DE-INSTITUTIONALIZING PSYCHIATRIC PATIENTS

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This paper attempts to study the transition that has taken place in the system of care for the mentally ill persons from institutional to community care. It focuses mainly on the process of deinstitutionalization with particular reference to the implications of this process for the care of psychiatric patients. The purpose is to draw lessons from the situation of the west so as to help avoid some of the pitfalls involved in the transition taking place in the field of psychiatric care in our country.

In the recent times there has been a growing interest in community based services as alternatives to institutional care of psychiatric patients. The new approach which involves the movement of hospitalized patients to the community is replacing the concept of Institutionalization. It includes:

- The preventing of inappropriate mental hospital admissions by providing community alternatives for treatment

- The discharge to the community of all institutional patients who have been provided adequate preparation for such a change.

- The establishing and maintaining community support systems for non institutionalized persons receiving mental health services in the community.

"Deinstitutionalization is the process by which large numbers of patients are discharged from public psychiatric hospitals back into the community to receive out patient care"[1]. It required attitudinal changes, new legal and administrative measures, new public policy, funding and personnel for executing the new programmes in the community. It demanded the discovery of new means for providing shelter and treatment to the psychiatric patients that met the contemporary requirements. However, a large number of patients had to be readmitted within a short period of discharge.

In the developed countries mental health services are moving from the mental hospitals to the community. Community care centres, rehabilitation centres, day and night hospitals, halfway houses, foster family care, transitional employment under supervision after discharge from mental hospitals are the new dimensions of mental health services. Psychiatric facilities in Mental Hospitals are basically treatment oriented and still at primary level. But research studies have demonstrated that patients can not sustain or improve through Mental Hospital without substantial help from outside.[2]

The shift is a post world War II phenomenon. The effects of World War II created a traumatic situation for the Western World. Mental health problems posed by separation, bereavement and destruction of homes as a result of the war stimulated interest in mental health and its influence on society. The conditions created by the war and the fact that soldiers of all social classes were receiving mental health care helped remove psychiatry from its relative isolation and brought about increased respect and public recognition for mental health professionals and services. The psychiatric problems that occurred during the war emphasized the role of social and physical environment in

the onset, process, treatment and care of psychiatric disabilities.[3]

The shift to community care is based on the premise that psychiatric patients are entitled to reside in an environment which is least-restrictive and conducive to as much independent living as possible.

In USA in the late 1950s "Many patients were released into various aftercare clinics, where they continued to receive psychiatric treatment and rehabilitative services. Others were placed in new types of institutions, such as halfway houses, board and care facilities, and public housing units".[4] However, Political battles developed between those who wished to strengthen mental health programs according to a traditional medical model and those favoring new approaches based on the public health point of view.[5] Those espousing the latter, more radical approach based on prevention and community care prevailed. This resulted in a proposal called for the creation of comprehensive community mental health centers that would make it possible for most of the mentally ill to be successfully and quickly treated in their own communities and to return to a useful place in society. The approval of committee's recommendations paved the way to the enactment of Community Mental Health Centers Act 1963 which became the basis for a major part of the government's involvement in deinstitutionalization.

Care of the psychiatric patients in Pakistan.

Pakistan having remained a part of the sub continent of India and ruled by the British, for over a hundred years, development in every field of life including public system and Medical services were required to support

the British army and civilian personnel residing in the sub-continent. It was in 1858, that the Royal Commission on

Health conditions of the Army in India decided to extend the medical services to the civilian population. Which opened the western medical services but only to a fraction of the population i.e., the affluent and the politically influential. This was also true of the services in the mental health field. Large custodial type of mental asylums were built in Lahore, Baraily, Patna, Madras and Bombay. At the time of independence, there was one mental hospital in Lahore which was built in 1940.[6]

These institutions were over crowded and under staffed particularly in specialists of mental illness. There were no professionals other than medical personnel on the staff of the mental hospitals. Psychologists and Social workers were unknown commodities. Even the physical structure of the institutions characterized by high prison like walls and barracks suggested their custodial character. This however, was in consonance with the social context. [7]

The services for the rehabilitation and community care of the mentally ill have been very slow to evolve in this country.[8] The facilities for the treatment of the mentally ill had not yet emerged from its dark ages, when mental illness was considered not only beyond cure but often attributed to possession of the patients by demons.[9] There is still immeasurable exploitation going on in this medical field on the pretext of possession by "Jins" and "Sayas" etc. Cruel methods are employed by ignorant men to expel sprits from mentally insane.[10]

"Psychiatric sections/units in Government hospitals/clinics came up after the availability of major tranquilizers from fifties onwards. Recent years have seen proliferation of these in the cities of the country with some initiatives in towns but not at the rural level. The major part of country side, therefore remained without proper psychiatric cover and an easy prey to practices such as bleeding, chained

and roped at shrines and at best at the disposal of "hakeems", "sanyasis" or religious and quasi-medical practitioners".[11]

During the late 1950s and early 1960s some major changes took place in medical field. Pilot medical social projects were established in some of the government hospitals. In the first five years (1955-60) plan medical social projects were instituted in some of the bigger mental hospitals including the government mental hospital at Lahore. Which necessitated the revision of our conception of roles both of the mental hospital and psychiatric team to include psychiatrists, psychologist and psychiatric social workers.[12]

In 1962 a group of motivated citizens and professionals formed Lahore Mental Health Association to solve the problems faced by former psychiatric patients after discharge from the hospital. The association aimed at advocating the cause of community mental health research and rehabilitation of the psychiatric patients. "It has long been recognized that discharged patients from mental hospitals find great difficulty in rehabilitating themselves in the community and to their work. The problem can be visualized through the increasing rate of re-admissions to the mental hospital and prolonged institutionalization of the mentally ill in Pakistan.[13] A survey of five years admission (1960-65) to Government Mental Hospital, Lahore was undertaken. It revealed that out of the total 8528 patients admitted during this period more than 12% were re-admission cases, who after returning to the community from the hospital were re-hospitalized within a short period of time.[14] It was therefore, decided to establish on experimental basis a community based rehabilitation service to bridge the gap between the hospital and the community. Many different kinds of facilities for community care of the mentally ill such as ex-patients club, the halfway

house, family care, sheltered workshop, day and night hospital had mushroomed in the West. The experts of the Lahore Mental Health Association selected a model and it was termed as " The halfway House and Day and Night Hospital" and it was established in December 1971 and named Fountain House after the name of a similar facility in New York.[15]

"Fountain House, Lahore is a unique experiment in the field of transcultural psychiatry because of the collaborative links between Fountain House, New York and Fountain House, Lahore established through Social and Rehabilitation Services, Department of Health Education and welfare U.S.A.[16]

The main objectives of the project were, to reduce the frequency of re-admissions to mental hospitals and vocational and social adjustment of the mentally ill.[17] The underlying philosophy for the "House" is that "the mentally ill must be helped to regain their self esteem and to become contributory member of the society by providing them with an understanding environment.[18] To meet these objectives the "House" is providing various services to its subjects, such as boarding and lodging, vocational training, treatment, family counseling, group therapy and individual care, re-creational activities like music sessions, games and social evening, job placement, public education and follow up.[19]

Fountain House is a research cum demonstration project initiated to meet the rigorous demands of a scientific investigation "and during its first two years of existence functioned as a halfway house for the improved mental patients, discharged from the Government Mental Hospital, Lahore. They were called "Members" and the programme was organized on the pattern of a Club House. The stages of its development, however, followed a different pattern

than Fountain House, New York, because of a variety of socio-economic and cultural differences.[20] Inspite of the experimental nature, the results obtained in this period were encouraging not only in terms of statistics but also in terms of human happiness and dramatic changes in some individual cases.

The first comprehensive follow up of the ex-inmates undertaken in 1974 showed that at the time of their acquiring membership in Fountain House only 25% of them were employed. At the time of their follow up, 50% of them were found to be in gainful employment.[21] Besides employment they adjusted themselves in the community. More than 2000 members have been successfully rehabilitated over the past 20 years.[22]

The findings of the study showed that the services of the House helped the patients in its programme in obtaining and retaining jobs. Their social adjustment as reflected in personal relationship also registered some healthy trends. The rehospitlaization or relapse rates, however, do not seem to be greatly affected. These findings confirm the results of the long-term studies of hospitalization rates conducted at Fountain House New York, which showed that attendance at the House delayed but did not prevent hospitalization.[23]

The Fountain House model is a pioneering effort in the filed of community care of psychiatric patients and it has demonstrated effectively that with the help of community and appropriate service patients can be de-institutionalized and cared for in the community. The Fountain House Model is being replicated in other parts of the country.

An other rehabilitation facility in Karachi at the Jinnah Post Graduate Medical Centre was instituted in 1960s. This too was supported by the social and Rehabilitation service U.S.A. It consisted of a workshop where schizophrenics

were provided with opportunities to improve their capacities in a sympathetic environment.

The community mental health programme launched in 1985 by Professor Malik Mubbashir in Rawalpindi is another significant development in community rehabilitation of psychiatric patients." It is community based where the existing infrastructure of health service is utilized to help identify and manage high priority mental health problems, which include psychotic states, depression, epilepsy and mental retardation".[24] Training is imparted to the family, community groups and teachers for creating awareness of the illness and its recognition and sympathetic care of the patient.

A Club House for persons with Mental illness has been established in Islamabad by the name of friendship house. Effort is being made to combine the positive elements of Fountain House in Lahore & New York, two culturally diverse settings with the same objectives.[25] The main elements of Friendship house programme are:

1) The membership concept is based on the policy "No payment to members for performing duties in the clubhouse".

2) Keeping the character of the clubhouse as an agenda of involving members in meaningful productive activities.

3) Shaping the programme to the individual rehabilitation needs of the members with the objective of making them productive members of the society.

Thus we find that in Pakistan too there has in the recent years been a perceptible trend in limiting patients stay in hospital: for shorter durations. The reasons have probably

more to do with the large number of the mentally ill over burdening a limited number of institutions and a high rate of readmissions. The readmissions probably indicate lack or inadequacy of post discharge rehabilitation services + social support system in the community or both. The joint family providing the necessary bullwork against contingencies of life is proving to be a myth. The system has grown much too weak under the socio economic pressures of modern day living. The psychiatric social workers bear a testimony to the fact that the families refuse to accept their ill members after discharge from the mental hospitals.

The problem of taking care of the mentally ill in the community is further compounded by our attitude towards mental illness and the mentally ill which are characterized by superstitious beliefs and practices.

On the other hand the efforts made so far constitute only a drop in the ocean as the problems of the people in need of community care are gigantic in magnitude. All the same these services must be considered as forerunners of a much more comprehensive system of services that hopefully will be evolved in times to come. A lesson that can be learned from the experiences of the west is that the process of transition from institutionalization to community care must be a gradual one and accompanied with careful planning and study of the implications for both the patients, their families and the communities. It must also take into consideration the socio-economic and cultural constraints involved in the process which is fraught with dangers.

End Notes

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