

*The Joint Commission on Mental Illness recognized the need for new patterns of care for mental patients. A task force was formed to deal with this problem. Here is a summary report on what was done, what was found, and what recommendations were made.*

## **NEW PERSPECTIVES OF MENTAL PATIENT CARE**

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**I**N 1957, the Joint Commission on Mental Illness and Health, operating under a general mandate from Congress, formed a task force on new perspectives of mental patient care with the following mission: (a) to describe mental patient care systems as they exist and explore assumptions on which they are based; (b) to look for new and promising leads in ways of providing better mental patient care; (c) to make specific and general recommendations, based on opinions and suggestions of experts in the field, as well as on current experiences, with new approaches under way in various communities across the nation.

The task force, consisting of eight professionals headed by Morris S. Schwartz, Ph.D., began its work early in 1957. Among the eight, there were six social scientists, an expert on rehabilitation, and a psychiatrist with considerable experience in community mental health practice.\* The group divided itself into three teams, each one assuming responsibility for the following elements of mental patient care systems: (a) services and facilities for outpatient care; (b) services and facilities

for inpatient care; (c) services and facilities for expatient care (i.e., for persons discharged or on leave from mental hospitals).

After several months of planning the three teams began a series of field visits which was to carry them to all sections of the United States and into Canada during the remainder of the first year of operation. The teams visited 112 separate facilities providing care to mental patients. Thirty of these were outpatient facilities, 32 inpatient facilities, and 50 expatient facilities. The teams observed aspects of the programs in each facility and interviewed individuals responsible for specific activities as well as the over-all operations of the facility. Institutions and personnel visited included referral services of mental health associations, emergency clinics, traveling clinics, court clinics, public health programs in psychiatry, private practitioners, psychiatric sections of general hospitals, small private hospitals, large and medium-size state hospitals, veterans' administration hospitals, home care programs, day hospitals, rehabilitation centers, training institutes, sheltered workshops, half-way houses, after-care clinics, as well as a number of agencies and services in public welfare, public health nursing, social work, and vocational rehabilitation.

In addition to these field visits, the

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\* Members of the task force in addition to the authors and Dr. Schwartz were Charlotte Green Schwartz, M.A.; Elliot G. Mishler, Ph.D.; Simon S. Olshansky, M.A.; Jesse R. Pitts, Ph.D.; and Rhona Rapaport, Ph.D.

teams interviewed 179 experts in the mental health field, 52 concerned primarily with outpatient care, 48 with outpatient care, and 79 individuals concerned with inpatient care and with a more general interest in the field. Experts included nurses, psychologists, social workers, psychiatrists, physicians in general practice, sociologists, anthropologists, administrators, research persons in psychiatry and mental health.

The universally cordial and interested response of institutions and individuals visited is worthy of special note. There is undoubtedly among professionals throughout the country great interest in devising new and more effective ways of providing mental patient care, ways and means that will permit new understandings of the nature of specific mental illnesses to be applied in effective action programs. Interviewed experts displayed impatience with the slowness of change and the anachronisms that pervade our care of the mentally ill and which prevent the most effective application of new knowledge. There is, furthermore, awareness of serious manpower shortages in the mental health field, of the generally low status and the substandard working conditions and lack of opportunities for personnel and for professional growth, and lack of funds—all of which exist in most of our public mental care systems. Throughout the field there is some recognition that part of the "mental illness problem" lies in the nature of the institutions themselves that provide care, and that the problem can be, in large part, traced historically back to the 19th century approach to the care of a special class of indigent persons. These included the deviant and the unpredictable. They were most often "committed" to mental hospitals through quasi-criminal court proceedings. These hospitals, in turn, were neglected by the legislators, avoided by the public and the community, and relegated to an inferior position by the medical profession, pub-

lic health authorities, as well as other professional and scientific groups.

Despite this dismal historical legacy which still affects the mental health picture in many parts of our country, many workers in the field of mental health have seen signs of a major change. These include increased interest in the mental health field by the public, often backed by increased legislative appropriations, the greater numbers of persons entering the mental health field and increases in research and training opportunities, sparked by the National Institute of Mental Health. New forms of mental patient care which imply an improvement of the general status of the mental patient are in evidence. There has also been a rapid development of community psychiatry in many states, often organized and financed under new community mental health acts, involving a partnership of federal, state, and local governmental units. Psychiatric inpatient units in general hospitals are now admitting as many mental patients each year as the state hospitals. In many instances the dignity and self-respect of the hospitalized mental patient is maintained by a simplification, or an outright abandonment, of traditional court commitment procedures. Psychiatric facilities, both outpatient and inpatient, are being used in many communities much sooner than before in the course of psychiatric disturbances. Mental health consultation services are being sought by many individuals and agencies, permitting a wider application of scarce psychiatric and mental health resources. Professionals who we interviewed were particularly excited about new methods of treatment that have been developing in psychiatry in recent years. These include social therapies and rehabilitation, combined individual and group psychotherapy, as well as new therapeutic possibilities opened up by developments in neurophysiology and neuropsychopharmacology.

However, many experts point to the

complexity of the relationship of psychiatric illness (and the psychiatric care system) to factors such as social class position, family and community disorganization, low economic status, lack of education and other variables. They urge that "mental illness" and "psychiatric care" be viewed in the perspective (and sometimes as the expression) of our culture and present-day society. For instance, many persons interviewed see the lack of funds and manpower as not simply a political or economic problem but a problem related to current values of our society, and particularly to general attitudes toward those individuals who fail to carry out their expected role obligations, such as being a successful school child, parent, or worker, or a positive contributor to neighborhood and community life. Experts also point to the disturbing lack of clarity regarding what is "mental illness." They also indicate that, in some cases and for some socioeconomic classes of our population, even the availability of mental care personnel and facilities will not necessarily mean that those who need treatment will seek it, or even benefit from it because of cultural differences between patients and treatment personnel. This has important implications for the development of appropriate care systems. Should, for example, all who fail in performance of expected roles be viewed as "sick"? Should only physicians, psychiatrists, and medical institutions take responsibilities for the care and treatment of the "mentally ill"?

During its second year the task force analyzed and wrote up its material in terms of nine themes of concern. These themes also represent the general recommendations that experts across the country urged upon us as we considered the reorganization, reconceptualization, and further development of psychiatric care. For purposes of analysis and write-up they have been specifically applied to

each element of the care system as follows:

- A. Outpatient themes of concern:
  1. Providing immediate help for the emotionally disturbed;
  2. Extending the outpatient system in the community;
  3. Broadening the conception of help.
- B. Inpatient themes of concern:
  1. Individualizing care and treatment;
  2. Breaking down the barriers between the hospital and community;
  3. Developing a therapeutic milieu.
- C. Expatient themes of concern:
  1. Tailoring care to expatient's needs;
  2. Grading stress;
  3. Providing continuity of care.

The forthcoming Joint Commission monograph, "Social Perspectives of Mental Patient Care," discusses each of these themes in detail.

Providing immediate help for the emotionally disturbed implies the development of emergency clinic and consultation services available at the times of crisis, with a minimum of delay. It also implies "open door" policies that encourage follow-up and the frequent use of consultation services. Such programs are now limited because of lack of funds and manpower, but there are more fundamental organizational considerations that must be overcome. For instance, the overspecialization of private and public psychiatric services leads to admission policies and procedures that are not directed to immediate help; on the contrary, they tend to raise barriers to eligibility, such as age, income, education, type of psychiatric problem, intelligence, "readiness" for treatment, and so on.

Extending the outpatient care in the community means several things. First, it means the development of mental health consultation services to the many community agencies that are involved in helping individuals and families. Second, it means to develop, in specific ways, the helping role of nonmedical "caretakers" who work with individuals

and families in community settings such as schools, public health and social agencies, industry, and others. This implies the need for preservice and continuing education in mental health subjects for many professionals as well as organized systems of mental health consultation. Lastly, special mental care and treatment programs must be developed for specific types of individuals in need of treatment and rehabilitation. These include such programs as day hospitals, therapeutic summer day camp programs, group recreation and community living programs for deprived and delinquent children, training and rehabilitation centers for the mentally retarded, the aged, and others.

Broadening the conception of help means, first, taking a broad look at our conceptions of "mental illness" itself and our traditional medical orientation on this subject. For too long the medical orientation to mental illness has been the search for the noxious agent, and its removal or neutralization to affect a "cure." Mental illness is no less complicated than somatic illness. Coping with mental illness must include an operational awareness of the complex biological, sociological, cultural, and psychological factors that underlie most psychiatric problems. This awareness in turn will permit a fuller utilization of nonmedical practitioners in responsible and effective roles in helping mental patients. A broadened conception of mental illness and mental patient care will help to put these issues in their proper perspective and enable systems of professional education and training to be developed that will be appropriate not only to the many special functions of mental health practitioners but also to the nature and degree of responsibility that both medical and nonmedical mental health practitioners must assume in their work.

Individualization of care and development of a therapeutic milieu are themes that

have many implications for public as well as private mental hospitals. Changes in attitudes and in staff-patient relationships can be planned and achieved, even in the face of the professional manpower shortage. Treating patients with dignity and ascribing worth to them, not relegating them to roles in large public hospitals that force further loss of personal identity, will help either to prevent or shorten institutionalization and, often, further irreversible deterioration. Changes in policies and procedures can eliminate the use of large state hospitals for receiving individuals who are not in need of psychiatric treatment (the aged indigents, for example). However, individualized care in a therapeutic milieu will cost far more money than the states currently are appropriating year-by-year. The Joint Commission has made a recommendation in this regard involving a plan for federal grants-in-aid.

Breaking down of the barriers between hospital and community involves not only clinical and rehabilitation services available before and after hospitalization, day care and foster home programs, but also interchange of personnel between hospital and community services, the development of volunteer programs, and the use of hospital facilities themselves by community groups. Any new hospital should be a small, active treatment center in the community, preferably with strong ties to universities in order to stimulate and develop professional education and research programs. Only by the concerted effort of state agencies, hospital boards and superintendents, community leaders, and volunteer mental health groups can this isolation be overcome, and a change in the traditional community attitudes of isolation, denial, and avoidance be brought about.<sup>1</sup>

The outpatient themes, tailoring care to outpatient needs, grading stress, and providing continuity of care, are of no less relevance than outpatient and in-

patient care. As broadened conceptions of help have been applied in recent years, we find concepts such as "re-education" and "rehabilitation" being specifically applied to individuals with mental, emotional, social and physical limitations and handicaps. These persons require long-term contact with community programs even though they no longer require hospitalization. After-care clinics, day hospitals, night hospitals, public health nursing services, foster family care, the half-way house, ex-mental patient social organizations, and social and vocational rehabilitation centers exist in small numbers here and there throughout the country. As more patients are being discharged into the community from mental hospitals, the importance of these community after-care programs becomes self-evident, especially in our large metropolitan population centers. To be sure, the new philosophy embraces the idea that many patients will have to return to a hospital setting during the course of their mental or emotional disturbance, but no patient should have to return to the hospital because of lack of appropriate after-care services within his reach in his own community.

The conclusions and recommendations of the Task Force on Patterns of Patient Care are summarized in the Joint Commission's final written report as follows:

" . . . advanced programs are relatively rare and unevenly distributed, with the large majority of state hospitals still custodial and punitive. The thesis of the final report, that the lag in the treatment of the mentally ill reflects a fundamental pattern of social rejection, is nowhere better evidenced than by the continued existence of these 'hospitals' that seem to have no defenders but endure despite all attacks . . . it is evident that the boundaries of responsibility among different mental health workers from each other often mean that the patient receives fragmented and discontinuous treatment and does not find his way to an appropriate treatment resource. . . . Above all, the field may be characterized as suffering from two major lacks: verifiable knowledge and competent

manpower. The new programs do nothing to solve the manpower problems, at least in the short-term view, since they require more and better trained personnel than are found typically in our treatment institutions . . . 'pre-conditions' of adequate patient care programs must first be established if we are to look forward to real breakthroughs. These necessary preconditions are funds for personnel, training and research; the replacement of political by professional control of mental health agencies; and the development of a community atmosphere that is receptive to new ideas for the treatment of mental patients."<sup>2</sup>

The task force offers guide lines rather than prescriptions for action. It urges that the following five principles be used as mental health leaders initiate changes in patient care systems. They are: (1) a comprehensive orientation; (2) a planned approach; (3) diversification of services; (4) flexibility of organizational response; and (5) an operational focus on patient needs. It suggests that experimentation with various models be instituted for helping institutions—models such as the home in addition to the conventional mental hospital (comprising an institution with a group of small cottages focusing on family living and interpersonal attempts to resocialize its members); the school (with primary help processes focusing on teaching social and other skills); a factory or workshop (in which learning of work habits and skills and performance of remunerative tasks are emphasized). A diversity of experimentation with such models might lead to the discovery of a "better fit" between the social organization of the treatment setting and patient needs. Diversity also should be effected through the development of specialized treatment units for certain types of individuals, such as children, geriatric patients, alcoholics, antisocial individuals, and psychopaths.

The task force hopes that its monograph will be widely read and discussed by mental health practitioners as they plan the psychiatric care systems of tomorrow. The ideas that have been ana-

lyzed in the forthcoming monograph have come from many individuals who gave generously of themselves during the task force field visits. We are confident that the report contains the "collective wisdom" of these leaders in psychiatric care and mental health practice. If public interest, excitement, and controversy concerning these ideas can be aroused and sustained, there should be

a bright future in the years ahead for the field of mental patient care, and the mission of the task force will have been, at least in part, discharged.

#### REFERENCES

1. Cumming, E., and Cumming, J. *Closed Ranks*. Cambridge, Mass.: Harvard University Press, 1957.
2. *Action for Mental Health*. The final report of the Joint Commission on Mental Illness and Health. New York, N. Y.: Basic Books, 1961.

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## A Public Health Explorer Post

"Through Public Health Practices We Can Live a Long and Peaceful Life," is the motto of History of Public Health Post No. 327. This Explorer Post of the Boy Scouts of America is located at 4127 West Liberty St., Cincinnati 5, Ohio, and its adviser is Robert J. Williams, R.S. According to a pamphlet the post has distributed, it "would like to correspond with other posts and exchange ideas on activities. If you have any difficulty in forming a post of this nature . . . we will help in any way that we can," the post advises. This Cincinnati post might also welcome correspondence with interested public health workers who wish to encourage groups like this which hold as follows: "Public Health Explorer Posts are cooperative, educational, programs in conjunction with high school students, their teachers, the Boy Scouts of America, and the Public Health Agency. . . . The aim . . . is to encourage young men to become interested in Public Health as a Vocation and to assure a better understanding of the profession and its services. . . . In this Atomic Age, many new fields are being discovered and viewed with Public Health significance. Therefore, there is and will be a need to stimulate high school students to seek careers in Public Health. We must provide guidance for those students who have expressed an interest. . . ."