Perhaps I Touched the Minaret, or How Patient-Centered Care Remains a Dream

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Keep true to the dreams of thy youth.—Herman Melville

Recently in *Psychiatric Services* I looked back at the 55 years I have spent as a psychiatrist, in which I observed that resources needed for patient care have quietly disappeared in America (1). The promise that psychiatry would mature to serve persons with severe mental illness in communities has withered and died. So, too, has the principle of caring for patients as persons rather than as diagnoses. Psychiatrists now focus on criteria for various disorders and write prescriptions for medications that do not necessarily improve the well-being of their patients.

This morning I awoke at 3 a.m. frankly anxious. I realized I was worried about two unexpected, colliding forces. How well had I met my responsibilities in the situations that constituted my career? What are today's implications of my past activities as a physician and psychiatrist? Memories had disrupted not only my sleep, but also the complacency of my retirement.

The evening before, at a social gathering, a friend whose adult son has a severe mental illness asked me to meet with our local Utah county authorities. She wanted to address the lack of services available to her son and others with severe mental illness. She had learned of my work aimed to reorient the care that psychiatrists provide to these patients. Her request was entirely reasonable, and I agreed to the meeting. Hours later, as I slept, darker concerns wakened me unexpectedly. These concerned on what grounds I had to consider myself effective with patients over this past half-century,

In my first postresidency position in Texas, I published an evaluation of a rehabilitation program I developed for chronically hospitalized persons with mental illnesses. While developing this program, I remember thinking to myself, "If I can create this level of resources here at a bureaucratic U.S. government public health service hospital, then what a pleasure it will be, after completing my Selective Service commitments, to return to Yale and all the resources in Connecticut." These dreams were never to be fulfilled, not at Yale, and not thereafter. In all following years, in spite of my successes besting, on many occasions, circumstances hostile to the interests of those with severe mental illness, I could never match the successes we had in Texas.

At my program's request, in 1964, the Texas Department of Vocational Rehabilitation (DVR) assigned a paid position of vocational counselor to the new rehabilitation program we were organizing. These resources enabled many patients to attend job-training programs at the Fort Worth Goodwill Industries. An example illustrates the levels of success these opportunities provided patients who had spent two to 30 years hospitalized. Mr. D. showed skills and interest in learning shoe repair, which he accomplished at Goodwill. The Texas DVR then funded, equipped, and initially supported his shoe repair shop, which for him became a successful business that sustained him in the community.

In 1966 I returned to Yale with the Department of Psychiatry's full support for developing a similar program. Matters were not as they were in Texas. The director of the Connecticut DVR would not discuss programming until he received a clinical professorship appointment at Yale. There were no diversely resourced, organized vocational training programs at the local New Haven Goodwill. Private businesses had no precedents for providing such training. With Yale and one of Connecticut's state hospitals, I opened the Orange Street Clinic.

During the clinic's years of operation, all clinical staff made home visits to patients and went to hospitals to plan aftercare with patients. Staff members found suitable work sites and then trained themselves so they could prepare the patients for the tasks they would need to perform. Staff supported parents at a public housing project to conduct a summer program aimed to prevent accidental deaths of children, given that several children had died in recent summers from playing in unsafe streets. No accidental childhood deaths followed. We provided supportive housing and social networking for newly discharged state hospital patients, lowering recidivism rates. After five years, the sponsors closed the clinic and moved the staff from the community to the main Yale facility, the Connecticut Mental Health Center. Home visits and interactions with community residents waned. Our plan to intervene on the basis of census-identified deficiencies in local community social life and services never came into being, and the opportunity to systematically resource community psychiatric consultation services in this way never arose again.

For me, these and other 20th-century circumstances deprived psychiatry and community-based patients of hope much as 19th-century circumstances had done for institutionalized patients. When American psychiatry suffered losses through President Ronald Reagan's New Federalism,

psychiatrists failed to appreciate the impacts that these losses would have. New Federalism compromised psychiatrists' training, research, and interests in and opportunities to provide community consultative and other social psychiatry services. Without a counter to New Federalism's harmful social policies, bleakness replaced hopes for patient-centered care (1).

Is seeking patient-centered psychiatry overreaching and naïve, a secular sin that detracts from psychiatry's primary molecular-biological mission? I ask myself, what would we have in psychiatry if we did not risk overreaching? Have I over these years simply gone too far? When he stepped down as chair of psychiatry at Yale to become its medical dean, Fritz Redlich ended his talk with "Reach for the stars." Mehadin Arafeh, the then-superintendent of a Connecticut state hospital, leaned over and said, "and you may touch the minaret." Afterward, he explained that he had completed the Arabic saying for me.

I was young, then, in my early 30s, with many minarets to dream of touching over the ensuing years. As I lay in my bed thinking now, decades later, even Arafeh's more modest aim seemed to have eluded me. At the University of Connecticut, supplemented nicely by federal training funding from the National Institute of Mental Health for community mental health, we innovated a social and community psychiatry teaching program. With time I became aware that these efforts were not turning young doctors toward careers that would serve those with severe mental illness. We were failing to inculcate an appreciation of the person who was the patient and the humanism that doing so brings into medicine. Seeking relevance not fulfilled by the tenure I had earned, I resigned and found a public-sector position in Rhode Island.

Strong support for improving services and training and for initiating clinical pharmacology research came from the Rhode Island governor's office and the Rhode Island College of Pharmacy. This was the zenith of clinical pharmacy, and my earlier interactions with pharmacists on our teams modeled how we could use these academic resources effectively on the more than 30 wards with psychiatric patients. My dream of carefully deinstitutionalizing patients from an 1,800-bed state facility and using it as a training site for psychiatric residents was to be shattered. The chairman of psychiatry at Brown University would have his department participate only if he could direct the programs now offered by the state. The governor, the director of the Rhode Island department of mental health, and I as hospital director were committed to the well-being and aftercare of our patients. We all thought we could improve their lives by creating a network of community mental health centers and group homes. Brown's chair of psychiatry indicated that he did not share our priorities, however. Some faculty continued to offer time and efforts in support of the state's aims, but the institution did not. When I tried to moderate the chair's decree, I was asked to resign from the Brown chair's advisory committee.

Chasing my dream that psychiatrists could be trained and serve persons with severe mental illness with a person-centered psychiatry, I moved on to become chair of psychiatry at Southern Illinois University. The dean supported my aims to have the Department of Psychiatry join with the Illinois State Department of Mental Health in the provision of services in the Greater Springfield area. The Illinois state director offered support and funding for these efforts, as did his local district administrator. We foresaw a network comprising psychiatric beds at a private community hospital; local state facility beds; a community-based program, which became the Community Support Network (CSN); and a project to divert persons from hospitalization to specially staffed group homes.

Our patients had severe mental illness and were referred from Illinois state hospitals as a result of multiple failures in community settings. In this CSN, some patients gained supportive, competitive employment when we successfully negotiated an agreement to staff housekeeping services at a local Days Inn. Other patients found work as landscapers, as cooks at fast-food restaurants, in state civil service positions, and so forth. No vocational training was available in any of these settings. We had to draw on patients' existing skills. We could help patients meet employers' basic expectations, but we could not develop new work skills for them. Society's competitive work environment would not integrate individuals with mental illness into its economic fabric. Isolation, which was total in the mid-20th century's pre-deinstitutionalized hospitals, did not dissipate despite psychiatry's person-centered, community-based, supportive patient care.

These programs succeeded until a new governor replaced the state director of mental health. Residents and students continued to rotate though the CSN, but state commitments became limited and tenured university faculty focused training on general hospital and office-based psychiatry.

As I lay thinking, I had to acknowledge how much psychiatry had accomplished over these decades and how much I had accomplished during my career but, also, how so little had changed. Thinking of my friend's request to talk to authorities to help her son, I was ready to recommend that they *not* follow the successful example being set with dedicated efforts by the courts and police in Salt Lake City (1). Police, not case managers, followed patients on streets and jailed them when they could not care for themselves. Courts developed care plans. No psychiatric residents were being trained to care for these people with severe mental illnesses. I had already made clear that America's current use of jails for this population was a blight on society and a shame for psychiatry. I wanted to go further. I wanted more of us to realize the ways my colleague Neil Meisler practiced: "I am as comfortable providing services directly as I am with organizing and directing the work of others. I have a compassionate interest in helping persons with serious psychiatric conditions gain relief from cognitive and emotional suffering and to live in a manner that sustains their health, contentment, and happiness. I believe that the best way to do

so is to deliver services through teams of staff members with diverse backgrounds and training who share a primary motivation to serve others, to nurture their independence, and to practice kindness, patience, and mindfulness towards service recipients and each other as well" (2).

In Texas I had created with patients a self-care ward. It was an in-hospital equivalent of community independent living. The residents were responsible for their lives and their ward-community's structures. These were the issues they would shortly face after discharge. To have staff provide solutions for problems of living loses an opportunity to assess with the patient how well she or he meets day-to-day challenges and responsibilities. We have much to learn from and with patients, learning opportunities we miss if we take on responsibilities that need not be ours and replace patients' social skills learning with formulaic psychiatric predispositions. I had thought an appropriate next step for community support programs should be for patients to bear increased personal but professionally supported responsibilities for services as soon as possible. Why should psychiatrists and case mangers do what patients can accomplish for themselves and each other?

It seemed in my early morning ruminations that all the clinical efforts and innovations I recollected led to nothing of lasting significance. So how was I to speak convincingly to a county and parents in need of constructive, innovative programming? The most innovative steps I had the privilege of sharing with patients in Texas—providing systematic job training, instilling self-care responsibilities, and supporting the person's hopes, dignity, and well-being—had so quickly became just moments in history not generalizable beyond the environment of their origin.

I am finding aging more complex than I had anticipated. Now I wonder if all psychiatrists who dream of a better future for their patients will fail to touch a minaret, as have I.

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REFERENCES

1. Becker RE: Policies and consequences: how America and psychiatry took the detour to Erewhon. Psychiatric Services 66: 1097–1100, 2015
2. Meisler NE: Biographical Sketch. Providence, Rhode Island Council of Community Health Organizations, Inc, May 29, 2009