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DEINSTITUTIONALIZATION: A REVIEW OF THE LITERATURE WITH  
IMPLICATION FOR SOCIAL WORK TRAINING AND PRACTICE IN RURAL AREAS

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ABSTRACT

The manuscript reviews the social, legal, and political background of the deinstitutionalization movement, reviews successful programs for deinstitutionalized chronic mental patients in the major problem areas of socialization skills training, supportive living, interventions with families, vocational rehabilitation, and medication monitoring. Problems which prevent the successful replication of these programs in rural areas, such as differing characteristics of rural and urban clients, distance and travel, and staff attitudes are discussed. Implications for social work training and practice in rural areas include the increased need for paraprofessional staff development and supervision skills, ability to utilize and mobilize existing community helping networks, and training in behavior modification techniques.

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The implementation of deinstitutionalization programs in rural areas currently presents a frustrating challenge to social workers. At the present time, few mental health professionals question the value of community-based treatment for those persons labelled mentally ill. However, widespread controversy centers on how best to develop humane, effective, and economically feasible community based treatment modalities. While deinstitutionalization policy is based on the concept of freedom of choice of treatment alternatives, the geographical vastness of rural areas, low population density, lack of such resources as adequate diagnostic, treatment, and referral centers, a paucity of residential placement alternatives and trained personnel, and rural residents' characteristic attitudes toward mental illness, all limit the extent to which this premise can be operationalized (Bachrach, 1977; Horejsi, 1977; Jeffrey & Reeve, 1978; Segal, 1973).

Deinstitutionalization involves a diminished focus on the mental hospital as the primary treatment locus, increased reliance on community based facilities for treatment of the mentally ill, and a return to the community of institutional residents who have been adequately prepared for this transition through socialization and vocational rehabilitation programs, establishment of a humane and appropriate residential environment, development of prevention programs for those individuals who are at risk of becoming "institutionalized," and promotion of community acceptance of persons labelled mentally ill (Bachrach, 1977; Horejsi, 1977). As this policy applies to social work practice, it dictates that the responsibilities of the mental health professional include such diverse activities as prevention, resocialization instruction, vocational rehabilitation, client advocacy, coordination of community services, public relations and consultation and education--a task of overwhelming proportions at best, but especially in rural areas where staff turnover and burn-out rates are disproportionately high.

A number of researchers feel that large-scale implementation of deinstitutionalization programs may have begun too soon. Political pressure to discharge vast numbers of patients into the community before an adequate system of community care could be developed and results of pilot studies analyzed may have created program plans which have not been firmly based on empirical data (Mannino, Ott, & Shore, 1977). The rush to deinstitutionalize these often weak and highly dependent individuals has frequently resulted in discharging them to environments which are even more impoverished and unstimulating than the hospital (Turner & Ten Hoor, 1978). Alone and unsupported, with atrophied coping skills and S.S.I. dollars in their pockets, former patients are frequently exploited by unscrupulous board and care home operators and urban criminal elements (Allen, 1976; Lamb, 1976; Mechanic, 1980; Silverstein, 1979). Fortunately, researchers, administrators, and clinicians have reacted to this sad state of affairs by endeavoring to assess the needs of this population and develop community-based programs to meet those needs. However, the available literature primarily concerns urban-based research and doubt exists as to whether or not many of these programs can be successfully replicated in rural communities. This manuscript examines the political, legal and medical advances which have created the thrust toward community treatment, reviews the current status of deinstitutionalized programs, discusses the issues which emerge when successful urban-based models are applied to rural settings and comments on the implications of these findings as they pertain to social work training and practice.

## History of the Deinstitutionalization Movement

A variety of social, legal, and medical advances have impelled the deinstitutionalization movement over the past thirty-five years. Though the community care concept has roots extending back to 13th century Flanders when the villagers of Geel housed mentally ill pilgrims who had travelled to the shrine of St. Dymphna, the modern trend toward deinstitutionalization probably began with the passage of the National Mental Health Act of 1947 which gave the federal government direct responsibility for assistance in research, training, and services in mental health (Huey, 1977; Kramer, 1977). Passage of this act stimulated a great deal of new clinical, field, applied, and administrative research and training of mental health personnel. As these new research findings were implemented in the field, the newly trained administrators and clinicians opened increasing numbers of outpatient clinics and inpatient units in general hospitals, assisting in the shifting of treatment locus from the state hospitals to the communities (Kramer, 1977).

The Mental Health Study Act, passed in 1955, established the Joint Commission on Mental Illness and Mental Health for purposes of evaluating and analyzing needs and resources of the mentally ill in order to make recommendations for a National Mental Health Program. The commission's report led to President Kennedy's message to congress on Mental Illness and Mental Retardation in February, 1963. This message proposed a national program for mental health centers, improved care in state mental hospitals, expanded research effort, and increased support for training personnel for research and service. Passage of the Mental Retardation Facilities and Community Mental Health Center Construction Act in October, 1963, further increased the range of treatment setting which shifted the emphasis from hospital to community treatment (Kramer, 1977).

Medicare legislation granting disability payments under Social Security legislation to individuals who had been hospitalized in mental institutions was passed in July, 1965, enabling former patients to pay for community treatment services, and private residential facilities more easily (Blain, 1975).

The Community Mental Health Centers Amendments of 1976 required state mental health authorities to develop and carry out plans to improve the quality of care in mental institutions, eliminate inappropriate placements in institutions, establish and enforce standards for operations of mental health programs and facilities, provide assistance in screening persons at risk of institutionalization, and provide after-care programs for ex-patients. Three of the seven essential new components added to the list of mandatory services had a direct bearing on services to long-term patients: assistance to courts and other public agencies in screening persons considered for referral to state mental health facilities, after-care for those discharged from a mental health facility, and establishment of half-way houses for ex-patients (Lamb, 1976).

In 1977, President Carter established a Presidential Commission on Mental Health. The commission's report argued for a greater investment in mental health services, as mental health currently received a disproportionately low percentage of all general health expenditures. The report also noted the need for more community-based services, as well as the need for those services to be more geographically, financially, and socially accessible and able to serve the needs of a variety of social and racial groups.

The report also called for increased attention to chronic mental illness. This report, therefore, implied that further programs for the patient in rural areas needed to be developed (Mechanic, 1980).

The commission's report led to passage of the Mental Health Systems Act in 1980 which mandates an improved network of services for the chronic patient and promotion of preventive care. The bill also supports mental health advocacy services and seeks to eradicate the discriminatory practices of communities against deinstitutionalized patients (Mechanic, 1980).

Under the Reagan administration, mental health, along with most other social services, has taken a back seat. While it is uncertain, at this time, exactly how mental health will be affected, it seems doubtful that any new programs will be implemented unless such programs can be shown to be extremely cost effective and accountable, and contain a strong evaluation component.

In addition to federal and state legislation, several important court cases have set precedents in such areas as the right of potential involuntary patients to procedural safeguards (Lessard vs. Schmidt, 349 F. Supp. 1978, Ed. Wis., 1972); right to treatment (Rouse vs. Cameron, 373 F. 2nd 451, D. C. Cir., 1966 and Wyatt vs. Stickney, F. Supp. 373, M. D. Ala., 1972); the responsibility to use the least drastic form of care (Lessard vs. Schmidt); the right of non-dangerous individuals to freedom (O'Connor vs. Donaldson, No. 74-8, 1975) and the right to treatment in the least restrictive alternative (Dixon vs. Weinberger, 405 F. Supp. 974, D. C., 1975). These legal decisions have all had a significant impact on the deinstitutionalization movement.

The advent of the major tranquilizers in the 1950s provided yet another impetus for the change in locus of treatment as psychotropic drugs provided both rapid stabilization of acute illness and symptom reduction in the chronic population allowing thousands of patients to be deinstitutionalized and preventing the "institutionalization syndrome," which often accompanies long-term treatment, from occurring in many more. Chemotherapy continues to be a vitally important treatment modality in both hospital and community settings. Following the first reports of therapeutic success with drugs, psychiatrists initially hoped that the chronic backward patient would become a phenomenon of the past. Unfortunately, the new tranquilizers were no panacea. Although the chronic schizophrenic's more pressing symptoms may be reduced or eliminated and social adjustment within the hospital improved, chemotherapy has not eliminated the necessity for hospitalization. Some patients fail to respond to psychotropic medication (Cochran, 1974). Freyhan and Merkel (1961) note that good clinical response to drug therapy does not guarantee a good clinical and social response once patients leave the hospital. These researchers found that mere symptom reduction does not ensure that a patient will recover motivation, ambition, and drive; nor that he/she will manifest an acceptable level of social skills. Furthermore, it was discovered that some patients can function adequately in their social and vocational roles even while manifesting a full-blown symptom constellation.

Discharge rates since the introduction of drug therapy are actually little different qualitatively from release rates achieved with such therapies as ECT and insulin. The available drugs are non-specific in their actions in that they affect no

known causal process (Klerman, 1961). The widespread use of the major tranquilizers has, however, made hospitalization periods briefer, if not less frequent. The effect has been that the public, in many instances, now perceives the hospital as a treatment center rather than a permanent home from which patients seldom, if ever, emerge (Klerman, 1961). Additionally, psychotropic medications can be prescribed and monitored on an outpatient basis. Administration of the older therapies usually required that the patient be hospitalized. Clearly, chemotherapy has been a major force in the gathering momentum of deinstitutionalization policy. Development of these "wonder drugs" combined with idealism in social policy and an increased emphasis on civil liberties created a fertile soil in which deinstitutionalization has mushroomed. It was an idea whose moment had come, but time, experimentation, and personnel training was necessary before the goals implicit in the policy could be effectively realized.

#### A Review of Problem Areas in Deinstitutionalization and Successful Intervention Strategies

As researchers have studied the special needs of the deinstitutionalized chronic patient, they have generally focused on identification of: 1) common characteristics of the chronic patients, 2) sub-groups of chronic patients most likely to be rehospitalized, 3) problem areas in the patient's environment in which interventions are most likely to have a positive impact on community adjustment, and 4) types of interventions most likely to be successful.

The characteristics common to chronic patients which have been identified are:

1) High vulnerability to stress. Even the minimal to moderate stress inherent in community life often causes relapse.

2) Lack of coping or everyday living skills. These individuals often depend heavily on their families, institutions, or aftercare programs for assistance in day to day living.

3) An inability to compete successfully in the job market which is largely due to lack of skills and work habits, poor interpersonal skills, and significant gaps in employment history.

4) Inability to establish and maintain close interpersonal relationships.

5) Lack of either motivation or ability to seek help from or sustain rapport with mental health professionals.

6) Tendency toward acting-out behaviors that interfere with their own well-being or that of others.

7) Dependency needs which are exacerbated by fears of abandonment or engulfment, as well as an incapacity for autonomous functioning characterized by a need to seek external structure and control.

8) Limited repertoire of problem solving techniques.

9) Abnormal sensitivity to interpersonal relationships, physical environment, and cultural attitudes.

(Glasscote, Cumming, Rutman, Sussex, & Glassman, 1971; Isenberg, Mahnke, & Shields, 1974; Lamb, 1976; Test & Stein, 1978; Turner & Ten Hoor, 1978)

Although most chronic mental patients share these characteristics, researchers began to notice that among the chronic population, certain sub-groups manifest a higher rate of readmission to institutions. Recidivism rates were higher for schizophrenics than for non-schizophrenics, but it was found that schizophrenics who received after-care services had a good chance of staying outside the hospital (Winston, Pardes, Papernik, & Breslin, 1977). Several studies have attempted to identify those patients most likely to be "drop-outs" of after-care programs: males were more likely than females to discontinue after-care services as were single rather than married individuals. Patients with less than a high school education were also considered to be at risk (Winston, et al., 1977; Wooley & Kane, 1977). Researchers also discovered that the longer a patient can remain outside the hospital, the greater are his/her chances of making a successful long-term community adjustment. Return rates are believed to be highest during the first three months following discharge and the first month in the community was found to be particularly critical (Cunningham, Batwinik, Dolson, & Weickert, 1969; Smith & Smith, 1979).

Numerous critics of institutional care have commented on the hospital's tendency to foster attitudes of dependency and passivity in patients which insidiously undermine their chances of making a successful adjustment to life in the community where autonomous and independent functioning is essential. During long years of hospital treatment, the patient loses confidence in his/her ability to meet his/her own needs. Work and interpersonal skills atrophy and families emotionally "divorce" the patient; he/she truly becomes "dead to the world" (Boettcher & Schie, 1975; Denner, 1974; Lamb, 1976; Lipsitt, 1961; Test & Stein, 1978; Wright & Kogut, 1972). These criticisms not only had the effect of accelerating the deinstitutionalization movement, but also led to significant changes in hospital treatment programs, undermining the medical model concept that rehabilitation training should not be instituted until after symptomatology is eliminated (Fairweather, Sanders, Maynard, Cressler, & Bleck, 1969). As researchers began to report on successful community-based treatment alternatives (Huey, 1977; Test & Stein, 1978), the hospitals began to institute short-term, crisis theory oriented programs aimed at preventing the "institutionalization syndrome."

As the characteristics of the chronic, overly institutionalized mental patient were examined, it soon became evident that ex-patients required long-term, open-ended community training and support programs aimed at the major problem areas of socialization, establishment of supportive living programs, vocational rehabilitation, helping patients become reintegrated into their families, and development of health maintenance and medication monitoring programs (Test & Stein, 1978; Turner & Ten Hoor, 1978). Community-based intervention strategy development began to be perceived in terms of the aggregate environmental demands placed on the client.

### Socialization

Socialization training involves the acquisition or revival of skills in fundamentals of nutrition; meal planning, shopping, and preparation; use of public transportation; money management and banking; leisure skills; essentials of grooming and personal hygiene and knowledge of basic social amenities. It also involves the control or elimination of bizarre and/or aggressive verbal and motoric behaviors and the development of interpersonal skills. Numerous researchers have suggested that socialization is probably the single most important factor in maintenance of community placement (Anthony & Margules, 1974; Cochran, 1974; Lamb, 1976; Paul & Lentz, 1977). Because socialization is so essential, tremendous effort has been aimed at developing successful intervention strategies. A review of the literature suggests that in order to be successful, a socialization program should be community-based, using non-mental health professionals whenever possible in order to provide a "normalizing" learning environment which facilitates generalization of skills, aimed at a specific socialization target, long-term rather than time-limited, and should define specific treatment goals for each client (Lamb, 1976; Test & Stein, 1978; Turner & Ten Hoor, 1978). Socialization programs differ in their approaches. Essentially, a review of the literature reveals that the three most commonly employed models are the educational program, the social club, and the companionship program.

#### The Educational Model

Lamb (1976) reported on the development of a "Personal Growth Education" course for ex-patients which was held at a local high school's adult education program, enabling patients not only to acquire socialization skills, but also to perceive themselves in a "normal" societal role. Gottesfeld (1976) mentions a successful skills education program using volunteers and operating on a very limited budget (\$150 a month in 1972) which trained ex-patients in self-care, current events, and use of public transportation. Furedy, Crowder, and Silvers (1977) devised a transitional socialization program in which patients and their families formulated behavioral objectives together and reviewed goal attainment at weekly group meetings. Patients and their families kept frequency counts between meetings in order to correctly assess the extent of behavioral change. Patients were taught daily living skills, money management, meal planning, and use of city transportation, recreational and social skills. The success of this program can be largely attributed to the use of behavior modification techniques and is consistent with a considerable body of literature suggesting that application of learning theory principles is the most successful, efficient, and cost-effective means of socialization skills training (Friesen, 1974; Furedy, et al., 1977; Glasscote, et al., 1971; Paul & Lentz, 1977).

Paul and Lentz (1977) conducted a highly ambitious and well designed study comparing milieu and social learning theory approaches. Two matched groups of severely debilitated chronic patients were housed in identical facilities and subjected to similar psychosocial rehabilitation programs.

The social learning program maintained clear superiority over the milieu program with 90% of the social learning residents remaining continuously in the community following discharge at the time of the 1½ years follow-up, as opposed to 70% of the milieu group. However, only 50% of the hospital group with which both programs were compared, maintained community placement.



Cost effectiveness analysis found that the social learning program was the most effective and least expensive. Considered economically, during the project period it returned over three times the dollar savings of the hospital program and over 30% more dollar savings than the milieu program for the same dollars spent on treatment costs.

Social learning therapy produced improvements across the board and clearly emerged as being the treatment of choice. Results of the project demonstrated that how staff activity and attention are applied is much more important than how much occurs. In the area of adaptive behavior, both programs produced initial improvement in self-care, interpersonal, and communication skills. However, the communication of expectancies, group pressure and practice in group problem solving and crises resolution in the milieu program led to no further improvement beyond activating the performance of dormant skills. In contrast, the social learning residents produced consistent gradual increase in the acquisition of new socially relevant skills (Wodarski, in press).

In the area of maladaptive behavior, social learning also emerged as more effective than milieu therapy for reduction or elimination of bizarre behavior. Such bizarre motoric behaviors as rocking, repetitive movements and blank staring were the most frequently observable class of "crazy" behavior. Social learning techniques for dealing with these problems primarily consisted of ignoring them and reinforcing incompatible adaptive behaviors. Bizarre disfunctional cognitive behaviors (such as verbalized delusions and hallucinations, incoherent speech, smiling without apparent stimulus) were reduced about equally in both milieu and social learning programs. These findings are in keeping with a considerable literature suggesting that cognitive functions in general tend to be more consistent within individuals, less variable across situations and more modifiable through simple transmission of information (Paul & Lentz, 1977).

### Social Clubs

Bell (1970), Lamb (1976), and Wechsler (1961) have commented on the rehabilitative effect of client participation in ex-patient social clubs. Besides providing social skills training, leisure time activity, and exposure to "normal" role models when community volunteers are used, these clubs also help clients to develop a support system, overcoming their very real feelings of isolation and alienation. Clubs can be led by members, professionals, or volunteers and may be highly goal-oriented or strictly social. Belonging to a club may help the ex-patient cope with the sense of abandonment he/she may feel when no longer belonging to the hospital.

### Companionship Programs

This model stresses the benefits of forming close one-to-one relationships between former patients and community members. Denner (1974) and Lamb (1976) comment on the positive modeling effects which occur when this model is implemented, but both researchers stress that the companions must encourage independence, use public transportation, and encourage the client to participate in the planning of the activities in order to help him/her overcome apathy and dependence.

A variety of both formal and informal socialization programs can be extremely

valuable in helping the long-term patient meet the normal demands of daily living. Formal programs with a learning theory approach can teach such basic living skills the patient needs to give him/her confidence in his/her ability to cope independently. Informal social clubs and companionship programs give him/her an opportunity to cement those skills and to practice the development of interpersonal relationships in a supportive, low-stress situation. Both kinds of experience are necessary to help the patient meet the inevitably stressful demands of normal life.

### Supportive Living

Arrangement of adequate residential placements for ex-patients has been a major problem plaguing mental health professionals since the inception of the deinstitutionalization movement. Locating clean, comfortable, and affordable rooms for ex-patients is next to impossible in some communities. Many ex-patients are unable to live independently and need at least minimal supervision in order to remain in the community. Even where housing programs for these individuals are ongoing, numerous problems prevail. Many board and care homes are as effective in "institutionalizing" patients as are hospitals, due to lack of stimulation and rehabilitative treatment efforts. Buildings are often sub-standard, with numerous safety hazards existing and clients are sometimes fed starchy, nutritionally unsound diets (Allen, 1976; Silverstein, 1979). "Mental health ghettos" evolve in the inner city due to local zoning ordinances, requirement for use permits, and other interpretations of various ordinances, all of which are designed to prevent the establishment of residential facilities in more attractive neighborhoods (Lamb & Edelson, 1976). Findings suggest that half-way houses are probably the best residential alternative with one study reporting that 80% of half-way house residents make a successful community adjustment and that rehospitalization rates are lower for this population (Gottesfeld, 1976). Unfortunately, relatively few such facilities exist. These environments generally provide a rehabilitative, high-expectation milieu in contrast to the stultifying atmosphere common to most board and care facilities. Paul and Lentz (1977) note that patients often regress in functioning in such environments, with the highest regression rates being found in facilities which benefit financially for retaining ex-patients.

In an effort to remedy this unfortunate situation, a variety of residential alternatives have been successfully developed, including cooperative apartments, group homes, family and foster care homes, foster care communities, half-way houses, and lodges (Earles, 1976; Fairweather, et al., 1969; Goldmeir, 1975; Huey, 1977; Mannino, et al., 1977). These programs differ extensively in the degree of supervision, size, and the extent to which the facility limits the number of choices the resident is free to make for him/herself. Although space limits an extensive discussion of each of these residential models, comprehensive descriptions are available in the literature cited above. What this array of models does have in common is a commitment to stimulating, high-quality residential care. Although a wide variety of alternatives exist, the mental health practitioner encounters many difficulties in locating a placement.

The worker must take a number of factors into consideration, such as the level at which the patient can function, the patient's treatment needs, and the patient's personality in relation to the personalities of the staff and other residents at a given facility. In addition, there is often a problem of timing. Perhaps no vacancy exists

at the time it is needed, or perhaps the community does not offer the kind of residence the patient seems to require (Lamb & Edelson, 1976). The size of the facility is another factor that should be taken into consideration. Cunningham, et al., found that ex-patients placed in larger homes tend to remain in the community longer. Earles (1976) also found that schizophrenics were more comfortable in larger homes.

### Interventions with Families

Although a considerable body of literature suggests that ex-patients should not be discharged to family members, such placements are often inevitable due to the lack of acceptable residential facilities. Byers, Cohen, and Harshbarger (1978) found that the best single predictor of recidivism was the person to whom the patient was discharged. Patients released to a spouse were the most likely to be readmitted and averaged the fewest number of days in the community between release and first readmission, while patients discharged to a sibling averaged the fewest number of days in the community during a two year period. Patients discharged to a child or non-relative comprised the most successful group. Leff (1976) noted that severely disturbed behavior among patients was reported for 30% of patients living with a spouse or parent and that these patients were readmitted at least once in the final three years of a five year follow-up. Nevertheless, as deinstitutionalization accelerates more families will probably find themselves burdened with the responsibility of caring for their mentally disturbed relatives, and efforts should be directed toward providing patients and their families with the services and support needed to make such placements as comfortable as possible for all concerned. Additionally, research indicates that a patient's relationship with his/her family can serve as an index of his/her total social adaptability. A mature, cooperative attitude towards the family generally corresponds with successful social adaptation, while the patient who maintains a hostile or indifferent attitude toward his/her family usually exhibits poor social performance (Meszaros & Maszaros, 1961). Clearly, the complex emotional relationships existing in a family unit require special handling if a family placement is to be successful. Lamb (1976) mentions that the family members need contact with professionals who can understand their problems, answer their questions, and comprehend the stress involved in living with an ex-patient. In answer to this need, he recommends the use of diagnostic family interviews in day treatment programs. Such diagnostic interviews allow the staff to gain insight into the family's interactional patterns which the patient may be unable to verbally describe.

Huey (1977) reports Aguilera's suggestion that family stresses arise, in part, because the family members eliminated the patient from their lives while he/she was in the hospital. The family must undergo a readjustment when the patient returns home. If the patient fails to adjust to the routine the family has established during his/her absence, they may want him/her returned to the hospital. When a family wants a patient readmitted, the practitioner must learn to identify who is in crisis--the patient or the family. The family's attempt to have the patient readmitted may be a reaction to its own anxiety about the patient's possible disruptive behavior. When original symptom displays reappear, there is usually a correlation between some change in the family's routine and the patient's resumption of abnormal behavior. The practitioner needs to determine what event precipitated the return to psychotic behavior and also whether or not the patient is taking his/her medication.

Crisis resolution techniques include helping the patient to understand his/her crisis and openly express his/her feelings, exploring coping techniques used in the past that can be used in the present, finding family members and friends in the patient's environment who can support him/her, and planning with the patient ways to reduce the likelihood of future crises.

Lamb and Oliphant (1978) recount many of the stresses with which family members must cope when the patient lives at home. The schizophrenic's behavior is unpredictable, often socially embarrassing, and even violent at times. The patient's social withdrawal, inactivity, excessive sleeping, and lack of conversational skills provide little positive reinforcement for the family. In addition, the family experiences the stigma of having produced a schizophrenic. The family also experiences trauma when confronted with the notion prevalent in some psychiatric circles, that the entire family unit is sick and the patient simply happens to be the person labeled as ill. The authors report on the recent growth of family advocacy and mutual-support groups. Such groups help members feel less isolated; many parents of schizophrenic children withdraw from their social contacts because of the guilt and stigma attached to their situation. The group can share feelings, get each other through crises, work through guilt feelings, and learn to see themselves in a less self-condemnatory light. Such groups can act as an emotional catharsis. In addition, one study found that participation in groups facilitated individual casework. Family members felt less threatened by the exploration of sensitive material once they had aired their feelings in a group (Grinspoon, Courtney, & Bergen, 1961).

Group members can also share practical tips which make living with a schizophrenic easier. If professionals and the relatives can mutually agree on what a patient can achieve, and if the relatives can maintain emotional objectivity, they can apply pressure to counteract the patient's withdrawal. However, the patient must not be pushed to achieve beyond his/her capabilities and must be given the opportunity to exercise a good deal of control over his/her own behavior.

Relatives learn that it is often useless to contradict delusional ideas, but patients can be taught not to talk back to hallucinations in public. They can also learn to expect a certain amount of withdrawal, which may be a necessary defense mechanism. Too much withdrawal, however, can lead to a form of institutionalism at home.

Family members are especially in need of support when the first psychotic break occurs. At that time, the family is particularly vulnerable and sensitive. They may feel guilty and wonder what they have done to "cause" such a thing to happen. Marital relationships are also strained during this time. Siblings of patients are often ignored or neglected while parental attention is focused on the "sick" member of the family. Practitioners should provide understanding and reassurance at this point. They should always explain to the relatives that schizophrenia is not merely the result of environment; heredity and biological factors are equally important (Lamb & Oliphant, 1978).

### Vocational Rehabilitation

Because an ability to compete successfully in the economic marketplace has long

been an important criterion of success in American society, many researchers have directed efforts toward vocational training for ex-patients. An ability to successfully perform in the work world gives patients a sorely needed sense of mastery. Gottesfeld (1976) reports Gibson et. al. as finding that when an experimental group of chronic patients were given work assignments commensurate with their skills and interests, the community re-entry rate was 37%. Only 18% of the control group was able to make a successful adjustment to the community.

Gottesfeld (1976) also describes a rehabilitation program in Virginia in which chronic patients in a state hospital received vocational training before entering a community residence and finding local employment. The majority of the group studied made a successful readjustment and very few group members were readmitted.

Kirk (1977) reports that the unemployed may constitute a special population at risk of readmission, while Wooley and Kane (1977) note that patients with less than a high school education tend to evidence more recidivism and a higher rate of unemployment. Yet those patients who had been previously employed in professional and managerial positions may have an equally difficult time finding employment. Generally, those patients from semi-skilled, labor, and agricultural fields have a higher probability of being rehired (Wooley & Kane, 1977). Ex-patients often report that co-worker conflict, low pay, and lack of skills interfere with their ability to make a successful vocational adjustment (Peretti, 1974). Additionally, such patients have been found to hold unrealistic and grandiose expectations regarding their employment potential (Fairweather, et al., 1969; Huey, 1977; Peretti, 1974). Other problem areas which have emerged include difficulties in interpersonal relations, phobic attitudes toward work in general, fear of failure, ineffective use of job interviews, projection of self-rejection to authority figures, oversensitivity to disappointment or inadequacy, inability to persevere toward task completion, and an inability to take orders (Greenblatt & Simon, 1959; Huey, 1977). Despite the apparently acute need for vocational skills training few opportunities for rehabilitation exist. Day treatment programs seldom maintain a sheltered workshop on the premises and mental health centers and public vocational rehabilitation programs are often scarce (Gottesfeld, 1976). Such public agencies usually focus on the plight of the physically disabled and perceive the problems of the mentally disabled as belonging to the mental health system. In order to address these problems, numerous experimental programs have been developed. Researchers have generally found that in-house vocational rehabilitation programs should be designed to be as much like a genuine work environment as possible so that the patient can create an identity of himself as a "worker," rather than a patient. Lamb (1976) found that among patients in transition from day treatment to a sheltered workshop behavior varied considerably. Patients spent one-half day in each setting; since "crazy" behavior was not tolerated in the workshop, patients behaved like workers. In the morning, however, when patients attended the day center, they exhibited bizarre behavior never seen in the workshop. Apparently, patients can learn to behave like "normal" workers when it is required of them. Fairweather and his colleagues (1969) found that when a patient was asked not to hallucinate on the job, he could comply, and began to hallucinate only when he was back in the truck on his way home after work. A great deal of the patient's work behavior has to do with the supervisor's expectations.

Freisen (1974) argues that behavior modification techniques can be extremely useful

in teaching work habits to patients. When a patient is having a work problem, his/her behavior can be observed and the environment modified to remove those elements which encourage "sick" behavior. Token economies imitate the real world and help to accustom the patient to working for secondary reinforcers. Tokens can be saved and spent as the patient wishes and teach him/her to postpone immediate gratification.

In addition to job and interpersonal skills, ex-patients also need to learn how to look for a job and behave on an interview. Furedy, et. al. (1977) included behavioral rehearsals to teach job-finding skills in their socialization program. Patients role-played job interviews and job-related social situations. Clearly, training in job seeking and interviewing imparts motivation and a sense of confidence to these chronic patients.

### Medication Monitoring

Research literature suggests that drug therapy must remain a constant for many chronic patients if they are to survive in the community. Gross and Reeves (1961) note that the risk of relapse is considerably greater if medication is discontinued, at least during the first year after discharge. Some patients may even require an increased dosage when they return to the community, due to the increased level of stress and excitement (Kris, 1961). Therefore, medication should be carefully monitored during the initial post-release period, particularly as some patients--notably males and patients who are aggressive, paranoid, or hypomanic--resent taking medication and tend to discontinue doing so (Freyhan & Merkel, 1961). However, Paul and Lentz (1977) feel that no changes in drug status should be made during the first few months after discharge believing that such a change inhibits the transfer of behaviors learned in the treatment setting.

A variety of experimental medication monitoring programs have enjoyed success. Gottesfeld (1976) reported that as many as 40% of patients may fail to report to office-centered therapy sessions, but that a goal achievement oriented home visit program for twenty after-care patients resulted in a recidivism rate of zero during the first six months. Staff members monitored drug ingestion during non-scheduled visits and dispensed rewards to those patients who continued medication. The investigators estimated that costs for the home visit group amounted to only about one-third the costs incurred by the control group.

Isenberg, Mahnke, and Shields (1974) successfully implemented a weekly medication group for outpatients in a Massachusetts clinic. The authors noted that the patients' fears of being unable to regulate their dosage and of being dependent on the drugs lessened as they had the opportunity to discuss their feelings with others.

By and large, the literature suggests that regular medication is almost essential for most chronic patients. Unfortunately, these patients typically lack the motivation necessary to continue self-medication and maintain contact with after-care services. Behavior modification programs, group meetings, and home-centered outreach programs may be essential--particularly for the high risk groups mentioned earlier. Despite its importance, drug therapy is no cure-all. Psychotropic drugs often create such side effects as extra-pyramidal symptoms and tardive dyskinesia, causing these patients to

manifest such bizarre motoric behavior that "normal" community members may be shocked or repelled. Although these side effects can usually be counteracted by the administration of additional medication, it is nevertheless ironic that chemotherapy has created yet another barrier to community acceptance for the chronic patient.

### Emerging Issues in Rural Deinstitutionalization

Throughout history, artists and writers have romanticized country life as idyllic and carefree and to some extent, these ingrained stereotypes of rural environments have stunted the development of research efforts aimed at meeting the special needs of rural mentally ill individuals. The "back to nature" ideology of the sixties and seventies further promoted the notion that pastoral life enhances rather than diminishes mental health. However, the available evidence now suggests that rural communities tend to be characterized by higher than average rates of psychiatric disorder, particularly depression, and data from one study in Tennessee suggest that 12% of the rural population requires psychiatric care (Report of the President's Task Force on Long-Term Care, 1978).

Rural individuals differ significantly from urbanites in their attitudes toward mental illness. They are more inclined to perceive the cause of mental illness as societal, citing such sources as the unsettled world situation, economic pressures and stresses within their county, and the failure of such traditional institutions as the church and family to provide necessary emotional support (Segal, 1973). Rural people frequently manifest a suspiciousness of outsiders and may be wary of mental health services, particularly when treatment demands that they disclose a substantial amount of personal information (Helton, 1977). This fear is not without realistic basis as confidentiality is considerably more difficult to maintain in small communities (Horejsi, 1977).

Rural residents often have a fatalistic attitude toward life in general which is fostered by the fundamentalist religious beliefs common in these areas. They often have low expectations for even their "normal" family members and are unable to see the value of training and education for their mentally and/or emotionally disabled offspring (Helton, 1977; Horejsi, 1977). The President's Task Force on Long-Term Care (1978) notes that rural people have restricted opportunities to develop adequate coping mechanisms for facing stress and problem solving and have little faith that change is possible. However, rural residents may have higher tolerance for the idiosyncratic behavior of mentally ill persons. Segal (1973) mentions that rural patients were rated by their relatives as less helpless and more stable than their urban counterparts. These same rural people were judged by their clinicians to be more adaptable, less impaired, and less perceptually disturbed than city patients in their manifestations of hostility and grandiosity. As a possible explanation, Segal (1973) suggests that the urban patient who is excited, hostile, and grandiose is more likely to land in a full-time hospital than a rural patient who is manifesting the same symptoms. Urban patients exhibited more of the passive-type symptoms (helplessness, instability, and impairment) which are associated with the "institutionalization syndrome" and are caused by longer and/or more frequent hospitalizations.

Rural patients are generally felt to be less of a source of distress to their

families, despite the strong bonds of interdependency common to rural families (Helton, 1977; Segal, 1973). Meszaros and Meszaros (1961), however, feel that dependency problems are more severe among rural patients. They argue that geographical isolation and social isolation go hand in hand, causing the members of the family unit to be highly dependent upon the adjustment of each other member, as interests and activities are often confined to the family itself. Therefore, family stresses and tensions are more apt to tip the emotional balance of rural patients.

A lack of adequate residential and treatment facilities further compounds the problems of chronically mentally ill individuals. Sparsely populated communities are frequently forced to place rural patients in urban after-care settings because of limited or non-existent residential alternatives in their home communities. Unfortunately, these "transplants" experience heightened psychological and social problems in urban rehabilitation settings (Bachrach, 1977). Because the half-way house is a predominately urban phenomenon, rural residents must often be discharged to their families which, as previously discussed, necessitates that clinicians be available for family counseling and crisis intervention. Yet this mode of intervention is rarely feasible due to geographical distance and transportation difficulties (Horejsi, 1977). Many impoverished rural residents do not own vehicles and though traveling teams of professionals are often used, travel time shrinks the federal budget dollars as the professional hours it buys are then proportionately diminished (Segal, 1973).

Staff attitudes also contribute to the problem of meeting rural clients' needs. Community mental health centers are often committed to primary prevention and treatment of life crises; treatment of the chronically mentally ill is frequently a low priority (Lamb & Edelson, 1976). The chronically mentally ill individual is not always a rewarding client, but practitioners' frustrations probably have more to do with a lack of appropriate clinical skills than with the client's degree of "treatability." Behavior modification techniques have been demonstrated to be a successful treatment strategy with this population, yet most social workers have received their training in schools which stress a traditional psychoanalytically-oriented treatment approach. Workers in community mental health centers understandably feel resentful and rejecting when called upon to provide services for vast numbers of chronic clients; neither the workers nor their agencies have been adequately prepared to deal with this population (Silverstein, 1979; Test & Stein, 1978). The demands of practice in rural areas are even more overwhelming. Breadth of duties and excessive travel causes staff burnout and high turnover. Yet rural communities can rarely afford or attract a wide variety of professionals with specialized skills. Practitioners may also suffer from loneliness and isolation, and lack of professional stimulation, supervision, and consultation (Horejsi, 1977).

#### Implications for Practice and Training

If rural practice presents many problems for social workers, it also offers many challenges and potential rewards when practitioners have developed the necessary competencies.

1. One essential competency is the ability to train and supervise paraprofessionals and volunteers. Paraprofessional mental health workers will probably play an



increasingly significant role in rural community mental health. Use of indigenous workers can be invaluable in remote areas where recruitment of skilled professionals is difficult and funding for highly trained workers scarce (Horejsi, 1977). Paraprofessionals can be extremely valuable in outreach programs and aid in early detection and intervention. Personnel who live among the people they treat and with the people who form a network of community caregivers can more easily keep a finger on the pulse of the community (Dyck, 1974; Wodarski, Giordano, & Bagarozzi, 1981).

Use of paraprofessionals has already become a trend in many urban day treatment centers and preliminary findings have suggested that they may actually have fresher, more optimistic attitudes toward chronic patients' potential than do professional staff members (Gottesfeld, 1976; Wright & Kogut, 1972). Obviously, social workers will be needed to provide consultation, education and supervision in order to ensure that these workers have the adequate skills and training to carry out these tasks.

2. The ability to coordinate and mobilize existing community resources is an essential competency rural social workers must develop. Numerous authors have noted that one major problem in effective deinstitutionalization exists because no one agency at any level of government has been clearly charged with responsibility for comprehensive assessments of mental health and such community support needs as planning and implementing a system to assure needs are met, and monitoring the quality of both institutional and community programs. Consequently, many of the people most seriously in need of services "fall through the cracks" (Gottesfeld, 1976; Horejsi, 1977; Smith & Smith, 1979; Turner & Ten Hoor, 1978). Social work practitioners must use their relationship skills to cultivate bonds not only with existing public agencies, but with such leaders of the indigenous helping network as physicians, teachers, ministers, volunteer groups, and service clubs (Horejsi, 1977). Service clubs are often the prime movers in rural American communities. Although they may lack professional knowledge and sophistication in the mental health field, community leaders and influential people capable of motivating community support are often members of such organizations and can be extremely helpful if the social worker can learn to break down the needed tasks into components that the members can handle (Horejsi, 1977). Community leaders can also help the worker gain knowledge of local folklore which may have a bearing on the community's acceptance of certain kinds of programs (Horejsi, 1977).

A few of the services volunteer, church, and service organizations can provide include transportation for clients, respite care in their homes, fund raising activities, and local business contacts for work which clients can complete in sheltered vocational rehabilitation settings. The social worker who is skilled in community organization, public relations, and community education techniques can capitalize on the rural community's characteristic slant toward "helping the person" rather than "curing the illness" (Segal, 1973).

The social worker in rural community mental health must also strive to overcome interagency conflict and bias. Comprehensive mental health care can be

developed by drawing on local resources. Johnson and Nelson (1972) report on a program in Iowa comprised of the psychiatric unit of a general hospital, a locally supported mental health center, a private group practice and a half-way house for alcoholics. Long-term care and partial hospitalization services are provided by a nearby county home with a separate psychiatric unit. This coordinated system has resulted in a continuing drop in the area's admissions to the state hospital and substantial financial savings for the counties involved. This program model can be applied to many rural areas. The elements on which to build a high quality comprehensive program are available if imagination and foresight are utilized.

3. As previously noted, the available literature resoundingly supports the use of behavior modification techniques in socialization training, vocational rehabilitation, family interventions, and medication monitoring (Friesen, 1974; Furedy, et al., 1977; Glasscote, et al., 1971; Paul & Lentz, 1977). Social workers dealing with the chronic population have a responsibility to provide their clients with the most effective treatment strategies available, and behavior modification has been shown to be not only the treatment of choice, but also the most cost-effective, a major consideration in rural areas where travel expenses rapidly gobble up federal budget allotments (Paul & Lentz, 1977).

### Summary

Social, legal, and medical advances since World War II have caused the deinstitutionalization movement to snowball, and mental health professionals may now be wondering whether or not they have created a monster. There are no simple techniques for dealing with the chronic population. Indeed, the term "chronicity" implies that the programs serving this population must be long-term and open-ended (Turner & Ten Hoor, 1978). The numbers of chronic clients, in both rural and urban areas, are expected to increase while available federal monies decrease (Silverstein, 1979). This literature review has cited successful programs and techniques and discussed the issues and implications for practice as they apply to the rural chronic population. The emerging profile of the successful rural-based implementer of deinstitutionalization strategy suggests that he/she: is familiar with the characteristics of the rural chronic population; is skilled in learning-theory based intervention strategies and applies them to the five major problem areas of socialization, supportive living, family intervention, vocational rehabilitation, and medication monitoring; effectively trains and supervises paraprofessional workers; and skillfully utilizes existing helping networks and coordinates community services. Schools of social work have a responsibility to the chronic population to train their graduates to meet the challenges of implementation of deinstitutionalization strategies in rural areas.

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