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THE POLITICS OF MENTAL HEALTH AFTER CARE

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Essential to the development of a positive practice in mental health after-care is a precise formulation of clients' needs. Clarity about a statement of needs provides added information about anticipated obstacles to meeting those needs, both at the client and systemic levels. To accomplish this preliminary task, it becomes necessary to create what we refer to as a "problem definitional" level of theory. Problem defining theory mediates between more global theory, which establishes a larger context for understanding the broad policy issues and direct implications,* and the articulation of practice theory.

Problem definitional theory is a prerequisite to practice as it establishes both a direction and a baseline for evaluation of practice activities. At a programmatic level, it is necessary to recognize that all providers of services operate out of one or another approach to defining clients' needs (= problems) as well as a structure for delivering services. Properly construed, a service agency or organization is simultaneously a social system of interlocking roles/functions and the embodiment of an ideology or identifiable thought structure that frames the way the organization perceives social reality. These often underlying assumptions contour agencies perceptions of clients' existence, and establish the parameters of the functions they have to perform vis-a-vis one another (Warren et. al., 1974; Rose, 1972). The thought structure of an agency contains the problem definition or theoretical formulation that underlies all services and client-worker interactions. The thought structure also provides the formal and implied rationality for the infrastructure of the organization and for its location within the interorganizational network at the community level. As Warren and his co-authors state, the institutionalized thought structure constitutes,

> a common frame of reference regarding the nature of social reality, of American society, of social problems, and of efforts at social change and human betterment. (Warren, et. al., 1974, p. 19)

*For an elaboration of this approach, see Vicente Navarro, "Health and the Corporate Societies," Social Policy, Jan/Feb. 1975.

The thought structure or set of operating assumptions which typically characterize the commonly found health and social service agencies in most American communities is widespread: its hidden, but practiced beliefs assert the basic soundness and equity of U.S. society, its institutions, and patterns of behavior. The concealed social validation for our political economy and social structure is found in the overwhelming commonality in the way agencies define the needs/problems of their clients. Whether the client's assumed defect was in intellect, personality, discipline, values, family structure or neighborhood, one or more of these factors were taken to be the determinants of the client's social position in society. Agency responses, in the form of programs and service designs, for example, are often incapable of recognizing poverty as an inherent structural characteristic of our society; incapable of recognizing race, sex, age, or handicap as structurally and historically determined aspects or characteristics of American society. Problem definitional assumptions, validating inequity and/or discrimination, find their expression in paradigms of practice which carry with them practice technologies and assessment methods that turn out to be self-serving. They are incapable of critical reflection beyond the parameters of clients' defects. Rose's earlier research on the Community Action Program identified the same phenomena: in this case, agencies directed to engage in social change defined services delivered instead a common litany of individual defect modelled, and residual services (Rose, 1972).

The scope of commonality in problem definition across different types of agencies, operating in different service domains, in different cities was so typical that Warren et. al. referred to the pattern as an "institutionalized thought structure." (Warren et. al., 1974, p. 19). While agencies as different in their areas of special interest as the public schools, the urban renewal agency, the antipoverty program, the major mental health planning agency, and the health and welfare council were present in most communities, and had allocated various functions and tasks among them that differed widely, their locus of common understanding was in their operational paradigms of practice, all founded upon a set of basic assumptions invalidating their clients and validating the social system. (Warren et. al., 1974).

Upon closer examination, these agencies appeared to have established "legitimate" domains of domination locally, dividing the turf according to functions and prerogatives, claimed expertise, and professional leadership. What was found to exist was an informal, yet pooled hegemony over community activity and decision-making related to service design and delivery, a rather loosely orchestrated collaboration determined to protect individual agency turf from infringement or criticism.

Agreement among servie providers at the level of basic assumptions about clients, and ultimate responsibility for problems, allows agencies to attribute program failure either to client defects ("blaming the victim," as it has become known) (Ryan, 1971), or to a form of quantitative rationality. This

latter dimension manifests itself in continuous demands for more funds, more staff, more local control over program decisions, etc. Funding agencies, from the vertical system or extra-community (Warren, 1963, Chapter. 8) at the state or federal levels, most often share the institutionalized thought structure. In the unfolding of federal and/or state programs, vertical input rarely relates to problem definitions, especially so long as funding is available. During these periods, the nature of criticism, such as it was, assumed the problems that existed were related to lack of adequate coordination, insufficent comprehensiveness, and/or inappropriate representation on advisory boards, all examples of what we have referred to as administrative or management rationality. As fiscal constraint gradually increases, the demand for more effective coordination is joined by a growing interest in greater program monitoring and improving accountability mechanisms, introducing some strain between vertical system funding agencies and horizontal or local system providers of service.

When fiscal crisis continues unabated, however, the vertical system becomes more determined to locate measures of program effectiveness tied to cost containment. This trend has accelerated in public mental health care. Its pronounced mainfestation is reflected in the increase of people whose training is in disciplines and/or professions outside the typical mental health-social service preparatory schools. As a result, incoming policy planners, program developers and managers, decision-makers have little commitment to the various particular forms of individual defect explanatory paradigms of the prevailing institutionalized thought structure. Corresponding to basic values espoused by State Bureaus of the Budget, or the Office of Management and Budget at the federal level, their focus has been on management by objectives, fiscal accountability mechanisms, cost containment and system development.

The "New Breed" of mental health policy makers, however, are not consciously predisposed against prevailing individual defect models, since their systems training and management outlook contains no ideological or substantive critique of the structure of society. Instead, their professional set of responsibilities initially leads them to accept local system institutionalized thought, and, later, to begin to question it on the basis of cost-effectiveness measures of program outcomes. Recidivism rates probably stand as the most critical evidence available, with lesser variables including average length of stay on in-patient services, altering discharge planning to avoid nursing home placements, etc.

Because all socially legitimated professional training accepts prevailing ideology uncritically (Berger and Luckmann, 1967), and extends it by posing the functions of the professions as technical problem solving (Marcuse: 1964 and O'Connor: 1973), the "new breed" simultaneously struggles to improve services that are cost-efficient while having no substantively new criteria for determining what services will either be of value to clients or cost efficient. This phenomenon - of increasing technical and

management systems without precise theoretical focus - creates the opening for a problem definitional level of theory, a conceptual articulation of needs that offers a new paradigm for service design, implications for practice and bases for evaluation and training.

Basic Statement of Needs

A large number of studies have been done over the years which describe the process of becoming a mental patient in a state psychiatric hospital. Perhaps the most detailed account, Asylums, by Erving Goffman (1963), demonstrated the connection between defining a problem in a particular fashion, in this case, seeing dysfunctional behavior as a medical entity, and fashioning an entire social system whose ultimate function is to confirm that definition and rule out all possible alternatives. An absolute prerequisite to the smooth operation of any institution is the process through which its incarcerated participants learn the new parameters and intestines of the social reality they must accept in order to survive.

In the mental hospital, patients must come to accept their situation or "problem" as mental illness, as a disease which they had somehow acquired which, from that point forward, dictates the realm of possibilities for them, as interpreted by hospital staff. Staff, in turn, must produce mental patients out of people in order for their own professional identities to make sense. Once the activity of production of the mental patient has occurred, thus validating staff and invalidating patients (by turning them into adaptive, objectified response units), the drama of ongoing social interaction simply reproduces the inequality, domination, and manipulation inherently built into practice of the medical model.

At the center of the process of becoming a mental patient is "decontextualization," the severing of the patient's subjectivity from the objective historical context that frames and contours human social life. Another way of looking at decontextualization is to see it as removal from social reality. The reduction to isolated, asocial existence is bounded not by history, but by a belief system committed to psychopathology, medical hegemony, and somatic interventions such as shock treatment, drugs, and pseudomedical examinations. Decontextualized experiences of daily life also become saturated with new language, the language of mental illness, which contains such concepts as symptoms, regression, decompensation, "acting out," etc. These are all terms used to reduce social reality to intrapsychic distortion. In place of living one's life, however painfully, one now "functions" more or less well, and according to a set of rules and standards which have no bearing on rehabilitation or return to community living, but rather reflect management priorities decided by staff to be in patients' best interests.

When examined closely, the behaviors necessary to becoming a good patient, especially years ago, are behaviors exactly opposite to those needed by a person to survive in the social world

of community life. The good patient is docile, acquiescent, adaptive to commands both overt and subtle. She/he is overwhelmingly dependent upon staff, socially naive regarding rights and/or entitlements, and demoralized or frightened to be him/herself. After a time, the externally imposed new social order becomes incorporated subjectively - the problem definition coercively held out is tacitly accepted. But in the process, the patient undergoes an experience of anomie - of an abrupt withdrawal of norms and forms (universe of meaning) that communicated the exigencies of daily social life as she/he knew it before entering the hospital. The experience of such extraction of one's known universe of meaning is profound. Even conventional common sense communicates this to us when an significant threat of social change is raised in the common assumption that any departure from the routine represents absolute chaos. Rather than chaos, however, the hospital institutes systematic order, and the patient's experience of heightened anomie together with the hospital's rigid definition of reality combine to produce the mental patient. Any conscious or non-conscious effect at resistance, whether expressed behaviorally, emotionally or conceptually is understood to be part of the patient's symptom pattern, and thus brings about increased treatment responses designed to attain manageablity or control.

So as one gains the knowledge and skills necessary to survive in and adapt to the world of the hospital, one loses those same capabilities for life in the community. Seeing oneself as sick, having lost the ability to link subjective experience to objective circumstances, and seeing the necessity to quickly perceive the expectations of power holders, the mental patient's potential for independent or interdependent social life in the community is thoroughly compromised. Patients' social being, or personhood, is overwhelmed by their patienthood; their active participation in the consciousness of historical/social reality is overwhelmed by their passive acquiescence to and acknowledgement of their own invalid state. They have been disconnected from ongoing social existence, almost as if their capacity to engage in the process of struggling to live meaningfully had been surgically severed. It is exactly this objective aspect of utter oppression, behaviorally and conceptually, that constitutes what is called "chronic disability," or "institutionalization." It is a prerequisite to understanding practice to comprehend the experience to which people have been subjected, and to see their histories in the hospitals as a central ingredient in designing practice activities with them.

The other aspect of daily life that converges to form the matrix of understanding how to define the problem properly is much easier to elaborate. It requires that we remember that the mental patient, before entering the hospital, during their stay, and after their release, is essentially like us - a human, and,therefore, social historical being. In this capacity, so estranged from them because of hospitalization, they have needs/interests exactly as we do. Simply put, those needs include: adequate, safe, supportive housing; nutritious food; adequate clothing; varying knowledge of their rights and entitlements to

benefits and programs; legal protection; and the choice to participate in socially meaningful interaction with others who treat them with dignity and respect. Ex-patients need these resources socially, as a person living in the community, and not psychiatrically, as a patient residing outside the hospital. As such, any effort to deliver social resources in a psychiatric manner constitutes a situation in which the person's needs may be met, but in a way which contradicts his/her interests.

At this point, a slight departure is necessary to further articulate the difference between needs and interests as these terms were used in the preceding paragraph. Statements of need are common enough among mental health and social agencies. What such statements rarely take into account is that the way in which they define needs and/or construct services is entirely confined by their institutionial thought structures. Where those thought systems are premised on some assumption of the inherent defectiveness of their patients or clients, then the orientation towards defining needs will be confined to the parameters of their thought structure. In practice, this is commonly reflected in mental health providers' coupling psychiatric focus to community resources, or psychiatric determination of generic needs such as those outlined above: Sheltered housing has as its basis not some form of care for those unable to live independently, but rather the assurance that psychotropic medical regimens will be followed; Case management, rather than being built on advocacy and/or empowerment principles designed to guarantee the essential dignity and benefits needed, instead focuses on ensuring ongoing connection to mental health clinics and other treatment outlets. These psychiatrically oriented services, based on continued attribution of and re-inforcement for mental patienthood as an enduring identity, act against the interests of the former patient because they continue the pattern of enslaved dependence/hegemony, they disregard the exploitation inevitably built-in to profit housing arrangements, and they support passive dependence upon staff where it is not needed, thus manipulating the former patient into continued subservience.

The interests of former patients are quite different. They need the social resources described above delivered in a way which recognizes their hospital experiences as oppressive and debilitating, and works with them to increasingly regain their human vitality and activity in locating what they require. The true needs of the ex-patient are, therefore, complex in nature, reflecting the experience/existence of the ex-patient understood as a human being, not as a manufactured commodity/mental patient. Th use of the term "complex" here is intended: the needs interpreted in a way which recognizes the ex-patients' status as members of a class, are infused with the necessity to begin with material conditions - housing, food, health care, etc. - as a basis for understanding subjective responses. Put more simply, the ex-patient cannot be understood apart from his/her context, and that the form of self-expression used in any context is a crystallization of the social relations contained therein.

The behavior of the "chronic" ex-patient must be seen in two ways at the same time: it must be understood as a learned survival strategy, as historical baggage that the person brings with him/her from the hospital; and it must be seen as recapitulating and reflecting the self-confidence or self-image experience the person has as a result of the social relations she/he is and has been involved in over time. This latter dimension can be elaborated by seeing in the typical behavior patterns of the ex-patient the reciprocal functioning of the typical behavior patterns of the mental health professional; one cannot be understood apart from the other. When examining the ideological and organizational bases from and in which mental health theory and practice emerge, the larger context of social control, oppression and domination of both workers, confined to mental model paradigms, and their products - the institutionalized ex-patients-can be seen. Because the ideology and organizational environments are similar across states, the conditions for former patients discharged into communities across the country are quite similar. The ex-patients, then, while existing as individuals, simultaneously are essentially members of a class.

This issue is both complex and vital, and must be explained here at greater length. This will be done by drawing a distinction between what are referred to as essential aspects of former patients' lives and existential dimensions. Following the theoretical distinctions drawn above, the essential component or tendency in ex-patients' lives are the political and economic conditions which all endure in common that aggregate them as members of a common class. These conditions, in addition to the common base of long term hospitalization and its impact on self-confidence and self-image, and its effect on how reality is preceived (i.e., incorporation of the medical model), also has other constant characteristics: placement in profit-organized long term care facilities of one kind or another (varying by degree of regulation); dependency on third party payments for medical care; dependency upon continued eligibility and recertification for SSI or other forms of public assistance; and, most likely, continuation on psychotropic drugs. In this complex organization-infused and dominated existence, ex-patients are subjugated, exploited, and manipulated in common, as members of a class, and the contours of their daily lives are conditioned by these oppressive, coerced factors. Because this is so, and uniform, this dimension can be viewed as essential or political - it contains the objective parameters for subjective expression, and is the focus of the advocacy component of an advocacy-empowerment design.

This design is based on the assumption that objective, historical conditions contour the parameters of everyday life, and establish the bases for individual subjective experience and expression. The conditions exist, therefore, to create a bond between ex-patients, even the severely disabled, and ourselves. The bond is forged by acknowledging the essential human quality that comes from being part of history, from being socially alive, and, therefore, actually or potentially a creative participant in shaping the future. It is in this socially human crucible that

the enduring and inherent connection is made between political or essential life and personal or existential life.

Each of these aspects of every person is inextricably woven into the other, each a tendency without the capacity to lose its omni-present life. While both are present, however, they are not equally active participants in shaping daily life. Quite obviously, the historical/political dimension - bringing with it an ongoing political-economy, culture, ideology and social role structure - plays a pre-eminent role in determining the personal exigencies experienced by all of us. Particular patterns of self-expression, such as those manifested by ex-patients, reflect the particular forces which dominate existence: self-expression and personal experience, therefore, emerge as a social relational/political statement about each of us. Where the patterns of subjective experience and self-expression fully inculcate the political environment in its existential forms, our behavior functions to reproduce that environment and our place within it (mental patient, husband/wife, parent/child, for example). Where our form of self-expression is in conflict with the exigencies of the political environment, we pose a challenge or threat to it. Such a position requires some form of response from those political contexts invested in domination and control. The unwritten rule is that people must both behave appropriately, or according to the dictates of the social role structures of such a society, and must perceive reality in such a way that the behaviors they embody appear natural or normal. Peter Berger and Thomas Luckmann describe societal response to abandonment of this latter element, which they call a "conceptual machinery," similar in the individual to what we have earlier described in organizations as an "institutional thought structure":

> Therapy entails the application of conceptual machinery to ensure that actual or potential deviants stay within the institutionalized definitions of reality, or, in other words, to prevent the "inhabitants of a given universe from "emigrating." It does this by applying the legitimating apparatus to individual "cases". ... What interests us here, however, is the conceptual aspect of therapy. Since therapy must concern itself with deviations from the "official" definitions of reality, it must develop a conceptual machinery to account for such deviations and to maintain the realities thus challenged. This requires a body of knowledge that includes a theory of deviance, a diagnostic apparatus, and a conceptual system for the "cure of souls." (Berger and Luckmann: 1967, pp. 112-113.)

Sharing in the common universe of meaning, as the background for our own socialization, creates the basis for shared action. The particular experience of the ex-patient, in the process of becoming a "mental patient," is an example of the political role of-therapeutic enterprise in personal life.

Institutionalization, combining coercive physical relocation and rearrangement of thought to comply with a dictated reality,

extends the therapeutic mode of social control. Berger and Luckmann address this form of internal domination:

> Such a conceptual machinery (therapy) permits its therapeutic application by the appropriate specialists, and may also be internalized by the individual afflicted with the deviant condition. Internalization itself will have therapeutic efficacy.... Successful therapy establishes a symmetry between the conceptual machinery and its subjective appropriation in the individual's consciousness; it resocializes the deviant into the objective reality. (1967: p. 114)

The behavior patterns of the institutionalized ex-patient reflect their resocialization into acceptable patterns of thought and action. Severed from the knowledge of the objective conditions of reality, and medicated beyond its emotional impact, the ex-patient serves the State successfully by assisting to decrease State budgets; by serving as the conduit for transferring public funds to the private profit sector; and by being the "beneficiary" of federal-state funding programs which transfer power to the federal level.

These characteristics, coupled with the more commonly acknowledged matters of material need and program responses in the forms of profit housing and therapeutic activities, become the objective universe that extends the worst aspects of hospital life into the community. The pervasive influence of these objective factors reinforces the demoralized self expressed existentially by the ex-patient. It is exactly this demoralized self, communicated as mental patient self-expression, that becomes the focus of treatment by most after-care provider systems. In the implementation of programs which, either overtly or subtly, are founded upon a medical/therapeutic definition of reality, providers reinforce the decontextualization of hospital life. Taking the mental patient to be the same as the person disassociates mental health and other social service workers from their responsibility for their own activity. Accountable to both a profession and to an agency which employs people socialized into professional roles and thought structures, the workers become as disconnected from their real activities - consciously understood and chosen - as are their products, the ex-patients. Where the absolute confrontation with the material or objective circumstances of daily life is not seen as the basis for subjective expression, the essential and the existential components of living are transposed. In this process of turning reality on its head, the expressions of self of the ex-patients are presumed to be the determinants of their objective situation. The "treatment" strategy accompanying this outlook thus asserts that the subjectivity of ex-patients, as manifest in their self-expression, becomes the target for intervention. Therapy, drugs, and all rehabilitation programs are premised on this peculiar, but all too understandable belief. This effort is directed to reshaping the subjectivity of former patients by improving their functioning <u>within</u> their existing social roles, thus reaffirming the very aspects of the person they find most abhorrent.

The alternative position follows another road entirely. It asserts the primacy of reconnection to objective circumstances as the central problem to be addressed, as an ever-present theme to be interwoven in every aspect of practice. Rather than conceal its nature in subjectivism, it demands that ex-patients be understood as social, historical beings. Validation, a central value of this position, derives its meaning from the concept of reconnection. People, not mental patients, exist in history as actual or potential producers or paticipants in their own lives. Validation is communicated through the processes of reconnecting people to their sociality, disconnecting them from their object-status as mental patients. Idiosyncratic or existential differences, while not denied, are relegated to secondary importance, as commonalities rise to the position of primacy, and essential aspects of daily life that bond people together become the data base for creating support networks among people.

The task of engaging people as producer/participants in comprehending and acting on their contextual environment differs dramatically from working to improve individual patient's functioning, even though both may claim to improve the quality of life and self-image of the former patient. One way to view the scope and depth of the difference is to examine the meaning of being a producer/participant as compared to being a consumer/attender. The producer/participant must come to know the active ingredients which compose her/his social world of immediate influence. The framework for development of such a view is open-ended, confined by limits in our practice and by the interaction of resources available and decisions to act. It implies a conscious strategy for action, not an acquiescence to dictates. Since each of us is immersed in social role behaviors and ideology, in varying degrees, we all actively and perhaps consciously engage in a process of becoming. It is important to see that we are not moving either toward some predetermined model of what a proper adult might be, and thus subject to manipulation, nor are we posing some rhetorical infinity such as "the liberated person." In contrast, each of us can come to increase our knowledge of our historical and immediate context, and with active support, strategically intercede into it as participants/producers of what the outcome might be. While a group of ex-mental patients can not transform their condition of poverty, knowing that poverty has much to do with their present situation can produce different outcomes from seeing their condition as the result of an incurable disease.

More conventionally, service providers would like their clientele to become more adroit consumers of services. Consuming mental health or social services, however adeptly, communicates an entirely different outcome than engagement in a process of participation as a producer. There is a striking parallel between consumers of services and consumers of commodities: both are out of control of what they consume; both stand outside the determinants of the process of production; both act in response to a definition of their needs outside their conscious control; and both are passive recipients of the interaction. Navarro describes the effect of consumption on identity in the following

way: consumption, whether of goods or services, is the residue allocated to workers and non-workers by capitalist production, from which the workers are removed as a source of power and control. Being coerced into consumption creates feelings of helplessness, malaise and pessimism. (Navarro: 1976, p. 114). Consuming services is a process through which the consumer must take on the problem definition of the provider, much like the situation described above in relation to in-patient care. The process of consuming the service consumes the person: the likelihood of the consumer transcending the given universe of meaning established by the provider is very little, indeed. Marcuse captures this activity of service provision and consumption in a manner which aptly describes the mental health clinic - former patient relationship:

> To the degree to which they correspond to the given reality, thought and behavior express a false consciousness, responding to and contributing to the preservation of a false order of facts. (Marcuse: 1964, p. 145).

Marcuse's concern is with the diminishing capacity to develop critical analyses of society and its impact on peoples' thought and behavior, a concern which can be applied to mental health after-care.

In programs where people have been reduced to mental patients, where presentation of self and the essence of a person are presumed to be the same, both the person involved and the workers become flattened out. There is little to no room for creativity, for development, for change. The world of the possible becomes reduced to the situation at hand; stasis, paralysis, and demoralization occur. In a program which medicalizes poverty, exploitation, domination and abuse, the contrast between the given and the possible is collapsed or crushed. When the range of needs is defined in terms of medicalized interests, those needs which can be satisfied by this model are merged with those which cannot, creating a false universe of satisfaction or a defective or resistant patient. In this typical pattern, the concepts of patients and needs are "reduced," according to Marcuse, and these reduced concepts come to govern the analysis of human reality. The result is that these ideas convey

> a false consciousness - a concreteness isolated from the conditions which constitute its reality. In this context, the operational treatment of the concept assumes a political function. The individual and his (sic) behavior are analyzed in a therapeutic sense - adjustment to his (sic) society. Thought and expression, theory and practice are to be brought in line with the facts of his (sic) existence without leaving room for the conceptual critique of these facts. (Marcuse: 1964, p. 107).

Consuming mental health after-care services free from a conceptual critique of the objective reality of hospitalization and of post-hospital conditions is to consume a false reality. Living that false reality reaffirms the mental patient role, the

mental health worker role, and the set of institutions which created them. When we ask the question - who benefits? - we can see that the primary recipients are outside the equation. They include the profit accumulated by landlords and pharmaceutical industries; the savings sustained by the state governments; and the comforts extended to the professional hierarchies dominated by psychiatry.

What, then, is to be done? What is necessary is a practice paradigm which combines some a priori understanding of former patients' hospitalization experience together with a clear formulation of their needs - real, material needs - as residents of a community. It must seek to accept what former patients communicate about their lives as statements about their self-expression and their view of the perception of them held by powerful others in their past and present environments. It must devise ways of reflecting this shared communication back to the former patients in a critical manner, so that the interaction neither reinforces the oppressive reality nor reproduces it. To formulate such a practice requires a theory of practice consonant with the broader theory and problem definitional theory presented above, a practice, for example, based on the work of Paulo Freire (Freire: 1971). By applying Freire's "pedagogy" to former mental patients, we can more easily recognize the class nature of their oppression and develop strategies for change which do not replace one pattern of hegemony with another.

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