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Inpatient and Day Care Service

An inpatient psychiatric service is a key service element of a local program. It may also provide a home base for professionals who work in reception, outpatient, and consulting settings. The special characteristic of inpatient service, when conducted as an aspect of a larger local service program, is rich linkage with other types of local service. Such links allow movement of the objectives of inpatient service away from shelter and asylum toward operations that enhance adaptive capacity for life in ordinary locations. As inpatient service is more fully linked with other categories of service, average inpatient stays are shortening, now averaging fewer than twenty days. Inpatient service can be conducted using practices that productively involve the family and network. An inpatient setting can be a constructive place for commencement of coping work and for testing new life skills. When hospital care is conducted in a manner that does not separate an individual from his usual life pattern and from his social network, it can provide an advantageous setting for the titration of psychotherapeutic drugs, for withdrawal from an addicting material, for assembling clinical planning information, and for drawing together the patient's fragmenting social network. Key professional activities in inpatient care, when conducted as an element of a network of services, are provision of a temporary social system

that can help a person return to usual function and arrangement of circumstances for the work of reconstructing a more permanent social network. If an inpatient service is distant from other local services, or included within a larger, regional hospital facility, for example, a state mental hospital, it seems important that the service be reaching toward increasing linkage with a network of extramural services rather than operating primarily as a component of the regional hospital plant. Administrative movement to accomplish these objectives is sometimes called “unitizing” a mental hospital.

Inpatient service can offer hazards to a local service program. It is usually the most expensive element of local service. Unless used precisely, inpatient service can encumber so large a fraction of the program resources as to constrain their overall productivity. If offices, administrative activities, and clinical records for many parts of the local program are located at the inpatient service space, inpatient operations can divert attention from important events in the more distributed program elements. Also, inpatient service appears to carry more recruitatory effect than nonresidential services: It tends to separate an individual more completely from his network and from ordinary environments and draw him into a life pattern embracing extended contact with service networks and environments. In some locations, the courts and the legal code governing movement to and through some forms of treatment status join in viewing the service network as if it were constituted principally of inpatient activity. Such a view can jeopardize

development toward a network of more varied service elements. When the interested court is brought into service planning work, particularly around efforts for the court and service agents to relate as collaborators in planning an effective reception service, the court can be a force of consequence in developing a varied service network.

Day care and night care, perhaps because they do not separate a person from the ordinary setting of his life throughout the whole of a twenty-four-hour period, appear to convey distinctly less recruitatory effect. They are relatively inexpensive and offer efficient extensions of the staff and other resources that comprise an inpatient psychiatric service unit. Hertz et al. demonstrated that day hospitalization frequently offers a shorter, less expensive, and more valuable clinical product than inpatient care, in studies that seem to control for severity of illness and other important variables. In order to use day care, a patient must be able to travel back and forth between the service point and a residence or job and must not be addicted to a narcotic material. The productivity of day care service seems to be related to its special capacity to provide intense, precise service during one portion of a day, while allowing the individual to operate in ordinary locations for the balance of the day.

Outpatient Service

The volume and variety of outpatient service is in a phase of rapid expansion in the United States and is likely to be the major element of local services in most areas. In this discussion we use the term “outpatient service” to designate service in which the patient moves with free social excursion about the community, is not located in a specially designed, residential facility, and comes intermittently to a place of service for contacts lasting minutes to several hours. The principal components of service provided in a psychiatric outpatient facility are psychotherapy, decision counseling, application and monitoring of psychopharmacological agents, services that monitor the behavior of individuals who have experienced a significant episode of disability, and services that enlarge an individual’s operating social network. The demonstration that expanded outpatient care tends to prevent, shorten, or reduce the frequency of return to inpatient care has been made for many risk groups and for many parts of the United States.® It has also been demonstrated for many communities that risk groups underrepresented in outpatient care, for instance, children, retarded persons, old persons, and delinquents, will tend to be overrepresented in inpatient care. From these findings emerges the precept that outpatient services for any territory can have the greatest impact on reducing the use of institutional modes of care if such outpatient services are designed for, and focused onto, persons and groups known to be likely to be institutionalized from that community.

Within the overall group of persons at risk of institutionalization, those

who often can use outpatient care most effectively are persons whose role performance and network linkages are substantially intact. Persons whose adaptive efforts and skills for maintaining their social attachments are discovered to be even partially operative usually can be serviced in outpatient settings.

Several design features of outpatient care seem to expand its potential contribution to the overall service capacity for a settlement. If closely linked with a reception service, it can interrupt and control the routes to and from institutional care. If linked with other categories of service, especially job training and general health services, it can provide the setting for groupings of service that benefit particular individuals. The arrangements for groupings of interlocking services, often provided under several agencies' auspices, are most expeditious if they include service exchange agreements of the reciprocal, non-decline type. Other important characteristics of effective local outpatient services are staff competence in the provision of temporary, task-directed relationships, provision for convening the family unit or other portions of a patient's network, funding arrangements to provide service access for migrant persons and poor persons, and apparatus for participation by the service consumers in the design and assessment of services.

Home Care Service

Judging from the best results reported, home care may be advantageous and currently underutilized in local service programs. Perhaps it is not more prominent because of the cultural and organizational supports it requires. When the necessary professional skill, administrative support, and family interest are present, the use of the home as the setting for all, or a portion of, a program of care appears to offer advantages in cost and social outcome. The use of the home as a principal location, and the family as central providers of care activity, can result in prevention of hospital admissions, significant expansions of staff skill, expansion of the management options available to reception service workers, reduction in extrusive activity by the social network and a lower likelihood of future hospitalization. Used with children, it bypasses a very difficult design requirement of residential services for children, the need to provide a special school and a substitute family unit during treatment. With elderly persons it bypasses the hazards attendant separating an individual from a nurturing family unit and familiar environments. With schizophrenic persons it can result in increased effectiveness of the family unit as a problem-solving entity during crisis periods.

In order to deliver effective assessment and treatment work within the home, it is necessary for the family unit to have a suitable dwelling place and willingness to participate. The home care staff group needs appropriate experience, mobility, and rapid response capacity. The capacity of the family

to attempt care of a member in the home can be assessed in ordinary reception service settings or in the home. Professional ideological beliefs suggesting that home care cannot be expected to be successful may contribute to the existence of styles of practice that omit home assessments or treatment arrangements. Home care is seldom useful as the setting for withdrawal from drug addiction or abuse or when the family cannot be diverted from a fixed pattern of extrusive sentiment, as assessed during reception service or during an exploratory home care visit.

Shelter Care Service

Included under the term “shelter care” are halfway houses, sheltered workshops, and expatient clubs. They are grouped together because of an identifying similarity: They couple the provision of a specially altered local environment, or group, with an absence of limitations on free movement about the community. Such programs attempt to enhance individual adaptive capacity by offering a special environment or group for a part of the time only. They envision competent engagement with ordinary life settings as the primary objective of service. Halfway house service usually follows inpatient service, a response to the fact that much of the adaptive work formerly done in inpatient settings can be accomplished more easily in other settings. Halfway houses embody a small social unit and a sharp focus on skill-enhancing objectives. Other features of shelter care environments may

include an organized schedule of daily social activity, an associated work setting for wages or for the acquisition of job skills, sleeping and domiciliary provisions, often somewhat like a boarding house, participation in a regularly convened social network comprised of persons with similarly precarious attachments, decision counseling, behavior monitoring and direct critique by professionals and by members, and other outpatient services, including phenothiazine monitoring. In all the variations of shelter care, the central objectives remain the expansion of role and job skills and the expansion of skills for maintaining a social network. The risk groups effectively serviced in shelter care settings cover the full range of diagnostic and symptom groups but have in common the atrophy of social attachments and job skills, sometimes derived from experiencing prolonged, or repeated, institutionalization.

Shelter care services have a capacity to flourish under a variety of auspices and organizational arrangements, including families and expatient groups, whether local or affiliated with a larger grouping, such as Recovery, Incorporated or Alcoholics Anonymous, and with or without continuing professional participation. Most shelter care organizations work toward autonomous financing and policy development and to involve all their members in the tasks and governing of the group. Most tend to emphasize an intense, but transitional, membership in the group, leading toward a goal of movement beyond the group into a social network comprised largely of

persons without residential institutional experience. Shelter care organizations usually have a pipeline view of themselves and maintain ordinary expectations for conventional conduct. They tend to dissociate themselves from attitudes linked with careers of permanent residence in a sanctuary, or asylum, and from special expectations not compatible with general social excursion throughout the settlement. Sometimes a few permanent figures maintain the philosophy and structure of the group, while most members pass through with an average residence or active membership time of several months. Changes often destructive to the rehabilitative capacity of shelter care occur when it is conceived as a continuing method of care or when the average time in residence goes beyond about a year. Key features of an environment organized to maintain a continuing flow of intense but transitional opportunities are a psychological set that emphasizes performance achievement as a personal identity element, a daily organization around accomplishable tasks or role elements, and a local culture that can detect competent, attractive performance by a person who presented to the service with an offensive reputation. Linkage and ombudsman services of a character similar to those that are part of ordinary reception services can make a substantial impact on the productivity of shelter care service.

Services for Repeating and Prolonged Users

Services termed “after care” are composed of elements not unlike other

outpatient services but drawn into a focus on experiences benefiting persons who have been in inpatient care, especially prolonged inpatient care. Such persons often need service after the inpatient phase. Services termed “re-entry” or “rehabilitative” use inpatient, outpatient, home care, and shelter care elements organized to achieve non-institutional life for individuals who have been institutionalized repeatedly or for prolonged periods. Services designed to lower the likelihood of rehospitalization are often termed “after care.” Services designed to assist a person to be able to move from a period of prolonged or repeated institutional care to continuing non-institutional life are termed “re-entry” services. Although only a small percentage of a territorial population becomes hospitalized even once during a lifetime for mental or social disability, a fraction of the group who do become institutionalized become multiple occasion and multiple type service users. Previously institutionalized persons are therefore a population of more than usual risk justifying a category of services of special focus in design and administration. The aftercare and re-entry categories of service can be expected to comprise major sectors of the steady service activity in most territories, approximating, perhaps, 20 percent of the reception work, 30 percent of the outpatient and linking work, and 40 percent of the inpatient work. 101-103,207 whereas services for other risk groups may be omitted or ineffective and the service network will not be resultingly incapacitated, services for the group at high risk of continuing, or repeating,

institutionalization must be effective or the troubles of this risk group will encumber the major part of the capacity of the service network. The characteristic persons who present for multiple or prolonged service include social isolates, migrants, and persons with clearly defined, familial schizophrenia. In addition to expanding the service capacity of the treatment system, effective aftercare and re-entry services can be expected to free significant amounts of resources previously committed to prolong institutional care for other use. The successful introduction of such services to a local area can cause expansions in public understanding of the assets and liabilities of institutions as components of a strategy of casualty management.

Phenothiazine medication can be expected to be helpful in many but not all situations in which a diagnosis of schizophrenia is made. This fact is sufficiently important to suggest the value of precise service design for this group. The appropriate clinical contacts used to be reliable over a period of years. Prolonged phenothiazine administration and monitoring can be done in group settings. Patients can make effective use of telephone and postcard methods for keeping in touch without unnecessary inconvenience and disruption to their employment and pattern of life.

Aftercare and re-entry services use substantial components of decision counseling, employment training, linkage and ombudsman service, and services to enhance group skills and affiliative capacity. Many persons at risk

of prolonged, or repeating, hospitalization have no social network available for the daily maintenance of life patterns and personality.! Successful services to this group often provide direct assistance in identifying, linking, and maintaining a social network. An example of a method for providing service, which apparently enhances affiliative capacity, is the spin-off group. The spin-off group method employs a highly structured routine for several months. There are meetings and a set of roles, conventions, and group exercises. The therapist group assistant works to spin off a competent, autonomous, continuing group after eight to ten get-ready meetings. The method is conserving of professional time and appears to be a precise response to the predicament of isolated persons. It appears that isolated persons, given assistance in formation of new, small groups, show significant improvements in general social performance and surprising release from psychiatric distress.

Many service areas contain a substantial number of hospitalized persons who have experienced years, even decades, of hospitalization. About half of those in state and county mental hospitals have been there more than a year, and one quarter for more than ten years. Perhaps half of the persistingly resident group have a physiological status compatible with life outside an institution. But the atrophy of social and employment skills is often profound. Many local service programs are attempting service for this group. Several investigators have reported surprising results if the service program

is suited to the presenting difficulties. Re-entry service programs for this group have been carried out in inpatient, outpatient, and shelter care settings. Common elements in several designs to service this group include a social system that expresses vigorous expectations for competent performance, combined with a finely structured daily routine and a focus on a closely organized, small cohort of persons in a similar performance status. Movement toward full, independent excursion in the community proceeds in a series of graded steps, often augmented with ombudsman and linking services. Services for this group often last a year or more. The longer a service is expected to extend, the greater is the indication to define an observable feature of behavior that will signal an end point to service and the proper occasion of exit from service. Such a provision operates to reduce the risk of recurring recruitment into the social system of treatment on the part of individuals with precarious social networks.

Services to Agencies and Groups

Consultation and Prevention

Services to agencies, collectivities, and, indirectly, to classes of persons at special risk are a characteristic feature of local service programs. Such services are required in federally funded programs and comprise an area of rapid technical development, often under the terms “consultation” and

"prevention." As is the case with services to individuals, each example of such services is intended to benefit a particular risk group, focused on characteristic disabilities in the target group and organized around design features of setting, timing, participants, objectives, and end point. Activities in which the action responsibility remains with another professional, and in which the recipient has the option to decline the use of the information or observations comprising the service, are usually termed "consultation." Services altering an environment or social aggregate, intended to reduce the occurrence or severity of disability in a group, and often provided in a manner not requiring individuals to enter formally into patienthood status, are termed "preventive." Most local services to agencies and collectivities involve elements of both consultation and prevention. Services to groups derive their main design characteristics from relevant properties of the persons for which benefit is intended and from the specifics of an environment or experience thought beneficial.

The action ingredients in service endeavors to agencies and collectivities seem to be similar to those in services to individuals. They include components such as counseling, convening, facilitating adaptive work, teaching role skills, and advising regarding assessments for service and routing of persons in distress. These components appear to comprise the delivered service even though a wide range of rhetoric is used to describe such endeavor, employing such concepts as "facilitating normal growth and

development" and "developing new institutions to enhance communal adaptation of migrants." In such a rapidly developing field, efforts to provide service are generally enhanced if the desired change is simply identified. Frequently discussed categories of preventive endeavor include the increased use of personal crisis as a period of flexible growth rather than as an occasion for labeling an individual for removal, the alteration of hazardous social roles in structured organizations, and the development of closer linkages between individual aspirations and group allocations of status, sometimes termed "the Hawthorne effect."

The process of selecting groups likely to benefit from indirect services is often aided by using epidemiological data, particularly data from reception service settings. Data originating in reception services can give information on risk groups that are not successfully managed in their current setting or services and, therefore, are presenting for transfer to the mental health system. Data from inpatient and residential services can provide information on risk groups that have been presented to the mental health system but currently are not managed within its non-institutional settings. Other considerations can suggest the value of an indirect route in approaching the problems of a particular risk group. A concern to avoid risks accompanying psychiatric labels, such as patienthood roles and reputations, combined with anticipation of higher leverage in approaches to larger numbers of persons with imminent but unexpressed trouble frequently suggest indirect service

designs. Indirect approaches sometimes excel in avoiding or reducing disability status but can present complex problems in program design, administration, and evaluation.

Services to agencies and collectivities in many local programs are designed to benefit school-age children, persons in nursing and old persons' homes, aged isolates, unwed mothers, persons abusing drugs and chemicals, widows, unemployed persons, and persons in welfare programs. Promising experience has accrued with respect to the design characteristics of programs associated with prepartal care, battered children, lead poisoning, children separated from families during hospitalization, and operations in institutions that operate as family and home to dependent children. Because poor persons are overrepresented in many categories of institutional and disability status, local service programs sometimes attempt to enhance by service the capacity of individuals or groups to extricate themselves from continuing poverty status. For example, some local programs attempt to facilitate capacity for decision and action within organizations of relatively powerless persons. Some risk groups are included indirectly in service efforts through service to an agency or category of professionals with whom they are in direct relationships. The variety of such indirect services is large, and includes efforts through schools, courts, police, and juvenile officers, home visiting nurses, clergy, undertakers, physicians, and welfare workers. Throughout many indirect services is the common element of influence on a critical

turning point in life or on an event of role passage. For example, indirect services to recent widows can be designed around direct services to groups that convene widows to help one another, or by consulting with clergy or undertakers or physicians. Efforts to increase the likelihood of successful accomplishment of the tasks of student-hood can be focused around consulting with teachers, counselors, truant officers, or school administrators, or by convening groups of parents or groups of parents and school personnel.

Children's Services

The volume and precision of children s services seem to lag in development in many territories, perhaps because additional design features beyond those usual for adult services are often necessary. The recent report of the Joint Commission on Mental Health of Children reviewed the situation and termed it a "dire crisis." It recommended, even so, that expanded services for children are not likely to be effective in nurturing healthy growth, and preventing disability, unless such new capacity embodies a service model that emphasizes the maintenance of the child within a family unit, within a school, and within an ordinary communal environment. Therefore, they recommended enhancing local services for children via expanded reception, home care, and school consultation services, including psychiatric participation in interdisciplinary assessments of a child's performance in the student-hood role. They also recommended a heavy emphasis, in local

services for children, on counseling and convening services. For children who are institutionalized for service, they stressed the importance of smaller institutions, with a family-like social unit, and with opportunity for full participation in the standard program of the local school district. Because of the catastrophic risks attending separation of a child from a family unit, school, and community, most children's services in local service programs stress designs based around a non-institutional location for the child, and on types of service to a social network that are supplemental rather than eclipsing to the existing family unit. The school is the dominant setting for children's services whether or not such services are conducted under strictly educational auspices. Apparently promising are designs that aim to increase the capacity of the school to help more children achieve a successful student-hood experience. Designs that appear effective include services that convene parents for an exchange of experience, especially parents who have children in distress, in trouble in school, or before a court. Whatever the active ingredient in a service is thought to be—educative, task learning, role learning, counseling, or social attachment or relationship—the trend in children's services emphasizes offering such service to children's established social networks rather than through special systems that label children for unique handling or removal from the settlement. Few see much productivity in extended inpatient care, of any design, because of its powerful capacity to recruit children into permanent casualty status and to separate them from

families. In spite of these facts, perhaps because reception service as well as outpatient and consulting services are in short supply in many territories, children are currently entering inpatient facilities in larger numbers and beyond their increased representation in the population. Consulting programs to juvenile courts, to police officers with juvenile surveillance responsibilities, and to foster homes, foster parents, and well-baby clinics are usually productive. The underlying strategic decision in many developing designs for children's services is one to offer intense, continuing service to the parents, schools, and institutions that provide environments for children. The focus on inputs to the environments of children is made in order to make effective interventions in the lives of troubled children without recruiting such children into special institutions and constrictive roles.

Services for Old Persons

Between 10 and 15 percent of the populations of most settlements can be expected to be persons sixty-five years of age or older. Perhaps 10 to 20 percent of this group can be expected to appear in reception, outpatient, or institutional service during an average year. Older persons are highly overrepresented in inpatient care admission rates and, once admitted, tend to remain until death. For most territories, between two-thirds and three-quarters of the institutionalized older persons are in nursing homes rather than public mental hospitals, a trend that is increasing. Older persons are

underrepresented in reception, outpatient, and shelter care service as compared with their representation in residential service. Yet when such services are developed within a settlement, the use of institutional care declines substantially. Of those older persons who become institutionalized in a mental hospital, more than two-thirds are social isolates, having either lost a spouse or never having been married. A major fraction experienced a physical health crisis in the interval just prior to admission. The health decline was followed by a decline in role and network performance, culminating in a performance crisis leading to institutionalization. Services for the elderly attempt to engage with declines and crises in physical health, deficits in adaptational and psychological capacity, poverty and its restriction of options, and general social isolation. Service efforts can focus on efforts to enhance adaptive work to manage events of loss by death, illness, and dignity disruptions coming in the later years, years that often seem oriented to the special experiences of the young-adult portion of the life cycle. Local service designs for elderly persons can be based on the premises that relatively small inputs of health service, and of convening, linking, and counseling service, will make significant improvements in the quality of life and that institutional service, when required, should work to maintain or renew an older person's social roles and network attachments. The setting for much of this service is in residences and in nursing and old persons' institutional homes. Reception services are helpful to older persons if they offer precise assessment, service

planning, and service linkages. Reception service of a type that can develop access to a variety of local services, within the context of a presentation for institutionalization, can often avoid or postpone entrance to institutional life. Home visiting and home care services, together with brief day care and shelter care services, can help many older persons avoid institutionalization in the context of a health or loss crisis. Counseling and brief outpatient services can help many older persons handle the loss of a spouse without moving to restricted life styles, depression, or suicide. It is well known that brain changes in older persons can lead to a wide range of troublesome behavior and positive findings on the mental status exam. But apparently it is not so well known that losses in the richness of a person's social attachments can produce similar findings. Services that facilitate development of new networks, of friends and task groupings, are a promising category of service for older persons. Such service is useful before, during, or instead of movement into institutional care.

Services for Persons Abusing or Addicted to Drugs and Chemicals

From the standpoint of local services, persons who are addicted to or abusing chemicals offer special planning programs. Such persons often present with a biological (tissue) dependence on a chemical, a situation best managed in a controlled, hospital setting. The withdrawal phase of the care of addicts is strictly institutional, whereas much of the rest of local

programming aims for non-institutional designs. Addicts frequently present for service as a result of illegal behavior, for example, the possession or marketing of a chemical. Their service, under such circumstances, is framed within legal boundaries. In addition, the principal social network of many addicts, and alcoholics, is comprised of persons who are also addicts or who collaborate in the destructive use of the chemical. Management in ordinary social networks and settings is, therefore, neither legal nor usually effective. Local programming for persons abusing alcohol or addicted to a narcotic chemical is based around health service and chemical withdrawal, or methadone maintenance, followed by extensive, intensive efforts to develop a new life style within a new social network. Often a group of ex-alcoholic or ex-addict persons combine efforts in a corporate attempt at revamping their whole life patterns.

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