A Proposal.

We should emphasize that what follows is a description of a group of services to be offered in the community and by which we hope to change the service patterns to a majority of patients who without these services would be considered proper for treatment in a large mental hospital.

Disadvantages of the system.

We will not belabor the inhumanity of the traditional system. We state as a premise that treatment for mental illness should be humane, as effective as our knowledge permits, and readily available with a minimum of environmental dislocation. Nor will we recapitilate the arguments that large institutions are harmful, per se. We will rest our case on the twin arguments that these forms of treatment are relatively ineffective and that they are very expensive. They are expensive because of the generally high chronicity rate, that is, the number of persons who are not

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discharged and whose hospital stay comes to be measured in decades. This is a minor but fiscally most important group.

To understand this situation better we must consider again the nature of much serious mental illness, particularly schizophrenia. These illnesses are inherently chronic and remain a powerful influence on the person between the more flamboyant episodes. The major symptom of the chronic state is a relatively pervasive lack of competence which makes normal life stresses become a crisis situation for such a person. In a crisis situation they tend to decompensate and have recurrences of their acute symptoms. Acute episodes are relatively easy to deal with by use of drugs and a structuring of the environment. To improve the stability of the chronic patient we can change his reaction to crisis, increase his competence, or both. Even before the advent of modern drug treatment, about 1954, most patients (perhaps 75%) were discharged from hospital. Today, an acute hospital which says that it only sends 15% of its patients on to a large hospital should be regarded as useless since it is only about 15% of patients who pose a substantial therapeutic problem. However, if as few as 6 - 8 % of patients move into the really long-stay category the hospital population will probably increase and with it the treatment cost.

<u>The Needed Elements of an Alternative System</u>.

The first element of an alternative system should be problem solving help, easily and quickly available when needed. Not only should help be available but the patient must feel and

believe that it is available. Help would be defined here as any manoeuvre which will alleviate a crisis situation. It is down to earth and practical. The second element should be some sort of learning situation where either the patient is made more competent and thus less subject to crisis or the patients reaction to crisis is changed.

The core of our system we will call the Community Care Service. A Community Care team would take primary responsibility for the care of serious mental illness from an area whose population ranged from 50 - 100,000 depending on the rate at which the area generated serious illness. Those who are familiar with the current Home Treatment Experiment will see similarities between the functions of the Home Treatment Team and the Community Care team. We have given the group a new name to indicate that in this plan they play a wider and more general role than they were able to play in the absence of a system of service alternatives to hospitalization. It might consist of an administrator, a psychiatrist, a senior mental health worker (i.e. a qualified and experienced social worker, psychologist or graduate level trained psychiatric nurse) and five or six basic mental health workers (in our experimental studies we have used psychiatric nurses, elsewhere psychiatric aides with special in-service training have been used). Any person who was considered seriously mentally ill would be referred to this team and team members

would quickly assess him, usually by a home visit made by one or more team members. If upon assessment the person seems to need treatment he is accepted by the service, if not he is placed with the most suitable alternative help available. The most common reason for non-acceptance will be that the person is not sick enough. If he is accepted he will be assigned to a basic worker who will be his helper, advocate, therapist and friend until he is discharged from the system of services. This is the core linking service and a patient must be accepted into it before he can use any of the specialized services ancillary to it. The task of the basic worker is to see that the patients problems are solved, through his own efforts if possible, but with guidance and outright assistance if that is necessary. Over time we would expect the basic workers to become proficient in working with therapeutic groups and to understand drug therapies. While in some cases the patient might be managed by the Community Care Services alone, it would be more usual that responsibility would be shared by a referral to one or more specialized services. We would emphasize that the basic worker-patient relationship would be maintained throughout these additional contacts and that the patients final separation from the system of services must be effected by the Care Service.