Psychiatric Rehabilitation in the Community

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ANY FULL-SCALE PROGRAM in psychiatric rehabilitation must concern itself not only with what can be done for mental patients in the hospital (*1*) but also with what actually happens in the community. What services, if any, are given, and what might be done after the patient leaves the hospital?

It would indeed be fortunate if a mental patient could leave the hospital with the mental disease either cured or arrested, and also be completely "rehabilitated," so that he could at once assume his optimal role without further help or specialized attention. Such is obviously not so, in fact. Adequate statistics on rates of readmission to mental hospitals are not available. We do know they are high. It is a fair guess that they are significantly higher than they might be with concerted rehabilitative efforts in the hospital and in the posthospital period. In New York State, for example, one-third of all admissions to mental hospitals in 1947 are readmissions (*2*). Readmission rates, where available, may underestimate the problem, however, because patients returned from convalescent care or from some status other than full discharge may not be counted.

The extent of rehabilitation cannot be fully measured by readmissions because the patient may fall considerably short of his optimal social role even if he succeeds in remaining out of the hospital. Still more basically, it can never be expected that all patients can be fully rehabilitated on leaving the hospital, because the protected hospital setting is, of necessity, significantly different from many of the situations to which patients return.

Efforts can and have been made to simulate pressures of the outside world in hospital settings. For example, patients may be put through a graduated series of work tasks in which more and more rigid scheduling is involved. But the patient is still "protected" in the very special hospital sense, and there is the problem of readjustment to more normal social situations.

The Meaning of "Community"

Psychiatric rehabilitation has already been defined (*1*). But what is meant by "psychiatric rehabilitation in the community"? The term "community" is used in a variety of meanings. Within the social sciences, it can be used broadly and analytically to refer to persons who share or participate in something in common, for example, a community of language.

It may be used more narrowly to refer to persons who share the basic conditions of a common life, for example, geographic territory,

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basic educational, medical, and other services.

It can be used still more narrowly to refer to people who share the basic conditions of a common life and who identify themselves as a primary group. In this last sense, many people do not actually live in communities today, and the most typical examples of communities would be found in peasant villages, or among certain nonliterate people.

The term "community" is frequently, and on the whole rather loosely, used in discussions of problems of health and welfare. It is often difficult to pin down just what is meant, other than known interactions between clients and specific health and welfare agencies.

For present purposes "community" will be defined very broadly and residually to refer to whatever nonhospital setting patients go on leaving the hospital. This definition is broad because little is known about what the "community" is and what it means to former mental hospital patients. An important, initial step in posthospital rehabilitation research is precisely to determine the dimensions of the community to which the patient returns. In a general way, it may involve his relations to a family, a job, a circle of friends and acquaintances, his participation in various organized groups or in civic affairs, and his identification with smaller or larger local groups, including his nation. As research proceeds, community functions and structures as they affect the life of the expatient can be identified much more exactly.

Subdividing the General Problem

A fundamental first step in adding to knowledge of rehabilitation in the community is to make a detailed analysis of the real social world to which a patient returns, whether or not a formal intervention by health or welfare agencies occurs. We need to know:

The type of family, if any, to which he goes back.

The degree of his isolation from, or participation in, primary groups (family, close friends, cliques).

His relation to the occupational world and many other aspects of his group identifications.

The informal institutions, basic cultural forces, and commonly shared attitudes into which he plunges.

The major objective is not to document these situations historically for each individual patient but rather to determine general patterns which affect large numbers of patients and to assess the rehabilitative or illness-producing values of forces within these patterns. Ultimately, the objective is to find modes of intervention which will increase the rehabilitative value of the total situation. This phase may be called the basic analysis of community structure and functioning.

What kinds of treatment, assistance, or support do patients need after leaving the hospital? These include emotional support, assistance in various kinds of economic and occupational adjustment, and help with living arrangements and social activities. A basic question is the optimal amount of support needed, for there can undoubtedly be too much as well as too little support, and disfunctional passive-dependent attitudes might develop.

How, and by whom, can the treatment, assistance, or support best be supplied? What should the role of the hospital and of the various hospital personnel, such as psychiatric social workers, be after the patient has left the hospital? What kinds and amounts of clinic facilities are needed? What is the extent of the role of the vocational rehabilitation agency? Probably various agencies will be involved in the total rehabilitation process, and effective coordination of their efforts is an important aspect.

What kinds of information—through what channels, to what audiences—might build up communitywide attitudes which would facilitate the rehabilitation process? Basically, what can and should be communicated to whom? A considerable body of general knowledge has been built up in the field of communications research, but, as yet, it has not been systematically applied to problems of rehabilitation.

Some Plans for Analysis

There are a few people throughout the country who have developed some empirical knowledge or who have had some professional training in relation to these problems. However,

we are far from having a systematic body of knowledge about psychiatric rehabilitation in the community which could be communicated and utilized in program development.

As a first step in this direction the Public Health Service's National Institute of Mental Health has recently made a grant to the Harvard School of Public Health to explore the problem and to develop a research design for a full-scale analysis of the Whittier Street area of Boston.

This area, as described by the staff at Harvard, has been the focus of considerable and continuing ecologic and demographic analysis and is currently being used for training and research by the Harvard School of Public Health in cooperation with the City of Boston Health Department. Thus, much of the costly background investigation has already been carried out.

Previous analysis showed that the area has a population of about 60,000, includes a wide distribution of cultural and socioeconomic groups in its 11 census tracts, so that it is possible to compare one subgroup with another. There are three main ones: a very low economic group, primarily Negro, with a stabilized population and a high illness and accident rate; a predominantly Irish working class group, with a stabilized population and a moderately high illness rate; and a middle-class apartment house area, with a geographically mobile population and a low illness rate. Preliminary analysis suggests that annually approximately 100 patients from the Whittier Street area are admitted to Boston State Hospital alone. An equivalent number are presumably discharged from the hospital.

Research techniques in the Whittier Street area will include observation and interviewing in the field, as well as the use of statistics and intensive case studies. During the pilot study phase there will be opportunity to develop and suitably adapt sociologic and anthropological techniques and concepts for this particular type of research. The socioecologic and illness-incidence information already available on the population of the area should provide a strategic baseline for intensive analysis and efficient sampling in the selection of patients and families to be interviewed. It should thus be possible to compare patients' families with socially and culturally similar families to disclose possible significant variables in interpersonal structure and emotional climate contributing to emotional or mental disorder in family members.

Research of this type should contribute not only to a better understanding of the problems of rehabilitation as such and furnish a sound basis for program development but should also add significantly to basic understanding of sociopsychological factors in mental disorders.

Bridging the Wide Gap

There are, and probably always will be, basic differences between the structure of the hospital and the structure of social situations into which patients go when they leave the hospital. There is growing awareness that at present the resulting gap between the hospital and the community is quite wide indeed. This "psychological distance," as Schwartz calls it in Public Health Monograph No. 17 (*3*), may well account for the relatively large number of failures among discharged patients on the one hand, and for reluctance to discharge many other patients on the other hand. Thus, if the gap could be narrowed or, better still, actually bridged, there could be significant increases in the number of successfully rehabilitated mental patients.

The several ways in which this gap could be bridged may be classified into four main areas, each one of which will require major efforts in research and program development.

The Hospital Itself

Changes within the hospital, including administrative changes, the addition of rehabilitative services, and increased interaction between the hospital and community could make the gap less extreme. There is already a tendency for mental hospitals to be less isolated geographically and socially. There are efforts to bring in more of the outside world as patients are ready for it. Hospital personnel are becoming more aware of working closely with other agencies in the community.

The Patient's Immediate Contacts

It should also prove valuable, while the patient is still in the hospital, to work with the

people who are "significant persons" to the patient—his family, friends, employer, minister, and the others. They could be better prepared to receive the patient and to foresee the problems he will have when he returns. Also, by this same process, much could be learned concerning the patient, his problems, the situations from which he has come, and the situations to which he could or could not return.

Transition Rehabilitative Services

Direct rehabilitative services to the patient after he leaves the hospital could lessen the more extreme changes and severe adjustments in making the transition to a nonhospitalized pattern of life. This could include provision of outpatient clinic services for continued therapy or emotional support, the services of the vocational rehabilitation agency in providing counseling, guidance, placement, and, for some patients, training, services for family counseling and guidance, and possibly others.

The Halfway Shelter

Increased facilities of the character of a halfway house to act as a very specific bridge may prove to be highly desirable and valuable. Schwartz (*3*) has analyzed several such attempts, and Jones (*4*) has described a number of arrangements of this type found in different countries. They may take the form of special living arrangements where expatients can find some protected shelter and mutual support, plus a minimum of professional help. The expatient can begin employment, contribute to his own support, be much less of a burden on public funds, and learn gradually to live in the outside world.

Expatient clubs without living arrangements can also be of value. They have been tried with some success in England and on a smaller scale in the United States. Provision for foster homes or other kinds of home care with one or sometimes more patients present in the household also appears feasible and valuable. On the basis of past experience, it is particularly important to have careful selection and preparation of the family and of the expatient, and to have good but not overdone publicity by press and radio to build receptive attitudes in the community generally.

Sheltered workshops can be a valuable bridge in the occupational sphere and provide, as well, a more permanent place for patients who may never be able to function in most occupational settings. But, again, research of the general type indicated above should provide important guidelines for the development of any of these plans or for several of them in combination.

Adjusting to the Community

On the other hand, we should at least be aware of the possibility that for some patients the gap between the hospital and the community may be in a sense not wide enough, or in another sense, of a very special type.

Take, for example, the situation of the patient living in an open ward. He has ground privileges and can go downtown on occasion. He may have made some close friendships and developed group identifications within the hospital, but he may also have lost all contact with family and friends on the outside. He may have achieved a satisfying vocational adjustment in one of the hospital industries, and, of course, he has an assured place to sleep and three meals a day. He has, in effect, brought the "community" into the hospital. Any other "community," on the "outside," would have little, if any, appeal, and might even be quite frightening. Such an adjustment may be fairly "good" from the point of view of the patient but costly to the taxpayer.

How can a program motivate such patients to move on into a more independent and productive status, without doing something to destroy the values of improved hospital care and improved inhospital adjustment? This problem, too, must be faced in any operationally significant research on rehabilitation on mental hospital patients.

Developments in Vocational Rehabilitation

Small but important beginnings have been made in furnishing the services of State vocational rehabilitation agencies to persons with mental and emotional handicaps. Since the passage of Public Law 113 (78th Cong., 1st sess.) in 1943, several States have developed

specialized programs for psychiatric clients. In some States, a vocational rehabilitation counselor has been assigned full time to a mental hospital. In other States, increasing numbers of such cases have been added to the general caseload. Rennie, Burling, and Woodward (*5*) have estimated that about 15 percent of the patients who leave mental hospitals need the services of vocational rehabilitation. This figure has been cited frequently since the publication of this pioneering study in 1950. It may underestimate the potential use of such services because of the relative newness of the vocational rehabilitation program and because of the relatively small numbers of cases on which experience has been built thus far. In any event, less than 15 percent of these patients are receiving such services now and there is room for much development in this field.

The National Institute of Mental Health, in collaboration with the Office of Vocational Rehabilitation of the Department of Health, Education, and Welfare, has recently been active in stimulating special training programs for vocational rehabilitation counselors who are working with or who might work with mental patients. Three institutes were sponsored during 1952–53 and three more are planned for 1953–54, making it possible in each of these years for each State to have at least one member of its staff to attend. An analysis has also been made of the background of some of the people working in this field. They were found to be an unusually mature, stable, and highly motivated group. They are beset by many of the strains of a new profession, particularly the strains of budget. There tends to be some pressure to increase the numbers rehabilitated, because dollars-and-cents justification is possible and does make sense in this work. But, by and large, they have developed some very successful programs. However, it was also found that there are urgent needs for further training and research results and for more effective utilization and coordination of all resources in the community. Much of the success so far is based on the practical experience of individual counselors and a few empirical and commonsense principles which have not been systematically explored or analyzed in readily communicable form.

Some Indications of Payoff Value

Rehabilitation can and does pay off in dollars and cents. It can produce substantial savings in costs of hospitalization and even more substantial savings in increased earning power of rehabilitated patients, and, hence, a more effective utilization of our national manpower. Furthermore, rehabilitated patients pay taxes on their earnings which offset the costs of vocational rehabilitation services.

Numerous figures have been compiled for vocational rehabilitation in general, for example: "The 60,000,000 disabled persons rehabilitated in 1950 added an estimated $93,000,000 to the national income the first year they were rehabilitated—more than three times the amount expended for rehabilitation services in the same period and about five and one-half times the annual rate of $17,000,000 earned by these individuals at the time they were accepted for service" (*6*).

Figures indicating costs and savings in the total rehabilitation of mental patients have not been compiled. However, in an analysis made of one State program by the National Institute of Mental Health, it is clear that savings through vocational rehabilitation of mental patients were substantial. In the first 4½ years of the period analyzed, during which a vocational rehabilitation supervisor was assigned full time to the State hospital, 238 cases were closed as rehabilitated. The rehabilitated patients earned a total of $256,304. This figure would give a fictitiously low average, because a number of the patients counted had been out of the hospital and earning salaries only a few weeks at the time of the study; the average weekly wage is about $50. The costs of keeping them in the hospital during the period they were employed and out of the hospital would have been $449,222. Thus, there was a gross gain in values produced and in savings of $705,526. If we estimate that they paid 15 percent of these earnings in various taxes, there was a tax return to the public of $38,445, or a gross gain to public funds of $487,667. The program cost $6,478 in direct services to clients (tuition for training, and other costs), and $46,358 for guidance and professional services, or a total of $52,836. If we attribute all of the

hospital savings to the program, there would be a net gain of $434,831 in public funds. Some of these patients would have been out of the hospital without the program. However, we only need to attribute about 5 percent of the hospital savings to the program to have it pay for itself in public funds alone, and undoubtedly the program accounts for several times this amount.

These figures look, and are, convincing. However, too much insistence on this type of argument is likely to create pressure to turn people out in quantity. Cases are sometimes closed too soon and cases which do not need service are taken in order to make a better record. We should always bear in mind that we are not producing machines on a mass production basis. Rather, we are attempting to help people lead more satisfactory lives which in turn create many intangible values not only for themselves but for those with whom they are associated. Some of these values are more difficult of measurement. However, it seems quite safe to conclude that programs in rehabilitation have a very high potential payoff, both in terms of values which can be measured directly in dollars and in terms of the less tangible human values which cannot be so measured.

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Cancer Control Letter Discontinued

Publication of the monthly *Cancer Control Letter* was discontinued, by direction of the Bureau of the Budget, with issue number 67 dated September 1, 1953. The National Cancer Institute of the Public Health Service had issued these reports as a service to public health officials, voluntary health agencies, educational institutions, and others concerned with cancer control activities and techniques. Every effort will be made to supply the information furnished previously by the Letter through publication in *Public Health Reports* and other publications and agencies.