The Use of Community Networks for Chronic Psychiatric Patients

(community-institutional relations, group therapy, mental disorders, occupational therapy, program development)

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<th>Catherine V. Daniewicz</th>
<th>Lucy C. Swan</th>
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This paper describes a program, the Work Readiness Seminar, designed in collaboration with a community organization, the Altrusa Club, to respond to needs of chronic psychiatric female patients. The five sessions of the program provide the women with information about everyday survival skills and an opportunity to practice these skills. The excellent role models provided by the Altrusa Club members and the programming of life skills “in vivo” are the strengths of the program. This paper also briefly describes three additional programs that evolved from the Work Readiness Seminar. All four programs use community groups as a resource for teaching life skills to chronic psychiatric patients.

This paper describes the development of a program based on the use of a community network. The program is designed to help chronic psychiatric patients reenter the community or to help them remain in the community after they have been discharged from the hospital.

Rationale

A major thrust in the rehabilitation of the chronic psychiatric patient has been to focus on skill deficits in functional behavior (1). Rehabilitation is defined as the “development and improvement of specific skills and capacities that may be directly related to successful economic and social functioning in the community” (2, p 149). A life skills treatment approach can help the psychiatric patient acquire more successful adaptive behaviors in preparation for living in the least restrictive environment (5). Such an approach is based primarily on the concepts of social learning theory and uses educational techniques. Lamb (4) points out that rehabilitation is a process that focuses on “reality factors rather than on intrapsychic phenomenon” (p 2).

Many chronic psychiatric patients in institutions or communities assume a life-style of passivity and inactivity, which serves to intensify their dysfunction (5, 6). For this population, the goals of in-and outpatient occupational therapy are to promote autonomy, independence, and competence in daily living. In addition, work, according to Reilly (7), “can and should be used as an integrating focus for rehabilitative behavior” (p 64). Work can be viewed not only in the narrow sense of a job but also in the broader sense of wanting to know and see things, “the everyday exercises of abilities (that) are crucial to the attainment and maintenance of self-esteem and a sense of competence” (5, p 295).

The Setting

At St. Elizabeths Hospital, a federal psychiatric facility in Washington, DC, that serves 10,000 in- and outpatients, occupational therapists provide life skills group programs to chronic psychiatric patients. A mandate of the hospital's

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The program, called the Altrusa Work Readiness Seminar, consists of a series of five sessions on work readiness and community living skills for female patients. The seminar provides information about everyday situations that patients encounter in the community and gives patients an opportunity to practice the skills needed to handle these situations.

Program Planning to Meet Patient's Needs

Most patients at St. Elizabeths Hospital and in the program are from an inner city catchment area. The majority are racial minorities from deprived social, economic, and educational backgrounds. They are typical of chronic psychiatric populations found in large urban mental health centers who characteristically have low levels of achievement in all areas (from vocational to educational) (5) and share a sense of hopelessness and failure. To combat these feelings, modest challenges need to be presented accompanied by strong encouragement and support. The challenges posed by the Altrusa seminar program are a) to participate in the program and b) to attend all five sessions to be eligible for the graduation luncheon.

Adaptation or behavioral change occurs as the patient acquires a sense of personal efficacy or competence and independence. The seminar program strives to provide a “mixture of respect, hope, and challenge with the help of practice and models” (9, p 15).

To create this environment of respect, hope, and challenge, good role models are essential. Bandura (10) demonstrated the effectiveness of role modeling as a technique for behavioral change. Role model characteristics that are considered effective in producing behavioral change are “high status, being viewed as highly skilled, empathic, friendly, and helpful” (11, p 42). Altrusa Club members are highly skilled, successful working women representing a variety of backgrounds and thus are excellent role models. This interaction between role models and patients is a very important part of the program. Equally important is the fact that the program is operated in the community, for it is commonly agreed that life skills programming should be done in vivo (4).

Patient Selection

Female patients in the program (in order of priority) are a) those preparing for a job (defined as paid employment, job training, sheltered work, or return to family responsibilities), b) those preparing for placement in the community in supervised or unsupervised settings, and c) those without immediate job or placement plans who still need exposure to the community as a long-term goal for placement. Five other factors influence patient selection: a) the potential for learning, b) the level of motivation, c) the risk of assaultive behavior, d) the level of orientation, and e) the elopement risk. All patients are from the hospital’s Richardson Division, which serves approximately 246 inpatients and 287 outpatients. Tables 1 and 2 give the diagnosis and age range, respectively, for the 37 patients who participated during the first year of the program.

Occupational Therapy Responsibilities

Two occupational therapists coordinate the program. All patients are interviewed to assess their backgrounds and to determine
Table 1
Diagnosis of Patients in the Program

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<th>Diagnosis</th>
<th>Percent</th>
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<tr>
<td>Organic mental disorder, 290.00</td>
<td>3</td>
</tr>
<tr>
<td>Personality disorder, 301.70 antisocial</td>
<td>3</td>
</tr>
<tr>
<td>Personality disorder, 301.22 schizotypal</td>
<td>3</td>
</tr>
<tr>
<td>Psychosis with endocrine disorder*</td>
<td>3</td>
</tr>
<tr>
<td>Schizophrenia, hebephrenic*</td>
<td>3</td>
</tr>
<tr>
<td>Schizophrenia, 295.9 chronic undifferentiated</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia, 295.2 catatonic</td>
<td>11</td>
</tr>
<tr>
<td>Schizophrenia, 295.3 paranoid</td>
<td>30</td>
</tr>
<tr>
<td>Schizophrenia, schizoaffective*</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
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Results shown used DSM III except for * (DSM II still in effect when the program began); n = 37.

Table 2
Age Distribution of Patients

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<th>Age Range, yr</th>
<th>Percent</th>
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<tr>
<td>18-25</td>
<td>11</td>
</tr>
<tr>
<td>26-35</td>
<td>30</td>
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<tr>
<td>36-45</td>
<td>16</td>
</tr>
<tr>
<td>46-55</td>
<td>32</td>
</tr>
<tr>
<td>56-65</td>
<td>8</td>
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<tr>
<td>66-75</td>
<td>3</td>
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<tr>
<td>Total</td>
<td>100</td>
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goals and specific treatment objectives. An observation form is then filled out on each patient to compile a baseline score for specific adaptive behaviors in appearance (self-care), social interaction, and reaction to the community settings. A second observational behavior score is taken at the graduation luncheon and compared with the first session as a measure of acquisition of adaptive behaviors. The therapists also act as representatives to the eight treatment teams and transport patients to the seminars.

During the seminar sessions, the therapists set realistic limits, assist in managing behavior problems, and determine the strategies of intervention most likely to succeed with the individual patient. The therapists also help the patients overcome their anxiety about attending the program and/or leaving the hospital.

The therapists inform the Altrusa volunteers about the patients' needs and about occupational therapy services. They give feedback and assistance in each session to all the instructors and help them adapt their presentation to meet the special needs of the patients. This is necessary. Some instructors would use examples that were not pertinent to the patient's economic level. One instructor initially spoke about credit cards and automobile ownership. After feedback from therapists, the instructor changed the focus to safeguarding identification cards (rather than credit cards) and spoke of travel by bus (instead of by car).

Components of Seminar

The five sessions of each Altrusa Work Readiness Seminar provide practical information about women in the world of work and their daily living requirements or experiences. The topics identified by the occupational therapist, patients, and hospital staff for the seminars were a) money management, b) personal crises and community resources, c) the job market, d) evaluation of self, and e) consumerism (including street law). Altrusa volunteers present each lecture and arrange for the learning site. For example, recently the money management session was held at a downtown bank (with the bank's vice president as speaker); the other four sessions were held at a career school for women in downtown Washington, DC.

Each session lasts two hours and includes a refreshment break, which brings patients, staff, and faculty together for informal conversation. During the session, patients are encouraged to discuss session topics that directly affect them. All participants role-play situations, such as job interviews, completing application forms, street safety techniques (e.g., how to carry a purse to avoid theft), and making a good first impression. Two different Altrusa volunteers team teach the sessions which are attended by a maximum of 12 patients. Two occupational therapists are present at each session.

When participants complete both series of seminars (four series are held each calendar year), Altrusa Club members host a graduation luncheon in a downtown restaurant. To encourage conversation at the luncheon, a graduate is seated between two Altrusa volunteers. Each person introduces herself to the group and says a few words about the seminars. It should be noted that no patient attending the luncheon has ever refused to participate in this segment. Following the meal, an officer of the club gives a talk and then calls forward each graduate to receive a rose and a Certificate of Completion.

Outcome

The outcome of the program was measured in several ways. An evaluation form was used to determine the patient's perception of the usefulness of each session. Ninety-five percent of the patients
marked the session “very helpful,” five percent marked it “somewhat helpful,” and no one checked “not at all helpful.”

Patients spontaneously talked to the staff about their experiences and told them how much they enjoyed the sessions. One psychologist remarked that the experience seemed tremendously ego-enhancing.

Adaptive behavior changes were also noted. The observation form that compared adaptive behaviors in the first session with adaptive behaviors in the graduation lunch-eon (in the areas of appearance, social interaction, and reaction to the community settings) showed some improvement in all patients. Specifically, there was a gradual increase in the number of times per session that the patients entered into role-playing exercises and discussion. Patients socialized and interacted with others more often. Many appeared to take extra pride in their appearance; they had made special trips to the hospital beautician before the session; some even saved a dress for the graduation luncheon.

The modest challenge of attending all five sessions that the program provided to participants was met by 25 (67%) of the 37 patients who started the program. However, this in itself is not a reliable measure because the patients do not have complete control over whether they are able to attend when interferences, such as medical appointments and illness, occur.

We believe this community network program contributed to the positive outcome of patients who were a) maintained as outpatients, b) moved to outpatient status, and/or c) became involved in employment programs; all were part of the psychiatric rehabilitation process.

New Developments

As the seminars have progressed, three new programs have been developed. A description of each follows.

1. A follow-up series. After the first year of the program, the Altrusa members, the Richardson Division staff, and the patients all agreed that a follow-up group for the graduates of the seminars was needed. The Altrusa members decided to sponsor and implement a follow-up series of four sessions per year at the YMCA. The primary goal of this series is to provide continuing support and ongoing community networks for the graduates. The sessions are designed to promote self-development, socialization, and the use of community resources, and encourage graduates to help each other with problems that arise while they are living in the community. At the first session, the name “All Together Club” was adopted. Twenty-four work readiness seminar graduates have attended the All Together Club since its beginning in October 1981.

2. Seminars for male patients. Because of the success of the program with female patients, the idea evolved to develop a similar program for male patients using male role models. The Kiwanis Club of Capitol Hill has since started work readiness seminars for men based on the Altrusa Club model.

3. Seminar for male and female patients. The volunteer employee organization of the Chesapeake and Potomac Telephone Company is now offering a Communication Workshop. Both male and female role models are used. There are five sessions and a luncheon. The topics focus on practical communication issues, beginning with the use of the phone and ending with listening skills and how to project a positive image.

Conclusion

The community network program described in this paper contributes to the rehabilitation process of the chronic psychiatric patient, heightens community members’ awareness of these patients’ needs, and exposes them to occupational therapy services. However, the program does have limitations. For example, the seminars are relatively short-term and therefore cannot promise sustained behavior changes or greatly advanced skill levels. The seminars provide approximately 24 treatment hours per patient over a six-week period. The most effective life skills programming and the most comprehensive rehabilitation for achieving sustained, adaptive functioning is done in community-based, structured day treatment settings (4, 5, 11, 12). However, community networks could be used effectively within day treatment programs.

The community network program was geared to the needs of the long-term chronic psychiatric patient rather than the short-term acute patient. The latter often has had no previous psychiatric admissions and has a good premorbid adjustment; this results in different treatment needs. Some acute short-term patients were included in the program, but they frequently did not complete the program because of their short hospital stays. The program could have application in an acute care setting as a motivating experience for return to work and/or other occupational responsibilities. Instead of offering five sessions once a week for five weeks, the program could run five sessions in one week.

Finally, the program is most ef-
ffective if it is followed with continued rehabilitation programming. The Work Readiness Seminars are only one program group for the patient in a full schedule of program groups. Rehabilitation is, empathically, a coordinated team effort. Occupational therapy at St. Elizabeth's Hospital is only one part of the treatment process. Success or failure of any program is therefore shared.

Life skills programs within the context of social learning theory and educational principles are a significant contribution to the delivery of mental health services. Occupational therapists who provide life skills programs help patients move to less restrictive environments, which is the basic thrust of psychiatric rehabilitation and deinstitutionalization. The community networks approach to life skills programs can be a tremendous resource for occupational therapists.

REFERENCES