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Phillip Fellin
University of Michigan

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Phillip Fellin
The University of Michigan

Community based care has traditionally been defined as residential location. An alternative is presented of including the patient's membership in multiple communities, both geographical and identificational. The literature on social supports is cited as a basis for social integration as a goal.

From the beginning of the deinstitutionalization movement to the present, the planning of community care for seriously mentally ill persons has focused on the local community as a residential and treatment setting. One of the major goals of deinstitutionalization has been the social integration of these individuals into neighborhood communities (Test, 1981; Kruzich, 1986). Mental health professionals have assumed that reintegration would enhance the treatment and retention of patients in the community. Living arrangements that support social integration were expected to provide social interactions, social supports, and treatment resources that would contribute to the person's quality of life, minimize social isolation, and prevent rehospitalization.

Efforts to achieve the goals of social integration, especially for "people with severe, persistent, disabling mental disorders", have been constrained by various obstacles (N.I.M.H., 1991, iii). These obstacles include protective zoning ordinances, neighborhood opposition to group homes and treatment centers, social rejection by neighbors, the stigma of mental illness, lack of informal support systems of family, friends, and neighbors, and inadequate aftercare services by the formal health and welfare system. Mental health professionals who play major roles in the planning and provision of community care for the mentally ill have been involved in attempts to overcome these obstacles

(Segal and Baumohl, 1980; Dudley, 1989; Thompson et al., 1989; Test, 1981). This involvement has been based on the belief that residential services and social supports are an important component of community treatment of the mentally ill, especially the seriously mentally ill (Aviram, 1990; Bachrach, 1988).

While deinstitutionalization has brought about a dramatic decline in the number of "long stay" hospital patients, there remains a continuing need to plan for the discharge of "short stay" patients as they move from hospitals back into the community. As Segal and Kotler (1989) have noted, "There is a greater need for supervised residential care for the mentally ill now than at any time since the early 1950's" (p. 237). This kind of residential care includes "therapeutic residences, halfway houses, group homes, foster family homes, supervised apartments, and independent apartments" (Levine et al., 1986, p. 34). The lack of adequate planning for care in these facilities results in an increase in the numbers of seriously mentally ill persons underserved in the community, especially in the number of the homeless mentally ill and the mentally ill in jails. Public Law 99-660 recognized the need for community care by requiring the States to "provide for the establishment and of implementation of an organized community-based system of care for the chronically mentally ill individuals" (Title V, Sec 1920c). In planning for this kind of service system, mental health professionals must take into account two important dimensions of community care, that is, the nature of the patient's community environment, and the goals of social integration. The purpose of this paper is to draw upon research studies on residential care for the mentally ill and from the literature on urban communities to redefine the community as a social context for care, and to reexamine the goals of community integration and reintegration.

Redefining Community

Traditional approaches to the planning of mental health services have defined community in terms of residential location, that is, as a catchment/service area and as a local neighborhood. When viewed as a catchment/service area, the community was defined as a geographical area with a target population eligible

for service from the community mental health system. Catchment areas were established as the major locus of community services when Public Law 88-164 (1963) was enacted. For example, large urban communities were divided into smaller community areas composed of several residential neighborhoods. The catchment area concept was developed as a way to insure that services were available within a reasonable distance from the person's residence. This approach had its merits, especially from a public health perspective, as it made services more accessible and facilitated interventions directed toward changing the environment to promote community mental health. However, when the main function of defining the catchment area as community is to establish boundaries for eligibility for services, this approach tends to neglect the person's immediate neighborhood as the location of meaningful membership groups. This may lead to a lack of attention to the social supports which may be available from family, kin, friends, and neighbors, especially in ethnic and racial neighborhoods (Kirk and Therrien (1975); Saltman, 1991).

For some purposes, especially in establishing new group homes or residential treatment centers, community mental health planners have defined community in terms of the patient's immediate neighbors. These planners believed that it was especially important for the patient to integrate into the local residential neighborhood, thereby becoming accepted as a "normal" member of a neighborhood primary group. This definition of community as neighborhood assumes that immediate neighbors are a necessary and primary source of social interaction, social support and social resources. Critics of this perspective caution against solely defining community in terms of the immediate geographical surroundings, as this approach tends to neglect the broader communities which may provide treatment resources for patients.

Rather than limiting the patient's community to either a catchment area or a neighborhood group, it is more useful to focus on the patient's membership in multiple communities, both geographical and identificational. Geographical communities include metropolitan areas, municipalities, catchment areas, and neighborhoods of various sizes of space and population.

Viewing all of these areas as communities assures consideration of a person's social integration into a more complete range of geographically based groups. Some or all of these communities may offer the benefits of group membership, such as social interaction, collective identity, shared interests and social resources.

The concept of multiple communities is not restricted to a geographic definition of communities. Patients may also have membership in non-place, identificational communities. Members of such communities need not reside in the same neighborhood, catchment area, or municipality. These communities of interest include groups such as ethnic/cultural/religious groups, patient groups, friendship groups, and workplace groups. While membership in these communities often overlaps with geographic communities, membership is not determined by place, but by interest or identification with the group (Longres, 1991; Germain, 1991).

How does the concept of multiple communities, including communities of place and identification, contribute to the planning of residential care for mentally ill persons? This conception of communities broadens the scope of potential social interactions and social resources. Even more importantly, it establishes a foundation for a corollary conceptualization of community, that is, the individual's personal community. This definition of community is developed in Davidson's (1986) work on the urban sociology of community-based treatment. A personal community includes all of the interactions and identifications an individual has with individuals, informal groups, and formal organizations in multiple communities. The concept of personal community focuses on each individual and his or her "relevant" community. In Davidson's (1986) terms, these communities may be viewed as "emergent, unbounded, dynamic networks that must be created by each resident of the neighborhood" (p. 123). With this formulation, the personal community serves as a context for the development of treatment and social service goals. There is less reliance on the immediate neighborhood as a necessary source of social interaction and social support, and a recognition of a much broader community context for achieving goals of community care. Thus the personal community may include people in informal and formal helping

networks, such as families, kinship and friend groups, self-help groups, daytime drop in centers, club house programs, church groups, recreational groups, and mental health and social welfare organizations.

Redefining Social Integration

What does it mean for an individual to be socially integrated into one or more communities? Kirk and Therrien (1975) note that "An integral component of the ex-hospital patient's rehabilitation was to be his reintegration into the community" (p. 212), that is, a return to "previous sources of support and previous social responsibilities." (p. 213). These authors assert that such reintegration has been a myth, in part due to "a rather vague notion of what constitutes a 'community' and a naive view of the patient's life 'in the community,' " (p. 213). Kirk and Therrien's findings suggest the need to reexamine the meaning of community and social integration for individuals with serious mental illness.

Segal and Aviram's (1978) classic work on the return of mentally ill persons to their communities provides a good starting point for this examination. Segal and Aviram (1978) define social integration as the inclusion of the mentally ill "into the mainstream of social life" (p. 54), into a "level of involvement in local life" (p. 55). Community integration is then defined in terms of five areas of involvement, such as: presence . . . "the amount of time spent at a given place"; access . . . "the availability . . . of places, services, and social contacts open to other community members"; participation . . . the "degree of behavioral involvement in social activity"; production . . . " income-producing work"; and consumption . . . "control of finances and purchase of goods and services" (p. 55–57).

Additional ways of defining and measuring social integration have been employed in other studies of community care (Bootzin et al. 1989; Kennedy, 1989; Kruzich, 1986). For example in Kruzich's study (1986) of chronically mentally ill individuals in nursing homes, a distinction was made between internal and external integration. Internal integration was defined in terms of the frequency of involvement in activities such as reading,

watching television, playing games, crafts, and visiting and talking with others. External integration was defined in terms of activities outside the individual's residence, such as "going to a shopping area; attending movies and concerts; attending sports events; participating in sports; visiting parks and museums; going to restaurants or taverns; going to community centers; visiting a church or other place of worship; taking a walk, and engaging in a form of employment, including participation in sheltered workshops" (p. 7).

The measures used by Kruzich do not actually require a high level of communication between individuals and neighbors. In contrast, measures on interaction with neighbors were used by Sherman et al. (1984) in a study of former psychiatric patients. Examples of these items include asking residents if they have met any of their neighbors, how frequently they spend time with them, if there have been any positive incidents with neighbors, and if the individual has friends in the neighborhood (p. 184). Sherman et al. (1984) focused on community acceptance through the construction of an index of satisfaction with neighbors. This study used positive items such as satisfaction with how polite and courteous neighbors were to the respondent, and how much the person felt at home in the neighborhood. Negative attitudes were measured by items such as, "You are out of luck in this neighborhood or area if you happen to be from a psychiatric center", "Real friends are hard to find in this neighborhood or area" (p. 195).

Neighborhood Types and Social Integration

While neighborhoods form only one of the multiple communities individuals relate to, the neighborhood environment appears to have an important effect on social integration. Research studies on residential treatment centers (Davidson, 1982; Dudley, 1989) and sheltered care facilities (Segal and Aviram, 1978; Segal et al., 1980; Segal and Silverman, 1989) provide illustrations of efforts to understand the relationships between different types of neighborhoods and levels of social integration. For example, Davidson (1982) identified two major elements of neighborhood environments which were thought

to have an impact on reintegration of individuals placed in community based treatment centers. The first element in the environment was neighborhood treatment resources, such as access to transportation, education, employment, recreation, and shopping (p. 58). These factors were thought to increase an individual's development of social interactions, social skills, and participation in social networks. The second neighborhood element in Davidson's formulation concerned the extent of opposition of residents to residential treatment centers, including but not limited to centers for the mentally ill. Neighborhoods with high resources and low opposition were generally thought to facilitate social integration. However, some neighborhoods with these characteristics, especially in inner cities, suffer from high rates of crime and other social problems which make the residential area undesirable as a treatment environment.

A second example of the construction of neighborhood types comes from the work of Segal et al. (1989), Segal and Aviram (1978) and Segal et al. (1980). Segal and his colleagues have examined the characteristics of community care facilities, individual patient characteristics, and community types in regard to sheltered care for mentally ill persons. These authors used five dimensions to create neighborhood types: degree of political conservatism; family orientation; socioeconomic status; amount of criminal activity; degree of nontraditional orientation (Segal et al, 1980, p. 348). Neighborhood types were then examined in terms of social integration. For example, these authors found the liberal, non-traditional neighborhood fostered social integration, in contrast to the low level of integration found in conservative middle class neighborhoods.

Studies of the effects of deinstitutionalization on the mentally ill have also recognized the importance of public attitudes relative to social integration. Segal et al. (1980) have noted that "extreme negative reaction . . . does appear to have a profoundly negative influence on the social integration of community care residents" (p. 355). In their report on young adult former mental patients, "street people", in urban areas of California, Segal and Baumohl (1980) note the adverse effects of negative public attitudes on social integration, effects which include "direct exclusionary activities by the general community", the blocking

of "access to community resources", and the biases of mental health professionals (p. 361).

These studies illustrate how the classification of neighborhood types helps in the understanding of the person-environment fit of mentally ill persons in the community (Segal and Silverman, 1989). The negative characteristics of a neighborhood are of special concern when deinstitutionalized persons are "dumped" into these neighborhoods. Segal and his colleagues (1980) note the social costs involved, concluding that "No community, no matter how good-hearted, can long suffer the accumulation of society's wounded and outcast without exhausting its resources and patience." (p. 355).

Desirable Levels of Integration

These studies of community care point to some of the factors which enhance or inhibit social integration. The findings have been of special interest for mental health planning, as the assumption is usually made that a high degree of participation and social interaction is desirable. However, this assumption needs to be reexamined. Studies of mentally ill persons in relation to social networks and social supports suggest differential goals of social integration should be established by mental health professionals. Thus, for some individuals who are seriously mentally ill, the goal might be for the development of internal social integration mainly within a treatment center or a nursing home facility (Bootzin et al, 1989), with limited interaction with the surrounding community. In some respects, the residential facility may be the most relevant community for these persons. For individuals who live in apartments in residential areas, the goal might be to have such persons recognized by neighbors and not treated as strangers (Hunter and Baumer, 1982). In this instance, social interaction limited to friendly greetings might be viewed as a sufficient level of integration. For other persons, social integration might mean social contacts and participation beyond the neighborhood community, such as participation in workplace activities, recreational activities, drop in centers, self help groups, and agency treatment groups. For still others, integration might be mostly related to contact

with formal organizations which provide professional services, such as community mental health centers.

Cautions in regard to establishing social integration goals for the mentally ill in general have been noted in the literature. For example, Kirk and Therrien (1975) have raised question about the "limits and dangers of the forced attempts at reintegration" in community placement (p. 214). Kennedy (1989) suggests that "community integration is not always associated with well-being..." (p. 74). His findings "suggest that community integration, in an absolute sense, may not be a desirable goal for all chronically mentally ill adults. Rather, community integration is more appropriately viewed as a continuum, and for some individuals less participation is desirable." (p. 74). In his review of research on community based care of the mentally ill, Rubin (1984) noted that "Tentative findings suggest that overstimulating environments, including family environments that are overstimulating, may have a harmful effect on the chronically impaired." (p. 174). Studies of social networks also suggest that high levels of social network interaction may be detrimental to some mentally ill persons (Granovetter, 1973; Powell, 1987). Thus, differential levels of social integration need to be specified in the planning of community based programs, as well as in the development of individual treatment goals. This is particularly important in view of the fact that many seriously mentally ill people may never have been very well integrated into their communities. In addition, patient's return to neighborhoods where there are fewer primary group relationships and more secondary group interactions than found in the gemeinschaft community of earlier times.

Conclusion

Planning for community based care for mentally ill persons can be facilitated by a reformulation of the concepts of community and social integration. Mental health professionals can fruitfully plan programs and individual treatment goals by recognizing the "multiple communities" to which patients belong, and by formulating social integration goals in terms of each individual's "personal community". By viewing social

integration in differential terms, various levels of participation and involvement in geographical and identificational communities can be person specific. Using these formulations of community and social integration, individual treatment goals can be established within a context of a person-environment fit. At the same time macro level interventions of service development and the changing of public attitudes toward the mentally ill can be directed toward multiple communities.

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