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A CONVERSATION WITH DR. AHMED

by *Martha Gillmor*

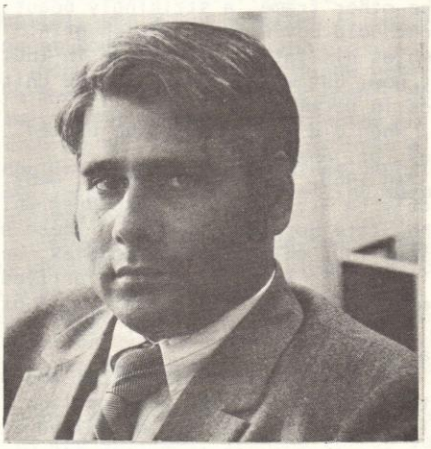
When formal announcement was made that Dr. M. B. Ahmed had been appointed Director of SVTN-CMHC, Center staff knew only the following things about him: Dr. Ahmed had been born in India (or perhaps Pakistan--there was some confusion about this); he was a psychiatrist; he had been director of a community mental health center in St. Louis; the Search Committee, with representatives from Center staff, AECOM Department of Psychiatry faculty, and the three Community Advisory Boards, had voted unanimously for his appointment.

Just a few days after Dr. Ahmed arrived on August 16, I telephoned Mrs. Gloria Moreira, the Director's secretary, with the request that Dr. Ahmed allow me to interview him for SVTN-CMHC *REPORTS*--when he could spare the time, of course. Within a few minutes, Mrs. Moreira called back to say that Dr. Ahmed could see me in five minutes, if that were convenient. It was completely convenient; access to senior staff usually is more difficult to arrange. With pad and pen, I went up to the third floor to meet the new Director.

A dark-skinned man of medium height, with hair graying at the temples and intense, deep-set, dark eyes came around his desk to shake hands and offer me a chair. He gestured ruefully toward a pile of cartons near his desk and said, "As you can see, I am still in the process of moving in."

His voice was soft. It was necessary to listen carefully because the air conditioner was noisy.

DR. M. B. AHMED, B.Sc., M.B., B.S., D.P.M. (Lond.)
Director, Sound View-Throgs Neck Community Mental Health Center



Born, 1935, India. Medical degree taken in Karachi, Pakistan. Psychiatric residency, Glasgow University, Scotland. Diploma in Psychological Medicine awarded by the Royal College of Physicians and Surgeons, London. Former position: Director, St. Louis Metropolitan Mental Health Center.

My opening was hardly a question. "You've taken on a challenging job here."

Dr. Ahmed smiled. "I suppose so. But you know, any job with genuine responsibility is a challenge. Each situation has problems. The problems may be different from one place to another, but they always exist."

.....Continued on Page 2, Col. 1

SOUND VIEW-THROGS NECK COMMUNITY MENTAL HEALTH CENTER
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We got through the biographical notes quickly. Born in India in 1935. Medical school in Karachi, Pakistan, then post-graduate training in psychiatry at Glasgow University in Scotland, and a Diploma in Psychological Medicine from The Royal College of Physicians in London. Dr. Ahmed handed me his card: a string of degrees follows the name: M. (for Mohammed) Basheeruddin Ahmed, B.Sc., M.B., B.S., D.P.M. (Lond.). A diffident smile again: "You know how it is in Europe. Degrees are very important."

Married. Dr. Ahmed handed me the double photograph frame that rested on his desk. Mrs. Ahmed gazes serenely into the distance, a distinctively Indian beauty. In the other frame, a strikingly beautiful 18-month-old boy with an impish grin. He resembles his father. They are in India right now, but will be back in the United States in December.

"When did you come to the United States, Dr. Ahmed?"

"In 1968. From Scotland. I went directly to St. Louis, to take over Unit I of the State Hospital Complex. There are, you see, four units in that complex, but Unit I was the largest. When I arrived, there were 500 patients there. Most of them had been in hospital for years. It was a shock to me.

"The whole system of medical and psychiatric care in England and Scotland is so different from that in the United States. I took the time to go to Boston and visit some of the best institutions there. Then I came back to St. Louis to try to accomplish what I had set for my first year's goal: to get those patients out of the hospital and back into the community."

The catchment area served by Unit I contains almost 450,000 people. Dr. Ahmed was mandated to establish a comprehensive community mental health center to serve that area. But he had no federal staffing grant and very limited staff. How do you go about setting up comprehensive services in a situation like that?

"You understand, Unit I was a traditional, custodial institution. Patients expected to stay there for the rest of their lives. Their families had the same expectation. We had to change that attitude first. The staff had to be involved in this, to make contact with families and help them understand that these people should be back in the community.

"I restructured the Unit first. On a ward, the psychiatrist has absolute authority. I began to set up a team system,with a coordinator for each ward who was not a psychiatrist--perhaps a psychiatric nurse, or a social worker. It was not an easy situation. Established roles were being changed. Authority was being challenged. Even more difficult, people were being asked to accept responsibility without authority. But on the other hand, they were being given an opportunity to make an important contribution on their jobs, and to see the concrete results of these contributions.

"We discussed the question of authority. I agreed that this could not be delegated. But I felt that good suggestions from staff would not be rejected by the psychiatrists. It worked out this way. Cases were discussed in full staff meetings, with all levels of staff participating. The problems somehow got resolved."

A good negotiator, I was thinking, as I listened. Best of all, a man who does not promise what he cannot deliver. And incidentally, did he pick up degrees in anthropology, sociology, and political science along his academic way? How much intellectual power does it take to move from one culture to another, and then to a third where the organization of service delivery in his own field is totally different from England's National Health Service, and so quickly grasp the differences and begin to operate effectively?

Dr. Ahmed was still talking about St. Louis. "You know, the staff had to get the patients used to the idea that they didn't belong in the hospital. Many of them had come to look on it as home. And of course, there were the 'good' patients--the ones who helped with the housekeeping, with the other patients. Nurses hated to lose these patients. Still, it worked. In January '68 Unit I had 500 inpatients. By December 1970, there were only 115. Of these, only 69 had been in the original group of 500, and most of them had been transferred out for a time, to nursing homes or vocational rehabilitation units, and then returned."

During that same period, inpatient

admissions had jumped from 157 in 1968 to over 1300 in 1970. But inpatients were no longer being treated on a custodial basis; they were being returned to the community or transferred to rehabilitation units within the system until they could return to the community. Unit I had had 11 wards when Dr. Ahmed arrived in 1968. By December of 1970, only five wards were still open.

"When I had the team system operating, I wanted to find a way to set up inpatient wards in a general hospital rather than a state hospital. We got in touch with the Director of the St. Louis County Hospital, which was right in the middle of our catchment area and much easier for people to reach. County Hospital had a psychiatric ward, but had been functioning only as a detoxification center for alcoholics, a short stay unit for psychotics until they could be transferred to a State Hospital and as a holding place for patients brought brought in by the police or prisoners transferred from jail for psychiatric evaluation.

"In March 1968, Unit I staff began outpatient services there. We began to get more and more referrals for after-care patients. Finally, in July 1969, we took over the psychiatric inpatient unit, along with its nursing personnel, and provided psychiatrists and other professional staff from Unit I. This was possible because the patient census in Unit I was dropping rapidly, and this freed staff for work at County Hospital."

Dr. Ahmed's description was rather matter-of-fact. How did he manage to negotiate this cooperative arrangement? (I thought about the territoriality battles in most institutions.) He negotiated, with support from Missouri University and The State Hospital, directly with the Director of St. Louis County Hospital. Somehow he bypassed City Hall and all the other bureaucracies. Does he realize that this is something of a feat? He tells it casually.

By 1970 the mental health services at County Hospital are growing. There is a twenty-four-hour emergency service. The 25-bed inpatient service relies on crisis intervention and comprehensive care. That includes intervention in social, familial, and economic problems, when necessary.

About 10 per cent of the patients have to be transferred to the State Hospital, but by now Unit I is a therapeutic milieu. Patients are encouraged to take responsibility for themselves, to make decisions, to expect to leave the hospital. Vocational training is available.

Alcoholic and drug abuse patients are referred to specialized units of the St. Louis Hospital for treatment. Evaluation services for children were available at a Child Guidance Center in a nearby Public Health Department. Children under 16 are hospitalized, if necessary, at the Youth Center of the St. Louis State Hospital Complex. Outpatient and after-care services are provided at County Hospital, and a Day Hospital is in operation at County Hospital.

"In the year 1970, 391 new patients were evaluated at St. Louis County Hospital, and 4,965 had been treated in follow-up and after-care. We were also accepting referrals from other departments in the hospital and giving them consultation services.

"Concurrently, we had been establishing education and consultation services to other community agencies, working in the direction of prevention and rehabbilitation. With a limited budget for staff, we needed as much help as we could get."

Dr. Ahmed paused briefly and looked up at the ceiling. Then he turned back, the smile flashing again. "You know, you can't ask people for help without offering them something in return. Our catchment area included both rural and urban centers, and St. Louis County had a lot of public health nurses. We offered them a six-month course--lectures and group meetings--on mental health and mental illness. The course helped them understand some of the things they were meeting in the families with whom they work. Fifty-four nurses participated."

By now the smile was one of pure pleasure. "They began to act as case finders for us. Then they took on after-care visits to our patients who lived in sections the nurses visited. They would drop in to see that a patient was taking his medication. Or to be sure the family was able to tolerate deviant

behavior. They'd explain the patient's situation to the family, help them understand."

Did *you* understand, I wondered, how rigid the tradition of public health nursing is? They deal with *physical* illness, not mental illness. How in the world did you convert 54 civil servants? Persuasion? Conviction? That course must have been awfully good.

In the same period Dr. Ahmed's staff trained clergyman in counseling and supportive therapy. They now see patients referred from both inpatient and outpatient departments. What had become in fact a mental health center was also training residents from Missouri University in community psychiatry, and beginning to initiate research projects.

"In 1970 we were ready to begin to move outside the hospitals and start to set up community based programs. The first place we chose was a very deprived black community. We contacted a community group and arranged a meeting at the Lutheran Church in Kinloch, in the northern section of St. Louis. Only one doctor served that area, once a week. Ten thousand people lived there."

Once more Dr. Ahmed paused. Then he continued thoughtfully, "When I first came to this country, I found it hard to understand the undiscriminating hatred of black people for whites. It did not seem reasonable to me. And when we went to Kinloch, I was startled to meet hostility, when we were, after all, coming to offer help. But as time went on, and I came to know the people, they talked about their feelings, about the reasons for them."

This time he looked directly at me during the pause. "I am afraid I feel they are justified." (I agree with you, Dr. Ahmed, but I don't say so because words can sound too glib. Again, though, I am impressed with how much the man at the desk has grasped about American society, so quickly.) "There is now a comprehensive health center in Kinloch, run by the community. Mental Health Center staff provide psychiatric consultation and treatment to this center."

Dr. Ahmed's training was in organic and general psychiatry. But in England, general psychiatry is community psychiatry, in many senses. "What," I asked, "do you see as the primary responsibilities of this Center?"

"Treatment for acutely ill patients. Comprehensive rehabilitation. Prevention--in the community. If one is missing, the others are useless. You simply get a vicious cycle of breakdown, then abandonment. Eventually, you end up with custodial institutions again.

"It is a question of priorities, really. Does one service need a greater share of our resources than it is getting? We will have to explore together for a while, before we jump to conclusions. I am impressed with many of the people here. No doubt there will be problems. As I said, there are always problems. We will meet them as they come."

Good luck, sir.

EDITOR'S NOTE

This issue of SVTN-CMHC *REPORTS* is only an interim issue, meant primarily to introduce the Center's new Director, Dr. M.B. Ahmed, and to say goodbye to Dr. Sutherland Miller and Miss Erlene Collins (although the farewell to Miss Collins is only temporary).

A longer issue will be prepared for the end of October. By then, a number of pending negotiations should have been resolved, and decisions held up for Dr. Ahmed's arrival will have been made. In that issue, we will also include our regular reports on personnel changes.

A few short notes about special summer activities run by various units of the Center are included in this issue.

We hope everyone had a good summer.

Martha H. Gillmor

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