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TREATMENT OF THE CHRONIC MENTAL PATIENT:  
ISSUES AND IMPLICATIONS

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## ABSTRACT

The aim of this study is to clarify the unique needs of the chronic mental patient, and draw implications therefrom for the design of comprehensive and effective systems of continuous care.

The history of treatment for mental patients in the western industrialized world is reviewed, with special emphasis on the ethical, legal and socio-cultural background to the de-institutionalization movement, and the development of new models of caring for the chronic mental patient. Recent attempts to humanize mental health care are examined for guidelines to more successful planning in the future.

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NOTE:

The bias in terminology toward psychiatry, rather than psychology, in this dissertation reflects the present bias in the literature but it is not intended to imply that the field is of more relevance to psychiatry than psychology.

Planners of mental health services for the future stress that multi-disciplinary teams - with equal and overlapping responsibilities among members - will most efficiently meet service needs.

The psychologist shares a concern and involvement with all other mental health workers with the issues discussed, and should play an increasingly active part in the development of flexible and balanced systems of continuous care for the chronic mental patient.



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## INTRODUCTION

The past three decades have seen a revolution in treatment for the psychologically ill, reflecting important sociocultural trends in Europe, England and the United States of America. A major focus has been the the issue of the chronic psychiatric patient - primarily the schizophrenic - who has formed the bulk of the long-term population in the large and dismal psychiatric institutions.

Human rights movements, the discovery of neuroleptic drugs, and socio-economic policies have contributed to far-reaching changes in the approach to mental illness. We have come to think of rehabilitation not only as reduction of symptomatology and discharge from hospital, but also in terms of quality-of-life - encompassing such concepts as dignity, happiness and social acceptance for the seriously mentally disabled. The ideological battle regarding responsibility for 'deviance' - whether it rests with the individual or an alienating society - provides a significant backdrop to the de-institutionalization movement, which has resulted in sweeping changes in the pattern of mental health policies in the western world.

The closure of the institutions - and discharge, or reluctance to admit - many thousands of mental patients, has had unexpected sequelae. One consequence of de-institutionalization - a revolution with the ideological aim of reducing human suffering

- has been a considerable increase in suffering of some patients and their families.

It has been calculated that the prevalence of schizophrenia is between 3 and 8 per 1000 of the population, and it is predicted that the number of diagnosed cases will increase at a rate almost double that of the expected increase in the population in North America during the coming decade (Lackner, 1978, p.30). Furthermore, "of those initially affected by schizophrenia, it is estimated that 50 percent will experience some form of disability in an intermittent course of the illness throughout their lifetime; and an additional 25 percent will never recover from this initial episode and will require life-long care (Talbot, 1984a, p.7).

While all chronic mental illness is not schizophrenia, and schizophrenia follows no single set course, schizophrenics form the largest single group of long-stay patients in the mental institutions (Stein and Test, 1978; Talbot 1984a). Furthermore, it is presently the view of many professionals that the diagnoses of schizophrenia and major affective illness - the other major chronic psychiatric syndrome - may overlap.

Thus most attention has been focussed on this illness in the following discussion, as in many ways the handicaps of the schizophrenic are representative of the problems and needs of the chronic mental patient.

The issues involved with care for the growing group of psychogeriatric (demented) patients present special problems, and will not be dealt with in this dissertation.

The issue of effective long-term care is pressing in terms of patient, family and community burden - and it is world-wide. Present service-delivery systems have been accused of mirroring the discontinuity - even chaos - of the thought-processes of the very patients for whom they are intended. In Italy and some American states, for example, huge numbers of the formerly 'incarcerated' (Scull, 1979) are now eking out existences in private institutions in the community, are in jails or wandering the streets.

Although the development of an adequate community-based system of care for chronic mental patients in South Africa is urgent, discussion of the special problems and opportunities in the First- and Third-World mix, with examination of relevant experience in developing countries, is considered beyond the scope of this mini-dissertation. While developing countries may well have more effective ways of coping with some of the needs of the chronically ill (e.g. Waxler, 1979), programmes for the Third World must take account of different priorities and different resources.

Accordingly, this study is restricted to an examination of recent attempts to humanize mental health care in western industrial developed countries, a necessary preliminary to planning for South Africa in the future.

History has demonstrated yet again that there are no simplistic solutions, and that a more sober appraisal of the real nature of chronic mental illness is necessary. The characteristics of the relevant population are being clarified, and a better understanding of the issues involved is beginning to emerge.

Above all, we have learnt to take account of the fact that "the concepts of rehabilitation or shelter are often more appropriate than that of treatment" (Wing, 1976, p. 602) - and that it is **care** rather than **cure** upon which we must focus.

"Overcoming the challenge of schizophrenia will not be easy; overlooking it is not acceptable" (Talbot, 1984a, p.13).

## SECTION ONE

## CHAPTER ONE

BRIEF HISTORICAL OVERVIEW -  
THE DEVELOPMENT THE INSTITUTION

The mandate of those who attend the mentally ill has always been shaped by the social, economic, religious, and philosophical tempo of the times ...

"As the power of the churches waned, so did the view that disturbed behaviour was a symptom of demonological possession, to be dealt with by exorcism and death. In its place came the belief that deviance was a reflection of sloth and moral turpitude, best managed by disciplinary methods and segregation from society" (Bassuk and Gerson, in Brown, 1985a p. 128).

Until the 18th century the mentally ill in Europe and the United States were generally to be found in private homes in the community, in almshouses, workhouses and jails - or as homeless and destitute itinerants. While some of the more strident critics of the mental institution (e.g. Rothman, 1971) present these as halcyon days, it is likely that for most, arrangements were inadequate or punitive. Even Scull (1979) doubts the existence of "The mythical pre-institutional Golden Age, when ... families gladly administered to their own troublesome members ... the Paradise presumably Lost when the insane were consigned to the asylum" (p.262)

In fact, the mentally ill who were violent and difficult to control were housed in correctional facilities, and Deutsch (1949) reports that auctions were held to sell off 'lunatics' to the highest bidder. Certainly "no form of treatment or rehabilitation was intended, or delivered" (Talbot, 1978, p.15)

In the mid-eighteenth century the first facilities specifically for the mentally ill were founded, although they provided little but harsh custodial care. "Chains, beatings, extremes of temperature and inhuman living conditions were employed both in efforts to restrain patients or to shock them back to sanity" (Talbot, 1978, p.16).

### 1.1 The birth of the asylum

The turn of the nineteenth century saw a profound change in attitude to the treatment of the mentally ill: the era of moral treatment, characterised by "kindness, open wards, pleasant surroundings, no or minimal restraints, structured activity, and above all, a familiar, if not parental, relationship between superintendent and patients" (Talbot, 1978, p.16). These early institutions were fairly small, and competed to claim prodigious rates of cure.

In America in the 1840's Dorothea Dix exposed the appalling conditions under which the mentally ill in the community lived, campaigning vigorously and successfully for a comprehensive network of public mental hospitals to provide the more

enlightened cure offered by the asylum. An influential group of medical superintendents formed the first speciality medical society (now known as the American Psychiatric Association) which joined forces with the social reform movements led by Horace Mann and Dorothea Dix, lobbying to provide properly organized institutions for the insane. By 1860, 28 of 33 states of America had at least one public mental hospital.

### 1.2 The establishment of the large state mental institutions

However, the character of the mental institution all too quickly changed in unplanned ways. The advent of industrialization and the influx of impoverished immigrant groups caused a massive increase in the numbers of patients, and by mid-century "they had become warehouses characterized by rigid regimentation, personal repression, long-term confinement, and overcrowding" (Wilson, 1982, p.xvii).

Huge isolated asylums - designed that way for efficiency and peace - quickly lost the family atmosphere of the early institutions and became overcrowded and impersonal.

"One of the features of moral treatment - the emphasis on quiet, silence, orderliness and regular routines - so essential to moral treatment - became perverted into regimentation, control, and the maintenance of the status quo" (Talbot, 1978, p.18).

Social Darwinism provided conceptual support for the idea that "mental illness and the lower classes were intertwined causally

and the focus of psychiatric treatment should be the prevention of propagation by these 'inferior' groups" (Talbot, 1978, p.20). Public exposes of these "human warehouses of the insane" (Bellack, 1984) resulted in few successful reforms.

Chronic cases crowded the institutions, cure rates dropped off, and "insanity became associated with pauperism and incurability" (Morrissey and Goldman, 1984, p.786).

"Perhaps as a reaction against over-optimism an attitude of moral blame towards the mentally ill began to replace the attitude of moral treatment. There was a return towards a view which equated insanity and crime and a movement towards similar solutions for all people presenting socially unacceptable behaviour ... Management of all types of social deviance was based on the expulsion from society of the deviant person ... These attitudes were reflected in the Lunacy Acts of 1890 and 1891" (Reed and Lomas, 1984, p.78).

Private facilities were increasingly used for the well-to-do mentally ill, "while the state asylums were left to provide long-term custodial care to poor, disturbed involuntary patients" (Morrissey and Goldman, 1984, p.785). According to Bellack (1984), by the 1850's state hospitals had assumed the character they would have for the next 100 years - and ideas of treatment reverted to the simple aim of custody - often for life. "The promise of reform had built up the asylums, the functionalism of custody perpetuated them" (Rothman, in Birley, 1986, p.331).

In 1890 the precedent for states in America to assume financial responsibility for the care of the mentally ill was established with New York's State Care Act. State mental hospitals gradually took over from almshouses the provision for the incurable and senile - thus entrenching the trend for the asylum to become a vast holding operation for the poor and disabled. "Growing pessimism and therapeutic nihilism ... began to envelope psychiatric theory and practice" (Morrissey and Goldman, 1984, p.787).

### 1.3 Moves to reform mental health practice

In England 'mechanical restraint' of the mentally ill had been abolished in 1839, and some 'open door' hospitals were established in the 1860's, but "further advances required alterations in the structure and outlook of society" (Bennett, 1973, p.58).

The turn of the century brought the stimulation of important theoretical and diagnostic frameworks to the field, with the ideas of such men as Sigmund Freud, Adolph Meyer and Emil Kraepelin restoring hope that the mentally ill might be effectively treated. In 1908 Clifford Beers, an ex-mental patient, began a reform movement in America. The National Committee for Mental Hygiene was founded, which revived the notion of treatability. A network of Child Guidance Clinics sprang up, various experiments with alternatives to the traditional mental hospital, such as the psychopathic hospital

for acute treatment were tried, and the new profession of psychiatric social work made its appearance.

In the early 20th century there was a wave of social, economic and political reform in response to the effects of industrialization, urbanization and monopolization. The movement in the United States which saw the health centre as having responsibility to all the families in a particular district drew sustenance from the spurt of progressivism and the current urge toward voluntary associations. The ideas of catchmenting, preventative care and community participation - essentially liberal progressive ideas of reform - were delineated. However,

"the initial reform fervour of the health centre movement was soon replaced in the conservative post-World-War 1 period with a professionalized public health model that had little of the crusading spirit of the earlier, pioneering attempts. Bureaucratic considerations of municipal administration and efficiency were in the fore" (Boyajian, 1975,p.20).

In Britain the Mental Treatment Act of 1930 reflected a new, more open attitude toward management of mental illness: mental patients could henceforth be admitted without certification, and outpatient clinics and other community services began to be set up. "The gaoler-prisoner bond gave way to the doctor-patient relationship, and British psychiatry took its first step out of the custodial hospital into the community" (Bennett, 1973, p.58).

Both World Wars highlighted the extent of mental disorder in England and the United States, and contributed experience in treatment of acute and crisis conditions. Max Glatt, a German Jewish psychiatrist, described the development of institutionalism in normal internees, himself included.

The importance of the influence of social factors in mental illness and its treatment was recognized in Britain by the 1930's, and ideas such as therapeutic milieu, group work, rehabilitation, re-settlement, early discharge and aftercare were well in evidence in the most advanced hospitals by the 1950's. The belief that health services should be available to everyone produced the National Health Service in 1948. Health services are spread evenly throughout the country, and each region has its own quota of doctors and specialists (Jones, 1975). The shift of emphasis from hospital to community care was formally recognized following the report of a Royal Commission set up to examine the law relating to mental illness and mental deficiency in 1957.

In the United States the American Psychiatric Association was reorganized in 1946 specifically to take account of the psychiatric needs of the nation, and to stimulate training and research. The National Institute of Mental Health (NIMH) was established in 1949, followed a year later by the citizens' organization the National Association for Mental Health (NAMH). Thus the triad of major influences in mental health - professions, government and citizens - were all represented by organized national bodies by 1950.

The discovery of anti-psychotic drugs in the 1950's suggested the possibility that many patients previously considered manageable only within the institution could be handled in the community, and combined with financial and political pressures to prompt the Joint Commission on Mental Illness and Health established by Congress in 1955. The Commission's recommendations provided the groundwork for the 'bold new approach' adopted by President Kennedy in the Community Mental Health Centres Act of 1963, which created the elaborate system of community mental health centres (CMHCs) in the mid 1960's. Federal funding was henceforth provided for community-based facilities if they provided five essential services:

1. inpatient care
2. outpatient care
3. emergency treatment
4. partial hospitalization, and
5. 'consultation and education'.

The early demise of the state hospitals, and their replacement by a new community-controlled mental health service delivery system were called for.

#### 1.4 The place of the schizophrenic in the institution

The commonest syndrome of severe mental illness is that of schizophrenia, which can be preceded, accompanied or followed by chronic impairments, necessitating long-term support of varying degrees.

In England after the second world war two-thirds of the patients in mental hospitals were long-stay (i.e. had been there for more than two years), and two-thirds of these long-stay patients had been diagnosed schizophrenic (Wing, 1980). In all probability the diagnosis of schizophrenia covers a group of disorders of differing aetiology, and there is no single set course which schizophrenia follows, but disability of some sort will probably affect many sufferers for much of their lives.

In 'process' schizophrenia initial breakdown typically occurs early in adolescence, with symptoms recurring in the course of relapses throughout life. Positive symptoms, evident in acute breakdown, include serious loss of contact with reality, and bizarre delusions and hallucinations. Negative symptoms are the typical residual signs of schizophrenia, which may linger for years. These include apathy, social withdrawal, slowness, odd ways of speaking and thinking, and an inability to function as well as previously.

In addition, social disadvantage, such as lack of money, occupational skills and personal support systems often precede admission, and almost certainly accumulate in proportion to length of stay.

In the optimistic upheavals in mental health during the 1960's, when the writings of people like Goffman (1961) and Scheff (1966) identified a syndrome of effects resulting from long-term institutionalization remarkably similar to the negative or residual signs of schizophrenia (social withdrawal, lack of

motivation, dependence, etc) many people were convinced - in the spirit of the times - that most disablement was iatrogenic, and that institutions created the disorder they were supposed to treat. As Wing (1980) points out, it is certainly indisputable that the isolation, the size, the poor resources and understaffing of most mental hospitals affected morale of staff and patients alike, resulting in social understimulation, restrictive practices, depersonalization, authoritarianism and pauperism.

The fortunes of the schizophrenic patient and the institution have been intertwined: "The size, the culture and the social organization of mental hospitals were geared to the needs of the long-stay schizophrenic patients" (Brown, Bone, Dalison and Wing, 1966, p.2). The discovery of the neuroleptics - with their dramatic effect on the more obvious and bizarre positive features of major psychotic illness, together with the identification of the apparent cause of the 'negative' features (i.e. institutionalism), sounded the death knell for the asylum.

The far-reaching revolution of de-institutionalization -the run-down of the large mental hospitals, and the search for alternative forms of care - began.

### 1.5 Summary

The development of care arrangements for the mentally ill, and how these arrangements reflect the social, economic and philosophical mood of the times are discussed in this chapter.

Whether psychological illness was attributed to demonological possession or moral turpitude, a degree of blame has until recently been attached to 'deviance'. The community has generally been neglectful or punitive, and early facilities provided little but harsh custodial care.

While the 'asylums' founded in the nineteenth century offered benevolent retreat and treatment, they quite soon deteriorated into massive, hopeless and overcrowded 'warehouses of the insane', in response to such social pressures as over-population, urbanization and poverty.

The contribution of social factors to mental illness was recognized by the 1930's and new attitudes toward management of psychiatric disability gradually developed. The discovery of anti-psychotic drugs in the 1950's, combined with the identification of the syndrome of institutionalism hastened the call for community-centred mental health services.

Since the majority of long-term patients were diagnosed schizophrenic, and it now seemed possible to treat both acute symptoms (with neuroleptics), and chronic symptoms (by discharge from the institution), the idea that the large mental hospital had become redundant was very appealing by the mid-1950's.

## SECTION TWO

## CHAPTER TWO

SOCIOPOLITICAL BACKGROUND TO CHANGES IN  
MENTAL HEALTH POLICIES

The major social upheavals in the western world during the last 25 years are reflected in the transitions and turmoil of mental health arrangements in recent times.

A new egalitarianism arose after World War II, a questioning of political and social authority, a rejection of old attitudes, and a learning explosion, with the result that people were no longer content to leave decisions about their lives and welfare to others. 'Minority' groups such as blacks, women, homosexuals, people accused of criminal offences - and mental patients - have all fought for, and gained, an extension of civil rights. The mentally ill, previously deprived of the right to make any decision affecting their lives and futures, have won the right to have a say in such issues as planning of treatment programmes, indications for involuntary admission, and the definition of informed consent. The effects of consumerism, and more recognition of the uncertainty of professional decision-making have also tended to make for the decreased acceptance of paternalism on the part of health care workers.

The policy of de-institutionalization in the 1950's, and the Community Health Center Movement which began in the 1960's, had a

common goal: the improvement of the quality of life of the chronic mental patient.

Milieus became more democratic, nudged along by increased accountability following the growth of advocacy and consumerism. For the psychiatrist the consumerism movement has been particularly difficult, forcing him into new ways of defining his responsibilities, and highlighting a number of ethical dilemmas. Society's expectations may well conflict with patients' goals, and mental health workers often have considerable power in this dilemma:

"The psychiatrist is often expected to deal with behaviour that does not conform to a family's or a community's standards, but is not viewed as dysfunctional by the subject. Is the subject sick, or deviant, or merely 'doing his own thing'?" (Roth and Bluglass, 1985, p.50)

Klerman (in Bellack, 1984) includes psychology and psychiatry among the 'halfway technologies', with which we make people better but not well. He likens neuroleptics for schizophrenia to dialysis for kidney disease: both cost society more, as patients live longer and become an increasing social and economic burden, in societies newly obsessed with cost-consciousness.

## 2.1 Roles, goals and values

The relationships between ideology, social context, ethics and roles are complex. Our definition and goals for rehabilitation, for example, reflect the Judeo-Christian world-view dominant in

the western world. This view insists that we seek meaning in life and are uncomfortable with dependency and passivity. Our model of rehabilitation, according to which the patient is rescued from crisis to undertake responsibility for himself, echoes the prevailing social ethos. Thus we feel it is insufficient to let patients vegetate, and we insist on making a positive effort to do more than simply provide asylum (shelter, food, safety). We aspire to humanitarian goals of improving quality of life: we want patients to be fulfilled according to our view of how humanity should be.

Quality-of-life values held by the individual reflect those of society. This has implications for roles - not only should mental health workers examine and explicitly state their own values, but they should facilitate the explication of values within the communities' cultural, political and social structure (Lazarus, 1986).

"All of us have a responsibility to act as competent, informed citizens in ... moulding public opinion, overcoming ignorance and prejudice in inherited attitudes, and influencing our executive and legislative branches of government ... perhaps the most important single resource that we have at our disposal (is) the potential an informed and supporting public has for helping us to utilize all the other tools that are available - particularly our scientific knowledge and human skills) (Blain, 1975, p.609).

Sharfstein points out that the sociopolitical arena in which we live, the particular current combination of cultural and economic value systems, determines basic life opportunities for the mentally ill.

"Societies' governmental processes translate these values - they define the lawful boundaries of action and allocate public resources accordingly" (Bellack, 1984, p.122)

## 2.2 The revolt against psychiatry

There was optimism in psychiatry following the introduction of effective new drugs, leading to the expectation that acute psychotic illness could at last be dealt with, and chances of relapse significantly reduced.

"An atmosphere of positive endeavour and high aspiration permeated a large number of mental hospitals, and led to the introduction of active programmes of social rehabilitation and resettlement for patients who had, in the past, been all too liable to become residents of such hospitals for years or for life" (Roth and Bluglass, 1985, p.vii).

This optimism concerning the future of mental health services was not shared by all, however: the psychiatric profession was one of the main targets of the mental patients' liberation movement, and treatments such as psychosurgery, electroshock and forced chemotherapy were widely challenged.

"All procedures for the care, admission and treatment of patients with mental disorders were soon to be assailed as infringements of basic human rights" (Roth and Bluglass, 1985, p.2).

The profession's role in preserving the status quo was criticised, and people like Laing (1959), Scheff (1966), Cooper (1967), and Szasz (1972) attacked the class, race and sex biases in psychiatry, claiming that mental health ideology maintained and reinforced many social inequalities. The profile of a mentally healthy human being corresponded to that of mentally healthy men, for example. Psychiatry - in the service of capitalism - was decried as an instrument of coercion whose function is to exercise control over deviants revolting against the existing social order. Such writers as Szasz and Foucault alleged that as an ideology it mystified and obscured the power struggles within society. It was claimed that

"What passes as mental illness is for the most part no more than politically subversive ideas, protests against racial injustice or deviant sexual behaviour ... it is the metaphor of illness that enables the thought-policemen to deprive the individual of liberty without due process of law or adequate right of appeal" (Roth and Bluglass, 1985, p.2).

To many critics it seemed likely that most severe disablement was iatrogenic, and 'mentalism' - the belief in the existence of

mental illness - was vigorously opposed by patient liberation groups, who claimed that what has been labelled mental illness is merely a normal reaction to oppressive social conditions.

The mood of the sixties suggested that without mental institutions and the professionals whose livelihood depended upon them, there would be no mental illness.

### 2.3 The law and the patient

The interface between psychiatry and the law has been much expanded in the last twenty-five years. Changes reflect the values of respect for liberty, autonomy and self-determination. Western societies have generally come to accept the principle that infringement of any person's liberty should only be possible in exceptional circumstances. The Courts have been used as a forum to claim constitutional rights for mental patients, and reforms have confirmed the principle that disabled persons have the same fundamental rights as their fellow citizens. Somerville (in Roth and Bluglass, 1985), reminds us:

"It is increasingly recognized that the sick, particularly those who are mentally ill ... may have increased vulnerability ... The combination of bureaucratization and technocratization can have a dehumanizing effect ... There is (therefore) a need to be sensitive not only to potentials for dehumanizing patients, but also to those which may dehumanize professionals dealing with patients" (p.196).

The movement to guarantee legal rights for mental patients began in the United States in the 1960's. By 1978 the World Health Organization had published a comparative survey of mental health legislation. And in 1980 the International Commission of Jurists formed two working parties at the invitation of the United Nations to draft a set of principles for the protection of persons of unsound mind.

More informal admission procedures have been gained, together with safeguards against unnecessary or inappropriate admission, and there is an increasing trend toward an initial limited detention with regular periodic review.

Important principles addressed in Britain and North America in recent years include the following:

### 2.31 The right to treatment

In America in 1966 Judge David Bazelon ruled that inadequacy of resources was an unacceptable reason for failing to provide treatment: If a person was deprived of liberty on the grounds that he or she needed treatment, then such treatment had to be provided. Further, in a 1971 ruling (*Wyatt vs Stickney*), a U.S. District Court Judge held that 'involuntarily committed patients unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition.'

"Creating an entitlement to services through statute is one of the most positive recent changes in the legal approach to mental health" (Gostin, in Roth and Bluglass, 1985, p.154).

### 2.32 The right to refuse treatment

Various suits in America have established the right to refuse treatments such as electroshock, chemotherapy, forced seclusion and psychosurgery. The basic principle that treatment should normally only proceed with the informed consent of the patient also implies access to information, including the consequences and risks of treatment, and access to medical records.

The suggestion that admission to hospital and treatment genuinely intended for therapeutic purposes may violate minimal standards of human dignity and autonomy is a new departure in the international human rights field.

### 2.33 The right to due process in commitment

In Britain it is now required that certain groups of mentally disordered persons must be treatable if they are to be detained. More informal admission procedures have been adopted, and the Mental Health Act of 1983 lays out the principle that admission - voluntary or otherwise - should be without the intervention of magistrates or courts of law. The British system on the whole reflects the value of trust in the medical profession, which generally retains the upper hand over the legal profession in the process of decision-making with regard to the treatment of mental patients.

British law also reflects a concern that involuntary hospitalization only be resorted to when other possibilities - in the form of community and social services - have been exhausted. The Mental Health Act of 1983 sets up an independent, large, transdisciplinary monitoring and advisory body - the Mental Act Commission - empowered to keep under review any aspect of care and treatment. This Commission represents, among other things, a recognition of the relevance of community values and community involvement in supervision of powers given under mental health legislation. Orders for involuntary hospitalization automatically expire unless renewed, and patients may also apply for review. The durations of both initial detention and its subsequent renewal are halved by the 1983 Act.

#### 2.34 Dangerousness

In the United States it is policy that treatment within the community, or voluntary hospitalization are considered preferable to involuntary commitment - the criterion for which is usually 'dangerousness'. The prediction of dangerousness carries weighty implications for the disposal of offenders:

"A sharp dilemma is posed for those responsible for decisions ... in that the need to protect the community may clash the the obligation to respect the human rights of the offender ... Are communities prepared to tolerate risks of this order, and if they are not is their attitude socially or morally defensible?" (Roth and Bluglass, 1985, p.231).

Further aspects of 'due process' now recognised include the right to a speedy hearing for an allegedly dangerous patient, the right to be present at hearings, the right to remain silent, and the right to counsel. Indefinite commitment has been abolished, and periodic reviews are now required.

### 2.35 The right to punishment

It has generally become accepted that the mentally ill should have the right to punishment by due process of law rather than lengthy hospital commitment, should this be appropriate. In the case of serious crime, this principle is complicated by considerations of the long-term risk for society. "Everywhere the concept of illness expands continually at the expense of the concept of moral responsibility," Lord Devlin is quoted as complaining (Roth and Bluglass, 1985, p.ix).

### 2.36 The least restrictive environment

This concept, dating from 1972 (the Wyatt vs Stickney decision), is defined in the President's Commission on Mental Health as "the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind and spirit for the individual while he or she participates in treatment or receives services".

Bachrach (1978) describes the 'least restrictive environment' as

"both a legal and clinical concept that represents an effort to grant to mentally ill persons a full complement

of personal rights and civil liberties as they undergo the most effective treatment for their illnesses," (p.97)

and asserts that the concept is the quintessence of the humanitarian assumptions justifying the philosophy of de-institutionalization.

Liberatory movements since the sixties have achieved recognition of clear rules regarding acceptable use of medication, with mandatory weekly medication reviews. The use of physical restraint and isolation have been restricted, staffing minima laid down, and standards for certain conditions of in-patient living (such as floor space, toilet doors, etc.) have been prescribed. The patients' rights movements also led to the withdrawal of patient labour, on which mental hospitals depended to keep their costs down. Patient labour has now been outlawed unless it is voluntary, and paid at minimum wages.

#### 2.4 Summary and comment

Side by side with vigorous criticism of prevailing social systems in the western world in recent decades, there has been a steady development in civil rights, with recognition of the right to liberty and self-determination for all, including the mentally ill. In the process major dilemmas have been highlighted.

The psychiatric profession has been one of the main targets of patients' liberatory movements, and has been accused of attempting to 'fix' the patient to conform to the repressive

goals of entrenched powers. Somewhat unfairly, while the psychiatrist has been held responsible for aspects of the behaviour of his patient, (for example, he is expected to accurately forecast 'dangerousness' and real risk of suicide), he has simultaneously been accused of interference with the patients's freedom.

The courts have been used to claim or extend the constitutional rights of psychiatric patients, especially in such areas as more informal admission procedures and patients' right to refuse certain treatments. Both the criteria for hospitalization, and the nature of the hospital have changed, and there is a trend toward voluntary hospitalization, and more limited detention periods, with regular review. The community is increasingly seen as the preferable environment for treatment.

However, the increasing emphasis 'on accountability has been accompanied by 'a dangerous tendency to supplant medical judgement with legalistic procedures'. (Roth and Bluglass, 1985, p.49).

In this setting of vast social change and intense controversy new regimes in psychiatric wards have been introduced, new laws passed and the closure of the large mental hospitals planned.

The notion that without mental institutions, and the professionals who run them there would be no mental illness has been a corner-stone of the de-institutionalization movement.

It was assumed that if people received vigorous, early treatment, and could stay in the community with the help of medication, chronic mental illness would disappear.

## CHAPTER 3

## DE-INSTITUTIONALIZATION

3.1 The transfer of care: from confinement to community

Rothman (1971) points out that large mental institutions are comparatively recent arrivals, and their monumental size gives a misleading impression of permanence.

Changing treatment and care practices resulted in a steady decrease in hospital populations in the United States since about 1955, when the peak of  $\pm$  560,000 inpatients was reached. By 1976 the national mental hospital population had dwindled to  $\pm$  194,000 (Talbot, 1978), a reduction of almost two-thirds. The attitude toward institutionalization in the 1960's is well exemplified in the story of a nursing supervisor at Boston State Hospital who threw a bed out of a second-storey window whenever a patient was discharged, to prevent the bed from ever being filled again (Huey, 1976). The policy of de-institutionalization, which became official in the early 1970's, contributed to the decline of the large state hospital as the focus of mental health care.

In England there were 344 inpatients per 100,000 of the population in 1954. In 1967 there were 256 inpatients per 100,000, and numbers have continued to decline.

### 3.2 Goals of de-institutionalization

While de-institutionalization has been put into practice in different ways in different countries, the overall goals of the movement are described by Bertram Brown, former director of the United States National Institute of Mental Health (N.I.M.H.):

- (1) The prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment;
- (2) the release to the community of all institutional patients who have been given adequate preparation for such a change, and
- (3) the establishment and maintenance of community support systems for non-institutionalized persons receiving mental health services in the community.

Legislative direction, especially in such areas as commitment procedures, and directives to care for the mentally ill in the 'least restrictive environment' added formal pressure to the idealistic goals of prevention, treatment and care in the community, as a supplement to short-term acute intervention in hospitals.

Perhaps the most striking example of de-institutionalization, swept in virtually overnight by Law 180 of 1978, occurred in Italy.

### 3.3 Where did the patients go?

#### 3.31 The Italian experience

Professor Franco Basaglia, founder of *Psichiatria Democratica*, a political pressure group which campaigned for the radical reform of the Italian mental health system, was medical director of the San Giovanni mental hospital in Trieste from 1971 to 1978. He drew from neo-Marxist theory, and the writings of such as Szasz, Foucault, Laing, and Goffman, to illustrate his thesis: namely that the causes of mental illness are social. Capitalism was accused of defining as 'sane' those who were productive, and as 'sick' those who could not work, and sentencing the 'sick' to segregation from society. Thus no institution could be therapeutic since the institution was an agent of repression and social violence. If mental illness was caused by societal rejection, simply returning the patient to the community and societal acceptance, would negate the negative consequences of illness. 'Social violence' and exclusion were relevant, rather than the process of illness itself.

Jones and Poletti (1985) sum up Law 180 of 1978 as follows:

It forbade the admission of any new patients to mental hospitals, required a review of patients already in hospital with a view to discharge, and set up Diagnosis and Cure units - 15 beds per 150,000 population - in general hospitals. Compulsory admission was limited to 48 hours on the signature of the mayor of the commune, and a renewal for seven days required the approval of a judge. A series of 'alternative structures' were to be provided in the community to supplement this short-stay provision .

Italian mental hospitals at the onset of the 1970's were generally restrictive and grimly custodial. Basaglia demonstrated his ideas in Trieste, where he reduced in-patient population from 1200 to 500 in 5 years, and set up a number of 'day structures' in the city. He used this example, and dramatic, evangelical propoganda to push through the sweeping reforms of 1978. These reforms virtually abolished the large mental hospitals, and substituted an uncoordinated medley of local initiatives, which, together with the patients's social network, were expected to take their place.

### 3.32 De-institutionalization in North America and Britain

Stimulated both by therapeutic innovations and political-economic considerations, both America and Britain have adopted policies of deliberate run-down of the large hospitals, and the provision of alternative networks of care in the community.

In America since the late 1960's, there has been a rapid de-population of state mental hospitals, despite the lack of sufficient facilities in the community to meet the needs of those who would once have been inpatients. Legislative and administrative decisions enforce the continuation of the policy of de-institutionalization, despite a backlash of public and professional opinion.

The British have followed a more conservative pattern. Within the coordinating framework of a National Health Policy there has been a deliberate process of building up of community services

appropriate to local needs in advance of, and coordinated with, the wind-down of the large mental institutions.

### 3.4 Discussion: The uncaring community

#### 3.41 In Italy

"Is the amount of misery caused greater or less than under the old system?" ask Jones and Poletti, reporting in 1985 that the policy of hospital closure in Italy is now to be reversed by law. Only the Communist Party still supports Law 180, the other major political parties having drawn up proposals for new legislation suggesting the utilization of the old mental hospitals for medium- and long-stay care (to be called Residential Centres for Re-socialization).

While the new psychiatric services reportedly worked quite well in Trieste (Jones and Poletti, 1986), it is likely that this is due to special circumstances in this city (Basaglia's energy and charisma, the fact that Trieste has a declining population, and consequently an adequate supply of low-cost housing, etc.). Generally, "if the old system was regimented and repressive, laissez-faire merely substituted a chaotic poverty of provision" (Jones and Poletti, 1985, p.346).

The 15-bed admission wards allowed by law are just not sufficient for local health districts of 100,000 to 200,000 people, and many of the outlying health districts have not in fact set up such units. Becker (1985) reported that the supply of alternative services, especially day centres and housing, was slow and inadequate, leading to a new market in private psychiatric

accommodation (for those who could pay for it) - which hardly represented the envisaged 'return to the community'. The chronic patient has been ignored: while private hospitals for acute patients (with money) are adequate, "chronic institutions ... usually resemble more a concentration camp than a hospital - they are even worse than old mental hospitals" (Papeschi, 1985, p.253). Inadequate care is also suggested by the mean length of stay in psychiatric units in Italy of about 12 days, compared with about 47 days in other industrialized countries. This reflects the very high turnover rate of patients, imposed by the small number of beds available (Papeschi, 1985).

In Piedmont, for example,  $\pm$  50 percent of discharged patients have moved to private nursing homes, boarding houses, or old-age homes, many exclusively run for psychiatric patients, and it is estimated that a good proportion of the remainder are homeless (Becker, 1985). In Trieste, many have drifted to the former Jewish ghetto, where they are tolerated (Jones and Poletti, 1986); or are in jail. Extramural services in Turin were available to 150 to 200 of the  $\pm$  6,000 psychiatric patients in the city.

The lack of integrated or coordinated planning and administration make assessment of the general quality of care difficult but Bennett (1980), Becker (1985), Jones and Poletti (1985,1986), all express doubts about the possibility of ensuring adequate standards in the kaleidoscope of small hospital wards and community centres. Jones and Poletti (1986) point out further inadequacies - in particular that the need for psychiatric beds has been underestimated, and that while younger, psychotic

patients are catered for, the elderly, senile mentally ill, and 'quietly deteriorating patients' are overlooked. They express concern that the system might not fully meet the needs of patients suffering from depression, anxiety states or long-term psychoses. Jones and Poletti also criticize the lack of regular programmed day activities (a backlash against the previous misuse of patient labour), and the fact that no use is made of psychoanalytic insights (which are considered bourgeois), or group therapy techniques (which are considered manipulative), or any of the modern developments in social work such as family therapy, the systems approach, or network theory.

"What we have seen in Italy is a violent step along the path to de-institutionalization ... with nothing in the way of planned community services to mitigate its effects" (Jones and Poletti, 1985,p.347).

### 3.42 The United States and Britain

The massive change in social policy represented by de-institutionalization, together with its corollary policies of admissions-diversion and short-stay hospitalization has had many unplanned effects. According to New York City's Mayor Kock,

"The state policy of releasing de-institutionalized patients without adequate support has turned the city's neighbourhoods into mental wards, and the police into hospital orderlies" (Herman, 1980, quoted in Crawford, 1981, p.276).

By 1971 N.I.M.H. reported that thousands of patients were living "isolated marginal lives, ... wandering the streets, incoherent and incontinent with no place to go" (Gochman, 1981, p.110).

**The old chronic patient:** In some states large numbers of persons with serious mental illness have been discharged into an unprepared community. The majority are handicapped to a greater or lesser extent by the effects of institutionalization, by the negative symptoms of chronic mental illness, by poor social skills and/or by lack of material resources. Consequently most remain unemployed, and since too few day - care or sheltered employment facilities exist, many vegetate in nursing homes, board-and-care homes, or marginal lodgings in the poorest quarters of the inner city. The nursing homes paid for by the new federal financing are generally unregulated by state or federal authorities, often inadequate, poorly equipped and staffed, and make no pretence at 'treatment'. i.e. 'The back-alleys have become the new back wards'. (Trotter and Kuttner, quoted in Morrissey and Goldman, 1984).

**The 'new' chronic patient:** The growing population of young adult chronic patients, who, as a result of new admission policies, have remained community outpatients, or are discharged - often in a state of incomplete remission - to the street, are presenting a potential crisis to the public mental health system. The fact that they have grown up as members of the community and do not perceive themselves as psychiatric patients colours their expectations, and enhances their problems. As Pepper, Kirshner and Ryglewicz (1981) point out, they carry the burden of normal

life expectations of their age-group - in school, work and relationships - without being able to attain their goals in any of these areas.

"(They) suffer repeated failures without the forgiving public identity of a handicapped person, which may be onerous but at least operates psychologically and socially as an explanation of limited functioning and as a curb for unrealistic expectations." (Talbot, 1984, p.34).

This population is frequently associated with substance abuse, and they are often violent or disruptive, rejecting treatment, and rejected when possible by many care givers, who find them difficult to handle. They pose a special group of problems - in continuity of care, in medication compliance, family intervention, employment, housing and social and vocational rehabilitation. Of a group of young adult chronic patients investigated by Pepper et al. in 1980, 60% were unemployed, 30% received a disability grant, 37% had a history of known alcohol abuse, 37% had a known history of marijuana abuse, and 42% had attempted suicide. (Pepper, Kirschner and Ryglewicz, 1981).

The neglect of this population is particularly hazardous because of the ease with which they can be seen as socially unacceptable deviants, rather than as impaired persons in need of treatment.

Talbot (1984) warns:

"The size and nature of this population, if not adequately handled by the psychiatric service system, will make them an increasingly unmanageable problem for all social agencies, including the courts and prisons, with staggering human and economic costs". (p.46).

The effects of precipitous reform have been more dramatic in the United States than in Britain, where a slower rate of hospital run-down, together with a comprehensive infrastructure of health and social services in the community has resulted in a lesser 'decarceration' problem.

### 3.43 The need for asylum

In the United States jail populations have increased by  $\pm$  33% since 1978, reflecting the prediction of an inverse linear relationship between the populations of mental health facilities and jails (Biles and Mulligan, 1973). Many ex-patients experience difficulties in living, leading to contact with the police, and once they are in jail the conditions they confront exacerbate the deterioration in their mental health.

"They are made to live in filth, and usually receive no treatment of any kind ... Jails (are) without guidelines and policies for handling the mentally disordered and without anyone who is sympathetic" (Pogrebin and Regoli, 1985, p.410). Guilt, hopelessness, desperation, family separation and social isolation are associated with imprisonment, and self-mutilation and violence in jails has reportedly reached endemic proportions.

The failure of service structures to be responsive to the needs of the chronically mentally ill, and the absence of community-based alternatives, have left many homeless (Bachrach, 1984). The chronic mental patient has frequently to negotiate the often inadequate community support network handicapped by neuroleptic side-effects, in addition to his primary disability.

#### 3.44 Family burden

More than 50% of long-term patients in the community in the United States have been found to be living with their families, who have in fact become the real 'primary care agents' for a large proportion of schizophrenics (Lamb and Oliphant, 1979). Day programmes and sheltered vocational workshops often reject schizophrenic patients (refusing to be 'baby-sitters' for their families), thus denying them the opportunity to be productive and increase self-esteem. While parents of a child with leukemia, for example, are treated with sympathy and understanding, parents of the schizophrenic frequently receive scorn and condemnation.

Doll (1976) notes that increasing numbers of families are being forced into dangerously unendurable situations, with the result that many former mental patients are socially and affectionally rejected, though not re-hospitalized.

"The disorganization of many of the families poses a real threat to any home-care programme. It is not at all certain that (some) patients would not do as well or better living alone or in night-hospital facilities."

(Pasamanick et al., quoted in Brown et al, 1966, p.6)

### 3.45 Costs to the mental health worker:

We also need to consider the cost to the mental health worker of the unrealistic expectations raised by de-institutionalization. The idea that the chronic patient would vanish, and that the acute patient could be cured has resulted in previously enthusiastic staff becoming demoralised, as they begin to have doubts about their healing ability. A high rate of burn-out is the result, and a tendency to reject the patient who is not meeting the professional's need for efficacy.

### 3.5 Summary and comment

The grimness of most of the old institutions contrasted sharply with the appealing goal of prevention, treatment and care in the community, and there has been a steady decrease in hospital populations since the mid-1950's as a result of official policies of de-institutionalization. Unfortunately, the alternatives for many patients inappropriately or prematurely discharged without adequate community preparation have been just as grim.

The policy of de-institutionalization has actually resulted in re-institutionalization in inadequate and unregulated shelters in the community for many 'long-stay' patients, and large numbers of young chronic patients have simply taken on the label of 'deviant', with all the deprivation and discrimination that this implies.

The diversion of chronically mentally ill individuals into the criminal justice system and homelessness is an indication of the

need for a place of asylum, a need not adequately recognized by the policy of de-institutionalization.

Increasing numbers of families are having to bear the burden of caring for the chronic mental patient, and this situation is frequently destructive for the patient as well as for the family. At the same time high levels of frustration and failure in dealing with this difficult population make for demoralization and burnout among mental health workers.

Lamb (1984) suggests that

"It was not appreciated that the state hospital fulfilled some very crucial functions ... these imperfect institutions did provide asylum and sanctuary from the pressures of the world with which, in varying degrees, most of these patients were unable to cope" (p.100).

The importance of developing supportive living arrangements for the non-institutionalized patient was not foreseen, nor was the resistance of community mental health centres to providing services for these people.

It is difficult to avoid the conclusion, with Tantam (1985), that the perils of de-institutionalization now equal the perils of institutionalization.

"What has changed is the location of suffering, not the amount" (Talbot, 1984, p.7).

## CHAPTER FOUR

## WHAT WENT WRONG: A CRITICAL RE-APPRAISAL

"The kernel is the knotty question of what illness or disease is, and ... how it is to be differentiated from sin, or crime, or creativity" (Campbell, in Roth and Bluglass, 1985, p.10).

As Lackner (1978) says, we have moved beyond what, in retrospect, seems the naive optimism of the 1960s, and it is time to reassess the assumptions, the policies and the goals of our programmes for the chronically mentally ill. How could such a well-intentioned movement as de-institutionalization have created so many problems? Wildavsky suggests that the objectives of the humanitarian and idealistic 1950s - maximum care, maximum understanding, maximum opportunity, maximum health - were set so high that they simply could not be reached, and they have been an embarrassment to governments ever since. Public expectations grew too fast, and had to be checked, but, he adds, "the retreat from objectives may become a rout" (In Jones, 1982, p.225).

#### 4.1 Patients' rights: Has the pendulum swung too far?

Discussing social and medical consequences of legal reforms of mental health law in the United States, Stone (in Roth and Bluglass, 1985) suggests that two images of mental illness - both

reflecting reforms in the 1970s - have come to dominate the public imagination.

The first image of madness - one of violent insanity unleashed by incompetent psychiatrists and radical civil libertarians - has resulted in a growing public demand for protection. The other public image of mental illness is typified by the 'bag lady' ... "wandering the streets of all our major cities - distracted, dishevelled, homeless and acting peculiarly" (Stone, in Roth and Bluglass, 1985, p.10). Between 50 and 85 percent of the homeless in America are estimated to be chronic psychiatric patients.

Public reaction to the first image is fear, and to the second often that of shame and outrage. Both represent a second generation of problems created by attempts to deal with the evils of institutionalism.

New admissions policies aiming at the provision of short term acute treatment mean that many patients are discharged in a state of incomplete remission. The aim of providing treatment in the community ignores the real need for asylum for some. Lamb and Peele suggest that the idea of normalization cannot be achieved for every mentally ill person and point out that "if we persist in fruitless efforts to push people to a life-style beyond their ability ... we run the risk of contributing to manifest pathology" (1984, p.799).

In the United States the use of 'dangerousness' as the major criterion for compulsory admission has displaced more traditional

criteria such as the person's need for protection, care and treatment. While the deprivation of freedom is a serious matter, it seems that present criteria for admission are not sufficient, for we now have the situation where a family may beg for a patient's admission, which is not permitted by law. The concern with freedom has overtaken the right to receive adequate treatment.

Stone (in Roth and Bluglass, 1985) criticizes the allocation to psychiatrists of a primary role in the control of violence, as the prediction of dangerousness is a highly unreliable exercise. The insistence on the criterion of dangerousness for commitment has prevented many grossly disturbed patients from having the treatment they need unless and until they break out in some act of violence, while procedural safeguards actually increase the risks that the really dangerous mentally ill will go free. Roth adds another caveat:

"Only a small proportion of psychotic patients are dangerous and therefore qualify for admission to hospital. The majority are consequently denied the treatment they often need as a matter of urgency" (Roth and Bluglass, 1985, p.6).

It is equally difficult for the mental health professional to accurately estimate the risk of suicide, yet he or she may be sued for negligence should he or she fail to anticipate self-destructive or violent behaviour. We also need to consider that self-neglect - so common in schizophrenia - can amount to

dangerousness to self and hence might serve as a criterion for certification.

"Faced with such double-bind situations there is a danger that those engaged in the practice of psychiatry will assume an increasingly defensive posture ... Many ... who would benefit from treatment but fail to qualify for compulsory commitment ... by present-day criteria wander the streets without help" (Roth and Bluglass, 1985, p.238).

The right of offenders to opt for punishment rather than treatment has resulted in a steep increase in the number of prison sentences for individuals who are actually mentally ill. While it is recognized that the prisons are in dire need of a therapeutic component, most remain as yet without facilities for psychiatric treatment, and are an inappropriately punitive placement for many of the victims of well-meant, but ill-thought-through reform.

Campbell postulates that the mutual disenchantment that has arisen between psychiatry and the law owes its existence in part to the tenet of the civil libertarian that the patient must be protected at every turn of the road by a lawyer, with the result that the doctor-patient relationship is transformed into an adversary process:

"Securing the best fit between patient and treatment is a sensitive and delicate process. To superimpose a

cumbersome, costly, extra-clinical, and potentially disputatious legal tier would risk its dissolution" (in Roth and Bluglass, 1985, p.54).

The present legal distinction in the United States between 'voluntary' and 'involuntary' patients is problematic in that in fact many 'voluntary' patients are chronically disabled, helpless and in need of treatment - yet it is only the 'involuntary' patient whom the law requires receive treatment. The 'right to treatment' provides an illustrative dilemma: if the patient refuses treatment, we are no longer providing care, but only custody, and thus the patient must be released to the community. Roth comments that:

"The problem with principles and doctrines such as the right to refuse treatment is that they advance simplistic solutions to problems of a complex and obdurate nature ... (for example) there are the human rights of parents and dependent wives and children to be considered, as well as those of the patient" (Roth and Bluglass, 1985, p.5).

Which should prevail - the patient's right to refuse treatment, or his family's or society's view that he needs it?

Bachrach (1978) provides a powerful critique of the closely-related concept of the least restrictive environment - 'the quintessence of de-institutionalization' - claiming that it rests

on the uncritical acceptance of at least three unwarranted assumptions:

1. The notion that certain kinds of places have essential qualities that make them good or bad for patients. "This idea tends to minimize the fact that individual patients vary in their needs and that what is restrictive for one patient may not necessarily be so for another ..." (p.99). This is confusion between the locus of care and kind or quality of care needed.
2. The notion that certain classes of residence are either more or less restrictive, when in fact any measure of restrictiveness based on a single criterion is too grossly oversimplified to be useful. For example, such factors as location, staffing, rehabilitation efforts, programme goals, and degree of autonomy accorded patients are all more relevant to 'restrictiveness' than class of residence (Carpenter, 1978).
3. The idea that there is a continuum of restrictiveness, and that some classes of residence are superior to others. There is in fact tremendous variation within a single setting type such as nursing homes. We need to remember that internal factors can throttle the spirit as much as external ones.

Bachrach (1978) urges that a far more useful concept than 'least restrictive' would be 'most therapeutic'. The patient and his level of functioning must be acknowledged as a vital force in the determination of restrictiveness. The only relevant question to ask is: "Is a given environment restrictive for a particular

patient?" (p.107). Hence we need to focus on people instead of places: "It is quite conceivable that for some patients the least restrictive environment is an institution" (Bachrach, 1978, p.99). Wing (1976) makes the point that:

"It is important that a proper insistence on protecting the rights of individuals should not, as happened in the last century, develop into a narrow legalism that prevents recognition of real needs" (p.102).

#### 4.2 Reassessing basic assumptions

Central to the 'tragic failure' of de-institutionalization lies its foundation upon well-meaning but unrealistic assumptions, most important of which are the notion that all psychiatric handicap is due to institutionalism, and 'resocialization' in the community would naturally follow the release or non-admission of chronic patients. The acute symptoms of schizophrenia, while manageable to a certain extent in some patients by medication, may be exacerbated by the stress of life in the community. The chronic symptoms of the illness, once thought to reflect the evils of institutionalism, are now known to reflect the process of chronicity, and to be inevitable for many regardless of environment.

Furthermore, the 'negative' symptoms characteristic of institutionalism may arise just as easily in response to too little stimulation in poor quality residential settings in the community. The situation is so bad that Jones (1975) urges a reappraisal of "the trend toward handing over helpless

individuals to the vagaries of private enterprise" (p.98). There has in addition been a failure to recognize that there are many different kinds of long-term patients, who vary greatly in their capacity for rehabilitation. Lamb and Peele (1984) point out once again the necessity of avoiding simplistic conceptions that suggest a homogeneous patient population: "Asylum must mean different levels of social support and different types of protection for each patient" (p.800).

'Resocialization' has also raised complex and knotty issues. Nordwind (1982) cites as problems massive lack of preparedness on the part of the community, and the need for a significant network of long-term, coordinated services. The community health centre programme in America has in fact only addressed the needs of the treatable cases of mental illness, and is failing to grapple with the problems of chronicity.

All too often patients have been denied inpatient care before an appropriate network of comprehensive community care has been built up - including the provision of residential, occupational and social supports. Aggressive outreach and case management are needed to compensate for the passivity, dependence, apathy and inadequacy of many chronic patients. The present necessity for the handicapped patient to negotiate a chaotic discontinuous system of services, and the dislike some health workers manifest for the seriously disabled multi-needy person have resulted in far too many of the chronically mentally ill 'falling through the cracks'.

Families remain the major care providers for the chronic patient but complain that their burden is greatly increased by the patronising and critical attitude of many professionals. Despite lack of adequate evidence concerning aetiology, the mental health worker all too often imposes blame on the family, whose collaboration in medication and treatment programmes may be actively discouraged (Hirsch and Leff, 1975).

As Hibler (1978) points out, the mental health system still tends to encourage the family to let go, yet there are few professionals who have the time or energy to follow and support as closely as the concerned family. Treatment for the chronic patient "needs to move away from perceiving the family as the source of the illness and toward perceiving the family as a resource for patients" (Lamb and Peele, 1984, p.801).

The idea of the 'caring community' ready to reabsorb its deviant members has turned out to be a figment of the reformists' imagination. A massive educational programme is needed to promote understanding of and sympathy for the needs of the mentally ill: to date fear, self-interest and a backlash following ill-thought-through legal reforms and inadequate social planning have resulted in public resistance, rather than assistance to the 'resocialization' of the chronic patient.

#### 4.3 The impact of values on visions

The sixties saw a swing to various socio-genetic views of mental illness placing, to a greater or lesser extent, the blame for psychiatric disorder upon the social and political environment.

The defence of the dignity and personal worth of the psychotic, and the repudiation of the tendency to belittle and stigmatise him were meaningful contributions to the humanization of mental health care. At the same time, however, the thesis that mental illness does not exist, but derives from 'social violence' and the exclusion process has caused actual harm to the chronic patients who have lost access to treatment and asylum as a result of the 'total cure' proposed by those advocating the closure of the 'total institution'.

Laing's insistence on the comprehensibility of psychosis added a rich dimension to the understanding of schizophrenia, but his theory does not do justice to the variety of pathology in the group of schizophrenias, and his indictment of the family for the patient's predicament has in some cases added a damaging and purposeless stigma to their burden.

The glorification of psychosis in such works as "Sanity, madness and the family" (1984) and "Politics of experience and the bird of paradise" (1967) e.g. "madness ... need not be all breakdown: it may also be breakthrough ... it is potential liberation and renewal" (Laing, 1967, p.110), made treatment within conventional models seem superfluous. But as Smith (1982) says,

"It is open to question whether his strident insistence that schizophrenics are not all ill - that they are in some way superior to ordinary people because of their inability to come to terms with normality - will really

lead schizophrenics or those who try to help them to a clearer understanding of their condition" (p.642).

The denial by writers like Szasz (1974) that mental illness exists made the release of patients to the community seem appropriate in the name of liberty, but as we have seen, this has left many defenceless and dependent victims of chronic mental illness to sleep in railway stations and under bridges.

The neo-Marxist analysis of psychiatry as being a tool of capitalist society, and the interpretation of the provision of mental health services as an infringement of basic human rights, have flimsy relationship to fact and have had severe repercussions for many of the unfortunates 'decarcerated' in the process of revolution. Jones (1982) criticizes "the inherent sentimentality of a view which assumes that all the deviant's problems are caused by 'society' and none by his own actions" (p.223).

Similarly, while institutions are embodied by men, within whom both love and violence (Eros and Thanatos) are in conflict, the statement that all is violence in society seems somewhat extreme. In fact the exertion of pressure upon individuals to conform is no more specific to capitalist than to socialist countries. While it is possible that there is less social violence in social-democratic societies, because they are characterized by greater tolerance, the numbers of deviants and psychiatric patients in such countries does not appear to have been reduced. Therefore it does not seem that social pressure or 'violence'

induce social or psychiatric deviance, or that they are the cause of mental illness:

"In the majority of psychiatric conditions (schizophrenia, manic-depressive psychosis, dementia, etc.) the fine mechanism of a 'social plot' is not demonstrable in the dynamics of admission to hospital and these diseases occur in all social classes" (Papeschi, 1985, p.258).

The Marxist analysis of social relationships postulates that human behaviour and social rules are determined by economic factors. Basaglia declared "It is economic logic that establishes what is humane and what is not, what is healthy and what is ill ..." (in Papeschi, 1985, p.249). This reductionism and oversimplification excludes from social behaviour such fundamental factors as unconscious, conscious, and sublimated instincts and drives, which over the centuries have helped to determine the stratification of behavioural rules.

"Social rules are universal, and although they may vary within certain limits according to the type of society and historical period, they are not reducible to a criterion of productivity" (Papeschi, 1985, p.249).

It has yet to be convincingly demonstrated that all psychopathological variables depend on economic and political factors.

Many radical critics declare that political action is the only acceptable intervention regarding mental illness. Thus psychopharmacology is rejected, along with all other therapeutic interventions -

"the ... social psychiatrist, the psychotherapist, the social worker ... are nothing but the new administrators of the violence of power, as long as they perpetuate that violence by ... smoothing resistances, resolving conflicts provoked by its institutions, with their technical apparently healing and not violent action ... They are nothing but instruments for the control of deviants on the part of the 'system', which should be treated with suspicion. This kind of more sophisticated ... violence [is] designed to prevent actual conflicts from developing ... thus allowing the preservation of the status quo of the capitalist system" (Basaglia, in Papeschi, 1985, p.250).

While admitting that mental hospitals everywhere had come to provide a repressive custodialism and a false psychiatric answer to problems that were mainly social, Papeschi (1985) criticizes the conclusion that it is therefore impossible to eradicate violence from any institution.

The view that responsibility for mental illness lies not with the individual, but solely with society can be criticized for denying man any kind of autonomy, and also denying the importance of genetic, biological and psychodynamic personal factors which

combine with social condition to determine behaviour. The Italian mental illness law of 1904 blamed the individual and disregarded the social implications of mental illness. It seems reasonable to doubt nevertheless that Basaglia's view - "being with the mad against society" - represents any progress for the patient. The results of the 1978 law have been a greatly increased demand for (often inferior) private facilities for those who can afford them, and - all too often - homelessness, jail or the ghetto for many others. Devolution to local authorities has resulted - in the United States as well as Italy - in diminished political accountability. Jones and Poletti (1985) conclude:

"If there are lessons ... in the Italian experience ... (they are that) mental hospitals cannot be abolished by legislative action and good intentions: they have a way of returning in disguise. Patients do not automatically become well if they are discharged from hospital - they and their families still need help. [Also] ideas about de-skilling and the abandonment of professional roles are not a substitute for good training programs ... Above all, political pressure groups are not a substitute for a broadly based and well-informed mental health movement ... The implication that mental hospitals can be abolished without extensive and expensive substitutes, that patients can be re-absorbed into the community without pain or effort ... [is false]. The real lesson is that this has been tried in Italy and has failed" (pp.346-347).

#### 4.4 Summary and comment

This chapter examines some of the major assumptions underlying mental health reforms in recent years, and attempts to identify misconceptions resulting in present problems.

Psychiatric optimism (the patient can be cured) and the optimism of the anti-psychiatrists (the patient is not ill) have resulted in moves toward a new system which has promise for the motivated, acute or neurotic patient - but which overlooks the chronic patient and his needs.

Well-meant legal reforms have tended to stress patient rights at the expense of patient needs, with the result that many people who really need treatment or 'asylum' are denied them in the name of 'freedom from restriction'.

Two important factors have been overlooked. Firstly, depending upon the values of the observer, blame for mental illness has been placed either on the patient or upon society. In fact any useful understanding of the problem must encompass both the intra- and the inter-personal, and recognise both individual and environmental components of dis-ease. Solutions which address only one facet of illness can only be partial.

Secondly, there has been a failure to recognise that there are many different kinds of long-term patients - whose problems - and potentials - all differ. We need a blue-print of care which acknowledges the variety and vulnerability of **real** patients, and

allows them to receive whatever treatment (including rehospitalization) is necessary, without blame.

Recent reforms have over-emphasised the values of independence and responsibility, which may be inappropriate when applied to the schizophrenic, for example. This imposition of prevailing culture-bound values upon the realities of severe mental illness has meant that the real needs of the disabled have often been denied - both by the 'total institution' and by 'total solutions'.

## SECTION THREE

## WHAT HAVE WE LEARNED FOR THE FUTURE?

## CHAPTER FIVE

## WHAT ARE THE NEEDS OF THE CHRONIC MENTAL PATIENT?

The chronically mentally ill are no longer invisible - the de-institutionalization debacle has thrown this group of patients into the spotlight as the repercussions of over-looking them have accumulated. It is now clear that a scientific appraisal of the sub-populations within this group is needed before further plans can be made.

We will deal with the schizophrenic as representative of the majority of these patients. It should be noted, however, that those suffering from major affective illness, the mentally retarded, and geriatrically mentally disabled are also chronically disabled, and require long-term care. We need to plan different facilities for different groups of mental patients.

The diagnosis of schizophrenia used to carry a high probability that the patient would stay in hospital until death. Now, while the clinical course of schizophrenia has changed little, increasing emphasis on community care means that its social course has changed dramatically. The chronic mental patient has to negotiate survival as an outpatient, which requires rational treatment strategies to take account of his characteristics and

needs. The interaction between patient and environment must also be considered.

### 5.1 The handicaps of chronic mental illness.

We are now in a better position to elucidate the respective roles of illness, hospitalization and treatment in the life situation of the long-term patient.

#### 5.11 Symptoms of illness

"The deficits of schizophrenia extend over a wide range, affecting mental state, cognitive abilities, and current behaviour" (Mathai and Gopinath, 1985, p.514)

The premorbid personality of the schizophrenic may be characterized by traits such as poor social skills, inadequate rapport, suspiciousness or undue social anxiety. These traits, combined with the fact that initial breakdown is frequently in adolescence mean that many patients have not established stable work or social roles before they are hospitalized or handicapped by illness. Acute symptoms of schizophrenia include hallucinations, bizarre delusions, illogical thinking and blunted or inappropriate affect. Residual symptoms may include social withdrawal, odd behaviour, impairment in personal hygiene and grooming, circumstantial speech and impairment in role functioning. Herz (1984) reports that early symptoms of decompensation such as dysphoria, poor concentration, social withdrawal, changes in sleep pattern or depression may be recognised by approximately 70 percent of patients, and up to 93 percent of families. Furthermore, schizophrenia carries an

increased risk of both depression and suicide - the greatest likelihood of completed suicide being amongst those patients showing the best premorbid adjustment, particularly if they retain insight. (Drake and Cotton, 1986).

### 5.12 Environmental stress

Early discharge carries its own risks:

"A prolonged stay in hospital causes certain disadvantages which are avoided by early discharge but ... so long as patients are not completely cured, they remain liable to accommodate other types of secondary handicap" (Brown et al., 1966a, p.207)

Brown et al. go on to identify two main forms of secondary handicap:

1. Maladaptive personal attitudes and habits on the part of the patient include dependency, hopelessness and despair; and
2. Unfavourable reactions of important people in the environment to the fact that the patient has been ill.

Quality-of-life studies identify a number of dimensions on which the life of the chronic mental patient experiences deprivation. Although human beings need relationship, friendship and contact for happiness, the schizophrenic is unlikely to cope in this area without help - and consequently the lot of many chronic patients is that of loneliness, alienation and discrimination.

Having a job to go back to has been clearly linked to remaining out of hospital, but studies have shown that only 10-30 % of discharged patients are employed on follow-up (Lamb and Peeles, 1984). Extended periods of disappointing job-seeking (inevitable for the handicapped in today's recessionary climate) are as distressing as inactivity at home.

Schizophrenics need a clearly structured environment in which there are few complex decisions to be made. They do not cope well with emotional demands or pressure, and need a certain social space around them. The neutral supervision of a day workshop provides a useful adjunct to family life.

The schizophrenic is most likely to be unmarried and unemployed, with the increased vulnerability to stress implied by these conditions. The interaction of the everyday stresses of survival, poor social and work skills, and hyper-sensitivity to stress are compounded by the higher levels of stress associated with the drift down the socio-economic scale and into the 'twilight zones of the city' (Leff, 1976), into which the patient frequently gravitates. Other obstacles to successful re-entry into the community are absence of choices, and the unrealistic expectations of others. Return to families with high rates of negative expressed emotion, particularly where more than 35 hours week are spent with relatives, is associated with high relapse rates (Leff, 1976; Brown et al., 1966). Even where families are caring, the interaction effects between floridly symptomatic patients and stressed relatives may become destructive for all concerned.

### 5.13 Treatment effects

The evils of institutionalization have been well aired, and may compound or echo the negative symptoms of schizophrenia. In addition, loss of social skills and social networks may accumulate with length of hospitalization. Finally, over-ambitious or unrealistic rehabilitation programmes within the institution may stimulate resurgence of acute psychotic symptoms.

Many discharged patients do not continue to take their prescribed antipsychotic medication, and are consequently at risk of further breakdown. However, although the medication 'breakthrough' was one of the enabling roots of the de-institutionalization movement, it has also created a large population of iatrogenically damaged persons. Gochman (1981) points out that

"the infirmities of tardive dyskinesia, reflecting motor and other diffuse brain damage due to medication, are common effects among mental patients. They follow earlier common effects, such as loss of sex drive, dry mouth, loss of appetite, visual problems, leg tingling sensations and imbalances, and zombie-ism". He goes on to ask: "Where, and by whom are mental patients informed that the medication they are about to receive may be damaging, and will produce dullness in all the emotional and intellectual aspects of their lives? Are they given the opportunity to choose problems of living over possible permanent crippling?" (Gochman, 1981, p.111).

Compliance may to a certain extent reflect quality of patient-doctor relationship, and adequate education as to effects and side-effects of drugs. The professional mental health worker ought to remain constantly aware of his obligation to provide careful monitoring of dosages, and to be ever-sensitive of the balance between the costs and gains related to medication for the long-term patient.

## 5.2 The heterogeneous patient population

Today the chronic psychiatric population includes at least three groups of patients, with a variety of problems and needs which must taken into account if service planning is to be effective.

### 5.2.1 The 'old' long-stay chronic patient

These are patients who have been hospitalized for long periods and who are now expected to return to the community.

"They are people who have impaired social functioning, psychological disability, and residual symptomatology. They often have no home, no family, and no friends to whom to return" (Talbot, 1978, p.41).

Their more florid symptoms may be contained by pharmacotherapy, but their daily living skills are marginal, and there has been little change in their underlying pathology.

### 5.2.2 The young adult chronic patient

"During the past five years, ... even as our central vision was directed at the neglect of the shopping bag men and women in our city streets (and their unmet needs

for decent housing, support, and rehabilitation), our peripheral vision was beginning to be captured by the furtive, lurking young man or woman in the doorway ... the young, adult psychiatric patient in the community" (Pepper and Ryglewicz, in Talbott, 1984, p.33).

These patients have grown up following the introduction of deinstitutionalization. The typical profile of this patient is as follows: He is a single white male, age 27, city-dwelling, diagnosed schizophrenic, first hospitalized at age 22, and subsequently hospitalized frequently for short stays (Talbott, 1978). There is an alternate prototype who is female, diagnosed bi-polar disorder or borderline personality with alcohol or other substance abuse. These younger patients share 'Two overarching characteristics':

"their severe deficits in social functioning and their tendency to use mental health services inappropriately, in ways that drain the time and energy of clinicians, yet do not conform to viable treatment plans" (Pepper and Ryglewicz, in Talbott, 1984, p.39).

The young adult chronic group includes a high proportion of never-hospitalized people, and also many 'revolving door' patients. A problem implied for the system by these patients - who form a large untreated and under-identified population of high geographic mobility - is that even a range of appropriate and integrated alternative services would not eliminate such common difficulties as non-compliance, premature termination,

rejection of referral, and heavy reliance on emergency and crisis units.

They are significantly distinguished from the older population of chronic patients by the incidence of alcohol or other drug use and abuse, suicide attempts or risk, disruptive social behaviour, and rejection or inappropriate use of mental health services. A large number of children are being raised by this population (Talbot, 1984).

#### 5.23 The 'difficult-to-manage' patient

There is a group of patients - particularly among the young chronics - who present a management problem as a result of assaultive behaviour. They are difficult to handle as inpatients, and may be dangerous to others if discharged. An increasing number of patients is housed in correctional facilities, but appropriate management remains a problem.

#### 5.3 The needs of the chronic mental patient

"A major and lasting contribution of the de-institutionalization movement is that we have learned to think about the needs of chronic psychiatric patients in new ways" (Bachrach, in Talbot, 1984, p.167).

We now know that many chronic mental patients can aspire to a much fuller life with dignity in the community, given a certain support system. Both negative and positive symptoms may be kept to a minimum by appropriate manipulation of the environment.

With a more informed idea of the handicaps imposed by chronic mental illness and a better idea of the special needs of different groups within this population, we are able to reassess the psychological and social needs of psychotic patients and their families.

Turner (1978) puts it simply: mentally disabled adults, like other people, need food, clothing, accommodation, transportation, education, recreation and money. Also, like others, they need a personal support network. A community support system for this population must provide a number of special services:

1. Appropriate preparation for discharge, including ward programmes to prepare long-hospitalized patients for self-care, meal preparation and simple household tasks. Many hospitals use behaviour modification programmes for the shaping of more independent behaviour within the hospital and also in the community, where use of public transport, shopping and other everyday interactions are best learned.
2. Adequate housing: a wide range of different levels of accommodation and support services, subsidized if necessary, and offering security, privacy and autonomy.
3. Human relationships: This includes family therapy and financial help where these might prop up a positive support system. Over 65 percent of schizophrenic patients who are discharged return to their families. Family education should begin during the early stages of treatment, while families are still eager to learn constructive techniques for dealing with the patient. "A family's endurance should not be unduly taxed. Families of the mentally ill

have been asked to do too much for too long" (O'Connor, 1984, p.994). Also important are active development of social skills, daytime and evening social activities, and organized formation of social links with members of the community.

4. Employment or occupational programmes: A comprehensive system of sheltered and protected work and work training situations, flexibly adapted to the capacities of the individual. Day centres offering meaningful occupation for those who may not be suitable for employment of any sort are also necessary.
5. Leisure and recreation: this includes access to entertainment and adult education.
6. Safety: The mental patient is vulnerable to exploitation, and rendered potentially more so by some side-effects of medication.
7. Psychosocial rehabilitation services: including training in community living skills, with incentives for taking increasing responsibility.
8. Assistance in applying for income, medical and other benefits to which clients may be entitled.
9. Twenty-four-hour crisis assistance: Hospitalization must be available if other options are insufficient.

#### 5.31 Principles underlying the provision of these services

The principle of aggressive outreach is important, since the traditional 'waiting mode' of service provision is inappropriate for effective servicing of this population. Supportive services must be of indefinite duration, either to sustain present

functional capacities, or to keep further deterioration to a minimum. Deliberate involvement with the community by mental health workers is necessary to facilitate acceptance of the chronic patient, and involve community members in provision of services such as housing, employment and companionship. Case management, with team follow-up of each patient to facilitate movement through the system, and prevent patients from 'falling through the cracks' is essential in the provision of a system of continuous care. There is a need for self-help groups which provide peer emotional support and allow role-modelling and altruism; and also for advocacy: chronic mental patients cannot lobby for themselves.

Any long-term drug treatment carries risks, and education about medication empowers the patient, giving him or her the opportunity to play a responsible part in his treatment, thus meeting a valid need for a sense of efficacy. Furthermore, as Lackner (1978) points out:

"Updated education about drug management needs to be provided not only to the prescribing physician, but also to those responsible for daily administration, including board-and-care operators, relatives and patients themselves" (p.30).

Lamb (1984) stresses that it is necessary to recognize that some patients will need more structure and control, including possibly involuntary treatment in a secure intermediate or long-term residential setting.

In planning an environment for the chronic mental patient which will maximise his or her chances of living as full and normal a life as possible, we must remember the very real responsibility to take account of the patients' goals and values, as well as our own. As Jones has argued:

"We need to explore ways that will help them find their hidden potential and develop a therapeutic culture of their own. This calls for skills of a different order than our traditional treatment methods, which aim primarily at an end product in conformity with our fuzzy concept of 'wellness'. The problem about which we seem to know the least is the lifestyle and activities that could lead to a feeling of self-fulfillment for these patients. Left to their own devices, they remain apathetic and inactive. However, pressing them to fulfill our expectations of an active, independent existence may merely heighten their negative self-image" (Jones, 1975, p.98).

#### 5.4 Summary and comment

To plan appropriately for the chronic mental patient - of whom the schizophrenic is representative - we need a scientific appraisal of the sub-groups within this population, and of the handicaps specific to each group.

Three major groups of patient can be identified:

1. The old long-stay patients, who in addition to the effects of chronic illness, suffer the numerous secondary handicaps of institutionalism.
2. The young chronic patients, who suffer severe deficits in social functioning, are frequently drug or alcohol abusers, and tend to reject or make inappropriate use of mental health services.
3. The difficult-to-manage patients, who may be dangerous to themselves or others.

The handicaps of chronic mental illness - in particular of schizophrenia - reflect the respective effects of illness, hospitalization and treatment. Symptoms of illness include poor premorbid personality adjustment, inadequately established work and social roles, negative, positive and residual symptoms of psychosis, and increased risk of depression and suicide.

The present emphasis on community care means that environmental stressors now confront the chronic patient, who is likely to have to negotiate the unsupportive world outside the hospital with all the handicaps mentioned, and their corollaries of unemployment, social isolation and material deprivation.

Unrealistic expectations of both the patient and his environment have been responsible for the apparent failure of de-institutionalization to date. Informed design of care programmes, based on the **real** needs of the chronic patient, must include appropriate preparation for discharge, including psychosocial rehabilitation, provision of adequate housing,

employment or occupational programmes, help with social links within the community, and crisis assistance, with the option of hospitalization if necessary.

The chronic mental patient, with his particular problems and handicaps, needs aggressive follow-up within the community on an on-going basis - often for life - and requires advocacy to complement self-help in order to cope. Above all, we have to accept that some may require temporary involuntary admission or long-term asylum.

## CHAPTER SIX

## SOCIAL CONTEXT AND SOCIAL CHANGE

6.1 Social context and the role of the psychologist

It is increasingly recognized that psychological practice both reflects and is obligated to respond to social context; and in fact, psychologists - and other mental health workers - have been among the most powerful and effective challengers of the state mental institution.

Zautra (1983) points to the ethical responsibilities involved: when planning to study and intervene in community life, we have first to define what constitutes a good community. In fact, it is considered by many to be a dereliction of duty not to respond to the broader society within which live, and not to confront public policies where they might be considered inimical to mental health.

While the psychologist has traditionally been concerned with understanding and working with the individual, critical theorists in particular increasingly challenge us to concern ourselves with all social system levels, i.e. the individual, group or family, organization or institution, community and society (Lazarus, 1986). The preceding study of the literature indicates that appropriate response to the needs of the chronic mental patient includes accepting the role of advocate for these patients. The professional also has a responsibility to cooperate with and

develop non-professional and voluntary aid, if we are to meet the challenge of supplying an effective service. As Baxter and Hopper assert:

"Meeting essential needs is ... a political question, one of social justice, whereas the provision of services is commonly reduced to a technical or administrative problem. The domain of mental health practice cannot be restricted to the latter." (in Talbott, 1984, p.59).

## 6.2 Social change and the paradigm of community psychology

In our search for a just and humane society we have to accept that we cannot create utopia. Furthermore, history repeatedly demonstrates that many problems are inadvertently created by so-called solutions. Rappaport (1977) suggests that a search for new paradigms is more appropriate than a search for solutions.

He discusses the social determinants of mental health practice, and notes that different paradigms imply different modes of social intervention. To the extent that we are aware of how our beliefs and practices are constituted and mediated by culture, we are less subject to the tyranny of prevailing tradition. Since some paradigms are more conducive to the creation of a more facilitating and humane society than others, Rappaport suggests that it is particularly important for the helping professions to choose their guiding vision, or paradigm, advisedly: "The passive acceptance of status quo social forces is ... equally political as active intervention aimed at social change" (Rappaport, 1977, p.26)..

The concepts of first-order change (change within a system that looks like change but really is not), and second-order change (genuine change in a system), have implications for paradigm choice. The paradigm of community mental health attempts first-order change when it helps individuals to adapt to a system. Community psychology, on the other hand, attempts second-order change by addressing the rules that govern relationships between groups. This approach defines intervention tactics in terms of strengths rather than weaknesses, and communicates to its target population the expectation that it is competent and adequate.

Psychology is full of paradigms of the person, and is based on one idealized standard of man. According to Rappaport (1977) the current scientific rules addressing today's issues of relevance, such as social change, social justice, politics, economics and social systems - are just not working. Ordinary psychology, for example, has aimed at adjusting marginal people to the norm. Rappaport proposes that the paradigm of community psychology provides a more appropriate model for dealing with the moral, ethical and value questions facing today's diverse communities.

Community psychology attempts to find alternative ways for dealing with deviance from societies' norms, and avoids labelling differences as necessarily negative or requiring social control. It recognises every person's right to be different without risk of suffering material and psychological sanction. Diversity and cultural relativity are supported, and while individual differences are respected, economic policy must be one of shared

resources and social responsibility. The traditional expectation that clients should find their own way into the service network is eschewed in favour of bringing services or resources directly to the individual or community in need. Problems may be prevented prior to their onset by creating change in the various social systems of society.

This approach to social services can be seen as responding more appropriately than other paradigms to the press of current events. It emphasises equitable distribution of the central resources of power and control, money and independence, and it accepts the responsibility of implementing as well as inventing new programmes for social change (Rappaport, 1977). The community mental health approach may be criticized as aiming to socialize everyone to a single standard as defined by the establishment, whereas a community psychology is based:

"first on a social and ethical value system which recognises the right to be different; second, on an ecological perspective which views all people and all cultures as worthwhile in their own right; and third, on a belief in equal access to material and psychological resources" (Rappaport, 1977, p.53).

### 6.3 Social change process

While it has not been possible to consider socio-cultural context, or models for change in depth within the confines of this dissertation, the ability to survive the guerilla warfare of

promoting institutional change is an important skill for the concerned psychologist.

The search, for alternatives to hospital treatment programmes implies active involvement in the process of social change.

Fairweather proposes that:

"It is only through actual experiments that the value of a new innovation ... can be determined. Thus society needs to establish ... 'Centers for Experimental Innovation' ... to work directly with the social administrators in the society and the problem population in a cooperative effort to create continuously new and innovative models and to implement them when the usual programs developed and used by society are not solving the problem for which such programmes have been designed as solutions" (Fairweather, in Stein and Test, 1978, p.302).

Talbott, (1978), in discussing the complexities of the change process in state hospitals, declares that the state hospital provides an ideal example of a bureaucratic system more intent on preserving itself than on attaining its goals, and suggests that the very size of many institutions runs counter to the goal of providing the individual with human services. He identifies an obsession with paperwork and regulations as an active defence against grappling with the frustrations of treating the chronically mentally ill, and calls for leadership in mental health services to be placed in the hands "of those who value

people and quality, and taken away from those who thrive on paper and quantity" (Talbot, 1978, p.159).

It seems clear that approaches addressing only certain elements in a complex system cannot adequately address its more deep-seated problems. General systems theory suggests that if we hope to improve care for the chronic mental patient, we will have to alter the entire mental health system.

#### 6.4 Options for change

Talbot (1978) identifies a range of modes of social change available to deal with the problem of effective care for the chronic patient. He describes four options:

##### 1. The conservative solution

This approach usually involves maintaining the status quo: making modest changes to improve hospital functioning, and no attempt to change the philosophical approach to the treatment of the difficult patient.

Despite the undoubted need for residential care for a small core population of the severely ill, Talbot criticizes this option as a regressive solution since it is only by systems change that we can hope to grapple with the issue.

##### 2. The reformist solution

This would involve reform of all elements impeding the hospitals from performing their mission. It implies a

complete re-thinking, re-structuring and re-doing of the state mental hospital system, but also the retention of the purpose for which these hospitals were established - the care of those who are not cared for by others, especially the severely mentally ill. Such reforms would be costly, would go to the heart of entrenched political and professional vested interest, and they would require a long time to become effective.

Talbott points out that this approach is spurned by true radicals as comprising superficial 'Band-aid' reform that may actually prevent substantive change.

### 3. The pragmatic solution

This solution proposes retaining the facilities of the large mental hospitals, whilst altering their roles and functions. One approach within this model suggests that the state hospital take responsibility for a catchment area, fitting into the area's existing range of services, providing missing facilities, and serving whatever patient groups are not being served (Talbott, 1978).

While this is a cheaper alternative than total reform of the system, there is the possibility that it, too, could become just another administrative manoeuvre to preserve the status quo. Furthermore, assumption of responsibility and flexibility at local level may not always be warranted.

A positive move away from custodial care to active treatment approaches is implied.

#### 4. The radical solution

This is the approach attempted in Italy during the 1970's: it demands the closure of the large mental hospital, and its replacement by a network of community-based services.

Problems facing the implementation of this solution - in particular, lack of provision for the seriously mentally ill - have resulted in a backlash against closure. Talbott (1978) suggests that for this approach to be successful, there must be: (a) adequate preparation and retraining of state employees; (b) adequate and comprehensive services in the community; and (c) specific provision for the care, treatment and rehabilitation of the chronic mental patient.

#### 6.5 Summary and comment

This chapter examines the influence of social context upon the role of the psychologist, and suggests that to meet the challenge of supplying an effective service, it is a necessary responsibility for her to concern herself with all social system levels, since meeting essential needs is primarily a matter of politics.

The present mental health system is clearly not meeting patients' or society's needs, and consequently we are challenged to

consider the issue of change: what would constitute a more facilitating community, and how are we to achieve it? Change implies changes in priorities, changes in modes of intervention, in allocation of resources, and in roles and expectations. Do we choose first-order change or second-order change? Whether we choose to patch up the existing paradigm, or search for a new one is a central question, for some paradigms are more conducive to the creation of a humane society than are others.

The various options for change - classified as conservative, reformist, pragmatic and radical by Talbott (1978) are briefly considered.

The Italian solution to the problems of appropriate care for the mentally ill was in the mould of the 'radical solution' described by Talbott (1978). On the premise that the decision that someone is mentally ill is essentially a political one, it utilized political process to accomplish its objective. The slower process of running down the mental hospitals in Britain and the United States was seen as a compromise which 'polluted' and 'contaminated' the alternative networks: only a totally new paradigm, based on an idealistic vision of a different world was acceptable.

The pragmatic solution is well illustrated by the planning principles and certain experimental models within the British approach, to be discussed in chapters seven and eight. Whilst this solution does not require a total paradigm switch, the

careful management of change, or transition from a hospital-centred system, to a community-based one is central to success.

Thus whatever her world-view, the mental health professional cannot evade a concern with change. Indeed, Fairweather (in Stein and Test, 1978), proposes that deliberate on-going experimentation with new models is an appropriate way to meet our obligation to be actively involved in social change. The British system is now officially committed to supporting local initiative in an on-going search for innovative and effective programmes.

"New programs exist and more will be found that can replace the patients's lowly social position with first-class citizenship ... To accomplish this requires continuous social change in which experimentation is a key element" (Fairweather, in Stein and Test, 1978, p.308).

## CHAPTER SEVEN

THE DEVELOPMENT OF INTEGRATED  
SYSTEMS OF COMMUNITY CARE

"Doubt and cynicism have replaced hope and confidence ... is it possible to provide adequate alternatives to the mental hospital?" asks Bennett (in Stein and Test, 1978, p.266).

He suggests that the answer depends on our evaluation of community services where new methods of care are being pioneered.

As May (1975) points out, the traditional outpatient model, based on the naive proposition that patients and their families will be cooperative and eager to come in for treatment, is inappropriate for schizophrenic patients. The care of these patients needs to be coordinated, and the disparate elements of mental health, health and social systems must cooperate more effectively.

Psychiatric hospitals have been attacked since their founding as inhumane and providing only poor custodial care, yet, as Talbott (1978) reminds us, a cause of the failure of the mental institutions has been the difficult nature of their primary population.

The effectiveness of community alternatives has usually been measured by the outcome variables of:

1. Time out of hospital and re-admission rates;
2. psychotic symptomatology;
3. psychosocial functioning;
4. client satisfaction;
5. economic cost, and
6. family and community burden.

We now know that length of hospital stay, in-patient bed numbers, and number of re-admissions are not per se adequate measures of effectiveness, although extremely high rates of recidivism imply that social factors of relevance to clinical outcome are not being adequately addressed.

The elaborate network of services required

"constitutes a massive therapeutic/social effort with meticulous attention to detail and completeness in a population that neither expresses its appreciation for such heroic efforts nor responds to provide the care givers with intrinsic satisfaction for their attempts" (Talbot, 1978, p.168).

### 7.1 Experiments and innovations in service provision

Increasing use is being made by forward-thinking planners of experience gained from models of alternative services. For example, the Community Psychiatry Research Unit met in November 1982 at St. Bartholomew's Hospital Medical College in London to pool ideas regarding the development of comprehensive district

psychiatric services. Lord Trefgarne stated, in opening the conference:

"Communication and collaboration are key issues in the new pattern of psychiatric services" (Reed and Lomas, 1984, p.23). A programme of annual reviews to monitor regional progress in development of services, and regular production of circulars to pull together accumulated knowledge, have been established in England. Lord Trefgarne went on to spell out the British approach for the future:

"There is a need for regular information about the work of professionals, about various schemes, about methods of coordination ... we must not fail to capitalize on the power of modern information and technology to support and inform and assist the human factor" (Reed and Lomas, 1984, p.29).

Accordingly, "since local variation and experiment is of the essence" (Reed and Lomas, 1984, p.28), we will examine a few examples of services which demonstrate heuristic efforts to provide a more effective service.

## 7.2 Models in the United States

### 7.21 Preparation for community placement: Norristown State Hospital treatment programme

This programme, begun in 1970, was organized to address behavioural deficits resulting from long-term

institutionalization. Previous programmes had some success, but also limitations:

- (a) token economy wards, teaching basic self-care and social skills through operant conditioning procedures have been effective in shaping adaptive behaviour, but improved functioning was not maintained in the community, where environmental supports are not so immediate, consistent or lavish;
- (b) the social-democratic milieu - with group pressure directed toward 'normal' functioning and taking responsibility, did not address the chronic patient's need to improve daily living skills, and
- (c) pre-discharge wards, geared to provide training in community living skills, too often assume or require higher levels of functioning than such patients possess.

The Norristown Hospital programme was designed to provide four stages of comprehensive, continued treatment for chronic patients who are to be placed in the community:

1. Token economy wards provide the first treatment stage for severely regressed patients. Basic self-care and socialization skills are shaped using primary and secondary reinforcers. Tokens are distributed daily, and patients may visit the ward store twice daily.
2. A coed activities ward provides the second treatment stage, where a full schedule of recreational and occupational therapy is individually tailored to provide patients with rewarding experiences of success, physical fitness and mental alertness.

Where patients do not show sufficient improvement to actually leave hospital, they nevertheless benefit from a fuller, more independent life within the hospital.

3. Socialization within a coed ward in a democratic milieu provides the third treatment stage via an intensive group therapy programme. The ward environment is designed to resemble the community environment, links are made with the outside world, and self-initiated, stable, adaptive behaviour is encouraged.

4. The coed exit ward provides an accelerated community orientation programme and training classes in such aspects of daily living as banking, laundering and housekeeping.

Patients visit previously discharged patients, participate in a self-medication programme, and may live together in groups within the hospital in preparation for discharge as a group to the community. Relatives are involved in placement planning.

Becker and Bayer (1975) report that 88 percent of patients discharged via this programme have made a successful adjustment in the community (during a three month to five year follow-up period), giving a recidivism rate (12 percent) well below the national average of 60 percent.

#### 7.22 A rehabilitation centre: Fountain House, New York

"What we are trying to do ... at Fountain House is to serve more adequately the increasing numbers of people leaving our mental institutions who are obviously not needed by the community to which they are returning ...

We are trying to create a community ... where the individual patient ... can make a genuine contribution, can be clearly needed, authentically appreciated and recognized ... We are a kind of large extended family" (Stein and Test, 1978, p.203).

Fountain House is a social club, with six rehabilitation areas in which members can participate: the kitchen-dining room, the clerical office, the Snack Bar, the Education and Research Center, the Thrift Shop, and a diversified unit. Members and staff participate together in all club activities.

Members prepare meals, produce a daily newspaper, go shopping, clean up, make home and hospital visits to members, prepare and modify their own rehabilitation plans.

Fountain House provides a number of special rehabilitation services to its members which serve as a valuable model for community programmes elsewhere.

1. **Transitional employment.** For example, Fountain House in New York has negotiated job placements with some 40 business firms in New York City, in which over 120 members earn a total of \$300,000 per year (Peterson, 1982). Each job belongs to Fountain House rather than to any member, and is generally used by two members, so that pressures to succeed are considerably reduced. This programme circumvents certain barriers which all too often prevent the psychiatric patient from seeking, securing or holding down employment - such as the ability to pass a job interview. If the member cannot handle the job, he can hand it over to

another member, without the devastating feeling of failure - and closing of doors for future employment - which normally accompany this experience.

2. A place to live. Fountain House circumnavigates the barriers to decent housing which face so many ex-patients, such as references, deposits and the capacity to negotiate with landlords.

In 1978 Fountain House was leasing some 53 apartments in New York City - typically shared by 2 to 4 members, who were thus enabled to pool their resources and have a more attractive and supportive place to live. Modest furnishings are available through the Thrift Shop, and maintenance of apartments provides meaningful activities for members in the day programme.

The New York Fountain House served over 1000 members in a period of a month during 1978, with daily attendance of up to 400 people, representative of the spectrum of the city's population (Stein and Test, 1978). A large majority (83%) of the disabled population remained active in the rehabilitation process, and the unit served also as a training placement for psychiatrists, psychologists, psychiatric nurses, social workers and other mental health disciplines.

Fountain House actively supports the establishment of similar facilities elsewhere - not only in the United States, but in such countries as Australia, Pakistan, Poland and South Africa.

7.23 An integrated community system for the effective treatment of schizophrenia: The North Nassau Mental Health Center, Long Island

This centre has become the focus for the development of a model treatment system, comprising a clinic, a specialized laboratory, a hospital, a patient self-help group, a half-way house, a day treatment centre, and a local mental health organization geared specifically to the treatment of schizophrenia. (Hawkins, 1972).

All components of this system relate freely to each other on all levels, and patient, family and staff may be involved simultaneously in all of them. Referrals between the units are immediate and without red tape. Because many schizophrenics have recurrent drug or alcohol problems, liaison has been established with existing alcohol and drug programmes, and the entire system is linked to the National American Schizophrenic Association.

Patients may enter the system through contact with any of the component units or groups, and generally become involved successfully with a combination of them at various stages of their illness and recovery.

7.24 The mini-mental-health centre: The Veterans Administration Hospital, Los Angeles

May (1975) describes the model of the mini-mental-health centre, which he suggests could remedy deficiencies in community resources. He describes the reconceptualization of the

psychiatric hospital as the core of a new type of regional mental health centre, supervising the same team of mental health workers to provide continuity of care for both inpatients and outpatients in the region. The core facility would have inpatient facilities and a number of satellite residential and outpatient clinics.

This mini-mental-health centre is conceived as having the flexibility to provide treatment of any type, by any profession, in whatever framework is appropriate for a particular patient - including hospital or outpatient care, day or night care, and home visits.

The patient is always treated by the same staff members. This continuity of staff is particularly important because of the fragility of the object relations of many psychiatric patients - especially the schizophrenic. Patients transfer relationships with difficulty to new caregivers, and it is more efficient to capitalize on existing therapeutic bonds than to transfer patients to different teams in different parts of the system.

Each newly-admitted patient is assigned to one of two multi-disciplinary teams on the ward, who will also be responsible for his or her outpatient follow-up.

"When we discharge someone from in-patient care, we hope that he is able to live independently. But if he needs outpatient or day treatment, we discharge him to ourselves. We provide care for him at any hour of the

day or night, seven days a week" (Johnson et al., 1975, p.602).

The team pays particular attention to the development of relationships with staff of board-and-care homes, families and employers. Careful preparation for discharge of institutionalized patients includes basic vocational counselling, and training in the use of laundromats, public telephones and public transport. Day care programmes emphasizing social skills are provided at the hospital; activity groups are provided weekly in a number of board and care homes, and monthly follow-up groups are held.

The mini-mental-health centre model provides continuity of service and therapeutic relationships for the patients, and enhanced morale for staff, whose efforts are no longer thrown away by their inability to follow the entire course of the patients' treatment. As May (1975) points out: "the system ends the characteristic and tiresome buck-passing and bickering that so often occurs between hospital and clinic" (p.601).

### 7.3 Models in Britain

The British National Health Service is a pyramidal organization with a government department and cabinet minister at the top, and an infrastructure of 14 regional and 90 area authorities. Each area consists of one to three geographical districts with a population of 100-400 000. A District Management Team is responsible for planning and administering local health services to meet the needs of the district. Each district has a local

consumer organization - a Community Health Council - to keep a check on the quality of health services.

British practice sets the individual patient within the context of his family and society. The general approach is that hospital admissions are usually brief episodes, the significant parts of convalescence and rehabilitation taking place mainly in the community (Bennett, 1978).

Four main principles underlie the National Health Service:

1. Authorities are responsible for the whole of a geographical area, in which services should be accessible. Everyone needing treatment should be able to obtain it, and services should reflect local needs.
2. Services should be comprehensive and varied, should overlap with the provision of social and welfare services, and staff should be well trained.
3. Area health services should not only be comprehensive, they should be integrated, with easy transfer and free communication between facilities.
4. Each agency has a combination of diagnostic, therapeutic, rehabilitative and preventive functions. The aim of the health services is to decrease or contain morbidity, which involves limiting the development of chronicity, or the development of secondary handicap where chronicity is inevitable.

The official policy for the United Kingdom is that the number of beds in mental hospitals should decrease steadily until the major

hospital need will be for short-stay beds which will be in district general hospitals. A comprehensive local service will be provided by day hospitals, hostels and workshops and specially built psychogeriatric facilities. It is envisaged that 50 general psychiatric beds and 60 day places will be needed per 100 000 population. It is recognized that without an effective service for the elderly mentally infirm, the patients who are difficult to manage, and the 'new' long-stay patients, no local psychiatric development can call itself comprehensive.

While the English system is based on a good infrastructure of evenly distributed services, the separation of health and social services has disadvantages, and the opportunities for lack of coordination between NHS, Social Service departments and voluntary organizations are numerous.

#### 7.31 Moving away from centralised institutional services:

##### Exeter

It became apparent in the late 1970's that though patient populations were declining, the hospitals were not getting smaller; rather, they demanded more resources and management attention, while development funds were drying up. It was decided to devote resources to the development of community facilities.

"The radical conclusion was that instead of waiting for history to solve the problem, we would close the hospitals, and use the resources to create local services" (King, in Towell and McAusland, 1984).

It was decided that the creation of a better spread of local services in the Exeter district was to be paid for by the closure of the two main hospitals. Acknowledging the right of the community to participate in decisions about services, local consumer groups were involved, as in the commission of a major action research programme into the needs of all handicapped people aged 16-25 in the district. Joint planning with local councils and committees, and also social services, education and housing groups has been consciously pursued, and services are constantly reviewed to ensure that they are sympathetic to the needs of people.

"Services must adapt and not be set in concrete" (King, in Towell and McAusland, 1984).

The human context is the more real and rewarding because staff are local, and know and are known by their clients. Since they have been assured that the new system will result in no redundancies, trades unions and staff associations are supportive of the new programme.

This case study shows the importance of developing a broad vision of future services, and building a collaborative approach between health, local authority and community - based organizations.

#### 7.32 Developing good local services: West Dorset

"It is the task of local management and professional leadership to mobilise participation in the creation of new patterns of provision and identify innovative ways of

providing community-based alternatives to the institution which better meet the range of client needs" (Towell and McAusland, 1984).

The planners of decentralization in West Dorset envisaged a dispersed but comprehensive service, retaining central units for intensive treatment, and with local facilities in each discrete community:

"We wanted to deliver care in the living room or the high street and not in a distant hospital" (Dick, in Towell and McAusland, 1984).

To date the following services have been established:

1. Four community psychiatric teams.
2. A community mental health centre with day hospitals for general psychiatry and the elderly, and 11 'refuge' beds.
3. Travelling day hospitals providing intermittent services for each of the local towns in the area.
4. Five small day hospitals for the elderly mentally ill.
5. A community psychiatric nursing service.
6. A 20-bedded ward for the elderly mentally ill in a local community hospital.
7. A resettlement scheme for about 350 'old' chronic mental patients.
8. A network of social clubs, occupation and leisure activities.
9. A mental illness hostel.

10. A multi-purpose activities centre for all kinds of disabled people.
11. A day centre for the elderly in the main population centre.
12. A 12-bedded hospital hostel for new long-stay patients.

A consistent, long-term strategy for the implementation of new services is identified by Dick as an essential base from which component parts can be built and staffed step by step. The active involvement of the senior medical administrative and nursing staff in the design of the service, and the management of the district-wide service as a unit, are important.

### 7.33 Guiding principles for a community mental health service: Brindle House, Hyde

The following set of principles was used by the designers of this community mental health centre, which has been in operation since 1977:

1. It is assumed that most referrals reflect 'problems in living' rather than mental illness, and that the predominant treatment approach should therefore be psychosocial rather than medical.
2. The service should be as flexible, accessible and informal as possible.
3. There is a strong emphasis on day care rather than in-patient care.

A set of operational policies flowed from these principles:

1. Self referral would be possible.
2. Assessment and management would be shared between the major professions (psychiatry, psychology, social work)

on the basis of the most effective division of labour, with no presumption that the psychiatrist had overall authority.

3. The 'major' professions did not have a monopoly of skills, and other staff should be encouraged to contribute.
4. The staffing mix would be weighted towards the non-medical disciplines.
5. The centre would be as informal and non-medical as possible, and clients would be expected to retain a large measure of responsibility for their own lives.
6. There would be agreement with clients about problems to be worked upon, and clients would have access to their own notes. Orientation would be geared toward active short-term therapy.
7. Drug therapies and inpatient treatment would be used, but only when alternatives had been considered and excluded.

During its six years of operation, the number of emergencies referred to Brindle House has dropped by 70 percent whilst total referrals have increased by about 30 percent. Inpatient admissions have fallen by 40 percent, and bed occupancy rates by about 36 percent. Hargreaves (in Reed and Lomas, 1984), discussing the success of this facility, suggests that the improved service it offers its catchment area can be attributed to four factors:

1. Ease of access for clients, and rapid response to initial referrals.

2. The team's ability to concentrate on a problem in its early stages, and marshal its ranges of skills to best advantage.
3. The high degree of congruence between the objectives of client and therapist, as well as the active participation by the client in the treatment process.
4. The ready availability of day care as an alternative to inpatient treatment.

However, it is important to note that the centre provides better service to highly motivated neurotic clients than to the chronic psychiatric patient.

#### 7.4 Summary and comment

The experiments and innovations outlined above all aim at providing services geared to the needs of a particular locality and patient group, and the treatment approach is psychosocial rather than purely medical.

Adequate preparation for discharge is an important task, if return to the community is to succeed. Behavioural deficits resulting from long-term hospitalization are addressed in discharge programmes which attempt to prepare the patient for everyday life in a realistic manner.

There is a focus on providing a comprehensive, coordinated network of inter-related services, including help with accomodation, employment, social links and everyday living

skills. It is recognized that attention to just one facet of the patients' problems is likely to result in failure - treatment will be effective only if it addresses the full spectrum of the handicapped person's needs.

The need for continuity of care has been well met by the Veterans' Administration Hospital for example, where the same team of staff deals with a patient whether he is in hospital or in the community. Multi-disciplinary teams responsible for on-going case management have been recognized as appropriate to the task of dealing with the variety of issues and problems involved with long-term community-based care.

Inter-agency cooperation, with ease of referral, effects economies and makes services more accessible, helping to minimize inconsistencies, and prevent patients from 'falling through the cracks'. (e.g. North Nassau; Brindle House).

Many programmes now recognize the need for a reassessment of the place of the hospital in the service network, and use the institute in a pragmatic way to provide the core facility, supplementing community services and offering asylum where necessary. A central lesson of the de-institutionalization movement has been that alternative services must be provided before the run-down of the hospital, and this recognition is a cornerstone of most British planning.

The need for cultural relevance in mental health services is reflected in most of the examples discussed. Programmes are

geared to local realities, often following research into local needs. Community-based services make maximum use of the district and its resources, consciously work at involving and educating the public about mental health issues, and attempt to minimize community resistance to de-hospitalization.

Conspicuous among the values common to these experiments is the treatment of patients as full citizens, with rights and responsibilities. While programmes aim to help the individual to a fuller, more independent life - if possible in the community - there is a recognition that it is inappropriate to push for higher levels of functioning than are possible for the individual concerned. Goals are patient-centred, and while encouraging self-initiated, stable and adaptive behaviour, are not 'success' orientated in a punitive way.

All of these elements have contributed to significantly more effective services, with rewarding involvement for patient, staff and community alike.

## CHAPTER EIGHT

## PLANNING FOR THE FUTURE

"We must have the courage to admit our mistakes, and the humility to start again", declares Papeschi (1985, p.254), following an examination of the debacle in Italy. The years since 1955 - when mental hospital populations began to decline - have witnessed considerable trial and error in mental health policy. While some (e.g. Scull, 1977; Rappaport, 1977; Brown, 1985b), view the development of the community health service system with cynicism, the experience of these years, gained with considerable cost to patient and community, is a valuable base for coherent planning for the future.

Planning implies a statement of goals in which a central issue is the consensual definition of rehabilitation. Wing and Morris (1981) define rehabilitation as preservation of the best level of adaptation possible for the individual client, with recognition that what disabled people need above all is experience of success. Thus, while attainment of independence is an appropriate goal for some, the prevention of relapse or deterioration constitutes success for others.

It is important that goals be realistic for both patient and staff morale to be sustained.

### 8.1 The biopsychosocial model of schizophrenia: a basis for planning

Smith (1986) discusses the advantages of the biopsychosocial conceptualization of schizophrenia for the ongoing management of the illness.

This model, derived from general systems theory, takes both biomedical aspects and psychosocial factors into account, thus allowing for multiple perspectives to be considered in planning treatment. Systems theory posits a hierarchical continuum of systems, each of which is a component of higher systems, and contains within it the lower systems. Change at one level of the hierarchy has effects across all systems.

Schizophrenia may be considered an archetypal biopsychosocial illness because the links between the biomedical and psychosocial dimensions are all-pervasive. Poor work performance, poor interpersonal relationships, and failure to cope with everyday living are among the psychosocial consequences of psychotic symptoms. At the same time these symptoms may be precipitated by psychosocial stress.

While medication may modify or prevent symptomatology, life events - such as criticism and hostility within the family - may increase the need for drugs to prevent relapse (Leff, 1976; Wing, 1978; Van Putten, 1978; Smith, 1986). A patient's identification of medication with irrational authority, such as that of dominating parents, may result in non-compliance,

followed by exacerbation of symptoms. Similarly, unpleasant physical side-effects such as weight gain, shuffling gait and difficulties with vision might well encourage drug refusal. One consequence of this interaction between life situation and medication is the need for ongoing and careful monitoring following discharge.

A further example of the interaction effects of different systems upon each other is given by Smith (1986) who points out that societal and politico-economic considerations determine the availability of facilities for chronic mental patients. Cultures vary in their tolerance of mental illness, which fact will be reflected in prevailing laws, influencing such things as certification procedures, family structures, and funding arrangements.

Genetic loadings vary, and it is difficult to clearly delineate cause-and-effect relationships between factors such as poverty, material and emotional deprivation, and substance abuse.

A uni-dimensional model is not adequate to explain the complexity of the illness: even if a single organic defect were discovered to finally explain the aetiology of schizophrenia, the patient would still have to be regarded as a system reacting to and interacting with, a variety of other systems.

"Psychiatrists can remove florid psychotic symptoms with neuroleptic medication, and hope that patients will somehow accommodate to an unmodified stressful environment.

Psychologists may attempt to work with families, assuming that, by altering maladaptive dynamics, the identified patient's symptoms will somehow disappear. In isolation, both approaches fail with monotonous regularity" (Smith, 1986, p.26).

While the poverty of a unidimensional approach is theoretically clear, treatment all too frequently remains fragmented, possibly partly reflecting interdisciplinary rivalries.

"We must be continually on guard against a blinkered approach which allows us to see a schizophrenic patient only in terms of the particular sub-system at which level each of us has the most involvement" (Smith, 1986, p.27).

## 8.2 A blueprint for local services

Heginbotham in Reed and Lomas (1984) asserts that all planning must be based on a blueprint for a comprehensive local mental health service. A clear framework for the future should be provided, and scarce resources must be prioritized. This blueprint could be implemented in different ways in different districts, with the recognition that each district is different in its policies, its personalities and its problems. He also points out the need for clear socio-economic and legal frameworks for the development of better services.

While Hall (1986) states that it is not necessary to obtain highly precise information before planning can proceed, he lists those data about a designated catchment area which are necessary

to design a local service. These include natural boundaries, such as the limits of G.P. practices or local transport systems; formal organizational boundaries (e.g. the limits of Social Services or medical teams); and information about present and projected populations, including age structure, special social factors, special disease problems and environmental risks.

This type of information base is necessary not only for the planning of statutory services, but also for the guidance of local voluntary bodies. Consideration of variations in the present pattern of service provision, and also localized resource constraints aid the planning of priorities in service requirements.

It is appropriate to build an expectation of collaboration with the voluntary sector into service design. Families, informal caregivers, and advocacy groups all have a role to play. However, Heginbotham (in Reed and Lomas, 1984) warns that this does not mean de-professionalizing the service: training implies a disciplined accumulation of knowledge and supervised experience which is indispensable in the skilful care of the mentally ill. Case management is essential to integrate an adequate network of care.

Successful planning includes careful consideration of the implications of these plans for mental health workers, whose cooperation is essential for the success of operations. Staff should be given the opportunity to be involved in the build-up of

plans at local level, and Trades Unions must be brought in at an early stage to assist with employment issues.

Bennett (1973) advised that "the balance of care should be the over-riding consideration, that is, what mix of services is appropriate, and what weight should be given to each contribution to the mix" (p.11).

### 8.3 An information base for planning

Since projections indicate that chronic mental disability will increase dramatically by the year 2005 (Kramer, in Talbott, 1984) a data base is essential for appropriate planning.

Epidemiological studies establishing the prevalence and characteristics of the chronic mental patient population are vital to planners and policy-makers. Goldman (in Talbott, 1984) points out that a consequence of de-institutionalization is a lack of definitive information on the scope of the problem of chronic mental illness. The very term 'chronic mental illness' presents problems in that it is stigmatizing, is difficult to define operationally, and obscures the heterogeneity of the population. Assessment of prevalence is also complicated by the dynamic, episodic course of severe mental disorders. Definition of the boundaries of the target population does no more than hint at the clinical, socio-economic, ethnic and cultural diversities within this population.

Research in a number of areas is required. In addition to the obvious epidemiological studies, the area of medication

management needs further clarification. "We need to find better ways to determine who is most likely to benefit, and for how long, and who might do at least as well without maintenance treatment" (Lackner, 1978, p.30). We need to know more about the nature of the homeless population, and how best to reach them, and we need a better idea of which patients can cope in the community, given adequate support, and for which patients de-institutionalization is an inappropriate aim.

#### 8.4 Values and priorities in planning

Planning implies an agreed base of values. The following value base for the planning of a local service has been suggested by planners in England:

1. The mental patient should be treated as a full citizen with rights and responsibilities.
2. The greatest possible self-determination of the individual should be promoted.
3. An individualized programme of treatment, care and support should be provided.
4. The client should be helped to as ordinary a life as possible on the basis of realistic, informed choice.
5. Special needs arising from disability should be met through a local, accessible, fully coordinated multidisciplinary service given by appropriately trained staff.
6. Services should be delivered to the client's home or usual environment whenever feasible.
7. People now living in institutions should be actively

encouraged to return to the locality and use its services if they wish.

8. The enhancement of the collective capacity to cope with or alleviate distress should be aimed at. (Reed and Lomas, 1984, p.200).

#### 8.5 Essential elements in programme design

Bachrach (in Talbott, 1984a) states:

"Service planning, instead of relying on slogans as it did in the past, is beginning at last to proceed in a cautious manner by tempering idealism with objective assessment of needs and problems" (p.166).

She identifies the essential elements in programme design as follows:-

##### 1. Precise goals and objectives

A more comprehensive understanding of the nature of chronic mental illness is needed, as is a more informed identification of patients who will benefit from community-based, as opposed to in-patient services.

##### 2. Priority setting

The chronic patient - often especially impaired, resistant to treatment, and unappealing to mental health workers - needs guaranteed priority in the allocation of scarce resources. These patients need advocates as they are seldom able to compete effectively for resources themselves.

3. Reassessment of the place of the institution in the service network

A reconceptualization of the hospital, with an acceptance of re-admission as part of the on-going process of care for some is indicated. A comprehensive service should offer both community- and institution-based services to meet the individual patient's needs.

4. An adequate range of inter-related programmes

To meet the varied needs of the very diverse patient population, the service network should include at least the following services:

- (i) Screening and referral
- (ii) Crisis stabilization services
- (iii) A network of residential alternatives
- (iv) A range of treatment settings
- (v) A network of treatment services
- (vi) Transportation services
- (vii) Information and evaluation services

Different communities may require different combinations of the above services according to local needs and resources.

5. Interagency cooperation

An official policy of cooperation is essential for integrating service delivery, effecting economies, and reducing human problems in a complex and potentially competitive array of services. Conscious attention to this principle is required to minimize inconsistencies and poor coordination.

#### 6. Individualized programming

Programmes should be individually designed to emphasize each patient's capabilities rather than disabilities, and aim at providing him or her with resources for skill development, thus anticipating a higher level of functioning where appropriate.

#### 7. Cultural relevance

Community resistance has been a very relevant problem in the development of services. Programmes should be tailored to conform to local realities - including needs and attitudes - of the community in which they are offered.

#### 8. Flexibility

Flexibility implies an acceptance of the idea that the concept of linear progress along some continuum is inappropriate with chronic mental patients. It allows for decompensation without interruption in the flow of services, and also allows for modification of services in response to changing needs over time.

#### 9. Caution and restraint

Although rehabilitation is the desired goal of community-based care, we must avoid the goal of the 'quick fix'.

#### 8.6 Conclusion

We are now able to reconsider aims with the aid of planning principles gained from a quarter of a century's experience in programme design which has demonstrated "the absolute importance of asking the right questions in the right ways and with a minimum of prejudice and bias" (Talbot, 1984a, p.170).

If shorter hospitalization, and more patients living in the community imply success, the patient's mere presence in the community would be sufficient. But if maximising patients' independence is the goal, planning is much more complex, and success is not yet in sight. The goal of eliminating mental illness has been responsible for the apparent failure of de-institutionalization, and may prove to have been inappropriate. The belief that early treatment would relieve chronicity has not been confirmed. Denying or evading the difficulties inherent in humanizing mental health care builds failure into the system. The goal of care, rather than cure is one to which we may more successfully aspire.

We should not seek alternatives to mental hospital treatment—but rather goals for rehabilitation, and we need more systematic measurement of handicap in order to plan the kinds of non-hospital environments which are most likely to minimize morbidity.

"Rehabilitation consists in attempting to order the environment so as to minimize primary disabilities and prevent secondary handicaps or keep them to the lowest level possible. Rehabilitation efforts within the hospital must be continuously applied if hard-won progress is not to be lost ... and the same seems to be true after the patient has been discharged ... Unfortunately, it is precisely at the point of discharge

that rehabilitation efforts do tend to be relaxed"  
(Brown et al., 1966, p.207).

Finally, it should be noted that community care is not a cheap option, as some critics have implied. It involves re-allocation of funds and new and imaginative use of resources, but it is not cheaper than the average costs for hospitals. Dick points out that the capital and revenue of mental health services are locked up in large institutions, and that freeing funds is a long and tedious process which will require careful planning (Reed and Lomas, 1984).

Nevertheless, many mental health workers stress that 'money is not the answer to all problems'. The World Health Organization made a study of constraints in developing mental health services in 1977, and identified apathy, inertia and lack of flexibility as the biggest obstacles to development. Planners need to take note of the fact that information, collaboration and cooperation are the essential keys to progress.

## CHAPTER NINE

## DISCUSSION AND CONCLUSION

The years since 1955 have been marked by major change in the scope and diversity of mental health services, and in some parts of the world by the massive migration of the severely mentally disabled from the large mental institutions back to the community. Bellack (1984) warns that in a capitalist, competitive society, the prevailing values of independence, autonomy and individualistic achievement can overwhelm the collective responsibilities we bear toward the infirm and destitute. He reminds us that our political tradition relies on professional and citizen leadership to modify these values.

"Humane and quality delivery of care requires dedicated professional leadership, a caring and informed citizenship, and a government willing to tax its own people to lessen life's inequities" (Bellack, 1984, p.123). He goes on to add:

"These patients are not an effective political constituency ... and the cost effectiveness of treating them is marginal at best. But a grave moral issue is at stake here. As much for our own sake as for others, we need a renewed socio-political consensus that provides for the need of the schizophrenic patients" (Bellack, 1984, p.130).

Lackner (1978) warns that unless we improve the long-term effectiveness of treatment and supportive care, the number of persons needing services is likely to overwhelm the system.

### 9.1 What was wrong with the institution?

Chapter One discusses the development of the asylum, and its vicissitudes, from a haven of 'moral treatment' in the early nineteenth century to the 'warehouse of the insane' it became for the following hundred years. The intertwining of the fortunes of the schizophrenic - who formed the majority of the long-stay patients - and of the institution is discussed.

The institution came to provide, in most cases, a demoralizing and hopeless environment for patient and staff alike. The obvious failure of the large mental hospitals, together with the apparent implications for 'cure' suggested by the identification of the syndrome of 'institutionalism' and the discovery of the neuroleptics led to the decision to close the hospitals, and seek alternative community-based forms of care.

### 9.2 What was wrong with the solution?

Critics of de-institutionalization have pointed to the 'revolving door' syndrome of frequent short admissions, which has taken the place of long-term custody, as proof of the failure of the policy. It would be more appropriate to recognize the failure of a view of the chronic patient which does not acknowledge periodic re-hospitalization as a necessary part of the plan. The patient has simply not fitted into the closure of the hospitals, and the lesson we need to learn is to accept the periodic remissions and

exacerbations that characterize the course of the illness, and to produce a blueprint for care which enables the patient to receive whatever treatment is appropriate to his or her current condition - including re-hospitalization - without blame.

Claiming that the achievements of the best mental hospitals have been undervalued, Wing (1980) points out that most of the ideas now used in community care - including resocialization, vocational rehabilitation, transitional environments, day care, social clubs, sheltered workshops and domiciliary supervision - are derived from innovations and experiments in progressive English hospitals dating from the 1930's. The hospitals had important functions - of custody, asylum and treatment - which were overlooked by the critics, who indulged the logical fallacy that since bad hospitals are bad for all patients, any hospital is bad for any patient.

Placement in the community has thus not necessarily avoided institutionalism, and has ignored the possibility of rejection by the community. It certainly does not automatically give back to the patient his lost social role.

While Test and Stein (1978) conclude from an extensive review of experience in recent years that it is feasible to treat most patients usually admitted to a hospital in some kind of community alternative, we have now to recognise that this involves more than mere re-location:

"Institutionalism, once believed to be the consequence of living one's life within the requirements of an impersonal, bureaucratic state hospital, has emerged as a quality of mind rather than of location, created by settings that limit self-determination, self-care, and self-control" (Wilson, 1982, p.xx).

These settings can occur as easily in the community as in the hospital.

In considering the failure of institutional reform, we must face the conclusion that unidimensional solutions are inadequate to meet the challenge of the complex, multi-dimensional problems of mental health care:

"If the elusive goal of creating and sustaining a truly humane system of care for the dependent mentally ill is to be realized in this generation, then policy-makers must avoid the trap of quick and partial fixes" (Morrissey and Goldman, 1984, p.792)

### 9.3 Values and visions reconsidered

"If it is wrong to get patients out of the mental hospital, and wrong to keep them in, what are we to do with them?" ('Scull's dilemma', in Jones, 1982, p.223).

The value in Western culture place upon independence, and the individual's responsibility for his own life, has been inappropriate when applied to the schizophrenic. We have made demands for performance - vocationally and socially - which the chronic mental patient simply cannot meet. Effective management of this population will only be possible when we acknowledge that many of them will require ongoing and comprehensive support, possibly for life:

"Our dissatisfaction with a primary role of gratifying chronic dependency needs and our more or less covert moral rejection of our patients' surrender to passivity are probably two impediments to our embracing the concept of asylum for the long-term mentally ill" (Lamb and Peele, 1984, p.801).

The range of values demonstrated by new committal and treatment rulings may be said to include those of fairness, reasonableness, openness, access to review, listening to both sides, and access to judicial or quasi-judicial tribunal. However, as Margaret Somerville (in Roth and Bluglass, 1985) points out, we need to consider this range of values in terms of whether it includes only individualistic - or 'masculine' - values, or also integrative - or 'feminine' ones - because it is not sufficient to look at the mentally ill person simply as an individual. He also needs to be viewed within his social network. Somerville claims that the law has not, in general, been as protective of integrative values - i.e. the interests of family or society - as it has been of individual rights: hence the recent backlash of

public protest following a number of widely publicized acts of violence on the part of ex- mental patients (for example, the attack on President Reagan by Hinckley).

The influence of world-view upon solutions is clear in considering the issue of de-institutionalization. The asylum is viewed by some as an expression of humanitarian concern, a well-meaning attempt to care for those who could not care for themselves. To others it represents 'marginalization' and segregation of the deviant, a punitive disposal typical of capitalist treatment of those unable to compete or produce.

Similarly, de-institutionalization may be viewed as a rationalization of mental care, an egalitarian effort to advance human rights - or a cynical movement by governments with pressed economies to 'dump' patients.

The public preference for simplistic or sentimental solutions is problematic. Talbott (1984) fears that the sight of the obviously disoriented on the streets will result in a reactive backlash in defence of the traditional institution: we must avoid perceiving the options as being either mental hospitalization, or a life on the streets.

Political systems tend to proclaim a view of past, present and future which embodies a comprehensive view of how society ought to be. Different perceptions of social reality may not be tolerated, and social programmes will naturally tend to serve the world view and interests of those in power. Utopian visions

necessarily provide an outline of a desirable society, including the sort of standards of care, protection and opportunity desired for all people - in particular the disadvantaged.

Political arrangements determine the material and organizational arrangements that are made to provide this care - and also influence the attitudes in a given community concerning people, problems and proposed solutions.

The re-construction of society requires a re-ordering of priorities, and a re-allocation of resources. Facilities can be created with resources, and governments control resources. The availability of funds for mental health care - and answerability for appropriate use of these funds - is a particularly relevant example of the influence of politics upon psychiatry.

Nevertheless, the planning of treatment facilities for the chronic mental patient should primarily reflect the symptoms and needs of the patient, not the ideologies and interest of the politician.

The limited achievements of both radical and reformist strategies to date should lead us to re-examine our goals. Perlman and Gurin (1972) suggest that goals have generally been too vast and ill-defined to make success possible. Most importantly, they point to the fact that goals have been based largely on ideological convictions and hopes, and objectives have often been specified according to these ideological positions.

"It is now important ... to separate value issues from instrumental questions if progress is to be made in developing a more effective practice. This is not to deny the central place that values occupy in the setting of goals for change ... But effectiveness in achieving objectives must become the object of analysis and research, rather than a matter of faith and conviction" (Perlman and Gurin, 1972, p.273).

Receptivity to the goals of the patient must be part of our new vision for more humane mental health care - it may be that the world view of the schizophrenic is less subject to fashion than that of the psychologist. Psychology must become a discipline that listens to how people define their problems, and not one that, through ideology, defines the problems for them. (Zautra, 1983). And as we approach our goals, we must remain aware of the caveat:

"Flexibility and openness to new ideas ... need to be continuously fostered if one to avoid setting up a new status quo" (Rappaport, 1977, p.35).

Birley concludes a review of the asylum "with an acute nervousness about all social panaceas", and observes that "total solutions are always dangerous, and often disastrous" (Birley, 1986, p.331). Declaring that reform is less exciting, but more productive than revolution he suggests imaginative and varied

contributions to what Karl Popper calls piecemeal social engineering.

For many years the ideas of hospital and community provision have been polarized, but what we really need is an appreciation of the fact that the complex human problems presented by the chronically mentally ill cannot be solved by one discipline alone, and that social change is a process, and not an end-product.

#### 9.4 Planning for transition

What we particularly need to extract from our experience of recent years is guidelines for successful transition of services from the institution to the community. Wing (1980) observes:

"If the decision to accelerate the run-down of the large mental hospitals had been contingent on an adequate build-up of a different kind of service for those who remained chronically disabled there might have been a smoother transition, a more planned transfer of skills, less burden placed on relatives, less experience of prison or destitution among the mentally ill, and fewer side effects within the hospitals" (p.222).

The development of community psychiatric services is increasingly dependent upon the relocation of resources currently invested in large institutions, and successful management of this transition presents major challenges.

The British approach to transition of services includes a programme of action research, and educational and consultancy activities designed to assist people currently engaged in this challenge:

"Sustained progress towards local services ... requires a strategic framework to guide change ...the purpose of this framework is to foster energetic leadership in each district and widespread participation in creating new local services" (Towell and McAusland, 1984, p.8).

Planning is an opportunity for learning which only becomes effective when all those with a stake in the outcome are involved. Braisley, Davis and McAusland assert that

"The intensive demands on staff resources required in the short-term by this approach are more than balanced by ... the mobilization of skills and positive commitment to making things work which come from knowing personally the people being planned for" (Towell and McAusland, 1984, p.7).

It is essential to include in the making of the plans those who will be affected by them. 'Locality planning' implies consultation and negotiation with local consumers about needs and how they can be jointly met. Voluntary bodies, parents and relatives should be included, and the important role played by general practitioners in outpatient management must be recognized. As wide a range as possible of people with different interests should be involved, and it is useful to sponsor sub-

groups to undertake well-defined tasks at grass-roots level (for example, family support groups can be effective and powerful, especially in the role of advocacy). It is important that staff be reassured that service changes will not lead to redundancies in order to encourage commitment and support. Political support must be mobilized for a broad vision of future services.

Survival in the community requires active engagement with the new environment. Inpatients scheduled for discharge must be helped to regain basic living skills lost during lengthy hospitalization. Patients should be actively involved in planning for discharge (for example in negotiations for suitable accommodation). Friendship links between patients should be respected, and external placements made accordingly, so that the process of discharge does not sweep away personal contacts.

While rehabilitation programmes should be community-based where possible, it is vital to remain aware of the need to maintain hospital standards whilst developing local services. Quality of life for inpatients needs to be maintained, the anxieties of relatives must still be met, and the morale of staff in hospitals that are being run down may have to be retained over quite long periods.

Objectives should be checked against achievements at pre-determined intervals, and services must be under constant review to ensure that they relate to local community needs. They must be flexible, and adapt in the light of experience.

9.5 Directions for the future: focussing our aims and restricting our claims.

A review of the major cycles of reform in mental health care in the western world reveals the accumulation of a considerable body of experience to aid in meeting the challenge to increase effectiveness of plans for long-term care. Talbott (1978) warns that:

"No longer can anyone maintain that state hospitals must be emptied simply because they are 'so awful' - because the settings we have allowed to replace them are just as bad as their predecessors. No, the answer lies in looking at the problem again. And the problem is the treatment and care of the chronic mental patient" (p.38).

The idea of blame has always played an essential part in our conceptualization of mental illness. We blamed the individual for his deviance, and founded the 'moral institution' to cure him. When blame shifted to the asylum itself, or a repressive society, it was thought that cure would follow 'decarceration' and social reform.

At last we are considering systems which value and respect diversity (rather than associate deviance with blame), and which base social interventions on the goal of equitable distribution of material and psychological resources, rather than an improved socialization of all to a single standard (Rappaport, 1977).

Comprehensive planning which takes into account the needs of the chronic mental patient, the family, the community and the mental health worker is increasingly in evidence, and accountability and consumer participation are part of all the blue-prints we have considered. The countries discussed are starting to provide services which nurture strengths, and which accept, but do not foster, dependence. Facilities are more egalitarian, and most of the mistakes that have been made in recent years have erred on the side of unrealistic optimism, rather than exploitative or discriminatory repression.

If we consider that de-institutionalization was a protest movement - a protest against the lack of civil rights and dignity granted the mental patient, and against the custodialism, paternalism and repression characterising the mental institutions - this brief examination of some current guiding principles and model plans for community services indicates considerable and heartening progress.

## BIBLIOGRAPHY

Abbott, B. 1978.

Tailoring the service system to the community. Hospital and Community Psychiatry, 29, 35 - 36.

Abroms, G.M. 1969.

The new eclecticism. Archives of General Psychiatry, 20, 514 - 523.

Abroms, E.M. 1983.

Beyond eclecticism. American Journal of Psychiatry, 140, 740 - 745.

Asimus, D.M. 1976.

Predicting interprofessional alliances in the eighties (Open forum). Hospital and Community Psychiatry, 27, 732 - 733.

Bachrach, L.L. 1977.

Deinstitutionalization of mental health services in rural areas. Hospital and Community Psychiatry, 28, 669 - 672.

Bachrach, L.L. 1978.

A conceptual approach to deinstitutionalization. Hospital and Community Psychiatry, 29, 573 - 578.

Bachrach, L.L. 1979.

Planning mental health services for chronic patients. Hospital and Community Psychiatry, 30, 387 - 393.

Bachrach, L.L. 1980.

Is the least restrictive environment always the best? Sociological and semantic implications. Hospital and Community Psychiatry, 31, 97 - 103.

Bachrach, L.L. 1984.

Research on services for the homeless mentally ill.  
(Conference Report). Hospital and Community Psychiatry, 35,  
910 - 913.

Barnes, M. and Berke, J. 1973.

Mary Barnes: Two accounts of a journey through madness.  
Harmondsworth: Penguin Books (first published 1971).

Barter, J.T., Queirolo, J.F. and Ekstrom, S.P. 1984.

A psychoeducational approach to educating chronic mental  
patients for community living. Hospital and Community  
Psychiatry, 35, 793 - 797.

Becker, P. and Bayer, C. 1975.

Preparing chronic patients for community placement: A  
four-stage treatment program. Hospital and Community  
Psychiatry, 26, 448 - 450.

Becker, T. 1985

Psychiatric reform in Italy - How does it work in Piedmont?  
British Journal of Psychiatry, 147, 254 - 260.

Beels, C.C. 1981.

Social support and schizophrenia. Schizophrenia Bulletin, 7,  
58 - 72.

Bellack, A.A. (Ed.). 1984.

Schizophrenia: Treatment, management and rehabilitation.  
Orlando: Grune and Stratton.

Bennett, D.H. 1973.

Community psychiatry. Community Health, 5, 58 - 64.

Biles, D. and Mulligan, G. 1973.

Mad or bad? The enduring dilemma. British Journal of  
Criminology, 13, 275.

Birley, J.L.T. (Ed.). 1986.

Books reconsidered: The discovery of the asylum. British Journal of Psychiatry, 148, 330 - 331.

Bishee, C.C. 1979.

Patient education in psychiatric illness. The Journal of Orthomolecular Psychiatry, 8, 239 - 247.

Blain, D. 1975.

Twenty-five years of hospital and community psychiatry: 1945 - 1970. Hospital and Community Psychiatry, 26, 605 - 609.

Boffey, P.M. 1986, March 16.

Schizophrenia puzzle: Toll rises amid hope. The New York Times, 31 - 32.

Boyajian, L. 1975.

History strikes again: Two 20th-century reform ventures. Hospital and Community Psychiatry, 26, 17 - 21.

Braun, P., Kochansky, G., Shapiro, R., Greenberg, S., Gudeman, J.E., Johnson, S. and Shore, M.F. 1981.

Overview: Deinstitutionalization of psychiatric patients, a critical review of outcome studies. American Journal of Psychiatry, 138, 736 - 749.

Brown, G.W., Bone, M., Dalison, B. and Wing, J.K. 1966.

Schizophrenia and social care: A comparative follow-up study of 339 schizophrenic patients. London: Oxford University Press.

Brown, G.W., Birley, J. and Wing, J.K. 1972.

Influence of family life on the course of schizophrenic disorders: A replication. British Journal of Psychiatry, 121, 241 - 258.

Brown, P. 1980.

Social implications of deinstitutionalization. Journal of Community Psychology, 8, 314 - 322.

Brown, P. (Ed.). 1985(a).

Mental health care and social policy. London: Routledge and Kegan Paul.

Brown, P. 1985(b).

The transfer of care: Psychiatric deinstitutionalization and its Aftermath. London: Routledge and Kegan Paul.

Butterworth, C.A. and Skidmore, D. 1983.

Caring for the mentally ill in the community. Beckenham: Croom Helm.

Carpenter, M.D. 1978.

Residential placement for the psychiatric patient: A review and evaluation of the literature. Schizophrenia Bulletin, 4, 384 - 398.

Coe, R.M. and Pepper, M. 1978.

Community medicine: Some new perspectives. New York: McGraw-Hill.

Cooper, D. 1967.

Psychiatry and anti-psychiatry. London: Tavistock.

Cooper, D. 1971.

The death of the family. London: Allen Lane.

Cooper, D. 1978.

The language of madness. London: Allen Lane.

Crawford, J.L. (Ed.). 1981.

Psychiatric reform in Trieste, Italy: Implications for community psychology in the United States (Editorial opinion). Journal of Community Psychology, 9, 276 - 279.

Davis, E. 1978.

The role of the psychiatrist. Hospital and Community Psychiatry, 29, 33.

Davis, J. 1978.

The rights of chronic patients. Hospital and Community Psychiatry, 29, 39.

Deutsch, A. 1949.

The mentally ill in America: A history of their care and treatment in colonial times (2nd ed.). New York: Columbia University Press.

Doll, W. 1976.

Family coping with the mentally ill - an unanticipated problem of de-institutionalization. Hospital and Community Psychiatry, 27, 183 - 185.

Drake, R.E. and Cotton, P.G. 1986.

Depression, hopelessness and suicide in chronic schizophrenia. British Journal of Psychiatry, 148, 554 - 559.

Elpers, J. 1978.

Legal constraints in providing community care. Hospital and Community Psychiatry, 29, 37.

Engel, G.L. 1980.

The clinical application of the biopsychosocial model. American Journal of Psychiatry, 137, 535 - 544.

Forrest, A., Affleck, J. and Zealley, A. (Eds.). 1978.

Companion to psychiatric studies (2nd ed.). Edinburgh: Churchill Livingstone.

Foudraine, J. 1974.

Not made of wood: a psychiatrist discovers his own profession. London: Quartet Books. (Original work published 1971.).

Francis, H. 1978.

Towards community medicine: the British experience. In A.E. Bennett (Ed.), Recent advances in community medicine (Ch. 1). Edinburgh: Churchill Livingstone.

Gochman, S.I. 1981.

On the road to 1984: Twenty questions on the psychology of social action. Journal of Community Psychology, 9, 103 - 117.

Goffman, E. 1961.

Asylums. New York: Anchor Books.

Green, R. and Rabiner, C. 1978.

Making rehospitalization part of the plan. Hospital and Community Psychiatry, 29, 36 - 37.

Griffiths, R.D. 1974.

Rehabilitation of chronic psychotic patients: An assessment of their psychological handicap, an evaluation of the effectiveness of rehabilitation. and observations of the factors which predict outcome. Psychological Medicine, 4, 316 - 325.

Hall, J. 1986.

J.C.P.T. sub-group on mental illness: Planning and implementing a local psychiatric service. (Unpublished paper.)

Haveman, M.J. 1986.

Dehospitalization of psychiatric care in The Netherlands. Acta Psychiatrica Scandinavica, 73, 456 - 463.

Hawkins, D.R. 1972.

The development of an integrated community system for the effective treatment of schizophrenia. In David Hawkins and Linus Pauling (Eds.), Orthomolecular psychiatry: Treatment of schizophrenia. New York: W.H. Freeman.

Herz, M.I. 1984.

Recognizing and preventing relapse in patients with schizophrenia. Hospital and Community Psychiatry, 35, 344 - 349.

Hibler, M. 1978.

The problems as seen by the patient's family. Hospital and Community Psychiatry, 29, 32 - 33.

Hirsch, S.R. and Leff, J.P. 1975.

Abnormalities in parents of schizophrenics: A review of the literature, and an investigation of communication defects and deviances. (Maudsley Monographs No. 22.) London: Oxford University Press.

Hogarty, G.G., Goldberg, S.C., Schooler, N.R., Ulrich, R.F. 1974.

Drug and sociotherapy in the aftercare of schizophrenic patients. Archives of General Psychiatry, 31, 603 - 618.

Holder, H. 1978.

Building accountability into the service system. Hospital and Community Psychiatry, 29, 38 - 39.

Huey, K. 1976.

Special report: Alternatives to mental hospital treatment: Highlights from a conference in Madison, Wisconsin. Hospital and Community Psychiatry, 27, 186 - 192.

Hume, C. and Pullen, I. 1986.

Rehabilitation in psychiatry: An introductory handbook.

Edinburgh: Churchill Livingstone.

Ingelby, D. 1981.

The politics of psychology: Review of a decade. Psychology and Social Theory, 2, 4 - 18.

Intagliata, J. 1982.

Improving the quality of community care for the chronically mentally disable: The role of case management. Schizophrenia Bulletin, 8, 655 - 673.

Ivey, G. 1986.

Elements of a critical psychology. Psychology in Society, 5, 4 - 27.

James, J.F. 1978.

Principles in developing a community support system. Hospital and Community Psychiatry, 29, 34 - 35.

Johnson, E., Crockett, J., Crumpton, E., Froehlich, K. and Messick, J. 1975.

Adopting new models for continuity of care: The ward as mini-mental-health-center. Hospital and Community Psychiatry, 26, 601 - 604.

Jones, K. 1982.

Scull's dilemma. British Journal of Psychiatry, 141, 221 - 226.

Jones, K. and Poletti, A. 1985.

Understanding the Italian experience. British Journal of Psychiatry, 146, 341 - 347.

Jones, K. and Poletti, A. 1986.

The 'Italian experience' reconsidered. British Journal of Psychiatry, 148, 144 - 150.

Jones, M. 1975.

Community care for chronic mental patients: The need for a reassessment. Hospital and Community Psychiatry, 26, 94 - 98.

Joseph, D. and Peele, R. 1975.

Ethical issues in community psychiatry. Hospital and Community Psychiatry, 26, 295 - 299.

Kaplan, H.I. and Sadock, B.J. 1981.

Modern synopsis of comprehensive textbook of psychiatry III (3rd ed.). Baltimore: Williams and Wilkins.

Kunze, H. 1985.

Rehabilitation and institutionalization in community care in West Germany. British Journal of Psychiatry, 147, 261 - 264.

Lackner, J. 1978.

The chronic patient: Perspectives from the 29th institute on hospital and community psychiatry: An overview of the issues. Hospital and Community Psychiatry, 29, 29 - 31.

Laing, R.D. 1959.

The divided self. London: Tavistock.

Laing, R.D. and Esterson, A. 1964.

Sanity, madness and the family. London: Tavistock.

Laing, R.D. 1967.

The politics of experience and the bird of paradise. Harmondsworth: Penguin.

Lamb, H.R. and Goertzel, V. 1977.

The long-term patient in the era of community treatment. Archives of General Psychiatry, 34, 679 - 692.

Lamb, H.R. and Oliphant, E. 1979.

Parents of schizophrenics: Advocates for the mentally ill. New Directions for Mental Health Services, 2, 85 - 91.

Lamb, H.R. and Peele, R. 1984.

The need for continuing asylum and sanctuary. Hospital and Community Psychiatry, 35, 798 - 802.

Lamb, H.R. 1984.

Deinstitutionalization and the homeless mentally ill. Hospital and Community Psychiatry, 35, 899 - 907.

Lazarus, S. 1986.

The role and responsibility of the psychologist in the South African social context. Dissertation proposal, Department of Psychology, University of Cape Town.

Leavy, R.L. 1983.

Social support and psychological disorder: A review. Journal of Community Psychology, 11, 3 - 21.

Leff, J. 1976.

Schizophrenia and sensitivity to the family environment. Schizophrenia Bulletin, 2, 566 - 574.

Lehman, A.F. 1983.

The well-being of chronic mental patients: Assessing their quality of life. Archives of General Psychiatry, 40, 369 - 373.

Lewine, R.R.J. 1982.

Overview and reflections. Schizophrenia Bulletin, 8, 652 - 654.

Lieberman, H.J., Camponelli, P.C., Hahn, D., Beck, J., Western, R., Sacks, J.A.Y., Gordon, A., and Tabot, A. 1985.

The community residential treatment service: Developing a continuum of prosthetic environments for the chronically disabled. Journal of Community Psychology, 13, 46 - 53.

Martin, H. 1985.

How to gauge quality of treatment. Newsletter of National Alliance for the Mentally Ill (N.A.M.I.), 6, (3), 3.

Mathai, P.J. and Gopinath, P.S. 1985.

Deficits of chronic schizophrenia in relation to long-term hospitalization. British Journal of Psychiatry, 148, 509 - 516.

May, P.R.A. 1975.

Adopting new models for continuity of care: What are the needs? Hospital and Community Psychiatry, 26, 599 - 601.

McCranie, E.W. and Mizell, T.A. 1978.

Aftercare for psychiatric patients: Does it prevent rehospitalization? Hospital and Community Psychiatry, 29, 584 - 587.

MIND. 1983.

Components of a new service. Common concern. London: National Association for Mental Health.

Morrisey, J.P. and Goldman, H.H. 1984.

Cycles of reform in the care of the chronically mentally ill. Hospital and Community Psychiatry, 35, 785 - 793.

Neppe, V.M. 1982.

Schizophrenia: A guide to clinical diagnosis. South African Journal of Hospital Medicine, April, 88 - 92.

Nordwind, B.L. 1982

Developing an enforceable 'right to treatment' theory for the chronically mentally disabled in the community.

Schizophrenia Bulletin. 8, 642 - 651.

O'Connor, J. 1984.

Conference Report: Issues in the treatment of chronic mental patients. Hospital and Community Psychiatry, 35, 989.

O'Donohue, W.T., Hanley, G.L. and Krasner, L. 1984.

Toward the explication of the value context of the community psychologies. Journal of Community Psychology, 12, 201 - 205.

Papeschi, R. 1985.

The denial of the institution: A critical review of Franco Basaglia's writings. British Journal of Psychiatry, 146, 247 - 254.

Pattison, E.M., Hackenberg, D.A., Wayne, E. and Wood, P. 1976.

A code of ethics for a community mental health program. Hospital and Community Psychiatry, 27, 22-32.

Pepper, B., Kirshner, M. and Ryglewicz, H. 1981.

The young adult chronic patient: Overview of a population. Hospital and Community Psychiatry, 23, 463 - 469.

Perlman, R. and Gurin, A. 1972.

Community organization and social planning. New York: John Wiley and Sons.

Peterson, R. 1982.

What are the needs of chronic mental patients? Schizophrenia Bulletin, 8, 610 - 616.

Progrebin, M.R. and Regoli, R.M. 1985.

Mentally disordered persons in jail. (Editorial). Journal of Community Psychology, 13, 409 - 412.

Presley, A.S., Grubb, A.B. and Semple, D. 1982.

Predictors of successful rehabilitation in long-stay patients. Acta Psychiatrica Scandinavica, 66, 83 - 88.

Rappaport, J. 1977.

Community psychology: Values, research and action. New York: Holt, Rinehart and Winston.

Recommendations of APA's Task Force on the Homeless Mentally Ill.  
1984.

Hospital and Community Psychiatry, 35, 908 - 909.

Reed, J. and Lomas, G. (Eds.). 1985.

Psychiatric services in the community: Developments and innovations. Beckenham: Croom Helm.

Richman, A. and Barry, A. 1985.

More and more is less and less. The myth of massive psychiatric need. British Journal of Psychiatry, 146, 164 - 168.

Rizzardo, R., Rovea, A. and Magni, G. 1986.

The general practitioner and the psychiatric health service in Italy after the reform: Opinions and experiences in an urban district. Acta Psychiatrica Scandinavica, 73, 234 - 238.

Romme, M.A.J. 1974.

Social psychiatry and the prevention of mental hospital stay. Mental Health Society, 1, 56 - 61.

Rosen, I.M. 1976.

In further defense of the state hospital: Its rehabilitative function. Hospital and Community Psychiatry, 27, 820 - 821.

Roth, M. and Bluglass, R. (Eds.). 1985.

Psychiatry, human rights and the law, Cambridge: Cambridge University Press.

Rothman, D.J. 1971.

The discovery of the asylum: Social order and disorder in the new republic. Boston: Little Brown.

Ryan, W. 1971.

Blaming the victim. New York: Random House.

Scheff, T.J. 1966.

Being mentally ill. Chicago: Aldine.

Scull, A.T. 1977.

Decarceration: Community treatment and the deviant: a radical view. Englewood Cliffs: Prentice-Hall.

Scull, A.T. 1979.

Museums of madness. London: Allen Lane.

Shadish, W.R. Jr and Bootzin, R.R. 1981.

Nursing homes and chronic mental patients. Schizophrenia Bulletin, 7, 488 - 498.

Schaeffer, D.E., Schulberg, H.C. and Beard, G. 1978.

Effects of community mental health services on state hospital admissions: A clinical-demographic study. Hospital and Community Psychiatry, 2, 578 - 583.

Sharfstein, S.S. and Nafziger, J.C. 1976.

Community care: Costs and benefits for a chronic patient. Hospital and Community Psychiatry, 27, 170 - 173.

Sheats, J.L., Prevost, J.A. and Reihman, J. 1982.

Young adult chronic patients: Three hypothesized sub-groups. Hospital and Community Psychiatry, 33, 197 - 203.

Smith, A.C. 1982.

Books reconsidered: The divided self. British Journal of Psychiatry, 140, 637 - 642.

Smith, M. 1986.

Biopsychosocial model in the outpatient management of schizophrenia. Psychiatry and Clinical Psychology in practice, 1, (2), pp.23, 26, 27.

Stein, L.I. and Test, M.A. (Eds.). 1978.

Alternatives to mental hospital treatment, New York: Plenum Press.

Stevensen, I. 1979.

Comments on 'Is outcome for schizophrenia better in non-industrial societies? The case of Sri Lanka,' by Nancy Waxler. The Journal of Nervous and Mental Diseases, 167, 159-160.

Stickney, P. 1976.

Gaining community acceptance: Some practical tips. Hospital and Community Psychiatry, 27, 353.

Szasz, T. 1961.

The myth of mental illness. New York: Harper.

Talbott, J.A. 1978.

The death of the asylum: A critical study of state hospital management, services and care. New York: Grune and Stratton.

Talbott, J.A. 1984(a).

The chronic mental patient: 5 years later. Orlando: Grune and Stratton.

Talbott, J.A. (Ed.). 1984(b).

The need for asylum, not asylums (Commentary). Hospital and Community Psychiatry, 35, 209.

Tantam, D. 1985.

Alternatives to psychiatric hospitalization. British Journal of Psychiatry, 146, 1 - 4.

Test, M.A. and Stein, L.I. 1978.

Community treatment of the chronic patient: Research overview. Schizophrenia Bulletin, 4, 350 - 364.

Therborn, G. 1980.

the ideology of power and the power of ideology. London:  
Verso.

Thorpe, R. and Petruchenia, J. (Eds.) 1985.

Community work or social change? An Australian perspective.  
London: Routledge and Kegan Paul.

Towell, D. and McAusland, T. (Eds.). 1984, Oct. 25.

Managing psychiatric services in transition. Health and  
Social Service Journal, 1 - 8.

Turner, J. 1978.

Defining a community support system. Hospital and Community  
Psychiatry, 29, 31 - 32.

Valdes, N.P. and Montaluo, N.C. 1985.

Psychology in the rehabilitation of the chronic mental  
patient. Journal of Community Psychology, 13, 155 - 161.

Van Putten, T. 1978.

Drug refusal in schizophrenia: Causes and prescribing  
hints. Hospital and Community Psychiatry, 29, 110 - 112.

Vaughan, C. and Leff, J.P. 1976.

The influence of family and social factors on the course of  
psychiatric illness. British Journal of Psychiatry, 129, 125  
- 137.

Waxler, N.E. 1979.

Is outcome for schizophrenia better in non-industrial  
societies? The case of Sri Lanka. The Journal of Nervous  
and Mental Disease. 167, 144- 158.

Wilson, H.S. 1982.

Deinstitutionalized residential care for the mentally  
disabled: The Soteria House approach. New York: Grune and  
Stratton.

Wing, J.K. 1976.

Zusman, J. and Bertsch, E. (Eds.). The future role of the state hospital (Review). British Journal of Psychiatry, 128, 602.

Wing, J.K. 1978.

The social context of schizophrenia. American Journal of Psychiatry, 135, 1333 - 1339.

Wing, J.K. 1979.

Principles of rehabilitation of the mentally ill, (Published Seminar). Inter-Metropolitan Regional Group Study Day at the Social psychiatry Unit, Institute of Psychiatry, Maudsley Hospital, London.

Wing, J.K. 1980.

Innovations in social psychology. Psychological Medicine, 10, 219 - 230.

Wing, J.K. and Morris, B. 1981.

Handbook of psychiatric rehabilitation practice, Oxford: Oxford University Press.

Wolfe, A.W. 1981.

Discussion. Schizophrenia Bulletin, 7, 173 - 177.

Wootton, B. 1980.

Psychiatry, ethics and the criminal law. British Journal of Psychiatry, 136, 525 - 532.

Zautra, A. 1983.

The measurement of quality in community life: Introduction to the special issue. Journal of Community Psychology, 11, 83 - 87.