improving community care—some comments

To the Editor:

Our staff at Dr. Mackinnon Phillips Hospital read with a good deal of interest your editorial “Community Treatment—A Broken Promise?” (Schizophrenia Bulletin, No. 10:4-5, Fall 1974). I was personally struck with the contradictory nature of some of our own efforts in discharge planning for schizophrenic patients of long standing.

Working in collaboration with the local Welfare Department, we devised a pilot project for such patients; the project was replete with a Federal grant, above average boarding-home accommodations, and a work retraining program. The retraining program was the real nub of the idea, as the patients, some of whom had been hospitalized for over 25 years, were placed in work situations at a local home for the aged. The patients were not actually employed by this agency, but were paid an incentive allowance by local welfare funds obtained through the grant. In addition, the allowance permitted for the boarding-home operator exceeded the normal room-and-board provisions usually included in minimal welfare coverage.

The net result of this small project exceeded our expectations. Within a year, we had legitimate hopes that all of the ex-patients would be gainfully employed. More important than that, each of them was leading some sort of “real” life by any standards. The Welfare Department, in turn, was granted permission to assign several hard core employment problems from the general assistance rolls to our psychiatric hospital for a similar work experience. It is therefore true to state that both the long-term schizophrenic and the general long-term welfare recipient were treated in essentially the same fashion. Call it what you wish—restabilization, work retraining, or practical habit training under moderate supervision—the general goal has been the same for both groups of people. It has surprised some observers that a paranoid schizophrenic of 30 years’ standing can appear amazingly unpsychotic while working an 8-hour day, eating good food, living in pleasant surroundings, and being free to engage in recreational pursuits of his own choosing.

At the same time this program was going on, a number of rootless patients were discharged because they had every right to be. The usual support services, often too little and ineffective, were offered. These people tended to drift into the “backwards” of the community, living out of sardine cans in flophouse hotels and spending their days in aimless isolation on a disability pension or welfare allowance. In these cases readmission comes as no surprise, and animosity toward the hospital by the same cooperative welfare administrator is an ironic twist in this instance. Somehow we have failed to supply enough of whatever it takes to protect “our people,” and the public eye is indeed a jaundiced one where these citizens are concerned. Welfare subsistence is marginal, employers interested in rehabilitation are scarce, wage rates are all too low, and benign supervision amid reasonable comforts is hard to come by without funding and public interest. There are, of course, other alternatives with which we are all familiar—such as day care, boarding homes without work, and going back home to one’s origins, whatever they might be. The point to be made, however, is that successful community psychiatry or valid community mental health programs require that something extra which the mental health worker is not always at liberty to supply.

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To the Editor:

The community mental health movement developed as a reaction to the inadequate treatment and custodial care received by chronic mental hospital patients. Advocates rose to state that more humane approaches should be considered, and legislatures responded by passing community health acts. . . . Yet such acts, and the mental health systems they inspired, have never related well to the nature of the chronic mentally
ill or their particular needs for community integration. ... Too often, those occupying leadership roles have little understanding of the chronic patient, whether he is in an institution or walking the streets. Lacking this sensitivity, they have moved toward an emphasis on crisis intervention and acute care, and toward a dependence on psychotropic drugs as the answer for community treatment of the chronically ill. Unfortunately, the chronic patient usually lacks the verbal skills or capacity for insight that arouse the interest of community-based clinicians. Community mental health has thus concentrated on the acutely ill, tending also to manage the chronic patient on a crisis basis. ... Thus, to a great extent, the State hospital remains the major resource for chronic patients; although their lengths of stay have shortened, the number of admissions has increased. In essence, the community is not meeting the needs of the chronically ill—probably more because it poorly understands these needs than because it lacks the resources to deal with them. The State mental hospital is viewed as an archaic and dehumanizing storage house. Yet, as we move patients into the community, more inadequate storage houses are being created. Ironically, the decrease in patient census in State hospitals is freeing resources and, as a consequence, is stimulating these institutions to develop new programs emphasizing rehabilitation. They are applying, probably for the first time, the knowledge they have gained about chronic patients to a rehabilitation philosophy.

The State hospital has not been adequately looked at or used as a major manpower resource. ... In fact, administrators have tended to work harder to destroy the viability of the institution than to look upon it as a critical resource toward making community mental health a reality. This has resulted in decaying morale in the hospital, resistance in the community to the State hospital's involvement in treatment, an increase of "sick" behaviors on the streets, and a ground swell against the philosophy and operation of community mental health programs. Why is it that we always go to extremes in reaction to situations instead of looking for a middle-of-the-road-approach? Instead of destroying the one facility that has stood so long to serve the chronically ill, we should have evaluated its capability to be a part of the community mental health system, and then have drawn from it the expertise and leadership essential to developing balanced programming.

Integrated supportive programming is essential to the rehabilitation of the chronic patient in the community. In our institution, we have operated such a model for some time and have found it to be highly effective. Our approach has been to link programs developed in the hospital with later developed community programs that, in many ways, replicated the hospital programs. The impetus for this approach came from the State hospital. Its manpower and management were that of the State hospital. ... Nevertheless, leadership roles have been denied to the hospital staff because of their supposed narrowness in thinking and acting. Interestingly, the model cost no new dollars and made use of primary resources available through the hospital program. Prolonged failure to look at the State hospital in a more positive manner may be predictive of the long-term inability to deliver adequate mental health services to the chronic patient in the community. ... If community mental health is to serve chronic patients, it must begin to look toward the expertise, manpower, and coordinating capabilities of the State mental hospital. It is to be hoped that more administrators will be sought among those with institutional experience to help bridge this gap. When programs and systems operate under appropriate management, good care will be offered and treatment rendered. Further, the costs can be kept within restrictions by better use of current resources. ...

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To the Editor:

In AT ISSUE, the question was raised, What is to be done to diminish community backlash regarding treatment of the mentally ill? To this reader, there are three points to consider in successful community programs.

First, fear of the unknown is ubiquitous among people in any community. There are some, however, who fear neither the mentally ill nor the mentally retarded—the attendants who have worked in institutions. All of us who have had experience in an institutional setting can recall our first day of work and the feelings of fear occasioned by being a "normal" minority in a setting characterized by a "pathological" majority. Those of us who stayed long enough came to realize that the mentally ill were the most fearful and, very likely, the least dangerous of our species. Therefore, to overcome the community resistance to ex-mental patients, former or currently employed attendants might take part in a television series modeled after the Public Broadcasting System's "Nova" series. These fear-desensitized people, in concert
with professionals in a skillfully developed program or series, would appear to be “teachers” of choice. Further, where institutions have been closed due to the decline in the population of institutionalized psychotics, experienced and articulate attendants could be critical to the success of community-based programs, while still remaining in their field and serving their former charges, albeit in a different fashion.

A second point has to do with the prestige of the communicator. While it may be true that the prestigious, high status person is most effective in mass communication with a persuasive intent (Hovland, Janis, and Kelley 1953), the citizens of any community would tend to be more convinced by somebody “who has been there”—i.e., the attendant, rather than the town banker or the mayor. Naturally, inclusion of some patients willing to be a part of such a program (perhaps in a paid capacity) would add “steak” to such an educational venture and might offset some of the superabundant “sizzle” that apparently has not paid off.

Finally, cognitive dissonance (Festinger 1957) could be employed to help dissolve fear of the unknown. Some years ago my father-in-law provided a dramatic and effective example of fear reduction. At the time, I had been in institutional work long enough to answer some questions, and at my in-laws’ home I was the authority on such matters. At the evening meal, my mother-in-law reflected the concern of the town (population 450) over the release of a “well-known psychotic.” Following some discussion about the fears “so-and-so” and “so-and-so” had expressed at the grocery store, my father-in-law turned to me and inquired, “Charlie, when they discharge a patient, don’t they give him a paper saying he’s sane?” I allowed this was correct. “Well then, as far as I know, he’s the only man in town who has papers to prove his sanity!” It’s food for thought and it did evoke an audible sigh of relief.

References


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an invitation to readers

Providing a forum for a lively exchange of ideas ranks high among the Schizophrenia Bulletin’s objectives. In the section, At Issue, readers are asked to comment on specific controversial subjects that merit wide discussion. But remarks need not be confined to the issues we have identified. At Issue is open to any schizophrenia-related topic that needs airing. It is a place for readers to discuss articles that appear in the Bulletin or elsewhere in the professional literature, to report informally on experiences in the clinic, laboratory, or community, and to share ideas—including those that might seem to be radical notions. We welcome all comments.—The Editors.

Send your remarks to: At Issue Center for Studies of Schizophrenia National Institute of Mental Health 5600 Fishers Lane Rockville, Md. 20852