Escape From Asylum—Response to Wasow

by Michael R. Schroeder

Abstract

Wasow (1986) calls for a “Return to Asylum”—a reinstitutionalization of persons with major mental illnesses. This article argues that a philosophy of liberty and good comprehensive community support programming is a preferable way of meeting the needs of persons with long-term major mental illnesses. A program in a rural community in which institutional alternatives are not used and a model for building such programs are described.

Wasow (1986) has offered a view of the need for an array of institutional services for the chronically mentally ill that is not only internally contradictory, but is also an example of the logical fallacy of composition. She moves from the most specific to the most general without establishing a logical relationship.

While Wasow offers anecdotal evidence of people living in “streets, bus stations, parks, and shelters for the homeless,” she offers no evidence that these people have a chronic mental illness nor that they are participants in any of the programs she all too easily castigates. She asks if it is so wonderful that an outreach worker can bring medication and find someone staring into space without providing evidence either that this is the case or that this is all that is being done.

As the Director of a county mental health system in Wisconsin, a social worker, and a taxpayer, I am concerned that a professional would use the work of others in such a way that she misreads their findings to suit her own ends. In reading her article, for example, one could conclude that Dr. Estroff would agree with the need for asylum to protect people. Whether she would or not is not supported in Wasow’s article but is suggested when, in fact, the reference is to people not to programs.

This is typical of the confusion in her article. Wasow cites sources that conclude “that commitment is the only possibility for treating a loved one who is literally killing himself with neglect” (Lefley 1985, p. 10) without pointing out that commitment does not necessarily mean institutionalization—many commitments in this State are being made to the community support program—not that, while commitment may be an important step in the process, many patients subsequently accept services on a voluntary basis.

The article not only uses research out of context, but contradicts itself. Wasow opens by citing her son as a “success statistic” in her first paragraph, says that the program would not consider him a success in the fourth paragraph, and by the fifth paragraph says that he is listed as a success. She closes with the apology that she can be objective as a parent.

If one considers the essential components of a good community support program, Wasow’s fears will, I think, be answered. Her fears about extending civil liberties to mentally ill persons notwithstanding, it is my experience, and that of many of my colleagues, that freedom of choice is an essential component in building responsible behavior. Surely Wasow will recognize that it is the very institutionalization that she touts which has taught clients to act unreasonably.

The relationship between freedom and responsibility is one in which

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the two are philosophically intertwined. It is impossible to conceive of one without the other. No person, acting freely, can escape responsibility for his or her behavior. If a person can choose between two or more courses of action, she or he is responsible for the outcome of that choice. This presupposes that people make properly informed choices, but does not excuse them from the responsibility for gathering information that is available.

The other side of the equation is that we cannot be held responsible for behavior in which we did not have freedom of choice. This is not to opt for the "I was only following orders" defense, for we have long recognized our freedom to obey or to disobey orders. That choice is ours alone. It is, however, to suggest that we cannot be held accountable for behavior over which we have little control.

I would postulate that most people seek control over their own lives—in other words, freedom—and that, given freedom, most people will behave responsibly. I would further postulate that this holds true for people who have chronic mental illness, but that they require some support and/or guidance in living their daily lives responsibly. When in hospitals or other institutions (asylums), long-term patients "act out," refuse to eat, demand things of staff, and generally exhibit what we view as signs and symptoms that they are not yet ready to cope—are they not trying to exert a measure of control over a very coercive environment?

This side of the paradox in the relationship between freedom and responsibility would have us believe that people who behave "irresponsibly" in restrictive structures will act irresponsibly under conditions of liberty, without testing that postulate, or by testing it without providing supports. Good community support programming contradicts this assumption by allowing freedom and by providing support to the client to enable him or her to act responsibly.

In our community system in south-central Wisconsin, we do not indiscriminately put people out in the community, nor do we provide "asylum." All of our clients in community support are diagnosed as having a major mental illness. While most are schizophrenic, some have major affective disorders, usually with psychotic characteristics. They range from 21 to 65 years of age.

Many clients have been in the program for several years. While there is some turnover, it is minimal (about 10 percent per year). Currently, only 2 of the 41 clients are committed by the courts and required to participate. With increasing frequency, judges are ordering community support at initial commitment, and the clients improve to the point that recommitment is seldom necessary.

The fact that over 95 percent of the participation is voluntary is due, in large part, to individualization. The question is not one of discrimination in regard to who can use community support services, but in what types of and to what extent services are needed by the clients. This, we see, as standing in the best tradition of social work services, following from the medical and social diagnosis through planning with the client, his or her family, and other service providers.

I prefer to speak of community support programming (CSP) rather than of a community support program. Just as in any other mental health treatment modality, success is built on tailoring the program to the client's needs. The following are some basic requirements for successful long-term support for chronically mentally ill people in rural communities.

• All workers in the agency must be involved in community support. The entire staff must be committed to the idea of working with the chronically mentally ill. This is, in my estimation, the most difficult issue and must be confronted first. The staff will find resistance from people at all levels, because they are frightened by these clients; clients don't look and smell good; clients are loud and obnoxious or shy and withdrawn; clients hear noises or speak to people who aren't there; and, in short, they need mental health services. Some people want to operate in public agencies like private therapists. We have had that problem, and clinicians with this attitude do not work with this population.

• The program must have assertive outreach. This is true not only as the support workers bring people into the system, but also after they are in the program. The staff must be at the hospitals, advocating that people be released, and sitting down with the discharge planners and convincing them that what they advocate can be done. We found it essential to have the psychiatrists, psychologists, nurses, and social workers in our primary inpatient treatment facility come out to spend some time in our program so that they could believe what we did.

• The staff needs to be assertive in how they approach clients on a daily basis. They need to go out to them, to reach out to where they live. Support workers need to get people out of bed, to take them shopping, to movies, etc. It must be remembered, however, that these people also need their personal
space. Clients deserve to be called or notified in some way before they are visited.

- Although an identifiable staff is needed, you do not necessarily need an identifiable place. CSP has no walls. The borders of the program are the borders of the catchment area. There is no place in which community support is inappropriate. For the most part, this makes CSP services nonreimbursable, but it is essential that support workers maintain the integrity of the program by taking it to the client’s normal living and recreation space.

- Support staff must maintain a low profile when out with clients. Programs are most appreciated when clients are integrated into the community unnoticed. Shopping trips and other activities should be carried out in twos instead of groups—the way nondisabled adults do.

- On the other hand, support workers must develop cooperation between clients and the community. In order for a program to be successful, police, landlords, employers, storekeepers, etc., must see that clients can integrate into the community well. It only takes a few prominent but dissatisfied citizens to destroy a program.

- Clients often need help with money management. Most of our clients are on Social Security Disability Insurance or Supplemental Security Income. They forget to keep good records in their checkbooks, so they have frequent overdrafts. I think that is absolutely essential, especially in small communities where everyone knows everyone else’s business, to make sure that this important part of a client’s responsibility is taken care of. If a client is responsible, he or she can manage money with a minimum of help; if not, assistance must be given in writing checks, buying groceries, and other expenses.

- Clients who are taking medications must have professional monitoring. As I speak with clients about their problems, the most common complaint is of the side effects of medications. Clients need to be educated about their medications so they know what to expect.

- Clients need to live in normal settings, in clean, decent places. I am convinced that living in a clean apartment or house with sufficient heat in the winter and ventilation in the summer makes a tremendous difference in how people feel about themselves. To postulate that they will clean up the place when they feel better about themselves is to invite disaster. These people need structure.

- Support workers must be assertive with clients and not be afraid to be plain spoken and blunt. If someone smells and is unpleasant to be with, tell them so. If they are acting inappropriately, let them know.

- People need a reason to get up in the morning and a way to mark one day from the next. They need structure to help their lives make sense. This is something which is denied most chronically mentally ill people. I believe that people need work to make them feel like responsible, contributing members of our society. We get a sense of our value not only by what others will do for us but from what we can do for others. Those who don’t contribute through work are devalued, not only in their own eyes but also in the eyes of society. Support workers encourage, assist, and support clients to work in the community, not in sheltered workshops. Many can work a full 40-hour week, while others may need part-time employment and other supports. Those who cannot work in a competitive setting can do volunteer work. Those who cannot do either should have other activities planned.

- Directors of community support programs must be cognizant of all of the above when choosing staff. Support workers work long hours for little pay and do things with people whom the rest of society has rejected. This is not a job for the squeamish, for the unassertive, doormat personality. They help clients do laundry, clean house, set up their apartments, shop, job hunt, find recreational outlets, teach, coach, cajole, scold, and befriend people whose social skills are virtually nonexistent when they start. They need to be task-oriented people lovers and plain-spoken people who are, themselves, well integrated into their communities.

Over the years, I have heard much about the chronically mentally ill being narcissistic and unable to form close relationships with others. They are reputed to be largely incapable of real caring about others. Our clients do truly care for each other and for others, but in order to do so, they need to be free to do so. Clients often let the support worker know when another client needs help. Harvard philosopher John Rawls (Rawls 1971) in his book, A Theory of Justice, says, “Liberty can always be explained by a reference to three items. The agents who are free, the restrictions or limitations they are free from, and what it is they are free to do or not to do” (p. 202). Clients are free to care about others because their basic needs are met, because they are free of unnecessary restrictions, and because they are secure in the knowledge that they are responsible for what they do. Rawls (1971) states that “the establishment of a coercive agency is
rational only if the disadvantages are less than the loss of liberty from instability” (p. 202). If we can provide stability in the community, hospitals do not loom large in the future of the chronically mentally ill. We need them for short-term treatment—4- to 5-day periods, but seldom longer.

We can and must provide such support for every community in our rural areas. We do know that in providing a caring, supportive treatment environment in the community, we have done what Wasow promotes as permanency planning, but we have done it in an environment without walls. It can be amply demonstrated that when we have buildings—group homes, workshops, and day-treatment programs—we start to see the needs of clients through the needs of the programs. That is the problem with treatment planning in Wasow’s model. We don’t need “permanent, structured, supervised housing,” and neither do our clients. To give it to them would be countertherapeutic and thus, I submit, unethical.

We surely do need assertive, structuring programming, and highly individualized treatment planning. We need dedicated, knowledgeable professional staff, but we don’t need to harken back to “the good old days” of segregated facilities where clients may have been comfortable, but surely did not get well.

Change can be frightening, particularly when people are asked to behave more responsibly. It ill behooves a member of the professional community, especially one charged with educating young workers, to look with blinders on at those changes. We need more professionals who truly understand mental illness and the needed structure in community treatment. Professor Wasow needs to look at programs which work. There are many within a few miles of her classroom.

References


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Reply to Schroeder

This article is in response to Schroeder’s (1987) comments on Wasow’s (1986) article in the Schizophrenia Bulletin. As a parent of a mentally ill adult son who is in a community support program in Madison, Wisconsin, and also as the former editor of the newsletter of the Alliance for the Mentally Ill of Dane County, as well as a member of their Board of Directors, I have agreed to join Mona Wasow in replying to Schroeder’s comments.

The bulk of Schroeder’s article has little to do with Wasow’s (1986) article. It should be emphasized that Wasow never speaks out against community care. We are both aware that community care for the mentally ill is vitally important. There is just not enough of it anywhere or at any time. Wasow simply states that community support programs do not serve all chronically mentally ill persons. Personally, I have been fortunate. My son is afflicted with schizophrenia, and I feel he has benefited from the community support system in Dane County.

We object to Schroeder’s reference to Wasow’s “anecdotal evidence of people living in streets, bus stations, parks, and shelters for the homeless” as not showing that most of these people are indeed mentally ill. I refer Schroeder to the January 7, 1986, issue of Newsweek Magazine for the correct statistics.

We disagree particularly with Schroeder’s discussion of the relationship between freedom and responsibility. Schroeder is quite right when he states, “No person, acting freely, can escape responsibility” (p. 548). He is quite wrong when he applies this statement to the mentally ill. The mentally ill are not free to choose which way they will behave in a given situation because their brains do not function normally. If they did, they would not be mentally ill! Because of the medication most of them must take to achieve even a moderate measure of stability, the functioning of their brain is affected. This causes them to see things in a skewed fashion, and, therefore, they cannot make normal judgments and act freely.

I suggest to Schroeder that he re-read his statement, “The other side of the equation is that we cannot be held responsible for behavior in which we did not have freedom of