HUMAN SERVICES IN HISTORICAL PERSPECTIVE

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INTRODUCTION

Who is responsible for helping the disadvantaged within a society? The family? Religious organizations? The government? Is helping to be viewed as a basic human right or as a societal gift? Throughout history, societies have responded to these questions in various ways. If a society does accept some responsibility for helping its disadvantaged, additional questions quickly emerge. Which groups of people and types of problems should be helped, to what extent, and how?

How a given society answers these questions is based on its dominant values, attitudes, and beliefs. If a society believes that its poor or elderly members should be helped, then it will develop some system or method to provide the needed care for these target populations. Another society may give priority to its physically or mentally disabled members and develop services focused on these groups but excluding others.

The present range and diversity of human services are quite large. Throughout history, many people and events have influenced the development and direction of the field. As societies have changed through the ages, values and beliefs have often been replaced or at least modified by new ones. The developing human services systems of today are to some extent an outgrowth of our previously held societal values and beliefs concerning helping. It is likely that the quality, methods, and availability of human services in the future will be greatly influenced by current attitudes toward helping. Through knowledge of the past, we can better understand the present and also be in a more favorable position to shape the future.

For clarity and to help you understand more fully the historical development of the interrelated aspects of the human services field, this chapter is divided into several sections. The first sections provide a general overview of the historical roots of the human services field by tracing the development of early societal beliefs and helping practices. The next section traces changing societal attitudes and helping practices that have contributed to the development of human welfare services. The following section examines the historical development of mental health services. The chapter concludes with a brief discussion of future trends in the human services field.

PREHISTORIC CIVILIZATIONS

The earliest records of helpful treatments can be traced back to the Stone Age of approximately half a million years ago. Through cave drawings and the remains of primitive skulls, scientists know about a medical treatment called trephining. In this procedure, a small section of the skull was bored out, probably by means of sharp stones or other such crude instruments. This hole cut from the skull was supposed to allow a route of escape for the evil spirits that were believed to inhabit the afflicted person’s body, thereby curing the person. Scientists have surmised that this treatment was administered to people who evidenced certain forms of observable deviant behavior. It should always be
remembered that what constitutes deviant behavior is a product of what the norm for behavior is at a given point in time.

In this early era, most human problems were attributed to devils, demons, or other evil spirits. Belief in the supernatural or demonology was the dominant belief system of the age, and various procedures or rites were used to exorcise evil spirits. The belief in the supernatural arose from early humans’ attempt to explain the universe. All natural phenomena such as earthquakes or floods were attributed to the work of evil spirits. These ancient people also accepted the related belief, called animism, that spirits inhabit various inanimate objects such as rocks, trees, or rivers. The shaman, or medicine man who performed rites of exorcism, can now be viewed as the earliest human services worker. It was commonly believed that these individuals understood the secrets of the supernatural and possessed certain religious or mystical qualities that enabled them to help afflicted individuals.

Life during prehistoric times was at best a matter of pure survival against the hostile environment. Human problems centered around gathering food and having a relatively safe place to sleep. Poverty meant not being able to locate or secure food, and sometimes the weaker individuals were simply left to perish. In situations involving the physically disabled or infirm elderly, the tribe or extended family unit would usually share or provide for these individuals. However, how important afflicted people were to the tribe often determined the amount of assistance they received. In some instances, individuals separated from other tribes were taken in and befriended. Newcomers usually had to prove their worth in some manner in order to be allowed to stay with the tribe. The family was the primary source of help, but religion played an increasing role in the evolution of human services.

EARLY CIVILIZATIONS

Prior to 450 B.C., the world was believed to be governed by supernatural spirits. There were no major organized attempts to understand human problems and behavior from a scientific point of view. However, significant changes in beliefs were about to emerge that would alter the earlier supernatural explanations for human behavior.

During the Golden Age of Greece, a number of philosophers began to put forth new beliefs concerning human nature. One of these was the Greek physician Hippocrates (460–377 B.C.), who disagreed with the belief that supernatural spirits were the sole cause of human disease. He believed, rather, that most diseases were chiefly physiological or organic in origin. He shared the point of view earlier postulated by Pythagoras that the brain was the center of intelligence and that mental disorders were due specifically to the malfunctioning of the brain (Coleman, 1976).

Another contribution made by Hippocrates was his development of a system of psychiatric labels for patterns of deviant behavior. These labels included melancholia, mania, and epilepsy. To appreciate more clearly the radical
change in belief advocated by Hippocrates, one must consider that the previous explanation for epilepsy was that it was a sacred or divinely ordained disease. Hippocrates claimed this disease was caused by a blockage of air in the veins due to secretions of the brain (Hoch & Knight, 1965). The treatments advocated by Hippocrates differed considerably from the earlier skull-cutting procedures. His treatments often involved vegetable diets, exercise, and a tranquil lifestyle.

Whether Hippocrates had the correct physiological explanation or treatment is not of critical historical importance here. The theory that diseases could be explained by natural—as opposed to supernatural—causes is of major importance. This change in belief systems regarding the origin of diseases influenced another significant change. Because deviant behavior or psychological problems could now be viewed as diseases of organic origin, they could now be considered part of the domain of medicine (Rimm & Somervill, 1977). As such, physicians, rather than priests, medicine men, or other religious healers, performed the necessary treatments. This separation of treatment responsibilities was one of the first steps toward developing the system of specialization that has continued to the present time in human services.

In the ancient Rome of 150 B.C., another physician, Asclepiades, advocated treatment procedures for mental disorders that stressed a medical and humane approach. His recommended treatments often involved massages and baths to soothe excited or nervous patients, with wine to calm the nerves. He actively denounced the cruel and severely harsh treatments that were still popular at this time, such as housing patients in totally dark cells, beating them with chains, bloodletting, castrating, and subjecting patients to prolonged periods of starvation.

Galen (A.D. 130–200), a Greek medical writer, was able to compile, systematize, and integrate a considerable amount of material from many complementary fields. His topics included medicine, anatomy, physiology, and logic. In addition, he made a major contribution to the understanding of abnormal behavior by developing a system of classifying the causes of mental disorders. He believed all disorders were either physical or mental. He felt these disorders could originate from such things as injuries to the head, fear, shock, or emotional disturbances.

The early civilizations presented some striking contradictions in helping attitudes and services. Although many advances were being made and many individuals were attempting to struggle against fear, ignorance, and superstition, the use of cruel treatment procedures was still prevalent. Even as many advocated more humane and philosophical beliefs concerning the nature of people, the practice of buying and selling slaves also existed. The poor and disabled often begged for alms along city streets. Although physicians were available for the sick, only those who could pay had access to them. The Romans and the Greeks viewed physical weakness or disability with little tolerance. Often the physically ill were taken out of towns to uninhabited areas or deserted islands where they were left to struggle by themselves or die. Of course, this pertained predominantly to the poor or those without resources or
family protection. As in most societies, the rich were treated one way and the poor another.

The period A.D. 200–475 marked a steady decline for civilization. As major plagues killed thousands upon thousands of people between the first and fourth centuries A.D., intense fear and anxiety spread throughout Europe and the Middle East. In this climate of fear, Christianity emerged and developed a large and zealous following. Medicine could not stop the plagues, so people turned to the comfort and solace offered by Christianity, which became the prime religion of the Western world. Religious figures replaced medical figures as the saviors from illness. The causes of disease were again explained in terms of loss of faith to demons. Evil spirits were viewed as the cause of most human misfortunes.

**THE MIDDLE AGES**

The Middle Ages date from the fifth century with the collapse of Rome at the hands of the barbarians advancing from the east. During this time, exorcism reemerged as the prevalent treatment for most disorders. The medical advances achieved by Greece and Rome were mostly forgotten (Fisher, Mehr, & Truckenbrod, 1974). Christianity became the dominant power throughout the Middle Ages.

As the Church became steadily more powerful and organized in the early part of the Middle Ages, it developed and provided a variety of human services. Monasteries often served as sanctuaries, refuges, and places of treatment for the mentally ill. The Church established institutions for the poor, provided residences for people with disabilities, sponsored orphanages, and founded homes for the aged. Initially, these services were housed within church facilities, but later other, nonreligious sites were founded.

In its earliest beginnings, the Church espoused the belief that the wealthy or those with adequate resources had a duty or responsibility to help the less fortunate. The less fortunate, in turn, began to expect assistance as an obligation or duty from the wealthy. Both the rich and the poor developed social roles and expectations for one another, and a clear distinction between the two classes was evident. It is important, however, to note that assistance given to the poor was set at the lowest subsistence or survival level. Much of contemporary human services philosophy can, in fact, be traced back to these early interpretations of religious values and teachings.

During this period, there was little interest in finding out why the disadvantaged were disadvantaged. The causes of poverty, for example, were of little interest to those providing human services. The rights and obligations for each class of society were clearly spelled out, and no further understanding was felt to be needed.

Initially, people believed that giving to the disadvantaged was important simply because others were deserving of and needed help. The Church gradually began to lose this emphasis on helping out of humanitarian concerns and replaced it with the notion that helping had to be done if one wanted to ensure
a peaceful afterlife and achieve salvation. The Church preached that giving was a means of salvation, a means to an end. People would be rewarded in an afterlife for fulfilling their obligations in this life. Giving was seen as a necessary responsibility or duty of the wealthy that they often fulfilled reluctantly.

As the Church developed human services, the overall climate of the Middle Ages was marked by extreme cruelty and chaos. During the period 1200–1400, there was a strong increase in the belief in witchcraft, and in certain regions mass outbreaks of flagellation (whipping) rituals occurred (Russell, 1972).

Although the Church tried to control all opposing beliefs and alternative religious movements, it was not completely successful. As people became disillusioned with the ability of the Church to protect them from misfortune, a variety of fanatical sects emerged throughout medieval Europe, and fear of witchcraft became a mass obsession. As Rimm and Somervill (1977) point out:

Witches were viewed not only as degenerate beings in league with devils, but also as causes of sickness, disease, personal tragedies, and the stealing and killing of children. They were perceived as vicious instigators of terror, highly dangerous to a threatened and unstable society. (p. 16)

In the Middle Ages, the growth of fanatical sects represented a form of extremism, an impulsive act often characteristic of youth. In fact, the Europe of the Middle Ages was a youthful society. The death rate was extremely high, and people did not often survive past 40 years of age.

Beginning in the 13th century under Pope Innocent III, a religious tribunal was established. This tribunal, referred to as the Inquisition, was given the responsibility of seeking out and punishing any and all crimes associated with witchcraft or other forms of heresy. The methods employed by this ecclesiastical body to obtain confessions for accused crimes included intimidation, burnings, boiling suspects in oil or cutting their tongues out, and other inhumane forms of torture. The Inquisition, although it used cruel and inhumane measures, espoused the belief that the Church was providing service to society by getting rid of the causes of disease and famine. It also served as a means for the Church to exert its power and encourage loyalty by threatening those who did not conform with stated policies and beliefs.

Throughout the Middle Ages, a major power struggle existed between Church and state. Each faction wanted more power to govern without interference from the other. The Church developed a steady source of income by demanding that its parishioners donate approximately 10% of their incomes for church-related activities. The state viewed this steady source of income as a threat to its own base of power and sought many times to make it illegal to give money or services to those who could work.

Gradually, the disadvantaged came to be classified according to whether they physically could work or were unfit for work, such as the disabled, elderly, and children. Those individuals deemed legitimately unfit for work came to be known as the worthy poor, whereas the others were looked upon as being lazy and unworthy of assistance. Even though this steady clash for
power existed, the Church was successful through most of the Middle Ages at preserving its domain, especially as far as providing human services to “worthy” individuals.

**THE RENAISSANCE**

As Europe emerged from the Middle Ages, it entered a period of rapid and turbulent change marked by the end of the feudal system, the birth of industrialization, and a decline in the power of the Church. As the government became more powerful and influential, individual states, cities, and towns developed more power. The middle class, composed mainly of tradespeople, grew, prospered, and became a more visible and distinct part of society.

By the 16th century, change had significantly altered the previously established religious, social, and economic order. The government, the Church, and newly emerging business leaders shaped the nature and direction of societal change. Unfortunately, the rationale for change is often based on the priorities and complex concerns of those in power and does not necessarily benefit all in society. These changing societal forces had a tremendous influence on the direction and quality of human services. It is important to realize that what has become today a system providing an enormous range of services for the welfare of human beings from birth until death originally started out as simply providing food or shelter to people as a form of social welfare.

Having now provided a general overview of the early development of human services philosophy and practice, we will next examine the subsequent growth of human welfare services and then that of mental health services.

**HUMAN WELFARE SERVICES SINCE THE RENAISSANCE**

During the 16th century, the Protestant Reformation escalated the many struggles for power between Church and state. By the end of the 16th century, the state had finally established authority over the Church. As a result of diminished Church power, it became incumbent upon the state to take over many services formerly provided by the Church, which included providing for human services.

Under Henry VIII of England, the government formally took over the human services functions of the Church to provide for people who were not self-sufficient and established a system of income maintenance and public welfare. The official policy mandating this transition of power was outlined in the statutes of 1536 and 1572. In 1601, the Elizabethan Poor Law established a system that provided shelter and care for the poor. This law also specified local responsibility for the poor and disadvantaged. It was first the responsibility of the family to provide for all human services. If the family could not provide such services, it then became the state’s responsibility to provide for disadvantaged individuals within their communities.
Although there were people with good motives and intentions, the Poor Laws were not initially created as a generous humanitarian gift from the state to aid its disadvantaged citizens; the Poor Laws were a means of social control following an era of mass frenzy, disease, famine, and economic instability that threatened to break apart the existing social structure.

As a result of these Poor Laws in England, a system for classifying the disadvantaged into three categories was established: (a) the poor who were capable of work; (b) the poor who were incapable of work because of age, physical disability, or motherhood responsibilities; and (c) orphaned or abandoned children who became wards of the state. The poor who could work were forced to work in state-operated workhouses. Massive overcrowding, filth, and inadequate food and sanitary conditions made these workhouses barely tolerable. If the individual was incapable of work and in need of food or shelter, he or she could be sent to an almshouse (poorhouse). The living conditions there were similar to those of the state workhouses. By comparison to the almshouse or workhouse, a more tolerable alternative was available for the more “fortunate” of the disadvantaged.

In certain communities, it was possible for individuals or families to remain in their own dwelling and receive contributions of food and other items from their community. This circumstance was far less common than the other methods of providing services. Money was never given directly to the poor family, and any other essential services such as medical care were not generally available.

As this early, often crude, human services system evolved, procedures and rules were more clearly established and defined. Policies were established to decide who would be eligible for available services and who would have the authority to decide who got what and who went where. As the programs became more complicated, the government created a subsystem with sole responsibility for overseeing its public welfare system. Each community had its specified government welfare administrator, who made the local decisions regarding a person’s eligibility for services. As the number of individuals who were in need of assistance increased, the local community bureaucracy became more impersonal. Indeed, this is still a problem with modern welfare systems. The form of welfare bureaucracy created in England during this period became the early forerunner of our modern welfare system in the United States.

The Industrial Revolution

By the 1800s, the Industrial Revolution was developing momentum. The Industrial Revolution began with the invention of a few basic machines and the development of new sources of power. The advent of industrialization created the mechanization of manufacturing and agriculture, changed the speed and methods of communication and transportation, and began the development of factory systems of labor. These events, in turn, caused dramatic changes in economic systems (Perry & Perry, 1988).

Large populations of unemployed individuals moved from rural areas to urban centers in search of work. Although new forms of labor were needed and work was available for some, the great majority of people still found
themselves in poverty. As a result of the swell in the disadvantaged population within urban areas, many public institutions were created. The majority of the urban poor found themselves facing worse conditions than those they had left behind. Adequate living space was scarce, producing overcrowded and unhealthy conditions. Food was in short supply, and the urban environment provided little room to grow crops. Families often found themselves separated as members left in search of work.

Workers were generally seen by businessmen as commodities, to be used only when needed and disregarded when work was not immediately available. It was during this time that workers started to band together to share and provide what they could for one another. This banding together for the collective benefit of all resulted in the development of the early guilds and unions. In an effort to deal with the perceived threat to the social order brought on by these large numbers of disadvantaged people in urban areas, the government created more workhouses, debtors’ prisons, houses for delinquents and orphans, and mental institutions.

The Industrial Revolution brought about a new social philosophy that had a strong influence upon society’s attitude toward the poor and disadvantaged. This new social philosophy, known as the Protestant work ethic, reinforced a set of values supporting the virtues of industrialization and condemned idleness as almost sinful.

Hard work, and thereby the accumulation of wealth, was interpreted as God’s reward for leading a virtuous life. On the opposite end of this philosophy, poverty was often viewed as some form of punishment from God. This philosophy, as most notably preached by John Calvin, supported the notion that poverty-ridden individuals should remain in their disadvantaged conditions because God had divinely ordained this condition for them.

It was during the 1830s in England that the concept of less eligibility was established. This concept set forth the guideline that any assistance given to the disadvantaged must be lower than the lowest wage paid to any working person. Work was seen as an ultimate good, and its absence, for any reason, was to be looked down upon. In theory, this concept sought to provide an incentive for all to work.

Another corresponding influence on society’s attitude toward the disadvantaged was the concept of laissez-faire economy, introduced by the Englishman...
Adam Smith in 1776. His book *The Wealth of Nations* argued for an economy in which government had virtually no influence and placed no restrictions on the free marketplace. According to Smith, without government control, society would grow and prosper by itself based on people’s individual merit and hard work. Supporters of this concept saw human services not as a right but as a misguided societal gift—a gift that they perceived would actually hinder overall economic production.

As previously described, many of these events and philosophies that were developing in England and Europe had a strong influence on societal attitudes toward helping in the United States. The economic value system emerging from England was again reinforced in the United States by the writing of another Englishman, Herbert Spencer. It was Spencer who interpreted Charles Darwin’s writings on evolution in a provocative manner. His ideas, which came to be known as **social Darwinism**, applied theories of animal behavior to human behavior. Using Darwin’s biological premise in regard to natural selection and coupling it with an economic argument, Spencer espoused the idea that those disadvantaged people who were unfit for society should not be helped; it was the natural order of things for them to help themselves or perish, as in nature. This, it was felt, would provide another incentive for people to work. Of course, this theory did not take into consideration those individuals who, for physical or other reasons, were unable to work. Additionally, this theory did not consider the many individuals who wanted work but for whom no work was available. In essence, social Darwinism only served to foster an attitude of indifference toward the poor.

**Early Reform Movements in the United States**

As the many institutions for the disadvantaged grew in size, workers were needed to supply the various types of helping services. One positive effect of the growth of these public institutions was that it helped formalize the system of “professional” helpers. Conditions within institutions were intolerable. The large number of people housed in small spaces created unbearable overcrowding. Lack of heat in winter, instances of brutality, inadequate food, and many other examples of inhumane treatment generated a good deal of concern by private citizens over these conditions and led to a series of attempts at social reform.

Many of the social reformers of the mid-19th century did not focus their efforts on a single injustice but instead called for a voice of reason and humane concern in every area of human welfare. In the late 1800s and early 1900s, the movement toward human welfare made great advances. In this period of heavy immigration to the United States, many thousands of newly arrived immigrants found themselves homeless and displaced in their new country. It was during this time that settlement houses were developed to provide immigrants with the essentials of life and to help them get a foothold in American society.

The **settlement house movement** was a reflection of early human services philosophy. Settlement house workers embraced the view that it was the
responsibility of society to help. They also advocated a major shift in helping attitudes and human services thinking to the belief that many of the problems confronting individuals are created by environmental circumstances rather than by personal inadequacy. This point of view has recently come to be known as the human services perspective. The founders of the movement expressed the idea that one must work toward improving the social conditions that exist within society. To accomplish this goal, a system providing for basic human services must be created to facilitate an adequate quality of life. It was further believed that a truly successful human services system should provide opportunities for all people to improve their lives and realize their potentials.

One notable early settlement house was Hull-House, founded in Chicago by Jane Addams. It was here, many authorities believe, that contemporary social work was born. Using Hull-House as the primary hub of her human services activity, Addams managed to create a small but comprehensive network of human services in her Chicago neighborhood that included basic adult education classes, kindergartens, and an employment bureau. In the following years, many other settlement houses were founded throughout the country. They served as a training ground for those providing social work services.

The early 1900s in the United States marked the resurgence of another significant human services movement. Often referred to as the progressive or social justice movement, its aim was to bring about social change through political action and legislative reform. This movement, which reflected liberal reform ideas, was embraced by many factions of society including the unions. Accepting the earlier idea that the social environment is a major factor in creating people’s problems, the reformers advocated a series of economic reforms including a minimum wage standard, a pension system for older workers, an eight-hour day and a six-day workweek, as well as laws providing for unemployment insurance and the regulation of child labor. Many successful changes occurred despite the prevailing conservative outlook. The government began to assume greater responsibility for the provision of human services. During this period, a growing number of Americans became aware that a system of human services is integrally connected to the economic system and the role of the government. A comprehensive system providing for human services requires the support and interconnectedness of all institutions within society.

The Depression and World War II

The stock market crash of 1929 and the Great Depression dramatically changed the lives of many Americans. With huge numbers of unemployed workers and a depressed economy, the need for expansion of human services was evident. With millions of people unemployed, the relationship between environmental circumstances and human problems could not have been made any clearer.

As pointed out in Chapter 1, the federal government under the direction of President Franklin Delano Roosevelt established a series of government aid
programs called the New Deal. These programs attempted to make work available where possible and to provide direct assistance to those people incapable of work. Examples of such programs were the Works Progress Administration, which provided jobs; the Civilian Conservation Corps, which provided training; and Aid to Dependent Children, which provided direct government aid.

In 1935, a major governmental response to the existing social conditions was the Social Security Act. This legislation established a form of social insurance and protection for individuals against an unpredictable economy. This measure not only helped alleviate the current social conditions but was also calculated to aid and protect future generations. This human services legislation subsequently provided for a wide array of health and social welfare services.

It has happened throughout history that people’s attitudes change but sometimes have a difficult time being completely erased. There are always those who cling to previous ideas and attitudes for both good and bad motives, as well as those who advocate change for similarly varied reasons. The 1940s in the United States witnessed a reemergence of the trend toward conservatism. Public criticism was again heard, denouncing the governmental system of providing for human services as helping create a form of “welfare state.” Conservatives felt that too much aid would rob people of the incentive to help themselves. However, as conservatives and liberals debated how much assistance is beneficial, returning World War II veterans created a further need for a variety of human services. As we indicated in Chapter 1, this clash between conservative and liberal thinking is still very evident today.

The 1960s through the 1980s

The 1960s were characterized by social unrest in the United States. The Vietnam War was being waged overseas, and many Americans at home participated in marches and demonstrations to protest the ills they felt existed within the system. This was a turbulent, sometimes violent period marked by protests at many college campuses across the country. Widespread and organized efforts of this kind resulted in an eventual end to the war and advanced the civil rights movement and the War on Poverty. These latter movements were successful in bringing national attention to the plight of minorities and the poor. New legislation was enacted that resulted in the establishment of many programs and services. Although the civil rights movement and the War on Poverty did create increased economic and educational opportunities for the disadvantaged, they did not eliminate poverty and discrimination in the United States.

In the 1970s and 1980s, human welfare services in the United States grew considerably. A massive number of programs were developed to provide for human services throughout the life cycle. In the midst of such an array of services, the need for services of these types still remains great. Debates continue to rage over which programs are truly helpful and worthy of funding and which should be trimmed from our federal or state budgets. This controversy over social policy is discussed in more detail in Chapter 7.
MENTAL HEALTH SERVICES
SINCE THE RENAISSANCE

The historical development of our system of mental health services in certain instances paralleled the development of our system of human welfare services, as previously described. It is now apparent that having an adequate food supply, shelter, income, and other necessities of life has a direct bearing on one's mental health. Of course, our contemporary knowledge and understanding of how environmental factors influence human problems are much better than they were in the past. Previously, individuals deemed mentally ill faced a grim future without any substantial alternatives. In the sections that follow, we examine the people and events that have helped shape our societal attitudes and treatment of the mentally ill.

Early Mental Asylums

Early institutions created to house the behaviorally deviant were commonly referred to as asylums. The word asylum, when used in this context, refers to a place of refuge that provides protection, shelter, and security. Although many mental patients did view the asylum as a place of refuge or safety, a good number probably did not. It was society that viewed the asylum as a form of protection and shelter from those people labeled as deviants.

The early public mental institutions in Europe and the United States were located within communities, and the community was primarily responsible for the governance and maintenance of the institution. As communities tend to be different from one another, so too did these institutions differ from one another. No universal guidelines for patient care or procedures were established among this broad network of community mental institutions, and mistreatment and abuse frequently occurred.

One noteworthy exception, among others, to the generalized inhumane treatment and lack of concern toward the mentally ill was the mental hospital established in 1409 in Valencia, Spain. This hospital is probably the oldest mental hospital still functioning today (Andriola & Cata, 1969). As a rule, patients were readily discharged after they were seen as able to return to society. Patients were treated with relative dignity, and a system of voluntary admissions was established. The example set by this hospital is even more striking when one considers that the Inquisition and witch-hunting mania were also prevalent during this era.

One of the earliest public asylums and the one most typical of the overall character of these institutions was St. Mary’s of Bethlehem (Bedlam), created in 1547 in England. Although originally intended to be humanitarian in nature, this institution, as well as others to follow, was little more than a dungeon in which the behaviorally deviant were locked up and subjected to cruel, often ghoulish, treatment. Inadequate food, insufficient clothing, filth, infectious disease, and overcrowding were commonplace. The more difficult patients were subjected to
treatments that consisted of days, weeks, or months spent in mechanical restraints or chained to the walls and denied food or water. The majority of patients were either mentally retarded, aged, physically ill, or accused or convicted of crimes. Little attention was given to individual cases, and the patients could just as easily have been sent to a prison or poorhouse as to a mental institution.

The Era of Humanitarian Reform

During the next 200 years, similar conditions existed in institutions for the insane in this country, such as Pennsylvania Hospital founded in 1752 and Williamsburg Hospital founded in 1773 (Bloom, 1977). During the late 1770s and early 1780s, a reform movement began that would alter significantly, although briefly, the existing conditions in mental institutions. This movement toward humane treatment of the insane has been referred to as the era of humanitarian reform and the moral treatment movement. This movement, which had its earliest beginnings in Europe, had great influence on institutions in the United States in the late 18th and early 19th centuries.

Following the French Revolution in 1792, physician Phillipe Pinel became the director of La Bicêtre, a mental institution in Paris. It was here that Pinel, inspired by the idea that the insane might be curable, unchained some prisoners, and provided adequate food, clothing, and other necessities of life to all. Although reform was clearly evident, Pinel and other early reformers still advocated the use of harsh measures as sometimes useful tools of treatment. However, the reforms of Pinel are considered by many to be the first major revolution in mental health care (Wahler, Johnson, & Uhrich, 1972).

This reform movement, begun in France, spread to England. In 1813, the British physician Samuel Tuke, the director of the York Retreat, initiated a similar series of reforms. In the United States, other physicians also advocated similar improvements. It was during these early years of reform that physicians gained most in prestige and prominence in their evolving interest and later specialization in treating the behaviorally deviant.

Even though the early reforms advocated by Pinel, Tuke, and others had an impact on the institutions of the day, by the middle 1800s in the United States public awareness and interest in the plight of the mentally ill had waned. Without such interest, the institutions once again fell back into a period characterized by neglect and widespread mistreatment. It was in the mid-19th century that Dorothea Dix became a prominent figure in the evolution of human services. Through her efforts, the earlier reform movement that began in Europe and lost temporary impetus in the United States was again revived and gained its greatest foothold in the United States. Dorothea Dix was instrumental in gathering enough public support to make greatly needed changes in the inhumane conditions in the asylums as well as in prisons and many poverty-related shelters.

Following a personal investigation of asylums and prisons throughout the country, Dix wrote many newspaper articles outlining the plight of the disadvantaged. She contacted legislators and began a successful lobbying effort to
inform and educate the public concerning these conditions within the institutions. As Bloom (1977) notes:

Before [Dix's] career came to an end, 32 state mental hospitals had been built in the United States, care of the mentally ill had been removed from the local community, and the professional orientation toward the insane had been changed from seeing them as no different from paupers or criminals to seeing them as sick people in need of hospital care. (p. 11)

The creation of a system of large state psychiatric hospitals to replace predominantly poorly run smaller community institutions was seen as an improvement in care for the mentally ill. However, this progress was followed by new problems. Believing the large psychiatric hospital to be the answer, the public seemed to lose concern for this population. In the following years, a gradual and steady rise in new admissions to these hospitals once again resulted in overcrowding, mismanagement, and mistreatment.

During the early 1900s, advocates of the social justice movement, who had been active earlier in other areas of human welfare, turned their attention to abuses within mental institutions. Having no desire to dismantle these institutions, they sought rather to change the system of patient treatment and procedures. New policies creating individual treatment plans were established. This appeared to be a more humane and responsible way to administer treatment. Each patient would be treated individually, taking into consideration his or her prior history. This policy seemed a step in the right direction, but it unfortunately created other abuses within the system. Too much arbitrary power and authority were given over to the professionals and bureaucrats overseeing these systems. Of course, some patients benefited from more individualized consideration, but generally the large and unchecked state system often ignored individuals’ rights and denied the possibility that the state could be wrong in certain instances.

**Freud’s Influence**

By the 1920s and 1930s, Sigmund Freud’s classic theories concerning human behavior were well established and widely accepted. Having had to endure considerable criticism in the earlier years of his developing work in response to his emphasis on human sexuality, his later refined theories had a major impact on most facets of society. Although Freud did not work directly in institutions, he had a strong influence on the prevailing treatment approach. His theories were so widely accepted by the public that the mental institutions of the 1930s adopted his approach to treatment and became psychoanalytically oriented. His contributions were so influential that many consider the second mental health revolution to have begun with public acceptance of his work (Wahler et al., 1972).

As we will discuss in Chapter 4, many criticisms of certain aspects of Freud’s theories still continue today. One such criticism by those who employ a human services perspective is that Freud’s psychoanalytic theories focus too narrowly on the inner person, excluding the environmental factors that influence human behavior.
Freud’s impact, though considerable, did not lead to significant changes in the institutional system of care for the mentally ill. Steady deterioration in this system continued. Although there were exceptions, most hospital staffs were generally overworked, understaffed, and poorly trained. Patients were often neglected, and many remained in hospitals for years.

The Trend toward Deinstitutionalization and Decentralization

Beginning in the early 1950s, certain changes began to develop in several hospitals as the result of growth in the field of psychopharmacology. It was now possible through the use of drugs to effectively reduce a patient’s bizarre behavior, thereby affording other opportunities for treatment. Many patients previously viewed as untreatable were now able to return to the community while continuing with drug treatments at home (Pasamanick, Scarpitti, & Dinitz, 1967). Many controversies surfaced regarding the alleged widespread misuse or abuse of such drugs. Critics claimed that patients who were not in need of such drugs were given them routinely to keep them under control. Others pointed out that drugs may cause side effects that are as bad as the illness being treated.

Deinstitutionalization became a major policy in institutions during this time. There was a growing belief that people could be treated more successfully in familiar community settings. Some felt that deinstitutionalization was implemented more because of financial concerns than for treatment reasons. It was felt that it was just too expensive to keep people institutionalized on a round-the-clock basis, and treatment was initially thought to be less expensive in community settings.

Another change appearing at this time in the large state hospitals was geographic decentralization. This procedure, which initially began as a change focused on administrative admissions procedures, was eventually to have a significant effect on the role of mental patients and their communities. Through this new administrative procedure, patients were placed in hospital wards based on their place of residence prior to admission. Patients were housed and treated with other patients from their own community rather than dispersed throughout the hospital system. Prior to this change, state hospitals generally remained isolated and removed from the communities they served. Through geographic decentralization, communities became more aware of the patients residing therein. Many problems have resurfaced regarding this issue, as many communities have openly voiced fear and dissatisfaction with having mental health facilities or programs located within their borders.

The Community Mental Health Movement

The 1960s were an important era for the field of mental health. Many professionals have in fact referred to this decade as the third mental health revolution (Hobbs, 1964; Wahler et al., 1972). The changes occurring in this period marked another significant shift in human services philosophy as characterized primarily by the community mental health movement.
To appreciate more fully the sweeping changes advocated by the community mental health movement of the 1960s, one must look at the various issues that preceded this movement. The community mental health approach came into being as a result of a growing disenchantment with the traditional large state psychiatric hospital system of the 1950s. Many reformers pointed to what they perceived as the failings of the existing system. Here are some of their criticisms of the traditional system:

1. The traditional system focused exclusively on the treatment and rehabilitation of existing mental illness rather than on the prevention of mental illness.
2. Many of the state psychiatric hospitals were too far away from the communities in which their patients resided.
3. Services were fragmented, with poor coordination between hospital and community agencies.
4. The traditional system emphasized long-term individual therapy to the exclusion of innovative clinical strategies, such as outreach programs, crisis hotlines, and family therapies, that might have been helpful to a greater number of individuals.
5. Nontraditional sources of personnel such as generalist human services workers were not being used despite a growing worker shortage.

The Joint Commission on Mental Illness and Health (1961, p. 2) evidenced the thrust of the community mental health movement as it recommended that the objective of modern treatment should be the following:

1. To save patients from the debilitating effects of institutionalization as much as possible
2. If patients require hospitalization, to return them to home and community life as soon as possible
3. Thereafter to maintain them in the community as long as possible

In 1963, the Community Mental Health Act was signed into law. This legislation reflected a growing philosophy that mental health services should be located in the community with the government allocating funds for the creation of these comprehensive community mental health centers. In Chapter 2, we examined the specific services offered by these centers. Deinstitutionalization was encouraged, resulting in a major shift of mental patients from the large mental hospitals to these community mental health centers.

The community mental health movement has its advocates and its opponents. Some assert that, although the number of patients in the large institutions has decreased and the average length of stay has been reduced considerably, the tendency to readmit patients over and over again to the institutions has correspondingly grown (Wahler, 1971). Other watchful observers of the movement have pointed to instances in which patients have been placed in community settings without adequate supervision. Opponents of the movement indicate that the initial community centers often resembled the traditional hospital organization. The difficulty of developing new mental health services grew out of a situation in which the workers were already socialized and evolved from the old hospital system (Perlmutter & Silverman, 1972).
Advocates of the movement point to the healing power of the community and the need to normalize the method of treatment as much as possible. If the goal of treatment is eventually to return the patient to a functioning life in the community, the community must be an integral part of the treatment.

The Advent of Generalist Human Services Workers

Another important development in the 1960s was the formal recognition of the role of generalist human services workers as reflected in the new careers movement. The title generalist human services worker, most recognized and used today, was originally paraprofessional worker in the 1960s. In addition, several other titles were also popular during this period of time, including lay therapist and new professional. The 1964 Economic Opportunity Act and the Schneuer Subprofessional Career Act of 1966 provided the impetus and the government funds to recruit and train entry-level workers for a range of positions within the human services field. These related pieces of legislation, coupled with other antipoverty amendments, created approximately 150,000 jobs for generalist human services workers (Reissman, 1967).

The rapid growth of the paraprofessional movement arose from a perceived worker shortage as the new community health centers sought initially to use personnel in more innovative ways. Albee (1960) pointed out the critical shortage of trained mental health professionals. He predicted an even greater shortage in the future and advocated the creation of a new kind of generalist mental health worker who could be educationally prepared in a shorter period of time. Through the creation of two- and four-year training programs based in colleges, it was believed that aspiring workers could receive enough broad-based education and general human services skills to function on a generalist level alongside the more highly trained professionals. Many of the basic tasks previously performed by psychologists, psychiatrists, or social workers—such as intake interviewing and setting fee schedules—could be delegated to the generalist human services worker, thus freeing the professional to focus selectively on more advanced clinical aspects of treatment and diagnosis that often required more extensive graduate preparation.

Although no single description would adequately encompass the diversity of roles of generalist human services workers, there is agreement on some important common characteristics of the generalist, including the following:

1. The generalist works directly with clients or families (in consultation with other professionals) to provide a variety of services.
2. The generalist is able to work in a variety of settings that provide human services.
3. The generalist is able to work with all of the various professions in the field, rather than affiliating with any one of the professions.
4. The generalist is familiar with a variety of therapeutic services and techniques, rather than specializing in one.

Some of the more common work activities of generalist human services workers include but certainly are not limited to the following:
• Helping clients in their own environments with various services
• Helping people get to existing services (as in simplifying bureaucratic regulations and acting as client advocate)
• Acting as assistants to various specialists (for example, psychiatrists, psychologists, nurses)
• Carrying out activities for agencies and programs such as budgeting, purchasing, and personnel matters
• Gathering information and organizing and analyzing data
• Providing direct care for clients who need ongoing services
• Working with various community groups to create needed programs and develop resources

Since the 1960s, new and expanded roles have been created for generalist human services workers. Gartner (1971), Wahler et al. (1972), and Alley, Blanton, and Feldman (1979), among others, have traced the evolving functions and roles of these workers. The role of the generalist human services worker, once narrowly defined as merely custodial in nature, had grown by the 1970s to include a wide range of therapeutic activities. As Minuchin (1969) noted, the paraprofessional movement initiated a reexamination of professional roles and tasks, which resulted in a renewed interest in environmental factors as opposed to the intrapsychic view of maladaptive behavior. As a result, the human services field of the 1970s through today emphasizes the use of generalist human services workers in roles reflecting the importance of a patient's social and environmental needs.

Chapter 6 provides a closer examination of the diverse functions and roles of generalist human services workers, and Table 3.1 contains a listing of changes in the mental health movement through history.

FUTURE TRENDS

The many tasks and problems facing our human services system today are similar to those faced previously. Poverty, unemployment, and mental illness among other problems, still exist. What is different, however, is that new methods and approaches are needed to deal with them in our highly complex and technological society. Society today is unlike any other in our history. The rate of change is so rapid and the changes so complex that it is almost impossible for anyone to keep pace with those occurring in the field. Technological and social change, although beneficial in certain respects, have also created significant stress, anxiety, and insecurity for many. Along with the trend toward increasing specialization, more and more people find that their previously acquired skills are rapidly becoming obsolete. Although scientific achievements have increased the life span, the continued threat of war and increased terrorism, economic upheavals, the AIDS epidemic, and the massive drug problem as well as other problems, have given rise to widespread concerns about what type of future awaits us and our children.

In an effort to keep pace with a changing society, the human services system must also change and grow. For example, agencies must develop new sources of funding such as grants from government, foundations, and other private groups.
### TABLE 3.1 | HIGHLIGHTS AND LEGISLATION IN THE MENTAL HEALTH MOVEMENT

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>800–1300s</td>
<td>Church becomes major provider of services to the mentally ill.</td>
</tr>
<tr>
<td>1409</td>
<td>Oldest mental hospital still functioning today is established in Valencia, Spain.</td>
</tr>
<tr>
<td>1752</td>
<td>Pennsylvania Hospital for the Mentally Ill is founded.</td>
</tr>
<tr>
<td>1792</td>
<td>Phillipe Pinel, director of a French mental institution, believes the insane might be curable and initiates reforms.</td>
</tr>
<tr>
<td>1800s</td>
<td>Dorothea Dix and other social reformers help to establish the state psychiatric hospital system in the United States. National Society for Mental Illness (Hygiene) is established to study the care of the insane.</td>
</tr>
<tr>
<td>1920–1930s</td>
<td>Freud’s theories concerning human behavior gain widespread acceptance.</td>
</tr>
<tr>
<td>1935</td>
<td>Aid to Families with Dependent Children and Social Security Act.</td>
</tr>
<tr>
<td>1937</td>
<td>First International Committee for Mental Hygiene is formed. Hill-Burton Act provides funds for building psychiatric hospital units.</td>
</tr>
<tr>
<td>1946</td>
<td>National Mental Health Act establishes federal funds to develop training programs for mental health professionals.</td>
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<tr>
<td>1948</td>
<td>World Federation for Mental Health is formed.</td>
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<tr>
<td>1950s</td>
<td>Major advances are made in the field of psychopharmacology.</td>
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<tr>
<td>1955</td>
<td>Congress creates Joint Commission on Mental Illness and Health. This committee evaluates the needs of the mentally ill and seeks to make resources available.</td>
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<tr>
<td>1961</td>
<td>World Psychiatric Association is formed.</td>
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<tr>
<td>1963</td>
<td>Mental Retardation Facilities and Community Mental Health Centers Construction Act is passed. Trend begins toward community care for the mentally ill and decentralization of the mental health system.</td>
</tr>
<tr>
<td>1964</td>
<td>Economic Opportunity Act is passed. Passage of Schneuer Subprofessional Career Act gives impetus and funds to recruit generalists for training in human services and mental health field.</td>
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<tr>
<td>1967</td>
<td>Federal government provides money for the staffing of mental health centers.</td>
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<tr>
<td>1968</td>
<td>Community Mental Health Centers Act provides for comprehensive services for the mentally ill.</td>
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<tr>
<td>1970</td>
<td>Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment, and Rehabilitation Act is passed.</td>
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<tr>
<td>1973</td>
<td>Rehabilitation Act—Access to vocational rehabilitation services for adults.</td>
</tr>
<tr>
<td>1974</td>
<td>Juvenile Justice and Delinquency Prevention Act is passed.</td>
</tr>
</tbody>
</table>
In addition, more agencies are reaching out to attract volunteers to help maintain various programs and services. As indicated in Chapter 7, the shortage of funds has become an increasingly large issue in the early 2000s and will continue into the future. And as our earlier discussion in Chapter 1 indicated, the movement toward privatization of service agencies is yet another trend that continues. Over the past thirty years, with the change from hospital care to community care for the mentally ill, there has been a dramatic increase in the use of paraprofessionals or generalist workers in the human services field. At present, they are the single largest group delivering direct care to the mentally ill. According to the Occupational Outlook Handbook, jobs within the human services field are rapidly growing. The number of social and human service assistant positions is projected to grow much faster than the average for all occupations between 1996 and 2006. (U.S. Department of Labor, 1999). One of the more recent trends, which is likely to continue for quite some time, is the establishment of bachelor’s degree, master’s degree, and doctoral degree programs in human services. Many programs formerly titled “mental health technology” or “mental health assistant” have been changing to adopt the more generic title of “human services.”

Current population trends indicate an increase in immigration into the United States. U.S. Census figures predict that sometime between the years 2030 and 2050, racial and ethnic minorities will become the majority population (Sue, 1996). Our human services system will be hard pressed to meet the needs of this culturally diverse population, many of whom will possess little or no formal education and will see no immediate job opportunities. The great diversity in cultural backgrounds has already initiated many changes in the provisions of services and has caused a reexamination of the role of Western and non-Western helping strategies. Multicultural programs and ethnic sensitivity training are already a part of our current training system and they are

1975  Education for All Handicapped Children Act and Individuals with Disabilities Education Act ensures right to education in least restrictive environment.
1979  Mental Health Systems Act establishes bill of rights for the mentally ill and the right to refuse medication.
1984  Office of Prevention is established within the National Institute of Mental Health.
1986  Protection and Advocacy for Mentally Ill Individuals Act is passed.
1987  McKinney Act created for job training, child care, and literacy programs for poor and homeless.
1990  Americans with Disabilities Act is signed into law. It prohibits discrimination against people with disabilities.
1996  The Personal Responsibility and Work Opportunity Reconciliation Act replaced Aid to Families with Dependent Children.
likely to continue on a larger, more formalized scale in the future. Chapter 5 examines the various issues of multicultural awareness in further detail.

Another important demographic trend is what many gerontologists refer to as “the graying of America.” This refers to the growing number of people 65 years of age and older. Over 15% of the population is currently over 65 years of age and estimates indicate that by the year 2040, more than 25% of the population will be in that category (Harris, 1990). To understand this trend more clearly, consider that there are currently more people living in the United States over the age of 65 than the total population of Canada. The growth of the aged population indicates an increasing need to provide specialized services to meet the physical and emotional needs of later life. Programs for the elderly can include day treatment programs within community mental health centers, programs housed in senior care retirement settings, long-term care facilities such as nursing homes, or a variety of other services offered through senior centers throughout the country.

It is clear that as people live longer, quality of life issues will receive more attention. Thus the growing emphasis on community-based services will continue. Moreover, an increased focus on prevention and wellness rather than the emphasis on illness and treatment will occur. This rise in the elderly population will create an increased need for more people trained to provide service. An increasing number of undergraduate and graduate programs are offering specialized gerontological coursework and internship training opportunities working with the elderly population.

Advances in computer technology have changed our society. Such technology has affected the delivery of human services as well. Human services agencies are turning to technology to help them provide better quality care in a more cost-effective manner. These new technologies have altered the very nature of communication within the field. There is an increasing reliance on electronic mail (e-mail) for immediate discussions and consultations with colleagues in other work-related activities. The Internet serves as an invaluable resource to quickly obtain information or conduct research to aid in planning and implementing programs to help those in need. For example, we are witnessing the growth of counseling online in which people can receive immediate assistance within the privacy of their home.

Computer technology continues to transform information management as all intake interviews, billing, assessment results, treatment, planning, and other client record keeping can be coordinated, stored, and transmitted almost instantaneously. Software programs are now being used for the training of human services professionals. Interactive videos, CD-ROMS, and other interactive multimedia tools can provide specific training in a variety of selected topics. In addition, software programs are emerging for use with clients. These tools are designed to help clients gain knowledge and skills in areas such as parenting, adult daily living skills, vocational skills, or substance awareness and prevention strategies. Very clearly, the need for trained human services personnel with computer technology skills is growing. This issue is certainly multifaceted and complex, but clearly there will be a necessity to retrain workers as their skills become obsolete.
Another very important trend within the field is an increasing emphasis on advocacy and on the need for human services workers to develop competency in the use of advocacy. Advocacy, as we know, occurs on many levels. One can represent a client within an agency in an attempt to gain additional services for the client; represent an agency within the political system to fight for increased funding of social service programs; or lobby for new state or national legislation to benefit an underserved population or group, such as the poor or homeless. As Chapter 5 examines more closely, advocacy work is becoming increasingly vital to this field.

As the human services profession continues to evolve and expand, the need for insuring minimal levels of competency will increase. The National Organization for Human Service Education and the Council for Standards in Human Service Education are two organizations among others, working toward this and other goals. Competency guidelines now exist as do ethical standards of practice, skills standards, and training program approval standards.

Historically, human services have been focused on client populations in need of basic services such as food, shelter, or financial support. As we have discussed, the scope of human services has expanded beyond the goal of providing basic services. Another trend likely to continue well into the future, finds human services programs expanding into corporate America. Employers have recognized that workers who have fewer psychological problems, are more likely to be more effective and productive workers. Industry has encouraged its workers to seek help and has responded by creating employee assistance programs within many large corporations. A variety of services are available to employees that may include drug and alcohol abuse counseling, marital counseling, stress management, and many other types of personal intervention strategies that require trained human services personnel. Human services workers will find increased employment opportunities within this sector.

As the managed care approach continues to dominate the delivery of human services in America, the expanded role of case management will likely increase. More and more human services workers will find themselves functioning as case managers within this diverse service system.

Additional Reading


References


