Transition from Mental Hospital to Community

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During the past twenty years the population of state mental hospitals throughout the country has been declining. The responsibility for care of the mentally ill is moving into the local community. In California, the community is now the locus of service effort. Yet, one must observe that there has been little change in the needs of the mentally ill population. Although we must be aware of the problems of defining mental illness and measuring its rate in the population,\(^1\) it seems that the incidence of psychosis in the eighteen to sixty-five age group has not varied in the past century.\(^2\) We have found no miraculous cure for this disorder. Though the introduction of psychoactive drugs has been credited for enabling a community care emphasis, the decline in the hospital population began before the introduction of these medications,\(^3\) and there have been successful

\(^1\) Bruce Dohrenwend and Barbara Dohrenwend, "The Problem of Validity in Field Studies of Psychological Disorder," *Journal of Abnormal Psychology*, LXX (1965), 52–69.


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community care efforts carried on without drugs. It therefore seems reasonable to conclude that while the needs of the mentally ill have not changed, what has changed is our perception of how these needs might best, or at least more economically, be met.

The necessity for a sheltered living arrangement has not disappeared with the closure of some state hospitals. In fact, a full third of the formerly mentally ill living in sheltered care in California have not been institutionalized in the sense of being socialized into a state hospital life style but were admitted to the state hospital system following the passage of the Lanterman-Petris-Short legislation in 1969 and have stayed short periods of time in a hospital environment. Their primary experience, therefore, has been in community-based sheltered care facilities.

Glasscote, Gudeman, and Elpers define "halfway house" in terms which are broad enough to encompass all types of sheltered care living arrangements:

A halfway house for the mentally ill is a non-medical residential facility specifically intended to enhance the capabilities of people who are mentally ill, or who are impaired by residuals of or deficits from mental illness, to remain in the community, participating to the fullest possible extent in community life.5

While these authors looked only at halfway houses, our research group studied the total system of sheltered care facilities which has developed in California in the past thirteen years. Facilities in this system include not only professionally operated halfway houses and certified family care homes but also former boarding houses, old hotels, converted apartment buildings, expanded single-family homes, and other types of living arrangements which have come to provide board and care to the released hospital patient.

Our study involved a sample census of all nonretarded individuals with a past history of mental illness between the


ages of eighteen and sixty-five living in sheltered care facilities in California. Interviews were conducted with 499 residents and the operators of the 234 facilities in which they lived. The results indicate that sheltered care, at least in the foreseeable future, is here to stay and along with it a set of five major issues which, as much as we try to ignore them, continue to be of primary importance.

1. Should we focus our help on the traditional categorically defined patient groups or emphasize the necessity to provide residential care for all socially dependent groups?

2. Should we emphasize rehabilitation or the prevention of social deterioration?

3. Whose rights have priority—the former patient or the community?

4. How do we insuire the individual’s right to treatment, not merely maintenance, in the community?

5. How do we take up the responsibility to insure, or even begin to assess, quality care in community facilities?

1. Traditional categorical need as compared to the needs of the socially dependent. At issue is whether there should be joint care of the mentally ill, mentally retarded, aged, drug abuser, physically handicapped, and other traditional categories of clientele under the same roof, as part of a generalized, socially dependent population.

The sheltered care service system in California was only in part developed to provide traditional categorical care. Primarily, it developed in an ad hoc fashion to serve the socially dependent as an aggregate. Glasscote and his colleagues in a nationwide sample found that only 47 percent of the halfway houses they studied catered solely to the mentally ill.6 Our study results indicate that in California approximately 68 percent of the facilities now serving the mentally ill also serve other groups, such as alcoholics, mentally retarded, dependent aged, and transients, on more than an occasional basis. As a general policy such care represents a return to the poorhouse approach, emphasizing aggregate care for all those unable to “make it” in our society.

6 Ibid., p. 15.
In this situation it is not simply a choice between a negative labeling process and a beneficial shedding of a stereotype. We are, in fact, exchanging one label for another—“mental illness” for “totally disabled”—or, perhaps worse, burdening the individual with the negative stereotypes associated with several labels. The public reaction could well be to generalize all the negative characteristics associated with the categorical groups in a given facility to each individual in the facility. This seems to be the situation in San Jose, California. Moving from the traditional categorical approach to the current situation limits the application of specific helping strategies to specific groups by submerging their special needs in the more general and variable needs of the larger group.

2. Social rehabilitation as compared to preventing social deterioration. At issue is the emphasis placed on reintegrating the former mental patient into the community and the practicality of such a goal, considering the extensive social and psychological handicaps of this group.

In an achievement-oriented society, it is difficult to focus on the goal of preventing deterioration. Success is “movement,” and work with the chronically mentally ill—the primary mandate of the psychiatric social worker—is perhaps less rewarding because of what appears to be client intransigence or, at best, limited movement. The basic problem is that in order to be rehabilitated one must first be habilitated.

Our data raise serious question as to whether the residents in our sample were ever qualified participants in society. Almost half of the population of concern are between fifty and sixty-five years of age, and 59.8 percent have never been married. One third have never had steady employment for a year or more. In addition, the level of psychological disturbance was found to be a significant handicap in current social interaction. Given this population, a selective use of the rehabilitation model seems more realistic and an emphasis on preventing further deterioration, crucial.

3. Individual or community protection. At issue is the current emphasis on protecting the rights of the former mental pa-
tient versus community fear of sickly people. How real is the danger posed by what one newspaper called “a mass invasion of mental patients”?

In the past five years communities throughout the country have reacted strongly to the influx of former mental patients. Community reaction has primarily focused on the most visible members of the group—those individuals living in sheltered care. While few communities have gone so far as Long Beach, New York—passing an ordinance which in effect bars former mental patients from registering in local hotels—zoning ordinances, fire clearance regulations, and bureaucratic stalling have been employed as effective exclusionary devices throughout California.\(^7\) One rationale for these procedures is the threat to property values perceived as a result of locating community care facilities in a given neighborhood. In fact, those neighborhoods which have actually experienced a large influx of community care facilities were already in a stage of decline, and the addition of a single community care facility has not depressed prices in high property value areas. This rationale for excluding the sheltered care facility, however, seems to be of only secondary importance in the community’s fear of the mentally ill.

The popular conception of the mentally ill is the “raving maniac” whose acts have no rational basis and are, therefore, unpredictable.\(^8\) Such unpredictable individuals are viewed as always posing a potential threat. While it is realized that questioning the validity of this stereotype will have only minimal impact in changing behavior, it is important because the stereotype is used to justify continued denial of patient rights.

The evidence comparing violent crime in the released hospital population with violent crime in the general population is equivocal. Although a recent study in California found


higher conviction rates in the total released patient population than in the general population, previous reports have indicated little difference between the two groups, or a lower rate in the released patient group. One finding, however, consistent in all these studies, is that the older people in both groups have the lowest rates of violent crime. This is significant in that almost half the adult, nonaged residents in sheltered care are between fifty and sixty-five years of age. These facts indicate that the community's fear of the sheltered care resident is misdirected. If any released patients pose a serious threat to the community, it is those who "fall through the cracks," who are so disintegrated that they are unable to establish themselves in a more settled sheltered care environment. Yet, even if these individuals were in sheltered care, our current ability to predict "dangerous behavior" would hardly justify their involuntary detention over a long period of time. Even though the best known predictor of the commission of a violent act is the threat of such an act, McDonald found that out of 100 "threat-to-kill" admissions to a Colorado Psychopathic Hospital, only three patients eventually took the lives of others and four committed suicide. This represents only a 9 percent accuracy rate in predicting violent behavior. We wonder if the results would have been much different had he studied serious "threats to kill" among the so-called "normal" population.

Thus the continued peremptory exclusion of sheltered care facilities from residential zones in violation of state law has dubious justification. While the community is entitled to protection, such protection cannot be guaranteed at the expense of the civil liberties of the released patient population.

* Larry Sossisky, "Putting State Mental Hospitals Out of Business—the Community Approach to Treating Mental Illness in San Mateo County" (Berkeley, Calif.: University of California Graduate School of Public Policy, 1975; mimeo.).


4. Right to treatment. At issue is the right of the formerly hospitalized patient in a sheltered care facility to receive treatment on the same basis as any other member of the community, as opposed to relying on a separate treatment system to meet his needs.

The *Wyatt vs. Stickney* (Civil Action No. 3195 N.M.D.) decision in Alabama and similar court rulings have emphasized the right of the chronic hospital patient to receive treatment in state hospitals and have defined this right in terms of improved institutional financing and patient-staff ratios. Although there was a precipitous transfer of patients to community care placement following this decision, community care rather than hospital care does not change the treatment needs of these individuals; on the contrary, it raises additional problems in providing care. The degree of psychological disturbance found in our surveyed population emphasizes the necessity for treatment of a more interpersonal nature than mere supervision of medication.

The first problem in the provision of community-oriented treatment programs is that hospital programs are competing with community care programs at a time when resources are becoming tighter; in other words, is it to be institutional treatment or community treatment? By institutional treatment we mean the development of self-contained treatment facilities in local areas—chronic "mini" hospitals similar to those which have developed in Wisconsin in the past hundred years. By community treatment, we mean a system to meet the treatment needs of individuals in sheltered care on an outpatient basis in the same fashion as the needs of other community members are met. In this type of system the hospital would be used more directly as a "prosthetic" device.

The pressures mounting around attempts to provide community treatment are well illustrated by the effort of the

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Hoch Psychiatric Treatment Center in Long Beach, New York, to provide outpatient care in a central location. According to the physician in charge of the aftercare unit, this effort was blocked by community interest groups who wanted psychiatric care to be provided in the facilities where released patients lived. Such an approach can result in the creation of a small hospital within the community and raises question about how services can be offered in the small facility. If the resident has a "right to treatment," will this force the small facility out of existence or lead, perhaps, to a "home visit" type of treatment? At least one demonstration project providing services to the aged in small facilities is currently underway in California. One must question whether this type of service delivery enhances a sense of exclusion and apartness. If former patients are to live in the community, they should not have to sneak in the back door of the local community mental health center.

5. Assessment of quality care in community facilities. At issue is the ability of the community and its state representatives to monitor the quality of care in the sheltered care facility system. In the past we have failed to maintain a high level of care in a small number of state hospitals in California. How can we expect, even with a licensing system, to assess and insure the quality of care in more than a thousand community facilities?

A partial solution to this problem is currently built into the sheltered care system. Although it has not been so named, since the enactment of the 1963 California welfare regulations, a voucher system for the provision of sheltered care to the adult socially dependent population has been in effect. The Supplemental Security Income check at the special board and care payment rate is the sheltered care resident's voucher. In theory, though not in practice, he acts in a consumer role in choosing his residence. Unlike a cash grant, the level of payment to the resident is tied to the use of a specific service and is reduced accordingly when it is determined that the resident is no longer in need of this service. This type of
organization rests on the implicit assumption that an approximation of a free-market economy will develop whereby low-quality service providers will be forced out of the market. The free-market concept, however, is a fragile one and needs safeguards built in to protect its functioning. In the case of the former mental patient, these safeguards can, perhaps, most effectively be exercised by service providers who have already adopted the role of resident advocate—for example, the placement workers. An even more desirable addition, of course, is the development of an active consumer organization among the residents themselves.

The need to structure consumer input as a safeguard in a voucher system is particularly important when the individual concerned is both the commodity and the consumer; that is, both an object of barter and the recipient of a service. The extent to which an individual adopts the recipient role is determined by his level of participation in the decision-making process relating to his care. Yet here we face a situation where the resident is powerless in terms of his ability to organize, in terms of his dependence on the facility operator and other service providers, and in terms of his lack of funds to invest in consumer activity. Given these obstacles, patient organizations to act as third-party participants in the negotiations between a resident and his service providers are needed. Implementing or at minimum supporting this participative action is crucial in order to enhance the resident's role as a community participant and to insure higher quality care.

SOCIAL WORK AND THE SHELTERED CARE SERVICE SYSTEM

In its role as a provider of service to the released mental hospital patient, social work occupies a unique position—a position which can be central in making the community care system a constructive step forward. As the primary placement officers, social workers have a strong influence on the referral system. In encouraging a resident to take a more active role in choosing facilities and in maximizing their informa-
tion on facility vacancies, the social worker can begin to exercise effective sanctions against poor-quality facilities. Such a strategy, however, will not be effective in a system where there is a lack of facility placements. Social workers must therefore, in addition, promote laws to attract new facilities into the market to provide a choice among available beds.

There currently is empirical evidence supporting the utility of hospital-based social work service in reducing the community burden and enhancing patient outcome.\(^{13}\) In an effective community-based service, social workers must join with their clients in a facilitative role to maximize the fit between facility characteristics and resident need, to prevent the resident’s social deterioration, and to insure the individual’s right to treatment. Such action will result in less community burden, less justification for the social exclusion of this population, and more assurance of a continued emphasis on the civil liberties of former patients.