

Community Residential Treatment for Schizophrenia: Two-Year Follow-up

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Two-year outcome data from a study comparing two types of treatment given similar groups of young, newly diagnosed, unmarried schizophrenic patients deemed eligible for hospitalization are reported. The experimental program, Soteria, is a nonmedical, psychosocial program with minimal use of antipsychotic drugs; it is staffed by nonprofessionals and located in a home in the community. The control program is a short-stay, crisis-oriented inpatient service in a community mental health center where neuroleptic drugs are the principal treatment. The experimental group had significantly fewer initial stays, and only 8 per cent received neuroleptics during their initial admission. Over the two-year follow-up period, there were no significant differences between the groups in readmissions or levels of symptomatology. However, experimental subjects significantly less often received medications, used less outpatient care, showed significantly better occupational skills, and were more able to live independently.

"Community psychiatry" has been a slogan for the mental health professions for more than a decade. Although the term is widely used, it is applied to very disparate programs. For example, the movement of former patients from mental hospital wards to nursing homes is labeled community psychiatry. The use of an additional medical-model inpatient ward by a community mental health center is called community psychiatry. Yet neither example represents a departure from practices that existed before the advent of community psychiatry; rather, both are examples of business as usual in geographically different settings.

For us, true community psychiatry means attempting to develop new types of treatment programs that are

community-based—that is, the participants have ongoing interaction with the local neighborhood. By this definition, much of what currently parades behind the community psychiatry banner would not be included.

Although the clinical program we describe here represents a departure from many traditional practices, we nevertheless view it as a logical next step in the mental health system's shift away from large distant treatment institutions to smaller ones located nearer the patient's home—which today usually means wards in general hospitals. That is, although Soteria (the name of our facility, from the Greek meaning "deliverance") is an alternative to inpatient care, it is even smaller than such wards and interacts much more with its own neighborhood than a hospital can. We hope it will serve as an imitable example of how far the concept of community psychiatry can be extended to provide care for severely disorganized persons.

In addition to its roots in community psychiatry, Soteria can trace its heritage to the moral treatment era,¹ the tradition of intensive interpersonal intervention in schizophrenia,² therapists who have described growth from psychosis,³ the current group of psychiatric heretics,⁴ descriptions of the development of psychiatric disorders in response to life crises,⁵ research on community-based treatment of schizophrenia,⁶⁻⁸

¹ J. S. Bockoven, *Moral Treatment in American Psychiatry*, Springer, New York City, 1963.

² F. Fromm-Reichmann, "Notes on the Development of Treatment of Schizophrenics by Psychoanalytic Psychotherapy," *Psychiatry*, Vol. 11, August 1948, pp. 263-273.

³ J. W. Perry, "Reconstitutive Process in the Psychopathology of the Self," *Annals of the New York Academy of Sciences*, Vol. 96, January 1962, pp. 853-876.

⁴ L. R. Mosher, "Psychiatric Heretics and the Extra-medical Treatment of Schizophrenia," in *Strategic Interventions in Schizophrenia: Current Developments in Treatment*, R. Cancro, N. Fox, and L. Shapiro, editors, Behavioral Publications, New York City, 1974.

⁵ E. Lindemann, "Symptomatology and Management of Acute Grief," *American Journal of Psychiatry*, Vol. 101, September 1944, pp. 141-148.

⁶ G. W. Fairweather et al., *Community Life for the Mentally Ill: An Alternative to Institutional Care*, Aldine, Chicago, 1969.

⁷ D. G. Langsley, F. S. Pittman, III, and G. E. Swank, "Family Crisis in Schizophrenics and Other Mental Patients," *Journal of Nervous and Mental Disease*, Vol. 149, September 1969, pp. 270-276.

⁸ B. Pasamanick, F. Scarpitti, and S. Dinitz, *Schizophrenics in the Community: An Experimental Study in the Prevention of Hospitalization*, Appleton-Century-Crofts, New York City, 1967.

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and on our own clinical training and experience.

Evaluation has recently become a byword for community psychiatry. It is sometimes difficult for researchers to understand why we know relatively little about the adjustment of "community-treated" patients. In particular, data on the quality of life or psychosocial adjustment of formerly hospitalized patients are sparse. The Soteria clinical program is hypothesized to have especially good results in those areas and will therefore be the principal focus of this paper.

The rise of "evaluation" in the community psychiatry hierarchy has been paralleled by a similar interest in cost-benefit ratios. It is worth emphasizing that our view of cost-benefit is a long-range one. We believe the maintenance and enhancement of patients' psychosocial competence over a fairly prolonged time is more critical in terms of cost-benefit than is short-term resource utilization—that is, the direct cost of treatment—which is the most commonly used cost parameter. We have taken this view because, as Gunderson and Mosher point out, about two-thirds of the cost of schizophrenia to the country comes from loss of productivity.⁹ The direct cost of treatment accounts for less than one-fourth of the total cost of this disorder.

SOTERIA HOUSE

Although the wards that treat the Soteria project's control subjects are part of a community mental health center, and therefore an example of community psychiatry, the two programs are quite different. Soteria House is a 1915-vintage, 12-room residence located on a busy street in a "transitional" neighborhood of a San Francisco Bay Area city. On one side of it is a nursing home, and on the other a two-family home. The neighborhood has a mixture of small businesses, medical facilities (a general hospital is one block away), single-family homes, and small apartments (usually homes that have been remodeled into apartments). It is a designated poverty area inhabited by a mixture of college students, lower-class families, and former state hospital patients. Some 15 to 20 per cent of the residents are Mexican-American, and there are a few blacks.

Due primarily to licensing laws, Soteria House can accommodate only six residents at one time, although as many as ten persons can sleep there comfortably. One or two new residents are admitted each month. There are six paid nonprofessional staff plus the project director and a one-fourth-time project psychiatrist.

In general, two of our specially trained regular nonprofessional staff members, a man and a woman, are on duty at any one time. In addition, there are usually one or more volunteers present, especially in the evening. Most staff work 48- to 60-hour shifts to provide them-

selves the opportunity to relate to spaced-out (long-term) residents continuously over a long period of time.

Staff and residents share responsibility for house maintenance, meal preparation, and cleanup. Residents who are not "together" are not expected to do an equal share of the work. Over the long term, staff do more than their share and will step in to assume responsibility if a resident cannot do a task to which he has agreed. The project director acts as friend, counselor, supervisor, and object for displaced angry feelings by staff. A part-time project psychiatrist, in addition to his formal medical-legal responsibilities, supervises the staff and is seen as a stable, reassuring presence.

Although the staff vary somewhat in how they view their roles, they generally view what psychiatry labels a schizophrenic reaction as an altered state of consciousness in an individual who is experiencing a crisis in living. Simply put, the altered state involves personality fragmentation, with the loss of a sense of self.

Few clinicians would disagree with a description of the evolution of psychosis as a process of fragmentation and disintegration. But at Soteria House the disrupted psychotic experience is also believed to have potential for reintegration and reconstitution, resulting in a more stable sense of self, if it is not prematurely aborted or forced into some psychologically strait-jacketing compromise.

Such a view of schizophrenia implies a number of therapeutic attitudes. Basically, psychotic persons are to be related to in ways that do not result in the invalidation of the experience of madness. All facets of the psychotic experience are taken by Soteria House staff members as "real." They view the experiential behavioral attitudes associated with the psychosis—clinical symptoms, including irrationality, terror, mystical experiences—as extremes of basic human qualities. Because "irrational" behavior and mystical beliefs are regarded as valid and as capable of being understood, Soteria staff try to provide an atmosphere that will facilitate integration of the psychosis into the continuity of the individual's life.

When the fragmentation process is seen as valid and as having potential for psychological growth, the individual experiencing the schizophrenic reaction can be tolerated, lived with, related to, and validated—

We believe that the maintenance and enhancement of patients' psychosocial competence over a fairly prolonged time is more critical in terms of cost-benefit than is the direct cost of treatment.

⁹ J. G. Gunderson and L. R. Mosher, "The Cost of Schizophrenia," *American Journal of Psychiatry*, Vol. 132, September 1975, pp. 901-906.

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...led" or used to fulfill staff needs. Limits are set if
...person is clearly a danger to himself, others, or the
...team as a whole, not merely because others are
...able to tolerate his madness. Neuroleptics are ordi
...nally not used for six weeks. If the patient shows no
...change at that time and either is paranoid or has an
...sudden onset, Thorazine (300 mg. a day or more) is

...Although we have previously described and com
...pared Soteria staff with those in more traditional pro
...grams,^{10,11} a word about the background for our use of
...specially trained nonprofessionals as primary staff
...is in order. We believe that relatively untrained, psy
...chologically unsophisticated persons can assume a phe
...nomenological stance in relation to psychosis more eas
...ily than highly trained persons (for example, M.D.s or
...Nurses) because they have learned no theory of schizo
...phrenia, whether psychodynamic, organic, or a combi
...nation of both. Because they lack the preconceived
...theories of professionals, our nonprofessional staff mem
...bers have the freedom to be themselves, to follow their
...instinctual responses, and to be a "person" with the psy
...chology of an individual.

...Highly trained mental health professionals tend to
...exercise that freedom in favor of a more cognitive, theory
...based, learned response that may invalidate a patient's
...perception of himself if the professional's theory-based
...behavior is not congruent with the patient's felt needs.
...Professionals may also use their theoretical knowledge
...defensively when confronted, in an unstructured set
...ting, with anxiety-provoking behaviors of psychotic
...patients. This pattern of response is not so readily avail
...able to our unsophisticated nonprofessional therapists,
...and is reinforced by a professional degree with its
...accompanying status and power.

...Experimental subjects are free to obtain whatever
...level of discharge care they need. In general, however, it is
...clear that Soteria will be available to them as a
...day center, a place where they can drop by if they
...need to, or as a residential treatment facility if there is
...agreement about their needs and space is available.

CONTROL FACILITY

...The control facility, the community mental health
...center's inpatient service, consists of one open and one
...locked ward of 30 beds each. About 250 patients are
...admitted per month, including readmissions. One ward
...is oriented toward slightly longer-term care and usually
...receives transfers from the other, shorter-term ward.
...The service is an active-treatment facility with a
...patient ratio of 1.5 to 1 and is oriented toward

10. M. A. Hirschfeld et al., "Being With Madness: Personality
...Characteristics of Three Treatment Staffs," *Hospital & Community
...Psychiatry*, Vol. 28, April 1977, pp. 267-273.
11. R. Mosher, A. Reifman, and A. Menn, "Characteristics of
...Professionals Serving as Primary Therapists for Acute Schizo
...phrenia," *Hospital & Community Psychiatry*, Vol. 24, June 1973, pp.

**Because they lack
the preconceived ideas
of professionals, our
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...crisis intervention; it uses high doses of neuroleptics.
All of the control patients reported on here received
therapeutic courses of antipsychotic drugs during their
inpatient stays. Only one was discharged off drugs. The
immediate goal of the service is rapid evaluation and
placement in other parts of the county's treatment net
work; when possible, the service refers patients quickly
to one of the four open private inpatient facilities in the
county.

Over-all, the staff are well trained, experienced, and
enthusiastic; they see themselves as doing a good job.
Patients are assigned to one of five treatment teams on
each ward; the teams meet daily to decide treatment
plans. Patients are also assigned a paraprofessional ther
apist who provides a half hour of psychotherapy daily
and takes a major role in treatment planning. The
wards have one and a half hours a day of occupational
therapy and a daily one-hour community meeting. All
patients participate in a crisis group, which meets for an
hour and a half five times a week. A couples group, for
married patients and spouses, meets two hours a week;
a psychodrama group, for all patients who are able,
meets two hours a week; a women's group meets two
hours a week; and a survival group, for readmitted
patients, meets for one and a half hours three times a
week.

Because the center's inpatient service takes patients
from all over the county (it is the only facility with 24-
hour-a-day psychiatric emergency service and locked
wards), most patients are referred back to one of four
regional centers nearest their homes for outpatient care.
This care may include partial hospitalization (day or
night care), individual, family, or group therapy, and
medication follow-up. The county also has an extensive
board-and-care system and eight halfway houses for
adolescents and adults. A subacute facility with 30 beds
and various locked (so-called "L") facilities intended to
shorten hospital stay are also being used. As is the case
with many programs these days, this one is frequently
in flux, usually because of changing economic circum
stances.

Table 1 summarizes the comparisons and contrasts
between the programs in a somewhat exaggerated and
oversimplified form. It compares institutional variables,
social structure, staff attitudes, and family involvement.

