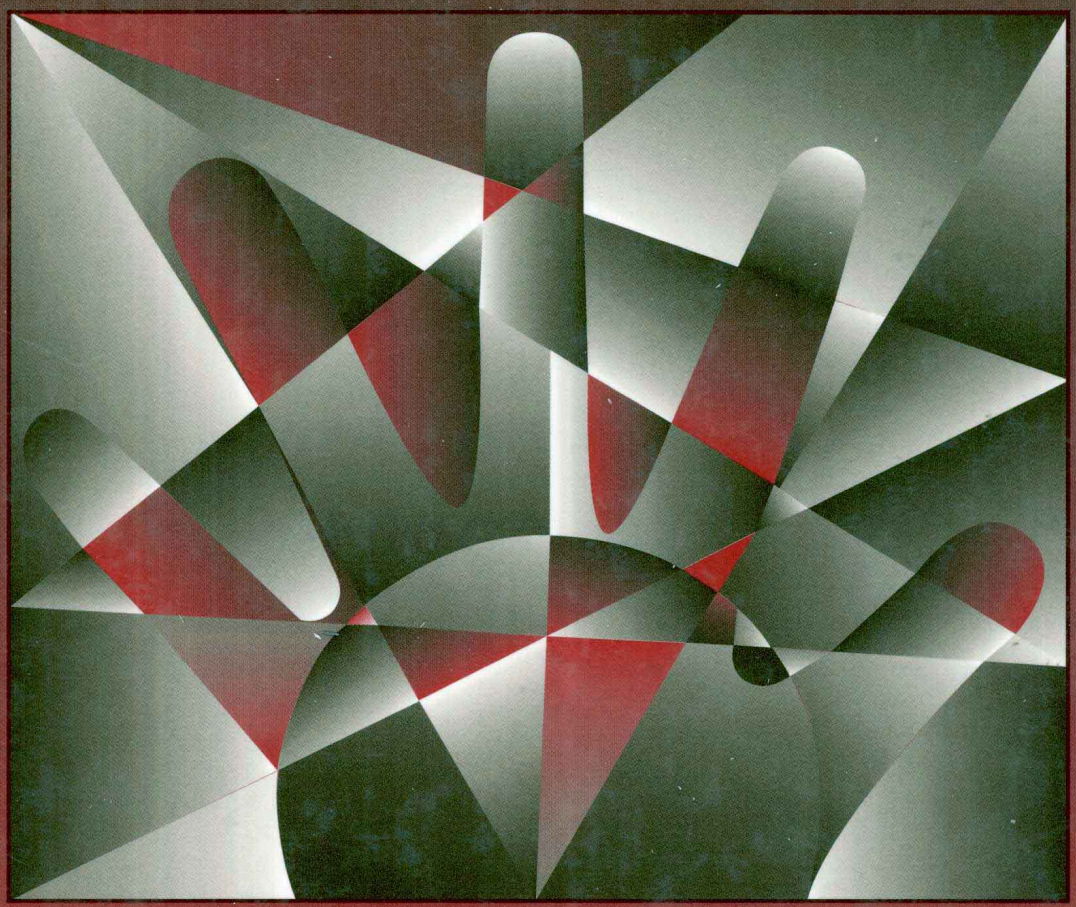
SIXTH EDITION

# HUMAN SERVICES

## CONCEPTS AND INTERVENTION STRATEGIES



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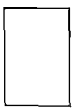

# HUMAN SERVICES

## Concepts and Intervention Strategies

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# PREFACE

As this sixth edition of *Human Services* goes to press, U.S. society continues to experience major transitions and profound uncertainties. We are witnessing unpredictable financial markets, major changes in tax legislation, an ongoing federal budget deficit with threats of social welfare funding cuts, and the transition from a conservative Republican to a more liberal Democratic presidency. Since the election of President Clinton, there appears to be a renewal of the federal government's determination to reduce the federal deficit while at the same time introducing a significant reform in the availability of medical care to all segments of the population. However these initiatives turn out, one constant in our society will continue to be that many people need helping services, and many others are interested in providing those services.

Being interested in human services means being interested in and committed to finding solutions to the human problems that face people in modern times. These social and psychological problems are extremely complex and require a coordinated and integrated approach. This is what the human services are all about—helping ourselves and helping others to solve problems.

The term *human services* has become an all-encompassing phrase used to label services provided to individuals or groups who, for whatever reason, have failed to be included in the mainstream of the society and culture or who experience the pain and anguish of life in these troubled times. The clientele, depending on which expert one reads, includes 36 million poor people, over 900,000 inmates of correctional institutions, 500,000 to 1 million children with school behavior problems, approximately 500,000 adults in mental hospitals and sheltered living facilities, close to 500,000 persons who are mentally retarded, and a large number of people with other severe problems who struggle daily with the issues of living.

In short, the field of human services is oriented toward dealing with all major social, psychological, and economic ills. Unfortunately, the dollar resources that exist at the federal, state, and local levels are limited, and it seems unlikely that they will increase greatly in the foreseeable future. In fact, in the

1990s, those dollars are shrinking. Our economy has been troubled by inflation, high interest rates, and deficit spending. Elected officials are cutting federal and state spending in an attempt to deal with these problems. These cuts will continue to have major impacts on the human services. This fact has prompted the approach taken in the sixth edition of *Human Services*—that is, a focus on concepts and strategies that can have a significant impact on human problems in spite of limited fiscal and human resources.

People with major problems must receive the maximum application of resources if human services is to be a workable concept. Our primary concern must be with those who are at risk and with the conditions that have brought them to that low point of survival.

From this approach, dealing with the child-abusing parent is more critical than dealing with the parent of an underachiever, dealing with the dangerous adolescent gang member is more critical than dealing with the middle-class delinquent, and dealing with the psychotic housewife and mother is more critical than dealing with the dissatisfied homemaker. This is not to imply that the underachiever, the middle-class delinquent, and the dissatisfied homemaker do not have significant problems and do not deserve help but rather to emphasize that we must concentrate on the groups of individuals with the most severe problems and the fewest assets as the prime targets in the allocation of resources.

The content of *Human Services* reflects this view. The book does not ignore traditional systems for dealing with problem behavior but focuses primarily on newer approaches to human problems that hold promise for the future. These approaches are presented within the framework of human services concepts such as integrated services, recognition of the importance of environment and social institutions, rapid problem solution, and perhaps most important, a new consciousness about the directions in which we need to go in meeting the needs of both client and community.

Part I provides an orientation to and presents a perspective for viewing the field of human services. It examines the development of human services concepts. It distinguishes between integrative and generic concepts of human services and places modern human services in an historical context. Part II focuses on the parameters of the field of human services. This part of the book discusses the roles of human services entry-level professionals and workers and explores human services problems and the boundaries of the field. Part III surveys the strategies that have been used traditionally to treat people in need. It concludes with examples of how human services workers can integrate these approaches into their work and emphasizes the importance of personal relationship factors in all human services delivery systems. Part IV explores the new strategies for helping people in need that are most closely identified with a human services approach. The section concludes with an examination of ethical and legal issues that affect human services workers.

At the conclusion of the book, you will have a basic understanding of human services and the prevailing strategies for dealing with the major problems of people in need. You should also be able to understand the most important

approaches of professionals in correctional institutions, community mental health centers, mental hospitals, crisis centers, substance abuse service centers, facilities for mentally retarded people, and multiservices centers. In addition, the role functions of human services workers should be clear: what they do, how they do it, and what effect they can have on people in need.

## *ACKNOWLEDGMENTS*

Many individuals have contributed to the development of the six editions of this text. The human services students and workers with whom I have had contact for the past twenty-five years have taught me as much as I have taught them. I owe a particular debt to Al Levitt, editor of the first and second editions of this text. Judy Shaw, editor of the third edition, also deserves thanks. The fourth, fifth, and sixth editions owe much to the support of their editor, Karen Hanson, and to the human services professionals and educators she asked to critically review previous editions of the text. They are Dennis B. Cogan at Georgia State University, Mikel Garcia of California State University at Fullerton, Carol A. Jenkins at Biola University, Tricia McClam of the University of Tennessee, Patrick McGrath at the National College of Education, and Cynthia Tower of Fitchburg State College.

# CONTENTS

## PART II *Human Services: Defining Roles, Problems, and Boundaries*

# 1

# HUMAN SERVICES: A NEW DIRECTION

- What is the meaning of *human services?*
- What recent circumstances have resulted in the growth of the field of human services?
- What is meant by *social policy?*
- What are the differences between the concepts of *integration* and *generic human services?*
- What are the ten attributes of generic human services?
- What is a human service worker?

*Human services* is a phrase that is often used to group activities that focus on helping people live better lives. In the broadest sense, the human services include formal systems such as government welfare programs, education, mental retardation services, mental health organizations, child care programs, physical health care establishments, and the correctional services of the legal justice system. The phrase also has more specific meanings. Some authors have described its most important feature as a new consciousness among workers and clients in the formal helping systems. Others have focused on human services as a concept that embodies an integrated delivery of services to consumers. Still others have defined it as a sociopolitical movement that has aspects of a subtle revolution. Individual human service workers may focus on one or more of these factors as the most important aspect of human services, depending on their training, experience, and personal goals. The theme that all share is the improvement of quality of living for the neediest members of our society.

## ANTECEDENTS OF THE HUMAN SERVICES CONCEPT

Following the upheaval of global conflict in the 1940s, people in the United States began slowly to realize that all was not well with the traditional helping systems. Prisons were dramatically overcrowded, the crime rate was rising, mental hospital populations soared, and educational opportunities were unequally distributed. In spite of advances in social welfare policy, psychology, education, and social work, it seemed as if society was waging a losing battle. What was particularly striking about the battle was that the losers were usually members of the lower **socioeconomic strata.** It was most often members of this group who ended up on welfare; in the prisons, jails, and mental hospitals; and in the ranks of the educational dropouts. They had no money to purchase high-quality medical care, legal representation, or quality education. Several sociopsychological studies in the fifties and early sixties focused on some of these problems and drew them to the attention of professionals and the public (Goffman, 1961; Harrington, 1962; Myrdal, 1964; Redlich et al., 1953).

It was becoming obvious that, in most cases, those with the least need were receiving the most services, while those with the greatest need were receiving almost nothing at all. Although many helping professionals were being trained and were entering the world of work, by and large they offered their services to those who could pay—the White middle and upper classes.

The mental health delivery system is a particularly good example of the situation during that era. Beginning in the late 1940s, state and federal governments implemented massive efforts to train psychiatrists, psychologists, social workers, and a host of other mental health professionals. (In fact, in a period of twenty-five years, over $2 billion was spent by the federal government alone on mental health training.) It has been reported that between 1948 and 1975, the National Institute of Mental Health funded the training of more than 50,000 mental health professionals: 12,000 psychiatrists, 11,000 psychologists at the Ph.D. level, 17,000 master's-level social workers, and 9,500 psychiatric nurses (*American Psychological Association Monitor*, 1976).

During this period, the great majority of these individuals were trained in public mental hospitals through the use of federal and state tax dollars. A small percentage of the patients in these institutions, those who were considered good teaching cases, received excellent services. However, the rest were consigned to poorly staffed, overcrowded back wards in abysmal conditions. Once finished with training, many professionals quickly deserted the mental institutions for the more lucrative field of private practice, where they offered their skills to the better educated middle and upper classes who could afford to pay well for their services. In fact, only 9 percent of these trained professionals remained employed in the public mental health sector.

While the exodus of professionals continued, the hospital populations soared even higher during the late 1950s, until many institutions had two or three times as many patients as their rated bed capacity. It was during this period that some

experts began to question the usefulness of the traditional medical-oriented approaches to dealing with people who had severe problems of life adjustment. However, the introduction of new drugs in the middle to late fifties both reinforced the medical approach to human services problems and paved the way for a conceptual change in mental health services. The masking of symptoms that resulted from the use of new drugs for mental hospital patients was one of the major factors in the growth of the notion that many people who were in mental hospitals did not belong there and could exist in the community. Slowly but surely, the movement of patients from the hospitals to the communities began.

The ability to control the more exaggerated behaviors of some patients (hallucinations, delusions) had a positive effect on the attitudes of mental hospital staff members. New ideas and treatments began to be introduced in the hospitals, such as patient government, group psychotherapy, and vocational rehabilitation. The movement of patients to the community gained momentum partly as a result of the success of the new modalities but probably more because of a new attitude on the part of many of the staff—something could be done. The change in attitude of staff members from a custodial approach to an active effort to help patients was a landmark change in the recent history of mental health services.

While changes were taking place in the mental health systems, similar events were occurring in the legal and correctional systems. There, too, recognition was growing that different standards were applied depending on race and socioeconomic class. White middle-class citizens tended not to be charged as frequently for crimes (even when they *had* committed them), tended to be found innocent more often, and tended to receive lighter sentences when found guilty. In the correctional system, prisoners were mostly Black, Latino, or White members of the lower socioeconomic classes.

Recognition of the discrimination inherent in the differential treatment of low-income or minority group offenders and White middle-class and upper-class offenders has led to a gradual change in the judicial and correctional systems. Today there is much more sensitivity to the impact of social conditions on the likelihood of criminal behavior. In addition, there is much more concern with the rights of the accused and the convicted and a growth in programs that attempt to address the social causes of crime. Rehabilitation of offenders is more of a goal now, although the judicial and correctional systems are still haunted by the specter of retribution and punishment.

The changes occurring in the mental health and correctional systems, although based on problems within those systems, were reflective of changes in the culture at large. There was, from the 1940s to the 1970s, a broad change in attitude from the conservative to the liberal in political and social life. Fisher, Mehr, and Truckenbrod (1974) offer a more intensive examination of this process and its relationship to the human services. Consult Nicks (1985) for a discussion of currently recognized inequalities in human services delivery systems that are partially due to the return to conservatism seen in the late 1970s and the 1980s.

A major expression of social liberalization can be seen in the civil rights movement that began with the events around Selma, Alabama, in the 1950s.

Although focused on the plight of Black children and their problems in obtaining an education equal to that of their White counterparts, the civil rights movement has precipitated wide-reaching changes in the educational system. While still not entirely successful, desegregation progressed significantly during the 1960s, and we have witnessed the growth of a number of compensatory mechanisms, such as Head Start programs and busing. Among the broader effects of the movement has been the expansion of the concept that quality education is a right of all citizens, not a privilege, and that *all* disadvantaged persons must be served by the educational system.

For individuals with an investment in the notion that all members of our society have an equal right to needed services, the sixties were an exciting time. There was a massive growth in programs in all areas for the disadvantaged: the Economic Opportunity Act, the model cities programs, urban renewal, aid to education, and great strides in racial desegregation. As these programs continued, we seemed on the way to what President Johnson called the Great Society.

During the decade of the 1960s, one important approach for achieving the Great Society was the development of programs that created a new kind of worker. The Economic Opportunity Act of 1964, for example, resulted in the employment within one year of 25,000 paraprofessionals in community action programs and 46,000 paraprofessionals in the Head Start program for disadvantaged preschoolers. The Office of Economic Opportunity thus attacked the problems of the disadvantaged on two fronts: (1) it employed the disadvantaged, who would (2) help other disadvantaged people. This frontal attack on the problems of poverty was replicated in federal funding for similar programs in law enforcement and corrections, education, health, vocational rehabilitation, drug abuse programs, mental retardation services, and mental health. The programs have all been instrumental in the creation of a wide acceptance of new careers in the helping services.

Even though developmental events in the areas of human services (mental health, mental retardation, corrections, public welfare, education, and so on) have not been completely parallel, the similarity is great enough to use mental health as an example. And the mental health system is particularly appropriate as an example since the concept that an individual's problems in living are internal in nature (caused by psychological problems of the person) has been widely adopted by the fields of correction, education, public welfare, and mental retardation.

In the field of mental health, the growing dissatisfaction with available services stimulated Congress in 1955 to pass a resolution that established a Joint Commission on Mental Illness and Health. The commission conducted a nationwide study on the extent of mental illness and its attendant problems, and the study and recommendations were published in 1961. Even more significantly, President John F. Kennedy appointed a cabinet-level committee to study the commission's report. In February 1963, Kennedy's message to Congress dealt with mental illness and mental retardation. In part, Kennedy said:

> *I propose a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill. This approach relies primarily upon the new knowledge and the new drugs acquired and developed in recent years which make it possible for most of the mentally ill to be successfully and quickly treated in their communities and returned to a useful place in society.*
>
> *These breakthroughs have rendered obsolete the traditional methods of treatment which imposed upon the mentally ill a social quarantine, a prolonged or permanent confinement in huge, unhappy mental hospitals where they are out of sight and forgotten. . . . We need a new type of health facility, one which will return mental health care to the mainstream . . . and at the same time upgrade mental health services.*

In effect, the problems of human services had obtained a national political priority. By the end of October 1963, a law (Public Law 88-164, the Community Mental Health Centers Act) was signed by the president; this law provided direction on a national scale for the community mental health movement and indirectly gave impetus to the development of human services.

What is particularly striking about this period is that much of the pressure for change did not come from the established systems. Although there were a few groups in the traditional human services who were working in new directions, most of the impetus was coming from what has been called the *grass roots level.* It was during this period that much societal dissatisfaction found expression in events such as the radical student movement, the riots in Watts and Detroit, the Attica prison riot, the ecology movement, and the actions of people such as Cesar Chavez and the United Farm Workers Organizing Committee, Ralph Nader and the consumer movement, the gay liberation movement, and the Gray Panthers. While the broader society was embroiled in the turmoil of this period, a series of events in the mental health system reflected that turmoil and a raised level of consciousness. It also reflected dissatisfaction with the mental health system itself. Events such as these were critical to the development of the human services concept.

Even though the concept that the community rather than an institutional setting is the appropriate place for intervention predated the report of the Joint Commission, the enactment of Public Law 88-164 provided a major impetus for the changes of the sixties. It provided the sanction for moving patients from the institutional setting back to the community and for developing resources to support those patients once they had been moved. A major accomplishment of the federal legislation was the funding of about 600 comprehensive community mental health centers around the country. However, even in areas where these centers were not funded, local groups created county or city mental health centers that in many cases were supported by a local tax base.

The principal functions of the mental health centers as outlined in the Joint Commission's report were "(1) to provide treatment by a basic mental health team . . . for persons with acute mental illness, (2) to care for incompletely