

COMMUNITY ADJUSTMENT OF FORMER MENTAL PATIENTS AND NEEDED  
STEPS FOR THEIR ASSISTANCE

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During the past fifty years, different therapeutic approaches in the field of psychiatry have been advocated sporadically. However, it is only recently that the psychiatric profession at large became alert to new concepts in the areas of intra- and extramural psychiatric treatment and the profession at large became aware of the vast psychosociological responses evoked by our new therapeutic measures. The entire concept of aftercare and follow-up, although known for sometime, has only recently begun to receive greater attention. This all started when new pharmacological compounds, generally known as tranquilizing drugs, were found to be effective in the treatment of psychotic patients. It is true that chemical agents have been used before in the care of mental patients, but it has to be stressed that never before has any drug been used on such overwhelming numbers of individuals. Dr. Paul H. Hoch, New York State Commissioner of Mental Hygiene, recently stated that today some 40,000 of the State's mental hospital patients, or 45% of the total mental hospital population, are receiving drug therapy as compared to other treatment. As a result, large numbers of patients have been released from our mental hospitals and returned to their communities. Since July 1, 1955 when it reached the peak of an ever-ascending spiral, the population of the New York State Mental Hospitals has dropped by some 3,500 patients. This reduction in population was achieved in the face of rising admissions and in spite of an economic recession, the latter factor being known to generally bring about an increase in the state hospital population.

The use of these new drugs has resulted, not only in a significant increase of discharges, but in a tremendous lessening of disturbed behavior in all psychiatric hospital wards where these drugs are used. There was no outstanding increase of either personnel, time, or in the expenditure of fiscal money appropriated. The only appreciable change was in the fact that during 1955-56, 30,000 patients, and lately, as was mentioned before, 40,000 patients received drug therapy in New York State alone, an increase large enough to produce a material effect or release, if the treatment is therapeutically active.

It is interesting to note that the highest discharge rate from our mental hospitals came from those categories of patients who received the most intensive drug therapy. It is also noteworthy that the greatest improvement in rate of discharges occurred among patients with a long hospital residence, and was less among the newly admitted cases. It was found that during the past four years the state hospital population in New York State decreased by a total of

3 to 40,000 patients, instead of an expected increase of about 8,000 patients.

The question has been posed, why this form of therapy has had this result? There are possibly a number of reasons why this was possible, but one of the most outstanding reasons seems to be that for the first time an agent became available which could easily provide continued treatment for a prolonged period of time, on a maintenance basis, thus making it possible for patients to be kept on a level of satisfactory mental functioning for a prolonged period of time. This is due to the fact that for the first time therapy can be carried out outside of the hospital by just administering medication, whereas before, complicated forms of therapy, such as, electroshock, were necessary in order to maintain a certain level of mental functioning. Also, for the first time, we were able to come near our therapeutic goal; that is, to achieve for our patients optimal psychological, social, and vocational capacities in the community.

There is another factor of importance to be added here. While before the advent of our modern drugs, the return rate of patients, who after release from the hospital required renewed hospitalization, amounted to about 33 to 35%, it now, for the first time, became possible to keep this return rate down to between 10 and 20%. However, for the first time, also, the assistance of the general practitioner has become imperative, because extensive drug therapy requires supervision, and this frequently can only be provided by the general practitioner.

In considering the needs for continued care of the former mental patient in the community, several outstanding questions are generally asked:

1. Which patients do require maintenance therapy? After several years of investigation, it can now be stated that most all chronic patients, that is, those who have had extensive hospitalization, or several hospital admissions, must be kept on maintenance therapy, if recurrence of symptoms are to be prevented. Some cases, however, although of a more acute nature, do require maintenance therapy, if the stress situations in the environment are considerable. It appears, for instance, that the excitement of coming home and adjusting to the outside world is better tolerated if maintenance therapy is given for at least the first few weeks, after which it can be again discontinued.

2. How long should maintenance therapy be continued? Chronic cases seem to require infinite

continuation of maintenance therapy. If such therapy, however, is started in order to bridge the period of readjustment, this can be safely discontinued after the patient is comfortable and establishes a new routine of life. Occasionally, when a patient starts employment and the tension interferes with his sleep, maintenance therapy over the first few weeks has proved to be helpful in assisting the individual in work adjustment.

3. How high should maintenance dosage of the mostly used drugs be? Generally, most of our patients released from mental hospitals are given information regarding the type of drug used effectively inside the hospital, as well as the amount required, so that they can pass this information on to their family doctor, and, not infrequently, the family physician is contacted directly by the hospital doctor prior to the patients' release. These recommendations usually cover existing needs to maintain the level of mental improvement achieved inside the hospital prior to patients' release. If, however, symptoms, such as anxiety, insomnia, hallucinations, delusions, or vague somatic complaints appear, the dosage has to be increased for several weeks. With the disappearance of symptoms, the dose can be lowered again to the previous amount. In this way, it has been possible to control cases of impending serious relapse. A single daily dose at bedtime seems in the majority of cases to maintain the level of improvement without causing drowsiness that might interfere with work. But it appears imperative for these patients to be under regular observation of a psychiatrist or a general practitioner for control of dosage and of possible complications, and in order to vary the dosage according to individual needs. Another important reason for seeing these patients at regular intervals, is the need to determine whether the drug is actually being taken. Sometimes, patients coming to the office show considerable irritability and tension, and, upon questioning, it will be noted that these patients have not taken their medication for several days. Moreover, stress situations requiring change of dosage can be discovered only if these patients are seen frequently enough.

4. Another question frequently posed is: What is the incidents of complications? The question of greatest concern, particularly in connection with the aftercare of mental patients requiring maintenance therapy outside of the hospital, centered around this possibility of complications resulting from prolonged drug administration. Thus far, however, it seems that there are far less untoward side effects caused by any of these phenothiazine derivatives, even when taken for a prolonged period of time, than might have been anticipated. The only side effects observed on a large number of patients kept on maintenance therapy in the community over a period of years were: mild skin rashes, constipation, and occasionally, drowsiness.

It should be mentioned here, that generally the literature on psychiatric complications arising during pregnancy and childbirth reveals

that almost all authors agree that rapid and dramatic changes in the course of normal life processes frequently are accompanied by emotional reverberations. Thus, many authors considered pregnancy and childbirth to be immediate precipitants of schizophrenic reaction types. There seems to be general agreement that persons with a history of earlier emotional and personality disorders are liable to become overtly psychotic in reaction to the stress of child bearing and childbirth. In my own study, I have had the opportunity to observe twenty-four women who had been hospitalized between two and ten years, how, after returning to the community, became pregnant again. They went through pregnancy, childbirth, and the post-delivery period on maintenance therapy without the psychopharmacological compounds. As a result, the relapse of the mothers into a psychotic condition, was prevented, and, up-to-date, these women continue to function successfully in the community and are able to take care of their infants. These infants, up-to-date, have shown no ill effects and are developing normally. The oldest of these children are now about two and one-half years old. In this group, only two women who had refused to continue with drug therapy, relapsed at the end of their pregnancy and had to be returned to the hospital.

It actually can be stated now that the greatest problem encountered in this form of therapy lies not in any ill effects of such therapy, but in the fact that the patients themselves are frequently reluctant to continue with drug therapy. To overcome this, better indoctrination of families, as well as of the patients themselves, is absolutely necessary.

In addition to these factors, we have to consider what returning our patients to the community really means psychologically and socially. One cannot disregard the fact that, frequently, families show a great deal of anxiety when faced with the necessity of accepting relatives back into their circles sometimes after years of separation which that member had spent in a mental hospital. One has to consider that institutionalization does effect an individual's habits, and that these habits and modes of life, at times, are difficult to be tolerated by the environment. It thus will frequently be important for the family physician to discuss existing problems with all members of the family, as well as with the patient, and to attempt to assist the in straightening out such existing problems.

Among other factors, for instance, families frequently wonder why the patients returned home cannot start working immediately. Although they are willing to admit that after any physical illness an individual requires some time for recuperation and readjustment, they are unwilling to allow the same thing after prolonged hospitalization for reasons of mental illness. Others, again, are rather over-protective, interfering with the patients' attempts to do things on their own; to work, to start any kind of social

life, frequently being afraid of what neighbors might think or say.

In the unfolding of a special study of the social factors involved in the general rehabilitation of mental patients, it became apparent that a greater number of individuals, about 32%, were able to find gainful employment on their own initiative than had been anticipated. These findings are particularly interesting, as many of the patients in this group were hospitalized from over two to thirteen years. While, presently, a number of patients are unemployed, only about 10% are considered not employable at all. About 47% need some form of vocational rehabilitation, either to learn new skills, to brush up on old skills, or to develop work tolerance.

While several of the men and women returned to their former jobs, others found employment through contacting private or public agencies; others, through contacts of one or the other member of the family, or through the daily newspapers. While the employers of those patients who returned to their former jobs knew about their employee's former illness, most of the other patients withheld this information after having had experienced on two to three occasions when applying for a job, that they were not hired after having told the truth. When asked about recent employment thereafter, these patients stated that they had been physically ill for some time, or gave some other personal reason for their recent period of unemployment.

In a group of three hundred and fifty patients under observation for the past three years, 65% of the men and women gainfully employed, required maintenance pharmacotherapy. In none of the cases did this interfere with their work capacity or work performance, nor was their any accident proneness observed. But it was noticed, that when these patients were exposed to too much pressure on the job, symptoms were quickly reactivated; they disappeared as soon as pressure eased off.

Several patients were able to learn new skills and to go through some type of formal education, as for instance, working toward a high school diploma. Pharmacotherapy did not interfere with these undertakings.

In the majority of cases, a single dose of any of the tranquilizing drugs given at bedtime, was all they needed to help maintain these patients' functioning in their community.

In concluding, it can be stated, that new psychopharmacological compounds are of great value in helping to maintain former hospitalized mental patients in the community. No drug, however, can change the social and economic pressures which prove to be the underlying cause of many of the relapses encountered. Our new drugs can help insulate the former mental patient from the stresses caused by ignorance and prejudice, but the stresses are still there, and every attempt possible should be made to gain better knowledge about their nature and to find means by which they can be eliminated, or, at least alleviated.

To achieve this, we will have to provide sufficient extra-mural services, making available for these patients all forms of psychiatric treatment.

Some of the other existing needs which became apparent are:

1. Better education of employers and the public in general to counteract the still existing prejudices.
2. More sheltered workshop facilities where patients could develop work tolerance, as well as be provided with the opportunity to refresh previous skills.
3. Supervised residences of the boarding house type for patients who have neither a family, or where realignment of the family circle has proven to provide unfavorable circumstances for the returning patient.
4. More and better organized family care programs, particularly for younger patients.
5. Social clubs of the A.A. type for these patients to counteract the so frequently existing isolation.
6. Community clinics to provide, where necessary, supervision of pharmacotherapy, and particularly, to provide the so frequently needed supportive psychotherapy.

In taking these needs into consideration, we will be better able to achieve the goal we are striving for- that is, full social, economic and vocational rehabilitation of our mental patients returned to the community.