ADDRESSO'SET
707/643-5100 BOX 3009
VALLEJO, CALIF. 94590

Written for the Creative and Productive of our Society

Our Letter

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Editors: F.H. Ernst Jr., MD, Fellow, American Psychiatric Assn
Franklin H. Ernst III, Architect

MENTAL HEALTH DELIVERY SERVICES

I. "It is important to differentiate between the major classes of 'emotional disorders!' This is especially true in regards those emotional disorders which afflict some of the children and youth of this and other counties and require placement away from the family home."

It was gratifying to listen to Don Feiner, Director of the Solano County Mental Health clarify this at a recent Mental Health Advisory Board Meeting. It is important that this be stressed more often.

To quote a successfully treated inmate: "Doc, **first you have to separate the bad from the mad. You have to sort out the sick from the slick."**

SORT OUT THE SICK FROM THE SLICK !

The diagnostic differentiation (separating)of the major classes of disorders is the primary key to achieving success, knowing the difference between the social level of life and the psychological level. After this foundation for treatment is defined then the means of prescribing and allocating treatment resources can be clearly objectified. I agree that it is critical to any success that we as professionals diagnostically separate the group of (1) character disorders, behavior disorders and psychopaths from the group of the (2) mentally ill, the psychotic and the depressed. To leave these two major groupings intermixed conceptually in the thinking of the public, let alone intermixed with each other during their treatment, is a disservice to the patient-client and to the public or private agent affording their care.

As I and many other professionals have seen in our experiences, the character disorder grouping tends to be primarily organized at the social level (contrasted to the psychological level) around immediate gratification of impulsive drives. The person who has a character disorder is motivated primarily to exploit his neighbor. His contact with reality is generally intact. He knows what he is doing, can differentiate between right and wrong, good and evil, and can control his own actions. **When a person with a character disorder runs onto the mentally ill person, too often the psychotic or depressed person is brutalized and/or terrorized by the character disorder personality.** This may even occur to healthy people walking down a street, but generally most people do not allow their psychological and social lives to become confused. In the past we saw this too

often as Superior Courts unrelentingly kept on and kept on sending character disordered children to the Children's Unit at Napa State Hospital. It does no good for the character disorder personality individual to exploit the mentally ill. **Circumstances which permit this form of acting out by the character disordered person, youth or grownup, in any (institutional) setting does not in any way foster his mental health or better behavior from him. It is unrealistic.**

DIFFERENTIATE THE PSYCHOLOGICAL FROM THE SOCIAL LEVEL !

The mentally ill have a defective contact with reality while the character disordered have a defective control mechanism over their impulses. The problem generally in the group of character disordered individuals is the absence of **internalized personal standards** compatible with society's well being. Reliable self-control and self-discipline are missing. Modification of these standards would enable them to become reliable individual members of society, even productive members. An internalized set of standards of self-control and self-discipline could, if present, take care to direct their impulsivity and societal exploitation drives towards productive and compassionate norms of behavior.

Successful treatment of these two groupings, "the sick and the slick," requires that they be treated as different disorders. Penicillin is no good for the treatment of juvenile diabetes or cerebral palsy. Insulin does not help strep sore throat or middle ear infections of childhood. Success in treatment, whether in the model of the Davis City "Praul House" or in the model as mentioned by L. Lawless, of "the Berkeley, to-the-left way" of treatment, needs to take into account these differing treatment requirements.

The acts of "acting out" by a person with a character disorder are primarily aimed at getting society at some level to limit their behavior, furnish them with limits as to what is realistically acceptable, to restrain them physically if necessary. This has certainly been abundantly documented by those working in the Department of Corrections and the Youth Authority prisons.

The primary character deficits of the character disorder and behavior disorders are: **a)** not having a reliable and reasonable set of internal discipline, **b)** not having a set of reliable internal restraints that works within the range of social **temptations and stresses** one finds in a viable society. The flowering of abundant "nurturing care" without appropriate limit setting on their behavior activities during treatment is like trying to grow flowers sewn on rock. Programs that pour $2000 to $6000 ($3466 in one Solano County Program) per youth per month of staff time and good intentions devoted to "nurturing care" unmindful of the nature of the illness, is not going to take care of the illness for which the funds are being expended. It follows that the disordered behavior must be treated, encouraged and disciplined to respond to incentives that foster self-restraint, self-discipline, and self-respect; not incentives that pro-long dependence.

The numbers of our youth with some mixtures of these two disorders has increased. It has been noted by some writers this is at least coincidental with the steady march of legislation and **bureaucratic intrusions** into families, private homes and the private property rights of individuals over the last two decades. We in mental health have even had to develop new diagnosis labels (eg. borderline personality) to accommodate the new clinical pictures.

Drug usage and abuse are primarily behavior problems (disorders). There are times when drugs trigger the appearance of mental illnesses but these illnesses cannot be touched until the behavior problem has been dealt with. More at another time on the adverse effects on our youth from the social engineering and social insurance programs with their attendant "moral hazards." (see Wealth and Poverty by G. Gilder)

TO RECAP: The primary rule in any successful treatment program of "the emotionally disordered youth" requires a recognition of the basic differences in the pathology (trouble) and therefore different treatment needs of these major classes of disorder.

II. A recent front page article in the San Francisco Examiner of 5/2/84 publicized the problems caused by the character (behavior) disordered and mental disordered on their streets, but in its style of writing it damaged the lives of the mentally ill in the community. The article was an assortment of sensationalisms, plausible half-truths, skewed emphasis stories as excuses to sell papers and fill copy space, mixing as it did the stories of the mentally ill with the character disordered.

As many of us are aware, since the State Legislature decided to empty the State Hospital system in favor of local care, we have had increasing numbers of the chronically mentally ill wandering from place to place, from home to home, in and out of $500.00 plus per day acute care hospitals with no continuing ability on the part of the mental health professionals or, incentive on the patient-client's part to improve the self-regulation of their own social behavior. If they "decide they want to move," as so many do, they do it. Sometimes the grass looks greener somewhere else. They are not too much different from most people in that regard. Other times the decision to move is made regardless of adverse results to their mental health and/or when that "decision" is a manifestation of the illness itself. These moves are often helped along by "just trying to help" personnel with neither the faintest of professional awareness or else with minimal concern for the effects on the mental health of these individuals. These indigent-ill, with their lack of a reliable internalized reality testing ability plus the legal establishment's philosophy of housing them in the legally "least restrictive setting" (contrasted to "clinically the most appropriate") furnish our out-of-hospital chronically ill patients-clients with no incentive or opportunity to better themselves. These factors of **mandating socially blighting incentives** continues their plight of inadequate contact with reality. Pile on top of these the fact that they are further paid on monthly "payday" only and if they have NOT "saved for a rainy day" to care for themselves. Instead they get paid off both by monthly funding and by continuing to receive life sustaining strokes for their indigent-illness life style and aberrant, bizarre behavior. **These behaviors are illness-born, aimed among other things at getting people around them to shun them, restrict them and avoid them and their bizarrity and/or rarely to bring them into better contact with reality.**

Mental health care of the chronically ill was better when the State Hospital used the majority of the buildings and beds, (now closed down and vacant), for the "Skilled Nursing Facility" type of care and treatment, a system and facility on

the same grounds. This was typified for example at Napa State Hospital by the Acute Care Receiving and Treatment Building and its Services integrated into a treatment program with the SNF type "S" and "T" wards, Wilkins, Chambers, Francis and Philips cottages, etc as the sub-acute and skilled nursing facility and "continuing care" programs of treatment. Privately owned and run Skilled Nursing Facilities now privately provide this care for less than $50.00 per day per patient with private medical care on call and as needed, estimated to average out to no more than $15/day. (There are some "Patch" programs with some additional funding in these settings principally for the "squeaking wheels" among their clientele.) Even with acknowledged inefficiency of governmental programs the State should be able to revive "State Hospital SNF's" to alleviate the shortage of beds and provide **"BETTER QUALITY CARE and TREATING"** instead of "least restrictive setting (legal)" and at a reasonable cost.

III. We understand the local County Counsel's office to have given the green light to the Chairman of Solano County Mental Health Advisory Board to call and schedule a grant-supported sequestered, weekend retreat in October "for policy and education purposes." Is this out-of-sight meeting aimed at excluding those who might understand the psychological level of events in such a program? Would the Local Director of Mental Health Services or the Board of Supervisors happen to know what the nature, orientation and agenda of this training program is? Who will the trainers be?

There are, as the readers are aware, the widest variety and assortment of "accepted" trainers around. What "training" of public-representing-appointees is better carried on out of sight of the public? As we read over the selection criteria of the Short-Doyle MHAB members, adequate diversity of membership, education and background on these Boards is already mandated by State Statute. The sequestered training of these public body members, at least up to this date, has not been necessary or desirable, let alone legal under the Ralph M. Brown, Secrecy-In-Government Act of the State of California.