of mental illness:

"The state and local agencies shall emphasize the development of crisis and information and referral services with some diagnostic capabilities and strengthen those services which exist." The report prominently refers to deinstitutionalization and preventive measures, including crisis services.

During the 1980's, the National Alliance for the Mentally Ill (NAMI) garnered a national membership comprised of persons with mental illness and their families. Their lobbying influence and grassroots involvement focused additional attention on the dilemma facing a mentally ill person in crisis. Standards for involuntary commitment of a person in crisis were being debated. Civil libertarians, on one side, wanted to avoid wrongful commitments and loss of liberty of committing people in crisis to a hospital; on the other side, psychiatrists felt that people who needed treatment could not get it due to the time involved until a person had deteriorated to the point of committing an overtly dangerous act toward self or others (Korr, cited in Hudson & Cox, 1991). Also, the growing numbers of the homeless mentally ill increased the visibility of "gravely disabled" mentally ill who may not exhibit overtly dangerous behavior but, through an inability to feed, clothe, and shelter oneself, exhibit a unique danger to self. This trend did not go unnoticed.

The American Psychiatric Association's Task Force on the Homeless Mentally Ill (1984) published major recommendations to address this vulnerable population. It stated the chronically ill have a right, equal to that of other groups, to having their basic needs met (APA, cited in Hospital and Community Psychiatry, 1984). Additionally, it called for crisis services to be available and accessible to both the homeless and the chronically mentally ill:

> Too often, the homeless mentally ill who are in crisis are ignored because they are presumed, as part of the larger homeless pop-

> ulation, to reject all conventional forms of help. Even more inappropriately they may be put into inpatient hospital units when rapid, specific interventions such as medication or crisis housing would be more effective and less costly. Others in need of acute hospitalization, are denied it because of restrictive admission criteria or commitment laws. In any case, it will be difficult to provide adequate crisis services to the homeless mentally ill until they are conceptualized and treated separately from the large numbers of other homeless persons (p. 908).

Response to the Problem

In light of the information presented thus far, we can determine that the focus of mental health policy was directed at the issue of providing greater efficiency in service delivery while federal support for mental health services and inpatient care was decreasing. As the issue gained prominence nationally , it also found its place on the state legislative agenda. P.L. 99-660, at least in Minnesota, was implemented.

In 1987, the Minnesota State legislature passed the Comprehensive Adult Mental Health Act and in 1989, they passed the Comprehensive Children's Mental Health Act . Both acts defined an array of services to be implemented in each Minnesota county; it targeted residents with serious and persistent mental illness (SPMI) or acute mental illness, and it emphasized further development of community -based services. The children's act included a focus on children with serious emotional disturbances (SED). In addition, the children's act also required that services have a family focus, and that mental health services be integrated across the various service systems: health, mental health, educational, social service, and correctional systems.

Additionally, the State of Minnesota developed a statewide effort to develop more comprehensive and responsive crisis intervention services. In March, 1992, James Stoebner, Assistant Commissioner for Community Mental Health and Residential Treatment Center Administration announced the availability of funding and identified the specifics for requests for proposals (RFP) for the development of crisis services over a four-year demonstration project. The proposal included funding from the federal ADM Block Grants and Rule 14. Because approximately one-third of the funds are from Rule 14, at least one-third of the population served must be adults with serious and persistent mental illness. It was anticipated that the proposals would demonstrate innovative ways to address crisis situations and to develop on-going services:

> Crisis services can offer the immediate help a person in crisis needs in order to re-establish equilibrium. Just as there exists a wide variety of life crises so is there a variety of effective crisis service modalities. The most effective crisis services are not those that stand alone, but those that are integrated and delivered in the normal day-to-day operations of a mental health system. (MN Department of Human Services, 1992).

The grant was to fund two to four projects and only county boards were eligible to apply. County boards were to designate any public or non-profit entity as the recipient for the funds. At least one project would be for a non-metropolitan community, and one project will be funded in a metropolitan community. The $330,000 total was comprised of a federal $230,000 ADM grant and $100,000 from Rule 14. The intent was to continue under the ADM grant for the following three years of the project with renewal of applications for the project based on

the availability of funds and the grantee meeting grant objectives each year. Applicants were encouraged to seek alternative funding equal to at least one-third of the first year's grant for subsequent years.

The 1994 Minnesota legislature required the State Commissioner of Human Services to monitor and evaluate emergency mental health services pursuant to Minnesota Statutes, Section 245.469 of the Minnesota Comprehensive Mental Health Act. It defined emergency services as: "...an immediate response service available on a 24-hour, seven-day-a- week basis for persons having a psychiatric crisis, mental health crisis, or emergency. It further required emergency services to: 1) promote the safety and emotional stability of adults with mental illness or emotional crises; 2) minimize further deterioration of adults with mental illness or emotional crises; 3) help adults with mental illness or emotional crises to obtain ongoing care and treatment and 4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs. The legislation required that three counties in the state be the focus of an evaluation of emergency mental health services and identified attributes that the three counties must meet: one was to be a metropolitan county, one a metropolitan county other than Hennepin or Ramsey counties, and one located outside the metropolitan area.

Following the mandate of P.L. 99-660, states' planning and evaluation committees were to include persons who are advocates for persons with mental illness, family members of persons with mental illness, and persons who have received emergency services or have a mental illness. Thus, each county committee in Minnesota's evaluation was to be composed of nine county residents. In addition, five of the nine-member committee must be chosen from

persons who are advocates for persons with mental illness, family members of persons with mental illness, and persons who have received emergency services or have a mental illness.

Some limitations of the state evaluation were documented: the report was limited due to time constraints and the limited resources each committee had to assess emergency services to the extent that they might have liked to. Another limitation was the difficulty in gaining information from persons with mental illness due to the surveys "being returned that were difficult to understand because poor spelling, sentence structure, and grammar were confused." Other means of including consumer input such as focus groups may be more effective. Finally, because of the diversity of available crisis mental health services across the state, this evaluation of only three counties would not adequately represent a picture of the crisis services statewide. Emergency services vary from county to county. Consequently, the results must be viewed with some reserve (MN Department of Human Services, 1996). More information was produced from another source.

A survey of statewide mental health crisis services was conducted by the Mental Health Crisis Provider Network and the Department of Human Services in July and August of 1995. The results seemed to indicate that there is a telephone emergency service available in all 87 counties within Minnesota, and that there are 34 mobile crisis services, 74 walk-in services, 41 inpatient crisis services and 28 crisis residential services in Minnesota. Based on this survey, it was concluded by the State that emergency mental health services are available to citizens of Minnesota. Commonly, law enforcement officers are called on to provide transportation to crisis services. In several counties, the

local law enforcement agency is the designated "after-hours" crisis mental health telephone line. (MN Department of Human Services, 1996). However, it was stated there was room for improvement, with the following recommendations:

1.) Assure that the emergency mental health response system can deal with mental health emergencies regardless of insurance coverage or payment sources.

2.) Assure consistency among health plans for the coverage of appropriate and necessary services, such as hospital care and crisis intervention regardless of commitment or hold status.

3.) Encourage communication, cooperation, and education between law enforcement agencies and those agencies which provide mental health emergency or crisis services. Clarify the roles of each.

4.) Encourage more emphasis on prevention through education and supportive services.

Another factor in developing and improving the level of crisis mental health services in Minnesota resulted in the development of a Minnesota Statewide Network of Crisis Providers. A directory of statewide mental health crisis providers organized and identified crisis services in each county and expanded awareness of the "integral aspect of crisis intervention in human service delivery" (Cronin, Felland, & Reynolds, 1995). The network provides opportunities for crisis service providers to meet and network, brainstorm solutions to common problems, look at programmatic issues, and to develop clinical skills related to crisis services. (Reynolds, 1996).

The next chapter will synthesize the information and review it in the context of the initial research questions posed by this study. Conclusions of the study and its limitations, as well as, its implications for social workers are included in Chapter Six.

Chapter VI

RESULTS AND CONCLUSION

The emergence of crisis theory and crisis intervention services has been examined through its evolution throughout history to answer the initial research questions:

1.) What were some of the changes in the design of mental health services that led to the development of crisis intervention theory and services?

2.) What impact have legislative policies and provisions had upon crisis intervention?

Answers to these questions were framed under the assumption that the nature of social policy is not a rational planning process, but rather is an incremental process. The earlier information gathered in this study will be reviewed to determine the extent of the incremental nature of the policy process in answering the above questions.

Findings from Historical Data

During the mid-1800's, as noted in previous chapters, the prevailing treatment of the mentally ill occurred in asylums, at local governments' responsibility. A two-class system emerged which was comprised of state asylums which predominantly housed the seriously disturbed and lower-class patients , as well as many of the poorer immigrants which were moving to America. The other class of patients chose to be treated in private facilities. The former continued to strain the local governments' ability to adequately care for growing numbers of patients. The inhumane conditions and overcrowded

conditions in the asylums began to emerge as a problem beyond local government control. Toward the end of the 19th century, states began constructing larger facilities to house the mentally ill, which were redesignated state hospitals.

In the 1900's, the conditions that had plagued the asylums had only slightly improved with the construction of state hospitals. The mental hygiene movement emerged with the intent to reform state mental hospitals and, on a national level, preach the benefits of early intervention and prevention in the treatment of the mentally ill as well as others in need of support. This movement signaled a trend toward greater awareness of mental illness; it also set the stage for new forms of theory and practice to emerge in the transition from state to local and family responsibility, namely, treatment not only occurred in institutions, but in the community. America's participation in the World Wars increased the realization of the extent of mental illness in the population and signaled an increase in the role of the federal government.

After World War II, the passage of the Mental Health Act of 1946 created a framework for the emergence of a mental health lobby that helped to redirect priorities away from reliance on state mental hospitals and to replace them with a network of community initiatives that would serve the entire United States. This legislation created the National Institute of Mental Health which was instrumental in funding national and state programs related to the research and treatment of mental illness. In 1949, the Minnesota Mental Health Policy Act of 1949 was enacted and federal grants provided for the expansion of treatment and research activities. These state and federal initiatives represent attempts to implement similar concepts that were used in the charitable and private treatment approaches established during the mental hygiene movement,

namely, community-based services and prevention efforts. This evaluation supports an incremental approach that existing policies and programs form the base from which new policies flow.

In the 1960's and 1970's, we see through the Community Mental Health Centers Act, and its amendments, the creation of community health centers and services to provide an array of outpatient-focused services to persons either being discharged from state hospitals or at risk of being admitted. This federal involvement in the funding and directing of mental health services took over many of the financial responsibilities that had been the responsibility of state governments. The NIMH continued funding for research, training, and service models targeted at treating the large numbers of persons being discharged. Crisis intervention theory and crisis intervention services began to be formally referred to as an essential part of the array of mental health services during this era.

In the 1980's, with the election of Ronald Reagan and Congressional passage of OBRA, spending for social programs shifted away from federal responsibility to the states to meet the needs of individuals in crisis. As a result of Block grants and federal reductions to fund community health centers, states differed in their spending on various programs aimed at treating the mentally ill and homeless.

Findings from P.L.-99-660

What impact did the State Comprehensive Mental Health Service Plan Act have on crisis theory and crisis intervention mental health services? A definition of social change by Smelser and Halpern (cited in Zimmerman,1995) is used to outline the historical developments that help create a context for change. Over time, value themes can be observed to oscillate, one value

theme being dominate over competing themes for a period of time. According to this model, the situation takes on political dimensions when different "moral entrepreneurs" attempt to persuade others by pressing others into some kind of purposive social action or groups to press for changes. The resulting social action may be moral crusades, new institutions, or new legal regulations. Moral entrepreneurs such as Clifford Beers during the mental hygiene movement; Robert Felix who was a driving force in establishing the NIMH; John F. Kennedy and the passage of the CMHC; Jimmy Carter and his Administration's interest in mental illness prevention; and Zigfrids Stelmachers' call for crisis intervention services in Hennepin County are all examples of mobilizing others into pressing for new mental health services. Minnesota's response in implementing P.L. 99-660 represents the impact of legislation on crisis intervention services and is also an example of an incremental shift away from federal to more state and local responses to addressing the needs of the mentally ill.

Under the social change model, struggles over competing values and definitions of the situation refer to the debates that have characterized the issue of deinstitutionalization and budgetary constraints in approaches to the care of the mentally ill. Crisis intervention services, already part of the array of mental health services, were reiterated again during the Carter administration (1977-1980). The Reagan administration (1981-1988) minimized the federal role in human service programming. The policy intent of P.L. 99-660 addressed the need for increased outreach to the mentally ill who were homeless. Inducements to states to implement these services were found in enforcement sections of the policy and called for reductions in federal funding for states which had not implemented the Act's plans.

From 1909, when the mental hygiene movement promoted the importance of providing a supportive environment outside of the hospital, to 1996, when Minnesota published its Crisis Provider Network, crisis intervention services have been stressed as an important component in the array of mental health services. Under P.L. 99-660, the Act is a trend toward greater state funding and responsibility for the implementation of additional outreach and services for the chronically mentally ill.

Implications for Social Workers

The findings of this study indicate that the impact of legislation on crisis intervention services has occurred in an incremental way, relying on past programs and legislation to guide future policies. Two predominant themes in this study involved the competing values and costs associated with institutional treatment of the mentally ill and the provision of appropriate outpatient services.

The historical review of the social issues and events regarding the treatment of people with mental illness shows that there were different groups responding to mental health needs, including charity, professional, and research organizations, as well as local, state, and federal government. Separately and together, solutions to the problems emerged and gained the attention of those able to impact the governmental agenda.

A limitation of this study was its focus on past legislation and its impact on crisis intervention theory and crisis intervention services. Thus, additional studies of the growing influence of consumers in the planning of mental health services, especially subsequent to recent welfare-to-work legislation, would be useful.

Social workers can benefit from historical information as it clearly recognizes practitioners as an integral part of policy formulation and implementation. As Donna Franklin wrote (1990), "social workers must continue to work on the problems of integration and balance, using frameworks and methods for holistic analysis and intervention and engaging in both direct individual practice and collective social action" (p.76). Knowing this, social workers can be challenged to use opportunities to speak publicly on important issues. Social workers can also raise the public's consciousness of issues and assist in building coalitions and gaining support to press for needed change that will best serve society. Influencing future legislation and social work practice lies in the willingness of social workers to remain politically involved to be able to shape future policy cycles.

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