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Mental Health Administrators' Knowledge and Perceptions of Delivery of Relationship-Based Services

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Abstract

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Dissertation Submitted in Partial Fulfillment
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Abstract

Past research has recommended that clinical mental health (CMHC) administrators employ a relational focus to their work, but little evidence exists that such a relational focus is actually being utilized. Guided by Rogers' principles of client-centered therapy, this study examined whether CMHC administrators possessed the knowledge and attitudes to utilize the recommendation of relational based therapy and whether implementation in the CMHC was feasible. A qualitative multiple case study design was utilized to collect personal interviews with 12 CMHC administrators who could discuss Norcross and Wampold's single recommendation about therapeutic relationships. Results were triangulated with the guide for CMHC financing, namely Rule 132, as provided by the administrators. Thematic content analysis of the data revealed that administrators were knowledgeable and in favor of the recommendation where funding could be provided. However, the administrators considered implementation unreasonable because of regulations, low financing of CMHC services primarily through Medicaid, burdensome paperwork requirements, and limited staff qualifications. Understanding these answers from CMHC administrators within the context and limitations of the CMHC should impress upon lawmakers the need for adequate financing of resources to implement the recommendation, which could result in promoting social change in the delivery of services for mental health.

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Dedication

This dissertation is dedicated to the millions of world citizens who struggle with a mental illness in the hope that all people can truly receive the help they need. Additionally, to the professionals who work to care for all people in need. In this spirit, I stand with them in their valiant dedication, their work, and their fight for humanity to Never Ever Give Up until all people can be healthy, physically, mentally, and spiritually.

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Additionally, I want to acknowledge the people who have crossed my path and have inspired to strive for a better life. This list includes the many teachers over the course of my life that has shaped my life, and my success! Thanks also go to the long list of clients who have trusted me to coach them over the years: those who struggle with mental health issues, whom I have met in the past or will meet in the future, and those whom I may never meet in person. I hope that my work can continue to advance the fight for better mental health care for all people. I will never stop working to advance positive social change for all.

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Chapter 1: Introduction to the Study

Background

Norcross and Wampold (2011) provided 17 recommendations about the manner in which therapeutic services should be delivered, based on a meta-analysis of recent research. However, these 17 recommendations can raise more questions than answers because none of the studies reviewed in the meta-analysis were conducted in the community mental health center (CMHC) setting. In this study, I focused on one of the recommendations in particular, the implementation of which would most likely encounter problems in the CMHC setting. The studies referenced in the meta-analysis explained the benefits of treatment type for patients and compared therapeutic intervention in many research areas. In the current research, I investigated the application of this knowledge through qualitative interviews with CMHC administrators. I explored the knowledge and attitudes of 12 CMHC administrators by discussing one of the 17 recommendations directed particularly at mental health administrators and that intimately affects their work.

I undertook a qualitative, multiple case study with the goal of gaining a better understanding of the administrators' level of knowledge and their perceptions regarding Recommendation 17 by Norcross and Wampold (2011), which states: "Administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations" (p. 100; see Appendix A). I wanted to learn from the administrators of mental health centers what, in their view, would happen if Recommendation 17 were to be implemented in CMHCs.

The therapeutic relationship between client and therapist has a long history; it is repeatedly discussed as a critical aspect in the improvement of clients with mental health needs. Yet, advocacy for clients' mental health needs has always been part of a larger struggle for the mentally ill. The history and the struggle for positive mental health care in the United States dates back to the 1840s (National Association Social Work, 2005). The history of the profession of social work, additionally, is tied to the same fight later in the 1880s, stemming from Dorothea Dix's 1846 advocacy for the mentally ill. Dix's fight originally had the goal of providing services for the mentally ill outside of jail, the only place at the time where mentally ill people were housed. The fight continued and was later taken up by Richmond (1899) who developed the notion of becoming a *friendly visitor*; this became a precursor of the social work profession. The struggle continued, leading to Robinson's (1930) advocacy through which the notion of a relationship with the client developed and critical innovations and social change through better mental health services occurred.

This critical early history laid the groundwork, according to Cutler, Bevilacqua, and McFarland (2003), for what would later become the CMHC, where the poor with mental illness have now for more than 50 years received the help they needed for their disorders. In reviewing the history of mental health care, the growing importance of positive human relationships and proper ethics in human services emerge as center pieces and major goals of the profession of social work (NASW, 2005). Moreover, researchers have studied the therapeutic relationship repeatedly as the main reason for clients' improvement (Wampold, 2001). Yet, within the CMHC, as Cutler et al. (2003) pointed out, lack of funds and proper training of therapists have not only plagued the history of community mental health, but also hindered the desirable focus on the therapeutic relationship (see Appendix D for a short history and development of the CMHC). With this lack of funds and proper training of therapists clearly acknowledged, the questions about how administrators could attend to relationship-based therapy, as suggested by Norcross and Wampold (2011), needed to be researched.

Over the long history and development of the process of psychotherapy, the connection between ethics and building therapeutic relationships rose to increasing levels of importance. Rogers's (1951, 1957, 1961) theories took the process of relationship within the context of psychotherapy to a new level. Rogers worked to develop a new type of intervention by building on human interaction and defining an alliance in therapy. This then became, via Rogers's methods, the humanistic approach to therapy, and patients became clients.

Rogers (1957) discussed his personal belief that it was chiefly through the relationship between the client and therapist that change occurred; yet, he could not prove this as a fact. Rogers discussed the working association between therapist and client in therapy and specified three vital conditions: empathy, congruence, and unconditional positive regard. The goals of treatment can be achieved only, according to Rogers, when these conditions are present. Howard, Moras, Brill, Martinovich, and Lutz (1996) described how Rogers's ideas have led to patient profiling and the development of a focused approach to the therapeutic relationship and how the profession was thereby slowly changed over time.

More recently, Mickle (2012) contributed a discussion of how, through many avenues such as the court case of Wyatt v. Stickney (Alabama, 2012), clients have eventually achieved new mental health rights during the long history of mental health (see Appendix D). However, the one recommendation by Norcross and Wampold (2011) addressed to administrators—Recommendation 17, which is the focus of this study—failed to take into account the historical basis not only of the CMHC but also of the central aspect of the recommendation itself: the therapeutic relationship. I came to realize that the history of mental health and the research conducted along the way cannot be ignored without impunity; to do so will carry the loss of the intense focus upon the needs and the issues that have been established over many decades. I first asked myself whether the notion of client rights could be equated with a demand for the client–therapist relationship if both the rights and the therapeutic relationship are as vital to the clients' well-being as the research and the history jointly seem to imply. Over time, the struggle for mental health services for the poor and the ever-changing focus have shaped the continuous development of the client treatment process, and this history cannot be ignored when one considers the implementation of Recommendation 17.

As the long history of mental health has been unfolding, change has become a constant factor. Cohen (2011) discussed how professionals in the helping professions have struggled to facilitate client services through better relationships and lauded the newest change, which became known as evidence-based practice (EBP). Cohen noted, as did Norcross and Wampold (2011), that EBP has evolved as the latest process of how human service workers such as social workers and counselors engage in helping people in need. Cohen's (2011) research focused on mental health problems from the EBP perspective and the confusion and controversies surrounding different kinds of services.

Cohen (2011) noted that researchers have not placed enough emphasis on the therapeutic relationship between the helping professional and the client; recent research focused instead on developments of EBP and what therapy types could be documented as being effective. Norcross and Wampold (2011) led their conclusions with the idea of a return to relationship first and the component of EBP-related work in tandem with the relationship. This concept, then, leads to the continued need for detailed studies of changes in therapeutic services, as suggested by Norcross and Wampold.

The meta-analytical research by Norcross and Wampold (2011) brought together the notions of the relationship in therapy and EBP based on the studies they reviewed. This combined concept underlined just how powerful one notion, namely the therapeutic relationship, is for success in therapy. The first studies were focused on the ideas advanced by Rogers (1957) and documented an observed therapeutic change happening within the developing connection with a client. These studies surmised that the relationship itself appeared to be the origin of change in the patient, at least in some cases. Norcross and Wampold (2011), in looking at and analyzing the conclusions in these research studies, developed their recommendations for understanding the entire process of therapy. Ultimately, they compiled a set of 17 recommendations, suggesting that their implementation would move therapy forward and result in better treatment outcomes for clients seeking mental health services (see Appendix A for the 17 recommendations).

The current study, as previously indicated, focused on the last of the 17 recommendations made by Norcross and Wampold (2011). Recommendation 17 encouraged administrators of mental health serviced to “attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations” (p. 100). From the study of therapeutic processes that comprise EBP and the therapy relationship, Norcross and Wampold provided the 17 recommendations to answer urgent questions about the ways in which therapeutic services could be positively impacted. It must be pointed out, however, that not one of the research studies assessed the thinking of the people to whom Recommendation 17 was addressed: the administrators charged with making these changes. The main question of this study was how CMHC administrators view Recommendation 17. Exploring the administrators’ reactions to this one recommendation could then serve as a starting point and a template for how the complete set of ideas advanced by Norcross and Wampold might be viewed and addressed within the CMHC setting.

Norcross and Wampold (2011) arrived at their conclusions and subsequent recommendations by analyzing the results of 11 years’ worth of interdivisional group studies by the American Psychological Association (APA). The focus of Recommendation 17, which I chose for this discussion, focused on the delivery of therapy services. Norcross and Wampold noted in their conclusions that better therapy was due in part to the use of EBP and the therapeutic relationship. This conclusion thus validated what Rogers (1951) was the first to suggest, namely that it was the relationship built with the clinician that produced beneficial results in the client. This idea provided in the background literature ultimately led to the formulation of Recommendation 17. In fact, the notion of therapy-relationship practice has been portrayed as one of the leading factors on the list of ideas the authors compiled to bring about better therapy outcomes.

As I will discuss in the literature review chapter, the research analyzed by Norcross and Wampold (2011) did not include the unique setting of the CMHC. The current study, therefore, sought to add to the discussion regarding the improvement of mental health care by focusing on Recommendation 17 from the perspective of the CMHC. Moreover, with this study, I was able to expose a wide gap that exists between the reality of the CMHC setting and the system of care required for offering the help recommended by Recommendation 17 to the people who need this kind of help (i.e., relationship-based care) the most.

Cutler et al. (2003) identified issues encountered in the CMHC with this type of care and described problems encountered over the decades of development and implementation of CMHC. Cohen described issues of recent origin involving social workers, their ethics, and the services they provide. Cohen also noted how these services directly influence the everyday lives of the people they touch. The information provided by Cohen, however, was too broad to be useful for the current study, but it did point out some of the deeper and ongoing issues regarding this topic within the CMHC. The Cohen study, thus, provided the impetus and the need for developing the minihistory of the social work profession that is enclosed in Appendix D. This history and Cohen's ideas have further provided insights regarding these services: how they are laid out, why there is a push for an EBP model, and why emphasis on the relationship with the client is absent.

The NASW Office of Social Work Specialty Practice (2005) noted that the policy for social work is to promote EBP, and the NASW (2008) code of ethics emphasized that the ethical manner of delivery is of the highest importance. All of these notions are based on large areas of individual disagreements and open discussions, which were found to be entirely absent from the studies upon which Norcross and Wampold's (2011) Recommendation 17 is based. These considerations prompted me to conduct this multiple case study under the auspices of Walden University to provide CMHC administrators with an opportunity to delve into their personal knowledge and air their perceptions regarding the possibility of implementing Recommendation 17 within the CMHC setting.

Throughout the written history of the NASW, in the social workers' code of ethics, and now additionally in the National Organization for Human Services (NOHS) code of ethics, human relationships have been a key focal point (Wark, 2010). From the viewpoint of the NASW (2008) code of ethics, social workers have an obligation to deliver services from the perspective of human relationships. The current study, therefore, begins with exploring and reflecting the CMHC administrations' thinking regarding Norcross and Wampold's (2011) Recommendation 17 and contributing thereby to the ongoing discussion on improving mental health services. By attempting to close some potential gaps in the administrators' thinking, I am also providing information about some of the perennial questions regarding the therapeutic relationship in order to promote the provision of research-based, relationship-centered services (Norcross, Hogan, & Koocher, 2008). The data compiled in this study revealed large gaps and challenges faced by CMHCs, which are not only old themes, experienced throughout the history and development of the CMHC, but themes that are fresh and current because they remain unsolved to this day.

In summary, I used a qualitative, multiple case study to bring about a deeper understanding (as explained by Patton, 2002) of one of the recommendation made by Norcross and Wampold (2011) through interviews with 12 administrators. I discuss the research questions about Recommendation 17 guiding this study in detail in Chapter 3. I fully expected from the outset that many more questions would surface as the interviews unfolded and the opinions of those most affected by the recommendation became known. This was indeed the case. My goal for this study was to deepen the understanding of what was entailed by moving the recommendation forward.

The clients of the CMHCs are not in a position to avail themselves of private counseling. To appreciate what this means, social workers must recognize the full history of mental health care and the people who are in need of such care, as documented in Appendix D. In addition, social workers must be cognizant of problems that exist with funding, an issue that has grown within the CMHC over its history. The services intended to be rendered by the CMHC, which was built to serve the poor, are today in danger of being lost as history repeats itself and more individuals with mental health problems are, once again, served in the nation's prisons rather than in their communities (Fallon & Rearer, 2011). This is where clients were housed in the days before Dorothea Dix started her asylum movement. However, if there is a manner of saving the CMHC and providing improved services through relationship-based therapy, then all means should be explored, including the implementation of Recommendation 17. In this research, I chose as the beginning step an exploration of the level of knowledge and the attitudes displayed by CMHC administrators vis-à-vis Recommendation 17 to determine if both were sufficient and promising for ushering in a positive change.

This research and its conclusions focused on a better understanding of whether the level of knowledge and the attitudes displayed by CMHC administrators, with respect to the recommended change in focus toward the therapeutic relationship, would be sufficient and favorable for a successful implementation. In considering the implementation of Recommendation 17 in their CMHCs as of today, the administrators' reactions came as no great surprise. Their answers were the same as those provided throughout the history and development of the CMHC whenever a change for the better was envisaged, but this history had not been taken into account by the authors of Recommendation 17.

Problem Statement

Norcross and Wampold (2011) put a recommendation that administrators of mental health centers concentrate on making changes toward the synergistic aspects of the client-therapist relationship. There are two problems associated with this recommendation. The first problem is that the recommendations were not based on input from the people whom the recommendations were meant to help. The second problem is that the CMHC is already beset with its own internal problems. Research by Cutler et al. (2003) showed that this system of care for the mentally ill was designed as a different type of care from what is available in the private sector. A critical lack of training and understanding was evident among the personnel (i.e., the therapists who actually provide the services within the CMHC) about what a clinical relationship is and what it is meant to achieve. I asked the administrators who, with few exceptions, demonstrated their knowledge and understanding of the therapeutic relationship, whether such relationships could become part of what was offered in their CMHCs, or whether they considered this idea rather impracticable. I began by asking if Recommendation 17 was now or could ever become viable within the CMHC setting, as such input had not been sought before this advice was formulated by Norcross and Wampold (2011). Moreover, I presented my questions to assess whether Recommendation 17, which I had chosen as the focal point for this study, would be useful within the CMHC setting. The care provided in a CMHC was shown to be a different type of service than what a client could expect to receive from a private agency; as the history showed, the CMHC was developed over a long time period to serve the poor who are mentally ill within their communities, as opposed to in jail or asylums. The studies reviewed by Norcross and Wampold (2011) for their meta-analysis differed in focus from studies that were conducted within a CMHC setting with its unique clientele and set of problems. Norcross and Lambert (2010) further stated that many factors are necessary for a successful therapy, and one of them is the relationship that develops between client and therapist. However, I show in the literature review chapter that the *therapeutic alliance* with its current focus on EBP moves away from the relationship-centered approach in the CMHC setting (Cohen, 2011).

Cutler et al. (2003) and Alimohamed-Janmohamed, Charvat, Gheytanchi, Beutler, and Breckenridge (2010) highlighted issues relevant to the developmental history, the training of therapists, and the current financial situation of CMHCs. These researchers exposed a view of the CMHC that showed that the services were insufficiently developed with respect to clients and the training of human service workers handling the clientele. Norcross and Wampold's (2011) Recommendation 17 conflicted with Cutler et al.'s (2003) portrayal of the CMHC, which raised a number of fundamental questions regarding the state of basic knowledge and attitudes held by administrators with respect to relationship-based services.

Questions regarding Recommendation 17 remain. First and foremost was the question whether implementation of Recommendation 17 would be financially feasible within CMHCs. Norcross, Hogan, and Koocher (2008) raised an important point: namely, what worked was a relationship-based therapeutic service with proper assignment of the client to a therapist. However, the administrators interviewed explained why the latter may be a problem for the clients at the CMHC, and that the finances to implement these ideas are simply not available, as shown in the interviews. The problem to be solved by this research was to bring clarity to the questions: Can CMHC administrators foresee that the principal idea of Recommendation 17, namely to provide relationship-based therapy, will be implemented in the CMHC setting? Are CMHC administrators knowledgeable about and receptive to the idea of relationship-based service delivery? What adaptations to Recommendation 17, if any, would make implementation of the recommendation feasible?

Nature of the Study

With this qualitative, multiple case study, I sought answers to questions about the feasibility of implementing one of Norcross and Wampold's (2011) recommendations in the CMHC setting, chiefly: What was the basic knowledge and perceptions of CMHC administrators regarding the delivery of relationship-based services? Through the research strategy of a multiple case study, I collected the data through face-to-face interviews with CMHC administrators and verified the information obtained by reviewing Rule 132 (Department of Health and Human Services, 2013). I also took notes in a personal journal during and immediately following the interviews to record fleeting thoughts and nonverbal communications on the part of the respondents.

I conducted this research as an empirical inquiry to investigate the phenomenon of Recommendation 17 and its potential impact within a real-life context (Yin, 2009). The perceptions and the state of knowledge present in the CMHC administration regarding Norcross and Wampold's (2011) recommendation were the focus of the inquiry. I conducted the interviews at six CMHC sites, spread through northern Illinois. Participants at each site were the executive director and the clinical director. These administrators reflected on personal experiences, knowledge, and attitudes they held and that are directly related to Recommendation 17. Exploring this recommendation in a real practice setting helped to determine the viability of the recommendation and its practicability within CMHC settings.

Research Questions

The central research question was what the CMHC administration knew about and understood with respect to the Recommendation 17 made by Norcross and Wampold (2011). Recommendation 17, the only recommendation chosen as the focus of this study, notes that “administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations” (p. 100).

The research questions posed for the study were as follows:

1. How will this recommendation to administrators be viewed by the CMHC administration?
2. What would make this recommendation to be considered viable by administrators within a CMHC setting or, conversely, not viable?
3. What is the current level of administrators’ knowledge of and attitude toward the delivery of evidence- and relationship-based services?
4. Do the administrators anticipate that there would be financial costs involved in attending to the relational features of service, as Norcross and Wampold recommended, and can the administrators calculate such costs?
5. What ideas and perceptions will administrators within the CMHC relate regarding the training of therapists and the financial costs of following through with this recommendation?

Research Objective

The objective of this research was to assess the degree to which administrators in the CMHC have experience with aspects of relationship-based therapy and the extent to which they believe that these principles are relevant to community mental health services. I selected Recommendation 17 by Norcross and Wampold (2011) as the focus for this study. The research strategy was to conduct an empirical inquiry to investigate the experience of administrators with respect to Recommendation 17 and their views on the applicability and feasibility of implementing this recommendation within the real-life context of the CMHC setting.

Purpose of the Study

The purpose of this qualitative multiple case study was to discuss Recommendation 17, formulated by Norcross and Wampold (2011) and based on their meta-analysis of studies conducted under the aegis of the APA, with administrators at whom this recommendation was directed. I explored how these administrators perceive the appropriateness, as well as the feasibility, of following through with this recommendation in the CMHC setting. I sought to determine the level of knowledge and experience of these administrators relative to the area of relationship-based therapy and how they understood the concept of applying these principles within a CMHC. I also explored what obstacles these administrators might see for implementation and how they thought such obstacles could be overcome.

The results indicated that CMHC administrators considered Recommendation 17 unreasonable with respect to CMHC services. Determining their level of knowledge and attitudes about relationship-based therapy was an important first step in starting a dialogue regarding Recommendation 17. A logical second step was exploring the administrators' thoughts regarding practical aspects of the actual implementation as suggested by the authors. Further questions emerging during the interviews were explored as follow-up questions during the interview process, the main purpose of which was, however, to determine the CMHC administrators' level of knowledge and attitudes with respect to the recommendation of providing relationship-based therapy.

Conceptual Framework

The current study was both necessary and timely because of the recommendations made by Norcross and Wampold (2011) for relationship-based services, based on their conclusions drawn in a meta-analysis of 11 years' worth of studies conducted under the aegis of the APA. The meta-analysis led the authors to conclude that therapeutic relationships as practiced in a variety of settings are a key factor in bringing about positive change in mentally ill clients. A big drawback of this meta-analysis, however, was that none of the studies included in the meta-analysis were conducted in a CMHC setting. A unique feature of the current study is that it sought to expand the understanding of these concepts by exploring their applicability within the CMHC setting—a setting that, based on its long history and development, must deal with the care of a unique clientele, which tends to be characterized by a lack of financial resources and private health insurance. Beginning with Dix's (1843) struggle to rescue these patients from their jail cells and leading over many years to the eventual establishment of the CMHC of today (see Appendix D for a brief history of mental health, social work, and the CMHC).

Another cornerstone of the conceptual framework of this study was the seminal work by the theorist Rogers (1951, 1957, 1961), who promoted the person-centered approach to therapy. A main feature of Rogers's person-centered theory was self-exploration and inquiry developed in therapy based on the relationship with the therapist. Rogers's work contributed to the ideas of many of the studies Norcross and Wampold (2011) reviewed to reach the conclusion that a relationship with a therapist is at the heart of change within a client, and should be promoted. The idea of relationship-based services, as Rogers began a debate about, was part of the interview questions asked of administrators.

Definition of Terms

The following terms are defined as used in this study:

Attitude: How CMHC administrators consider the idea of relationship-based service delivery to clients, as recommended by Norcross and Wampold (2011).

CMHC administration: Persons who are the principal drivers of the policies and decision making in an agency known as a community-based mental health center, or CMHC (Association of Community Mental Health Authorities of Illinois [ACMHAI], n.d.).

Community-based mental health center (CMHC): A decentralized center, located in the community, that provides services for persons with mental illness to deflect the need for inpatient care (ACMHAI, n.d.).

Evidence-based programs and practices: Theories and practices that have been tested and show positive change in clients (APA, 2006).

Knowledge level: The assessment of what information CMHC administrators possess regarding relationship-based services, as defined by the APA (2006).

Relationship-based services: Services that focus on the relationship developed between a clinician and client prior to and during the first phases of a therapist–client interaction (APA, 2006).

Therapeutic alliance: A therapeutic alliance refers to the level of positive relationship that is built between a helping professional and the client (Wampold, 2001).

Scope, Assumptions, Limitations, and Delimitations

The scope of this study was CMHCs in northern Illinois and the current administrators of these centers. One of the administrators was a business major with an MBA, not a clinician; the other participants had various lengths of experience as clinicians or counselors, mostly within the CMHC. Their knowledge level and theoretical understanding with respect to relationship-based services and EBP varied by their educational background. At the outset, I assumed that the administrators possessed sufficient knowledge to understand the questions regarding relationship-based services. I also assumed that they understood what the implementation of such services in their agency might entail. I further assumed that the participant–administrators would react candidly and provide honest answers to the interview questions (see Appendix B).

Limitations in any study derive from the integrity and sensitivity of the researcher. Upholding ethical standards in a study could be considered as enforcing certain limitations on the questions that can be asked, which might affect reliability, legitimacy, and construction of the study. Stake (2010), however, noted that a decidedly ethical point of view should be considered a strength of the study, not merely a limitation with respect to content. To maintain high ethical standards, I conducted a pilot interview that I then reviewed with my dissertation committee prior to conducting the full battery of interviews. The pilot interview helped guide positive interview questions for future interviews. I describe the pilot interview in detail in Chapter 3. Furthermore, I address each limitation within the detailed research plan.

Delimitations of this study are factors that I, as the researcher, could not control or predict. I planned to explore one of Norcross and Wampold's (2011) recommendations with CMHC administrators. At the planning stage, I considered that some CMHC administrators might not know about or understand what the chosen recommendation entails; this limitation turned out to be a point in fact in only one of the 12 cases. In this research, I focused on the administrators' knowledge, perceptions, and honestly described attitudes regarding relationship-based service provision in their own agencies. Individuals interviewed in a future study might provide different answers to the same set of questions. Paramount in my mind, however, was to start a dialog regarding Recommendation 17, and the first step was to assess what the administrators knew and how they felt about providing relationship-based services in the CMHC agencies they were directing.

Significance of the Study

By investigating first the knowledge level and the attitudes of CMHC administrators with respect to Norcross and Wampold's (2011) Recommendation 17 and then discussing with administrators what steps would be necessary if this recommendation were implemented in their CMHCs, I can begin a path of full understanding. Although the administrators rejected the feasibility of implementation, they demonstrated both knowledge and a basic openness for the concept of relationship-based services. The significance, therefore, of this study is that it helps to start a dialog among the administrators who are the decision makers in a system that has grown to provide the largest proportion of mental health services in the United States today (Cutler et al., 2003). After having achieved this important step, the results of the study will serve as a launching pad for propelling the Norcross and Wampold (2011) recommendations forward and translating them into actions for the betterment of the lives of the mentally ill.

Chapter Summary and Overview of the Study

By adopting EBP, where the evidence shows positive improvement in clients based on demonstrable facts, a change in focus of service provision has occurred (Cohen, 2011). In a meta-analysis of research completed over the previous 11 years under the auspices of the APA, Norcross and Wampold (2011) offered 17 recommendations for achieving better therapy outcomes. One key idea was the development of the therapeutic relationship as a focus of EBP, begun even prior to the start of therapy. Human relationships in therapy are governed by the standards of ethics of a social worker's practice. In this study, I explored the feasibility of implementing one of these recommendations within the CMHC setting and what might be possible roadblocks for the adoption of these recommendations.

In this chapter, I provided the background of the problem and the problem statement. I described the nature of the study and the conceptual framework, which is closely linked to the history of social work and the development of community-based services for poor, mentally-ill persons. I provided the research questions guiding the study and discussed scope, assumptions, limitations, and delimitation. I also provided definition of terms and described the significance of the study.

In Chapter 2, the literature review chapter, I will show that the notion of relationship between clinician and client or the uses of EBP are frequently topics of controversy. Yet, Recommendation 17 by Norcross and Wampold (2011), based on the conclusions reached in their meta-analysis, advised that administrators of mental health services adopt precisely these seemingly controversial practices. Not only was this research into the knowledge and attitudes of mental health administrators thus necessary and timely, but the research questions themselves were derived from the reviewed and often conflicting literature and even from literature that was highly critical of the CMHC and its administration. Norcross and Wampold themselves maintained that a serious gap in understanding of these issues existed.

In Chapter 3, I will describe the research methods used in this multiple case study and show how the process of triangulation through expert review provided quality and credibility in this research. As the research unfolded, the potential for social change became increasingly apparent, as shown in Chapter 3. I present the data analysis and validation strategies as well as ethical considerations and measures taken for the protection of the participants' rights. I present the results of the study in Chapter 4 and conclusions based on the findings in Chapter 5. Finally, I offer recommendations in an effort to move the discussion of Norcross and Wampold’s 17 recommendations forward and, perhaps, add a new chapter to the valiant history of CMHC services for the poor.

Chapter 2: Literature Review

Introduction

Norcross and Wampold's (2011) Recommendation 17, which was the focus of this research, is a recent publication, and therefore, the recommendation has not yet been tested. The notion of relationship-based therapy, however, is not a recent phenomenon; it is rooted in Roger's (1951, 1957, 1961) seminal work. Furthermore, not one of the studies analyzed by Norcross and Wampold had been conducted in a CMHC setting, which made it especially appropriate to explore this recommendation from the perspective of the CMHC administration. These recommendations provided the impetus to undertake this multiple case study. The literature review chapter provides useful information about past research and sheds light upon the feasibility of implementing the recommendations in CMHCs. By reviewing the literature pertaining to EBP and the importance of relationship-centered therapy, I was able to show why it was critical to examine the Norcross and Wampold recommendation with respect to the CMHC system. Moreover, it was important to consider how the development of the profession of social work and its history are bound to affect the feasibility of implementing this recommendation. Because Norcross and Wampold had not sought the input of CMHC administrators before formulating their recommendations, a knowledge gap existed, which this study attempted to bridge.

Key Search Terms

Key search terms used in the literature search were as follows: *evidence-based practice, relationship-based services, Norcross and Wampold recommendations,* *community mental health, community mental health financing, Watt v. Stickney, deinstitutionalization, person-centered approach, right to mental health treatment, attachment theory, mental health recovery model, direct social work practice, social work theory and skills, social work history*, and *mental health history*.

Literature Review

The literature describing the history and policies of mental health care in United States documents the conceptualization, development, and financing of services over the last 170 years, leading to the development of a system of care known as community mental health. From Cutler, Bloom, and Shore (1981) to Cutler et al. (2003) and Cutler and Huffine (2004), a plethora of research exists about the history and development in the mental health field, the concept of the CMHC, and the reasons for the establishment of this type of care. The CMHC is, as Cutler et al. (2003) noted, often a different type of service for a unique clientele that is different from what might be seen with clients who are able to pay for their care through private insurance or private means. The history and development leading to the establishment of the present-day CMHC are broad and profound, and retelling them would exceed the framework of this chapter. They are, however, essential for understanding the vision, the goals, and the neverending struggle of the champions of mental health services for the poor; they are, therefore, included in Appendix D.

Progress through research has resulted in many new concepts, and the provision of mental health services is no exception. EBP is a relatively new concept for providing therapeutic services to clients, and many questions remain unanswered regarding EBP and the causative factors of the curative relationship (Norcross & Wampold, 2011; Wampold, 2001). A review of EBP and the existing research prompted Norcross and Wampold (2011) to put forth their recommendations. Recommendation 17 for relationship-based services provided the impetus for my study, which explored administrators' perceptions regarding the recommendation and its design and the feasibility of implementation within the framework of today's CMHC. In this study, I sought to ascertain whether Recommendation 17 would be embraced by the CMHC administration as recommended and whether it could be disseminated to CMHC workers who are providing therapy to a special clientele.

Cutler et al. (2003); Adler (1977); Agnew (2004); Axinn and Stern (2008); and Auxier, Farley, and Seifert (2011) discussed the history and social policy of the poor and underserved populations over time. The struggles and, indeed, the fights that led to the development of CMHC services had to be repeated over and over for many decades, as these studies pointed out. Studies by Kliewer, McNally, and Trippany (2009); Koizumi, Rothbard, Smith, and Mayer (2011); and Lopez and Basco (2011) focused on the central idea of the CMHC and the implications of contrasting ideas advanced by people who did not understand the unique challenges faced by the CMHCs. These authors emphasized the critical importance of the administrators' input regarding research. They insisted that, as the drivers of policy, the administrators must be part of the research, or CMHC services intended for the poor will once again fall short of their goals and disregard the rights of the poor for effective mental health care.

Since the time of its inception by Dix (1843), community-based service rather than jail has developed (in its present form as the CMHC) into the largest provider of mental health services across the United States, noted Cutler et al. (2003). Since the 1980s, therapeutic services have been included as a concept separate from medication needs, which was not part of the original idea regarding these centers (Cutler et al., 2003). Over time, the formulation of social-worker ethics and changes in client rights helped to shape the concept of therapy delivery within these centers. Additionally, in recent years, EBP had become best practice for the delivery of services and part of the solution to providing mental health care services to clients (McNeill, 2006). As CMHCs became the primary way for the poor to receive mental health care (Cutler et al., 2003; Feldman, 2003; Stevens et al., 2011), it became critical that these concepts be well-understood; they are the foundation and justification for the help provided to the clients in need of these services.

Norcross and Wampold (2011) emphasized in their recommendations one particular concept for the process of therapy, namely, the development of a positive relationship between client and therapist. The literature over the past 50 years, ever since Rogers's (1951) seminal work, has backed up this idea (see Appendix D). Lacking in the literature, however, was any evidence of relevancy of the Norcross and Wampold (2011) recommendations and the ideas they promulgated for service delivery within the CMHC. The critical question became: Will CMHC administrators be open to the implementation of these recommendations and promote the provision of mental health services through therapeutic relationships in the CMHC setting? In reviewing the literature, I point out gaps that must be bridged before Recommendation 17 can be put into practice within the CMHC.

In the planning stages of this study regarding implementation of Recommendation 17 in the CMHC setting, my fear was that CMHC administrators might not be knowledgeable enough even to consider relationship-based services for their agencies with a positive attitude; however, in this assumption, I was mistaken. Not only were the administrators who participated in this research able to discuss this concept knowledgeably from an historical perspective, but they were also quite favorably disposed toward it. They were, however, as predicted, unanimous and quick to point out that CMHCs lacked the necessary financing to even consider the idea of implementing this recommendation. The participating administrators considered Recommendations 17 as it was stated completely irrelevant for the CMHC setting.

The provision of mental health care services developed over a number of stages since the idea was first put forth in 1846 and subsequently developed into the community care of today. Community care for mental health can be seen in various proposals since the time of the Civil War (Cutler et al., 2003; Goldman & Grob, 2006; Snow, Newton, & Task, 1976). Policies and financing of mental health care, which came into being after the development of the CMHC, contain other important aspects. Rules were established owing to court oversight. The need to follow these rules for service provision and financing became extremely time-consuming, burdensome, and costly, though. Most of the research reviewed in this chapter was published after the establishment of the CMHC; yet, a closer look at the history and development of mental health services is necessary (see Appendix D) to expose the critical lack of understanding, so prevalent today, of what the mental health client served in the community by the CMHC is truly facing day in and day out.

The foundations of the client–therapist relationship, as seen in the seminal work of the theorist Rogers (1951, 1957, 1961), represented an original approach that led, over time, to the current person-centered theory. The person-centered theory of Rogers is thus the conceptual framework of this study and guided the development of the interview questions (see Appendix B). His professional history showed how Rogers came to understand the importance of attachment in human relationships and how the notion of attachment relates to the therapeutic alliance. Consideration of these historical developments suggested relevant questions for this study. Moreover, I will explore the standards of professional ethics that were developed for the profession of social work.

Evidence-Based Practice and Therapy Relationships

Research about evidence-based therapy relationship does not lead as far back into past as does the history of mental health concepts. Luborsky, Singer, and Luborsky (1975) were the first to renew the argument of the Dodo Bird verdict, which had been discussed for some time. Years later, Duncan (2002) tried to renew the debate; he considered the Dodo Bird effect prophetic for psychotherapy as a measurement of change. Duncan noted that Rosenzweig’s (1936) Dodo Bird effect, even with the revival of the idea by Luborsky et al. (1975), had not gained the attention it deserved. Research in the current era seems to forget these seminal studies. Yet, the ideas of past historical theories such as the Dodo Bird verdict are relevant to Recommendation 17.

Wampold (2001) picked up the Dodo Bird verdict and applied it to therapy. He noted that psychotherapy is a unique and delicate process and that the therapeutic alliance has been shown as one the predictors of outcome, regardless of the method used. Wampold further discussed the research of Rogers (1951, 1957, 1961) and how Rogers developed his ideas of the client–therapist relationship and his simple conditions for change. Wampold (2001) also discussed EBP in combination with relationship-based therapy and showed that Rogers's concepts were, indeed, validated by research over time.

McNeill (2006), however, pointed out that, while the importance of relationship was expounded in the literature, the training of social workers has not kept up with these ideas. McNeill suggested that, while the social work profession was founded on helping clients through relationships, the EBP focus has forced the profession to train on interventions rather than on the all-important therapy relationship. It appears that, over the last few years, the treatment focus has been intervention-related and based on EBP skills and not on relationship development.

Cutler et al. (2003) discussed what was later echoed by McNeil (2006), namely, that from the inception of community-based therapy, workers' skill improvement lagged behind in the CMHC and its service delivery. Researchers have studied the therapeutic alliance for many years, involving therapist-matching and prescriptive psychotherapies with great success (Wampold, 2001). Now, the newly formulated recommendations by Norcross and Wampold (2011) aim at providing relationship-based therapy, yet the history and development (see Appendix D) indicates that the idea may not work within the CMHC as suggested.

Kaut and Dickinson (2007) noted that, in the late 1970s, social workers became the primary providers of psychotherapy services as the complexity of working with clients in both the biological and the psychological practice of mental health changed once more. Raines (2004) discussed the characteristics of social workers who practice from the EBP perspective and how they provide ethical services. Research produced over time documented that such rapid changes in therapeutic practices will lead to confusion.

Faust (2008) argued that social workers were the needed advocates for mental health, but that their calls went unheeded in the era of EBP. This information revealed that these social workers wanted to place the client’s interests first, that is, the developed relationship and not merely the focus some EBP. However, EBP has also been credited with emphasizing more humanistic methods (Farber & Doolin, 2011). Much of the research is contradictory and can be confusing when it tries to determine whether an evidence-based intervention or the relationship-based delivery caused a change in the client. EBP methods tend to be systematic and purposeful and, at the same time, eclectic in their choice of therapeutic approach. Norcross and Wampold (2011) recommended one specific aspect of EBP, namely, the therapeutic relationship. What remains to be seen is how the CMHC will face the challenge of bringing together the ideas of evidence-based intervention and the therapeutic relationship, given the current conditions of its setting and the insufficient preparation of its personnel.

Spencer, Dietrich, and Slocum (2012) described how evidence-based medical treatments were used for the management of problems for which empirical evidence existed. Spencer et al. discussed the term *evidence-based* and how it had been debated over time. As the term became popular through its use in medical practice, other professions began to use the phrase and the ideas behind it as well. Spencer et al. named dentistry, nursing, education, and other disciplines as professions that have adopted the term, while Wampold (2001) argued that the one idea in EBP that has been steadfastly missed throughout the history of psychotherapy was the critical factors associated with the relationship between clinician and client.

Reandeau and Wampold (1991) began to discuss the evidence in EBP and noted that it lacked relationship as the key component of effective therapy. Wampold (2001) wrote that the evidence was focused on interventions that worked over a long period; nevertheless, they missed one key factor, namely, that the study of interventions took no notice of the person or the relationship with the person who delivered the intervention. As I will discuss later, Norcross and Wampold (2011) reviewed 11 years' worth of APA-sponsored studies in their meta-analysis, looking for evidence that the therapeutic relationship was a critical aspect of the change in the client's condition. Many APA-sponsored research projects, thus, culminated in the recommendations provided by Norcross and Wampold (2011). Years in the making, Recommendation 17 was built on strong ethical principles. However, as previously mentioned, lacking was recognition of the fact that the CMHC setting and its type of clientele are rather unique. These services were set up for clients who might otherwise be institutionalized, as was the case in the past. However, thanks to the creation of CMHC services, these clients can now be served in the communities where they live and work and may have the support of family and friends. What are lacking in the professional literature, however, are studies that explore if and how the newest of the EBPs, relationship-based practice, can be utilized for the benefit of the CMHCs unique clientele. It is to this need that the current study addresses itself.

The Norcross and Wampold Study

Norcross and Wampold (2011) advanced 17 recommendations based on their meta-analysis of APA-sponsored research studies. These studies were conducted in the areas of individual and group therapy, as well as adult, couples, and child therapy. Setting was not one of the concepts researched, as for example, the CMHC setting. The ideas advanced by Rogers (1951,1961) were some of the main concepts researched, including empathy, congruence, and genuineness. Additional research exists that examines adapting the relationship to the individual patient. The list of areas and the types of therapy upon which the recommendations by Norcross and Wampold (2011) are based is impressive. However, the main failing, from the point of view of the current study, is that the CMHC setting, its type of clientele, and their specific health issues were not taken into account.

Norcross and Lambert (2011) noted that they used “20+ meta-analyses” (p. 1), which represented various studies over time, and all showed consistent findings about the developed relationships between client and therapist. The authors stated that relationship in therapy is definitely a large factor, but not the only factor to consider. Norcross and Lambert noted that consistency in the type of therapy is also an important point. Auxier, Farley, and Seifert (2011) expressed a different point of view; they stressed that the CMHC network was developed for clients who presented the special challenges of behavioral health patients. The history and development of the CMHC (see Appendix D) cites other factors that must be considered, namely financing and the training of providers. Auxier et al. discussed the fact that mental health clients are expensive to treat; they pointed to the burdens and financial costs as factors in developing the necessary care to serve CMHC clients.

In recent research, Constantino, Glass, Arnkoff, Ametrano, and Smith (2011) discussed clients and their expectations. Some researchers have reported that client therapist mismatch appears to be a key factor when therapy fails. Constantino et al. pressed the point even further and claimed that such a mismatch causes potential harm. Safran, Muran, and Eubacks-Carter (2011) took this situation another step further and researched how to repair a ruptured alliance. Smith, Rodriguez, and Bernal (2011) studied the importance of culture and its influence on a successful client–therapist relationship. Clearly, Norcross and Wampold (2011) analyzed varied research projects and topics and based their recommendations for effective therapy outcomes on a preponderance of the conclusions reached in these projects: Therapy relationships are key to successful outcomes.

Repeatedly, research on relationships in therapy was able empirically to validate Rogers's (1951, 1961) original theories. Norcross and Wampold (2011) featured research by Burlingame, McClendon, and Alonso (2011), who reviewed ideas of cohesion in group therapy. Elliott, Bohart, Watson, and Greenberg (2011) explored empathy by the therapist, one of Rogers's original ideas. These original ideas advanced by Rogers (1951, 1961) all became factors in Recommendation 17. Moreover, Kolden, Klein, Wang, and Austin (2011) provided afresh the concepts of congruence and genuineness as important points in the service of therapy, which also were points made in support of Recommendation 17. What must be kept in mind, however, is that none of these findings were produced by studying therapeutic services provided in a CMHC setting. This represents a serious gap in the professional literature. As the history and development of the CMHC in Appendix D will show, many critical concepts such as the clients' right to treatment were developed over time (Mickle 2011); yet, none of these many historical highpoints found their way into the "20+ meta-analyses" (Norcross & Lambert, 2011, p. 1), leading to the formulations of Recommendation 17.

In 2001, Wampold initiated a debate by presenting evidence of success of the therapeutic alliance in the hope of inspiring further research. The author noted that in numerous studies the therapeutic alliance was credited with producing favorable results (Gomes-Schwartz, 1978; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Moras & Strupp, 1982; O'Malley, Suh, & Strupp, 1983; Strupp & Hadley, 1979). Based on many years of studying the notion of the therapeutic relationship, Wampold eventually included this idea as the last of the 17 recommendations (Norcross and Wampold, 2011).

Kirschenbaum and Jourdan (2005) noted that, as the use of Rogers's (1951, 1957, 1961) ideas increased, the focus gradually turned away from Rogers's true intent, which was to built up the relationship and observe the conditions he had set forth. Development of EBP led to the abandonment of the notion of alliance by strictly focusing on the therapeutic method, the type of intervention. Spring and Hitchcock (2009) described how developing EBP ideas continued for some time as the evidence, seemingly due to various theories, was studied instead of the concept of relationship. The idea of EBP, also emphasized by Norcross and Wampold (2011), continued to be popular and spawned a great deal of research, which led many to conclude that practice based on evidence was what counted (Wampold, 2001). Wampold (2001) noted that the list of studies was impressive, and it continued to grow. Later, when Norcross and Wampold (2011) conducted their meta-analysis, the overwhelming evidence led the authors to conclude that it was the therapeutic relationship that provided the substrate leading to successful outcomes, which led them to recommend that mental health administrators move these ideas forward. How this important conclusion and the ensuing recommendation by Norcross and Wampold may be applied in the context and with the unique clientele of a CMHC is the topic of the next section.

Development of the CMHC and Current Research

The CMHC was originally conceived as the test of a new theory, known as deinstitutionalization. It led to the policy of community support for the mentally ill in America (Feldman, 2003; Krieg, 2003). The CMHCs were shown to be a win-win situation for everyone: The public stood behind the changes, and the federal government was funding the changes (Krieg, 2003). President Kennedy offered community services, as the 1961 Commission tested and then recommended his programs to provide care at locations right where the people lived in their communities. These tests, however, were not undertaken on a large enough scale. Yet, in 1963, President Kennedy’s proposal and the law further reduced the number of people in institutions by releasing them into community care (Caplan, 1974).

Deinstitutionalization from the asylums increased, as development of care at a community level progressed and became known as CMHCs (Feldman, 2003). However, these developments were in part at the root of what would later lead to the court case of Wyatt v. Stickney, which, in turn, led to the establishments of patients' rights. Mizrahi (1992) noted that, due to this court case, the new and developing rights of the mentally ill rapidly increased. The social policy from asylums to the development of the CMHCs and the right to treatment became the foundation for the delivery of mental health service in CMHCs from 1963 onward (Cutler & Huffine, 2004). The history (see Appendix D) shows that Dix's (1843) actions had led to profound social change and to one formal policy that established the building of asylums for the mentally ill, instead of sending them to jail. Now, the asylums were emptied in favor of community care, in the form of CMHCs.

Auxier et al. (2011), however, published research about the failures of the mental health care system. The authors noted that mental health is the third most expensive health care problem, and a lack of real care has been shown to exist and seems to be accepted in the services provided by the CMHCs. In writing about the importance of attitude by the staff toward recovery of mental health clients, Tsai, Salayers, and McGuire (2011) found that, the focus of proper care as a matter of policy still lacking in the CMHC. Through all the years of development, noted Auxier et al. (2011), the lack of focused ideas and research about what truly helps clients, namely the relationship, has persisted. Moreover, as the need for CMHC services increased exponentially over time with the development of medications, the focus on the therapy relationship has never really taken hold.

In reviewing current research, I did not find a single study examining the recommendations made by Norcross and Wampold (2011) that involved the CMHC. Alternatively, no study was found on how CMHC administrators might view the relationship between therapist and client CMHC care, with the possible exception of research by Abdul-Adil et al. (2010) regarding EBP and the collaboration necessary between researchers and community-based services. These authors pointed out several evidence-based studies and noted the gaps that EBP researchers and scholars researching at universities were finding. Their own research focused on discrepancies between needed clinical services and the ability to deliver and evaluate these services in the CMHCs. The Abdul-Adil et al. study did not focus on the therapy relationship with clients per se.

Studies evaluating the effectiveness of therapy and culture in CMHCs are numerous. Gamst, Dana, Der-Karabetian, and Kramer (2000) noted a positive difference in client responsiveness to therapeutic care when ethnic matches between client and therapist prevailed. The researchers recommended that more studies be conducted to further evaluate and produce clear evidence about cultural needs. In their 2011 study, Koizumi et al. (2011) concurred that cultural needs are a major concern in the selection of a therapist. Bradshaw, Roseborough, Pahwa, and Jordan (2009) wrote about the difficulty in evaluating psychodynamic therapy because the correlations are missing important variables such as cultural responsiveness. Feldman (2003) found that workers lacked the necessary training for both service provision and cultural sensitivity. Feldman further maintained that lack of leadership was the chief reason for these deficiencies.

Gioia and Dziadosz (2008) noted that services in CMHCs did not have the proper focus on EBP, nor did service delivery target the true needs of the clients. These problems were repeatedly discussed as the findings of serious research. Thirty years after CMHC services began, the real problem found by Gioia and Dziadosz involved the administration and its lack of understanding and listening ability.

Numerous authors have related how community mental health was conceived as a test program; however, without being fully tested, it was propelled into full motion by Congress (Cutler & Huffine, 2004; Feldman, 2003). Kliewer et al. (2009) continued to point to the lack of needed funds as the main problem, as the impact of deinstitutionalization was fully felt in Alabama even after Wyatt v. Stickney had laid down the law. Kliewer et al. decried the lack of training and funding combined with a lack of workers. These problems are compounded in services in rural communities. While Feldman (2003) had discussed the lack of understanding and training of the administration, Jameson et al. (2009) related the difficulty of rural communities even to obtain workers. Jameson et al. point to the need for training and empirically supported treatments, but they also noted the lack of funding. Moreover, they found that a positive attitude toward the necessary changes by decision makers was absent.

At this point, some critical questions needed to be asked, such as: How difficult will it be, under these circumstances, to implement Recommendation 17 made by Norcross and Wampold (2011)? These negative research results prompted me to seek more information about how administrators were likely to respond when asked to attend to the relational aspect of therapy. The stalled training of workers, and the perennial financial problems besetting community mental health care were amply discussed in the literature. How these services were developed over many decades, and also how testing of the proposed services in the form of the CMHC was not only inadequate in its scope but prematurely aborted, is detailed in Appendix D.

Carl Rogers and the Path to Person-Centered Therapy

Turner (1996) reflected on Rogers's (1951) thinking regarding relationship in therapy and how Rogers's theories may have influenced the development of future social workers. Rogers first described how he himself had been trained in the unemotional ways of the psychoanalytic perspective, which was the norm in the education of therapists at the time. Private therapists can offer this kind of therapy, and their services are aimed at clients who can afford these lengthy and costly services. Rogers, however, began to diverge from his training and began to discuss his beliefs that the therapist should be an interactive member in the client-therapist dyad. He was convinced that the therapist's optimistic view was necessary for improvement with all clients.

Rogers's (1961) view of therapy was based on his belief in human nature and the self-actualization potential of the person. His premise was that the perceptual reality of a client could be changed through the relationship with the therapist. The core conditions of the relationship that Rogers considered essential for effective therapy were unconditional positive regard for the client, empathy, and congruence. These factors became a natural balance brought about directly through reactions of the therapist. This new and positive interactive viewpoint would help the client to develop solutions through the reflections provided by the therapist, which were generally not accompanied by any direct advice. Recommendation 17 by Norcross and Wampold (2011) goes to the heart of these ideas.

The roots of Rogers's (1951, 1961) person-centered theory are deeply anchored in relationship and humanistic factors of the therapist. Rogers (1961) described how a deep understanding of what was being taught about functional social work at the Philadelphia School of Social Work led his ideas into new directions. This new understanding led to his opposition to what he himself had been formally taught and a realization of the profound effects of human interaction. To develop some manner of relationship with the client became the leading aspect in bringing about change in the client's mental health.

Change for the client, in Rogers's (1951) view, was set in motion at the first interview, which he termed the "therapeutic interview" (p. 131). It is a main point in relationship development. This is the point where the therapist will begin to organize and understand how to help a client and, at the same time, begin to build the needed connection. Rogers found that, during this interview, certain conditions were essential if the client is to helped in the future and positive change is to be achieved. Rogers's original list of conditions was lengthy, and these conditions became the central idea in his research. The original list was eventually pared down and summarized in three conditions: authenticity of the therapist, acceptance, and understanding the client. Rogers (1951) began to develop his theory by focusing on the person in therapy. He also looked to other researchers for help. He endeavored to expand his own thinking through the views and concepts of others. Rogers (1961) discussed his use of other viewpoints and contemporary theories and how he worked to make additional contributions from his personal background and experience.

Over time, Rogers (1961) solidified his ideas and summarized his thinking about the person-centered approach with one word: attitude—that is, the attitude of the therapist. Rogers maintained that attitude starts with the stance of the therapist, and what a therapist needed most of all was respect and a position of reverence for the person. Rogers was convinced that any relationship should begin with respect—a concept harking back to Richmond (1899). Rogers firmly believed in a point of significance and worth in every person, and this was the best way from which to view each person.

Rogers (1951) discussed how vital it was for a therapist to possess the ability to understand a client. The central idea of Rogers's (1951, 1961) person-centered approach was firmly focused on the connection with the client. Rogers wrote about how client and therapist bond in the therapeutic interview. In discussing his views and ideas about this connection, Rogers (1951) fully recognized that creating a positive therapeutic relationship was a difficult task even for an experienced counselor. Rogers wrote that communication between therapist and client would not always be easy because of the way a client may view the therapist and the power discrepancy that a therapy relationship involves. He suggested, however, that, if the client is receptive to the positive attitude and the reflected statements of the therapist, it may help the client to open up about a specific problem. While the central goal for Rogers was to work on developing this relationship, other characteristics had to be present in therapy to create this outlook, and this led to the next condition a therapist will have to establish.

The next stipulation begins with understanding what the client may be experiencing in the therapeutic relationship with a therapist. Rogers (1951) stated that, before moving forward, the therapist needs to pause and ask what the client is feeling in the relationship. Rogers related this notion to understanding what the client had experienced in the therapeutic interview. Rogers's person-centered therapy involved finding a path to the client to help him or her solve problems simply by reflecting them back. The goal here is to help the client realize what the problem is and what the answers might be. Rogers, at times, sought to limit giving direct advice to a client. He also thought that the therapist needed to balance her or his views with the client's perspective and take into consideration what role each of them plays. The expectations of the client led Rogers to declare that perception, positive attitude, and nonjudgmental acceptance are all well and good, but, without knowing what the client is feeling or experiencing, the therapist does not develop the relationship as necessary. Rogers was convinced that an intervention would not succeed unless a relationship could be established that is genuine and positive.

The roots of Rogers's (1951, 1961) person-centered therapy are firmly planted in the therapist's right attitude: The therapist must be nonjudgmental and genuine. Rogers's point of view was that these conditions must not be merely on the surface; the therapist can, at any time, lose the client's respect if he or she acts in a way that is contradictory to the developing relationship. Thus, Rogers recommended that the therapist must be genuine at all times, not merely during the initial therapeutic interview. Rogers's purpose with person-centered therapy was to create a relationship where these conditions were present, so that the client could come to accept the problems and develop the ability to cope with everyday social situations and personal relationships. If such conditions are created, Rogers believed, then the client would be able to face the problems and grow emotionally through therapy.

Viewed together, Rogers's (1951, 1961) ideas of person-centered therapy and the NASW (2008) code of ethics highlight the importance of human relationship as a value for personal well-being. Social workers who work as therapists must uphold this value of the human relationship because it is the medium through which people can change for the better. Rogers's (1951, 1961) reflections about the importance of relationship in therapy have become the primary way for helping the mentally ill. Dignity and worth of the person are values about which Rogers wrote explicitly. Additional ideas comprise service and integrity, which become the path of trustworthiness by which social workers are helping people in need (NASW, 2008). These ideas represent the conceptual framework that will be applied throughout the analysis of themes comprising the knowledge and attitudes expressed by the participants in this study. The way the administrators of CMHCs understand the concept behind Recommendation 17 is the major focus of this research.

Summary

This chapter began with an introduction explaining what prompted me to undertake this study and conduct a review of pertinent literature. I believed that, in basing their recommendations solely on studies outside the CMHC setting, Norcross and Wampold (2011) took a great risk, meaning that these recommendations may not be suitable for use in the CMHC, which today is the largest provider of mental health services in the United States. I thought it imperative to explore the feasibility of implementing the recommendations in CMHCs and to start by assessing the knowledge level and attitudes of CMHC administrators with respect to one of the recommendation, Recommendation 17, which is directly addressed to the administrators and decision-makers of the CMHC system. Both the reviewed studies and the history and development of the CMHC (see Appendix D) revealed that CMHCs experienced frequent financial challenges, that these centers served a unique clientele, and that hiring, training, and retaining properly training workers was a perennial problem. I presented key search terms used for the literature review, and then organized pertinent studies into the following sections: evidence-based practice and therapy relationships, the Norcross and Wampold study, development of the CMHC and current research, and Carl Rogers and the path to person-centered therapy. The chapter concluded with a summary.

In Chapter 3, I present the research method used in this qualitative multiple case study and discuss its strengths and limitations. I describe participant selection; the interviews conducted with CMHC administrators; the interview questions, which were tested, refined, and examined for their suitability to elicit trustworthy data through a pilot interview; and data collection and data analysis procedures. I also discuss validation strategies, the use of a reflective journal, ethical considerations, and the role and background of the researcher.

Chapter 3: Research Method

Introduction

The goal of this research was to close a gap in the professional literature with the hope that this effort would lead to the provision of better service to clients of Community Mental Health Centers (CMHCs) and, thereby, promote positive social change. My immediate goal was to find answers to questions concerning one of Norcross and Wampold's (2011) recommendations, stating that "administrators of mental health services are encouraged to attend to the relational features of those services" (p. 100). As this recommendation was addressed to the administrators of mental health services, I proceeded to interview the executive director and the clinical director of six CMHCs in northern Illinois. Exploring the questions raised by this recommendation and follow-up questions that emerged as the interviews unfolded helped to move the dialog toward implementation and the consideration of next steps necessary for the provision of relationship-based services in the CMHC setting.

The research design, setting, research questions, and data collection and data analysis procedures are described, as well as validation strategies and the role and background of the researcher. Also described are ethical considerations and the measures taken for the protection of the participants' rights.

Research Methods

A qualitative multiple case study was found to be the best method for exploring Recommendation 17 addressed to the administrators of mental health services by Norcross and Wampold (2011). I studied the last one of these 17 recommendation and its implications for the CMHCs. The primary research question sought to assess the knowledge level and attitudes currently in place in the CMHC administration regarding this recommendation for relationship-based services.

The attitude currently held by administrators of CMHCs toward the changes found to be of critical necessity by Norcross and Wampold (2011) was explored to gauge the feasibility of moving forward with this vital idea for improvements in therapy. My primary goal with this multiple case study was to assess the CMHC administrators' knowledge and attitude and explore questions regarding financial implications if this one recommendation were to be followed. In the following sections, I will discuss why this research was both necessary and timely and why a multiple case study was the most appropriate method for finding the answers.

To study the feasibility and impact of this recommendation, I needed to develop relevant questions. I also needed to discuss why conducting face-to-face interviews were the most appropriate method for data collection. It was not possible to perform random sampling, nor could I expect a diverse group of CMHC administrators in northern Illinois to respond enthusiastically to an invitation to participate in this study without a face-to-face approach. Using measurement tools and quantitative methods of data collection were, therefore, rejected in favor of face-to-face discussions and a qualitative approach. Yin (2009) described how quantitative methods would gather information via surveys to result in numerical data. However, pursuing relevant issues regarding the Norcross and Wampold (2011) recommendation could better be achieved with face-to-face, open-ended questions in a conversational atmosphere. Therefore, to answer questions regarding the recommendation from the perspective of the CMHC, qualitative research was the method of choice. I did ask some demographic background question regarding how long administrators had been in practice or what their educational level was to ascertain that the sample of participants presented the kind of variety found among the CMHC administration.

A number of authors explained that, in a qualitative study, the researcher is used as the key instrument for data collection (Creswell, 2009; Gerring, 2007; Merriam, 2009; Stake, 2006, 2010; Yin, 2009). A qualitative method is often used for gathering data in a natural setting. The data is then examined to find patterns in the information obtained such as ascertaining what the administrators, as a group, know and feel about the topic under study. Yin (2009) explained that the participants' meanings and the unfolding design of the process are emergent patterns to be interpreted through a theoretical lens. For this research, the administrators' understanding became the holistic account of their knowledge of the recommendation in light of the history and development of the CMHC.

A phenomenological approach was considered; however, this would entail a narrower approach than a multiple case study could provide. I, therefore, chose to gather information regarding the views of a sample of CMHC administrators to assess what constituted their current understanding and attitude toward Norcross and Wampold's (2011) Recommendation 17. To inquire about both Rogers's (1951) person-centered approach and the recent Norcross and Wampold (2011) recommendation could best be pursued through interviews in a multiple case study approach. Both Yin (2009) and Stake (2006, 2010) explained that a multiple case study allowed turning the relevant focus upon a specific period, so as to take a snap shot of the thinking present. Furthermore, Stake discussed that a multiple case study would permit the researcher to use a conceptual foundation such as Rogers's seminal work to sharpen the focus of the research. I, therefore, provided a conceptual foundation through the literature review of Chapter 2 to sharpen the focus of this study of CMHC administrators' knowledge and attitudes toward the Recommendation 17 and its endorsement of relationship-based services.

A multiple case study was the approach in which the same steps were repeated several times to draw out the meanings in the data (Yin, 2009). The use of a qualitative multiple case study allowed me to gather ideas from administrators during personal interviews in a natural setting. Using multiple sources (i.e., interviews, field notes, and other documents) was also a way to shed more light on the participants' meanings regarding this one recommendation. Keeping an eye on the history and development of the CMHC allowed me to examine the information obtained from the participants in light of the conceptual foundation (Merriam, 2009; Stake, 2006, 2010).

Stake (2006) noted that multiple case study is a method in which the qualitative approach can bring out rich detail, which could best be achieved through personal interviews. Yin (2009) discussed that a multiple case study could be used to view the results as pertaining to the whole population, as I did, which in this study would be all the CMHC administrators of Illinois at various administrative levels. In this way, I could assess different perspectives and collect additional data in each successive interview that might enrich the study. Merriam (2009) noted that a multiple case study would allow the discussion of the results from different perspectives. Crabtree and Miller (1999) discussed another idea of the qualitative approach, namely the use of the researcher as the primary tool of the study. My goal was to gather 12 different opinions, and analyze the trends in each of the interviews.

Strengths and Limitations of the Study

With this multiple case study, strengths reside in the real-life examples provided by the respondents (Thomas, 2011). Yin (2009) noted that the data gathered in a multiple case study are practical and allow examination from different perspectives, which helps to reduce bias that could otherwise result from a single point of view. Creswell (2009) related that one of the strengths of a multiple case study is that it allows for an open-ended discussion of ideas, rather than limiting it to closed-ended answers. Merriam (2010) noted that using a multiple case study allowed the use of a descriptive and probing manner to gain real understanding. My goal, with this study, was to gain a broad understanding of the perspectives of CMHC administrators through the open-ended questions I posed. Through these open-ended discussions of ideas relating to the history, development, and mission of the CMHC, a realistic assessment of the knowledge and attitudes of the administrators was achieved. On this basis, the conversation about following Recommendation 17 by Norcross and Wampold (2011) in the CMHC setting could be pursued in a realistic and meaningful manner.

Yin (2009) explained that the limitations of a multiple case study tend to result from the lack of a controlled environment in which reliability or validity could be difficult to achieve. Gerring (2007) wrote that the large quantity of data could present difficulties for generalizing the results. I met these issues by putting in place several structures to countermand the limitations. First, I collected information through face-to-face interviews and, then, I personally transcribed the answers, thereby, eliminating the need to obtain signed confidentiality agreements of professional transcribers and reducing the chance of errors and misunderstanding of the data by a third party. Merriam (2009) wrote that, if the interviewer transcribes the results personally, it should be considered a strength of the research. As ideas and meanings emerge, they allow for further insight "about what's going on in the data" (Merriam, 2009, p. 194). Thus, my understanding of the issues became more comprehensive and profound through the transcription exercise. Second, I subjected the transcriptions to review and verification by the respondents. Stake (2010) wrote that this type of member checking, or informant feedback, results in a more complete understanding of the answers, as the participants view what they have said and validate their answers through feedback. As will be noted in Chapter 4, some answers were changed in a limited way, mainly to tone down the earthiness of some remarks.

To minimize the effect of other potential limitations, I organized and analyzed the data with the use of the NVivo software (QSR International, n.d.). Merriam (2009) noted that software such as NVivo assists the researcher while organizing data obtained in interviews and linking them through memos and codes. After gathering, transcribing, member checking, and organizing the data, I triangulated the data. What will be presented as the interviews of the administrators, resulted from this triangulation of the transcriptions', plus member checking, my personal notes taken during and immediately following the interviews, and an examination of Rule 132 (Department of Health and Human Services, 2013). Rule 132 had been referred to and implicated in limiting the services that could be provided in the CMHC by the interviewees. Triangulation of the data of each interview allowed evaluation of the extent to which the information obtained was reinforced or presented an anomaly. Each interview then built on the previous interview, as shown in Chapter 4. These planned procedures were intended to minimize the effects of potential limitations of the methods and tools employed, which are described in detail in a later section.

Participant Selection

Location. The sample was chosen from the population of administrators within the community mental health services to whom Norcross and Wampold (2011) addressed their Recommendation 17. As reported by the Illinois Department of Human Services (DHS, n.d.), there is at least one CMHC in place for each of the 102 counties in the state of Illinois. This meant that a pool of at least 102 administrators was available. However, time and resources for conducting this study under the auspices of a university were limited, and I needed to resort to a form of convenience sampling. I, therefore, sought to enlist administrators in northern Illinois for this study. The DHS noted that several of the more densely populated counties had more than one CMHC because the locations were originally determined based on population needs. Most of the multiple locations are concentrated in the Cook County area of Chicago, which is the most densely populated county in the state. DHS mapping of the counties, other than Cook County, showed that the bulk of these counties were rural centers, but I also found that many of them were connected. I purposively focused on county centers located outside Chicago and Cook County, but within northern Illinois.

As discussed by the DHS (n.d.), each of the Illinois centers is funded by a combination of federal and Illinois State funds, as regulated by local 708 Boards within each county. Illinois Mental Health Rules noted that a "708 Board, or Community Mental Health Board, was established by a community, municipality, or township for the purposes of planning and funding mental health, developmental disability, and substance abuse services" (ACMHAI, n.d., p. 1). My aim was to assemble an assortment of centers that were similar in some respects and divergent in others to broaden and diversify the pool from which the interviewees would, eventually, be chosen. In this effort, I was successful. As I was limited by the pool of administrators who would agree to be interviewed, my aim was to establish a large pool. This search, however, could not be undertaken until approval by the Internal Review Board (IRB) of Walden University had been granted. Approval was given, Walden IRB approval number is 03-21-14-0175403 and the search began.

Criteria for center selection are described in the next paragraph. The goal was to enlist a variety of participants for the proposed study from a pool of established centers in several northern Illinois counties. The original plan was to include up to 20 CMHCs in the pool from which to draw potential participants. After IRB approval was obtained, I personally called each center and invited the administrators to participate in the study. From the group of CMHCs that agreed to participate, I selected six centers with the idea of interviewing two of its administrators. This yielded 12 interviewees: the main administrator of the center, or its executive director (ED), and one person representing the clinical director (CD).

Selection criteria. Selection of two participants from six CMHCs was based on the following criteria: (a) their location, but with an eye on diversity, (b) the strongly expressed willingness of the centers' leaders to participate in the study, (c) my best efforts to assure that I could obtain trustworthy answers to the research questions posed for the study. As previously noted, I approached this study with apprehension because I thought I might not find any of the center administrators willing to participate in a study regarding needs for improvement of their facilities. This idea proved somewhat justified. From the list of 20 selected centers, only 7 agreed to participate. I eventually chose six, and kept an alternate in reserve in case of attrition of participants.

Description of the sample. The purpose of the interviews was to explore the knowledge and perspectives of CMHC administrators regarding Recommendation 17 made by Norcross and Wampold (2011) for improving the service delivery to mental health clients. In order to gain multiple perspectives, I followed Creswell's (2009) and Yin's (2009) recommendations and aimed for maximum variation in the sample. Yin wrote that samples of this type would contain a group of people who were extreme in several ways; yet, it would also contain people who are average in other ways. My goal was to achieve maximum variation in order to gain multiple perspectives (Stake, 2010) in selecting the 12 participants from the six centers in northern Illinois.

Interviews

Pilot interview. First, I conducted one interview to serve as a pilot study. After the results of the pilot had been transcribed, I reviewed the questions, the recorded interview, and the transcription with the methodologist on my dissertation committee to refine the questions, explore what kind of follow-up questions might expand upon the results, and general ways of drawing out the most comprehensive answers from each participant. If warranted, a second pilot interview would have been conducted to refine the process, hone my interviewing skills, and to hear the data properly (Rubin & Rubin, 1995). No further pilot interviews were necessary. It was suggested, however, that it might become necessary to contact the IRB and seek approval of potential changes in direction of the follow-up interviews that could not be determined at the interview planning stage. Potential changes were built into the IRB application, in as much as they could be foreseen. Returning to the IRB at later date proved not to be necessary.

Follow-up questions. In addition to reviewing the ideas my original questions and the follow-up questions have elicited from each participant, I also examined whether there were key moments that, if more skillfully pursued, could have yielded more positive responses from the interviewees. Some difficulties in the data are discussed in Chapter 4; they did, however, not compromise the results.

The interviews. I conducted 12 individual interviews with the ED and the CD at each of the six selected locations. Each interview lasted 1 hour or less, based on the participants' answers and the follow-up questions the answers engendered. I requested that the interviews be conducted at the CMHC operated by the two interviewees of the respective center. I audiotaped each interview with the participants' written permission. Prior to the interview, each participant was provided with an informed-consent form that had to be signed by the participant (see Appendix C). The form notified participants that their participation was voluntary, and that they could withdraw from the study at any time without recriminations and without jeopardizing any relationship with Walden University either current or in the future. I reconfirmed that participants were free to withdraw from the study at any time when I provided the transcriptions for member checking. None of the participants withdrew from the study, and the alternate seventh center that had volunteered did not need to be called upon.

Interview Questions

The initial list of interview questions, shown in Appendix B, guided the data collection in the effort to find answers to the research questions. The research questions were developed largely from the conclusions reached and the recommendations for further study offered by the researchers whose work was reviewed in Chapter 2. Follow-up interview questions were developed as the interviews unfolded by following a trustworthy path, meaning that they complied in every respect with the ethical standards set by the social work profession (NASW, 2008) and the IRB of Walden University.

The research questions1 guiding the study were as follows:

1. How will this recommendation to administrators be viewed by the CMHC administration?
2. What would make this recommendation to be considered viable by administrators within a CMHC setting or, conversely, not viable?
3. What is the current level of administrators' knowledge of and attitudes toward the delivery of evidence- and relationship-based services?

4. Do the administrators anticipate that there would be financial costs involved in attending to the relational features of service, as Norcross and Wampold recommended, and can the administrators calculate such costs?
5. What ideas and perceptions will administrators within the CMHC relate regarding the training of therapists and the financial costs of following through with this recommendation?

I developed a short opening statement and an informed-consent form (see Appendix C) to accompany the list of semistructured interview questions (see Appendix B). In this statement, I explained the goal of this research with respect to the Norcross and Wampold (2011) recommendation. In this opening statement, I also notified participants of their rights and noted that the interview would be recorded upon their written consent.

After completing the described pilot interview, I proceeded to hold the remaining 11 interviews. I gathered no personal information from the participants that could lead to their loss of anonymity. I also did not seek any confidential or ethically sensitive information concerning the participants or any clients of their agencies. None of the participants are identified, nor are real names used in conjunction with the information they provided. The transcribed interviews, agency documents furnished by the respondents in support of their answers, state of Illinois documents, the signed consent forms, my opening statement, and the initial set of interview questions are considered data for this study.

Reflective Journal

During the interviews, I took notes in a personal journal to record ideas that would help to connect the information at a later point in time. The personal notes helped to preserve fleeting ideas that, I hoped, would generate additional ideas and follow-up questions and provide enrichment during the analysis and reporting stages. Note taking assisted me in interpreting nonverbal communications that accompanied the participants' words. I avoided excessive note taking but jotted-down key words that helped in the process of transcribing the information gathered. The notes, I thought, would help in creating a design while weaving the threads of information into a coherent fabric. This field journal became part of the overall information to be discussed in the results section of Chapter 4. Additionally, the notes were useful when I requested input from my dissertation committee regarding the meanings and resultant ideas from the data. No personal or confidential information was included in these notes. No otherwise sensitive data were collected that could compromise the anonymity of any participant or client of the agency. The purpose of these personal notes was strictly to help in bringing forth meaning based on otherwise fleeting hunches as the interviews unfolded.

Data Analysis and Synthesis

I collected data through individual face-to-face interviews, which were conducted at the CMHC offices of the participants. I kept a reflective journal during each interview and asked for additional documents that might support the information provided such as policies and procedures. However, in each case I was directed to Rule 132 of the State of Illinois (Department of Health and Human Services, 2013). Then, I personally transcribed each recorded interview into a Word document and presented it to the respondent for member checking. Member checking allowed the participant to read the transcribed information and verify that it related what he or she intended to say. Respondents had the opportunity during member checking to make corrections as they saw fit and to add additional information if they desired (Stake, 2010). These conditions are further described in the section on validity in Chapter 4.

The goal of this research was to ascertain what CMHC administrators knew about the recommendations set forth by Norcross and Wampold (2011) and how they felt about Recommendation 17, which is specifically addressed to them. As soon as all the data had been collected, I proceeded to the data analysis by looking for key words and identifying themes. To follow my plan of using an interpretive process, I applied what Merriam (2009) described as working the thoughts about the data by organizing the data so I could verify my ideas and interpretations. Yin (2009) provided the caveat that there must be a well-developed set of actions, not just subjective justifications. The researcher, therefore, apply methodological rigor to demonstrate the correctness of his or her interpretations of the data. Methodological rigor is discussed by Merriam (2009) with respect to representativeness of the data, outcome assessment, intervention explanation, bias and confounding, and the investigative approach the researcher has chosen. Each of these aspects is discussed in Chapter 4 as applicable to this study.

Stake (2006) noted that the quality of any research will be reflected in the reactions of peers and readers of the study. With qualitative data, there can be great debate about how to read results. Quantitative data, as noted by Yin (2009), is black or white—the results are either statistically significant or they are not. By contrast, with this qualitative study, I sought to promote debate with respect to Recommendations 17 while, at the same time, preserving methodological rigor. I took care to develop this study along some narrow questions in the hope of providing a stepping-stone toward social change in the spirit of the long and valiant history and development of community-based services for the mentally ill.

While the judgment of the quality of my work will be reserved for future readers, I nevertheless attempted to adhere to methodological rigor in my interpretations of the data by making logical deductions and rigorous interpretations based on verification by triangulation. Merriam (2009) discussed that the data collection would be an ongoing and developing process, and thus each interview built on the agreements found over the course of all the interviews. Adhering to this concept provided the backbone for the methodological rigor and the quality of the data I strove to collect and present.

With the first interview designated as the pilot study, I approached my dissertation committee for feedback on the data I had collected, and for an outside perspective of how I had heard this data (Rubin & Rubin, 1995). I sought the guidance of experts regarding my initial interpretations and potential follow-up questions. Utilizing the field notes taken during this first interview, I received valuable feedback and training in my interviewing skills and in “hearing” the data, as emphasized by Rubin and Rubin (1995). It is important to point out that the idea was never to postpone the interpretation of data until all the data had been collected and transcribed (Merriam, 2009), but rather to initiate the process of meaning making from the outset, with the very first pilot interview.

Interpretation was conceived of as an ongoing and expanding process of exploring ideas, meanings, and hunches as they emerged during successive interviews.

As previously indicated, I used a narrow focus to assess the knowledge and attitude prevailing among CMHC administrators regarding Recommendation 17 in order to determine what the next step toward implementation ought to be. Yin (2009) suggested that, during the data interpretation process, one may need to return to the literature to seek guidance on how to follow up on some of the answers. This proved to be useful advice, which was also seconded by Merriam (2009). Merriam noted that this step would not only help the researcher to expand her or his thinking but also lead to a deeper understanding of the meaning of the information obtained. Repeatedly returning to the questions and answers in light of the extant literature could also reveal unforeseen implications of the information and enhance the quality of the final product.

Validation Strategies

Several authors discussed legitimacy and the concerns it presents in an interpretative and explanatory research project (Creswell, 2009; Gerring, 2007; Merriam, 2009; Stake, 2006, 2010; Yin, 2009). Creswell (2009) described the following eight validation strategies used in qualitative research: prolonged engagement and persistent observation in the field; triangulation; peer review or debriefing; negative case analysis; clarifying; member checking; rich, thick descriptions; and external audits. Yin (2009) discussed looking for perceived causal explanations, and this was my first goal with an eye toward the history and development of the CMHC. Yin explained that to have a valid interpretation using the total technique, at least two of Creswell’s (2009) eight strategies must be present in a research project. I use three of the strategies, namely triangulation; member checking; and rich, thick description to validate the findings. This process brought accuracy and details to the exposition.

To explain how I pursued the process validation in this qualitative study, I need to describe the successive steps I chose to follow. I began by looking for causal explanations with an eye turned to the literature reviewed in Chapter 2, exercising interpretation and logic. By utilizing member checking, I obtained informant feedback during the interview process; this is also a form of validation of the information obtained and transcribed as I understood it (Stake, 2006). Yin (2009) elaborated on the values of this process because it builds trust in the participant when the interviewer present the typed results of the interview and allows the respondent to critique the researcher's understanding and the meanings implied in the transcript, change his or her answers, and add to the information if desired. This step proved to be a fruitful exercise in this study, which will be further described in Chapter 4.

Member checking was a way to get validation of the concepts as intended by the informant; future researchers will be able to replicate the study and compare their results with confidence to the original opinions and attitudes held by these interviewees. Yet, member checking was not the end of the process. A rich and thick description of the interviews, enhanced and supported by my field notes, brought the answers to life. Rich, thick description relies on paying close attention, noting details, and recording nonverbal clues to bringing out the full social meaning of the case (Stake, 2010). Social meaning is a comprehensive idea that captures not only the knowledge and attitudes of the interviewees but also the potential implications for their personal and professional lives and the functioning of their agencies.

Lastly, I made ample use of triangulation in support of validation of the information obtained. Merriam (2009) discussed this powerful technique of verifying the data from a number of different perspectives or through various sources. Triangulation increases credibility of the data and the answers to the research questions. Yin (2009) described how triangulation works to validate the data by finding intersecting points that come about when data are gathered from different sources. An example from this study would be the interviewees' description of an overwhelmingly burdensome amount of paperwork demanded by the state compared with the state's regulation, known as Rule 132 (Department of Health and Human Services, 2013).

To summarize, by describing the validation strategies employed in this study, I tried not only to show how I endeavored to validate the results of this study but also to facilitate the replication of this research in other CMHC centers in the state of Illinois as well as in other states of this nation. It is my hope that this as well as future studies will keep the discussion regarding Recommendations 17 alive and move the concepts of research- and relationship-based mental health services toward implementation.

Ethical Considerations

As pointed out by many authors, ethics are of great importance in any study (Merriam, 2009; Stake, 2006, 2010; Yin, 2009). The participants in this study were CMHC administrators, specifically the ED and CD of six selected centers. These centers are serving the mentally ill in northern Illinois. No clients were used as informants, and no information was collected from or about clients. The information collected and analyzed in this study was provided voluntarily and with the informed consent of the interviewees. The objective of the study was to assess the knowledge level and attitudes of CMHC administrators with respect to one of the recommendations made by Norcross and Wampold (2011) for the improvement of mental health services through evidence- and relationship-based therapy. The opinions and attitudes of the CMHC administrators are reported in aggregate form in order to protect the anonymity of the participants. No personal information is revealed that could lead to the identification of a participant. In this study, I complied in all respects with the ethics standards set by the profession of social work (NASW, 2008) and the IRB of Walden University #03-21-14-0175403.

Role and Background of the Researcher

As the researcher, I brought to this project 10 years of experience of working in three CMHCs: as a caseworker in two CMHCs and as an administrator in the third. My administrative title was area office supervisor; I supervised one entire office and managed the office under the direction of a regional manager. To minimize personal bias and social desirability bias, I excluded from participation in the study any individuals I was professionally involved with in the past.

As a person who has direct knowledge of the CMHC, its workers and clients, and the unique challenges experienced in this setting, I have a passion for social change in this area. After becoming a social worker, my first job was working in a CMHC. I have personally experienced, both as a therapist and as an administrator, the extent of the problems that exist in the CMHC. I have extensively researched these problems in search of finding solutions. I have personally witnessed the inadequate training of hundreds of case workers and observed how clients are served by a succession of case workers. The clients and their needs have driven me to continue to research the facts and work for change in this area of mental health care. To guard against researcher bias, I “bracketed” (Merriam, 2009; Patton, 2002) some of my reactions to the information offered during interviews in my personal journal.

Summary

In this chapter, I presented the method for this qualitative multiple case study of 12 CMHC administrators in northern Illinois. I provided an introduction to the chapter, describing the goal of the study, which was to close a gap in the professional literature, resulting from the fact that none of the studies on which Norcross and Wampold (2011) had based their recommendations had been conducted in a CMHC setting, nor had the input of any CMHC administrators regarding this recommendation heretofore been described. I, then, described the research design, setting, research questions, and data collection and data analysis procedures as well as validation strategies and the role and background of the researcher. Also described were ethical considerations and the measures taken for the protection of the participants’ rights.

In Chapter 4, I present the results of the study by restating the research questions and describing the pilot interview, which served to refine the interview questions (see Appendix B), explore the direction of possible follow-up questions, and afford me the opportunity to sharpen my interviewing skills and practice “hearing” the answers, as advocated by Rubin and Rubin (1995). After briefly describing the demographics of the interviewees, the setting, and evidence of trustworthiness, I present the administrators' responses as they relate to each research question. The chapter ends with a summary.

Chapter 4: Results

Introduction

This research was undertaken to explore what the administrators of Community Mental Health Centers (CMHCs) knew about Recommendation 17 offered by Norcross and Wampold (2011) and how they felt about the chance of implementation in their agencies. The recommendation states, “Administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations” (p. 100).

I interviewed two administrators, namely, the executive director (ED) and the clinical director (CD) or person who was a designated representative from six CMHCs in northern Illinois. Not every center held a CD position; many centers used a team of directors with various responsibilities to fill the role of the CD. To stay consistent, this person will be referred to as the CD for the purposes of this study. The two separate interviews of the ED and the CD were conducted back to back in their respective centers over a 7-week period during April and May 2014. The first interview served as a pilot study and was undertaken 2-weeks before the scheduling of the remaining 11 interviews. The centers were equally divided into three urban and three rural centers. These six centers and a seventh center that was held in abeyance in case of attrition were those that had accepted the invitation to participate in this research out of a pool of 22 diversified centers from northern Illinois. The seventh center was not used because all the original participants completed the interviews, and the answers obtained with the data showed no appreciable difference from the view point of a rural or urban center.

In this chapter, I will provide a brief description of the 12 administrators who participated in this study. The descriptions will include information on their background and experience and the setting of the agency in which they worked. I will review the piloted interview, the demographics of the participants, and how they viewed Recommendation 17as revealed through their answers to a set of open-ended interview questions (see Appendix B). These interviews were tape-recorded with the participants' written permission and personally transcribed by me. The transcripts were subjected to member checking, and I performed triangulation of the information I obtained by reviewing agency documents and state regulations, notably the oft-cited Rule 132 (Department of Health and Human Services, 2013). The transcriptions themes were enriched through the field notes I took during the interviews in a reflective journal. Data analysis revealed the themes presented in chapter 4, which comprised the interviewees' beliefs and perceptions regarding Recommendation 17 and the evidence- and relationship-based service provision it suggested. The information provided by the administrators and their meanings are presented in this chapter through rich, thick descriptions of the interviews with the inclusion of direct quotations of the informants' often colorful language based on high-spirited emotions.

Research Questions

The following five research questions were used to guide the study. To answer the research questions, I developed a set of open-ended interview questions (see Appendix B) that were reviewed with members of my dissertation committee and subjected to a pilot study prior to conducting the remaining interviews. The answers provided by the interviewees will be presented as they relate to each of the five research questions.

1. How will this recommendation to administrators be viewed by the CMHC administration?
2. What would make this recommendation to be considered viable by administrators within a CMHC setting or, conversely, not viable?
3. What is the current level of administrators' knowledge of and attitude toward the delivery of evidence- and relationship-based services?
4. Do the administrators anticipate that there would be financial costs involved in attending to the relational features of service, as Norcross and Wampold recommended, and can the administrators calculate such costs?
5. What ideas and perceptions will administrators within the CMHC relate regarding the training of therapists and the financial costs of following through with this recommendation?

Pilot Study

I originally compiled a list of 22 centers as possible citations for conducting the study. I identified potential participants in this study following IRB guidelines (approval # 03-21-14-0175403); additional details are described in Chapter 3. These centers were located in northern Illinois, but they were outside of the city of Chicago and Cook County. The list included a variety of centers in both urban and rural settings; the idea intended to facilitate convenience sampling. Seven of the centers accepted the invitation to participate in the study after I had explained the purpose of this research in a personal phone call to each center. The list of seven volunteering centers was vetted by the chair of my dissertation committee. Six of the centers were randomly chosen as the sample for this multiple case study, leaving one of the centers as an alternate in case one of the centers dropped out of the study. Of the six participating centers, one center was randomly chosen to serve for the pilot interview. The ED from the center became Interviewee 1, and the designated CD became Interviewee 2. Interviewee 1 became a social worker in 1967 and had been directing the agency as its ED for 33 years. This ED described his work and related details of his personal experience during the interview, which lasted 1 hour and 7 minutes. The interview took place in the ED's office, and it was tape-recorded with his permission through informed consent (Appendix C). After the formal interview had ended and the recording stopped, the administrator continued for an additional 20 minutes with an emotional discussion regarding the state of Illinois and the problems from his opinion faced by the CMHCs. Allowing him to process, I continued taking notes in my reflective journal.

I, then, personally transcribed the interview and sent the transcript to the participant via e-mail for member checking within a few days. The interviewee made several changes to the transcribed interview. For example, he changed (toned down) some of the language he had used and deleted the idea of giving me copies of the policies he had discussed. However, overall, the interview remained as first recorded. A major point was that this administrator initially had no issues with sharing his personnel policies. Later on, however, he decided that he could not share any personnel policy decisions. He suggested that I instead seek out the State of Illinois Rule 132 policy information (Department of Health and Human Services, 2013), which turned out to become a pervasive theme in all the later interviews. This policy information, known as Rule 132, is explained in detail later in this chapter.

With the pilot interview completed, transcribed, and member checked, I sought feedback from the chair of my dissertation committee. We reviewed the content and questions, and I received the go-ahead to conduct the study. I called the list of participants and I schedule the remaining 11 interviews. At one point, it should be noted that I became aware during Interview 8 that this participant had spoken with a previously interviewed participant to compare notes. This incident is further discussed in Chapter 5.

Overall, it does not appear that the results of the study were compromised. I gained the impression that Participant 8 merely focused on the fact that the previous interviewee was poking fun at the authors and laughing about their recommendations (full details of the incident, together with the relevant answers, will be given in Chapter 5). Because there is a large perceived difference between academic scholars who perform research in the rarefied atmosphere of academia (theory) and those who practice in real time. In reflecting back on this incident, I do believe that the added focus it provided on the emotions of the earlier interviewee was illuminating for the results. What became very clear was that there could be a large difference in the conclusions reached by people who practice and those who do research in academia. In this sense, the current study is also bridging a gap between the perceptions of those who administer and practice in

CMHCs and the conclusions reached by studying evidence-based mental health care in other settings.

Demographics and Settings

The experience of the administrators interviewed ranged from 42 years for one participant down to 6 months for another person holding that position. The majority of the 12 administrators had over 30 years of experience in the field of mental health and a working knowledge of CMHCs in the state of Illinois. One participant held an MBA and had no mental health experience prior to taking the ED position. Overall, the set of 12 administrators might represent the core features of administrators found in other regions in the state. The seventh agency on the list of those who had expressed interest in participating in this study was kept as an alternate in case one of the other participants dropped out. This alternate was, not needed because all the participants completed the study.

Each of the 12 personal interviews was conducted at the respective CMHC office of the participant. Ten of the 12 participants were men; two were women. Each CMHC appeared to be well-maintained, and the administrative offices in five of the six centers were quite luxurious. The ED offices generally were the largest in each center; the CD offices were about half the size or even smaller. Most of the ED offices had several sections with an area for meetings around large tables and another section with couches. Holding the interviews in the respective offices of each participant contributed to the comport and confidentiality of the information provided with anonymity of the respondents.

I personally transcribed each interview and sent the transcript to each participant within one week for member checking and approval of the resulting narrative. All 12 administrators returned the transcripts with minor changes in wording such as removing swear words, but no one materially changed her or his answers. Several e-mails provided additional thoughts that the participant had forgotten to mention during the recording session, but which were an essential part of the administrator's emotions displayed after the tape recorder had been turned off. The final answers were, thus, enhanced and more comprehensive than the original transcript. Member checking provided each participant with a chance to reflect on his or her answers and gain an understanding that reflected a complete deliberative process. Because the process provided confidentiality, the participants wrote back and confirmed that they felt happy about being able to speak freely. Because they knew that I would print their exact words, they wanted to clean up some of the language used, but their answers were frank and direct about the state of Illinois and the condition of mental health services for the poor. This ultimately reflected a view of the public sector mental health system and provided answers to the research questions.

The final transcribed document with the participant's added comments, as a result of member checking, became the interview data used in the analysis. This chapter will provide this data, and develop a theme that Administrators have the knowledge and positive attitudes toward these services, but do not hold the resources to implement the idea. In addition to these 12 interviews, I used written documents for verifying data through the process of triangulation. These documents included publications by the

Illinois Department of Human Services to which all 12 administrators repeatedly referred during the interviews. Two of the documents, Rule 132 (Department of Health and Human Services, 2013) and *The Crosswalk* (Crosswalk, 2013) provided regulations that the administrators had to follow within their agencies. *The Crosswalk* is a version of Rule 132, in which provisions or services are detailed, along with the reimbursement rate for each 15 minutes of a particular service. Finally, I used my reflective journal, or personal field notes, taken during or immediately following the interviews. This allowed further comparisons of the ideas expressed by the participants during and after the personal interviews. Additionally, following their comments because of member checking and deepened my reflections on the recurring themes. I took note of key words, emotions displayed, and ideas expressed to recognize themes and plumb the meanings provided by my sources.

Data Collection and Analysis

After the first interview, which used as a pilot study, I obtained the documents referred to by the interviewee (i.e., Rule 132 [Department of Health and Human Services, 2013] and *The Crosswalk* [Crosswalk, 2013]) and, together with the notes taken in my reflective journal, I went about the process of triangulation, first alone and then together with my dissertation committee. With approval of the first transcript and the university's permission to conduct the study, I quickly scheduled the remaining 11 interviews and conducted them in the respective offices of the CMHC administrators.

As soon as the piloted transcript had been evaluated and approved, I began to make notes on the printed copy, circling words and phrases that appeared to hold special meaning for the interviewee. Later, as the other interviews unfolded, I used the NVivo software in addition to my notes to store and evaluate the interview data, as described in Chapter 3. The NVivo process helped with the organization of data and in locating key words in each successive interview. This assisted in developing codes and themes as the data analysis progressed, even while the interviews were still being conducted. With this process, I developed the final themes and patterns and isolated the views that described the beliefs held by this set of administrators, as revealed through their answers to my interview questions. With each subsequent interview, related ideas emerged through the interview questions to be organized, coded, and compared. The emergent ideas were triangulated with the contributions of other participants and the data of the aforementioned state documents. After I completed the 11 interviews, I put together the final answers to the interview questions, reflecting the views provided by this group of administrators regarding Recommendation 17. I reworked this process several times and in several ways. I began with a different interview each time to find the codes and extract the themes. The collective answers to the interview questions remained the same, implicating politics, lack of money, and the inability to proceed with the recommendation due to the current situation in the state of Illinois.

Evidence of Trustworthiness

Credibility, confirmability, and dependability of data can be shown in several ways (Merriam, 2009). I began this multiple case study with a large group of potential participants, which was narrowed down to 12 administrators willing to participate in this research. The background of the 12 participants was diverse; each was considered a case of this multiple case study. Yet, the information they provided showed considerable overlap and redundancy, so that the final answers to the research questions are based on congruent information obtained from the 12 cases.

In addition to member checking of the transcribed interviews, I utilized triangulation upon the interview data with the use of several official documents that were repeatedly cited by each interviewee (i.e., Rule 132 [Department of Health and Human Services, 2013] and *The Crosswalk* [Crosswalk, 2013]) and my field notes in the form of a reflective journal. Repeatedly checking my personal notes with my bracketed reactions (Merriam, 2009; Patton, 2002) to the information provided by the respondents helped to guard against potential researcher bias due to my personal experience of working in the CMHC, as described in the section Role of the Researcher. Lastly, I used rich, thick descriptions with quotes taken directly from the administrators' interviews in support of the trustworthiness of my interpretation of the meanings intended by the respondents.

Research Questions and Findings

Five research questions, inspired by the literature review, were used to guide this study. A set of interview questions was developed for the purpose of data (see Appendix B), and follow-up questions were asked as necessary to assess the knowledge level and attitudes of CMCS administrators with respect to Norcross and Wampold's (2011) Recommendation 17, which stated, "…administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations" (p.100). The answers provided by the respondents are grouped in the following sections as the answers pertained to each of the five research questions.

Research Question 1: Administrators' Responses

Research Question 1 asked: How will this recommendation to administrators be viewed by the CMHC administration? The administrators spoke clearly against Recommendation 17. As will be shown later, most of the administrators agreed with the idea of relationship-based therapy, meaning to give clients a choice of therapist and developing the relationship between therapist and client as necessary for their growth through therapy. The respondents viewed the concept of relationship as a primary concern and an important idea in their respective centers. However, it became immediately clear during Interview 1 that a theme could be built to answer Research Question 1, when this administrator declared, "The talk about choice is bullshit." Further discussing the need to focus on relationship, as Norcross and Wampold (2011) proposed, elicited the comment, "It doesn't work. It only works for people who have resources and can seek help in the private sector." This view of money and that the talk is there without action begins the theme.

In this first interview, the administrator carried on with candid emotion while the tape was running and long after the recorder had been turned off. This respondent, in fact, used the interview to discharge some pent-up emotions about the financial situation in the state of Illinois and the dire situation faced by CMHC administrators. Afterwards, as we were leaving the office, the administrator joked to the secretaries that they were spared grief today because I, the researcher, had received the brunt of his daily rant. Passionate emotions became a theme that continued with each subsequent interview.

This first dialogue (i.e., the pilot interview) helped to build several themes. First was the contention that paperwork is such an overwhelming burden of his job with the CMHC that, in the opinion of this administrator, it was holding back services that could otherwise be provided to clients. The administrator noted, “We document what we do every 15 minutes.” This remark about having to bill for services in 15-minute increments was confirmed by checking Rule 132 (Department of Health and Human Services, 2013). Additionally, I really came to appreciate this heavy burden or the theme associated with Rule 132 of the state of Illinois and its consequences for losing funding. This administrator’s strong emotion was directed at the financing of services; indeed, several of the administrators referred to the fact that the rates had been set in 1993 and continued to remain in place, unchanged, to this day. This same theme, namely the financing of the mental health services and confirmation of the idea was in every interview after the initial pilot interview and was invariably accompanied by high emotions. The theme and further elaborations were discussed through a number of follow-up questions. As I identified the themes, I made a note for the eventual use in answering the research questions. The first interviewee was very clear about rejecting the suggestion of Recommendation 17 and the idea of improving care by focusing more on relationship building in the CMHC. Even though he spoke highly of the concept of building relationships in therapy, anger was clearly directed toward the current state of mental health services in Illinois. This administrator declared about the recommendation, “I don’t think it is even possible.”

Interview 2 continued to build on the first administrator's ideas, meanings, and themes. In this interview, I heard, "In private care you get what you want, but in Community Mental Health you can't." The Interview 3 respondent took up the notion of matching the therapist to the client by stating, "I believe that individuals decide in the first 15 to 30 seconds whether this is a good match for them," and it became clear that finding an answer to the research question was not going to be difficult. The second administrator related, with several heavy pauses, "I think, overall the recommendation may be a good thing. It's just not going to work in community mental health. It comes down to dollars and cents, and that's about all I can say." The theme of rejection of the recommendation kept going on throughout the interviews, and financing was the main reason; so, it became the next theme.

Interviewees 5 and 6 continued the theme of rejection of the recommendation, but they also brought out new themes that had similar meanings. Interviewee 5 related, "That would require for me not having to be involved in board meetings, grant review, staffing problems, and actually being present for supervision of each of the different treatment teams." Interviewee 6 added, "I think the recommendation is funny." As will be reported later in greater detail, the dual theme was clear: It showed that the administrators were both angry about the current conditions regarding mental health care in the state of Illinois and laughing at researchers in academia who seemed to have no idea what it was like to stand in the trenches, so to speak, but who attempted nevertheless to tell them how to run their business.

Interviewee 7 was the least experienced of the participants and was “sorry” about not understanding what I was asking, while Interviewee 8, who had an MBA but no previous mental health experience before taking over his agency, remarked, “No, I think it’s stupid—can I say that?” This theme continued, with laughing derisively at the recommendation repeated again and again.

Interviewee 9 struck me as being one of most candid of the respondents; he certainly was the most experienced of the sample, holding a PhD and having run his organization for nearly 30 years. This administrator stated, “I certainly believe in relationship learning therapy. It just doesn’t exist anymore. It may exist in an academic place or in somebody’s fantasies.” Interviewee 10, the respondent designated as this agency’s CD, who was set to retire soon, stated, “We really do believe that relationships are the foundation of life.” He seemed to be the most serious of all. He rejected the recommendation in the end, even after discussing at length how the therapists in their agency, did focus on relationship. The rejection of the recommendation came after a discussion of financing at the CMHC and how many workers would have to be hired in order to follow through with this recommendation.

The final two interviewees related similar thoughts and continued the themes of anger and ridicule. The theme that Administrator 12 discussed with anger was reinforced with the statement, “We try to do that here,” while Administrator 11, ultimately, presented the angriest persona in all the interviews. He was not angry with me personally, but rather emotional about the state of Illinois, which my questioning brought to the forefront. Interviews 11 and 12 were held in the largest of the centers I visited. This agency was neighboring Cook County with its multitude of big-city problems. The administrator was direct, “I think this recommendation is stupid and made by people who don’t know mental health for the poor very well. And, I don’t have a great deal of time for stupid questions.”

The 12 interviews produced several main themes regarding Recommendation 17: The recommendation was considered stupid or funny, and the suggested notion might work for people with ample resources or in organizations in the private sector. Every respondent pointed to Rule 132 (Department of Health and Human Services, 2013) as a factor undermining this recommendation. The overwhelming amount of paperwork required by Rule 132 was both crushing and unnecessary in their opinion.

These themes will continue to be explored in the pursuit of answers to the next question. Not a single one of these 12 administrators considered implementation of this recommendation practicable by any avenue. Even as all 12 respondents expressed their support of the idea of developing relationship in therapy and giving their clients a choice in therapist, financing the implementation of the recommendations was considered out of the question. The themes, concepts, and meanings all worked toward the expression of anger and outright laughing at the recommendation. The overwhelming burden of the required paperwork and the state of mental health care due to politics were dynamic issues. The themes of financing, paperwork and the emotion were present within administrator answers. These themes continue to develop with respect in the next research question, while new ideas form.

Research Question 2: Administrators' Responses

Research Question 2 asked: What would make this recommendation to be considered viable by administrators within a CMHC setting or, conversely, not viable? The 12 administrators outright rejected Recommendation 17. However, I explored whether the recommendation to strive for relationship in therapy could be made viable by changing or adjusting some of its aspects. This group of administrators soundly rejected this notion as well. It simply was not considered realistic in any form due to the current conditions in the CMHCs of Illinois. The information about their centers and the description of the services they provided rather convincingly supported these administrators' reasons for rejecting Recommendation 17. As I organized the data, I identified the following solid themes: The requirements of Rule 132 (Department of Health and Human Services, 2013) were dominant, the paperwork requirements were overwhelming and even stood in the way of service provision, and the current politics in the state of politics in Illinois did not bode well for support of the CMHCs. The administrators continued to voice their ideas with anger and sarcasm.

In the first interview, the administrator stated, "Medicaid is what dominates community service in Illinois. And in all their literature, which is all bullshit and propaganda, they talk about choice." In the second interview, the respondent stated, "While in private care, they get more with more. But you see that is the Number 1 idea. The poor get the leftovers." These first two interviewees could not conceive of any recommendation coming out of academia as viable; nothing worth pursuing could come out of such research unless it was pursued by someone who understood the CMHC. The administrators made it quite plain that in their perceptions Norcross and Wampold (2011) showed no understanding of the CMHC with this recommendation. What they found most objectionable and insulting was the second part of the recommendation, which says, “Attempts to improve the quality of care should account for treatment relationships and adaptations” (p. 100).

Interviewees 3 and 4 voiced the objections clearly with their ideas against viability. Administrator 3, in discussing the intake process and how clients were shuttled from one CMHC worker to another, explained how this does not lend itself to relationship building. The view was required, at the very least a way “so that your next appointment wouldn't be the first you'd ever seen the individual that you're going to see.” This administrator was discussing the idea that in CMHCs most managers would discuss the intake process with a focus on the enormous amount of paperwork required. These intakes would be started with one person, and then a clinical assessment was started with another. However, this second person may not end up being the therapist and case manager of this client. By the time clients talk to a final person, they may have told their story several times. Administrator 4 added to this theme by stating, “Our staffing is such that we don't have infinite possibilities, and sometimes we have to give the best possible choice of standard or close our doors.” The desire to focus on relationship was present, but the interviewees were saying that this could not become a focus under present requirements of Rule 132 (Department of Health and Human Services, 2013) and the lack of resources. Financing in public sector organizations was repeatedly shown to be the reason for the objections and negative emotions expressed.

Interviewee 4 began an important thread with the statement, “The initial assessment process, as I have said and getting myself boxed in a little bit, is one of the biggest challenges.” This was reinforced by Interviewee 5 who said, “I want to make sure that our patients, our clientele, are getting their needs met, but not in a way that takes away functioning and empowerment, which we are trying to build up and to help them regain.” Interviewee 6 noted, “To make it feasible, we would need more clinicians. We would need a different intake process that would help us understand what kind of a relationship the client would want or need, coming in.” This theme was repeated over and over. The unwieldy amount of paperwork of the intake process, demanded explicitly by Rule 132 (Department of Health and Human Services, 2013), and the financial aspects of needing more therapists would stand in the way of relationship-building. They saw no way to provide or to focus on what Norcross and Wampold (2011) were relating as attempts to improve the quality of care, with current funding.

Interviewee 7, the least experienced of the administrators, had no answer. Participant 8, the least serious of all the administrators, stated, “The concerns would be financing. You know, a lot of people love to mandate services without really worrying about how they're going to be paid for. And for some reason, my counselors like to get paid.” In Interview 9, the administrator was quite direct by stating, “You can't possibly be suggesting that's going to happen because it would be way too expensive. Somebody might want to throw that word onto something and call it *relational*, but it wouldn't be [the real thing]. I've been around too long. That's not going to happen.” Interviewee 10 provided two interesting quotes, first by stating, “Rule 132 turns our clinicians into formfillers, and just pretty much following, getting the papers signed at the right time." Then later, this administrator opined, "You need to change the Rule. You need to provide the right funding. That is not now and, in my opinion, never will happen."

The themes of paperwork, financing, sarcasm and anger, and politics continued through the final interviews. Interviewee 11 stated, "Well, the concerns are essentially twofold. One is financial, and it's problematic because in this kind of environment more infrastructure is required in order to sustain a revenue stream." The second problem was linked closely to the first: He stated that he cannot hire the personnel he needs with respect to both numbers and proper training. Interviewee 12 simply said, "Will you pay me to do that, so I can stay in business?"

The administrators did not feel that this recommendation could be made viable by any means. They communicated their reasons through anger and sarcasm: Overwhelming levels of paperwork and financing that is not designed for building the necessary infrastructure for this recommendation to succeed. These clear-cut opinions made it more necessary to pursue my original question to greater depth: Did these administrators have the basic knowledge and the necessary attitude to answer these questions in a plausible way? Further, did they possess the basic knowledge and the required attitude that would be essential for implementing Norcross and Wampold's (2011) Recommendation 17 if the financial burdens were removed?

Research Question 3: Administrators' Responses

Research Question 3 asked: What is the current level of administrators' knowledge of and attitude toward the delivery of evidence- and relationship-based services? It became quickly apparent that 10 of the 12 understood precisely what Norcross and Wampold (2011) were suggesting with the words “attending to the relational features” (p.100). Moreover, they had the basic knowledge regarding evidence-based practice and client choices that would be essential for the delivery of evidence- and relationship-based services. Interviewee 1 brought out the theme by directly discussing choice. In answering how he felt about a client’s being able to choose the therapist he or she personally felt might best be able to help. Participant 1 replied, “I believe that all clients have the right to choose; however, they can’t choose something that isn’t there.” This interviewee suggested evidence-based practice was not financially feasible in the public sector. This idea of public sector versus private therapy became a major theme in most of the interviews.

Interviewee 2 related, “Ok, well my thought is: A client does have a right or a choice in being assigned a therapist; however, I would say that happens in private practice, not in this work.” Interviewee 3 stated, “Absolutely. I do believe in the right and the choice.” Interviewee 4 noted, “From the research, from my experience, relationship is more critical than . . . there's a big body of research out there obviously that says that the relationship is the biggest indicator of change.” Moreover, Interviewee 4 stated, “Without a good relationship, the client is not going to really be honest in a session.” This began to reinforce the answer that yes, these administrators had the knowledge and understood what relationship and evidence-based practice could bring to the process of change in the client. However, the question remained: Did they fully understand that relationships needed full confirmation and commitment? As the interviews proceeded, this became quite clear.

Interviewee 5 related, “There needs to be some flex. If it's determined after the first appointment or two that it’s not a good fit, I think it's our responsibility to try to find out what fit the client/patient needs with a therapist.” Interviewee 6 stated, “If the client doesn't really care about that relationship, I don't think he or she tries as hard to change.” Interviewee 7 (as previously noted, the least experienced) did not understand or could not relate to the idea how relationship was supposed help in therapy. This administrator stated, “I guess first is the paperwork, and that is when the clinician would find out what the issues are. But, the paperwork is key here.” This answer pointed out just how deeply the idea of following The Rule is embedded in an Illinois administrator’s mind.

Interviewee 8, the only administrator without a mental health background, stated, “You need to be charting that they do care about what the issues are that they are there to help them rather than go, 'Okay, 50 minutes are up. Thanks, we'll see you next week.' So we really do try to reinforce it with all our clinicians. That's the attitude we should have walking into the counseling room. But they do need to make sure the paperwork is correct as well.” This administrator had a focus of caring, but it was expressed through maintaining the proper paperwork, which determines the funding. The notion of relationship with its enormous commitment was wholly absent.

Interviewee 9, who held a PhD, could relate every aspect of Rogerian therapy and agreed with what it brought to the client, even as he stated, “Well, if you have money you can have a choice, can't you? That really gets into the whole—I don't know if I'd call it ethics, but it's . . . there's a matter of demand and capacity for services across America." Interviewee 10 related how, in his agency, they use the concept of Level of Care Characteristics, or LOCUS, to start determining the necessary level of care. He stated, "So, between the mental health evaluation and LOCUS, we get a sense of what is the presenting problem in the individual, and the LOCUS helps guide us to what would be the most appropriate level of care that's shared with the individual. Then, depending on what the issues are, we'll make an assignment for the first therapy visit with a particular therapist." This administrator had knowledge of the assessments and the intake process, and he used what could bring a client to the right therapist. Furthermore, he shared the idea of an attempt to get clients to a therapist who, they had determined, was the best fit for the client's needs.

Interviewees 11 and 12 demonstrated that they understood what relationship-based service was and that they agreed with the prospect of this type of delivery. Yet, Interviewee 11 stated, "I think that would be a very nice thing. Unfortunately, the way we operate, we can't facilitate that off the bat. Do I think people have a right? Yes." Interviewee 12 remarked, "However, choice in this business is related to different circumstances such as what is available." This group of administrators knew what was meant by having choice in the selection of a therapist and what delivery of relationship-based services could provide; they just saw no possibility of bringing it about.

Repeatedly, in 10 of the 12 interviews, the theme was touched upon that the administrators had heard the term *evidence-based practice* and understood what relationships, based on evidence, could bring to therapy. They all were equally in favor of the clients' having a choice in whom they would like as their therapist. Ten of the 12 interviewees knew how much that would mean, if implemented. Yet, the reality of the matter was summed up best by the administrator in the first interview, who said, "So yeah, I believe in client choice, but as a practical matter in the publicly funded sector, especially in the state of Illinois, it really doesn't exist." High caseloads and not enough trained therapists leads to the clients being assigned to an available therapist, and if this does not work, they are stuck, whereas in a private setting, this same client could simply go to another location and work with another person of their choice. This is not an option afforded the public-sector client such as in these CMHCs."

The enquiry about the current level of the administrators' knowledge and attitude with respect to delivery of evidence- and relationship-based services can be answered unequivocally with: They clearly understood what the question of choosing one's therapist meant, and they were endeavoring in helping clients to develop a working relationship with the best therapist available. The majority of the respondents stated that they agreed with clients' having a choice to work with whom they wanted, and that this type of service worked exceptionally well. However, they did not have financing to develop a system of care at this level. The administrators clearly were emotional about the current financing of CMHCs. The next research question sought to determine how well-informed the administrators were with respect to the potential costs of implementing Recommendation 17.

Research Question 4: Administrators' Responses

Research Question 4 asked: Do the administrators anticipate that there would be financial costs involved in attending to the relational features of service, as Norcross and Wampold recommended, and can the administrators calculate such costs? This was the easiest research question to pursue. It is also where the anger at the current situation of care was most vividly displayed. Administrators provided evidence, directly related to how the operations were financed and how much it would cost to implement the recommendation. The estimates ran up to an overall cost estimate of $100 million.

Interviewee 1, aware that his was the first of 12 interviews, noted, "*The Rule* defines just what that service is, just who can give it, and in many cases it defines how much of it you can get. So if you go to Center A or Center B or Center Z, you are going to get 132-services, which are, if they are faithful to the law, all going to be the same." This administrator's sentiment was that the answer should be consistent and conform to Rule 132. In fact, looking at the Rule, the operation of service is set at a standard rate for each service.

Rule 132 (Department of Health and Human Services, 2013) sets the rate of service delivery in 15-minute increments of billable services. This service can, according to the Rule, be delivered by a mental health professional (MHP), who is supervised by a licensed professional. Rule 132 defines MHPs as various persons, the lowest qualification of whom provides "a minimum of a high school diploma or GED and 5 years supervised clinical experience in mental health or human services" (Department of Health and Human Services, 2013, Section 132.5). This is an important point. Therapy is being delivered at a set rate from the 1990s and can be delivered by people with minimal experience. This is an idea that will pertain to Research Question 5, but it must also be used in calculating the potential cost of implementing Norcross and Wampold's (2011) recommendation.

Interviewee 1 answered directly how many dollars and cents this recommendation of focusing treatment on the therapeutic relationship would cost, "So you could waste 3-4 hours a week doing that kind of thing. That communication is $75 per billable hour. That would cost us $300. At 11 clinicians—you've got 12, but you have 11 that are doing it—let's say theoretically, that's $3,300 a week. That is $160,000 a year. You can't survive that way." Continuing with this line of thought, Interviewee 1 said, "We would be performing a lot of extra activity that we couldn't bill." Rule 132 spells out how the services are to be defined and billed. Focusing on relationship development came down to dollars and cents for this administrator.

Interviewee 1 related that "the state took about $112 million out of the social services budget just this past year." He also touched on the theme that Rule 132 is the driver of services and the financing that is *not* being provided. Moreover, the anger at the politics of the whole process came out in this statement by Interviewee 1, "In fact, they have a scheme going now that could cost us a couple of $100,000. Here we are in the middle of April, and we don't even know. We won't know until we get our contracts at the end of June. And all of a sudden, there it will be. There is no opportunity to plan for it. In fact, we'll probably get a 6-month contract this year." The administrator alluded to the coming election, in November 2014, in which the fight over taxes in Illinois that pay for social services will be a key issue.

Interviewee 2 and subsequent interviews would keep building these themes. Interview 2 stated, “There is no money. They keep asking for money back. They keep doing everything possible to take money away from us, so that we spend literally hundreds and hundreds of hours double-checking paperwork to make sure every ‘t’ is crossed, every ‘i’ is dotted.” Interviewee 3 advanced a similar idea because the rates specified in Rule 132 are not being updated with the rise in the cost of living: “Going on 12 years without an increase in rates.” Moreover, Interviewee 4 stated, “Our system is looped more and more to a high-end, crisis-based system. Over the years, cuts and the squeezes that we felt have led us to concentrate our efforts more and more on the lower scale, the poorest.” This administrator is showing that therapy is very brief, and only occurs when a client reaches a crisis level. It is not being provided as needed or necessary to keep people stable over time. These themes never changed over the next few interviews.

Interviewee 5 stated, “We don't have the resources.” Interviewee 6 said, “This is an election year, and I am sitting in these meetings with our management that talks about how tight the money is.” These administrators were relating that elections control how the delivery of mental health services is financed. No matter what the need, at least right now, for this year, there is no money. While Interviewee 7 again was unable to relate to the question and attempt an answer, Participant 8 noted that providing “any extensive services outside of the normal counseling situation would be tough for us.” Participant 8 was not a mental health professional, and thus could not relate to feelings that Rogers (1951, 1961) alluded to with his conditions of genuineness, trust, and unconditional positive regard. However, the group of administrators as a whole was going to do what was necessary to help their clients, but could not do any more. Yet, Interviewee 8 came in with a ringing quote: “The grand state of Illinois’s pay is based on 1993 reimbursement rates. So, do you see how stupid your questions are, friend?” This was meant to be sarcasm, but the administrator clearly knew that financing was a problem in the state of Illinois.

Responses from the last four interviewees reinforced the idea that the Norcross and Wampold (2011) recommendation would be expensive, in part because of the manner in which the delivery of services in CMHCs was provided and by whom. Interviewee 9 tied the cost of following this recommendation to “Millions. Tens of millions. Maybe 100 million,” while his CD, Interviewee 10, stated it clearly by relating, “I think we would still be billing out, and probably over the course of the year, $70 an hour times . . . maybe we'll provide somebody a 100 hours; it might run us about $7,500 - $10,000 per patient per year, depending on their level of acuity.”

Interviewee 11 could only emphasize that there would never be enough money, while Interviewee 12 brought it right to the point, “They've up and changed. The cost of living and the markets have changed in a desperate way. So, trying to survive on early-90s funding in a market that's money-managed care and infrastructure is kind of getting hit, the dollar is getting squeezed both ways, the value is less.”

The themes were consistent with all the administrators. All the participants pointed to Rule 132, or the requirements and the politics of Illinois, as reasons for the cost estimates. They did not just reject the recommendation because of the recommendation per se. They rejected it because they fully understood that the cost and paperwork requirements of Rule 132 were simply prohibitive. Moreover, they discussed the facts repeatedly: If the paperwork is not in perfect shape, they have to return the money following an audit of their files. Therefore, instead of focusing on better services or training of clinicians, administrators stated they spent time and money on salaries for workers who double- and triple-checked the paperwork. This idea was the main explanation throughout the last and final research question.

Research Question 5: Administrators' Responses

Research Question 5 asked, what ideas and perceptions will administrators within the CMHC relate regarding the training of therapists and the financial costs of following through with this recommendation? Regarding the cost of implementing the recommendation, the administrators answered by quoting anywhere from an hourly rate up to a high of tens of millions of dollars. The reasons for their estimates can be seen through this last research question. With Interviewee 1, it should be clearly understood that he did not agree with the idea that people with severe and persistent mental illness should even be receiving therapy as a service at the CMHC. Severe and persistent mental illness, according to his idea, referred to illnesses such as schizophrenia or personality disorders that are more difficult to treat than what community mental health services could offer. This administrator stated, “When I started studying it a little more closely and reading some studies and talking to some other clinicians, I knew, it was clear to me that this was not the route to go. It is not that people with chronic illnesses very, very few can’t benefit from a more insightful therapeutic processes, but by and large they cannot.” Moreover, he felt that most of the services were not provided by trained professionals. This created several questions that reinforced the themes I had found in the course of this research, and that I will continue to provide and build into the results.

The first interview was triangulated with Rule 132 and my notes taken during and immediately after the interview. It was clear that therapy services in the CMHCs were often provided by unlicensed personnel and not by licensed clinicians with a Master’s degree. However, these clinicians are supervised by licensed professionals. By focusing on service provision in the later interviews, the administrators deplored the lack of resources and the low numbers of licensed therapists available in the public sector. Administrators discuss how these aspects therefore made implementation of the recommendation impracticable. The workers they do have available are not always trained and do not possess the qualifications necessary to provide the level of service envisioned by Norcross and Wampold (2011). The idea of taking people with no college degree and teaching or training them to provide a service such as this recommendation stipulates, could indeed run into tens of millions of dollars because these workers would have to be trained just as a college degree could have done it to begin with.

Interviewee 1 set up the idea of the lack of trained workers, while Interviewee 2 stated a similar concept: “I think most people aren't trained in that area.” What is more, Interviewee 2 stated, “While I say that, and well, yes that's probably really why I won't do as much training as I need to, because I don't keep therapists that long.” This brought up the idea of financing and the low-level workers who, as soon as they are better trained, will leave for better paying jobs in private care. The idea that training therapists for providing better therapy relationships was expensive came through loud and clear. First, because the therapists were not trained to begin with; and, second, if the administrators would consider training them, the person would turn right around and leave for higher paid work.

Interviewee 3 discussed the idea that they “have regular supervisory trainings—it's what we call them,” while Interviewee 4 opined, “I think the most effective way to address some of that is through individual supervision. What we really strive to do is to have individual supervisors throughout the time, and the resources to address the needs of their supervising.” In this discussion, they intimated that supervision was training, and that in their perception this was the way to train. Yet again, the key to these answers was a thought provided by Interviewee 5, who said, “We would have to focus: one part of it would be to hire more staff, and then address their approach to therapy or their school of therapy.” The administrators noted that they can train staff, but first they would need enough staff and, then, the kind of staff capable of being trained in relationship-based therapy.

The training necessary became a key idea, which would continue to reverberate throughout the interviews. Interviewees 1 and 2 both advanced the idea that they would not implement the recommended services because they lacked the resources as well as staff that could be trained for this level of service. Participant 6 related, “However, what you are talking about is great if we have workers that can do that—but they are not here for the long haul if they want to be paid. So, workers are the key in my idea. I want to train. Hell, I want to train myself! But where, how, what are you talking about? You see this is what I am concerned about." All these administrators suggest they hired therapists based on their ability to pay them—by rates set in Rule 132 (Department of Health and Human Services, 2013). These rates for services were set long ago and are not based on current economic conditions. This is the main problem, as confirmed in the final few interviews.

Participant 8 spoke to this idea: "If it's okay, we're going to get into case management, go out and play baseball with them, or those types of things, again that's not only a time and finance issue, but then—so is this expertise or how well are your counselors equipped to handle this new approach to therapy. My job is to run this place, so now I need to hire more experts. So, should I say the Grand part again [about the grand state of Illinois]?" The sarcasm was evident, but he was serious about the issue of hiring qualified people and the state not apportioning the funds to act on this issue.

Participant 9 related, "They'd have to have the money. I mean, Number 1, they're not going to do that. You can say it till the cows come home—I can't imagine that any classically trained therapist wouldn't love to have a mandate for relationship-oriented therapy." Interviewee 10 emphasized that the idea was "teaching them. Well, I'm having trouble getting people to do group therapy, psychodynamic group therapy." The perception dominated of having employees first, and what they know to begin with, or what issues may be connected to not having a college degree in many instances. The ability to pay them higher wages and keep them long-term, after they are better trained, was an issue repeatedly voiced by this group of administrators.

Interviewee 11 noted, “It's a changing market,” while the last interviewee, Participant 12, simply said, “Yes,” when asked whether his workers simply could not complete the training. The reasons given were confirmed in 11 out of 12 interviews: The administrators felt compelled to hire less experienced workers to provide the services. Training had to be provided through supervision of employees, who could ask questions and learn from licensed professionals. However, most of the money appeared to be spent on formalities and on paying those employees whose job it was to make sure that the paperwork was done correctly. The greatest fear of these administrators seemed to be not being able to provide the necessary services to clients or proper training for their workers. The greatest current concerns, indeed fears, were occasioned by state taxes and Illinois politics. How much money would be apportioned in the contract that is signed year to year? A main idea was best stated by Interviewee 2, “I have case workers with 170 or 180 people and they see 30 or maybe 35 a week. Does that sound to you like a good program?” Then, later on when he followed up this idea, the same administrator stated, “It's going to take money. But there is no money. They [the state] keep asking for money back. They keep doing everything possible to take money away from us, so that we spend literally hundreds and hundreds of hours double-checking the paperwork to make sure every ‘t’ is crossed, every ‘i’ is dotted.”

These administrators would like to train employees, but first they would need to be able to hire trainable workers. This is not possible, as the administrators work on year-to-year contracts, even when they know how many clients they will serve. The numbers of clients, even in the smaller centers, are very high.

Strengths and Limitations of These Answers

In the planning stages of this study and noted in Chapter 3, I was unsure about who among the CMHC administrators would be willing to participate in the interviews and whom I ought to approach in the CMHC administration. I wondered if I would be facing professional therapists or business people. What I found was a group of knowledgeable professionals. I compiled a list of 22 CMHCs in northern Illinois of which seven agreed to participate. The final list of six of these centers provided the 12 participants, and their answers were based on many years of work experience in the mental health field. All but one participant, who held an MBA with no prior experience, had worked in mental health care. A second participant was new in his administrative position, but he had experience working in both mental health and community care. The majority of these participants had worked in the same or similar centers for most of their careers.

The administrators I interviewed represented licensed clinical social workers (LCSW) and licensed clinical professional counselors (LCPC); one participant held a PhD and two had Doctor’s degrees in Psychology. Several of the participants had MBAs in addition to mental health experience. Only one, as previously indicated, had no prior experience in the mental health field or in any CMHC position, before assuming his present position. The answers forming the data for this study, thus, came from administrators with collective experience in both mental health and its public financing.

Summary

In searching the literature, I did not find a single study of northern Illinois CMHCs. Also, the CMHC administrators' opinions regarding the Norcross and Wampold (2011) recommendations had not been explored thus far. This study began with Illinois CMHCs because I, as the researcher, live and work there, and the gaps I found in the literature could be studied in this geographical area. Ultimately, I would like to see this study repeated in several states to see if the answers remain consistent. The answers provided by this sample of administrators reflected a community mental health system that is in need of continued discussion in the search for improvement.

The administrators' views of Recommendation 17 and its viability in the state of Illinois was dismissal. The answers the administrators provided reflected opinions of people who for the most part were intimately familiar with mental health services for the poor. The system of mental health for the poor in Illinois may be similar to that of the nation as a whole, and it is a community mental health system in need of improvement, according to the administrators interviewed, as well as the literature reviewed. The administrators simply did not see the ideas advanced by Norcross and Wampold (2011) as a redeeming feature for CMHCs. What conclusions may be drawn from the results of this study will be expounded in Chapter 5, and recommendations will be offered for practical application and further study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this research was to explore the reactions of a representative sample of Community Mental Health Center (CMHC) administrators to Norcross and Wampold’s (2011) Recommendation 17, which states, “Administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations” (p. 100). CMHCs provide the major portion of the country’s mental health services to the poor (Cutler, 2003); therefore, it was important to know how this recommendation would be received by the administrators who are intended to implement the recommendation.

The reactions of this group of administrators were unanimous, in that all twelve agreed to the answers: While they appeared to be both knowledgeable of and in favor of relationship-based services, they saw no possibility of implementing this type of service in their agencies. These agencies are largely Medicaid reimbursed and in their own words cannot realistically provide the suggested services. The administrators conceded that this recommendation might work for the private sector where clients can afford to pay for such services, but to suggest that it be adopted by a CMHC struck them as unworkable. All of the respondents pointed to Rule 132 (Department of Health and Human Services, 2013), which appears to dominate how they operate their agencies and what services they could realistically provide. Readers can access Rule 132 and peruse it in its entirety through the link provided in the references section; for the purposes of this study, however, I will discuss relevant section of this comprehensive document and the complex problems they bring to the CMHC administrators' work.

In this chapter, I present the conclusions drawn from the findings. The results for this study are based on face-to-face interviews with a sample of 12 CMHC administrators and data analysis that used member checking and triangulation. I will triangulate my conclusions by linking the findings of this research to the ideas gleaned from the literature review in Chapter 2, and I will describe the implications for positive social change. The realities of state-of-Illinois politics, Rule 132 (Department of Health and Human Services, 2013), taxes, and the funding of mental health services are brought out in this chapter; each of these topics represent a major theme in the professional lives of CMHC administrators. I will detail the ideas presented by the administrators and tie them to reasons and moral obligations discussed in the history and development of the CMHC. My hope is, that these conclusions and reflections will serve to improve the profession while providing better—and indeed even relationship-based—services to the clients by finding possible adaptations of Recommendation 17.

I would like to preface these reflections and conclusions with a statement of my personal bias: I consider Norcross and Wampold's (2011) Recommendation 17 an idea that has great merit. Only one administrator I interviewed had heard of Norcross and Wampold's and Recommendation 17; however, when hearing Recommendation 17 the opinion of the CMHC administrators was that this idea did not demonstrate understanding of the day-to-day realities of working in a CMHC or of the larger problem that stands in the way of this recommendation: Rule 132 (Department of Health and

Human Services, 2013) and public financing as applicable with Medicaid clients. The reflections on Recommendation 17 were considerable anger, scorn, and sarcastic humor. The administrators I interviewed implied the authors of Recommendation 17 sat in an ivory tower seemingly without the slightest understanding for the services provided by the CMHC, or the millions of dollars required for the implementation of such a recommendation. This disconnect might be addressed by understanding the history and development of the CMHC to consider the true value of Recommendation 17. Moreover, provide a link to relationships where this idea can become part of the services provided by the CMHC. My interpretations of the results hope to develop ideas for practical application, and recommendations for further research in the hope that Recommendation 17 will find relevance in some form in the CMHC model.

Interpretation of Findings

Interpretation of Data for Research Question 1

Research Question 1 asked: How will this recommendation to administrators be viewed by the CMHC administration? The administrators I interviewed rejected this recommendation. The CMHC administrators pointed to financing that would be required and the paperwork. Rule 132 (Department of Health and Human Services, 2013) names a long list of documents that CMHC client must complete, before any services can be provided. This does not occur in private practice, as several of the administrators pointed out; it is an entirely different process. Rogers's (1951, 1961) concepts of congruence, genuineness, and unconditional positive regard—as described in Chapter 1 and on which Norcross and Wampold's (2011) 17 recommendations are founded—are lacking in the

CMHC. Nowhere is this demonstrated in more clearly than during the intake process, as described by the administrators.

The answers to Research Question 1 regarding the intake process show different thinking between Recommendation 17 as a concept—and the idea administrators understood due to financing. The data indicated that nine of the 12 interviewees noted that a client might see several different workers and have to describe her or his difficulties each time, before meeting the eventual therapist. When the client finally meets the final person who will provide therapy at the CMHC, that person may not be a trained therapist at all—at least, not trained in the sense of a licensed and professionally trained individual who would be expected to understand Recommendation 17 or hold a Masters degree. These findings, which are detailed in Chapter 2 are related to the concepts offered by Cutler (2003), who addressed the lack of funding in CMHC, and those of McNeil (2006) that addressed the inadequacy of training in these centers

Elevated caseloads with limited staff. The administrators detailed the funding problems and the lack of professionally trained workers they have available to provide services. As explained by the administrators, the professionally trained workers at the CMHC are often used as supervisors and do not provide the services themselves. These themes were identified by Feldman (2003) who found that workers lacked the necessary training for both service provision and cultural sensitivity (see Appendix D). One supervisor may have several workers under her or his guidance, with each worker managing case loads of up to 170 clients. The administrators clearly would prefer to have an expanded workforce of well-paid, licensed professionals; this, however, is not in the budget. It should be noted that licensed professionals do provide some therapeutic services to clients, but not often enough because the demand for services is overwhelming, and budgets are not large enough to hire a sufficient staff of professionally trained therapists.

Cumbersome intake process. As related by the administrators and seen directly in Rule 132 (Department of Health and Human Services, 2013), before a client may see a therapist, he or she may have to fill out up to 20 forms. This process applies to clients who present without an emergency. In emergencies, brief therapy is offered and a referral is made. The client may or may not see the initial therapist again. Data from my interviews and triangulated with Rule 132 confirmed this process, as described by the administrators. The average client requesting services participates in filling out numerous forms and moves through a clinical assessment, which may take several weeks. After the forms and clinical assessment have been completed, writing of a treatment plan will occur before any services are provided. Only after this lengthy intake process, during which the client may see two or more individuals, who may or may not be professionally trained, that the mentally ill person would enter the therapeutic process. Research by Tsai, Salayers, and McGuire (2011) also focused on lack of proper care as a matter of policy.

Lack of professionally trained and licensed therapists. One may rightfully ask why Recommendation 17 would not begin at this moment when the assignment of a therapist has finally been made. The administrators provided a partial answer by pointing to the lack of trained professionals, capable of providing this kind of therapy, due to insufficient funding. The research by Cutler (2003) addressed this lack of funding (see also, the historical Appendix D). Added to this is the brief course of therapy, again due to financing. Interview data confirmed when one examines Rule 132, which states who can provide therapy: Such a person does not need to be licensed, according to the Rule, he or she only needs to be supervised by a licensed professional. The data provided by the administrators showed that a number of services can and often are being substituted for therapy, such as helping clients with functions of daily living. Furthermore, when the supervised workers become skillful enough to provide therapy, thanks to the supervision and training provided by their trained and licensed supervisors, the administrators discussed they tend to leave the CMHC for better paid work in the private sector.

The cost of exacting paperwork. Administrators additionally pointed to the process of what might happen if CMHC workers fail to fill out just one of the documents properly. When this occurs, the state of Illinois, per the administrators' interview data and Rule 132, will take the money back that was reimbursed for this particular service. And if this were not enough, the state will audit the files and take back money across the board for a percentage of any mistakes in the paperwork. A 10% error rate in paperwork may translate into hundreds of thousands of dollars paid back—for services already provided. Each one of the administrators discussed how they have been forced to divert precious resources toward paying for redundant checking and double-checking of the paperwork, so as not to be required to pay back money that could otherwise be spent for improved services. Double- and triple-checking the paperwork for accuracy was an oft-repeated theme. These administrators discussed what they view as the truth; the care provided to their clients is secondary. This group of administrators stated the correct way to view these ideas is by the paperwork required by the state; and, the State of Illinois Rule 132 that provides funding to these CMHC. This same theme is directly related to the research of Kliewer et al. (2009), where they point to the lack of needed funds as the main problem. Additionally, Gioia and Dziadosz (2008) who noted that services in CMHCs did not have the proper focus on EBP, nor did service delivery target the true needs of the clients.

The overriding theme: financing. One of the themes occurring repeatedly with these participants and presented with real anger and bitter laughs was financing. Community mental health is publicly funded through the department of human services, and the current cuts to the budget within Illinois portrayed by this group of administrators were noted frequently. Ten of the 12 administrators could explain some the history of the CMHC in detail. These administrators were knowledgeable and had a positive attitude toward building therapeutic relationships, as suggested by Recommendation 17 (Norcross & Wampold (2011). This group clearly knew that a relationship is a key concept in therapy and may be the deciding factor in change in the client. However, as these administrators regretfully reported the lack of money and Rule 132 guidelines did not support implementation of Recommendation 17. The same ideas noted by Cutler (2003), McNeill (2006), and of Kliewer et al. (2009). The same ideas that I wrote were missing from Norcross and Wampold in making the original recommendations. State politics and tax revenues would have to change dramatically in their words to provide better care to the poor in need of mental health services, but the coming election, of November 2014, did not foretell a change for the better. Sadly, per the words of these administrators this cycle seems to repeat with every election year.

Interpretation of Data for Research Question 2

Research Question 2 asked: What would make this recommendation to be considered viable by administrators within a CMHC setting or, conversely, not viable? The executive directors (EDs) and their designated clinical directors (CDs) from six centers pointed to Medicaid as the primary funding source for the CMHC as a major problem with respect to implementing Recommendation 17. These 12 administrators left no doubt that implementation of Recommendation 17 was out of the question, unless they would be able to hire many more workers and, then, invest hundreds of millions of dollars in salaries and training. They could not foresee either of these conditions being met anytime soon and certainly not during this election year with its harsh budget-related discourse and the harsh budget cuts that have occurred during this election year.

The right to mental health services. In Chapter 1, I reflected on the reasons why Recommendation 17 might pose a problem for CMHCs. I pointed out that Norcross and Wampold (2011) had based their recommendations on studies in which not a single one had been conducted in a CMHC setting, thus not taking into account the special responsibilities and needs of CMHCs. Furthermore, responses during the interviews reflected ideas related to the court case of Watt v. Stickney (Alabama, 2012), described in Chapter 1. This court case dragged on for over 33 years and established that clients have a right to mental health. The administrators indicated with sarcastic humor: If clients have the money, they have rights. One of the questions one must ask in all seriousness is whether all clients have a right to be treated by a licensed and trained professional, irrespective of how much money they have.

No money to treat the most severe cases. This group of administrators communicated that Recommendation 17 would be viable in the CMHC only if they could hire workers who are, first and foremost, capable of understanding what this type of service entails. One administrator ranted on about research showing that his type of client (the one seen in the CMHC) did not need this kind of therapy. He mentioned schizophrenia and personality disorders, for which he decided to stop providing therapy due to lack of adequate funding. He ruminated that, with adequate funding, he would gladly provide the therapy these cases required; however, with conditions being what they are (e.g., billing in 15-minute increments for specified services), he figured that not taking on this type of intensive therapy helps him to provide additional services to others clients. The problem is, that these clients miss out, because if they have a deeper problem than what the administrator could properly treat the client gains no help at all. This administrator’s dilemma came about because he did not have funding commensurate with the needs of severely mentally ill clients and the requirements of documenting the services he provided as driven by The RULE. These administrators did not intimate that they should be given open checkbooks; however, what they seriously wanted and needed was a reasonable balance of paperwork and service provision. They all welcomed to have these aspects researched and reviewed.

The uncertainty of year-to-year contracts. With the data processed and triangulated, it was evident that Recommendation 17 was not seen as viable by this group of administrators in part because of politics. At the time of the interviews, many of the participants were waiting for new contracts to provide services during the coming fiscal year, which began on July 1st. Moreover, several of them were afraid that they might receive only a 6-month contract and would have to wait for the election results to learn what the next 6 months would hold. Rule 132 provides that agencies be given a year-to-year contract for the public funding they will receive. They are free to find grants as well, as long as they fund the grant-writing process themselves. All of this raises more questions: How can an agency implement Recommendation 17 if it cannot hire workers to carry it out? Are they supposed to hire more workers and then, when they do not receive the financing needed, fire the workers because the election turned out wrong for the needs of mental health clients? These were some of the questions raised by this research and asked bluntly by the administrators.

This group of interviewees, most of whom were well-trained in the therapeutic process and all of whom had ample experience with its financing, were struck by Recommendation 17 and found it either “funny” or “stupid”. Anger appeared as a theme in the very first interview. Administrators continued to relate with anger to the themes of politics and financing and responded with disgust that the latter two themes should interfere with helping poor clients. Yet, politics and financing were clearly the drivers of care for these clients. The answer to Norcross and Wampold’s (2011) Recommendation 17 was a resounding, “No! We don’t have the staff or the money. Furthermore, the money is not coming anytime soon.”

Interpretation of Data for Research Question 3

Research Question 3 asked: What is the current level of administrators' knowledge of and attitude toward the delivery of evidence- and relationship-based services? Out of this group of 12 administrators, 10 were fully up to date with what Norcross and Wampold (2011) suggested in relationship-based services. They had a strong knowledge base, and all evidenced a strong willingness to provide services as suggested by Recommendation 17. However, the themes I have described above stood in the way. The value of the answers to this question was the clear affirmation that the administration of CMHCs is in possession of both the knowledge and the attitude to provide such services. This was confirmed in 10 of the 12 cases. Although I asked this research question with some trepidation, the answers supported both the work of the CMHC and the opinions of its administrators with credibility and transferability in that this group of CMHC administrators was knowledgeable and had a very positive attitude toward relationship-driven care. Future research may find a similarly strong base of professional knowledge and willingness to offer relationship-based services in CMHCs throughout the state of Illinois and the United States.

Interpretation of Data for Research Question 4

Research Question 4 asked: Do the administrators anticipate that there would be financial costs involved in attending to the relational features of service, as Norcross and Wampold recommended, and can the administrators calculate such costs? The answer to this question was simple and clear-cut: The administrators considered financing, as practiced by the state of Illinois, as the Number 1 barrier standing in the way of this recommendation. This group of administrators could and did compute what they perceived would be the real costs, that implementation of this recommendation would engender. Monetary needs and associated politics were not difficult to abstract from the interview data or view how this group of administrators went about calculating rates and estimating costs. The answers were given as hourly rates, leading up to tens of millions of dollars. One participant suggested up to $100 million. They all would be happy to put this money to immediate use. The answer to this question is a simple Yes; the administrators could calculate the perceived cost. However, none of them expected to see this money coming their way anytime soon.

Norcross and Wampold (2011) did not investigate public financing of mental health prior to compiling their list of 17 recommendations; hence, the fulfillment of my concerns that this research would lead to more questions than answers. For example: What would be the actual cost of implementing this recommendation throughout the CMHC? Based on the answers of this group of administrators and the current political atmosphere in the state of Illinois, the answer is simply: Financing, there will never be enough money to implement Recommendation 17 within the CMHC.

Interpretation of Data for Research Question 5

Research Question 5 asked, what ideas and perceptions will administrators within the CMHC relate regarding the training of therapists and the financial costs of following through with this recommendation? The administrators noted, and Rule 132 provided the back-up, that services in the CMHC are being undertaken by a staff that does not always hold professional licensure. Again, according to The Rule, this is seen as acceptable.

Another new question arising from this study was: When Norcross and Wampold (2011) recommended that administrators attend to the relational features of these services, did they see professionals or paraprofessionals carry out these services? The quality of care suggested by the authors was closely tied to treatment relationships. The CMHC administrators found conflict in this portrayal of “quality care.” Not only did they have the strong professional desire to provide quality care in their facilities, but they also were in favor of the concepts contained in this recommendation. However, to implement this recommendation would require a staff of trained professionals who are capable of providing this particular service. At this point, it would mean that the administrators would need to hire staff who are trained to the level where they can be trained in the provision of evidence- and relationship-based services, and, then, they would need to provide the advanced training in this form of therapy. The administrators felt these two steps of hiring and training alone, the cost would be enormous. Rule 132 provides that the administrators do not need professionally trained workers, as long as they are supervised by a licensed individual, nor are they reimbursed commensurate with professionally trained workers who could provide this service. By contrast, in the private sector, the client must see a licensed clinical professional who is master level, if the service is to be reimbursed by an insurance company.

In regard to Recommendation 17, this group of administrators was asking how they are supposed to train staff that they cannot hire in the first place. They were also asking who was supposed to train this staff. The ideas put forth by Rogers (1951, 1961) regarding congruence, genuineness, and unconditional positive regard in therapy have been set aside in favor of paperwork, a theme repeated over and over by the administrators with anger and bitter mockery.

Originally, I voiced an expectation that the perceptions of the administrators would provide an answer regarding the viability of implementing Norcross and Wampold's (2011) recommendation. The answer is very clear and can be summarized with the popular adage: Follow the money, as administrators spoke repeatedly about financing. Additionally: Follow the political process and the paper work. The administrators perceived the cost of the recommendation to be insurmountable, that is, it would be higher than what they could hope to receive from public funding. However, they would gladly take the amount needed for hiring and training staff and begin providing the services recommended by Norcross and Wampold because these services are similar with their own conceptions of quality services for mental health clients.

Strengths and Limitations

This research and accompanied findings were limited by the self-selected sample of those who agreed to be interviewed out of a divergent pool of CMHC centers from possible candidates for inclusion. Many of the potential participants expressed interest in participating, but their time was too limited to plan for the interviews of two of their administrators. It is possible that different answers could have been obtained had other EDs and CD from other centers participated in the study. Alternatively, if the interviews had been extended over a longer time span with additional follow-up questions, other themes might have emerged from the data analysis. However, the 12 participants were in agreement with the answers they provided to the research questions, and triangulation strengthened the validity of the information they supplied. I further note ideas from my personal bias could be a limitation that I have worked to contain. First through completing a pilot interview with one participant, and, then reviewing the questions and answers with my chairperson. Second, the full interview data was read by two committee members, and no leading questions were found in the data. These ideas helped to contain my personal thoughts and bias.

Trustworthiness

I could find no research study from northern Illinois that discussed Norcross and Wampold's (2011) recommendations with CMHC administrators, this study could be considered a stepping-stone toward other interviews to test the reliability of the information obtained. As previously noted, Interviewee 8 gave the impression that he had spoken with a previous interviewee to discuss his answers. As it turned out, his answers were similar in content but expressed with a good deal more humor. What I would term his lighthearted remarks were not directed at me or taken at my expense. He seemed to be laughing, along with the previous interviewee, at academic research in general. This administrator it can be said was roasting what he perceived as the stupidity at the current situation of the state of Illinois; and how the state cares for the poor in need of mental health services.

It should be noted that, in order to assure trustworthiness of the findings, I asked two dissertation committee members to review all interview transcripts, and they did not find evidence of any leading questions. I also reviewed the use of my observations and the personal journal made during and immediately following the interviews as well as my bracketed personal biases (Merriam, 2009; Patton, 2002). On another note: It might have been wise to complete as many interviews as possible in a single day or on several consecutive days, to reduce the possibility of interaction among the participants. However, distances between centers and traveling to face-to-face interviews, as well conducting a pilot interview and waiting for university level approval, were factors that stood in the way of such compact scheduling. Any possible communication between the two participants did not seem to affect the results of the study.

Recommendation for Action

I hope this research on this topic can continue for reasons I will discuss in this section, and my researcher reflections. I question how the Recommendation and CMHC can together use the history of CMHC, to build upon it and not hide from the ideas. Mental health care providers in private practice or in public service should work together for methods that will help clients to improve. Action will not come when the answer, reflected by the administrators is: We do not have enough money, and let this be the end of the efforts. We can stand up, and stand together for positive social improvement, as we provide new research from these answers. As detailed in the history of mental health (see Appendix D), the historical idea has always been a story of providing care for the poor who are mentally ill, and together we can uphold and help to add new chapters to the history and service.

Recommendation 17 is derived from Rogers's (1951, 1961) perspective of congruence, genuineness, and unconditional positive regard; yet, love in mental health work is just as vital. Based on Peck's (2002) writing, the concept of love in therapy will be described in more detail in a later section. Based on these reflections, I offer recommendations that will build upon the findings of this study and Norcross and Wampold's (2011) Recommendation 17.

I believe that the original study of Norcross and Wampold (2011) *must* be viewed with the entire history of mental health in mind. The proposed ideas together should be reviewed with experts who run both public and private services. I am a supporter of Recommendation 17, except the idea fails to reflect the history of community mental health. The history of mental health care and the fight for social change influences the answers for what is needed to move forward. A search into the history of mental health, beyond the immediate past of 5 short years, provides a notion of the therapeutic relationships were discussed long ago and, the idea was absent in community care to the detriment of successful service provision. I believe that the path forward requires that for a moment we take stock of the themes that were repeatedly expressed and wrestled with over the 170-year history of mental health (see Appendix D). My recommendation taken from this data is we begin to understand what we know about community mental health, the offered Recommendation 17, and together work to pursue mental health services, while leaving out the politics of the day. Using what is the best of evidence-based practice has to offer, as Norcross and Wampold (2011) completed.

What can administrators do rather than just accept the status quo? I suggest continuing to find actions to achieve that might work as these administrators discussed. Ideas I recommend are CMHC administrators that come together to lobby for funds to implement minimize, streamline or automate the paperwork process and leave more time for relationship building with clients. Administrators can link to universities, and make use of doctoral and master level interns on local levels. Additionally, administrators can explore ways to keep the client with the same service person throughout more of the process. These recommendations for action can become pilot studies together with the Illinois Department of Human Services. Together, administrators with the Illinois Department of Human Services can investigate the possibility of implementing Recommendation 17 in real time. Administrators and the state of Illinois together can examine how to disseminate information and train workers, as Norcross and Wampold (2011) envisioned. These recommendations can begin immediately.

Implications for Social Change

A reader of history, (see Appendix D) can see that Dix (1843) could have gone about her life and continued to pray with the inmates of the jails—who, as we now know, were people with mental health needs. Dix, however did not stay quiet, and she did not stop fighting. The movement she started led to change. The change was not perfect, but was better than what the mentally ill had endured before, and they did not understand what we know today. Similarly, my research could be put on the shelf and never picked up again. However, doing so would continue the current conditions. It is my personal belief as well as the historical perspective highlighted in this study that we need to continue working for the people struggling with mental illness who are unable to help themselves. I well realize the strength of this statement.

I hope to discuss this information locally and at the state level, adhering to my social worker standards of ethics and mission of social justice. I hope to collaborate with organizations such as the National Organization of Human Services and the National Association of Social Workers to uphold the cause of improving mental health care, and spread the knowledge. Professionals within these organizations, along with the CMHC, should read and consider the results of this study.

The benefit of Norcross and Wampold's (2011) research begins with the need to strive for the implementation of Recommendation 17. What is necessary is ways to make this recommendation workable with in the CMHCs of today. Moreover, promote the recommendation wholeheartedly, not just locally but nationally, because the recommendation holds the potential for positive social change. Rogers's (1951, 1961) work marked the beginning of the emphasis on relationship with the client, and a need exists to reconnect with this crucial understanding.

The administrators interviewed in this study possessed the knowledge and expressed the desire to implement changes in the direction of relationship-based therapy. What held them back from doing so was their claim that there was no money available. This claim is by no means a new story; it cropped up repeatedly in the history of mental health. Positive social change, so the history showed, was rarely ushered in by ample funds, but rather by someone taking on the difficult work and refusing to bow to the word *impossible*. Whether on the individual, the state, or the national level, positive social change can be promoted by disseminating the results of this study and moving the concepts contained in Recommendation 17 forward. By gaining access to professional organizations and joining together in the fight for mental health rights for every client, public or private, rich or poor, social change will occur and add a new chapter to the history of mental health. However, to understand this fight, people must understand the history and the perspective of the CMHC's answers within this research.

Researcher's Reflections

In looking back to the beginning of this journey when I first felt the impetus to pursue this research, I realize how much this study has changed me and how much knowledge I have gained. In concluding this writing about the journey I have taken, I want to leave a strong message about this work. To do this, I believe that I need to assess the entire journey. Chapters 1 through 3 started as a research proposal. Now, that the research has been completed, I can look back and review, but mental health professionals need to move forward and expand.

I have discussed my thoughts that this research would raise additional questions. This was confirmed by the results and proved to repeat what has occurred repeatedly throughout the history of mental health. I reject the idea that it is sufficient or wise to concentrate on the research of the last few years to the exclusion of what came before. While some may quote the old adage that every generation needs to reinvent the wheel, I believe that we should learn from our history and not slide back or accept the current status quo. Viewing the history is vital to the mental health movement. We know, by looking at the history, that the fight for mental health through the Joint Commission Report (1961) included the demand to triple the amount of money spent on mental health. This idea was not followed through. We can see in the history, as provided by Koyanagi (2007), the American policy change of 1975 when community mental health became a community support program. This change was important for the current research because it revealed why Recommendation 17, predictably, would be met with rejection from the view of academic impracticality.

I referred to the history of mental health and how Rogers's (1951,1961) ideas were not utilized in the development of community care. Caplan (1964) provided what we knew and what we did not know in helping set up the CMHC. He was a central figure in this effort. Caplan discussed at length all the relationships that were necessary within communities, but it was never the relationship with the client. Rogers's (1951,1961) ideas were making headway at that time, as described in depth in Appendix D. Yet, Rogers's ideas were not encased in the CMHCs when the latter were set up. As this research began, I made the prediction that administrators might say to follow the money. That is exactly what happened. The administrators pointed to budget cuts and finances. They discussed money and politics that get in the way. In their words, they feel this is an old and tired story, and we can look to history and see what is needed: It is the will to carry on the valiant fight the history speaks of and to move forward with real and effective care for the mentally ill.

Important information I found through this research came with the help my dissertation chair. Dr. Ayers's advice was to look at the history of Wyatt v. Stickney (Alabama, 2012), a court case that, as I discovered, lasted for 33 years. This case is a landmark for mental health clients and their rights within hospitals. Mental health clients have strong rights that, I believe, are not being observed in the present system for the needed changes. I believe the following questions needs to be pursued: Do all clients have a legal right to a therapy relationship with a professionally trained worker that best justifies the expectation of real help extended in the proper way? One would expect the answer to be Yes, based on the aforementioned court case; however, the answers obtained in this study were based on the idea relationship-based therapy was too expensive. I believe that Wyatt v. Stickney needs to be examined and that it is necessary to explore how this court case may help more the research forward.

History speaks to the idea recommendations of the Joint Commission were not followed. I wonder if we can return to the drawing board and begin again, to find ideas left off in the development of the system of CMHC. This chapter in the history of the CMHC needs to include the research and the recommendations of Norcross and Wampold (2011). My research provides, we must not only look at the history, but we need the research lessons.

Harrington (2013) noted that the way forward to help people with a mental illness may be through mental health courts. The author described in detail how many people are treated for mental illnesses in the jails and what it will take to find a way out this situation. Those with an eye to history know that this is where we started from 170 years ago: The mental health client in jail. What is different today is that billions of dollars have been spent on finding alternatives for mental health patients. Yet, we seem to be just where we started from all those years ago (Harrington, 2013; NAMI of Greater Chicago, 2013). I sincerely hope that the results of this study are a decisive first step in a new direction that brings the best of evidence-based relationship care to community mental health and makes the CMHC the effective system it was intended to be.

I recommend that this discussion not be confined to the state of Illinois. This study should be replicated in other states in the hope and with the goal of starting a national discussion. I believe what is needed is a new *National* Joint Commission on Mental Health Care. In 1961, the first Joint Commission on Mental Illness and Heath delivered its report. Several of the recommendations were followed; yet, many of the 1961 recommendations were forgotten due to politics. The CMHCs were built over a number of years, and, in 1965, Medicaid financing began. Shortly thereafter, mental health care for the poor was shifted to these new CMHCs. The history provided by Cutler and Huffine (2004) details the political changes and the fights over money that raged some 50 years ago. The resulting conditions experienced today should not come as a surprise, as I endeavored to point out in the background section of Chapter 1. To provide an in-depth look and further the understanding of the history of the CMHC, I have provided a short history of mental health in Appendix D. While the recommendations of Norcross and Wampold (2011) are based on solid research, they failed to take into account the history and development of community mental health and the conditions at the CMHCs today. The problems and the struggles leading up to the establishment of the CMHC and making it the largest provider of mental health care for the poor who must largely rely on Medicaid are clearly lined up against Recommendation 17. I, therefore, believe that the fight for better mental health services must be taken to the national level, instead of remaining local, and explicitly include a thorough understanding of the entire historical development and struggle that characterizes mental health care for the poor.

I further suggest the state of Illinois can, and should research and develop the necessary trainings' and offer this education immediately, so that Recommendation 17 can be implemented. While, over time the additional recommendations can be researched and/or put into practice over time. Training sessions requiring a few hours could provide a brief history, guidelines, and requirements of relationship-based therapy. The training sessions could be made available immediately for both professionally trained personnel and supervisors who provide this service through the workers they oversee. I recommend that this plan be explored immediately; such training sessions could be designed with relative ease and, I believe, without excessive costs. The training would help people to understand the struggle over time and build support for Recommendation 17.

In my estimation, the suggested training should focus on Norcross and Wampold's (2011) Recommendation 17, but additionally I would propose the addition of one more piece of advice to CMHC administrators, that the data provided. It is an idea that I have defined as the development, of not only a relationship, but of a further initiative researching and expanding the relationship concept into the notion of a *clinical friendship*. I would define clinical friendship as a new and different concept to be researched: I understand Recommendation 17, however with the added concept of a clinical friendship now there are two pillars that have their foundation in Rogers's (1951, 1961) ideas. Rogers developed the humanistic view, which later became known as the person-centered approach to therapy via his three main conditions for therapy: (a) empathy, or sensitivity to a person; (b) congruence, or trust that is built over time; and (c) unconditional positive regard, meaning support for the client no matter the circumstance.

Rogers's (1951, 1961) three conditions are an important start for the clinical friendship, but they are only the beginning. Then, I believe, a fourth condition must be added to span Rogers's concepts, and Norcross and Wampold's (2011) recommendation, and that condition is love. Peck (2002), a psychiatrist in his own right, contributed this further point regarding love. In his best-selling book *The Road Less Traveled*, Peck wrote:

> If the psychotherapist cannot genuinely love a patient, genuine healing will not occur. No matter how well credentialed and trained psychotherapists may be, if they cannot extend themselves through love to their patients, the results of their psychotherapeutic practice will be generally unsuccessful. (Peck, 2002, p. 175)

I believe that Norcross and Wampold's (2011) advice to focus on relationship in therapy needs to include this idea of love or clinical friendship within the recommendation itself while the concept is being promoted. If one ties together the concepts of Rogers (1951, 1961) and Peck (2002), it becomes evident that the relationship with the client is the primary factor in bringing about change within the client. To relate these ideas, I have coined the term *clinical friendship*.

As I define the idea, a clinical friendship involves a caring connection between two people. One person is the professional, the other is the client. This aspect is different from just stating that "administrators should attend to relational features of therapy" (Norcross & Wampold, 2011, p.100). Adding the idea of developing a clinical friendship within the therapeutic relationship emphasizes the notion that here is a connection between two people who hold mutual affection for each other. While the professional individual and the client develop a caring and fraternally loving connection, the professional continues to maintain an independent and objective viewpoint that remains outside the deep emotional bond between the two people.

That this clinical friendship will entail a difficult balance for the professional due to the feelings of love was clearly recognized by Peck (2002). The clinical friendship must at all cost be contained within fraternal feelings. Yet, researching and adding this idea to Recommendation 17 and start training professionals in the provision of a clinical friendship would contribute a deeper level of understanding to the client-therapist dyad, which is the key and the improvement with the client. Therefore, I recommend that Norcross and Wampold's (2011) Recommendation 17 be researched and expanded through the addition of an historical perspective and the notion of the clinical friendship. To design a training course with these two additions included would, in my estimation, make the implementation of Recommendation 17 more interesting to the administrators is seeks to reach.

Conclusions

As this study shows, the themes surrounding mental health over decades of attempted improvements have changed very little indeed. Although so much more is known today about what helps people with mental health issues through evidence- and relationship-based therapy and treatment provided in community-based centers, we seem to be back where we started. The News today relates the poor with mental health needs crowd the jails (National Alliance of Mentally Ill [NAMI] of Greater Chicago, 2013), while the administrators discussed the budget cuts, lack of funds for proper training of therapists. By focusing on the themes raised by the informants in this study and presenting them to colleagues, professional organizations, and political movers and shakers, I hope to expand the dialogue around Recommendation 17 and usher in social change by moving the recommendation forward toward implementation.

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Appendix A: The 17 Recommendations of the Task Force

General Recommendations

1. We recommend that the results and conclusions of this second task force be widely disseminated in order to enhance awareness and use of what "works" in the therapy relationship.

2. Readers are encouraged to interpret these findings in the context of the acknowledged limitations of the task force's work.

3. We recommend that future task forces be established periodically to review these findings, include new elements of the relationship, incorporate the results of non-English language publications (where practical), and update these conclusions.

Practice Recommendations

4. Practitioners are encouraged to make the creation and cultivation of a therapy relationship, characterized by the elements found to be demonstrably and probably effective, a primary aim in the treatment of patients.

5. Practitioners are encouraged to adapt or tailor psychotherapy to those specific patient characteristics in ways found to be demonstrably and probably effective.

6. Practitioners are encouraged to routinely monitor patients' responses to the therapy relationship and ongoing treatment. Such monitoring leads to increased opportunities to reestablish collaboration, improve the relationship, modify technical strategies, and avoid premature termination.

7. Concurrent use of evidence-based therapy relationships and evidence-based treatments adapted to the patient is likely to generate the best outcomes.

Training Recommendations

8. Training and continuing education programs are encouraged to provide competency-based training in the demonstrably and probably effective elements of the therapy relationship.

9. Training and continuing education programs are encouraged to provide competency-based training in adapting psychotherapy to the individual patient in ways that demonstrably and probably enhance treatment success.

10. Accreditation and certification bodies for mental health training programs should develop criteria for assessing the adequacy of training in evidence-based therapy relationships.

Research Recommendations

11. Researchers are encouraged to progress beyond correlational designs that associate the frequency of relationship behaviors with patient outcomes to methodologies capable of examining the complex associations among patient qualities, clinician behaviors, and treatment outcome. Of particular importance is disentangling the patient contributions and the therapist contributions to relationship elements and, ultimately, outcome.

12. Researchers are encouraged to examine the specific mediators and moderators of the links between the relationship elements and treatment outcome.

13. Researchers are encouraged to address the observational perspective (i.e., therapist, patient, or external rater) in future studies and reviews of “what works” in the therapy relationship. Agreement among observational perspectives provides a solid sense of established fact; divergence among perspectives holds important implications for practice.

Policy Recommendations

14. APA’s Division of Psychotherapy, Division of Clinical Psychology, and other practice divisions are encouraged to educate its members in the benefits of evidence-based therapy relationships.

15. Mental health organizations as a whole are encouraged to educate their members about the improved outcomes associated with using evidence-based therapy relationships, as they frequently now do about evidence-based treatments.

16. We recommend that the American Psychological Association and other mental health organizations advocate for the research-substantiated benefits of a nurturing and responsive human relationship in psychotherapy.

17. Finally, administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations. (Norcross & Wampold, 2011, pp. 98-100)

Appendix B: Interview Questions for CMHC Administrators

(Executive Director and Clinical Director)

1. Relate your background in mental health care?
2. Discuss how long you have you been in your current position and what led to your taking this position?
3. Relate to me, if you personally believe a client has right, or a choice in being assigned a therapist?
4. Can you describe your intake procedure for clients?
5. Discuss your knowledge and understanding about the relationship between the client and the therapist as a necessary part of the change or improvement in therapy.
6. Describe how the therapists at your agency build a therapeutic alliance with a client.
7. Discuss if you read current research or if you have knowledge about Norcross and Wampold's research recommendations?
8. One recommendation by Norcross and Wampold states that "administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations" (Norcross & Wampold, 2011, pp. 98-100).
9. What does this recommendation mean to you?

10. Keeping in mind those relationship-based services as discussed by Norcross and Wampold; discuss if your agency have the financial resources to provide such relationship-based services?
11. Discuss your thoughts of the viability of relationship based services in your CMHC?
12. Discuss your perceptions about delivery of relationship-based services within your CMHC, based on what Norcross and Wampold are recommending?
13. Discuss how you would implement relationship-based services in your CMHC, if you had a free reign and no road blocks in the path of implementation?
14. What, in your opinion, describe your prevailing concern about this recommendation?
15. Describe what changes your agency might need to make if, it was mandated that relationship-based services were to be implemented in your CMHC?

Appendix C: Opening Statement and Informed Consent Form

This research is seeks feedback on one recommendation, #17 by Norcross and Wampold (2011). The questions asked and your responses will help to shed light on the many questions surrounding these recommendations and how they might be implemented or adapted to fit the needs of the CMHC. If you decide to participate in the study, you are, nevertheless, free to withdraw from participation at any time. The answers you provide will be transcribed and then sent to you for your approval. If you feel that your answers need to be changed or added to, you may do so at that time. Please review the Informed Consent Form, and sign it in order to acknowledge that you are willing to participate in this study.

INFORMED CONSENT FORM

The purpose of this form is to provide a clear explanation of the nature of this study. The necessary procedures are described below. If, after reading this form, you have any questions or concerns, please discuss these with the researcher, the PhD candidate Alan F. Singer. Alternatively, you may contact Dr. Ayers, Chair of this dissertation project at the number provided below. Once you are entirely satisfied with this explanation and freely choose to participate in the study, you may indicate your willingness to participate by signing below. Participation is voluntary. You are free to take a break, or discontinue your participation in the study at any time. You will not be paid, or compensated in any manner.

In this study, one recommendation from Norcross and Wampold is being discussed. It proposes that administrators in mental health will concentrate on modifying facets of the client-therapist relationship. The 12 participants are administrators of Community Mental Health Centers (CMHC). They will begin a dialog on how to advance these recommendations in the CMHC setting. This investigation will seek to determine the feasibility of introducing the recommendations and, ultimately, putting them into practice within the CMHC by pursuing a thorough understanding of the history, development, and ethics of CMHCs. By discussion of your thought, this research may enable social change within CMHCs that will be furthered by your participation.

Each interview session will take approximately 1 hour or less to complete and will be audio recorded, and the researcher will take short notes that you may view. You will not be identified by name in any part of the research. You are also being asked for any additional documents they may shed light on this research (e.g. policies or memos about how clients are assigned to therapists.) The audio recording will be transpired, and you will have an opportunity to revise your answers if they do not reflect your true intent. Quotes of your answers may be used in my results. Any records will be kept locked up, and will only be shared with the dissertation committee. Your results will be combined with those of other participants and they will be studied only in this fashion. There is no risk of physical injury from participation in this study. This study will discuss the personal feelings and beliefs of the participants by seeking answers to a set of interview questions. Moreover, the participants may be asked for documents related to their CMHC setting, but without involving disclosure of any confidential information.

Informed Consent Form

I understand that the procedures used in this study involve minimal risks. With this in mind and with the above description of the project, I voluntarily agree to take part in the study. I have received a copy of this consent form to keep for myself. I have read and understand all of it. The researcher explained to me anything I did not understand in the form. Therefore, I agree to participate in the study.

I have read and understood this consent form, and I agree to participate in this study.

Participant's signature Date

____

Please print your name

____

Researcher's signature

<u>Researcher</u>

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If you have *any* additional questions, you may contact the Walden University Representative. They can answer questions about your rights as a participant, or other needs: **612-312-1210**

Appendix D: The History of Mental Health, Social Work, and the CMHC

From Mental Hygiene to CMHC: The Four Phases of Care for the Mentally Ill in America

Mandell (2011) discussed the origins of mental health care over the past 170 years and identified four distinct phases. Mandell noted that the asylum movement made famous by Dorothea Dix (1943), was the first phase. This led up to Beers's (1908) book about asylum care and a group that lent financial support to him; thus, Beers began the mental hygiene movement as the second phase (Mandell, 2011). Weiss (1990) discussed how services for the mentally ill began evolving again during World War II (WW II), as conscientious objectors (COs) filled the places of attendant workers who had gone to war in the asylums. The COs had raised concerns about conditions within the asylums over the wartime years, leading to new research, medications, and eventually the third phase, which was a movement of deinstitutionalization.

Cutler et al. (2003) described these developments over time, which led directly to the beginning of the fourth phase: the development of the community mental health system. This phase began in 1963 when President John F. Kennedy signed Public Law 88-164, the Community Mental Health Act. The official phase, as chronicled by Koyanagi (2007), was finalized with the official policy change in 1975, when the current period of community mental health care was activated with community support programs (CSP). Koyanagi stated that, since that time, CSP programs have dominated as the newest and biggest change; they are continuing as the current policy of mental health services to poor people in need of services through the CMHCs. Koyanagi pointed out that the National Institutes of Mental Health (NIMH) helped lead this push, after the realization had set in that moving people from one placement to another was an ill-conceived program. This is the same NIMH that supported the push for better care initiated by the war objectors of WW II, who worked in the asylums that had first been conceived by Dix (1843) as better care for those in need. These events will be discussed in greater detail in the following sections.

The development of community care and the eventual establishment of CMHCs will be shown as driven, over time, by policies and legislation with the goal of finding solutions to the social problem of caring for the poor (Cutler et al., 2003; Goldman & Grob, 2006; Viney & Zorich, 1982). Throughout its history, mental health care can be shown to be driven as much by policy developed and the definition of mental illness as a political statement as by the necessity of actual care (Goldman & Grob, 2006). The term mental health was derived from an idea about mental hygiene advanced by William Sweetzer, in 1843, who was the first to used this term (Mandell, 2011). The term mental hygiene was actually used until the late 1930s. Additionally, even with asylums being built, actual policies regarding what was called mental hygiene or psychological care did not come about until after the American civil war (Viney & Zorich, 1982).

Phase 1: Origins of the Asylum

The first almshouses, also known as poor houses, provided care for the poor in America as far back as the early 1700s (Colby & Dziegielewski, 2001). Colby and Dziegielewski (2001) reported that these houses developed into places called asylums in order to care for the deaf, dumb, and insane, which provided for a smooth schedule and, at the time, was thought to meet the needs of the occupants. These organization were run mainly though religious organizations and funded by various charities. These charities were run by human service organizations that contained the roots of the eventual social work profession, which will be discussed in the section From Friendly Visitor to Social Worker.

The asylum was, as described by Colby and Dziegielewski (2001), a place to provide structure and assistance. Often, there was a separation between the worthy poor and the unworthy poor. As related by Colby and Dziegielewski, the unworthy poor were placed and held in jail, while the worthy poor were given help through the asylums. According to the authors, asylums were supposed to be clean places, but only for the worthy poor. This spawned a larger social problem with respect to raising taxes. Most houses were funded by charity, although some taxes were raised for the local operations (Colby & Dziegielewski, 2001). Taxation continued to grow as people in need increased in numbers, were put in jail, and caused all the more need.

Dix (1843) had her own struggles with mental hygiene. After teaching the Bible to jail occupants, she began to detail the needs of inmates with mental hygiene concerns and started asking for their placement in asylums for humanitarian reasons. Viney and Zorich (1982) considered Dix to be one of the most prolific advocates for social change of all time, and the changes she brought about affected the mentally ill in particular. Dix did not conduct research in a methodological or theoretical way. Yet, her research is worthy of notice because it documents the needs of people and her efforts in seeking relevant care for them. Dix's goal was to change a social ill and secure help for the people whose needs she documented (Viney & Zorich, 1982).

After making a presentation to the elected representatives of Massachusetts, Dix (1843) began to campaign on behalf of those she recognized as being the poor, the idiots, and the insane in the jails. Dix's ideas and advocacy led to the expansion of Worchester State Hospital and to a movement for social change notably for trying to do away with the aforementioned division of the worthy and the unworthy poor (Goldman & Grob, 2006; Viney & Zorich, 1982). Later, Dix's efforts are shown to have led to building a number of additional asylums, the numbers of which continued to grow over the years and into the early 20th century (Goldman & Grob, 2006; Viney & Zorich, 1982). More advocacy happened after her death in 1887, as her efforts of asylum care were curtailed during the civil war (Viney & Zorich, 1982). In fact, the Dix Hospital in Raleigh, North Carolina , could assume its name over 100 years after her death, as she would not allow it to be named after her during her lifetime. Yet, eventually naming this hospital after Dorothea Dix shows the reach of her efforts (Viney & Zorich, 1982). Goldman and Grob (2006) presented Dix's efforts in historical perspective and showed how her efforts, in part, ushered in the asylum movement and the debate about better care, which lasted over the next several decades. Much later, Caplan (1964), in his history of mental health, showed how little was really known about the true needs of the mental health client, and this realization led, eventually, to community care.

The first ideas about providing community care for people with mental hygiene issues, are attributed to the psychiatrist Dr. Gray at the end of the civil war; in 1893, Isaac

Ray, the founder of the APA, joined the call for social change (Mandell, 2011). Goldman and Grob (2006) described a policy that provided that the state would take on and fund mental hygiene care, which was ushered in by New York, in 1890, and followed by Massachusetts, in 1904. The authors reported that the idea was to split funding between the needed asylums and the local communities. However, the communities used the asylums from the start to transfer people from poorhouses to help with financing of the local government. This saved the communities money because, before the new financing arrangement, they had to pay for the care of people until the states took on this responsibility. True help continued to be given by placement of people without regard to needs, and they were held without rights.

Phase 2: The Mental Hygiene Movement

The mental hygiene movement began with Beers's (1908) publication of an autobiography sponsored (financially) by William James and Dr. Adolph Meyer. The book related Beers's experiences within the asylum. Beers provided a brief history of his life and of the anxiety he so often felt. Beers told how he was placed into the asylum, of hearing voices, and of his general state of malaise over his life. In the book, Beers described his recovery as well as the appalling care he had received in the asylum.

In the same year that his book was published with the help of various professionals, Beers founded the Connecticut Society for Mental Hygiene. This organization was charged with promoting legislation and research-based help for the mentally ill. It was due in part to the publication of Beers's (1908) book and the recounting of his negative experiences during his asylum stay and due, in part, to the support of the professionals he coordinated that mental hygiene issues, at long last, received the attention of researchers (Mandell, 2011).

Leading up to WW II, the mental hygiene movement proved to be a robust effort. Mandell (2011) related that Beers's sponsor, Dr. Adolph Meyer, envisioned community districts of mental hygiene care. Strecker (1944) related how some of the events of World War I, and in particular the fact that shell shock was taken to be a mental hygiene problem, led to additional funding for research and, later, for social workers to be used to treat this condition. Johns Hopkins University led the way to begin a national committee of mental hygiene, which sought to understand the problems (Mandell, 2011; Winslow, 1938). Strecker (1944) described that, with the availability of money, came more research by universities and from the military, and a national discussion began taking place. Over the years, the funding lead to research about mental hygiene and the needs of patients. Most of the research focused on what was understood at the time. Winslow (1938) related for example that, in 1933, a Congress of International Mental Hygiene began to use the terms mental health and mental illness. These terms were used mainly to describe the environment, and this notion set up a new debate regarding research as being scientific, but not really useful to the well-being of communities (Strecker 1944; Winslow, 1938). This debate, important to the history of social work, and the Social Security Act of 1935 will be further elaborated in a later section.

Several events coincided with the debate about mental illness. In fact, it was robust and finally ready for the national stage (Sareyan, 1994), when WW II broke out. As discussed by Sareyan (1994), a significant change in mental health care was about to take place when the war began, and the United States entered both the war and the debate about mental health care, and a new phase of care began for those in need.

Phase 3: The Beginning of Deinstitutionalization

The Joint Commission on Mental Illness and Health Action (1961) first recommended deinstitutionalization as a policy in its final report to Congress. By this time, the residents had already left the mental health hospitals (Sareyan, 1994). The path toward deinstitutionalization began during the 1940s, when large changes in the mental health movement fomented and the United States entered the second World War (Mandell, 2011). Sareyan (1994) described conscientious objectors (COs) as persons who objected to the war effort and were drafted to staff the asylums, where they observed the conditions and pushed for changes in metal health care. Their objection to war was based in ethical, moral, or religious grounds. Sareyan discussed that, during WW II, a CO status was acknowledged for the first time, even though many had objected to war before this time. Of the people who applied and were granted CO status, 3,000 were placed in 56 mental institutions that existed at that time throughout America (Sareyan, 1994). These men were to work in place of other trained and capable people who had gone to war (Fuller, 1997). Sareyan (1994) recounted how this change of workers was going to have a profound effect on the mental health policy in America.

Fuller (1997) explained that, while the COs helped reduce the shortage of men who had gone off to war, they were generally unqualified to take up mental health work. However, while untrained for mental health work, most of these men were far above average. Fuller noted that these men were intelligent, educated, and possessed skills that the average mental health worker did not have. Some COs were teachers, and most were men who brought a high level of compassion to the work in the asylums. These workers found neglect, overcrowding, brutality, and conditions that were not the humanistic care intentioned at the founding of the asylums or during the development of institutionalization (Maisel, 1946; Sareyan, 1994). What began as an attempt to address the staff shortage in these institutions, turned in to a fight by the COs for people who suffered from mental illness or mental retardation. This fight would lead to court cases and eventually to the national funding of mental health care.

When Beers (1908) complained about the care he had received, the mental hygiene movement began funding research and the fight for better care (Winslow, 1938). The asylums, called state hospitals, which Dix (1843) had envisioned as a more humanistic way to treat people who could not care for themselves, had themselves become cesspools collecting humans behind walls and hiding the inhumane treatment of the residents (Sareyan, 1994). The COs at these hospitals felt that this was an honorable fight that had to be waged, even with the ongoing war; yet not everyone agreed (Fuller, 1997).

Sareyan (1994) described how the COs with little or no training in mental health were faced with wards with different people who were separated by need. Some wards contained people who were incontinent, walking around naked behind four walls of concrete and with a concrete floor (Maisel 1946). Other wards held people with a violent side, who were strapped down, laying without comfort in beds or worse: just against walls. Maisel (1946) described how these wards would become known, and publicized by floors, as a shame and a disgrace. Sareyan (1994) recounted that the COs did not have immediate success in this fight; the country was at war, and America did not have time to correct the social ills in these institutions.

Sareyan (1994) discussed that, during the war, times were hard, shortages of food and supplies were widespread, and the shortage of able-bodied men to help out was common. The COs were often replacing several men who had gone to war and were taking on maximum stress in their work. Before the war, the hospitals had one attendant for every 25 people in a ward. Fuller (1997) related that, during the war, a CO was expected to be the attendant for 500 patients. COs were finding life difficult and stressful and were afraid for their own lives at times, but they found the conditions in these wards so inhumane, that they could not eschew the fight for change. Sareyan (1994) pointed out that a CO was not an individual that simply gave up. The COs' fight was an effort to expose the conditions at home of real people who were locked away just as the men overseas were fighting for world citizens who were locked away in the death camps (Sareyan, 1994). The men would be successful in their fight, getting Ohio Governor John Bricker to establish a commissioner of mental health, who would confirm the allegations and send joy into the ranks of the COs; however, this was not the end of the fight (Sareyan 1994). Fuller (1997) related that grand juries were formed, and the COs would testify to what they had seen in these subhuman conditions, not just at one hospital, but at several hospitals throughout the country. From New York to Philadelphia and to Elgin, Illinois, the fight continued all over America.

Sareyan (1994) reported that the biggest change came when the COs gained a new ally in their fight against the conditions in mental institutions: Eleanor Roosevelt, wife of the recently deceased President Franklin D. Roosevelt, met with a CO who had been fired from a New York hospital. Edwards (1995) related that Eleanor Roosevelt was familiar with the needs of mental health patients through the social workers who had joined her husband’s administration at the conception of 1935 New Deal with its focus on social services. The COs had reported abuse and found themselves to become the ones accused, but this did not deter these men of strong principles. Sareyan (1994) discussed how these experiences helped them to fight on, and when Eleanor Roosevelt joined the fight, America would begin to listen.

Sareyan (1994) noted that it was in 1944 when the first COs banded together nationally and began to gain support from organizations outside the religious orders to which they belonged. As they banded together, the COs girded themselves for a national fight to secure the rights of others. They established a clearinghouse to share information on abuse, neglect, and conditions at the hospitals charged with caring for people who could not care for themselves. The COs were fighting hard against the tides of war and those who did not want the conditions exposed. The conditions Beers (1908) had described many years earlier had begun the struggle in the mental hygiene movement. Sareyan (1994) pointed out that the COs were separated from their families just as other Americans in the military were by fighting overseas. The COs worked without pay and without having a real home. Although they were being fed, the CO were working day after day without needed supplies and materials to care for those with mental health problems. The fight was for a good cause, and their effort would bring about a big change over the next several decades in how the mentally ill were cared for.

Eventually, several large victories were achieved. The first was the publication of Out of Sight out of Mind, in 1946, by the National Mental Health Foundation, an organization founded by the COs (Sareyan, 1994). The second victory occurred in the same year, as the national fight took on a new direction with the publication of an article in Life magazine (Sareyan, 1994). With Maisel's (1946) article, it was the first time that a national publication showed the picture of a naked man locked within four cement walls. Sareyan (1994) noted that this article showed many naked men, some restrained. Exposed were the overcrowded conditions in which thousands spent their days, handcuffed, reeking of filth, and with light only by day. These were men spending their days in tombs and often in worse conditions than the death camps overseas, which other Americans were fighting to liberate. The publication of this article signaled that the fight would soon be over for the COs as well as for the men overseas, and the fighters would soon be returning home to America.

Levine (1981) noted that the pressure brought by the COs was in large part responsible for the passage of the National Mental Health Act of 1946, signed by President Harry S. Truman, which led to the establishment of the NIMH. As President Truman signed this bill in the immediate postwar period, the COs seemed to have won their war on behalf of the mentally ill. With the National Mental Health Act of 1946, a law that was the result of the COs efforts, part of the costs of care was shifted to the federal government (Fuller, 1997; Sareyan 1994). The shift was engineered primarily toward education and research; it would ultimately solidify the move away from institutionally based care, which had become known as the asylum model, toward community care as envisioned by the psychiatrist Dr. Gray at the end of the civil war (Fuller, 1997; Sareyan, 1994; Viney & Zorich, 1982). However, this fight encompassed much more than new financial benefits and a new way of care. This fight waged by the COs had opened the door to seeking legal recourse and using social workers in later years.

Sareyan (1994) related that 5 years after the war, by the 1950s, the changes in mental health care began to take hold and multiply rapidly, in great contrast to the past 100 years. In the years after the war, America experienced a return to building capitalist ventures, which solidified U.S. power in the world. With this, Sareyan noted, sprang new hope for the mentally ill. Mental health commissions were about the recommend deinstitutionalization and community care for the first time in history.

Levine (1981) reported that drug companies returned to drug research, which would change conditions for many people and, especially, for the mentally ill. Sareyan (1994) discussed drug development, which became as powerful a movement as the efforts of the COs had been. Lehman (1955, 1958, 1961) reported that in France, in 1952, Drs. Delay and Denker administered chlorpromazine to disturbed psychotic patients for the first time and noted the clarity it provided the patient. The year 1953 saw the first American clinical trials of chlorpromazine, which would become a miracle drug for patients living in the deep dark world of mental illness. The impact of these medications caused surprise and even shock in the medical world and led to another type of research called psychopharmacology (Lehman, 1955, 1958, 1961). Psychopharmacology, as practiced by medical professionals since its inception, has become a major factor in the treatment of mental illness and in case management by social workers.

Levine (1981) showed that, during the years of the drug trials, the testing of community-based service began as well. Positive results were achieved at several locations, but the community research was not conducted on a large scale. The new medications worked so well that the time for hospitalization was cut down to mere weeks for many patients. The direct study of these new medications, developed through psychopharmacology in subsequent years, allowed for new hope to spring up that it might be possible to modify human behavior and emotions. The number of mental health patients began to decline for the first time in a major way; they were, however, tied to the hospitals for their medications. The first reaction to the effects of the drugs was simply surprise (Lehman, 1958). The extraordinary tranquilizing effect on patients gave researchers hope, direction, and an outline of principles for the developing areas of new psychotropic medications. The culmination of this research was the appropriation of funding by Congress, in 1956, in the amount of $12 million for clinical trials of psychopharmacology (Lehman, 1958)

Drake, Green, Mueser, and Goldman (2003) discussed that, by the early 1960s, 10 years of research and drug development had taken place. Successes were being understood as well as the failures with some patients and side-effect reactions in others (Lehmann, 1961). The treatment of acute psychosis returned patients to higher cognitive functioning, which lead to clarity of mind; the patients began to have rational and cooperative choices (Lehman, 1955, 1958, 1961). Drake et al. (2003) related that these patients began to be released at more rapid rates instead of being indefinitely confined as before. However, maintaining drug therapy was becoming an issue, as these medications were not yet available on the open market. Simply releasing the patients was not a clear answer because patients would often stop taking their medications, or medications were not available to them on a continuing basis (Drake et al., 2003). Krieg (2003) reported on another issue that arose at times, namely, how to find the right balance between clear thoughts and the side effect of tiredness.

A new blend of ideas ensued from community support via social case management on one side and psychopharmacology by psychiatrists on the other. New types of nonmedical treatment were used as therapy together with case management to help with balancing patients (Drake et al., 2003; Krieg, 2003). Fuller (1997) noted how, previously, such services were available only to the well off. Now, they became more and more widely used; however, no training of therapists took place with respect to the critical importance of the therapy relationship (Norcross & Wampold, 2011), and so the treatment approaches became fractured.

Fuller (1997) related how the pressure brought by the COs started a significant social change over the next 20 years. With the establishment of the NIMH, the signing of the Mental Health Act by President Truman, and increased funding in the postwar years, new researches were undertaken that led to new medications, deinstitutionalization of the mentally ill, and eventually to community care in the 1960s. The policy of deinstitutionalization was firmly set in motion with the Mental Health Study Act of 1955

(Drake et al., 2003; Krieg, 2003). Fuller discussed Public Law 84-182, which created a Joint Commission on Mental Illness to provide an analysis and reevaluation of mental health policy for America. This was an effort to develop a national program with the proper approach to mental health problems (Drake et al., 2003; Krieg, 2003). This was finally achieved, in 1961, with a recommendation of the Commission's final report. The Commission's findings led the way for a series of events to finally come together in a future course of action that developed into what is now known as CMHC services. By 1961, the state mental health hospitals had already a lower occupancy due to the new medications (Goldman & Grob, 2006). The final report of the Joint Commission on Mental Illness and Health (1961) directed the policy of deinstitutionalization, which was by then a formality to drive the idea that help was to be provided in the community.

Phase 4: Development of Community Care for the Mentally Ill

Krieg (2003) related that more money was needed as part of the recommendations by the Joint Commission. As the mentally ill needed services instead of confinement in mental hospitals, the expansion of services brought the need and the awareness to the public (Drake et al., 2003). Yet, much with respect to control over the direction of growth of services or the education of workers was unclear (Krieg, 2003). Educational needs were eventually going to be defined through the social work profession, organized from 1952 to 1955 (Barker, 1998). The main services that existed then were institutions, called asylums. The COs' fight had led to research, new medications, and the deinstitutionalization of the mentally ill, but where the patients in need could go became the subject of debate. Drake et al. (2003) related that people who had been put on medications often were placed back into the hospital involuntarily because there was no other option for these services. As the Joint Commission received a mandate from Congress in 1955, exploring resources was part of the authorization.

The Joint Commission on Mental Illness and Health (1961) published its results, which included a proposal to double the funds for research immediately and triple them over time. Krieg (2003) reported that this was not a popular suggestion in the current economy with one in every five families being in poverty at that time. The recommendations put forth by the commission also related the need for deinstitutionalization and a greater allocation of funds for full-time workers who understood the needs of the mentally ill. Barker (1998) noted that this expression became a definition to fit social workers, now formalized as one group. The Commission inserted a statement to the effect that workers who knew little about how to treat people with mental illness were not an option. In recommending deinstitutionalization, the Commission stated a further objective, in addition to supervising medication and maintenance, namely to provide care, with appropriate psychotherapeutic means, in an environment that enabled patients to become functioning members of the community. Barker discussed how social workers were drafted for these new clinical duties.

The findings of the Joint Commission on Mental Illness and Health (1961) regarding the question of finding the right balance to satisfy the rights of the mentally ill to live independently also brought out dissenters. Balance was not to be found even within the ranks of the Commission as the results were being published. Legal cases that had sprung from the pressure brought by the COs back in the 1940s had nearly made it to the Supreme Court, and stories about schizophrenics and alcoholics became a consideration of the Commission. As discussed by Krieg (2001), the courts of the future would ask questions about the least restrictive environment for patients with mental illness, which meant that patients considered not dangerous could no longer be held without being afforded any rights, as was the case in the past. Krieg noted that the courts would acknowledge, in the years to come, a patient's right to be treated and released back into the community. Moreover, patients had the right to refuse medication as long as they were not dangerous. This right will be reviewed later in the section on Watt v. Stickney.

The Joint Commission's final report considered the importance of understanding the history of mental problems, and this decision placed a new emphasis on education regarding mental illness (Krieg, 2003). Drake et al. (2003) noted that the ongoing short-term community research showed success and was, thus, used to rush into various implementations. Krieg (2003) emphasized that the debates of this era provided the seeds for the later fight for an individual's right to self-determined care. The Joint Commission stated that patients had the right to maintain themselves in the community for what they thought was a normal manner for them. However, what was considered normal, was different for each person and in every community and in every state (Drake et al., 2003)

The Presidential election of 1960 and the development of psychotropic medications, along with the court cases being decided, all would be heavy determinants in the report of the Joint Commission on Mental Illness and Health (1961). However, changes did not happen quickly, and people were still being held without the right to treatment, leading to more court cases being filed (Drake et al., 2003). The practice of care by institutionalization through the political activity of Dix (1843) had led to the mental hygiene movement tipped off by Beers (1908), and this brought the hope of better and more humanistic care for the mentally ill. Eventually, as Drake et al. (2003) related, deinstitutionalization would become the new the mental health policy; however, the path toward help within the community proved not to be a quick and simple process.

The Joint Commission on Mental Illness and Health (1961) took into consideration community programs run by the states that existed at the time, although they were not known nationally and scarcely discussed at the time (Drake et al., 2003). Cutler and Huffine (2004) wrote about Professor Gerald Caplan, a psychiatrist born in England, who came to America, in 1952, to work for a time as the director of a Community Mental Health Program at Harvard University. This program eventually became the main force behind care in the community. The programs Caplan (1964, 1970) directed were funded through the Joint Commission's budget and would become the foundation of CMHC programs nationwide. Caplan (as cited in Cutler & Huffine, 2004) himself became the trainer of community psychiatry for these centers. Caplan's plan was to create models of preventive psychiatry that would continue to evolve. This fed into one of the Joint Commission's tasks to forge the analysis and reevaluation of mental health policy (Cutler & Huffine, 2004).

Based on the information about the psychology and treatment in the asylums, the Joint Commission on Mental Illness and Health (1961) continued to argue that a different environment would provide patients with a more propitious situation to gain better mental health. While Levine (1981) described what was considered a manipulation of the environment, that is, a clean place with a regular regimen of cleanliness, the patients improved. Years later, when cleanliness had gone by the wayside and the notion of therapy through the environment had become nonexistent, it was thought that this was the reason why patients no longer improved (Levine, 1981). The Joint Commission, thus, needed to suggest treatment models for clients that focused on conditions of improvement, but it also needed to avoid the pitfalls that had occurred in the development of institutionalization of the mentally ill, once considered a great improvement of their situation. Additionally, work to train and employ human services and social workers who had basic and expanded knowledge about mental health issues had to be begin (Drake et al., 2003; Krieg, 2003; Levine, 1998).

After 6 years of study and several yearly reports and with political unrest settling down in America with the election of President John F. Kennedy, the Joint Commission on Mental Illness and Health (1961) report was ready, and the fight for community mental health was set for the Congress (Drake et al., 2003; Krieg, 2003). Kennedy would speak during his campaign about the need for a bold new approach to mental disabilities, due in part to the personal experience on his family (Fuller, 1997). The actions Kennedy took, more than 120 years after Dix's (1843) valiant struggle, would lead to a new course for mental health. A direction toward the development of CMHCs would begin, and mark the end to the policy of institutionalization that had begun with great hopes and the promise of a new way of treatment for the mentally ill. However, the changes continued to be controversial and did not lead to the rapid deinstitutionalization that was desired. Yet, the stage was set anew for change.

October 31, 1963, President John F. Kennedy signed Public Law 88-164, the Community Mental Health Centers Act (Fuller, 1997). Fuller (1997) noted that this was 1 month before Kennedy died, as an assassin took his life in a moment now frozen in history. Krieg (2003) discussed Kennedy's much debated policy about helping the mentally ill and the retarded. Yet, the final bill he signed came about in part because of the Joint Commission on Mental Illness and Health (1961). It was the culmination of events that led to the signing on that day (Drake et al., 2003; Fuller, 1997; Krieg, 2003).

The policy of institutionalization came about through an entire series of events, beginning with Dix's (1843) pressure. Beers's (1908) activism in the mental hygiene movement led to research about mental health needs and sought changes in helping within the institutional setting (Krieg, 2003). The placement of workers, who were the COs of WW II, into the asylums and the pressure they bought to bear was what led to new national policies of mental health, in 1946 (Drake et al., 2003; Fuller, 1997; Krieg, 2003). A fact noted at that time was that mental illness did not just affect a few people here and there, but that psychiatric problems were a pervasive problem (Drake et al., 2003). It became clear that a large number of people were so affected when the military screened out 12% of men with mental illness from entering service between 1942 to 1945 (Drake et al., 2003; Fuller, 1997).

Fuller (1997) related that, although the Mental Health Act of 1946, signed by President Truman, started the provision of services, it was not done in the proper manor, which directly led to the formation of the Joint Commission, in 1955, and its report, in 1961. A final problem discussed by Fuller was that money was being spent without any research to show that the services provided were right for the patient. The states did not care because, for the first time, in 1946, the federal government took financial responsibility for the psychiatric problems of the mentally ill (Feldman, 2003). By 1963, President Kennedy took the final step on the long path leading toward a policy that brought about the construction of several mental health centers. While this was just a single step, an American policy of community mental health was now in place, and this is the place where today the majority of mental health services are being delivered (Cutler et al., 2003).

Development of the CMHC and Current Research

The original CMHC was, in essence, a test of the new theory, which came to be known as deinstitutionalization. It led to the policy of community support for the mentally ill in America l (Feldman, 2003; Krieg, 2003). The development of medications and services for psychiatric patients left the state hospitals empty when the physiological basis of mental illness became known (Feldman, 2003; Krieg, 2003). The medications were working, and the trajectory of events from Dix (1843) to Beers (1908) and to the COs of WW II was converging with present-day court cases. All this made psychiatric care a lucrative business for doctors in private practice and benefited those who could afford it, but many more people in the lower socioeconomic classes were not able to receive such care (Fuller, 2003). The final report of the Joint Commission on Mental Illness and Health (1961) recommended changes that, in part, became the legislation of CMHCs, which was signed by President Kennedy in 1963 (Fuller, 1997; Krieg, 2003).

Yet, this was only a beginning. The research on CMHCs became bountiful over the years and was, simultaneously, lacking in essential information.

Research with proper validity was being conducted in the late 1950s (Krieg, 2003). The cost to society due to people with mental illness became part of the theory of deinstitutionalization, in as much as the development of medications and other events had led to the 1963 signing of the Act that pushed deinstitutionalization ahead (Feldman, 2003). Feldman (2003) reviewed research that showed that mental illness costs people their jobs, and those with better jobs who were also tax-paying citizens might fall victim to mental illness, which, in turn, cost the government tax revenue. Drake et al. (2003) related research that showed people who had once been influential members of society becoming victims of mental illness and, thus, dependent on society. Assistance in the community through community services helped people keep their jobs and continue to pay their taxes. The CMHCs were shown to be a win-win situation for everyone, the public stood behind the changes, and the federal government was funding the changes (Krieg, 2003). The rise of the American people from ignorance and unawareness to knowledge about mental illness and the needs of the mentally ill was rapid. This sudden rise of awareness was dramatic and led to big societal changes, and that was what the public wanted (Feldman, 2003).

Feldman (2003) related that the 1963 bill, signed by President Kennedy, was not exactly what he had desired, but it was a start, and that is what he intended with his bold new approach. The 1963 bill actually allowed for the construction of a small number of CMHCs, but it did not provide for staff or services (Feldman 2003). Many changes would come later as the events of Kennedy's assassination continued to propel the agenda of social change, including of CMHCs, forward (Feldman, 2003; Krieg, 2003). Drake et al. (2003) discussed the events of the preceding 100 years and the culminating events that were important promoters of social change. Drake et al. noted that Kennedy had been serious about change, and was ready to take the need for services in a new direction.

Stockdill (2005) discussed the practice of hospitalizing mental health patients, which went back over 100 years. A t that time, it had been conceived as a humanistic act of caring and of relieving the country of having to care for those with mental problems. Levine (1981) showed that the period from 1950 to 1963 had been a complicated time of change and social upheavals. It was clear to everyone that Kennedy wanted to bring the events together and have real social change for the disadvantaged (Levine, 1981).

February 5, 1963, when Kennedy was in the third year of his presidency, he delivered a special message to Congress about mental health (Feldman, 2003). He proposed legislation with ideas that had been gaining momentum over the preceding years and outlined plans to implement the changes in mental health services the Joint Commission had proposed in 1961. With these remarks and Kennedy's proposed policy, the idea for making changes would be outlined and services would be strengthened at the local level. Taking shape now were the ideas proposed after the civil war by Dr. Gray (Mandell, 2011). Kennedy offered community services, as the 1961 Commission tested and, then, recommended his programs to provide care at locations right where the people lived in the community. These tests, however, were not completed on a large enough scale.

The 1963 Kennedy proposal and law further reduced the numbers of people in institutions by releasing them into community care (Caplan, 1974). The test trials had produced positive results over time. Moreover, mental health care had come a long way from almshouses through the phase of institutionalization in asylums—all prompted by the desire to make care better for the mentally ill—to a new level of humanist care (Stockdill, 2005). Caplan (1974) related that the congressional representatives inclined toward voting for these proposals would discuss the large numbers of people affected by mental illness. However, in 1955, the number of people in state mental hospitals had peaked and, then, begun to fall sharply (Lasky et al., 1959). The new medications were working, and people no longer needed the services the hospital was providing. Still, the Kennedy proposals sought to prevent unnecessary hospitalizations by developing alternatives to housing, training, and improving conditions for those in institutional care. Often, these events were tied to social workers in these positions (Barker, 1998).

Hearings on the proposals would not be easy nor would they produce exactly what Kennedy had wanted, but the results propelled polices of mental health forward long after the president's life had ended (Krieg, 2003). Those who sided against these policies pointed directly to the lack of theory upon which to base a national policy development of the CMHC; they maintained that these policies were a form of socialized medicine (Feldman, 2003). Feldman (2003) related that the American Medical Association came out against the proposals, arguing that no research had demonstrated that the CMHCs worked as a positive solution. This stopped the 1963 legislation temporally and referred it back to a house subcommittee. The legislation would be changed and the funding of staff stripped from the 1963 legislation, which President Kennedy had signed (Feldman, 2003; Krieg, 2003).

When the actual legislation was passed by Congress, in 1963, the bill Kennedy had signed into law as PL 88-164 was only a construction bill (Feldman, 2003; Krieg, 2003). Feldman (2003) noted that the law contained funding for building several community health centers, but little else. After the assassination of President Kennedy, bills were quickly passed to fund the staff of CMHCs with human services personnel, mainly social workers as case managers and psychiatrists to work in these new centers (Feldman, 2003; Krieg, 2003). Krieg (2003) noted that, although the direction was set, the debate over CMHCs was far from over. The 1963 events would continue to shape the services, and the additional changes would continue the revolution in the care of the mentally ill. Part of this revolution involved the financial changes in the Social Security amendment that developed Medicare and Medicaid, in 1965 (Axinn & Stern, 2008).

Deinstitutionalization from the asylums increased, as development of care at a community level progressed and medications were delivered through what today is known as CMHCs (Feldman, 2003). However, these developments were partly at the root of what would later lead to the court case of Wyatt v. Stickney, which, in turn, led to the establishments of patient's rights. Mizrahi (1992) noted that, due to this court case, the new and developing rights of the mentally ill rapidly increased. Deinstitutionalization as a concept developed in the 1950s with medications and community services. The rights of the mentally ill evolved additionally through the filing of various court cases at this time (Mickle, 2012). Primary among the cases surrounding deinstitutionalization and client rights is the case of Wyatt v. Stickney, a case that continued for 33 years (Mickle, 2012; Mizrahi, 1992). Mickle (2012) noted that this case was only one among many, but it ranked first among those that brought the rights of the mentally ill into the national spotlight. This case was an important step toward establishing where the right to make mental health treatment decisions lay and that treatment planning belonged to the CMHCs, where the services were delivered to clients.

Mizrahi (1992) explained that this trend of filing court cases developed what is now known as the civil rights of the mentally ill. These rights to receive treatment voluntarily or to refuse care would become part of the NASW (2005) efforts to adopt policies and change ethical principles that recognized clients' rights. Mizrahi (1992) further related that this effort took place in four steps of case advocacy surrounding cases of persons with mental illness. The purpose was to help social workers join forces and fight for the rights of the mentally ill.

The social policy from asylums to the development of the CMHCs and the rights regarding treatment has become the foundation for the delivery of mental health service in CMHCs from 1963 onward (Cutler & Huffine, 2004). Dix's (1843) actions led to social change and to one formal policy, which established the building of asylums. The new direction of social change led away from the way service delivery had been conceived then and toward establishing the civil rights of the client, once the courts became involved (Krieg, 2003). Mickle (2012) and Mizrahi (1992) discussed the directions set by the court cases and how fights over services for people in need have added additional measures related to CMHC care. However, in all of these discussions, no research about the relationship with clients or whether the CMHC services had worked and proven themselves as a real and positive solution to client care could be found.

Cutler et al. (2003) pointed out that the delivery of services to the mentally ill through the CMHCs had not run as perfectly or as efficiently as envisioned by President Kennedy, while Mickle (2012) pointed to the 33-year fight that ended in 2003 with the ordered compliance to service provision to and the rights of the mentally ill when the case of Wyatt v. Stickney finally concluded. During all this time, not one aspect of the relationship with these clients was noted. Many of the problems have come from inadequate training and funding and a lack of focus.

The case of Wyatt v. Stickney is an integral part of these issues as the longest legal case in mental health history (Mickle, 2012). However, neither this case nor any other event has changed the official policy in America, merely the services that are being provided. Adler (1977) discussed how the services were conceived and changed by Caplan (1964, 1970), who developed the services provided in the CMHCs. Adler claimed in his 1977 essay that rebuilding of the services had already failed; yet, at same time, the CMHCs were rapidly growing in number as states were still applying for grants. Adler expanded on his observation that, while building a network of caretakers had failed, the services continued to expand. This is an important point made by Adler, and it is part of the journey of CMHC service development from its inception to the present time.

As previously stated, no current research has been undertaken on the Norcross and Wampold (2011) recommendations. While research does exist on EBP in CMHCs, none of these studies have focused on relationship in therapy. The CMHCs developed through social policy for American mental health care for the poor (Adler, 1977). Feldman (2003) discussed how, with the first bill signed, the Kennedy assassination led to the funding of CMHCs, which began a period of unlimited entitlement. Feldman deplored that, although this was a promising start, not all the states took up the offer to seek funding commensurate with the needs. Every U.S. President has changed the funding of the CMHCs since the funds began to flow in 1965. Feldman (2003) described how the problems increased as President Regan signed the Omnibus Reconciliation Act of 1981. Cutler et al. (2003) noted that this led to block grants, or lump sums of money and funds no longer tied to the needs. This increased the problems already evident in how the services were to be delivered through CMHC. The research focus over time was being devoted to these problems.

The services and policies as originally conceived by the NIMH, in 1965, where to be an ongoing task where each state developed its own plan for its CMHCs (Ozarin & Feldman, 1971). The NIMH had provided the funding to each state to create these plans, with only minimal guidelines for each state. By 1971, noted Ozarin and Feldman, 452 centers had been planned in America, and over 300 were in operation; each was running based on individual state plans. Adler (1977) related that his charge, by this time, was to unify and provide education about how the organizations could operate with the same measures. Ozarin and Feldman (1971) described the need for legislation and change in a newly developed and rapidly expanding system of care. Cutler et al. (2003) concluded that the current situation had come about by trying to solve a big social problem based on rushed test results in the CMHCs and the provision of rapidly increased funding recommended by the Joint Commission during the period from 1955 to 1961.

To fund the CMHC, Feldman (2003) showed that new taxes needed to be created. This brought forth the U.S. Social Security Acts of 1965. Feldman discussed how the event of President Kennedy’s death had spurred bipartisan support for this Act. Over the next 50 years, the Green Book (2012) showed 23 major changes in funding by way of amendments to Social Security, which changed the way funds for the CMHC were appropriated. Honberg, Kimball, Diehl, Usher, and Fitzpatrick (2011) deplored the current crisis in mental health care as dire and sad. The authors rated Illinois as the worst state with respect to funding of mental health, with the state cutting 31% of its money for care, since 2008. This begs the questions: What brought the CMHC to this dire situation, and how do social workers and the ethics of the social work profession fit into it?

Adler (1977) pointed out that the CMHCs helped to alleviate many social ills brought about by mental illness through collaboration and education. Adler also noted that his job was to work on fixing the mess that the CMHCs had become. Caplan (1964, 1970) noted that relationship with the client was a major focus and concern in the foundation of the CMHC service. Caplan, in fact, stated that relationships, education, and collaboration were foremost ideas upon which to build important concepts within the mental health community. Caplan, however, was discussing relationship with the community, not the person who had mental health problems. Adler claimed that none of the proposed ideas had been developed, as CMHCs were fractioned by the states’ individual development of different concepts of help for the poor. Caplan (1974) wrote that the CMHC had been envisioned as developing with a community effort and with relationships with community members as the primary focus. Yet, as Caplan pointed out, every community was operating in a different manor, leading to problems. Then, Caplan discussed the funding, which was different in every state, with some states choosing not to match the federal funds right away. This was not how Caplan had envisioned the implementation of his ideas.

Research in the 1970s focused on care, but as financing changed, studies on fees and client payments began to dominate. Balch, Ireland, and Lewis (1977) explored how payment and fees were related to help for clients. Their results showed the need for national standards in the financing of mental health. The Joint Commission on Mental Illness and Health (1961) had discussed this solution. However, these ideas has not materialized. Catalano, Libby, Snowden, and Cuellar (2000) reported that over 100 million Americans were receiving mental health services, and financing problems have persisted because there was no coordination of services. Catalano et al. showed that attempts were being made, but because each state operated differently and with different rules and different funding, results fell short.

Werner and Tyler (1993) showed that, over time, the changes in public policy were clearly not working. The authors noted that the model of the CMHC had been built on the results of tests and the vision of the Joint Commission between 1955 and 1961 and was signed into law by President Kennedy. However, in subsequent years, policy changes related to financing and services were key to the changes. Cutler et al. (2003) related that the overall policy continued to be focused on services in the community, which have grown as their history clearly shows, even as training and education were and are inadequate. Cutler et al. also noted the inadequacy of administration , which has deteriorated over time. Most often, the administration came from the ranks of poorly trained workers.

Auxier, Farley, and Seifert (2011) developed research about the failed health care system. The authors noted that mental health is the third most expensive health care problem, and a lack of real care has been established and accepted in CMHC care. Writing about the importance of attitude by staff toward recovery of mental health clients, Tsai, Salayers, and McGuire (2011) found this focus as a matter of policy still lacking in the CMHC. Through all the years of development, noted Auxier et al. (2011), the lack of focused ideas and research about what truly helps persisted. Moreover, as needs increased exponentially, the focus did not improve. While Norcross and Wampold (2011) are maintaining that they have the answers to what works in the therapy process with their recommendations, it needs to be pointed out that these recommendations have not been researched, at least not within the CMHC.

In reviewing current research, not one study could be found about the relationship between therapists and clients in CMHC care. Abdul-Adil et al. (2010) developed research about EBP and the collaboration needed in the CMHCs. The researchers noted several evidence-based studies and the gaps that EBP researchers and scholars researching at universities were finding. However, this research focused on discrepancies between clinical services and the ability to deliver and evaluate services in the CMHCs.

The Abdul-Adil et al. study does not focus on the therapy relationship with clients, nor does it mention the controversy that exists around this topic.

White and Susskind (1980) found sparse research about community awareness regarding the makeup of the CMHC and its population. Thirty years later, studies can be found about the treads in community health care and the cultural needs of clients; the findings emphasized that culture does, indeed, matter. Druss et al. (2008) related that the CMHCs are key to providing care to 12 million persons of color and the uninsured. Faust (2008) argued that social workers were the needed advocates for mental health, but their calls went unheeded. Whaley and Longoria (2008) asked the questions whether the CMHC was culturally ready to deliver the needed care. Whaley and Longoria's (2008) findings seriously questioned the competence and training and, therefore, the quality of culturally sensitive services provided in CMHCs.

Studies evaluating the effectiveness of therapy and culture in CMHCs are numerous. Gamst, Dana, Der-Karabetian, and Kramer (2000) noted a positive difference in client responsiveness to therapeutic care when ethnic matches between client and therapist prevailed; the researchers recommended that more studies be conducted to further evaluate and produce clear evidence about cultural needs. In their 2011 study, Koizumi, Rothbard, Smith, and Mayer (2011) agreed that cultural needs are a major concern in the selection of a therapist. Bradshaw, Roseborough, Pahwa, and Jordan (2009) wrote about the difficulty in evaluating psychodynamic therapy because the correlations are missing important variables such as cultural responsiveness. Feldman (2003) found that workers lacked the necessary training for both services and cultural sensitivity. Feldman further maintained that the lack of leadership was the chief reason for these deficiencies.

Gioia and Dziadosz (2008) noted that services in CMHC did not have the right focus on EBP, nor did service delivery target the true needs of the clients. These problems were repeatedly discussed as the findings of serious research. Hochstadt and Trybula (1980) discussed budgets cuts and accountability as research focus, as funding changed over the years. Thirty years later, the real problem found by Gioia and Dziadosz (2008) involved the administration and its lack of understanding and listening ability. While the methods of EBP seem to be neither understood nor implemented in CMHCs, caseloads and long waiting lists are an overwhelming problem. The authors also noted that EBP is discussed as a solution by moving directly into established therapy techniques and stabilizing clients in a shorter period of time, thus saving money formerly spent on longer therapy time frames with the client. What is overlooked by this proposal, however, is that the relationship factor is key in therapy (Norcross & Wampold, 2011) and EBP is not a cure in itself, a recognition that harks back to Rosenzweig's (1936) DoDo Bird verdict. Because the EBP has not focused on the relationship factor, argued Wampold (2001), this shortcut is not likely to work; in other words, therapy will not work, unless a relationship is first developed with a client. Thus, Norcross and Wampold (2011) developed their recommendations, maintaining that any EBP can be successful, providing that the relationship has first been developed.

Norcross and Wampold (2011) argued that relationship must be the focus and training toward this objective is a critical and urgent need. Gioia and Dziadosz (2008) echoed the need for changes in the administration of the CMHC, but recent budget cuts make it doubtful whether the necessary changes will be forthcoming. Alimohamed-Janmohamed et al. (2010) reported that the states have already begun cutting back on services as a direct result of the cost of mental health therapy. The authors noted that this raised questions about the current system of the CMHC's delivery of services in light of clients' rights to treatment. Among the questions raised was whether the right to treatment may include the right of building a positive relationship in therapy through relationship-based service delivery.

Numerous authors have related how community mental health was conceived as a test program, but without being fully tested, it was propelled into full motion by Congress (Cutler & Huffine, 2004; Feldman, 2003). Kliewer, McNally, and Trippany (2009) continued to point to the lack of needed funds as the main problem, as the impacts of deinstitutionalization was fully felt in Alabama, even after Wyatt v. Stickney had laid down the rules. Kliewer et al. decried the lack of training and funding combined with a lack of workers. These problems are compounded in services in rural communities. While Feldman (2003) had discussed the lack of understanding and training of the administration, Jameson et al. (2009) related the difficulty of rural communities even to obtain workers. Jameson et al. point to the need for training and empirically supported treatments, but they also noted the lack of funding. Moreover, they found that a positive attitude toward the necessary changes by decision makers was absent.

Miller and Martinez (2003) discussed the shift to risk factors and stabilization for the mentally ill, while most other researches focused on cost factors and financial concerns or on keeping appointments. Miller and Martinez agreed that such studies were necessary and valid, while Sherman, Barnum, Buhman-Wiggs, and Nyberg (2009) contended that none of these studies mattered. What they found of critical importance was that funding and capacity for providing necessary care and services to the mentally ill had to increase, not decrease. Sherman et al. noted that a new massive effort was required so that the limited budgets in rural CMHCs would be effectively utilized.

Stevens et al. (2011) found problems where clinical directors failed to follow up on medication guidelines with the prescribers of medications. Furthermore, the researchers discussed that, as the largest provider of behavioral health services, the CMHC had the obligations to use EBP services and disseminate evidence-based information; however, this whole area remained poorly understood. This opinion agreed with Feldman's (2003) earlier assessment of the CMHC, as being poorly run and suffering from a lack of knowledge at the leadership level. Yet, not one study could be found where the administration of the CMHC revealed what they know or what they believed needed changing.

Current research on the CMHC service gave some indication that EBP is being used. Moreover, a number of studies have concluded that the cultural background of the therapists makes a difference in therapy and that therapists should be paired with clients of similar background, but financial difficulties make this difficult in the CMHCs. Norcross and Wampold (2011) arrived at their recommendations by evaluating years of research. Asking the administration of the CMHC about how they understand these recommendations and measuring their attitude about them will establish what they know and how they feel about these recommendations. Their answers will present a way to estimate whether these recommendations might work within the CMHC. This would have provided an indication of current financing and the allow implementation and use of relationship-based services.

From Friendly Visitor to Social Worker

Social work in America, founded through the efforts of social reformers and charity organizations, has developed over many years. It is rooted mainly in the needs of people during the civil war and again in the late 1800s (Colby & Dziegielewski, 2001). While social work developed as a profession through casework, the time line of events spans the period from the asylum movement to the expansion of community mental health. The purpose of the proposed study was not to document the history of social work, but rather to provide a brief review of several key ideas that have developed into the profession of social work and established the ethics of social work as fundamental principles of the relationship-based services to be provided by the CMHCs. Many excellent sources exist that discuss the history of social work in detail. However, the ideas important for this research are the development of ethics and relationships with clients in social work, as well as the people who drove the discussion on ethics and relationship with people in need.

The history of social work would not be complete without mentioning two important names from the beginnings of social work: Jane Addams and Ellen Starr Gates, who founded the settlement Hull House in Chicago, in 1889 (Colby & Dziegielewski, 2001). Hull House was a location where community activities brought help to worthy people in poverty, which was a real change of the conditions when so-called unworthy poor were kept in settlement houses by the working class, merely to be locked away without any help at all. Colby and Dziegielewski (2001) discussed how such charity organizations were at the root of modern social work. The authors also noted that Addams won the Nobel Peace Prize in 1931, and her simple statements of ethics were important markers for the profession. The closure of the Hull House Association and the financial problems of the present are also markers, but of a very sad kind for the state of mental health and a reason for proposing this study.

The Friendly Visitor Becomes a Social Worker

Colby and Dziegielewski (2001) related how a Charity Organization Society (CSO) such as Hull House was, in the late 1800s, often led by wealthy charitable women, who would teach the poor how to be clean. These were not paid jobs but humanitarian measures of help based in the spirit of giving. The concept held that the problems of the worthy poor was not something within the individual, but rather something in the environment, which was similar to the thinking during the mental hygiene movement.

Agnew (2004) noted that the agenda for asylums was modeled after the British programs that had helped to correct the moral deficiencies of the worthy poor. The organizations were run by upperclass volunteers and paid administrators who were the people to model behavior for the worthy poor (Barker, 1998). Agnew (2004) related how a change of direction toward professionalism occurred when Mary Richmond was appointed as administrator of a CSO, in 1891. Up until this time, the organizations were run by men and staffed by women volunteers. Richmond (1899), as the first female administrator, would rewrite the rules and help develop a paid profession mainly for women caseworkers of her time.

In 1899, Richmond wrote *Friendly Visiting Among the Poor: A Handbook for Charity Workers*. This book details how to make friends with the poor and to teach them the better habits that the wealthy workers have. Richmond described a picture of men just out of the asylum. Moreover, she maintained that the reasons for the troubled people resided in medical issues and the environment. Richmond related that becoming a friendly visitor was not a task for the meek. Rather, the work was as difficult as an enjoyable hobby that was rewarded with friendships as the people grew over time. Agnew (2004) related that, under Richmond's guidance, the profession of the caseworker was born; it grew out of the help and extension of a relationship, which would be a benefit for both the worker and the transfigured worthy poor.

Barker (1998) noted that the social work profession celebrated 100 years as a profession, in 1998. Barker described the first classes on social work, in 1898, which marked the beginning of the profession. Yet, the classes at Columbia University in New York were classes about social philanthropy, offered by CSOs such as the one Richmond (1899) operated. In the next few years, the classes were offered as summer training for developing caseworkers, rather than for a degree or as leading to a profession (Agnew, 2004). Barker (1998) noted that the first person to use the term *social worker* in America was the educator Simon Patten, as he paired with Richmond in her friendly visitor movement. The term social worker was not ready to stick to the friendly visitor for a few more years, but a term for the work had been born in America.

Barker (1998) described the change to a degree program that occurred in 1904, when the new philanthropic profession offered an 8-month course leading to a degree. Edwards (1995) noted that this was a time when the friendly visitor, a charity worker, helped change the landscape of the worthy poor through casework. Edwards reported that the term *social work* began to be used after 1905 in lieu of the previous term *social philanthropy* because the new professional worker was now often paid. Controversy ensued over the term because not everyone agreed that this was really a profession until years later.

Agnew (2004) noted that the term social work would finally stick after 1915, when Dr. Flexner, an authority on education, claimed that the profession lacked goals and a direction. This event caused the profession to be defined. Barker (1998) noted that, in response, Richmond wrote the first code of ethics for social casework; it was one page long. Another responses came from Colombia University, which changed its name to the School of Social Work (Agnew, 2004). Additional schools of social work soon sprang up and the discussion would begin how to teach and produce social workers (Barker, 1998).

Agnew (2004) related another large change came as World War I ended, when the condition of shell shock began to be treated by social workers. Axinn and Stern (2008) described how the development of the social worker now was taken into various directions. Barker (1998) stated that caseworkers of the past who worked for the poor were developed as medical social workers, community organizers, group workers, and lately as psychiatric social workers. Mandell (2011) discussed that, in 1908, Dr. Adolph Meyer was hired as the first director of psychiatry at Johns Hopkins; this is the same man who had met Beers in 1907 and supported his mental hygiene movement. Barker (1998) related that Dr. Meyer was a fan and advocate of social workers during that time. By hiring a number of psychiatric social workers, Dr. Meyer helped develop the profession and infuse it with his thoughts regarding the environmental factors as part of the problem. The environmental problems were thought to be cured by the social workers of that time.

At the end of World War I, social work continued to develop into various jobs and develop further as a profession (Axinn & Stern, 2008). Barker (1998) noted that social workers were working closely with psychiatrists and psychologists, but the profession continued to splinter over additional opportunities. Growth of the schools of social work and research areas helped to define new methods of social work. New associations of social work were formed. Then, the events of 1929 began to change social work once again (Axinn & Stern, 2008). The stock market crash left charity organizations unable to meet the needs of all those who depended on their help over the coming years.

Edwards (1995) noted that, with the help of Columbia School of Social Work, the direction of social work would again change, as President Franklin Delano Roosevelt signed the Social Security Act of 1935. Later on, the expansion of this Act would tie into the funding of the CMHCs. In 1935, the Columbia School of Social Work had a hand in writing the Social Security Act and, thereby, setting a new direction for social welfare in America. Additionally, this Act propelled social workers to become part of the Roosevelt administration by providing advice. Social workers were going to be part of the solution, as the bill created new positions and jobs within the profession. Edwards (1995) discussed how the social work profession was front and center, tied to the programs, and social work was promoted as the cure. Everyone in America began to know what social work was.

Other events of the 1930s were important not only to the history of social work, but also for gaining an understanding of the factors of relationship, which would become an important concept for social work. Robinson (1930) developed her thoughts about social work and relationships with people during this period. She wrote about bringing social work back to its roots of assistance for those in need. Moreover, Robinson praised Beers (1908) and his efforts toward humane treatment through warm social influences. She also tied in the efforts of Dr. Myers and noted his labors in developing social workers who could help those in need. Robinson wrote of the efforts to establish schools for psychiatric social work and care for the mental welfare of people.

Robinson (1930) collaborated with two people important during her formative years in social work, and their ideas stuck with her throughout her growing influence as director of the Philadelphia School of Social Work (Barker, 1998). Robinson was influenced by the ideas of functional social work of Jessie Taft, a psychologist by trade, and by working with Otto Rank (Edward, 1995). Rank was an associate of Sigmund Freud, but his ideas differed from those of Freud, and these new concepts were shared with Taft and Robinson. Taft became a life-long partner to Robinson and even adopted children with her in a separate fight for child welfare rights. Edwards (1995) noted that the changes in Rogers's thinking were clearly moving toward service and establishing a relationship with the client, which also helped social work as a profession to move away from Freud and the ideas of transference and counter transference. The client now became the center and the therapist the director of goal setting by building trust and using the self for growth and change. This is directly opposed to psychoanalytic theory, which was the reigning idea at the beginning of therapy.

Barker (1998) explained that Robinson took the ideas gained through her collaboration with Otto Rank and wrote about important concepts for social workers that were combined with Richmond's (1899) thoughts of the friendly visitor. The friendly visitor was Robinson's ideas of the relationship with a person in need, which related to functional social work at the time and continues to be influential to this day, according to Barker (1998). Robinson realized that very little had been written about the importance of relationship in therapy as great changes occurred and the profession continued to develop. She wondered how such a powerful idea could have been left out of the discussions on helping people. Robinson used Richmond's (1899) idea of the caseworker being interested in the client as the basis for her own thinking. Richmond had discussed the relationship of the friendly visitor from a point of authority as well as from that of a friend. Robinson (1930) went into great detail to explain change in the client as a result of the relationship with the social worker, leading to growth and change. Robinson additionally discussed the changes in children due to traumatic separations to explain how people feel in later relationships.

Robinson (1930) agreed with Richmond's (1899) ideas for the most part, but she wanted the relationship with the client to go further. Robinson (1930) discussed the blended ideas of emotional dependence and security brought to the relationship. She showed that, when the social worker completed the task with the client in a proper manner, this person could remain receptive and would continue to improve. Robinson discussed the research on relationship based on her experience within the CSO of several communities. Robinson's ideas were to promote the growth of better relationships, as the social worker completed his or her work over time. Robinson discussed that, through functional social work, interactions as helper were not in the sense of service, but in the sense of a relationship with the client.

Edwards (1995) wrote of the New Deal and additional events in history that would to change the profession of social work over the following years. However, the profession was splintered into various associations, and ideas were not united in one cause (Barker, 1998). The events leading up to WW II and the CSOs under different plans and vocations plunged the profession of social work into a lack of purpose until the war arrived. Edwards related how, during wartime, social workers accepted their assignments willingly. However, after the war, the profession of social work was ready to be united and the event of war and its atrocities would help to bring educational standards and ethics to the forefront.

Due to some of the atrocities experienced in WW II, both in Germany and in the United States, a new code of ethics was developing for social workers (Barker, 1998). However, this remained simple and mainly related to the ideas expressed by Richmond (1899) in response to Dr. Flexner's criticism of the profession of social work. However, a new effort towards ethics over the next 50 years were set in motion. The effort of the profession to be ethical has its roots in Richmond's concepts, which have become the moral linchpin of the modern social worker (Reamer, 1998).

Over the period from 1952 to 1955, the profession of social work would come together and be one united organization (Barker, 1998). Teare and Sheafor (1994) related that this movement began in 1952 with the formation of the Council on Social Work Education (CSWE). This organization set up standards of education for social work, and developed the degree of Master of Social Work (MSW). In addition, Teare and Sheafor discussed the Doctorate of Social Work (DSW), which expanded after its first appearance in the late 1940s. The DSW degree continued expansion over the 1950s and ‘60s. These events caused the profession and the research to pull together; moreover, the events from 1952-1955 (i.e., the development of social work standards, the university degrees, and the discussions about professional ethics) helped to fuse the profession to a higher purpose (Reamer, 1998).

Barker (1995) chronicled the next and final step in how social work became a united profession through the formation of the National Association of Social Workers (NASW), in 1955. This event combined seven associations of social work to form one organization in the NASW. Barker discussed how social workers were now one group in an organization run by one leadership, but with many types of social workers under the umbrella of the NASW. Many additional changes would come over the next 50 years, and the discussion of the ethics of social work became primary in uniting or dividing the workforce over the years.

Social Worker Ethics

The NASW Code of Ethics (2008) is probably the most important document a social worker should know and understand. Yet, a lack of understanding of the code and its history exists (Reamer, 2008). Reamer (2008) noted that many do not feel that the history is as important as today's document, which makes the ethical ideology permanent. The NASW ethics was first established in 1960, and the first document was only one page long (Reamer, 1998). The code has gone through three distinct changes spanning four periods. Reamer (1998) discussed (a) the morality period, (b) the values period, (c) the ethical-theory and decision-making period, and (d) the ethical-standards and risk-management period. Each period will be briefly reviewed so that the importance of the code can be understood and the relevant literature about the CMHC and relationship-based services can be appreciated.

The morality period. Reamer (1998) called the first phase in the evolution of the ethics of social work the morality period. This was the longest period that lasted from the founding of the newly named social work profession to the values period, which began in the late 1950s. During the morality period, ethics focused on the social worker who endeavored to help the poor develop better habits. Reamer noted the similarity with the discussion of ideas of mental health leading to the establishment of the CMHCs; the discussions revolved around the habits of the worthy poor. Problems were seen as caused by laziness or the environment. Until the physiological factor of mental illness were better understood, social workers focused on making changes in people's work habits. Reamer likened the social work of these times to the efforts of parents: Social workers' efforts were seen as a redirection of moral requirements.

The values period. Reamer (1998) wrote that the morality period, oriented toward the values of the profession, began to change with the advent of WW II and many, as yet, uncovered events. The associations of social workers that were developed over the 1920s and ‘30s began to adopt a code of ethics and spell out how social workers should comport themselves in guidelines for workers. Reamer explained that the forming of the CSWE helped to propel ethical guidelines into a document that the NASW could adopt in 1960. Reamer discussed this first version of the code and its preamble and noted that it placed the humanitarian efforts above the self.

Reamer (1998) described that in the 1960s and ‘70s social unrest was high, and, under the guidelines of the NASW and the code of ethics, social workers had an obligation to work for social justice and social reform. Edwards (1995) noted that these changes caused an addition of new statements lauding the unselfish nature of social work and its foundation in a time of philanthropic efforts. The ideas attracted new social workers on the premise of fighting for change. Reamer (1998) discussed the new authors and a flood of publications focusing on social workers, their values, and ethics from various points of view.

The ethical-theory and decision-making period. Edwards (1995) described the 1979 change to the code of ethics as a change toward increased accountability and professionalism of the social worker. As such, the ethical-theory and decision-making period had begun. Social workers discussed the history of ideas, and, thus, a time for values and ethical decision making had begun. Ethical concerns and situations were discussed at regular points in order to avoid the pitfalls and ethical dilemmas of the past. Reamer (1998) noted that the first discussions about relationship and ethical behavior with clients began in 1959 with the publication of core values of social work by the

NASW. The debates raged over six core values and lasted for quite some time because not all of the people in charge of developing the NASW standards could agree on the wording. The six values were finally adopted, but the concepts have undergone some changes as the wording as well as the ideas were discussed and considered over time. The actual wording and the use of the term *relationship* began to appear more and more.

The ethical-standards and risk-management period. Barker (1995) wrote that, by 1993, the time had come to adopt a new code. Reamer (1998) noted this was the start of the fourth and final period, which continues to this day. Reamer (2006) discussed the NASW code of ethics, written in 1996 and finally adopted in 1999, and described it as a complex document containing 155 ethical principles. At the core, the concepts embrace the original six values for social work, going back to its inception in the early 1900s. The NASW (2008) code adopted the core values and obligations of the social work profession, and social workers were henceforth held to a high standard. The NASW (2008) Code of Ethics related the six values of the profession as follows:

> The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective. [These values are:] service, social justice, dignity and worth of the person, importance of human relationships, integrity, [and] competence. (NASW, 2008, p. 1)

Reamer (2008) noted that the social workers in every American state are now bound by the licensing laws of the profession of social work, which reflect the NASW

(2008) code as the primary model. Barker (1995) noted that, in the 1960s, few states had licensed the profession of social work. However, by the 1970s, this situation had changed in most states. Reamer (1996, 2008) noted that the states used the guidelines the profession had set for itself to craft the licensing laws. Wark (2010) explained that all human service professions have a code, and many are attempting to revise the standards of care to adopt stringent regulations. Reamer (2008) noted that the social worker's code of ethics is the longest and most complete version of any code of ethics.

According to the State of Illinois Department of Professional Regulation (2012), the licensing of social workers became law on November 18, 1971. The current regulations provide that 15 changes through adoption of bills in the Illinois congress have taken place. Moreover, the law states that a social worker practicing in the State of Illinois must abide by the NASW guidelines as put forth by the profession. Furthermore, a fine of $5,000 and up to $10,000 can be levied against persons who claim that they are a social worker without holding a valid license for social work. To hold a valid license for social work in Illinois, a person must have a Bachelor's (BSW) or Master's (MSW) of Social Work degree from an accredited school of social work. Moreover, the school must be accredited by the CSWE. Second, the person must have passed the license test put forth by the Academy of Certified Social Workers (ACSW), which is run by the NASW. Lastly, each social worker must report 30 hours of continuing education every other year upon renewal, with three of the credits based in ethical understanding. These factors demonstrate how much the profession has developed since the time of Richmond (1899).

To understand and follow the rules of the NASW code of ethics (2008) is now a serious matter and part of a licensed obligation. The State of Illinois Department of Professional Regulation noted that if a social worker does not follow the guidelines of the code of ethics, he or she could be fined, and punishment could even entail the permanent removal of the license (State of Illinois licensing laws, n.d.). Following the guidelines of the six core values is not optional. Primary among these values is the importance of human relationships. Human relationship and the concepts from the code of ethics will be the focal point of the study, which aims at testing whether the Norcross and Wampold (2011) recommendations can be implemented under the current administration of the CMHC.

Wyatt v. Stickney

The court case of Wyatt v. Stickney, filed in 1970, is one of the many cases important to understating the history and development of the CMHC and the rights of its clients. Moreover, court action was directly related to the professional development of social workers. Levine (1981) noted that this case spurred profound changes in the development of the CMHC. Levine observed that other cases before Wyatt v. Stickney had already affirmed the rights of a person with mental health issues. Moreover, this meant that a person could not be held without her or his rights being recognized. This became the primary idea in the case of Wyatt v. Stickney, in which the Alabama Bryce Hospital was found in violation of the law. The judge enlarged the case to a class action suit and referred it to federal court (Levine, 1981). This case became a turning point in the development of mental health rights for clients in America.

Levine (1981) related the state school for the retarded had become a part of the case. After a 6-month period without a resolution, the judge ordered testimony from medical professionals and the Civil Liberties Union. After hearing the case, the judge decided that patients had 18 rights; later, the list grew to 35 rights (Mickle, 2012). The state of Alabama could not meet the obligation of the judge's order due to lack of financial resources and the necessary labor force. This led to additional changes and the judge's making the case a landmark for mental health understanding.

Levine (1981) described the main person behind the suit: 15-year-old Ricky Wyatt, a juvenile delinquent with a mental health diagnosis. The other party became Dr. Stonewall Stickney, the superintendent of the hospital. Alabama later put out a brochure, relating the judge's statement:

> There can be no legal or moral justification for the State of Alabama's failing to afford adequate treatment for persons committed to its care from a medical standpoint. Furthermore, to deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process. -FEDERAL JUDGE FRANK M. JOHNSON, JR. (Alabama Brochure, 2012, p. 3)

Mickle (2012) stated that the result of the case was the rapid deinstitutionalization of mental health patients in Alabama and other states that did not want the same fight on their hands, but this did not end the lawsuit. In fact, after the ruling was upheld by higher courts, the case continued active litigation until 2003. Mickle related that Wyatt, now 49 years of age, attended the closing of the case. By this time the case had been held in federal court for 33 years, and Mickle noted that even the judge recognized his limits in the case by simply ruling that the litigation of the case would end. This case had changed federal guidelines of mental health care for the nation over the years, and no one disputed this fact. The main results were several, among them the seminal deinstitutionalization and the rights afforded clients due to court oversight of the case for 33 years. In fact, the court ruling still has an effect for every mental health client today (Mickle, 2012).

Notable parts in the ruling that would become measurements in the federal guidelines were the patients' right to the least restrictive environment and the right of individualized treatment (Levine, 1981). For every client, an individualized treatment plan is now required. Levine (1981) discussed that the court further required that mental health professionals be qualified and licensed. The court set staff guidelines that required an MSW degree from a CSWE-accredited programs as part of the plan. This requirement will be shown to lead, in part, to Social Security amendments, tied to the funding of Medicare and Medicaid. In a later section, it will be shown how Social Security funding became tied to the funding of the CMHC.

The last key issue from the ruling of Wyatt v. Stickney with relevance for the study is the constitutional right afforded to clients based on the ruling. Now, clients have a right to individual treatment that might give them the prospect to be restored to, or at least to improve, their health. This raises the question whether this ruling includes the patients' right to a relationship with a therapist of their choice. Before this question can be further examined in the conclusion section, the theories providing the conceptual foundation of the are reviewed.

Carl Rogers and his Path to Person-Centered Therapy

Rogers (1951, 1957, 1961) stated that he began to formulate his ideas about relationships in his childhood. He discussed that he was raised in a strict family where compassion and love were not always present. Turner (1996) reflected on Rogers's thoughts about the development of relationships and how this thinking would influence the development of future social workers. Rogers's described how his ideas developed over the course of his college years and expanded throughout his professional life. Several factors would add to Rogers's thoughts about a theory of relationship. One key factor was the close friendships Rogers (1951) developed with social workers. Tuner (1996) provided insights into how all signs would point Rogers toward the importance of relationship in therapy. Rogers's research took place at a time when medication and therapy in asylums were not provided or considered necessary. Rogers (1957) would thus develop his research and create a new type of involvement with clients, quite different from the interventions that lacked human interaction between therapist and client, known as psychoanalysis.

Rogers (1951) described how he was trained in the same unemotional ways of the psychoanalytic perspective, which was the norm of therapists' education at the time. Private therapists who offered this kind of therapy focused their services toward clients who could afford them, when Rogers began to discuss his beliefs that the therapist should be an interactive member and provide an optimistic view for all types of clients. Rogers's

(1961) view was based on his belief in human nature and the self-actualization potential of the person. His premise was that the perceptual reality of a client could be changed through the relationship with the therapist. The core conditions of the relationship that Rogers considered essential for effective therapy were unconditional positive regard for the client, empathy, and congruence. These factors became a natural balance brought about directly through reactions of the therapist. This new and positive interactive viewpoint would help the client to develop solutions through the reflections of the therapist, which were most often not accompanied by any direct advice. However, Rogers did offer advice at times.

The roots of Rogers's (1951, 1961) theory are deeply anchored in relationship and humanistic factors of the therapist. This was diametrically opposed to Rogers's training in the psychoanalytic perspective, and there were good reasons for Rogers to arrive at his views. A large part is credited to his meeting Jessie Taft and Virginia Robinson (Turner, 1996). Rogers (1961) described how a deep understanding of what they were teaching about functional social work at the Philadelphia School of Social Work led his ideas into new directions. This new understanding led to his opposition to what he had been formally taught and a realization of the profound effects of human interaction. Thus developed Rogers's seminal ideas for helping people in need. To develop some manner of relationship with the client became the leading aspect in bringing about change in the client's mental health.

The change, in Rogers's (1951) view, was set in motion at the first interview, which Rogers termed the "therapeutic interview" (p. 131). It is a main point in relationship development. This is the point where the therapist will begin to organize and understand how to help a client, but at the same time build the needed connection. During this interview, Rogers found that certain conditions are essential to helping the client with future change. Rogers's original list of conditions was lengthy, yet these conditions became the central idea within his research. The important step was in the approach the therapist took, and then, in due course, the original list was paired down to three conditions that are required to help a client: authenticity of the therapist, acceptance, and understanding the client. With the changes in his theory over time, Rogers (1957) decided to change the name of the concept from his original client-centered theory to person-centered theory.

The first interview, as Rogers (1951, 1957, 1961) noted, is one of the most important points of therapy and, thus, it is also a key point in the study because, as will be shown, this understanding appears to be lacking in the CMHC. Rogers maintained that the first interview set up much of what would happen over the course of therapy, and it was considered to be the beginning of a relationship as a key condition for change. The conditions developed by Rogers are the basis for change. In Rogers's view, the therapy will become difficult for client and therapist, if the relationship is not developed.

Rogers (1951) began to develop his theory by focusing on the person in therapy. He also looked to other researchers for help and for expanding his own thinking through the views and concepts of others. Rogers (1961) discussed his use of other viewpoints and theories of the time and how he worked to make additional contributions from his personal background and experience. He further explained that he was not apologetic for his views as they brought him to the point of accepting a person-centered position. Rogers recognized a profound lack of original material in his training; everyone had to accept one point of view, namely, the psychoanalytic perspective. He described his attempts to propose a new approach to therapy amidst all the controversy surrounding mental health at the time. Even after his way was clearly set, Rogers (1957) continued to develop and discuss supplementary thoughts. He noted that he was following a path in progress, and that his theory and ideas would continue to develop over time.

Over time, Rogers (1961) solidified his ideas and summarized his thinking about the person-centered approach with one word: attitude—that is, the attitude of the therapist. Rogers held that attitude starts with the stance of the therapist and that what a therapist needed was respect and a position of reverence for the person. Such understanding has come a long way indeed since the mental health concepts of the late 1800s, when people in need were categorized as the worthy or unworthy poor. Rogers was convinced that any relationship should begin with respect—a concept harking back to Richmond (1899). Rogers firmly believed in a point of significance and worth in every person, and this was the best way from which to view each person.

Rogers (1951) provided a lengthy question-and-answer session on his thinking to clarify the concepts and explain his views regarding attitude with the client as the primary concern. He wrote of the discussion of ideas not as judgment or disconnected from the actions of a person. The therapist’s complete being and attitude are in evidence for a full understanding of the person. This relates to Richmond’s (1899) ideas of the friendly visitor. Richmond put forth the concept of working to be a client’s friend; and this, in turn, relates to the NASW (2008) code of ethics of the social worker. Rogers (1951) discussed a therapist's need to possess the ability to understand a client. In this way, a client is not seen as worthy or unworthy, as was the original concept for dealing with mental hygiene problems. Moreover, every client has worth and can change through the beneficial effects inherent in human relationship. However, a gap will be shown to develop over time between Rogers's concept and the ideas manifesting for what the CMHC should provide from 1843 and the asylum movement right up to 1963.

The central idea of Rogers's (1951, 1961) person-centered approach is firmly focused on the connection with the client. Rogers wrote about how a client and therapist bond in the therapeutic interview. In discussing his views and ideas about this connection, Rogers (1951) fully recognized that creating a positive therapeutic relationship was a difficult task even for an experienced counselor. Rogers wrote that communication between therapist and client is not always easy because of how a client may view the therapist and the power discrepancy that a therapy relationship involves. He suggested, however, that, if the client is receptive to the positive attitude and reflected statements of the therapist, it may help the client to open up about a specific problem. While the central goal for Rogers was to work on developing this relationship, other characteristics had to be present in therapy to create this outlook, and this leads to the next condition a therapist has to establish.

The next stipulation begins with understanding what the client may be experiencing in the therapeutic relationship with a therapist. Rogers (1951, 1961) stated that, before moving forward, the therapist needs to pause and ask what the client is feeling in the relationship (Rogers, 1951). Rogers related this notion to the understanding of what the client had experienced in the therapeutic interview; he was alluding to thoughts the client may have had about the counselor even prior to the interview: Would this therapist be a parental figure, an advice giver, or a psychic?

Rogers's (1951) person-centered therapy involves finding a path to the client to help him or her solve problems simply by reflecting them back. The goal is to help the client realize what the problem is and what the answers might be. Rogers, at times, sought to limit giving direct advice to a client. He also thought that the therapist needed to balance her or his views with the client's perspective and take into consideration what role each of them plays. The expectations of the client led Rogers to declare that perception, positive attitude, and nonjudgmental acceptance are all well and good, but, without knowing what the client is feeling or experiencing, the therapist is not developing the relationship as necessary. Rogers was convinced that the intervention would not succeed unless a relationship could be established that is genuine and positive.

Rogers (1951, 1961) held that ideas developed through the therapeutic interview and that it required a pause to provide the understanding of what needed to be accomplished in the process of therapy. He noted that clients are entering therapy driven by problems that spoil their lives. Rogers (1951) cautioned therapists to be careful and not to make the client feel worse. After listening to recordings of hundreds of therapeutic interviews and reading the transcripts of these sessions, Rogers came to understand that therapists must achieve an understanding of the client's values. At this time, the therapist had to be mindful to project a positive attitude and a nonjudgmental point of view. This clearly requires a delicate balance and needs, additionally, to be conscientiously related to the NASW (2008) code of ethics and its explanations of the importance of human relationships.

Rogers (1951, 1961) was looking to achieve growth in the client through the process of therapy. This harks back to Richmond's (1899) ideas and the CSO in the beginnings of charity work with the worthy and unworthy poor, who were thought to need to learn better habits. Yet, Rogers was convinced that the therapist's giving advice to the client did not always achieve the emotional growth that needed to take place during therapy. What Rogers (1961) tried to communicate was his personal conviction that the client grows through the relationship with the therapist. In this context, Rogers was also convinced that the kind of intervention used was not the most important thing, but what made the intervention, any intervention, work was the emotional relationship between client and therapist. Additionally, this expressive connection will occur only if the client views the therapist as genuine and likable.

The roots of Rogers's (1951, 1961) person-centered therapy are firmly planted in the therapist's right attitude: The therapist must be nonjudgmental and genuine. Rogers's point of view was that these conditions must not be merely on the surface; the therapist can, at any time, lose the client's respect if he or she acts in a way that is contradictory to the developing relationship. Thus, Rogers was recommending that the therapist must be genuine at all times, not merely during the initial therapeutic interview. Rogers's purpose with person-centered therapy was to create a relationship where these conditions existed, so that the client could come to accept the problems and develop the ability to cope with everyday social situations and personal relationships. If such conditions are created, Rogers believed, then the client would be able to accepts the problems and grow emotionally through therapy.

With genuineness at all times, as understood within Rogers's (1951, 1957, 1961) theory, a new view of the individual's self-concept is being offered. The therapist is trying to help clients adjust their understanding by expressing their story. If the client's initial low self-concept can be raised, then the client will be better able to understand the problem in the reflected story. Rogers believed that the therapist should never impose personal values in the process of therapy. He desired to create a picture of the person's worth, and this may be achieved by viewing the client as a person without a disease. Rogers held that a person is not worthy or unworthy; a person is simply a person. Therefore, a person was considered a client by Rogers, rather than a patient. The client had a genuine identity as an individual and was deserving of the therapist's respect. If this view is genuinely and consistently reflected by the therapist, a client can become free of inconsistencies and negative thoughts about self. As the therapist brings out the improved concepts, awareness between congruence and incongruence becomes the main purpose. Here, the client is not seen as having psychiatric problems but rather as utilizing built-up defense mechanisms to reinforce problems. The problem is the distorted view he or she holds, and, according to Rogers, this is not due to a pathological problem in the person. With this view, Rogers exemplified the ethics of the NASW (2008), which have the dignity and worth of a person as their primary concern.

Rogers's (1951, 1961) person-centered therapy is rooted in three conditions: genuineness, acceptance, and recognition of the client's true needs; on this basis, the process of therapy begins. Until these conditions are set, Rogers believed that the client cannot accept his or her maladjustments. For Rogers, these conditions provided the necessary framework for the development whereby the client can come to accept the emotional and physiological processes behind the problems and their solutions. When the client starts to feels positive about the self because of the therapeutic relationship established with the therapist, he or she will enjoy the sessions. A client who feels positive about therapy is ready to accept the reflections of the therapist and begins to solve problems in a way that is acceptable to the client.

When one looks at Rogers's (1951, 1961) ideas of person-centered therapy and the NASW (2008) code of ethics, the importance of human relationships is a value that clearly stands out. Social workers who work as therapists must uphold this value of the human relationship because it is the medium through which people can change. Rogers's reflections about relationship become the primary way for helping, as social workers develop several additional values of the profession. Dignity and worth of the person are values about which Rogers wrote explicitly. Additional ideas comprise service and integrity, which become the path of trustworthiness by which social workers are helping people in need (NASW, 2008). These ideas are explored in detail throughout the analysis of concepts relevant to this research.

Conclusions

As was noted in the introduction, there were gaps in the Norcross and Wampold (2011) research concerning its usefulness within community mental health. The literature historically provided the indication that Norcross and Wampold's Recommendation 17, which states that "administrators of mental health services are encouraged to attend to the relational features of those services" (p. 100), would be taken into serious consideration by the administration of any kind of community mental health care service. This recommendation, then, lead to the next one: "Attempts to improve the quality of care should account for treatment relationships and adaptations" (pp. 98-100), a plan that has been well-discussed, herein in the development of CMHCs over time. Historical research, however, indicated that implementation of these ideas was most likely unfeasible for financial reasons, and social change from these considerations will not be forthcoming soon enough. In this study, I ask administrators about the first one these recommendations in hopes of opening a dialog that will eventually lead to real change.

A review of the issues and measures of CMHC services showed the path from 1963 when support for the conception of these centers rushed them into operation (Cutler et al., 2003; Feldman, 2003). In as much as the current research shows that changes have taken place, it also shows that little has changed in the service provision by the CMHCs. Services via the model of community mental health became the policy of America, and research continues to show needed changes. Financial concerns are not the only issue in mental health care. Bliss, Gillespie, and Gongaware (2010) attributed the problems to employee turnover. The authors blamed the turnover rates not only on a lack of adequate pay for workers, but also on lack of training and the necessary knowledge. Asking administrators about the Norcross and Wampold (2011) recommendations allowed for reflection of the same answers about the recommendations. Moreover, perhaps, opens up a dialog.

This research conducted in a CMHC setting, took into consideration the NASW ethical standards and client rights to examine one of the recommendations put forth by Norcross and Wampold (2011), namely, their suggestion to individualize treatment and build the relational aspects of services in therapy. Norcross and Wampold additionally recommended that administrators of mental health centers understand and have a willingness to improve the effectiveness of therapy assignments. In this research, I attempted to tie together the concepts of relationship-based services and the clients' right to treatment, based on ethical considerations of human service delivery as established through the NASW (2008) code of ethics. Even now, there exists a serious gap in the current literature regarding knowledge level and attitudes among CMHC administrators with respect to these recommendations and any necessary changes in service delivery. Moreover, researchers have decried time and again over the years that the administrators of community-based care lack the training and education to accept these ideas and implement them in the CMHCs and among their social worker-therapists.

The process of relationship-based therapy has been described in detail by Rogers 1951, 1957, 1961), and Bordin (1975, 1979) has refined the definition of the working alliance in therapy. The latter noted that an alliance has three parts: goals of treatment, tasks to accomplish, and how to achieve the goals. The roots of the working alliance, as defined by Bordin, lie in the historical nature of the alliance. Bordin began to use the term alliance, based on Rogers's person-centered perspective. Petr (1988) discussed how this relationship has changed over the years from Richmond (1899) to Robinson (1930), who began to emphasize the fact that these professionals were more than friendly visitors, as Richmond had portrayed the social worker. Robinson was a member of the profession of social work, who continued to shore up the foundation of this developing profession. Robinson helped to develop an understanding of the weight these exchanges between social worker and client had for the clients and their improvement as a direct result of these interactions. She discussed additional psychological factors that would add to the helping process and improvement in the client. Robinson described her own search for understanding the client's problems through the worker's establishing herself with the client. Robinson called this a "matter of simple friendliness" (p. 128).

Factors in building the relationship increased in level of importance when Rogers (1951, 1961) took the process of relationship to a new level. He worked to develop a new type of intervention built on human interaction and defined an alliance in therapy. This became known as the humanistic approach to therapy (Bordin, 1979). Rogers's ideas had sprung from his meeting Robinson (1930). Rogers (1951, 1961) embraced her ideas and the belief that a therapist working with mental health clients should become an interactive member with an optimistic view. Rogers's humanistic view was based in his faith in human nature and the self-actualization potential of the client. Bordin (1979) worked to refine Rogers's views and further defined the therapy alliance.

Over the years, from Richmond's (1899) conception of the friendly visitor to Robinson (1930) and Rogers (1951, 1961) and on to Bordin (1979), the focus on relationship and humanistic factors of the therapist has grown in importance. The level of importance of the clinical relationship and environmental factors continued to change as the theoretical understanding grew and unfolded. As social workers organized and better understood how to help a client, the first interview and the preparation for this interview became a focal point and educational need for social workers (Hill, Ebeling, & Hill, 1983). These are only some of the factors of which a large part of the literature should be noted with the ideas of Norcross and Wampold (2011). Moreover, these factors provide the foundation, which led to the Norcross and Wampold's task force and a recent study of the power of relationship. However, none of these research ideas was conducted within the CMHC, where the largest group of people with mental health needs is being served in America.

Bordin (1979) discussed the development of the working alliance that directly led to Horvath and Greenberg's (1989) development of a working-alliance inventory. The working-alliance inventory then, used to develop a positive understanding of the client-case manger relationship. Yet, a lack of research is evident regarding whether and how this well-documented working alliance has been used or attempted within the CMHC with its overwhelming majority of clients seeking mental health care in America. Even as the working alliance was shown, through research, to lead to an increasingly better understanding of the human relationship in therapy, argued Wampold (2001), the Dodo Bird metaphor was alive and well, yet not understood, meaning, that any therapeutic method could produce results as long as a positive client-therapist alliance had been established. McNeill (2006) argued that the factors of EBP are confusing and not properly taught and that the changes in the EBP led researchers away from their focus on relationship and toward emphasizing the nature of the intervention instead.

Norcross and Wampold's (2011) research identified gaps in the literature and provided recommendations for further study. The literature reviewed by Norcross and Wampold referred to the therapeutic relationship as the original idea that had ushered in real change in clients. This was prior to the employment of EBP methods. The latter will is discussed by McNeil (2006) as the concept pushed in the training of social workers over the past few years as the important factor for change. However, Norcross and Wampold's (2011) study provided validation for what Petr (1988) had presented as Richmond's work. Moreover, it provided validation for the life work of Robinson (1930) and Rogers (1951, 1961) and Bordin's (1979) research.

In the study, I worked to find answers to what perceptions and attitudes currently exist within the CMHC regarding the therapeutic relationship, what knowledge and attitudes are essential among the administration for the implementation of the Norcross and Wampold (2011) recommendations to succeed. Moreover, how cost effectiveness of care may be impacted. The social significance of this study lies in the expected results. For the large number of clients seeking mental health care services through the CMHC, but for society at large when the ethics of relationship-based services can be tested and integrated into mental health service delivery and a large number of clients are enabled to function as productive members of society.

The issues touched upon throughout this Appendix are explored, examined, and discussed via the multiple case study completed through this dissertation.

Curriculum Vitae

Alan F. Singer, MSW, LCSW, QMHP
ABD, Doctoral Candidate PhD Human Services,
Specialization- Clinical Social Work

Summary:

- Strong interpersonal and organizational skills; working well under pressure and adapting to new situations.
- Well-versed in different types of management and personnel situations.
- Self-starter, motivator, ability to train and teach teamwork. Able to assess peoples ability and needs.
- Proven to gain others confidence and trust through positive attitude.

Education:

- Ph.D, Human Services: Specialization Clinical Social Work. Walden University, Baltimore Maryland Expected December 2014.
  ~GPA 3.81
  ~Member Tau Upsilon Alpha National Organization for Human Services Honor Society
  ~ Dissertation: Mental Health Administrators' Knowledge and Perceptions of Delivery of Relationship-Based Services
- Master of Social Work, Aurora University June 2004, Aurora, IL
  ~Thesis: Perceptions and needs of Aurora University's Counseling Services

- Bachelor of Social Work, Cum Laude/June 2003, Aurora University, Aurora, IL.
  - Minor in psychology
  - Member of Phi Alpha Honor Society
  - Ivy Leaf card recipient
  - NASW student member, and liaison to AU
  - Recipient, George Williams Award, for Academic Excellence
  - Social Work Club, Treasurer 2002/3
  - NASW Student Liaison, for Aurora University

- Associate in Science, 2001. Waubonsee Community College, Sugar Grove, IL
  - Alpha Sigma Lambda National Honor Society for Adults, inducted 1999
  - Deans list - National Deans list 2001/2

Career History & Accomplishments:

Social Worker, DeKalb Clinic, 1850 Gateway Drive Sycamore, IL 60178 August 09 to Present

- Completing comprehensive client assessments, and completing psychological counseling

- Working with clients in individual psychotherapy, family therapy, clients with drug problems, and with couples. As well as working with persons with developmental disabilities and their families.
- Motivational speaker / Presenter of drug information to kids

- Area Office Supervisor, Sinnissippi Centers, Inc 125 South 4th St. Oregon IL.
  July 07 to July 10.

- Clinical Supervisor/Office Manger. Supervising, clinical, family, substance abuse out reach, and rehabilitation programs for persons with serious and persistent mental illness. Keeping a small personal caseload, providing psychological counseling.
- Member of local community programs, Juvenile Justice Council, Human Rights Committee, and various internal committees.

~ Helped begin and operate a Domestic Violence Intervention Program for offenders. Completing assessments for the courts, and working with probation officers

- Bridges Program Children, Adolescent and Family Therapist: Gateway Foundation, Aurora IL. 60506 May 04 to July 07

- Working in the community, schools, with DCFS and Kane County Juvenile Justice System, with emotionally disturbed and high risk children, adolescents and their families.
- Completing comprehensive client assessments, Substance use evaluations, formulating treatment plans
- Individual Therapy/case management/client centered consultation/medication training and monitoring with clients

- MSW Student Intern, Gateway Foundation, Aurora, IL. 60506
  August 2003, to May 2004

- Completed comprehensive client assessments and formulated treatment plans
- Individual psychological counseling/case management/client centered consultation/medication training and monitoring with clients
- Development and operation of various groups
- Worked with MISA clients in psychosocial rehabilitation day program

- DSP Certified Staff/ Therapist Individual Advocacy Group, Romeoville, IL
  May 03 to July 06

- Working with disabled individuals in a CILA. Supporting daily activities of living, mentoring, promoting self-development, and responding to client's behavior needs
- Mental Health Therapist and Qualified Retardation Professional

- Providing Individual Therapy for developmentally delayed individuals using various techniques to help them to overcome problems and look forward to a better life.

- BSW intern, Kendall County Health & Human Services, Yorkville IL.
  September 2002 to May 2003

  - Using a Bio/Psycho/Social approach: Working with / and development of various groups (i.e. mental health, anger/stress control, teen and caregivers). Community outreach, intakes, psychological assessments, supervised individual counseling.

- 1978 to 2003, Dominick's Finer Foods, 555 Northlake, IL

- Beginning as front-end service personal, promoted up to various management positions, including management of the store.

Memberships & Affiliations:

- Kendall County Operation Snowball volunteer staff counselor at spring and fall retreats 2003 to 2013
- Board Member Adventure Works-adventure therapy for teens
- Vice President and Board Member for the Joshua Tree Community
- National Organization for Human Services
- National Association for Social Workers

Published articles/presentation:

The Lighthouse: A social worker copes with a crisis 6(3) P.5

Ogle County Life/Rock Valley Shopper: Learning how to cope with and treat depression. Monday, Feb 9th 2009

January 2004 Presenter: "How You Can Work Effectively with your Elected Officials" at Aurora University.