CHAPTER - II

REVIEW OF LITERATURE
The concept of community mental health is very difficult to define. Community itself is a word of high level of abstraction and can be applied in a variety of situations. To some, it rings a public health note, to others it has a socio-political connotation. It may suggest a neighbourhood, a district or an ethnic grouping. (Panzetta 1971). The words 'mental health' are again equally difficult to define. There are no generally acceptable definitions of mental health. Early attempts to define 'mental health' equated it with absence of 'mental illness' which in itself defies definition. The most comprehensive attempt has been done by Caplan (1974). He uses the term 'community mental health' to refer to the processes involved in raising the level of mental health among the people in a community, and in reducing the numbers of those suffering from mental disorders. The term 'mental health' he further elaborates to refer to the potential of a person to solve his problems in a reality-based way within the framework of his traditions and culture.

Wing et al., (1970) describe the chief aim of the health services as, "to decrease or contain morbidity,
firstly in patients, secondly in patients' immediate family and thirdly in the community at large", and advocate that "primary, secondary and tertiary preventive methods should be used to stop disease occurring in the first place, to detect and treat illness at an early stage, to limit development of chronic disabilities following an acute illness, and to prevent the accumulation of secondary handicap if clinical disabilities are unavoidable. All this can be summarized as containment of morbidity and mortality. One model to achieve this end, that is widely accepted is one of responsible comprehensive and integrated community service".

This theoretical framework, when applied to community mental health, brings into its fold all activities, that are geared, to prevent or reduce stress, in order to reduce the occurrence of mental illness. It also includes services that attempt to help those who are actively ill. Any services that attempt to prevent secondary handicaps by means of rehabilitation or readjustment of those who have suffered illness, also fall into its purview.

This when taken in totality would include the mental hospitals as part of community mental health
services, catering towards needs of the community. Hawkes (1975) has described this situation succinctly. He says "the words 'community care' have a contemporary ring, although in fact the majority of mentally handicapped and mentally disturbed have always been cared for, in the community and hospitals are part of a community's facilities for caring".

In this sense, as Karno and Schwantz (1974) have put it, to recount the history of community mental health, even in brief form, is to recount most of the history of psychiatry and a good deal of Western social history.

The contemporary community mental health movement derives from the events of the nineteenth century — events which, paradoxically, took mental patients away from their communities and embalmed them in custodial isolation like flies in amber. (Yolles, 1969).

Various workers have brought out the ill effects created by the overcrowded mental hospitals; subsequently, others have emphasized the need to discharge patients as soon as they improve and the need to preserve their ties with families and communities (Schwartz 1971, Rusk 1972, Hers 1972). However, only with the introduction of
psychotropic drugs this idea of brief hospitalization and early discharge has really taken momentum. Since then there has been a gradual reduction in resident mental hospital population. This small and steady reduction continued in spite of a steadily increasing admission and readmission rate. This is accounted for by three factors: (1) Out-patient treatment, reducing the need for admission, (2) Earlier and more effective treatment in hospitals lessening the need for prolonged care, and (3) Active rehabilitation of the accumulation of the long stay patients. (Tooth and Brooke (1961); Brooke (1962); Brown et al., (1961)).

When we consider the large number of mental patients who would be thus depending upon rehabilitative and community services for their stay and treatment and useful occupation of time, it becomes imperative to examine what are the alternative services provided to accommodate these people in the communities. There have been various models offered and tried. This has ushered psychiatry into the era of community psychiatry or community mental health.

Literature in 1960's abounds with reports by various workers in the field of community mental health. These reports consist of description of various community mental
health programmes, new and innovative models of delivery system, evaluations of such services, comparisons of newer models with older models. Attempts have also been made to assess the costs and benefits of different programmes.

One cannot attempt to be exhaustive in a task of reviewing the entire community mental health literature. In the present study, an attempt is made to highlight certain studies representing each area of interest for the work. The review has been presented in six parts as described below:

1. **Follow-up studies**: Studies conducted on follow-up of (a) discharged chronic mental patients, (b) alternate services preventing rehospitalisation, (c) mental patients maintained in the community.

2. **Alternate care programmes**: Studies describing and evaluating various alternatives to hospitalization of mental patients.

3. **Studies pertaining to attitudes of family toward mental illness**: Studies assessing public attitudes toward mental illness and mental patients.

4. **Studies pertaining to stress felt by families**

   It is: Reports on researches that attempt
to measure burden placed on families by their relative mental patient.

5. **Evaluative studies assessing cost of treatment of different programmes.**

6. **Criticism of community mental health movement.**

1. **Follow-up studies**

   Studies reported in this area of research are mainly concerned with follow-up of long-stay patients discharged to the care of communities. These studies deal with adjustment of such patients to the communities. In these studies, criterion of relapse or readmission has often been used to indicate failure of adjustment.

   *Mendel and Rapport* (1963), studied 166 severely, chronically ill female schizophrenic patients maintained outside the hospital. The programme described by these authors is novel. It makes use of non-professionals (selected psychiatric aides) as existential therapists to such patients. The authors maintain that existential techniques of therapy can be easily and quickly taught to these non-professionals, and the result of their therapy compares favourably with that of psychiatrists. The findings of this study show that during the 51 months
of the follow-up period, all the patients were maintained at an adequate level of functioning.

Wing et al. (1964) report on a study concerning 45 moderately handicapped male schizophrenic patients attending a local industrial rehabilitation unit. The patients constituting their sample had come from hospitals which provided active rehabilitation training. The authors followed these patients for one year after their discharge, and report that twenty four were employed at the end of follow-up period. Twenty one of these employed patients were working satisfactorily. The authors conclude that on the whole no patient was worse for having been on this programme and at least half of them had benefitted considerably.

Waters and Northover (1965) followed up long-stay male schizophrenic patients for a period of over 2 years. These patients were discharged from a rehabilitation unit. Their findings reveal that 29% of their sample had been readmitted during that period and others had remained outside. 19% of the sample had caused a period of severe distress to their families.

Leyberg (1965), followed up a cohort of admitted schizophrenic patients for a period of 3 years. He
assessed them for clinical status and social adjustment. The sample includes new admissions as well as readmissions. In all 81 patients were contacted. The author summarizes his findings thus "... despite a high degree of chronicity and a poor employment record, the impact on family life by these patients was found to be less distressing than reported in similar other studies". This has been attributed by the author to the existence of a comprehensive psychiatric service close to the community. He suggests an integrated service with emphasis on speedy treatment, continuity of after care and day hospital facilities as a best mode of service for the management of schizophrenics in the community.

Esser et al., (1965), studied the productivity of chronic schizophrenics in a sheltered workshop. The authors note that in most cases, the capacity to work seems to be independent of intelligence and clinical picture. 70% of the patients including some severely regressed, reacted positively to the opportunity to work for money.

Brown et al., (1966), studied 559 schizophrenic patients for five years, subsequent to their admission, they aimed to assess their behaviour, social circumstances and contacts with psychiatric services. The patient's
employment record, distress caused to the families and communities, and constitution of domestic living group in the area of social circumstances was also studied. The authors find that half of the male population of their sample were employed at the time of the follow-up. All those who had been unemployed had worked for less than half of the follow-up period or not worked at all. For women patients in this sample two thirds of first admission and half of readmission were employed or had been performing their domestic duties competently. Regarding distress to the community, the authors state that about a quarter of first admissions and about a half of readmission showed more or less continuous handicap, and, when at home, were in most cases likely to cause serious difficulties for those with whom they lived.

From these foregoing description of the studies, the following points emerge. The studies have been conducted to see how well the discharged schizophrenic patients got adjusted to their communities. Criteria used to assess this have been variable such as number of readmissions, not doing adequate amount of work, etc. Accordingly, the results are also varied where re-admission has been taken as a criteria, family's opinion has not been considered, when such an
attitudinal aspect was considered the availability of rehabilitation facilities has been overlooked. As such the different studies become difficult to compare. However, certain points can be gathered.

It is obvious that schizophrenic patients pose the most complex problem of treatment and readjustment. These patients do show improvement in their clinical status with treatment, but have a tendency towards either chronic course, or recurrence and as such need continuous care and availability of other support systems. At the same time advantages of active rehabilitation are stressed. The various workers point out that most of their sample group benefitted by their discharge and community management.

2. Alternate care programmes

Since the influence of deinstitutionalization movement, a need for an alternate care and support system for such patients, who have been discharged from mental hospitals to the communities has been the largest. These patients may have been first admission or chronic patients.

Different alternatives offered to occupy their time and to care for them are, day hospitals, sheltered
workshops, rehabilitation units added to mental hospitals, co-operative arrangement between community mental health centres, welfare agencies and the mental hospitals, half way homes, etc.

Zwerling and Wilder (1964), Herz et al., (1971), demonstrate that two thirds of all referrals for psychiatric hospitalization could function in a day hospital setting. Gerratt et al., (1957), Hamsley et al., (1962), Stublebire and Decker (1971) have also made similar observations.

It is obvious that for such patients alternative care programmes which would prevent hospitalization, have become necessary and a number of workers have described their experiences with different models and given valuable suggestions.

Soole and Fino (1971) describe a programme in which the state mental hospital and a community mental health centre co-operate in providing an environment conducive to the continued well being of chronic mental patients, discharged from state hospitals. The follow-up of this programme for 3 years, indicates (a) 9% recidivism after 18 months, (b) yearly costs drop to approximately 1/3 of that required for hospitalization, (c) reduction in the amount of medication
for 63% of the patients.

Jolik et al. (1971) reflect on the outcome of a co-ordinated community care programme geared to reduce rehospitalization of patients released to the community. They compare the characteristics of patients who had to be rehospitalized in spite of the programme, with those who did not. The findings reveal significant differences between these two groups on characteristics of general patient background, response to treatment, patients' social behaviour and attitudes of the family members.

Lafaye et al. (1968) describe implementation of a community care plan. This team of workers report much lower recidivism. This may be related to the fact that alternate community facilities were well integrated in the delivery system, although they also excluded chronic patients from the plan.

Hogarty et al. (1973, 1974) present the relapse rates at one year and two year follow-up of 374 schizophrenic patients who were receiving drugs and socio-therapy. They also describe the adjustment of those patients who did not have a relapse. Their findings show that relapse in the placebo treated group was twice that of the drug group. Half of all relapses
(both groups) discontinued treatment prior to relapse. No significant effect of sociotherapy was noted on this group. But it reduced relapses among those who survived without relapse for initial 6 months period.

Lamb and Geerzel (1973) reflect upon a five year follow-up study of long-term state hospital patients and suggest two alternatives for the future care of such chronic or residual group of patients. The first is, a small core state hospital which would serve the residual group for whom no family or community placement is possible. The second alternative is integration of this residual group into the inpatient units of community mental health centres.

Test and Stein (1976), evaluate their 'training in community living programme' in relation to hospital treatment. These authors suggest that the community programme patients show much favourable results.

To facilitate service from available resources to most of the discharged patients, various models of delivery system have been tried out by workers of different socio-cultural and economic backgrounds.
Feinstein and Caranaugh (1974), describe a unique volunteer programme, which makes use of lay public volunteers as helpers to certain patients assigned to their care and with whom they meet once a week. The advantages of this model are obvious though limited. The volunteers can keep in touch with some of the patients and be responsible for their welfare and follow-up and the patients can remain still in contact with services through these volunteers. However, the success of such programmes will depend on continuous supply of such volunteers.

Cooper et al., (1975), evaluate the value of attaching a social worker to a metropolitan group practice, in the management of chronic neurotic illness and find it beneficial.

This has been another area which many places have experimented with, viz., making use of para-medical personnel in carrying out major part of treatment to the patients.

Brandwin et al., (1976) describe a new treatment method to facilitate out-patient treatment of chronically ill mental patients. The authors call it continuing care clinics. Among the specific treatment
features discussed are, multiple therapists, focus on available personality strength and reality and patients-staff group interactions.

Baker et al., (1977) describe a programme and follow-up of 60 institutionalised patients' rehabilitation. The use of non-medical staff as primary therapists, promotion of relations with community based facilities and continued liason with social workers are some of the major features of the programme.

Lieberman et al., (1976) describe a social inter-action programme for chronic psychiatric patients living in a community residence. After experimenting with one of the group with intensive treatment programme in socialization the authors find that there were not many differences in the improvement between experimental and control groups of patients although differences were noted on sex and age variables.

La Comare (1975), suggests a day treatment centre as an ideal alternative to state mental hospitals where patients of almost all diagnostic class can be treated.

Crisis intervention, with a view to prevent hospitalization has also been used (Granovetter, 1975; Langley 1962)
Washburn et al. (1976) compare a psychiatric day treatment programme with inpatient hospitalization. Their data indicate that day treatment is, on the whole, superior to inpatient treatment in five distinct areas, namely, subjective distress, community functioning, family binders, total hospital cost and days of attachment to the hospital programme.

Shapoor et al. (1976) describe a team consisting of physician, medical social worker and public health nurse handling the mental health problems of an underprivileged community on the outskirts of Tel Aviv consisting of Iraqi and immigrants. In this area, the traditional psychiatric services are not suitable due to its gearing toward verbal patients with high motivations. The modalities applied by this general practice team involve offering of treatment to the risk groups e.g., (a) discussion group for women in pregnancy, (b) preventive measures for the aged etc. (c) intervention in critical life situation usually after death of a relative etc.

Most of the researchers who have compared alternate resources or support systems that have been provided for the mentally ill people point out the advantages of community mental health alternatives.
However, the alternatives described so far seem to be suitable for the acutely ill. For the chronic patients, the only alternatives that have been successful are sheltered workshops, half-way homes etc., which are a product of community mental health movement, but at the same time are institutional in structure and are liable to suffer from the disadvantages of institutionalization. The countries which are at the beginning stages of community mental health movement should avoid this gap. This may be accomplished by providing services that prevent future chronicity and accumulation of long-stay patients, along with providing services for the existing chronic patient population. In order to achieve this, it may be necessary to expand the areas of participation by the para professionals in the delivery of services. It may also be appropriate to utilize the existing strengths within a family group. In fact, a number of studies have been carried out in this field.

3. Evaluative studies of models making use of home treatment and nurse therapist

The advantages of treating a patient in his own home have been well documented and accepted. But actual functioning of this theoretical acceptance is still not
clear. If patient is treated at home, how does he contact the psychiatrist? Some people have suggested out-patient visit only. Some advocate home visits by the clinic therapists, still others suggest visits by a social worker, or utilization of nurses for the contact by visits at home.

A few studies which have made use of these different modalities and which have also attempted to evaluate them, are highlighted here.

**Behrens (1967)**, emphasises the importance and usefulness of home visits by the clinic therapists in the treatment of low-class patients. He says that such programmes are not just feasible but are also advantageous as they provide better understanding of family dynamics and result in development of improved patient-therapist relationship. The author also suggests that such visits aid in prevention of hospitalization.

This programme, though ideal is not very practical as the lack of time on part of trained therapists has been the major one in the mental health care delivery and as such, cannot be applied on a large scale.

**Pesemanick et al., (1967)** are probably the earliest
researchers to utilise home care of schizophrenic patients and services of public health nurses to visit them at home. These researchers have documented a well planned home care programme for the schizophrenic patients, making use of a very good experimental design in its evaluation.

The authors studied patients with a diagnosis of schizophrenia. The subjects were assigned randomly to one of the three groups: (1) home care with placebo medication, (2) home care with psychoactive drugs, (3) hospitalization. All home care patients were visited and evaluated regularly by public health nurses.

Outcome criteria used for evaluating the groups, were frequency and duration of hospitalization, psychiatric and psychological assessment, social functioning and the extent to which significant others perceived the patient as a 'problem'.

After following the patients for 30 months, the authors report that (1) home care for schizophrenics is feasible and better treatment, (2) drug therapy is effective in preventing hospitalization, and (3) public health nurse can be entrusted with home care treatment effectively.
Paquin (1970) after conducting a treatment programme in the patients' home, notes the advantages of such programmes over others, to be in the area of supportive psychotherapy to the family and crisis intervention. Also it helps in adding much more information for diagnostic and management purposes.

Chappel and Daniels (1970) have attempted home visiting programme in a black urban ghetto in the U.S.A. They find such programme to be safe and feasible. The benefits enumerated by these authors are, (1) searching the unmotivated and isolated patients, (2) improving of patient-therapist relationships, (3) opportunities to educate families and (4) enlisting families' co-operation in a therapeutic alliance.

Woodberg et al. (1967), describe the functioning of an emergency and home hospitalisation programme which aims at (1) prevention of hospitalization, (2) preparation for hospitalization when unavoidable, (3) preparation for a quicker discharge from the hospital. The psychiatric team visits patients' home and treats the whole family in its own setting and socio-cultural environment using family therapy techniques.

This mainly is a descriptive report and no attempt at evaluating it has been made.
Ekmunchi (1969), reports a novel form of home hospitalization being practiced in a village 'Biapa', in Israel. Home care is popular, but the patient is restrained in a sitting position and food intake is rationed. This is done so as to reduce patients' weight, as excess weight is seen as conducive to violent behaviour. Relatives and friends are encouraged to visit patient and keep him company. In this study also no attempt has been made to evaluate its merits.

Singer et al. (1970), report on the functioning of psychiatrist - nurse team and home care in Soviet Union and Amsterdam. The authors compare observations on mental health service in these two places, where psychiatric home care is an integral part of serving the community's psychiatric needs. In these countries, the role of the psychiatric nurse has been expanded to a responsible working relationship with the psychiatrist. The authors note that the nurse's role involves less restriction of function and more independent responsibility than in the U.S.A. and suggest nurse's involvement in home care programmes as an effective treatment modality that may reduce incidence of hospitalisation.


Jarvis (1970) describes the functioning of a home visiting service in Canada. He also attempts to evaluate whether such service contributes to prevention. The findings of the programme team are, (1) they are accepted by the community at large, (2) home-visits helped to clarify the clinical picture, (3) approximately 55% of the patients welcomed the idea of being visited, (4) complete refusal was shown by 5% of the patients, (5) clinical improvement was noted in 70% of the patients, (6) 17% failed to respond to home visits and (7) home visits enabled a higher proportion of persons to be treated.

Linn et al., (1977) evaluate hospital treatment versus foster care for psychiatric patients. 572 patients from five hospitals were randomly assigned to these two groups. They were assessed before assignment and four months later regarding social functioning, mood, activity and overall adjustment. Experimental or foster care group showed significantly better improvement over controls (continued hospitalised group).

Goodacre et al., (1975) report from Canada, regarding their study conducted on, 212 patients randomly assigned to, (1) home treatment, (2) hospital and home treatment
and (3) hospital treatment. Their findings show that
(a) 33% of those treated at home, were never hospitalized
again, (b) assignment to different treatment groups did
not affect length of initial hospital stay or re-admission
rate, (c) patients treated at home were more likely to
stay in touch with the hospital and received more
service when they needed it, (d) patients without
families did not do well under home treatment.

Nesher (1975) presents outcomes of two year study
comparing two kinds of treatment given to similar
groups of young newly diagnosed, unmarried schizophrenic
patients deemed in need of hospitalization. One treat-
ment group comprises of involvement of non-professionals
and residence in a house in the community. This group
makes minimal use of anti-psychotic medication. The
other treatment group comprises of short stay hospita-
lization, crisis oriented inpatient service in a
community mental health centre where neuroleptic drugs
are the principal treatment. Findings reveal that the
first group had, (1) significantly longer initial stays
and only 8% received neuroleptics during that period,
(2) at the end of 2 years, there were no significant
differences between the two groups in readmissions or
levels of symptomatology, (3) the group managed without
drugs, significantly less often received drugs, used less
outpatient care showed better occupational levels and were able to live independently.

Clement et al. (1978) in Cali, Columbia involved auxiliary nurses, who were given special training and supervision. Equivalent groups of 30 patients each, who came to the psychiatric emergency room were treated by two alternate modes of treatment over a three month period. One by auxiliary nurses and the other by 'traditional' service, which relies mainly on interns and residents. The authors find that, (1) experimental group shows greater decrease in symptoms as measured by psychiatric ratings and self report scale. A questionnaire completed by family members substantiated these findings, (2) no differences were found between patient's attitudes toward services, on a self-esteem scale, or on a social adjustment scale, (3) the cost of the new programme was somewhat less.

Results of this study clearly indicate feasibility of nurses as therapists, but are based on only short-term experiment and have to be validated by further use.

From the review presented so far, it can be seen that literature provides an array of alternative approaches to hospital treatment. From the studies described so far,
it is evident that nurse has been used effectively in the treatment and follow-up of psychiatric patients. Advantages of home visits by any of the health team member, have also been documented. However, these studies do not compare strictly with each other. This has been mainly due to the differences in sample groups of different studies and the emphasis on different aspects in their evaluations. Such observations have also been made by earlier reviews. (Bachrach 1976). In general, they suggest favourability of alternative approaches such as brief hospitalizations with active rehabilitation, day hospitalization, home care for patients etc. Such programmes aim at preventing handicap of institutionalization, reduction in cost of treatment, utilizing family support for the preservation of social skills.

The needs of chronic discharged patients differ widely in various countries, based on socio-economic pattern of their societies. In developed Western world, the state accepts the responsibility of treatment of all its disabled and is financially able to cope with suggested better alternatives such as sheltered workshops, half way homes, day hospitalization, active rehabilitation and work placement.
However, in the developing and economically backward countries, such programmes have very limited applicability. These programmes may be needed and functional in the more westernized cities of the developing countries. But they are not practical to provide alternate care to their vast rural population, where even state hospitals do not exist to provide primary custodial care.

Such countries have attempted various models of delivery of care systems, not only from the point of view of accommodating discharged chronic patients, but their main need being, reaching the primary services to more number of their people.

In collaboration with the local authorities, W.H.O. has instituted programmes to improve strategies for extending mental health care in different developing countries. One of these countries who have reported on their study in literature, has already been described (Climent et al., 1978). Other centres have proceeded with different programmes such as, (1) training of auxiliary nurses and other mental health staff in detecting and managing mental health problems, (2) surveys of mental morbidity by the most economical methods, etc., (Murthy et al., 1978, W.H.O. Working Papers).
While the W.H.O. programme has involved a centre in these programmes from North of India, systematic efforts at extending mental health care delivery to the population away from any available mental health services, have been instituted in southern part of the country. These centres have attempted training para-professionals in detection and management of mental illness as well as evaluation of such training. Mobile screening and advisory services have also been functioning (Kapur & Issac 1978).

Indian Council of Medical Research is currently involved in a four centre study to test the effectiveness of involving the public health centre personnel in the recognition and management of epilepsy and psychosis (Kapur 1980b).

In fact, the country is reaching the stage where launching of large scale community oriented programmes seems possible.

4. Studies pertaining to attitudes of family toward mental illness

With regard to mode of delivery system for the care of its mentally ill, the developing countries have the best alternative in community mental health.
However, acceptance of community mental health involves treatment and residence of the mental patients within his family and community as much as possible. This has given rise to doubts regarding the burden, such continued presence of mentally ill in the family, may put on the other family members. It has been questioned, whether such burden is bearable and advisable, or would such burden place more and more people at risk. These doubts are genuine and are partly based on the general consensus existing among psychiatric professionals that public attitudes toward the mentally ill are generally negative and societies tend to reject and isolate such people than accommodate them.

Hence it is necessary that any community based programme should evaluate these aspects initially and understand the attitudes of the community from the point of view whether such programme will be feasible and acceptable. Crecetti (1971) has put it quite simply, he says, "Success of community psychiatric programmes and development of alternatives to hospitalization for persons suffering from mental illness depend, in a large measure on a favourable climate of opinion in the community".
In this section, studies and reports in literature pertaining to the area of people’s attitudes towards mental illness have been reviewed. Here again an extensive review has not been attempted as such efforts have already been successfully done by Crocetti et al. (1971), Habkin (1972).

Literature on attitudes towards mentally ill is again contemporary to community mental health movement and is generally in the area of public knowledge regarding mental illness and social distance felt by people towards the mentally ill. This information has been gathered from surveys based on questionnaires administered to general lay public, or sometimes specific population such as mental health professional, or relatives of the mentally ill people etc.

Earlier reports (Allen 1943, Bingham 1951) show that public feeling about the mentally ill was characterized by fear, stigmatization and rejection. More elaborate and structural studies were carried out by Star (1956), Cumming and Cumming (1957), Mupally (1958), (1961), Cohen and Struining (1962).

Star carried out her study on 3500 persons in a national sample. Her interview was based on presentation
of 6 abstracts consisting of a description of a particular diagnostic entity. Subjects were asked to rate these descriptions as to their extent of pathology, social distance etc. She concludes that people were greatly rejecting of the mentally ill, and admit only extreme psychoses, accompanied by threatening assaultive behaviour, into their working definition of mental illness.

Cumming and Cumming have published their book 'Closed Ranks' in 1957. Authors conducted a field experiment in two small Canadian towns. They tested the residents of the town before and after a six month educational campaign designed to promote more accepting attitudes toward mental illness. Their conclusion is that public attitudes toward mental illness were those of "denial, isolation and insulation of mental illness" and suggest this to be the reason for community's tolerance of deplorable conditions in mental hospitals. They theorized that this was necessary for the re-affirmation of the solidarity of the social system in which the norms are not violated. They also postulate that isolation of the mentally ill serves the purpose of reducing the guilt of relatives of the patients. This study demonstrates the initially negative
attitudes toward mental illness of a middle class community and their relationship to a more extensive system of values, and the unfeasibility of modifying a specific attitude in isolation from this system.

Nunnally (1961) reported on what the public 'knows and thinks' about mental illness. 350 people were measured on 7 point Likert type scale. After analysing the results he interprets his findings to show that public information about mental illness is not highly structured or crystallized and that public was uninformed rather than misinformed.

The latter researchers, however, find public attitudes not to be so negative as has been found by the earlier surveys. Many positive concepts of mental health seem to have been accepted in the later years.

Lemkan and Crocetti (1962) studied randomly selected population from the city of Baltimore, U.S.A. regarding their attitudes toward mental illness. Most questions used, were identical with those used in previous surveys and includes three of the six case descriptions from Star's questionnaire. The sample population proved to be "fairly well informed" and
shows "understanding and tolerance for the mentally ill". The majority identify given descriptions of behaviour as indicative of mental illness, feel that the patient should see a physician and are in favour of treating the mentally ill in the community. These findings are markedly different from the earlier researchers' 'denial, rejection and isolation'.

Ridenour (1961), Edgerton and Bents (1969) also reveal positive public attitudes.

Verghees and Beig (1974), in India, also found the public attitudes to be positive and favourable, after studying a randomly selected sample of 539 adults of Vellore town in the Southern region of the country.

Van Weerden, Dijkstra (1972), finds the attitudes of Netherlands sample to be ambiguous rather than either positive or negative. He also does not find any direct relationship between favourable attitude and real contact with the mentally ill.

It is obvious from the foregoing discussion that public attitudes toward mentally ill are variable and not extremely structured. With increased exposure to mental health principles and education regarding mental
illness, attitudes tend to be more favourable and accepting of the mentally ill. However, to the present research project relatives' attitudes would be of more interest than general public attitudes. Existing literature in this area of attitudinal research reveals that here also the findings are contradictory and not very conclusive.

Phillips (1963), finds that closeness of relationship was related to reduction in attitudinal distance, whereas Swingle (1965), finds non-relatives to be more accepting. Freeman (1961) finds that better educated relatives tend to hold more enlightened attitudes. He also reports that relatives' attitudes were not influenced by duration or number of hospitalizations of the patient. However, his recovery and behaviour after release from the hospital, does influence the families attitudes. He does not find any attitudinal differences by social class of the relatives. Hollinghead and Redlich (1958) in contrast locate striking social class differences in relatives' attitudes.

Kelley (1964) studied relatives of 65 released schizophrenic patients for their attitudes in order to assess its impact on patients' well being. The
attitudes were compared with patients' exacerbation of symptoms. He finds no such relationship.

Rodrigues and Kauth (1971), investigate differences in attitudes between people who had their relatives in a mental hospital and those who did not have a mentally ill relative. Findings reveal no significant differences in the two groups.

Wylan, Louise and Mintz (1976), find ethnic differences to be related with attitudinal differences among patients' families.

In India, relatives of hospitalized mental patients have been assessed, to find out their attitudes (Kshama and Channabasavanna 1974).

Although theoretically it seems reasonable that attitudes of the family members regarding mental illness will play an important role in their handling of the patients' subsequent management, no conclusive evidence of this is available in the literature so far. This may be due to the complexities involved in making of an attitude which are subtle and defy measurement. As Rabkin (1972) aptly puts it "attitudes involved in mental illness are far more
complex and interrelated than is generally acknowledged

4. Studies pertaining to stress felt by families of mental patients

Another sensitive and related area that is of importance to community mental health policy is the burden or stress felt by or exerted on the family of a mental patient when the patient continues to live in his own home rather than in a mental hospital. Various workers in the field of community mental health have attempted to assess or measure this burden and these studies are reviewed in this section.

Interest in this area of research is relatively recent, and has been as a consequence of starting community mental health centres; and emphasis on phased closing down of mental hospitals.

Earlier workers who studied the discharged chronic or long-stay patients living in the community attempted to assess social burden as measured by re-admission of the patient or relapse in his symptoms. Or in other words have assumed that a patient staying in the family relapses and is readmitted because he causes stress or burden to his family.
Mandelbroote and Polkard (1961) followed up patients, managed largely in the community with emphasis on avoidance of long stay hospitalisation. He has studied them for 4 years. He suggests that patients' families experience stress when patients' behaviour upsets the family functioning and restricts their activities. No attempt at assessing the stress felt by these families according to its severity has been made in this study.

Grad and Sainsbury (1963) have made a remarkable headway in assessing this phenomena on a 3 point scale. They rate the effect of patients' illness on family income, employment, social and leisure activities, domestic routine, children in the home, health of others in the family, relationship with neighbours etc. They also tested the scale for its reliability and found it to provide 75% agreement three interviewers.

The authors tried to identify the types of behaviour on part of the patient that exerted more stress to the families and find the most troublesome behaviours to be (1) constant bodily complaints, (2) possibility of patient harming himself and (3) excessive demands by the patient on the family.
The authors find the following factors such as patients' age, clinical status, chronicity of his illness, composition of the family, closeness of patient to responsible relative in the family to be significantly related with the amount of burden felt by the families.

Hoenig and Hamilton (1966) add another dimension to this assessment of burden on the patients' families. They attempt to differentiate objective burden from subjective burden felt by the family members.

'Objective' burden consist of areas such as,

A. (1) Financial, (2) Health, (3) Effects on children, (4) Effects on family routine and,

B. Any type of abnormal behaviour in the patient which was likely to be disturbing to others.

'Subjective' burden was assessed by asking the family members whether as a result of the patients' illness they thought the household had suffered a sense of burden. This was an inquiry more into attitudes of the family members.

Their findings reveal that the highest percentage
of households were affected in the area of family routine disturbance. Next in frequency come financial loss to the patient.

Clinical factors as diagnostic grouping do not seem to show significant differences in 'burden' and 'no burden' groups. However, duration of illness is significantly related to burden on family.

In the area of subjective burden the authors note that "these 'subjective' attitudes by no means correspond with what one might have expected from the assessment of the 'objective' burden". 'Subjective' burden shows more relationship with factors such as age of the patient, marital status of the patient, relationship of those with whom patient lived and social class of the family, than to the 'objective' burden.

These authors compare the burden findings of families of schizophrenics with families of other diagnostic categories and find financial suffering and effect on health of others to be twice as much more for these families (with schizophrenic patients).

Brown et al., (1966) assess the degree of social disturbance, a particular symptom causes. The degree of disturbance was assessed for each symptom on a
three point scale. The scale consists of descriptions of symptoms extracted from the interview schedules used for assessment of symptoms. Informants' reaction is ignored as far as possible and the assessment is made by the investigator by trying to put himself in the position of a tolerant relative. Certain rules regarding, which symptoms; and under what circumstances would be rated as causing severe, mild, or nil social disturbance were formulated. The subjective strain or disturbance felt by the family was not the point at issue.

However, in their further analysis they attempted to relate this level of social disturbance with reactions of the relatives (tested attitudinally) to patients' presence in the home. The results of this analysis indicate that patients who had been in hospital part of the time and in the home part of time were rejected by their relatives in 50% of the cases, wishing them to be kept in the hospital indefinitely.

This study assesses the burdensome behaviour of the patient and stress felt by the family members is measured only indirectly.

Copas et al.,(1974) described an investigation
carried out 'to determine differences in outcome which
may be attributed to treatment under different adminis-
trative conditions. The authors compared the results
of a psychiatric unit in a general hospital and its
associated day hospital, with those of a large modern
psychiatric hospital also receiving day patients. Both
places received patients from same geographic area.

Their findings show that, at six month follow-up,
burden on family, family's attitude, social adjustment
of the patient do not show any significant differences
for both the groups.

The authors continued the follow-up for 8 years,
after which they report that 'treatment in a psychiatric
unit, as distinct from psychiatric hospitals holds no
benefits in the long term (5-8 years after admission) as
far as patients' mental and behavioural status and employ-
ment, or the family's burdens, health needs or attitude
were concerned. However, schizophrenic patients from
both the settings receive more hospital treatment and
medication, are more often unemployed and have more
adverse effect on relative's health than neurotics and

Washburn, Vannicelli, Longbaugh and Sheff (1976)
whose study has been referred to earlier, use: yet another method to assess the burden on patients' family. Their 'burden evaluation line' is a graphic rating scale that was used by the informant to evaluate the extent to which the patient's illness had imposed a burden on the family. The line is defined by two end points "severe burden" and "no burden", and the informant is asked to rate (by placing a check mark at the appropriate place along the line) the current overall level of burden experienced by the family. To assist the informant in maintaining a constant calibration, at each semiannual assessment period following baseline, a line indicating the informants' previous responses is presented. All ratings are scored to the nearest millimetre along a 12.6 cm. centrum, with high scores indicating greater pathology.

Although the assessment tool is different, it corresponds to the subjective burden assessment mentioned in the earlier studies.

The authors have used this tool as one of the variable to assess differences in outcome of treatments in a psychiatric day treatment and inpatient
hospitalization.

Their findings in the area of burden on the family reveal that day and inpatient groups differ, specifically between 6 months and 1 year. The relatives of day patients experience a significantly greater drop in burden than is reported by the relatives of inpatients. In fact, at 1 year the relatives of day patients are continuing to report decreases in the amount of burden placed on the family, whereas inpatient families express a sudden increase in the amount of burden.

This study was not specific to schizophrenic patients and excludes patients who absolutely need hospitalization.

Doll (1976) studied 125 families who had their mentally ill relative living with them. The author here does not make use of any specific burden rating scale. He uses interviews and attitude tests to collect information regarding the effect of these patients on their families. He reports that families will generally care for the former patient in their house of ten with little shame and embarrassment and usually without re-hospitalizing him. But the former patients' presence, especially when severe psychotic symptoms persist often
puts heavy emotional and social strains on the families. The author warns that although families accept the physical presence of the patients, the accompanying social rejection could have serious consequences for the community mental health movement.

Hawks (1975), while critically analyzing various assumptions underlying advocacy of community care, sums up the findings of the studies assessing burden on families thus, "Despite the resulting discrepancies, such studies demonstrate with some consistency that in a significant number of cases the families most affected by the new policy (i.e., those families whose sick members would previously have been kept in hospital for longer periods) suffer adverse consequences as a result of the decision to discharge the patient home". He goes on to add "whether these disadvantages are offset by the positive rewards of caring for patients at home or merely reflect the, as yet, inadequate development of community services is a moot point'.

Lamb and Oliphant (1978) contend that families of schizophrenics have received too little help from mental health professionals and suggest methods for remedying this. They suggest that such families could be helped
by providing practical and realistic advice on how to deal with the illness, by offering empathy and support rather than placing blame and by working to ensure that there are adequate treatment and rehabilitation services available.

It is evident from the descriptions of the studies assessing burden on the families of mental patient, that burden is present whether subjectively felt and expressed or not. However, it is not clear whether this burden is entirely due to the illness and behaviour of the patient or because of lack of adequate understanding of the illness and knowledge and skill in its continuous management. It seems appropriate here to speculate a reduction in this burden if the family members receive adequate, support, advice and encouragement. This opinion has also been expressed by some other workers in the field. (Lamb and Oliphant 1978).

5. Evaluative studies assessing cost of treatment

Another area which has been of interest for evaluation of any services is the savings in cost of treatment to the patient and to the service agency. Interest in this area is mainly to satisfy the fund giving authorities as well as the administration and has little
relationship with clinical interest. Although, it is practical and necessary to assess the cost of a service, a proper cost and benefit analysis, an intricate area of research in behavioural sciences is still in its early development. Very few studies in this area are available which apply to home treatment.

Sharfstein and Nafziger (1976), report cost and benefits for a chronic patient who was kept at home with her family. The patient was an acutely disorganized woman. Cost effectiveness is measured by defining service units and then comparing costs and outcome of various programmes.

The types of benefits identified are, (i) savings to the public through the use of alternative health resources, (ii) increased economic output by the patient when she was able to remain in her home, (iii) increased satisfaction, personal growth and happiness that result from better health.

The authors show that economic cost was less in this type of management as well as that clinical status was better. However, the other area of benefit viz., satisfaction, personal growth and
happiness are entirely difficult entities to measure quantitatively in order to assess their benefit.

This study refers to only one patient and as such its findings cannot be generalised. For example, it does not provide an answer to the question; if the patient who stay at home, is not able to contribute toward economic output would it still be advisable to maintain such a patient in the home or not?

Murphy and Datel (1976) present comparative cost-benefit analysis of community versus institutional living. Authors project costs and benefits over a 10 year period for 52 clients, successfully placed in the community. The results show an average net saving for each client of $20,800 over a 10 year period, mainly to the State Government.

The clients were mostly mentally ill and mentally retarded and were considered as successfully rehabilitated. Costs of their maintenance to federal, state and local governments were worked out against the benefits the patients were receiving.

In this study, again, the clients were those who were successful in living outside the hospital and
had rehabilitation facilities.

6. Criticism of Community Mental Health Movement

In the foregoing five sections, various studies in the field of community mental health have been briefly reviewed. As can be seen, in each area, the findings are not comparable due to lack of similarity of design, or due to different cultural context in which they were conducted. Often the results are variable and sometimes contradictory.

In the area of feasibility and advisability of community care in general, in preference to hospitalization, there seems to be greater agreement among the professionals working in the field of mental health. A number of studies have documented conclusively the usefulness of community care as opposed to hospitalization. However, there seems to be greater disagreement or resistance to the extremist view in community mental health field which advocates total eradication of hospitals and complete maintenance of the mentally ill in the community or in their own families.

Glenn (1975) describes the community mental health movement as a humanitarian movement, and as
such has to pass through the stages that such movements have to undergo. In this regard, he says, "characteristic of each humanitarian movement are four distinct periods. The first is a period of innovation or new ideas. This peaks rapidly after the initial outburst of enthusiasm, as the community mental health movement did between 1965 and 1970. The peak is followed by a period of criticism and then a time of retrenchment. The four periods are thus, innovation, peaking, criticism and retrenchment".

At present, community mental health movement seems to be poised at the period of criticism. The criticism against the movement and various programmes are often due to general resistance to change, from communities, hospital administrations and so on. Some criticisms are based on valid apprehensions regarding pressure on communities and families, ethical issues such movements may precipitate etc. Often criticisms are levelled at the functioning of the community mental health services, and the lack of adequate facilities. Some of the more radical criticism have been against the theory of community mental health itself, challenging its validity and suggesting it to be an escape route to avoid responsibility of chronic mental patients.
Steinhart (1973) writes "the original theme of keeping patients at home whenever possible has become ritualized into keeping patients completely out of the state hospitals and even keeping them out of any mental hospital. Unfortunately, there are times when patients need to be hospitalized, whether in a state hospital or elsewhere.

Keighard (1974) suggests "psychiatry would do well to move from the ideological towards the specific, from the theory to the patient .... In particular, more should be known of those former patients who are somewhere in the community, but who are long out of sight and mind. The specific function of the psychiatric hospital in terms of what it has to offer or (with changes) might still provide for patients, should be high on the list of priorities".

Hawke (1975) challenges the assumptions implicit in the trend toward community care. He goes on to say, "There is a very pervasive tendency, whenever confronted with the inadequacies of a particular service, to assume that its reorganization will necessarily remove these inadequacies.... there is a reluctance to admit that the fault may lie rather in our understanding of the condition
and our inability to affect it.... the pre-occupation with reorganization directs attention away from the real problem. The real problem in the case of the mentally ill is the continued care of chronic patients.

Bachrach (1977) also points out the assumptions underlying the movement, namely that community based care is preferable to institutionalized care for most, if not all, mental patients; that the community is both able and willing to assume responsibility and leadership in the care of the mentally ill, and that functions of the mental hospital can be assumed successfully by community based facilities. While pointing out the problems with the deinstitutionalization movement, she goes on to add, "perhaps the most serious single issue is the fact that the deinstitutionalization movement which was originally designed to provide the chronically mentally ill, relief from the inhumane conditions of the institutions has let these patients "fall through the cracks".

Hensel (1978) finds "an unwarranted emphasis on the single episode users of service, a deficiency of interest in people with life long disorders, and unwarranted expectations about the effects that programmes of general social
betterment can have on serious mental illnesses such as schizophrenia".

In other words, the present available research literature raises more issues and doubts than answers to previous ones. Although many follow-up studies with varying degrees of sophistication in design are reported in the literature their results are largely inconclusive in a broad sense.

The movement of deinstitutionalization has often proceeded with such rapidity that there has hardly been time to plan carefully any community based programmes with a view toward meeting special needs and overcoming special problems of the target groups. Issues of acceptability and inaccessibility of services have often been over-looked in the haste of implementing new programmes. Backrach (1976), Carstairs (1968), also makes similar observation and points out objective evaluation of the effectiveness of procedures have seldom, if ever, preceded their gaining currency in psychiatric practice.

In India, where the atmosphere is just beginning to ripen for community mental health, it would be appropriate to learn from the experience of the other
countries which have already experimented with different ideas in the field of community mental health.

As Hirsh (1974), points out, 'at a time when many developing countries are just beginning to concern themselves seriously with the problems of the psychiatrically ill, it would seem particularly useful to take account of some of the factors and principles underlying these changes, so that this pattern will not be unnecessarily repeated and new techniques in different localities can be developed'.

It has been shown in the preceding review of literature that community mental health movement has been widely accepted all over the world, and various programmes have been instituted. Some of these programmes such as crisis intervention, brief hospitalization, prevention of hospitalization, utilization of para professionals in the treatment delivery, home treatment for the patient assisted by a visiting health personnel, have been shown to offer better alternative to hospitalization of mental patients. However, a drawback of this movement that has been repeatedly pointed out by various critics of the movement has been that it has not been able to provide a solution for the existing population of the chronic mental patients. It
has also been pointed out that in order to manage the chronically ill, discharged mental patients in the community, a number of adequate support systems should be created or made available to the patients and their families.

In this sphere, different societies with variable socio-cultural backgrounds have to adopt or develop models of delivery system that would best suit their specific needs, attitudes and acceptance by their public and availability of their resources.

Sartorius et al. (1977) after conducting two year follow-up of the patients included in the W.H.O. International pilot study of schizophrenia, indicate that patients diagnosed as schizophrenic on the basis of standardized assessments and clearly specified diagnostic criteria, demonstrated very marked variations of course of the illness and outcome, over the two years period. This could be explained mainly on the basis of the cultural differences that exist between the different countries included in the study.

It seems ideal therefore, that when socio-culturally different societies attempt to adopt any systems of delivery of mental health service, care should be taken
to adapt the system to the social, cultural and economic conditions present in their countries.