custodial care—a legitimate service?*

To the Editor:

American society is amazingly productive. Along with the torrent of goods produced, it also produces castoffs and misfits. Some of them are likely to become mental patients. These persons should not be discarded like junk. Neither should they be shuttled back and forth between hospitals and communities like an unwanted consignment of goods. At present they are not welcomed anywhere. We should acknowledge the special needs of these patients openly and honestly. Presented below is a brief view of their needs and a proposal for meeting them.

A small but significant number of patients who enter mental hospitals probably will continue to live there for the remainder of their lives. An even larger number might remain there if they were given the choice. The hospital serves a special function for such patients: It is a place to live, a shelter, a haven, an asylum from the outside world. Unless we are willing to expose the aged and infirm, the troubled and weary, the misfits and incompetents, there must be a place of refuge for them.

These patients have many different problems beside the ones that gained them entrance to a mental hospital. Too often patients' efforts at self-medication are incapacitating. Thus some drink too much. And some take too many drugs. Still others never learned any useful skills. Another group suffers from organic defects that limit their competence.

Taken together, these patients form a heterogeneous population. They may be referred to in a shorthand way as "mental patients." More accurately, some of them are simply homeless. They need custodial care or some suitable alternative.

Psychiatrists once accepted the need to provide such service. Now most have come to view the custodial function of mental hospitals as evidence of therapeutic failure. They are convinced of the general effectiveness of psychiatric treatment. This optimism, in turn, furthers the adoption of an unrealistic goal; all patients should be able to leave the hospital in an improved state. Any patient who wants to remain ipso facto must be suffering from a psychiatric illness or from strong dependency needs. Either that, or he is viewed as a moral pariah, a social parasite, an ungrateful malingerer. Yet a patient may have rational reasons for wanting to remain in the hospital.

The hospital offers much to the homeless and destitute. They know their creature comforts will be cared for there. Weary sojourners in a hostile world, they are satisfied when they find a place to rest. They also enjoy the recreation and entertainment available in the hospital. These patients have few friends in the community. The hospital, by contrast, provides them with companionship. The staff cares about them. So do other patients with whom they make friends. Obviously, they prefer this kind of life to the deprivation and rejection awaiting them in the community. The future neighbors of mental patients do not send the welcome wagon to greet them. Mental patients are objectionable intruders. Their neighbors fear them. Often they band together against patients.

Today, a new approach to custodial care is under discussion. It takes into account the views of patients and staff, families, and neighbors. Findings from past social-psychological studies were used in formulating this new approach. The guiding premise can be stated briefly: Custodial care is a legitimate service for certain patients. A custodial care program, therefore, is predicated not on failure but on need. In addition, the adoption of modest, limited goals for patients is proposed, goals which are in line with the current state of psychiatric knowledge.

The new approach suggests that facilities equivalent to those presently available in the mental hospital be made available in the community. Patients interested in custodial care would be entitled to a bed, a locker, meals, and clothing. The facility offering equivalent accommodations might be located on the hospital grounds. No staff other than a manager and a group worker would be employed in the custodial facility. The facility might be thought of as somewhat akin to a chronic ward with these significant differences:

* Residents would choose this style of life; it would not be imposed upon them.
* Residents would be free to leave the facility; they would be helped to leave whenever they chose to do so.
* Residents would not be locked in and confined to a small area; they would be encouraged to visit the community.
* Residents would not have to cope with a large bureaucracy with special needs of its own to which theirs would be subordinated; they would not have to accommodate
themselves to the needs of attendants, nurses, doctors, and other institutional staff.

A number of benefits might result from this type of solution. Therapists could concentrate more effort on helping patients who want psychiatric treatment. Under the new arrangement they would have more time to practice the things they dreamed of doing when they first chose to become clinicians. Family members would not have to worry about a patient living in the community totally unsupervised. The family would be grateful that the patient could live at the residence instead of in a hostile neighborhood where he is unwelcome. Lastly, homeowners in neighborhoods where large numbers of patients are currently congregating would be relieved. The need to saturate certain areas with chronic patients would decrease. Also, the number of incidents in which a patient shows a gross disregard for community standards might decline. Some of these may represent a patient's cry for someone to notice him and attend to his needs.

One feature of this new approach needs reemphasis. Little or no active treatment is contemplated for this residual category of patient. This does not involve any serious deprivation, since at present no one seems to know how to treat these patients.

A worrisome charge is that new abuses may arise in the residence which would be similar or even worse than those that occurred in custodial hospitals. Certain precautions can be taken to guard against this possibility. For example, the residence should be easily accessible. Frequent visits from outsiders help reduce abuses that flourish in isolated institutions. Also, patients should retain considerable autonomy over their lives. In addition, an ombudsman from some watchdog organization should make periodic visits to assess the well-being of patients. Perhaps the most important safeguard is the absence of a large bureaucracy pressing down on patients, making them conform to the needs of officials masquerading in the white robes of science.

The new arrangement holds much promise. Yet, its appeal is likely to be limited. First, a program that recognizes dependence without punishing it or exacting the price of conformity to social norms is likely to be unpopular. Mental patients must want to become independent and productive. They must crave re-habilitation. Without this saving grace, patients risk being treated like outcasts. In our society, beggars can't be choosers.

Second, this program sounds passive and pessimistic. Americans are doers. They are eager problem solvers. Recognizing limitations in what can be accomplished goes against the reformist American grain. The optimists expect that there is a happy solution for every mental patient: Every one should recover. What we must do is think positively and try harder. Then we Americans shall surely succeed.

Maintaining these grand hopes leads to a continued squandering of scarce psychiatric resources. At the same time, the call goes out for more and more mental health manpower. The net effect is to shortchange patients who want psychiatric treatment and needlessly to burden those who need service, not treatment. By refusing to adopt modest goals that can be achieved with modest means, we shall continue to fail both kinds of patients.

To the Editor:

When I first worked in a State hospital as a summer intern in 1932, I was disturbed by the fact that no followup was done after a patient's discharge. Thirty years later, I had the opportunity of working as a fill-in psychiatrist at the Watkins Glen Mental Health Center in Schuyler County, N.Y. I was amazed and delighted at the remarkable changes for the better that have taken place since my initial institutional experience.

If Willard State Hospital released a patient to Schuyler County, we obtained a history, had the patient visit our clinic at regular intervals, arranged for our clinic nurse to visit his family, assisted the family in setting up a system of care, and continued the mental health interviews at regular intervals. In other words, we never lost contact with the patient. If necessary, we had the patient attend our day care center. If the patient relapsed, we got in touch with Willard and returned him to the hospital. He was returned to us when he improved sufficiently. We still never lost contact with the patient and his family. We could continue this contact with the patient and hospital indefinitely so long as the patient did not become violent.

This system was infinitely superior to the system—or lack of system—observed at the State Hospital in 1932. . . . A continuum of supervision and review is the secret of care. You may need a minibus to get a patient to and from his home to the hospital; but you must have community concern and guidance provided by the mental health center. Let us strive for teamwork and concern. There is no alternative.

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