Portland State University

PDXScholar

Dissertations and Theses

Dissertations and Theses

1976

Strategies for Reducing Recidivism of Mental Patients in Region I

Ellen Magaziner

Portland State University

Kathleen McCarthy

Portland State University

Reyn Staffel

Portland State University

Follow this and additional works at: https://pdxscholar.library.pdx.edu/open_access_etds

Part of the [Social Work Commons](#)

Let us know how access to this document benefits you.

Recommended Citation

Magaziner, Ellen; McCarthy, Kathleen; and Staffel, Reyn, "Strategies for Reducing Recidivism of Mental Patients in Region I" (1976). *Dissertations and Theses*. Paper 2132.

<https://doi.org/10.15760/etd.2130>

This Thesis is brought to you for free and open access. It has been accepted for inclusion in Dissertations and Theses by an authorized administrator of PDXScholar. Please contact us if we can make this document more accessible: pdxscholar@pdx.edu.

STRATEGIES FOR REDUCING RECIDIVISM
OF MENTAL PATIENTS IN REGION I

by

Ellen Magaziner
Kathleen McCarthy
Reyn Staffel

A practicum submitted in partial fulfillment of
the requirements for the degree of

MASTER OF SOCIAL WORK

Portland State University
1976

TO THE OFFICE OF GRADUATE STUDIES AND RESEARCH:

The advisor approves the research practicum of
Ellen Magaziner, Kathleen McCarthy, and Reyn Staffel,
presented on May 21, 1975.

Barbara Friesen
Research Advisor

TABLE OF CONTENTS

	<u>Page</u>
I. INTRODUCTION	1
Purpose of the Study	3
Definitions	3
The Problem	5
Theoretical Framework	6
Assumptions	14
Delimitations	15
Organization of the Study	17
II. DATA	18
Methodology	18
Analysis of Data	24
Existing Resources	39
III. REVIEW OF THE LITERATURE	47
Historical Perspective	48
Alternative Models	57
Residential Options	57
Service or Treatment Options	68
Comprehensive Alternative Models	74
Alternative Models in Oregon	84
IV. CONCLUSIONS AND RECOMMENDATIONS	88
BIBLIOGRAPHY	99
APPENDICES	105

CHAPTER I

INTRODUCTION

The advent of the community mental health movement in the early 1960's led to a dual phenomenon in the pattern of hospitalization for mental illness in the United States. The emphasis on discharging patients from institutions and returning them to their communities resulted in a decline in the actual numbers of beds being occupied by mental patients. At the same time, the rate of recidivism among mental patients became an increasingly acute problem.

At the present time, it is no exaggeration to observe that the major problem in the field of mental illness is not the hospitalized but the formerly hospitalized patient. During the last several years, hospital by hospital and state by state, reports have appeared of a decline in the number of beds being occupied by mental patients. Furthermore, release statistics - particularly in states that have made the most radical modifications in hospital care - indicate that the length of hospitalization has become increasingly shorter. ...Optimism brought about by the statistics, however, should not lead to unwarranted conclusions about improvements in the efficacy of psychiatric practice. Perhaps the total accomplishment is the transfer of the problem from the hospital to the community: length of stay in the mental hospital has declined and fewer hospital beds are needed, but readmission rates have increased.¹

In recent years, more than fifty percent of admissions to mental hospitals in the United States have been readmissions.

¹ Howard Freeman and Ozzie Simmons, The Mental Patient Comes Home (New York: Wiley and Sons, Inc., 1962), p. 1-2.

In fact, the Oregon State Mental Health Division has felt sufficiently concerned with this problem to encourage the preparation of the following study of methods by which recidivism might be reduced in Region I, the counties of Multnomah, Clackamas, Washington and Columbia.

Although there are no hard statistics on the recidivism rate for this region, the 1973 state figure for recidivism was sixty percent. The at-risk population, those predicted to be in need of some form of treatment, in Multnomah County alone has been estimated at 60,620 - 130,258 through the use of prevalence rate estimates. Of these, at least 28,500 persons have marked or severe difficulty in functioning or are incapacitated by mental and emotional disabilities.²

A wide and always changing variety of treatment needs exist within the chronically mentally ill population, and an equally wide range of possible strategies also exist to aid their reintegration into the community. However, institutions and communities have failed to effectively implement or utilize those potential aftercare services and thus interrupt the pattern of rehospitalization. A hard look must be given at the programs and options which might be created in this community to alter the pattern of the chronically returning patients and to provide alternatives to hospitalization for both them and others.

² "Multnomah County Comprehensive Mental Health Plan," 1975-76, p. 5.

Purpose of the Study

The purpose of this study was to determine the type of community resources which facilitate community adjustment and tenure for ex-mental patients. Particular emphasis was placed on the extremely visible variable of post-hospital living arrangements available to mentally and/or emotionally disturbed patients. Initially, the researchers assumed that such living situations would be a decisive element in the aftercare needs of ex-mental patients. However, the study was in itself broad enough to introduce other significant factors of equal or greater importance to the target population. The study, then, attempted to assess the relative value of such interrelated activities as living situation, day treatment programs, crisis intervention, home visits, pre-hospital diagnosis and assessment, day hospitalization, brief asylum, and long-term sheltered settings to successful community adjustment for both the ex-patient and the community. Particular attention was focused on application of the findings to Region I.

Definitions

A number of terms are used repeatedly in this presentation. For the purposes of this study, definitions are as follows:

Aftercare: The term aftercare applies to all those services, resources and facilities that exist in the community to assist the mental patient after his/her inpatient psychiatric

treatment.

Chronicity: The target population is often referred to, here and in the literature, as "chronic." Used here, the term implies that their "illness," or emotional difficulties are long-standing and are characterized by periods of more or less extreme exacerbation of the original condition which have resulted in repeated hospitalizations. It is not intended to connote a sense of terminality or hopelessness. Clients within the target population cover the full gamut of psychiatric diagnoses, from depression to schizophrenia. The term chronic may have stigmatizing connotations to some, due to societal attitudes towards psychiatric institutions and illnesses.

Continuity of care: This concept refers to the continuum of resources and services which should exist in the community to meet the client's needs, including facility components ranging from total care to independent living. Clients should feel that services and treatment modalities from any point on the continuum are both readily accessible and sufficiently flexible to allow the mobility necessary to meet their changing needs.

Mental health professionals: The term "professionals" is used here to refer to those in the community who provide treatment or services to the target population, and in particular to refer to the service providers included in the survey of that group in Region I. Thus the term "professionals" includes psychiatrists, psychologists, social workers,

nurses, welfare caseworkers, group home operators, day treatment and clinical personnel.

Target population: Ex-mental patients between the ages of 18 and 65 who have been diagnosed as having mental and/or emotional disturbances comprise the target population.

Those with mental and emotional difficulties who also have alcohol or drug-related problems and/or require nursing care, were not considered in the target population, although the findings of this study may possibly be generalized to other groups.

The Problem

This study was directed toward discovering methods to offset the high rate of recidivism which typifies institutionalized mental patients throughout the United States, including Region I of the Oregon State Mental Health Division. An emphasis exists within this region, as elsewhere, on returning the mentally and emotionally disturbed to the community as soon as they are considered able to function in that environment. Yet the needs of many patients are not adequately met within the community, and they return to hospitalized settings.

This study set out to explore:

1. Aftercare needs as perceived by recidivist patients themselves, and ex-patients now in day treatment programs.
2. Aftercare needs as perceived by mental health professionals engaged in treating the ex-patient.
3. The extent to which services are available to

meet these needs.

4. Alternative programs and services which exist elsewhere and their varying degrees of success.
5. Programs which might better meet the needs of the target population in Region I.

Theoretical Framework

A fundamental theoretical underpinning of this study was the importance of the vital interrelationship between a mental patient's situational context and his/her behavior. This relationship has been called "psychological ecology." As described by Barker, psychological ecology as a concept accounts for all the persons, elements and objects within a bounded and defined area that have implications for the kind of behavior that occurs there.³ This framework views the individual as an integral part of a succession of open systems, each of which is a subsystem of a larger unit, and all of which are interrelated. Thus, he/she may be part of a family system, which in turn is a subsystem of an ethnic subgroup, which is a subsystem of a neighborhood system, and so on. A mental disorder in the individual may be one manifestation in her/him of strain in some or all of the systems.

Viewed in this context, the removal of the "deviant" or malfunctioning individual from her/his natural environment has ramifications both for that ecological system

³ Roger Barker, Ecological Psychology (Stanford, Ca.: Stanford University Press, 1968).

and that person's eventual re-entry into it. Concretely, psychiatric hospitalization requires major adjustments on the part of several systems involved and the individuals who comprise those systems: the individual, the family and the hospital. Since hospitalization, regardless of duration, is seen as temporary, further adjustments or re-adjustments of the same and/or new systems are necessitated upon discharge.

Inherent within the concept of "psychological ecology" is the significance of complementary role functioning, and the network of expectations and sanctions which ensure that people behave in ways that maintain the equilibrium of the social organization. Thus a mentally ill individual can be seen as not conforming to social expectations of appropriate behavior in his/her roles. This deviance may be caused by her/his inability to occupy those roles, and by the ineffectiveness of the usual network of expectations and sanctions in molding his/her behavior.⁴

How people tend to see themselves depends to a large extent on how others perceive them. This is particularly so when past frames of reference are no longer available, as is the case when someone is hospitalized. Research indicates that in this context, the individual becomes unusually dependent on current stimuli for cues regarding appropriate

⁴ Gerald Caplan, "Conceptual Models in Community Mental Health," Support Systems and Community Mental Health (New York: Behavioral Publications, 1974).

behavior.⁵ The person diagnosed as mentally ill, by virtue of that fact, generally has a weakened self-concept which makes him/her especially susceptible to this sort of situational conditioning. Thus, if the environment defines the individual as incompetent, helpless and incapable of self-control and self-determination, the person will tend to integrate these definitions into his/her own self-concept and respond accordingly. Psychiatric hospitalization in and of itself, regardless of setting, effectively communicates such a self-concept for many because of the societal stigma and ostracization it connotes. Regardless of the benefits intended through hospitalization, if the patient loses confidence in her/his own judgment and becomes excessively dependent on external factors for cues, a vicious cycle develops that defines the individual as unfit for life in ordinary society and for the responsibilities of an independent citizen, and ultimately reinforces that demeaning self-concept.

In this way, the persons who often come to be labeled "chronic" - including those that repeatedly are hospitalized - are initiated into the "sick" role and find that this is a role they can fill. The longer others perceive them and

⁵ Jack Zusman, "Some Explanations of the Changing Appearance of Psychotic Patients," in Evaluating the Effectiveness of Community Mental Health Services, ed. by Ernest Gruenberg (New York: Milbank Memorial Fund, 1966), p. 389.

they see themselves as "sick," the more difficult it becomes to let go of the security, protection, and passivity such a position offers. Both the clients and their mental health workers begin to lose sight of the possibilities and potentials they share, and the walls of the hospital no longer serve to define the "mentally ill" - those walls become extended far into the community in the form of a rigid way of seeing oneself and others that is tragically limiting.

Specifically, upon entering the unnatural ecological situation of hospitalization, the mental patient may develop symptoms of the "social breakdown syndrome" or what Russell Barton has called "institutional neurosis."⁶ Institutionalization, by removing the mentally and emotionally disturbed person from a more or less familiar social situation, may directly cause a loss of social skills and competencies necessary for survival in the community.

So foreign from "real life" is the institutional ecology that an actual negative correlation has been noted between the behavior of patients before and after hospitalization.⁷ A patient's problems in living in the community may, in fact

⁶ Russell Barton, Institutional Neurosis (Bristol: John Wright and Sons, 1959).

⁷ Paul Polak and Maxwell Jones, "The Psychiatric Non-hospital: A Model for Change," Community Mental Health Journal, IX (Summer, 1973), p. 125.

be totally misdiagnosed once he/she enters an institution, given the influence of situational contexts on behavior. If a patient is suddenly wrenched from the social system in which she/he has been acting out an illness, there is no reason to assume that symptoms will persist in a totally foreign context. Research has tended to demonstrate that hospital clinicians and patients disagree widely about goals of treatment.

Patients usually defined the important problem to be worked on in treatment within one or more groups of people with whom they lived. Staff members defined the problem within the patient and saw it in terms of illness.⁸

Not only can hospitalization create chronic symptoms in patients, it can also stigmatize the patient in such a way that she/he will be severely handicapped in functioning within the community nexus.

This is not to say that hospitalization is inappropriate for all patients. The question at issue is: Are the clients' needs being met in whatever ecology they find themselves? Many of the mentally and/or emotionally disturbed desperately need a secure environment which provides a predictable routine and an opportunity to avoid social isolation. "Staying out" as an index of successful re-entry into the community needs to be re-examined. As Silverstein states, "ex-patients may, in fact, be seeking to sustain their health

in edging back to a more accepting human society - the hospital."⁹ In this light, hospital re-entry may be seen more as a societal failure rather than a personal one, since the patient was not able to meet his/her needs in the community. The percentage of chronic patients who remain in the community should by no means be taken as a measure of the success of either an aftercare program or of hospitalization.

A counter-danger exists, in fact, in that the present emphasis on community treatment in such non-medical settings as nursing homes and room and board situations can lead to a patient's deterioration. Decisions to place a chronic patient in the community may come from less-than-professional motives.

It would seem that this aspect of community care stems more from political and economic considerations than from concern for the welfare of the chronic mentally ill. State and local authorities are transferring the financial burden of mental patients and the infirm elderly from state hospitals to the community, where private enterprise provides the major resource.¹⁰

As Kincheloe and Hagar point out, "one of the disservices people can do to one another is to become indifferent and

⁹ Max Silverstein, Psychiatric Aftercare (Philadelphia: University of Pennsylvania Press, 1968), p. 43.

¹⁰ Maxwell Jones, "Community Care for Chronic Mental Patients: The Need for a Reassessment," Hospital and Community Psychiatry, XXVI (February, 1975), p. 96.

cease having expectations."¹¹ Lack of therapeutic contact need not, and should not automatically follow institutional discharge.

An interruption of the hospitalization process can be effected either at the point of admission or upon therapeutic release. People with limited resources, who do not have knowledge of or financial access to such aids as local mental health personnel and agencies, when confronted with deviant behavior, often turn directly to the hospital. Although court-committed patients are screened to determine most appropriate treatment facility, voluntary admission into the hospital setting may occur before any evaluation of the deviant symptoms has taken place. For people caught in this dilemma, a non-institutionalized alternative could be extremely useful.

But at whatever point exit from the institution occurs, a flexible, mutually articulated aftercare network should exist for the patient in the community. Such a system provides the nexus necessary for the client to resolve his/her conflicts, often caused by and acted out within a social ecology.

Regardless of the structure of existing aftercare programs, sustained interpersonal contact between therapeutic

¹¹ Marsha Kincheloe and Lorraine Hagar, Out the Back Wards' Door (Denver, Colorado: By the Authors, Fort Logan Mental Health Center, 1974), p. 28.

personnel and the client in the community is absolutely essential to their successful functioning. As Kincheloe and Hagar conclude in their study of schizophrenia admission-readmission patterns: "The only kind of aftercare program that can hope to break this cycle is one that includes home-visiting as its major delivery vehicle."¹²

Or, as Silverstein puts the case in more dramatic terms:

Some talented and creative people have written about their own experiences (of madness), from Beers to Sartre. All refer to the critical moments of coming out of the depths into the real world once again, and what this rapid and radical change in milieu presents to the patient who is trying to re-establish himself. There is no mistaking that what most ex-patients seek is a human relationship which can be trusted to help provide the support and the continuing link until the ways of the "new world" are relearned. Beers said that what the mentally ill need is a friend... While creative and talented persons give the description in depth of the despair and horror of disabling mental illness, one of the released patients (in this study) put his finger on why an aftercare program has to be welded with "human glue."¹³

With a firm basis in interpersonal contact, aftercare systems, in order to function efficiently, must provide a continuity of care. A flexible continuum of resources, with components ranging from total care to independent living, should exist. Clients should feel that services from any point on the continuum are readily accessible. The client her/himself may not perceive the need to use various treatment modalities, and therefore, continuous monitoring of

¹² Ibid., p. 68.

¹³ Silverstein, Psychiatric Aftercare, p. 55.

changing levels of functioning and appropriateness of care is essential. Also, a continuous system of treatment allows communication between therapists and agencies involved in client treatment. A continuum of care holds out some hope that the crisis periods in a person's life can be responded to with creativity and speedy access to appropriate treatment.

Assumptions

The assumptions underlying this study reflect the theoretical basis shared by the researchers. These assumptions served as the touchstone for this exploration and can briefly be stated as follows:

- That if a significant number of people continually return to the hospital, there is a deficit of resources in the community to meet their needs.
- That for a large number of mentally and emotionally disturbed clients, there are more effective treatment modalities than hospitalization.
- That the living situation of the ex-patient is an important factor in determining successful readjustment to the community.
- That opinions of re-hospitalized patients and mental health professionals may differ as to the needs of ex-patients and therefore both groups need to be polled.
- That the mentally and/or emotionally disturbed client has a right to the most effective treat-

ment and services possible to ensure the maximal personal and societal adjustment.

Delimitations

In order to examine the multi-faceted problem of recidivism and community re-adjustment, this study was approached from several different perspectives. Although, as stated, the researchers initially assumed that living situations were the crucial factor in post-hospital adjustment, an overview approach to the problem resulted in this initial assumption becoming one part of the total study. Given the exploratory nature of this research, the relative importance of each component of aftercare was not analyzed.

Questionnaires were administered to current inpatients who had previously been hospitalized one or more times. They were at varying stages in their treatment programs at the time of the interviews---some were closer to discharge than others. Generalization concerning the relative level of functioning and clarity of this group was difficult. The subjective opinion of the interviewers was that some were more intact than others. These considerations should be kept in mind when examining the results of the patient questionnaires.

The interviews with the inpatients represent a sample of returned patients in three facilities (Dammach State Hospital, Woodland Park Mental Health Center, and Providence Medical Center) over approximately ten weeks. Given that

time-frame and the size of the sample, the results are not generalizable to ex-mental patients as a whole.

A different questionnaire was sent to mental health professionals (see "Definitions"). This group represents several different disciplines and a wide spectrum of agencies. This study attempted to poll a wide cross-section of those people in Region I who daily confront the concerns of ex-patients. The selection by no means comprises the whole of those service-providers. The lack of a cohesive tracking system for client service delivery created a difficulty in not only reaching, but being aware of all the significant people who work in this area.

Due to the large number of facilities providing housing to ex-mental patients, the lack of a centralized and complete register of these, and time limitations, the living arrangements of ex-patients were not visited.

It is recognized that in examining the issues of creation and utilization of aftercare services, the related problems of effectiveness and costs are important. A cost/benefit analysis was not within the realm of this study, although such an analysis could be a natural and useful outgrowth of this research.

Finally, the exploratory nature of this study does not provide an analysis of the total problem of recidivism and aftercare. It does provide an overview of the problem with particular application to Region I that should prove to be

a useful planning tool and lay the groundwork for further research.

Organization of the Study

The following chapter includes the methodology involved in collecting data from both recidivist patients and mental health professionals involved in service-provision to the target population; an analysis of that data; and a description of existing resources in Region I which are relevant to this study. The review of the literature provides an historical overview of the community mental health movement and describes residential, treatment, and comprehensive aftercare models currently in existence in other areas of the United States. Conclusions and recommendations based on this study are presented in the final chapter.

CHAPTER II

DATA

Methodology

This study was an exploration into the relevant factors influencing hospital recidivism and the successful post-hospital adjustment to community life by chronic mental patients. Two questionnaires were designed. One questionnaire was administered to current inpatients at local mental health facilities and one questionnaire was distributed to mental health professionals. A literature search was undertaken in the area of aftercare for the mentally and emotionally disturbed. Also, requests for information concerning current programming and research in this area were sent to the Mental Health Divisions of the other forty-nine states (see Appendix).

Patient Questionnaire

As stated above under "Delimitations," the researchers began with the assumption of the crucial nature of the impact of post-hospital living situations on recidivism. The patient questionnaire reflected this assumption more heavily than other aspects of the study which were mediated by additional information. The study attempted to sample not only patients' past living situations, but also to

give them the opportunity to express their notions of what factors might constitute a more adequate community life in the future.

The patient questionnaire (see Appendix) was designed to elicit pertinent demographic data, information regarding the present and past hospitalizations, and previous residences. Additional questions concerned medication, sources of financial support, occupation, and dependents. Those interviewees who had previously resided in a group home, halfway house, or room and board situation, answered a fourteen-part question concerning that living arrangement. All subjects were asked several questions regarding their future post-hospital needs in terms of living arrangements, time scheduling, household responsibilities and regulations, psychotherapy, work, vocational counseling and training, and socialization skills. The final question was an open-ended request for any additional information they felt was important.

Sample

Dammasch State Hospital and Woodland Park Mental Health Center were selected as sites for the inpatient interviewing because of the large number of patients admitted yearly to these two facilities: approximately 1900 at Dammasch and 1350 at Woodland Park from Multnomah County alone.¹

¹ Multnomah County Comprehensive Mental Health Plan, 1975-76.

A small number of additional patients in the Providence Medical Center Day Treatment Program were also interviewed. The administrators and social service departments of these three facilities were contacted, informed of the nature of the project, and asked to cooperate. The staffs of all three hospitals were cooperative and helpful in our effort to reach the target population.

The sampling procedure varied for each institution: at Dammasch State Hospital, the interviewer conducted the interviews once a week at which time he reviewed admission forms for the preceding week in order to determine the number of patients who fit the target population. Because of the large number of patients at Dammasch at any one time, a random sample of twenty-five percent of those patients who fit the target population was selected.

Due to the much smaller inpatient population at Woodland Park Mental Health Center, it was determined that a twenty-five percent random sample would be notably slight. Therefore, the researcher at this institution employed an accidental sampling method, interviewing as many patients as possible who fit the target population in the time allowed. (Each researcher spent approximately one day per week interviewing over a ten-week period from December 1, 1975 to February 15, 1976).

The interviewees at Providence Day Treatment Program were pre-selected by the staff as being appropriate for our study.

Procedure

The patient questionnaires were administered to the subjects by the researchers, and the questionnaire was designed with this technique in mind. Many of the questions have yes/no answers, while most of the others have clearly defined answer-options. The selected patients were informed by the interviewer of the nature of the questionnaire, given the option of participating, and assured that their identities would be protected. All patients approached cooperated as fully as possible. As previously stated under "Delimitations," the inpatient status and varying degrees of mental and emotional stability of the interviewees make the validity of this data questionable. Despite this drawback, the researchers strongly felt that it was of central importance to this study to obtain information directly from the target population. The results are analyzed in the "Analysis of Data" section of this chapter.

Professional questionnaire

Upon leaving the hospital, the ex-mental patient may find her/himself confronted with one or more of a variety of community-based social service and mental health agencies. The mental health personnel who function within these agencies serve their clients both as guides to the societal ecology and as direct links to the therapeutic community. In either case, they are intimately connected with the struggles of the ex-patient to adjust to life in the

community, and this study attempted to sample their opinions as to the needs of their clients.

The professional questionnaire was designed to be completed in a minimal amount of time to ensure greater return. The questionnaire was prefaced with an explanation of the study, a definition of the target population, and a request for cooperation. The professionals were asked to rate several items on a five-point scale ranging from "very important" to "not important." (See Appendix.) The items included those on the patient questionnaire in addition to eliciting information regarding patient participation in planning and decision-making, and the relative importance of whether ex-patients lived with and/or had social contact with: others, others who had/did not have mental problems, and family. The last page included an open-ended question regarding other critical factors affecting successful community adjustment and concluded with a request for additional comments and suggestions regarding the planning of post-hospital living arrangements for ex-patients. Information identifying the respondents by name, position and agency was also requested.

A list of personnel who are involved in service delivery to ex-mental patients was compiled. Included were welfare hospital liaison workers, group home operators, hospital social workers, county mental health program and day treatment staffs. This group represents several different

disciplines and a wide spectrum of agencies; thus the term "professionals " is not used solely in the traditional sense. (See "Definitions.") As previously stated under "Delimitations," an attempt was made to reach a wide cross-section of those people in Region I who work with ex-mental patients. It is recognized that our sample is not comprehensive.

The questionnaires were distributed and collected by mail; stamped returned envelopes were included to facilitate this process. The results of this survey are described and analyzed in the "Analysis of Data" section of this chapter.

In addition to the two questionnaires, information regarding current programming and research in this area was requested from the Mental Health Divisions of the other forty-nine states. (See Appendix for letter.) Nineteen replies were received. Pertinent information gathered from this source is included in the literature review.

In order to gain an awareness and understanding of existing resources and services in Region I, several agencies were contacted either through personal contact or telephone. These include welfare branches, county mental health programs, psychiatric hospitals, and day treatment programs. The services and resources are described in the "Existing Resources" section of this chapter. The Department of Human Resources study, "Deinstitutionalization in Oregon: A Review of Services within the Human Resources System," completed

in May, 1975, provided considerable information in this area.

Analysis of Data

Patient Questionnaire

Following is a description of the results of the questionnaire administered to inpatients at Dammasch State Hospital and Woodland Park Mental Health Center, including a small sample of additional patients from the Providence Day Treatment Program; this last group has been included with the Woodland Park population for statistical purposes. The patients fit the target population, as described above under "Definitions," and the interviewing and sampling procedures are described in the section on methodology. A copy of the questionnaire and the tabulated data can be found in the Appendix. In reporting the findings of the patient questionnaire, reference will be made to the composite totals of the three groups except when significant differences appear.

Demographic Data

Although the patient sample was predominantly female (65%), only 54% of the Dammasch sample was female, while 74% of the Woodland Park and Providence group were women. The sample ranged in age from 18 to 65, with 51% being 35 or under. On a differentiated marital status scale, 39% were single, 18% married, 36% either separated or divorced. Thirty-six percent (36%) had completed eleventh or

twelfth grade while 38% had had educational experience beyond high school.

When questioned concerning occupation, only 30% described themselves as unemployed at the time of hospitalization; however only 29% were deriving income from employment. Other sources of financial support were as follows: 32% receiving income from Welfare or SSI and 18% from their families. An interesting difference may be noted in that 42% of the patients sampled at Woodland Park and Providence derived income from employment while only 17% of those queried at Dammasch so did. Almost half (48%) of the sample had no children. In accordance with specifications of the target population, 94% were not being treated for medical problems.

Previous Psychiatric Hospitalizations

Tabulation of information concerning history of psychiatric hospitalizations of the sample indicated that 86% were voluntarily admitted and 14% were court committed. As can be seen from the table below, 58% had been hospitalized one or two times previously. Of the sample, 58% had been re-hospitalized in less than six months and 74% had been re-hospitalized within a year after their previous confinement. (See table below.) Our sample tended overwhelmingly (85%) to return to the institution of most previous hospitalization. Of the 38 members of the sample (74%) who were receiving medication prior to hospitalization, 35 were responsible

for administering and monitoring their own medications.

TABLE I: Previous Psychiatric Hospitalizations

Number	Dammasch		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
1-2	11	47	19	70	30	58
3-4	6	25	3	11	9	18
5-6	1	4	5	19	6	12
7-9	3	12	0	0	3	6
10+	3	12	0	0	3	6
TOTAL	24	100	27	100	51	100

TABLE II: Months Since Last Hospitalization

Number	Dammasch		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
0-1	3	12	8	29	11	21
2-3	4	17	4	15	8	16
4-5	5	21	6	22	11	21
6-8	1	4	3	11	4	8
9-12	1	4	3	11	4	8
13-18	1	4	0	0	1	2
19-24	3	12	2	8	5	10
25-36	0	0	1	4	1	2
36+	4	17	0	0	4	8
Don't know	2	9	0	0	2	4
TOTAL	24	100	27	100	51	100

In describing their living arrangements immediately prior to hospitalization, 35% of the subjects had been living alone and 13% had been living in room and board of group homes.

TABLE III: Last Residence

Number	Dammasch		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Home						
-with parents	1	4	4	15	5	10
-with sibling	1	4	0	0	1	2
-with spouse	2	8	3	11	5	10
-with children	1	4	1	4	2	4
-with spouse & children	1	4	2	7	3	6
-with roommates	1	4	4	15	5	10
-alone	8	34	10	37	18	35
Room & Board	4	17	2	7	6	11
Group Home	1	4	0	0	1	2
Halfway House	0	0	0	0	0	0
Other	4	17	1	4	5	10
TOTAL	24	100	27	100	51	100

Group living experiences

In an attempt to discover the characteristics of their previous group living experiences, the subjects were queried concerning the details of these situations. Of the sample, 35% had lived in a room and board situation, group home or halfway house within the last ten years. Of this group of 18 people, twelve (67%) had lived in room and board situations, two (11%) in group homes, and four (22%) in halfway houses. Thirteen people (72%) report that one-fourth or less of their time was scheduled. Approximately 50% had some housekeeping responsibilities; approximately 75% of this sample did not participate in cooking or shopping. More than 80% had responsibility for their personal tasks, which included laundry and caring for room.

Except in the cases of drinking and hours, most (61%) of these living situations did not impose regulations on their inhabitants. In those cases where there were regulations, the majority consistently felt that they were reasonable.

Approximately 48% reported never participating in social or recreational activities; an additional 40% reported only occasional participation in these activities. Two-thirds of the 15 people who were on medications self-administered the medication. Seven people reported involvement in psychotherapy and of these, 6 were receiving their therapy at a community agency while only one was receiving therapy at the site of her/his living situation.

Thirteen subjects in this group (72%) recorded themselves as unemployed during their group experiences. Only three persons were receiving vocational counseling at this time and only two vocational training. Almost none of these subjects reported having received assistance with money management, transportation, or shopping.

Ideal situation

The entire sample of 51 patients was polled concerning the post-hospital situation which they felt would best meet their needs. Thirty-one people (60%) wanted a living situation that featured permanence. Sixty-three percent (63%) said they did not wish to live with their families. Forty-eight percent (48%) stated they would like to live with others, and an additional 26% said they might like to live with others, depending on circumstances. When asked to express themselves as to why they would prefer to live with others, 11 people responded that they were either fearful of isolation or that an isolated living situation contributed to a continuation and deepening of depressive states. Four people felt that group living would hamper their individuality. However, 23 members of the sample (45%) said they would not be willing to live with others who had been hospitalized, expressing reasons including a need to deny their own psychiatric history and dislike for and fear of other mentally or emotionally disturbed individuals. Twenty-two percent (22%) said they would be willing to live with others

who had been hospitalized and 29% said that such a situation would depend on other factors including compatibility as the most prevalent response.

Of the entire group, 50% said they would like to live with four or fewer people; 70% expressed a desire for a private room. Seventy-four percent (74%) said that they wanted very little or none of their time scheduled, and 90% stated they would be willing to help with household chores. Almost all (96%) were willing to accept responsibility for tasks of personal maintenance.

When faced with questions concerning regulations, the sample group split almost evenly on acceptance of smoking regulations, a slight majority (51%) were willing to accept drinking regulations; only 31% would accept regulated hours, and only 27% would accept regulations concerning visitors. One-third of the people wanted occasional social and recreational activity with about 50% wanting to participate in these activities more often.

Approximately three-fourths of the sample wanted psychotherapy. About as many wanted to work either full- or part-time. Fifty percent (50%) of the respondents from Dammasch wanted full-time employment whereas only 29% of those from Woodland Park and Providence desired full-time work. Gender did not seem to be a factor in desire for full-time employment, since exactly half of those patients sampled at each institution desiring such employment were

women. Forty-three percent (43%) wanted vocational training and counseling.

Questioning concerning a desire for help in such matters as money management, public transportation, and shopping elicited a generally negative response. Of the subjects, 39% said they would prefer to live in a residential neighborhood, while 21% preferred a rural setting, 16% downtown, and only 10% suburban living.

Discussion

Several aspects of the statistical results of the patient questionnaire appear significantly important to warrant special emphasis and additional speculation.

One outstanding characteristic of the sampled patients is the fact that 75% were either single, separated, or divorced. (Table included in Appendix) This information, coupled with the findings that 35% had been living alone and 48% had no children, leads to speculation concerning lack of community and familial ties for these individuals which may have bearings on their recidivist tendencies. The absence of close interpersonal support in times of crisis may be a determining factor influencing re-hospitalization.

Approximately half (51%) of the total sample were 35 years of age or younger, which may indicate an inadequacy and/or insufficiency of resources and services for this age group.

The finding that 74% of the sample were receiving medication prior to hospitalization and that, of these, 92% were responsible for administering their own medications, may imply that medication regimes were not being carried out as prescribed. A proper level of the appropriate psychoactive medication can often control psychotic and depressive tendencies.

The high rate (74%) of recidivism within one year of discharge indicates that the first year, and particularly the first six months, following psychiatric hospitalization is a critical period for the ex-patient, during which time appropriate services, resources and support may be crucial.

When re-hospitalized, 85% of the sample had returned to the institution where they had last been hospitalized. As stated in the theoretical framework set forth in the introduction, a lifelong lack of personal and community options, often in addition to limited financial resources, is characteristic of chronic mental patients. High rate of return to place of last hospitalization could be a manifestation of this lack of personal power and/or actual alternatives. It might also be seen as a desire to return to a safe, familiar environment which offers the companionship, security and support the individual might be needing in the community.

This same characteristic may also have influenced patient responses concerning an ideal post-hospital

situation: if one's range of life experiences and options has been severely limited, one's capacity to project ways to satisfy unmet needs may also be limited.

In this area, the sampled group stressed the importance of privacy and a desire to have their time unstructured, two factors which may indicate a strong need for personal freedom and autonomy. This indication, coupled with a strong desire to work, to participate in social and recreational activities, and not to receive assistance with daily living skills, could point to a desire to conform to societal expectations for "normal" functioning and may not be realistic.

Professional questionnaire

Questionnaires were distributed by mail to forty-seven professionals working with ex-mental patients in various phases of their adjustment to community living. (See "Definitions" for a description of the term "mental health professionals" as used here.) Thirty questionnaires were returned. The data were tabulated and percentages of responses were computed. A complete set of tabled responses and a sample questionnaire are included in the Appendix.

The multiple choice response section of the questionnaire was conducted entirely under the rubric of rating a series of items on their relative importance in facilitating community adjustment of the ex-mental patient. The five choices for each item were: "very important," "fairly

important," "moderately important," "somewhat important," and "not important," in that order. At the end of the questionnaire, the respondents were given the opportunity to answer two open-ended questions concerning factors critical in community adjustment and planning of living arrangements for the target population.

In the presentation of this data which follows, selection has been made of those responses which seem statistically most suggestive and pertinent.

Ranked responses

The respondents placed a relatively high level of importance on eleven areas in the questionnaire. Of the 30 respondents 66% ranked as fairly or very important the necessity of having the client's time structured and 90% ranked as fairly or very important, involving the individual in the planning of his/her own schedule of those daily activities. In fact, two-thirds of the respondents ranked this client involvement as very important. Also receiving high marks - a 90% ranking of fairly or very important - was the opportunity for client participation in social and recreational activities. Participation in educational/cultural activities received a 60% ranking of fairly and very important. The respondents expressed a general agreement as to the significance of finding employment for ex-patients and providing them with vocational counseling and training. Seventy percent (70%) of the professionals agreed that

individual participation in the development of house rules within group living situations was fairly and very important. Socialization and training in areas of money management and use of public transportation gained high expressions of importance, significantly more so than the items of socialization in meal planning, grocery shopping and household maintenance, all of which received responses ranking them as distinctly less important. Professionals also ranked highly access to psychotherapy.

Living with other people received a high ranking: 76% rating it fairly or very important; however, 66% ranked as not or somewhat important the possibility of the ex-patient living with other people who have had mental problems. Living with people who have not had mental problems was ranked not or somewhat important by 50%.

Seventy percent (70%) of the respondents rated as fairly or very important the maintenance of social contact between the client and his/her family, and 56% rated as fairly or very important social contact with people who have not had mental problems. In contrast, 46% rated as not or somewhat important, social contact with other ex-patients.

Individual privacy and the comfort and attractiveness of the living facility gained a mixed reaction, with most respondents feeling that these items were only moderately important.

In responding to the two open-ended questions which completed the questionnaire, at least 80% of the respondents

contributed further remarks concerning the aftercare needs of the target population.

Open-ended responses

Responses to the two open-ended questionnaire items, regarding critical factors in successful community adjustment and suggestions for planning living arrangements, tended to overlap. Therefore, in discussing this section of the questionnaire, responses to these two final questions have been combined. Twenty-five people answered this section; themes they expressed are presented in the following discussion.

Responses have been divided into four general areas. Pre-discharge planning was an issue addressed by fourteen respondents. Individualized planning, which considers clients' goals and needs and includes maximal client participation in the process, was mentioned repeatedly as an essential pre-requisite to community adjustment. Selection of a living arrangement most congruent with a person's capabilities and needs was noted as an important part of discharge planning. Some respondents recommended pre-placement trial visits; others said direct contact with operators and knowledge of facilities was crucial for staff involved in discharge planning. Adequate planning must also include linking the client with his/her local community mental health program prior to discharge, as well as teaching the client about her/his medications.

Fourteen people provided comments related to post-hospital residential facilities, a second category of responses. Lack of sufficient suitable housing resources was frequently noted. Five respondents cited need for a larger number of structured group and/or room and board situations (especially in Washington, Clackamas and Columbia counties), and emphasized the importance of having housing options like halfway houses so clients are not always forced to return to family situations. Respondents also stressed that boarding home operators need more support and guidance in working with ex-patients; some suggested on-going contact between operators and staff of mental health agencies. Five respondents regarded medication supervision as a necessary function of the facility staff.

Comments provided by twelve people addressed psychological qualities necessary in a resocialization environment. Clients must be treated as responsible human beings; self-determination should be emphasized. Planning is essential; clients must be involved in developing their own, individualized programs. For socialization to occur, a client needs people who care consistently over a period of time, and reassurance that it is possible to stay out of the hospital. A client needs supportive, realistic relationships with people who respect his/her limitations and who encourage growth. Public education to increase understanding and acceptance of ex-patients' behavior is offered as a

way to facilitate resocialization. Involving families or other support systems in post-hospitalization treatment was also recommended.

The area of community resources, a fourth category, was addressed by thirteen people. Follow-up care was viewed as essential in maintaining ex-patients in the community. The most frequently cited aspect of follow-up was medication monitoring. Participation in mental health program services, particularly socialization groups, was highly recommended. Day treatment programs and outreach services were offered as suggestions for facilitating community adjustment of mentally and emotionally disturbed clients. Eight respondents pointed to the absolute necessity of knowing what resources exist and how to gain access to the services they provide.

Noting problems confronting clients in dealing with a maze of community agencies, several respondents suggested simplifying the network and/or providing advocates to help clients negotiate the system. Possible use of community volunteers was mentioned in this regard. Finally, in thinking about community resources, people stressed the need for better interagency coordination. Extensive liaison, linking all elements of clients' support systems, is necessary to effective community treatment.

Comparison of Patient and Professional Responses

One of the initial research assumptions in this study was that opinions of patients and mental health professionals might differ as to the ex-patient's needs in adjusting to community life. The discussion which follows presents a comparison of responses to the patient and professional questionnaires.

Patients and mental health professionals consistently agreed on the importance of the following variables in facilitating community adjustment: living with other people; accessibility of psychotherapy; vocational counseling, training and employment; and participation in social and recreational activities.

Several items elicited opposing opinions from patient and professional respondents. Patients generally expressed little or no desire to have their time structured or to have assistance in socialization skills such as money management and use of public transportation. In contrast, professional opinion strongly maintained that time structuring and socialization skills development are important in adjustment to community living. As mentioned earlier, the patients' negative response to these options might reflect desires for conforming to societal norms and having personal freedom. The professional stance on these items may well be more realistic, as it is based on experience with a wide range of ex-patients.

Two additional factors mentioned in the professionals' open-ended responses were supported by data from the patients' questionnaires. It was found that 74% of the patient sample was taking medication prior to hospitalization, and that 92% of these people were administering their own medications. This finding may imply that medication programs were not being accurately followed. Professionals stressed need for monitoring medication and teaching patients the importance of following their medication regimes. Finally, patient responses, as discussed previously, might reflect desires for personal freedom and autonomy. Professionals stated repeatedly that clients must be given responsibility and must be involved in planning their own programs.

Existing Resources

As stated earlier in this chapter in the methodology section, several agencies which provide services to ex-patients in Region I were contacted in order to ascertain what resources currently exist for this population. A description of the findings follows.

Mental Health Programs

The Multnomah County Mental Health Program is divided into five catchment areas; four are served by County Mental Health Programs and one area, North Portland, is served on a contractual basis by Delaunay Institute for Mental Health. Clackamas, Washington and Columbia counties are respectively

served by McLoughlin Mental Health Center, Tualatin Valley Guidance Clinic, and Columbia County Family Counseling Center, Inc.

All of the programs are currently providing services to former patients regardless of whether their hospitalization was voluntary or a result of court commitment. None of the programs is routinely notified when a person from its catchment area is hospitalized voluntarily, and notice of discharge of these patients is often dependent upon whether the center made the initial referral to the hospital and/or whether the individual requires medication follow-up through the center. When medication follow-up is required, it is often arranged by the hospital social service department prior to patient discharge.

Court committed patients differ in that they are assigned a monitor at the time of commitment to the Mental Health Division, and the monitor should be aware of admission and discharge and also be involved in program planning for the patient during all phases of his/her involvement with the mental health system.

Admission of discharged voluntary patients not requiring medication supervision in most cases does not differ from admission of other individuals in the community seeking mental health program services. The client will normally call or come into the center to make an appointment. Depending on the program, the patient may be seen immediately

or wait as long as four weeks for his/her first appointment. (The usual waiting period is from one to three weeks.) The services available to the former patient are the same as for the program population as a whole, although some of the centers have groups geared more specifically to the needs of the deinstitutionalized patient.

Tualatin Valley Guidance Clinic has greater awareness of patients from its catchment area who are admitted to Dammasch State Hospital, since a psychiatrist from the clinic goes to the hospital regularly to see patients from that county. This used to be the policy at Clackamas and is likely to be re-instituted in the near future.

After making contact with the Washington County program the patient is asked to attend an orientation session which is run twice weekly by two volunteers. The clients are given information regarding program services and procedures, and asked to complete an application form which describes their problem and history. This form is then used to determine the most appropriate therapy and therapist for the client. This intake procedure is the same regardless of whether the individual applying for services has been hospitalized or not. A first appointment will be scheduled within three to five days.

The procedure differs somewhat in Columbia County where one staff member of the new Columbia County Day Treatment Program makes weekly visits to Dammasch; she contacts

patients from Columbia County and participates in discharge planning. Follow-up and appropriate referrals are arranged through the Day Treatment Program.

Medication supervision is also being handled differently in this county. Due to poor transportation resources within the county, an agreement has been made with some pharmacists in the area that Center clients may pick up their medications one or two times per week at the pharmacy, rather than going into the Center. If a client fails to come in for his/her medication, the pharmacist contacts the client by phone; if the client still does not come in, the pharmacist contacts the Center. This system has been used effectively with antabuse and is just beginning to be implemented with psychotropic medications.

Day Treatment

There are four day treatment programs currently operating in Region I: Providence Hospital's Day Treatment Program, Mount Tabor Personal and Family Services Day Treatment Program, Clackamas County Day Treatment, and Columbia County Family Counseling Center, Inc. Day Treatment. Plans are now being developed for similar county programs in Washington and Multnomah counties.

Providence Day Treatment Program is the largest program, serving approximately seventy clients. Not all clients are involved in the program all day or every day. A specific program is negotiated for each individual, and clients

average about six hours per week in day treatment. The daily schedule includes morning and afternoon groups, skill training in meal preparation, occupational and recreational therapies, and individual therapy when appropriate. This program is based on a personal growth model, and therapy groups are oriented toward dealing with resolution of such issues as grief and anger. Clients tend to remain in the program less than six months and in most cases do not have a prolonged history of mental disturbance.

The Mount Tabor Personal and Family Services Day Treatment Program has a capacity of twenty clients and normally operates with about half this number. Like the Providence program, most referrals come from private hospitals, private mental health professionals and community agencies. Participation may vary from two half days per week to five full days, depending upon the needs of the client. This program also offers group therapies, occupational and recreational therapies, daily living skills and assertiveness training. Most clients remain in the program less than six months. Both Providence and Mount Tabor are private programs; the fee requirements may eliminate people who could benefit from such services.

Clackamas County Day Treatment Program serves approximately twenty-five regular clients who attend at least once a week, and a total clientele of about fifty. The program operates two full and two half days per week. Most clients

are former hospital patients, and many have their first contact with the program prior to discharge, a process facilitated by Dammasch State Hospital social workers who bring prospective clients to the program for an initial orientation. Programming includes: a daily living skills group for long-term clients, activity groups, growth groups, guest speakers, house meetings, and free time. The program emphasizes socialization. Average length of stay in the program is one year.

Columbia County Family Counseling Center Day Treatment Program began operation in mid-February, 1976 and thus is still in its infancy. This program is designed for a maximum of ten clients ranging in age from 18 to 55. The regular program operates two days a week and provides group therapy, socialization, and skills training. In addition, monthly evening family meetings are planned.

The staff at this day treatment program plan to function in other capacities, which differs from similar programs in the Region. As stated, in addition to regular program responsibilities, they will contact patients from the county currently at Dammasch and develop plans for their re-entry into the community. In some cases this may mean day treatment and in others, help with housing or job placement. They plan to work with public health nurses, Children's Services Division and vocational rehabilitation, and hope to establish and maintain contact with nursing homes,

ministers and lawyers. They hope that their services will be seen as an alternative to hospitalization in court commitment proceedings.

Welfare

The Public Welfare Division in Multnomah County maintains liaison workers who are assigned to each psychiatric hospital in the Region and are responsible for the assessment of patients' needs at the time of discharge, program planning, and the implementation of the initial phases of that plan. The case is then transferred to a follow-up worker in the area where the patient will be living.

If the ex-mental patient is receiving Welfare benefits, he/she may be eligible for a basic room and board payment of \$153 and may receive additional "service payments," which could provide for additional supervision or treatment, such as day treatment. There are four types of facilities to which Welfare provides payments: 1) Room and Board Facilities, which house less than six residents and provide no additional services; 2) Adult Foster Homes, situations in which one or two residents live in a home environment, usually with family or friends; 3) Group Foster Care Homes which have three to five residents and provide room and board plus some services; 4) Group Care Homes which provide facilities for larger groups; these must be licensed, with regulations similar to those applied to homes for the aged.

At one time, Welfare maintained a register of all facilities which met fire and safety regulations. However, there was no guarantee provided by the Welfare Division that these "approved" facilities would be used in lieu of other facilities, and home providers gradually stopped cooperating with the Division.

Presently, plans exist, although they have not been implemented, to create a "facility profile" that would list every facility with information on the type of residence, the age and kind of residents, services provided, and the physical layout.

Because most of the alternative living situations in Region I are in Multnomah County, Welfare liaison workers place most clients regardless of county of origin. In cases where clients are being discharged into other counties, these workers contact the Welfare office there.

Currently Public Welfare lists 174 Adult Care Homes and estimates there are probably many more of which they are unaware. There are six official group homes and one halfway house in Region I. Alternative living is particularly sparse in the outlying counties where most alternative facilities are geared to the needs of the aged.

CHAPTER III

REVIEW OF THE LITERATURE

The purpose of this literature review is to explore the issue of community care provision for people experiencing mental or emotional disturbances. Recent mental health care trends, which de-emphasize the effectiveness of institutional treatment have resulted in greater numbers of ex-hospital patients residing in local communities. Based on the current assumption that local treatment is potentially more effective than hospital treatment, communities are increasingly responsible for meeting the mental health needs of formerly hospitalized people. This shift in service delivery approach has created considerable confusion, and has prompted a re-examination of mental health needs, existing services, and priorities.

To better understand the emergence of this current community care issue, the literature review begins by developing an historical perspective on mental health trends in the United States. Discussion of mental health care prior to enactment of community mental health legislation is intentionally brief. Discussion of community mental health, the orientation launched in 1963 is more extensive, as the issue of community care for ex-patients is a direct

outgrowth of this most recent approach to service delivery. After placing community care in historical perspective and presenting some critical commentary on community mental health, the review focuses on local alternatives to institutionalization. This subsection presents models of alternative mental health care systems which aim to ease community adjustment through provision of essential services and support. It should be noted that a scarcity of publications addressing this relatively new area of community care for ex-patients prompted researchers to request relevant information from the other forty-nine states. The model presentation section draws heavily on materials supplied by mental health departments of other states.

Historical Perspective

Dorothea Dix's campaigns in the United States during the 1840's established state-supported mental hospitals based on the humane private psychiatric hospital model. These state hospitals, in which underfunding and overcrowding caused a deterioration in the quality of care, remained, until very recently, the primary type of mental health facility. By World War II state mental hospitals were essentially providing custodial care for much of the institutionalized population.¹

¹ Bernard L. Bloom, Community Mental Health: A Historical and Critical Analysis (Morristown, N.J.: General Learning Press, 1973), p. 5.

The federal government's limited involvement in mental health prior to World War II included a 1920's effort to establish community child guidance clinics, support of several hospitals for psychiatric and drug-addicted patients, and VA psychiatric hospitals. These efforts could be considered a precursor to the current community mental health movement. The National Mental Health Act of 1946 required the federal government to sponsor research on mental illness.²

Dissatisfaction with United States mental health services was widespread by the 1950's. Three developments of this decade paved the way for state hospital reform. Introduction of psychoactive drugs allowed more effective patient treatment, relaxed security, and earlier releases. Use of "therapeutic communities," an orientation which creates democratic patient-staff groups to enhance communication, increased treatment effectiveness. Finally, use of geographic decentralization, a policy of housing patients in wards according to their home communities, facilitated communication between hospital and community agencies. Following these innovations mental hospital census declined nationally: more patients were admitted annually, but average length of stay decreased.³

During the time hospital innovations were being

² Ibid., p. 8.

³ Ibid., p. 8.

initiated, the federal government reacted to national pressure to improve mental health services. Congress passed the Mental Health Study Act in 1955, which created the Joint Commission on Mental Illness and Health, to study the "human and economic problems of mental illness."⁴ Action for Mental Health (1961) presented the Commission's conclusions that more and better mental health services, research and training were needed. Recommendations included improvement and expansion of already-existing services, as well as establishment of outpatient community mental health clinics.

Community Mental Health Movement

Motivated by the Joint Commission's recommendations and by a personal commitment to improve mental health and mental retardation services, President Kennedy (1963) advised Congress to take what he termed a "bold new approach" by adopting the following national goal: to establish comprehensive community mental health centers in all communities, so every American could have access to quality services.⁵

The Community Mental Health Centers Act (1963) launched the most recent innovation in United States mental health

⁴ Ibid., p. 9.

⁵ John F. Kennedy, Message from the President of the United States Relative to Mental Illness and Mental Retardation, 88th Congress, First Session, U.S. House of Representatives Document Number 58 (Washington, D.C.: United States Government Printing Office, 1963), p. 2-3.

care. A guiding assumption of this orientation was that mental health services provided within communities would be more effective than traditional institutional treatment. The short-term goal of community mental health was to provide a wide range of services and a continuity of care for all people with emotional problems. Equal availability of services to all was specified in an effort to halt the practice of sending the poor to state institutions while the rich purchased more attractive treatment. Long-term goals of community mental health included promotion of positive mental health and prevention of mental illness. Target populations were specified by the founding legislation; however, methods of approaching the problem were expressed only generally. Actual treatment and residential models were left unspecified and development was postponed until individual states could act under the rubric of "innovation."

Community mental health developed as an attempt to improve a widely-criticized service delivery system; it was intended to be quite different from traditional clinical practice. To further define the community mental health concept, some of its prescribed characteristics are described in the following paragraph.

Community mental health emphasized service provision within the community rather than an institution. Its theoretical base differed from earlier mental health

orientations in that community mental health viewed mental disturbance as a social problem, and as the responsibility of a total community.⁶ Services were to be available for disturbances ranging from mild to severe. Community mental health encouraged innovative techniques capable of helping more people more quickly than traditional methods. It also urged innovation in person-power: use of para-professionals was recommended as a way to involve community residents and to ease financial pressure. The orientation stressed indirect services, including consultation and education, rather than direct services. Two public health concepts embedded in the community mental health approach were an emphasis on preventive rather than therapeutic services. Instead of assuming the source of mental illness always lay within the individual, community mental health recognized the societal contribution to mental disturbance and sought to identify sources of stress within communities. Finally, the community mental health movement emphasized a rational planning process, and comprehensive programming for entire populations.^{7,8} These tactics were incorporated

⁶ Nicholas Hobbs, "Mental Health's Third Revolution," American Journal of Orthopsychiatry, XXXIV (October, 1964), p. 822.

⁷ Bloom, Community Mental Health, p. 1-2.

⁸ Dorothy Miller, "Consultation Workshop: Consolidation of NIMH Grant," (unpublished report, Portland Oregon, Portland State University, School of Social Work, 1974), p. 19-20.

in the community mental health approach in an attempt to alleviate inadequacies and to improve the national mental health care system.

Critique of Community Mental Health

Almost every new program elicits advocate and adversary opinion. Critical commentary is presented in this literature review because much community mental health criticism directly and indirectly addresses the focal issue of this entire study: community care for people with mental and emotional disturbances.

Given the general nature of the founding legislation, it is not surprising that one attack on the community mental health approach is that major confusion regarding relationships among different levels of administration and various agencies abounds. Lack of clearly defined agency boundaries and relations has resulted in inefficient service provision. Frequently, services overlap and energy is wasted because there is no agreement designating specific agency responsibility for specific problems.^{9,10} Another facet of this problem is that clients are often needlessly shuffled between agencies in pursuit of needed services. Inadequate

⁹ Alfred J. Kahn, Studies on Social Policy and Planning (New York: Russell Sage Foundation, 1969), p. 33.

¹⁰ Franklin D. Chu and Sharland Trotter, The Madness Establishment: Ralph Nader's Study Group Report on the National Institute of Mental Health (New York: Grossman Publishers, 1974), p. 32.

coordination of social services is not a direct outgrowth of community mental health; however, rather than alleviating the problem, community mental health, with its focus on community care, has compounded it.

Much criticism is aimed at the failure of community mental health to devise innovative treatment approaches. Critics point to the fact that community mental health programs are dominated by mental health professionals, and contend that "community mental health" is nothing more than a new label for conventional psychiatry.¹¹ The movement is further condemned on the basis that service delivery and organizational structure are defined by the nature of mental health professions, the medical model, and pre-existing agencies, rather than by a community's problems.¹²

A common attack says that prevailing traditional clinical practices, which are geared to middle class clients, are often irrelevant to the poor. Thus, community services remain less accessible to lower class clients, who continue to reach state institutions.¹³ Another exclusionary charge levelled against community mental health programs is that they tend to treat people with minor disturbances, people who are likely to recover quickly, perhaps even

¹¹ Ibid., p. 203.

¹² Bloom, Community Mental Health, p. 23-25.

¹³ Franklin Chu and Sharland Trotter, The Madness Establishment, p. 91.

without treatment. The position asserts that, because community services are not geared to their needs, more severely disturbed people are either institutionalized or forced to fend for themselves.¹⁴

Reduction in institutional census was facilitated by hospital innovations of the 1950's, which are described above. The community mental health emphasis on keeping people in their own localities, rather than confining them to institutions, has continued this trend and increased the numbers of emotionally disturbed people in communities. In 1963, the national state hospital census was 505,000; in 1973 it had fallen to 249,000.¹⁵ This shift of patients from hospitals to communities has not been overwhelmingly successful. Fewer hospital beds are occupied at any given time, and average stays are shorter; however, readmission rates have increased.

Maxwell Jones argues that community mental health was based more on politics and economics than on concern for the chronic mentally ill. He says the federal government assumed communities could care for thousands of mental patients who up to this time were institutionalized in large state hospitals. "The race to 'rehabilitate' chronic

¹⁴ Bloom, Community Mental Health, p. 27.

¹⁵ Maxwell Jones, "Community Care for Chronic Mental Patients: The Need for a Reassessment," Hospital and Community Psychiatry, XXVI (February, 1975), p. 95.

patients was on, and state hospitals vied with each other to lower their bed-occupancy rates."¹⁶ States did not request adequate information before supporting the shift from hospital to community because political and economic pressure to reduce tax burdens by lowering hospital census was so strong. Thus, the public was not sufficiently prepared and communities have not been able to accommodate the numbers of patients being discharged to them. Insufficient intermediate facilities and services, as well as staff capable and willing to provide them, pose serious nationally-occurring problems. Alarming high recidivism rates, conservatively estimated at fifty percent, reflect communities' current inability to provide adequate services for this chronic population.

¹⁶ Ibid, p. 95.

Alternative Models

The following pages describe models which can be used as alternatives to hospitalization. Presentation is divided into residential options, services or treatment options, and comprehensive alternative models. The order in which they appear is in no way indicative of researchers' priorities.

Residential Options

Fairweather Lodge

The task-group community lodge is a model developed in 1969 by George Fairweather, to create a community living option for chronic patients. The lodge model incorporates Fairweather's task group approach, which involves: 1) provision of meaningful, rewarding, clearly specified tasks and roles that require interdependence and division of labor among group members; 2) sequential ordering of tasks congruent with tasks required in community living; 3) hierarchical group structure providing opportunities for growth and achievement; 4) incentives and group rewards for successful group performances; 5) members' power to make decisions regarding their own behavior; 6) supportive group membership; and 7) emphasis on human growth through living learning experiences.¹⁷

¹⁷ D.N. Daniels, A.B. Zelman, and J.H. Campbell, "Community Based Task Groups in Recovery of Mental Patients," Archives of General Psychiatry, XVI (1967), p. 215.

This task-group approach was first used on hospital wards to remotivate chronic patients to return to community life. Finding that community stay is more related to supportive living conditions in the community than the hospital, Fairweather developed the community lodge model. Members of a lodge initially receive extensive supervision from an experienced professional. Supervision is gradually decreased; finally the members' governing body becomes totally responsible for lodge operations. The community living situation requires certain features: there must be vertical mobility through whatever differentiated social structures exist; and a communication system must be established which overcomes the status difference between patient and professional.¹⁸

One example of this lodge model is the Williamsburg Living Project in Virginia, which began in 1969. The ten female patients who were selected for this project spent five months living in a semi-autonomous unit at the hospital and being trained as nurses' aides, food service workers and motel maids. Then they moved into a rented house and, with job-finding help from the Department of Vocational Rehabilitation, began working. A mental health professional holds weekly meetings with lodge residents

¹⁸ George W. Fairweather, et al., Community Life for the Mentally Ill: An Alternative to Institutional Care (New York: Aldine, 1969), p. 22.

in which practical problems are discussed. Residents have meetings to organize shopping, housekeeping and cooking tasks. They are also active in formulating rules and in deciding to invite new members into their house. After three years of operation, of the twenty-five clients who had entered the program, thirteen were living independently, nine were in the program, and three had been rehospitalized.¹⁹

Panta Rhei is a lodge-type program in Cleveland, Ohio which aims to promote personal growth for people stagnated by institutionalization. Clients live in cooperative boarding homes which provide a support group context for relearning living skills. Panta Rhei also provides job training, work adjustment, and extended sheltered employment in the agency office and in office cleaning, shoe repair, and sign engraving businesses developed by the agency.²⁰

Fairweather's research indicates that the lodge model leads to longer community tenure and employment experiences than traditional aftercare.²¹ A related finding is that "not only did the lodge society enhance community adjustment of all members, but it also had a comparatively

¹⁹ Glenn Shean, "A Social Learning Approach to Community Living for Chronic Mental Patients," Proceedings of the 81st Annual Convention of the American Psychological Association, VIII (1973), p. 456.

²⁰ Material provided by Ohio Department of Mental Health and Mental Retardation.

²¹ Fairweather, Community Life for the Mentally Ill, p. 17.

greater effect on those members who had been hospitalized for the longest time."²²

Halfway House

The psychiatric halfway house is one model being used in the effort to develop effective community services for people with mental and emotional disturbances. In 1960 there were ten halfway houses in the United States; by 1969, largely as a result of the community mental health emphasis on community treatment, the number of halfway facilities exceeded 200. Advocates of the halfway house claim that such facilities are an effective way to provide emotional and environmental support necessary to integrate ex-mental patients into the community, as well as to sustain otherwise hospital-bound residents in the community.

Halfway houses vary significantly in regard to target population, length of stay, program components, and success criteria. Despite such differences, halfway houses have essentially the same goals and objectives. The primary goal is integration of patients into the community. Some other objectives are: to encourage increasing self-reliance; to emphasize health rather than illness; and to encourage relatively "normal" living patterns.²³ One review lists

²² Ibid., p. 17.

²³ Dennis J. Rog and Harold L. Rausch, "The Psychiatric Halfway House: How Is It Measuring Up?," Community Mental Health Journal, XI (Summer, 1975), p. 155.

residence, transition, socialization, vocational assistance, and ancillary treatment services as the common functions of all halfway houses.²⁴ The expectations of halfway houses are related to transitional living, self-support, building of self-reliance, and ultimate movement into more independent existence.²⁵

A recent study investigated the effectiveness of halfway houses by surveying twenty-six statistical reports on halfway houses. The authors note limitations of their research: studies surveyed are not definitive; success measures vary; stage of rehabilitation at which studies were conducted vary; and objective evaluation is limited by the lack of control group studies. Data analysis indicates that of halfway house residents, 20.5% were rehospitalized, while 79.5% were able to adjust to community living. A 1963 study of halfway house effectiveness showed figures of 18.5% rehospitalization and 81.5% community adjustment for residents.²⁶ For purposes of comparison: a recent examination of hospital readmission rates in Maryland indicates a 37.4% recidivism rate within one year of discharge.²⁷

²⁴ David Landy and Milton Greenblatt, Halfway House: A Sociocultural and Clinical Study of Rutland Corner House (Washington, D.C.: Department of Health, Education and Welfare, Vocational Rehabilitation Administration, 1965), 4.

²⁵ Ibid., p. 13.

²⁶ Harold L. Rausch and Charlotte L. Rausch, The Halfway House Movement: A Search for Sanity (New York: Appleton-Century-Crofts, 1968).

²⁷ Rog and Rausch, "Psychiatric Halfway House," p. 156.

Despite limitations of the available statistics, the authors conclude that results generally suggest halfway house residency reduces an ex-patient's chances of being rehospitalized.

Value considerations are of interest in considering the functioning of halfway houses. Halfway houses ascribe to the values of the community mental health movement. Glasscote, et al. (1971) maintain that it is better to live in a community than a hospital, better to be productive than idle, and good to derive meaning and satisfaction from life. Most urban halfway houses stress middle class values of personal autonomy, occupational achievement, and acquisition of social skills. Although a majority of mental patients may initially lack these aspirations, they are often able to accommodate to middle class orientations and achieve successful transition from hospital to community.²⁸

Community Homes Program

The Community Homes Program is one component of the comprehensive St. Louis community placement system. It was started as a pilot project in 1971, and is now an integral part of the state mental health system. Initially the program was a community housing option for long-term psychiatric patients. Now clients are referred from outpatient clinics, boarding, foster and nursing homes, as well as from hospitals. Although most clients are diagnosed schizophrenic,

²⁸ Patricia Gumrucku, "The Efficacy of a Psychiatric Halfway House: A Three-Year Study of a Therapeutic Residence," Sociological Quarterly, IX (1968), p. 385.

all major diagnostic categories are represented.

A small group of clients, who usually know each other through hospital experiences, receive supervision in finding and furnishing a house or apartment. Clients fill vacancies in established homes by inviting a prospective resident for a trial period and deciding whether to ask that person to join. Clients can stay in the cooperative residences indefinitely or move to more independent settings. Volunteers help in leasing apartments and aid community acceptance of the program.

A community team comprised of psychiatrist, psychologist, social workers, nurses, aides and secretaries, does regular home visiting and is accessible by phone twenty-four hours a day for landlords, residents, and families. Nurses and aides are re-assigned from hospital to community teams as hospital census declines and community residence increases.

Supervision is flexible and is always geared to the needs of clients. Supervision of medications and other psychological treatment is a team responsibility. Staff initially provide intensive supervision to residents; staff encourage resident responsibility and gradually decrease supervision. Varying levels of autonomy, commensurate with residents' capabilities, are achieved in different homes. Community team members work with clients in developing individualized daily living plans. Some homes have regular group therapy sessions with team staff; others have more

social interaction with staff. Staff are always called in emergencies. Rehospitalization or movement to a more sheltered setting is easily arranged and is sometimes necessary in treating a long-term fluctuating illness.

After three years in operation, the Community Homes Program is well accepted in the community. Experience indicates that the team approach enhances public awareness of social services, and is therefore beneficial to the entire community. The model is less costly than nursing home or hospital care, and can be operated by minimally retrained hospital personnel. Most significantly, the program shows that many long-term chronic patients can adjust to community living with minimal supervision, and that many of these chronic patients can move to autonomous living situations.²⁹

Special Project

The "Special Project" run by the Missouri Department of Mental Health is a transitional living facility for 17 to 25 year old, predominantly schizophrenic clients. Other cooperative residential arrangements failed with this target group. The project operates in four-family apartment buildings. Three apartments are occupied by

²⁹ Hilary Sandall, Timothy Hawley, and Gloria Gordon, "The St. Louis Community Homes Program: Graduated Support for Long-Term Care," American Journal of Psychiatry, 132:6 (June.1975), p. 617-622.

clients, one by a staff person. Clients receive monthly payments from the state which cover living expenses. Treatment in the program includes individual and group counseling, and a structured approach to teaching life skills.

The program philosophy is that normalization of daily activities is a necessary prerequisite to normalization of other aspects of life. Within this framework, clients move through a system which reinforces increasingly responsible behavior. The system establishes "freshman" through "senior" levels of competence; graduates move to more independent living arrangements. The model is designed to facilitate smooth transition to independent living through progressive mastery of home maintenance tasks and development of socially acceptable behavior. At time of writing, the program had been operating eleven months, and evaluative analysis has yet to be performed.³⁰

Landlord Supervised Apartment

A similar cooperative apartment program for long-term patients of Boston State Hospital was established in 1967 through joint efforts of the hospital, public welfare, and private citizens. In this model, landlords provide daily

³⁰ Frank Williams, et al., "Transitional Living Environments: A Program Design and Case Study" (paper presented at Annual Meeting of the National Council of Community Mental Health Centers, Washington, D.C., February, 1975), p. 1-18.

supervision; a cooperative apartment team of hospital staff makes weekly visits and is accessible by phone at any time. Hospital staff maintain treatment planning responsibility to assure continuity of care. Clients of this program are expected to work or participate in day treatment every day.

This model has had a positive community impact. The team's responsiveness has fostered good relations with landlords. Landlords are assured regular rent payments, continuity of tenants, and property maintenance by tenants learning skills. Additionally, the model's team approach makes social agencies more accessible to community residents. Interestingly enough, this model has not engendered community resistance which is commonly experienced by halfway houses.

Evaluation in 1973, after five years of operation showed that 82% of the program's clients had been successfully maintained in the community. This model was developed for ex-hospital patients; it now also serves as a hospital alternative by accepting referrals from outpatient clinics.

Evaluative research examined the program's impact on clients living in apartments three months or longer. Enthusiasm about the project was expressed by 82 to 91% of the clients. Landlord supervisors rated all clients "much" to "very much improved" in mental condition, housekeeping skills, personal hygiene, personal relationships, and adjustment to community life. In 1973, living arrangement costs

in Massachusetts were computed. The following list is ordered from most to least expensive: hospital; nursing home; halfway house; boarding home, independent apartment, group home; foster care; and finally, cooperative apartments described in this section. The cooperative apartment model was approximately one-fifth as expensive as hospitalization.³¹

³¹ Ching-Piao Chien and Jonathan O. Cole, "Landlord Supervised Cooperative Apartments: A New Modality for Community-Based Treatment," American Journal of Psychiatry, 130: 2 (February, 1973), p. 156-9.

Service or Treatment Options

Day Treatment

Day treatment is an intermediate service involving intensive treatment for people requiring more than outpatient, but less than residential care. Day treatment serves several functions which provide: 1) an alternative to inpatient admission; 2) a transitional facility; 3) a system of support and maintenance for seriously impaired people who would otherwise require long-term hospitalization.³²

A day treatment program is a planned and organized program of services utilizing psychotherapeutic, re-socialization, and rehabilitative interventions for individuals with mental and emotional disorders who spend only part of a week, or of a day in the program.³³

Day treatment has also been called day care, partial hospitalization, alternative or intermediate care, and day hospitalization. Uniform distinction among these labels does not exist in this country.

Day programs at psychiatric units of hospitals were started in the Soviet Union in the 1930's; development was apparently inspired more by financial than philosophical concerns.³⁴ Day treatment has evolved into distinct

³² Raymond M. Glasscote, et al., Partial Hospitalization for the Mentally Ill: A Study of Programs and Problems (Washington, D.C.: Joint Information Service, 1969), p. 14.

³³ Marylyn Ruckwardt, "Day Treatment: Report of Programs Visited in California" (unpublished report, Oregon Mental Health Division, 1972), p. 1.

³⁴ Glasscote, Partial Hospitalization, p. 1.

programs which are no longer exclusively affiliated with hospitals.

Ideally, day treatment program development is based on the assessed needs of the mentally and emotionally disturbed population in a given community. Programs generally offer a spectrum of activities geared to reintegrate clients into community life. Psychotherapy (individual, group, marital, family) and medication supervision, building communication skills, teaching self-maintenance and homemaking skills, and social and recreational activities are included in most day treatment programs. The staff works with each client to design a treatment program which meets her/his needs, thereby providing therapeutic guidance in the development of individual adjustment plans. Day treatment often utilizes community resources to aid client resocialization; this strategy is also useful in increasing public awareness and acceptance of mental and emotional disturbance.

For many people with mental and emotional disturbances, day treatment is superior to hospitalization. Advantages of day programs include: clients' continued participation in some independent activities; minimal dependency and dehumanization; family living when desirable; more active, varied programming than most inpatient services; usually less expensive than inpatient services; less stigmatizing than hospitalization; a focus on strengths and abilities,

where inpatient programs often reinforce weakness and failings. In general, then, day programs are advantageous in that they provide treatment within a more "normal" living routine.³⁵

Controlled evaluation of day treatment and day hospitalization programs is scarce. The Glasscote study finds that, excluding suicidal, homicidal, and severely agitated, disordered, confused or disoriented patients, there is sufficient evidence to conclude that most people traditionally admitted to inpatient care can be successfully treated in day programs, as long as the necessary environmental supports are available outside the program.³⁶

Rehabilitation Programs

Rehabilitation programs are similar in many respects to day treatment services. While both aim to promote community adjustment and psycho-social growth, rehabilitation programs tend to emphasize employment motivation and training, and de-emphasize psychotherapy.

Fountain House Foundation, established in New York City in 1960, is a program based on the rehabilitation model. It was founded by ex-patients, who were committed to aiding the community adjustment process for themselves and others. Fountain House has a membership of 400 ex-patients, whose

³⁵ Ibid., p. 23.

³⁶ Ibid., p. 15.

participation in program services varies, depending on their levels of community adjustment.

Four kinds of services are offered at Fountain House. Social and recreational activities are sponsored by the agency on evenings and weekends. Work motivation and habits are built through participation in preparing and serving meals, housecleaning, office and clerical work, and miscellaneous maintenance tasks. A transitional employment project aids vocational rehabilitation. Various city employers provide rehabilitative positions, which are assessed by Fountain House staff. A client is then taught the requisite skills for a specific position, and encouraged to ease into the job. When a client becomes sufficiently secure, she/he moves on to competitive employment, and another client fills the transitional position. It seems inevitable that city budget cuts will take, or perhaps already have taken their toll on this work program.

The fourth service is a small residential program. Fountain House holds leases on several apartments in the city. Selected clients have the opportunity to develop independent living skills by residing in an apartment, paying rent and assuming household responsibilities. Volunteers are available to make home visits and provide consultation to residents when needed. Positive results of this program indicate need for its expansion.

A two-year experimental study of the Fountain House

program used a control group design. Data show that people receiving rehabilitation services had a significantly lower rehospitalization rate and higher employment rate than control subjects, suggesting that the program helped ex-patients adjust to community life. Further analysis shows differential rehospitalization rates between experimental and control subjects are most dramatic during the first six to nine months of community residence, indicating the value of involvement in rehabilitative services immediately after hospital discharge.³⁷

A project currently underway at the University of Southern California, called "Rescue and Rehabilitation instead of Therapy," is another rehabilitation model. This project is attempting to provide an alternative to hospitalization, rather than an aftercare model. Upon psychiatric admission, patients immediately enter work centers in the hospital, and are discharged to work projects as quickly as possible. This project emphasizes work skills and sheltered employment instead of psychotherapy. Evaluation of the program is in its initial stages.³⁸

³⁷ John H. Beard, "Evaluating the Effectiveness of a Psychiatric Rehabilitation Program," American Journal of Orthopsychiatry, 33 (1963), p. 701-12.

³⁸ Marylyn Klesh, "Report on Alternatives to Mental Hospital Treatment Conference, Madison, Wisconsin," (unpublished report, Oregon Mental Health Division, 1975), p. 1.

Family Crisis Treatment

The Family Treatment Unit at the Colorado Mental Health Center is a team of mental health professionals who provide crisis intervention services to a percentage of people seeking hospital admission. Family treatment rests on the realization that "a major effect of psychiatric hospitalization is psychiatric rehospitization."³⁹ The family team aims to alleviate the presenting problem and provide the services necessary to treat the identified patient and his/her family on an outpatient basis. Through use of family-oriented interviews, twenty-four hour availability, home visiting, medication, a holding bed in the emergency room, and post-crisis contracts, the Family Treatment Unit successfully averted hospitalization in forty-two out of the fifty cases which were examined in an evaluative study.⁴⁰ Another study of the same unit shows family crisis treatment to be a more economical and less stigmatizing form of treatment than hospitalization.⁴¹

³⁹ Frank S. Pittman, "Techniques of Family Crisis Therapy," in Current Psychiatric Therapies, ed. by Jules Masserman (New York: Grune and Statton, 1966), p. 187-96.

⁴⁰ Ibid., p. 196.

⁴¹ Kalman Flomenhaft, David Kaplan, and Donald Langsley, "Avoiding Psychiatric Hospitalization," Social Work (October, 1969), p. 38-45.

Comprehensive Alternative Models

Home Treatment

Aiming to ameliorate the lack of coordination among treatment resources and the accompanying lack of knowledge about existing services, Boston State Hospital, in 1957 established a pioneering demonstration project called the Psychiatric Home Treatment Service. Conception of the project was based on accounts of the Amsterdam Municipal Psychiatric Service, which is "a totally integrated, mutually sustaining system, of which each part has access to resources of all other parts."⁴² Home visiting is an integral service of the Amsterdam system, and is used to provide post-hospital as well as alternative care.

The Boston Home Treatment Service attempts to provide alternatives to institutionalization for people with mental disturbances. It makes use of a referral network in the community to encourage early therapeutic intervention, and attempts to involve patient and family in the treatment alliance. Recognizing that many patients can be treated in community agencies, the service emphasizes psychiatric evaluation prior to hospitalization. Initial assessment is made during a home visit by the psychiatrist and one additional team member - an RN, an occupational therapist,

⁴² Paul Lemkau and Guido Crocetti, "The Amsterdam Municipal Psychiatric Service: A Psychiatric Sociological Review," American Journal of Psychiatry, 117 (1961), p. 779-83.

or a social worker.

In early stages of the demonstration project, team members provided intensive treatment to patients and families in home settings. As the project evolved, it became clear that a more efficient approach to managing large caseloads in the community demanded prompt evaluation, proper referral, and long-term supervision.⁴³

The Home Treatment Service avoids long-term direct treatment relationships; home visiting beyond initial evaluation is limited to crisis intervention. Responsibility for long-term maintenance is given to community agencies. It was found that prevention of unnecessary hospitalization was relatively easy; the difficulty was in finding alternative methods of care within an underdeveloped community treatment system. Home Treatment takes an active approach to the community. It has developed alliances with general practitioners, public health nurses, clergy members, and welfare workers, who comprise an informal network of care providers. Home Treatment staff provide seminars and consultation for these community service agents.

The Boston Home Treatment Service was the first effort in this country to prevent psychiatric hospitalization through a program of home visiting, crisis intervention,

⁴³ Leonard Weiner, Alvin Becker, and Tobias Freedman, Home Treatment: Spearhead of Community Psychiatry (Pittsburgh, Pa: University of Pittsburgh Press, 1967), p. 17.

and conscious attempts to coordinate a fragmented array of agencies and services. In order to conform to community mental health dictates, models for alternatives to hospitalization are currently being developed. Many of these alternative models of service provision may be viewed as outgrowths of the Boston Home Treatment Service.

Training in Community Living

The Training in Community Living project was developed in an effort to reduce the high readmission rate at Mendota Mental Health Institute, a state hospital in Madison, Wisconsin. Designers of the project view strong dependency and limited problem-solving ability as the disabilities causing patients to seek readmission. Based on this view, Training in Community Living aims to help clients develop the autonomy and coping skills needed for community adjustment.

A controlled study of the project was performed; data were gathered after the first four months of operation. The sample consisted of sixty people seeking admission to Mendota Mental Health Institute, who were between the ages of 18 and 62, and who did not have severe organic brain syndrome or primary alcoholism. A matched sample of control subjects received standard hospital treatment. Experimental subjects entered the community living project. Community residences were located for project clients, and work and treatment plans were designed. The project is staffed by

a team of hospital mental health professionals and aides who were re-trained to work in the community. Team services are provided seven days a week, from 7 a.m. to 11 p.m.; staff are on call twenty-four hours a day for emergency coverage.

The project approach nearly eliminates hospital treatment: in extreme situations, clients receive short-term hospitalization and are quickly returned to the project. Treatment consists primarily of teaching coping skills through community learning experiences. Clients are treated as responsible individuals. Staff work with families and significant others to eliminate their expectations of the client's dependency. Team members also maintain close relationships with community agencies, and encourage them to approach clients as responsible people.

Data collected after four months of project operation were analyzed. Significant research findings showed that experimental subjects were hospitalized less often and for shorter durations than control subjects, and spent less time unemployed and more time in sheltered employment than controls. Additionally, there was a significant decrease in burden felt by families of experimental subjects, but not by families of control subjects.

The Training in Community Living model has been shown to be an effective alternative for patients who would ordinarily be hospitalized. Long-range studies are in progress

to analyze the program's cost and effectiveness in promoting lasting community adjustment.⁴⁴

Community Placement Program

Missouri operates a comprehensive system of extended care for clients with mental and emotional disturbances. The program, the St. Louis Metropolitan Community Placement Program is responsible for monitoring the care of 1800 mentally and emotionally disturbed patients in eastern Missouri. Its aim is to maximize each client's potential by helping her/him move toward the most self-sufficient functioning level possible; its approach rests on preserving as "normal" a lifestyle as possible, and improving quality of care whenever possible.

The program monitors client care in extended care facilities, which include nursing homes, boarding and domiciliary homes, foster homes, a hotel project, the "Special Project" for 17-25 year-old clients, and cooperative apartments of the "Community Homes Program," the last two of which are described earlier in the review.

⁴⁴ Leonard Stein, Mary Ann Test, and Arnold Marx, "Alternative to the Hospital: A Controlled Study," American Journal of Psychiatry, 132: 5 (May, 1975), p. 517-22.

The program is staffed by psychiatrists, social workers, nurses, psychiatric aids, and support and evaluation personnel. Staff provide consultation to extended care facility staff, and direct services, including recreation, counseling, and social rehabilitation to clients. Staff also monitor medications, except in nursing homes, and arrange rehospitalization when necessary. An important staff function involves monitoring of clients' capabilities so that moves to different levels of care can be made when appropriate.

The report of this comprehensive system is entirely descriptive; no evaluation is presented.⁴⁵

Southwest Denver Comprehensive System

The Fort Logan Mental Health Center, in Denver, Colorado was established in 1961, with the goal of treating as many patients as possible in day rather than inpatient programs. The treatment philosophy at Fort Logan is based on the therapeutic community approach.

The role of staff is to maximize opportunities for the patient to learn from experience. The setting is manipulated so as to be protective, yet to provide a variety of situations from which the patient can benefit.⁴⁶

⁴⁵ Timothy Hawley, "The St. Louis Metropolitan Community Placement Program: Extended Care for Ex-Mental Hospital Patients" (unpublished paper, Missouri Department of Mental Health, 1975), p. 1-6.

⁴⁶ Glasscote, Partial Hospitalization, p. 74.

The Fort Logan program also recognizes and incorporates the need for continuity of care. Staff view most mental disturbance as a long-term condition requiring differing treatment modalities at various stages. A continuum of inpatient, day patient and outpatient services is available. Patients are assigned to treatment teams rather than to specific services. Teams retain responsibility to their patients, linking them with services appropriate to their needs at any given time.⁴⁷

In 1970, responding to reports condemning boarding home conditions, the Fort Logan Center surveyed room and board facilities in its surrounding area. Findings of the survey indicated that much dissatisfaction, experienced by all parties concerned, could be attributed largely to the lack of communication between hospital staff and boarding home operators.⁴⁸

Based on the boarding home study recommendations, Fort Logan integrated hospital-community facilities liaison strategies into its comprehensive care model. Fort Logan specifically addressed the challenge of successful community adjustment for patients labeled "chronic," usually diagnosed "schizophrenic." The model is an intense

⁴⁷ Ibid., p. 75.

⁴⁸ Al Fontana, Gwen Oakes, B.J. Smith, "Boarding Homes" (unpublished report, Fort Logan Mental Health Center, 1970), p. 1-5.

follow-up and alternative system with residential and treatment components; the innovative aspect of the comprehensive system is its team approach to facilitation of community care.

A continuum of living arrangements providing differential levels of support is available to clients in the comprehensive system. At the independent end of the continuum are clients who live alone or with family or friends. Another relatively independent arrangement is the cooperative apartment: with sufficient supervision from a landlord or staff person, several clients rent an apartment and share household responsibilities. Another residential option is family care which, like foster care, provides opportunities for a limited number of clients to live with families in private homes. Boarding homes are a major type of living arrangement; the ones in the comprehensive system provide assistance with activities of daily living. At the more dependent end of the continuum, nursing homes are available for clients needing short- or long-term medical care.

The treatment component of this comprehensive model is individualized, utilizes community resources, and relies heavily on the community team's efforts. Community team activities are absolutely essential to the functioning of this comprehensive model. The community team's purpose is to bridge the gap between hospital and community, for both ex-patients and care providers, so that adjustment to community life will be more successful. Team members are

hospital outreach workers and hospital staff skilled in treating severely disturbed clients; their services are accessible twenty-four hours a day.

Home visitation provides the main vehicle for treatment and service delivery in this program. There are numerous advantages to this type of intervention: 1) facilitation of client adjustment to living situation; 2) support and consultation provision to family or home providers; 3) on-site therapy; 4) more accurate and complete assessment of client's needs and his/her interpersonal conflicts with on-site intervention; 5) increased trust-level and more rapid trust-building; 6) medication monitoring.

Client care and supervision by the team is individualized and personal. A specific team member is directly responsible to each client, and remains accessible throughout the client's community adjustment period, however long that might be. Team members get referrals from hospitals, as well as from community residents and agencies. Thus, their services provide aftercare and an alternative to hospitalization. Team members are dependable friends and service providers to their clients. This team system exemplifies the approach recommended by Silverstein, which stresses use of a counselor or caseworker who "attaches himself" to the patient.⁴⁹

Team members are community based and work closely with

⁴⁹ Silverstein, Psychiatric Aftercare, p. 55.

community agencies. They are responsible for developing treatment plans with clients, and for writing letters of introduction containing information that will help care providers ease a client's adjustment. Team members provide direct services and consultation to clients and people involved in client supervision. Their extensive hospital and community liaison work has been instrumental in making resources accessible to chronic clients. Thus, the community team approach has been effective in creating an integrated network of community care in Denver.^{50,51}

⁵⁰ Klesh, "Alternatives to Hospitalization Report," p. 2-3.

⁵¹ Marsha Kincheloe and Lorraine Hagar, Out the Back Wards' Door (Denver, Colorado: By the Authors, Fort Logan Mental Health Center, 1974).

Alternative Models in Oregon

Follow-Up System for the Mentally Retarded/Developmentally Disabled

Successful community adjustment of people being discharged from institutions is unlikely to occur unless adequate planning and follow-up are provided. Oregon's institutions for the mentally retarded/developmentally disabled have developed a model incorporating planning, follow-up, and accountability, for helping clients make the transition from institution to community.

Planning has several components. Community preparation programs offer clients the opportunity to learn daily living skills. Decisions regarding community placement are made formally, by a multi-discipline team, and informally, by soliciting input from client and significant others. Social workers at Fairview Hospital and Training Center engage in pre-placement communication with local agencies and services to learn what communities have to offer clients. The other MR/DD institutions communicate with Welfare liaison workers prior to placement decisions, as these institutions rely on the Welfare Referral System in placing clients. Fairview's planning process includes a client pre-visit to the placement facility for several days. Another planning step unique to the Fairview process is a pre-placement staffing, in which the client and people involved in the community support system (welfare worker,

field worker, service coordinator, parents, significant others, facility operator, day plan person) negotiate a plan for the client. Through this staffing, each party's role in the client's community adjustment is clearly outlined.

Follow-up, in this system, involves provision of direct support services to clients making the transition to community life. Fairview has field workers to provide follow-up; Columbia Park State Hospital and Training Center and Eastern Oregon State Hospital depend on Welfare Adult Service Workers for follow-up services. Fairview follow-up workers consult with the living facility to insure that client and home provider make acceptable adjustments to each other. The worker supervises the client's day plan and is responsible for seeing that the client's program is meeting needs and facilitating development of his/her potentials. Follow-up workers provide crisis services and are available on a twenty-four hour basis. Working with the community is another function of field staff. The primary responsibility of field workers is to advocate for and with clients.

Field workers are accountable to their clients and to the Placement Board. Every six months, workers present case reviews to the Placement Board. Field work positions at Fairview were established by redefining several existing social service positions; Columbia Park and Eastern Oregon

have recently made similar redefinitions to establish one field worker at each institution.⁵²

Lane County Alternatives Team

Lane County Community Mental Health Program has a three-person team which provides consultation to congregate care facility staff and direct services (psychotherapy, medication, socialization, and modified day treatment) to twenty most difficult ex-patients or hospital-prone mentally and emotionally disturbed clients residing in such facilities. This team is particularly directed to meeting the needs of elderly clients. It initially provided more direct services; however, limited resources necessitated concentration on consultation and education to care providers and coordination between agencies involved with ex-patients.^{53,54}

Hospital Improvement Project - Eastern Oregon State Hospital

Eastern Oregon State Hospital has a Hospital Improvement Project based on the Fairweather Lodge model described in an earlier section. This project establishes community placements for groups of patients who will live together and provide mutual support. A group of patients spend a

⁵² Edward Burling, et al., "Deinstitutionalization in Oregon: A Review of Services within the Human Resources System" (unpublished report, Department of Human Resources, Oregon, 1975), p. 11-22.

⁵³ Ibid., p. 74-75.

⁵⁴ Material provided by Lane County Mental Health Program.

period of time living in a semi-independent unit at the hospital and learning community living skills. When deemed adequately prepared, the group moves into a community residence.

Institution staff are actively involved with patients during early transitional stages; they gradually decrease their support. Eventually the patients assume full responsibility for managing their living situation. Ex-patients who live together usually work as a group. Residents are expected to become at least partially self-supporting through paid employment.⁵⁵

⁵⁵ Burling, et al., "Deinstitutionalization," p. 31-32.

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The major purpose of this study has been to explore strategies for reducing high recidivism rates of mentally and emotionally disturbed adults, particularly in Region I of the Oregon Mental Health Division. Contemporary emphasis on community mental health care demands the existence of sufficient community-based services to meet the needs of this population. This group's high recidivism rate underlines the absolute necessity of developing a more effective array of community mental health resources. In an effort to gain as balanced a perspective as possible, the problem was approached from several vantage points.

As described in detail in preceding chapters of this report, the research design included:

- 1) administering questionnaires to recidivist inpatients, and ex-patients currently involved in day treatment services, in order to collect information and opinions regarding their aftercare needs;
- 2) sending questionnaires to mental health professionals who work closely with the target population, to collect information and opinions regarding factors which facilitate community adjustment of mentally and emotionally disturbed clients;
- 3) reviewing the literature and requesting information from other state mental health departments on

recidivism and methods of alleviating the problems which cause hospitalization and re-hospitalization;

4) surveying existing community resources in Region I.

This chapter reiterates some of the major research findings, and presents recommendations for reducing recidivism among the population of mentally and emotionally disturbed adults.

An initial research assumption was that the living arrangement figured as the most crucial factor in successful community adjustment of the ex-patient. Evidence accumulated during the course of this study necessitated a shifting of priorities, or at least a redefinition specifying the elements of living environments which are critical in facilitating adjustment to community life. A recurring theme in the literature, in mental health professional opinion, and in the theoretical foundations of several other state programs, is that mentally and emotionally disturbed clients, like most people, must have supportive interpersonal relationships and meaningful daily activity to sustain adequate community tenure. Programs in which this population achieve long-term community residence are programs which provide their clients with consistent, long-term follow-up services. Optimally, a full range of residential and treatment services should be available to these clients. Developing a more integrated network of already existing services can be a first step in

creating the optimal continuum of care.

At present, glaring needs exist for coordination of existing services and assurance of continuity of care of all clients.^{1,2} Improved coordination of resources would create a more efficient and more readily accessible network of community services, which in itself would decrease the need for hospitalizations. Finding a positive correlation between non-utilization of aftercare services and hospitalization, Silverstein concluded that patients are often rehospitalized because they have difficulty locating and/or utilizing community services.³

Another aspect of improving existing resources entails making mental health consultation available to non-professional and paraprofessional care providers as well as to volunteers. Often clients are hospitalized unnecessarily because care-providers are uninformed about ways of handling symptomatology of mental and emotional disturbances.

In examining the recidivism problem and potential solutions, development of community aftercare services is a natural beginning point. Many of the models described in the literature review were created as aftercare resources for ex-patients. Looking at the issue in broader terms,

¹ Multnomah County Comprehensive Mental Health Plan, 1975-76.

² Clackamas County Comprehensive Mental Health Plan, 1975-76.

³ Silverstein, Psychiatric Aftercare, p. 42.

"aftercare" services can frequently be utilized as "precare" services, or in fact as alternatives to hospital treatment. Thus, while the research effort began with a focus on "aftercare for ex-patients" the conceptual framework expanded to include "alternatives to institutionalization for mentally and emotionally disturbed clients."

Recommendations

Based on the findings of the patient and professional sampling, the literature search, and particularly the material received from the states, recommendations for reducing recidivism and providing alternatives to hospitalization in Region I are as follows:

A. Community team approach - Similar to programs currently in operation in St. Louis and Denver (as reviewed in the literature), a community team comprised of multidisciplinary mental health professionals based in the community would provide a multi-focused approach to the problem of recidivism through performing a combination of the following functions:

1. Pre-hospitalization diagnosis, assessment and evaluation - This results in the choice of the most appropriate treatment modality and averts hospitalization whenever possible. As already stated, this procedure often does not occur prior to a voluntary psychiatric admission. In addition to the obvious advantage of reducing admissions

such a procedure would result in more efficient utilization of existing community treatment resources.

2. Crisis intervention services - Very often, hospitalization occurs during crisis periods or in order to avert crisis. Removing an individual from a critical situation is not always the most effective solution, since a crisis often provides the opportunity for personal growth within a family or social nexus. Removal could result in hampering long-term community adjustment. Providing assistance and intervention to people in crisis, particularly ex-patients, not only averts re-hospitalization but utilizes personal and situational strengths and develops problem-solving abilities.

3. Linkage of formal and informal helping networks in the community - It is absolutely essential that community team members have a thorough and active knowledge of all community resources, including contact with the more formal services such as Public Welfare, Vocational Rehabilitation, Community Mental Health Programs, public health nurses and day treatment programs, and also less formal helping agents such as general practitioners, clergy, and home providers.

4. Consultation provision to care givers - This also is essential in order to provide on-going contact and support and to ensure cooperation and communication. The informal agents in the community especially need information and assistance in working with the target population, and

particularly need to be informed about the functions and services of the community team in order to make appropriate referrals.

5. Pre-discharge planning - It is vital that a community team member, who will be committed to the ex-patient over whatever period of time community adjustment entails, be intimately involved in pre-discharge planning for this person. The community team member's knowledge and accessibility to community resources will be assets in the planning process. Not only would this team member be involved in and aware of placement decisions, which would facilitate consultation to the home provider or family and therefore ease adjustment, but also be able to assist the patient in utilizing other resources to meet his/her total life needs.

6. Home visits - Notoriously low rates of kept appointments and the fear, anxiety and social isolation which characterize this population and which often prevent them from seeking the support and services they need mandate home visits. The regular appearance of one concerned and committed individual can serve to fulfill a basic need for sustained personal contact for those who initially lack the courage or skills to reach out. In addition to on-site therapy, home visits can facilitate: medication monitoring; support, consultation, and/or group therapy to others in the living situation; more accurate

and complete assessment of the patient's needs, strengths and weaknesses; and a more rapid development of trust. As those involved in the Denver program discovered:

Efforts to "motivate" clients to come to the clinic are often a waste of time when compared with some of the advantages of meeting the schizophrenic person on his own ground, observing how he acts in his usual social setting, and gaining a small measure of personal experience with the physical and social constraints and interactions he engages in.⁴

7. Consistent support/advocate/liaison person -

Inherent in the recommendation for home visitation, as well as other above-mentioned functions, is the concept of providing each ex-patient with a consistent advocate and support person. This person is accountable to the patient and the Mental Health Division. Primary responsibilities of this team member involve assisting the client in negotiating the complex network of social services, to develop a relationship that provides on-going support and therapy, and to assist the patient in developing those interpersonal and self-maintenance skills which he/she needs in order to function on his/her own in the community. This is not to suggest that one person be able to meet another's total life needs; rather, it would be an attempt to meet the most basic needs of an individual and would certainly vary from case to case.

8. Twenty-four hour accessibility - In order to

⁴ Kincheloe and Hagar, Out the Back Wards' Door, p. 68.

provide the services enumerated above, twenty-four hour accessibility is a prerequisite. This is in contrast to nine-to-five, Monday through Friday schedule of county mental health programs and social service agencies.

Since county programs are responsible for providing follow-up to ex-patients, it would seem most logical and practical for such a team or teams to originate there, although in some states these teams are hospital-based. Oregon's mental retardation/developmental disabilities program, described in the section on alternative models in this state, utilizes a hospital-based team approach to follow-up service provision. Edward Burling et al. have developed a proposal for a Community Services Support Team based on this model.

B. Day Treatment - Since this treatment modality has proved to be an effective alternative to hospitalization, increased development and greater utilization of day programs is recommended. Such programs are sufficiently flexible to meet a variety of client needs for socialization, skill training, recreation, and therapy. Day treatment programs are designed to provide meaningful daily activity to those who have difficulty structuring their time and require considerable direction; such programs are not appropriate or accessible to all ex-patients and usually do not provide crisis intervention or consultation.

C. Alternative living arrangements - There is a serious lack of the wide range of living situations needed for ex-patients and others for whom such facilities could be an alternative to hospitalization. Both in kind and number, more options are needed, particularly in the outlying counties, to meet this deficit. The community should offer a continuum of care facilities ranging from more dependent to more independent, which allow movement within the continuum as client needs change. Welfare and hospital liaison workers report that the 18-35 year age group is most difficult to place, indicating a need for facilities tailored toward this group. (See "Special Project - St. Louis" in literature section.) To this end, Glenn Maynard of the Southeast Portland branch of the Public Welfare Division recently completed a proposal citing the need for a treatment-oriented facility for 18-35 year-old ex-patients (see Appendix). It should be noted that the majority of the population sampled here fell into that age group.

Currently there are at least two hundred "adult care facilities" in Multnomah County alone. Public Welfare maintains a register of those it utilizes; this is by no means a complete list of existing facilities. It is highly recommended that a complete list of all living situations available to mentally and emotionally disturbed clients be compiled and made available to all placement planners.

Such a listing should contain facility description, number and type of residents, services provided (if any), milieu and so forth.

Although it is recognized that a comfortable, supportive living situation is very important, the current research indicates it is secondary to the need for supportive human relationships and meaningful daily activity. Many patients return home following hospitalization and still need a large number of aftercare services. A community team approach could be instrumental in providing home operators with necessary information concerning ex-patient treatment.

D. Community education - Many people who are or have been considered mentally or emotionally disturbed sometimes exhibit bizarre behavior that, while not regarded as "normal," is not dangerous to themselves or others. The ability of these people to function in the community could be enhanced by more tolerant attitudes on the part of community residents. Community education concerning the needs of the target population is recommended. To this end, the increased utilization of volunteers in all areas of aftercare would be advantageous to both the disturbed and non-disturbed segments of society.

E. Client-tracking system - Many mental health professionals feel that a client tracking system is important to prevent ex-patients from "falling through the cracks." The researchers remain unconvinced, but feel a community

team approach would provide sufficient follow-up care.

F. Experimental program - It is strongly recommended that a community team approach be implemented on an experimental basis with an evaluation component in the 1977-79 biennium.

BIBLIOGRAPHY

- Alabama Department of Mental Health. Unpublished program proposals. Received 1976.
- Angrist, Shirley S.; Lefton, Mark; Dinitz, Simon; and Pasamanick, Benjamin. Women After Treatment. New York: Appleton-Century-Crofts, 1968.
- Aring, C.D. "Gheel Revisited." Journal of the American Medical Association, 230 (November, 1974), 849.
- Barker, Roger. Ecological Psychology. Stanford, Ca.: Stanford University Press, 1968.
- Barton, Russell. Institutional Neurosis. Bristol: John Wright and Sons, 1959.
- Beard, John H.; Pitt, Raymond B.; Fisher, Saul H.; and Goertzel, Victor. "Evaluating the Effectiveness of a Psychiatric Rehabilitation Program." American Journal of Orthopsychiatry, 33 (1963), 701-12.
- Berrington, W.P. "Resocialization: Undoing the Damage." International Journal of Social Psychiatry, 12 (1966), 85-97.
- Bloom, Bernard. Community Mental Health: a Historical and Critical Analysis. Morristown, J.J.: General Learning Press, 1973.
- Bray, J.D. "Alternatives to State Hospitalization Programs for Mental or Emotional Disturbances." Unpublished report, State of Oregon Mental Health Division, Department of Human Resources, March, 1975.
- Budson, Richard D; Meehan, Justine; and Barclay, Emily. "Developing a Community Residence for the Mentally Ill." Unpublished report, Boston: Massachusetts Department of Mental Health, 1974.
- Burling, Edward; Heath, Dennis; Jacobs, Tim; and Kaplan, Sharyn. "Deinstitutionalization in Oregon: A Review of Services within the Human Resources System." Unpublished report, Oregon Department of Human Resources, May 1975.

- Burling, Edward; Heath, Dennis; Jacobs, Tim; and Kaplan, Sharyn. "Deinstitutionalization: Follow Up Summary Report and Implementation Plan in the 75-77 Biennium." Unpublished report, Oregon Department of Human Resources, 1975.
- Caplan, Gerald. "Conceptual Models in Community Mental Health." Support Systems and Community Mental Health. New York: Behavioral Publications, 1974.
- Cheek, F.E. "Family Interaction Patterns and Convalescent Adjustment of the Schizophrenic." Archives of General Psychiatry, XIII (1965), 138-47.
- Chien, Ching-Piao and Cole, Jonathon O. "Landlord-Supervised Cooperative Apartments: A New Modality for Community-Based Treatment." American Journal of Psychiatry, 130 (February, 1973), 156-159.
- Chu, Franklin. "Report to the Commissioner of the Augusta Mental Health Institute and Selected Representative Community Mental Health Centers." Unpublished report, State of Maine Department of Mental Health and Corrections, February-June, 1974.
- Chu, Franklin and Trotter, Sharland. The Madness Establishment: Ralph Nader's Study Group Report on the National Institute of Mental Health. New York: Grossman Publishers, 1974.
- "Clackamas County Comprehensive Mental Health Plan," 1975-6.
- "Columbia County Comprehensive Mental Health Plan," 1975-6.
- Daniels, D.N.; Zelman, A.B.; and Campbell, J.H. "Community Based Task Groups in Recovery of Mental Patients." Archives of General Psychiatry, XVI (1967), 215.
- Denner, Bruce. "Returning Madness to an Accepting Community." Community Mental Health Journal, X (1974), 163-72.
- Easton, Karl. "Some Psychodynamic Considerations in the Program of Boerum Hill: A Psychiatric Halfway House." Community Mental Health Journal, X (1974), 395-401.
- Fairweather, George W. Social Psychology in Treating Mental Illness: An Experimental Approach. New York: John Wiley and Sons, Inc., 1964.

- Fairweather, George W.; Sanders, D.H.; Maynard, H.; and Cressler, D.L. Community Life for the Mentally Ill: An Alternative to Institutional Care. New York: Aldine, 1969.
- Fisch, Richard. "Resistance to Change in the Psychiatric Community." Archives of General Psychiatry, XIII (1965), 359-65.
- Flomenhoft, Kalman; Kaplan, David; and Langsley, Donald. "Avoiding Psychiatric Hospitalization." Social Work, (October, 1969), 38-45.
- "A Follow-up Study of Released Patients from Cleveland State Hospital." Unpublished report, Ohio Department of Mental Health and Mental Retardation, 1973.
- Fontana, Al; Oakes, Gwen; and Smith, B.J. "Boarding Homes." Unpublished report, Fort Logan Mental Health Center, Denver, Colo., 1970.
- Freeman, Howard and Simmons, Ozzie. The Mental Patient Comes Home. New York: Wiley and Sons, Inc., 1962.
- Friedman, T. "Home Treatment of Psychiatric Patients." American Journal of Psychiatry, 116 (1960), 807-9.
- Georgia Division of Mental Health. Unpublished placement materials. Received 1976.
- Glasscote, R.M.; Gudeman, J.E.; and Elpers, R. Halfway Houses for the Mentally Ill. Washington, D.C., Joint Information Service of American Psychiatric Association and National Association for Mental Health, 1971.
- Glasscote, Raymond M; Kraft, Alan M; Glassman, Sidney M; and Jepson, William. Partial Hospitalization for the Mentally Ill. Washington, D.C., Joint Information Service of American Psychiatric Association and National Association for Mental Health, 1969.
- Gumrucku, Patricia. "The Efficacy of a Psychiatric Halfway House: A Three Year Study of a Therapeutic Residence." Sociological Quarterly, IX (1968), 374-86.
- Gumrucku, Patricia, and Mikels, Elaine. "Combating Post-hospital Bends: Patterns of Success and Failure in a Psychiatric Halfway House." Mental Hygiene, 49 (April, 1965), 244-9.

- Hawley, Timothy. "The St. Louis Metropolitan Community Placement Program: Extended Care for Ex-Mental Hospital Patients." Unpublished report, Missouri Department of Mental Health, 1975.
- Heckel, Robert V.; Perry, Charles; and Reeves, P.G. The Discharged Mental Patient: A Five-Year Statistical Survey. Columbia, S.C.: University of South Carolina Press, 1973.
- Hobbs, Nicholas. "Mental Health's Third Revolution." American Journal of Orthopsychiatry, XXXIV (October, 1964), 822-33.
- Horizon House Institute for Research and Development. "Community Careers: An Assessment of the Life Adjustment of Former Mental Hospital Patients." Philadelphia, June, 1975.
- Jones, Maxwell. Beyond the Therapeutic Community. New Haven: Yale University Press, 1968.
- Jones, Maxwell. "Community Care for Chronic Mental Patients: The Need for a Reassessment." Hospital and Community Psychiatry, XXVI (February, 1975), 94-98.
- Kahn, Alfred. Studies in Social Policy and Planning. New York: Russell Sage Foundation, 1969.
- Kennedy, John F. Message from the President of the United States Relative to Mental Illness and Mental Retardation. 88th Congress, First Session, U.S. House of Representatives Document No. 58, U.S. Government Printing Office, 1963.
- Kincheloe, Marsha and Hagar, Lorraine. Out the Back Wards' Door. Denver: By the authors, 1974.
- Klesh, Marylyn. "Report on Alternatives to Mental Hospital Treatment Conference." Unpublished report, Oregon Mental Health Division, 1975.
- Lamb, H. Richard, and Goertzel, Victor. "Discharged Mental Patients - Are They Really in the Community?" Archives of General Psychiatry, XXIV (January, 1971), 29-34.
- Landy, David and Greenblatt, Milton. Halfway House: A Sociocultural and Clinical Study of Rutland Corner House. Washington, D.C.: Department of Health, Education and Welfare, Vocational Rehabilitation Administration, 1965.

Lane County Mental Health Program. Material received, 1976.

Lemkau, Paul and Crocetti, Guido M. "The Amsterdam Municipal Psychiatric Service: A Psychiatric Sociological Review." American Journal of Psychiatry, 117 (1961), 779-83.

Meyers, Roger; Schiff, Lawrence; and Becker, Alvin. "The Home Treatment of Psychotic Patients: An Analysis of 154 Cases." American Journal of Psychiatry, 123 (May, 1967), 1430-8.

Miller, Dorothy. "Consultation Workshop: Consolidation of NIMH Grant." Portland, Ore.; Unpublished report, Portland State University, School of Social Work, 1974.

Morgan, Ralph. "The Extended Home Visit in Psychiatric Research and Treatment." Psychiatry, XXVI (1963), 168-75.

Morrissey, John D. "The Chichester and District Psychiatric Service." Evaluating the Effectiveness of Community Mental Health Services. Edited by Ernest M. Gruenberg. New York: Milbank Memorial Fund, 1966.

"Multnomah County Comprehensive Mental Health Plan," 1975-76.

Perry, Stewart. "Home Treatment and the Social System of Psychiatry." Psychiatry, XXVI (1963), 54-64.

Pierce, Paul D. "Placement Survey of Boarding, Nursing, and Foster Homes." Unpublished report, State of Maine Department of Mental Health and Corrections, received, 1976.

Pittman, Frank S. "Techniques of Family Crisis Therapy." Current Psychiatric Therapies. Edited by Jules Masserman. New York: Grune and Statton, 1966.

Polak, Paul and Jones, Maxwell. "The Psychiatric Non-hospital: A Model for Change." Community Mental Health Journal, IX (Summer, 1973), 123-32.

Rausch, Harold L. and Rausch, Charlotte L. The Halfway House Movement: A Search for Sanity. New York: Appleton-Century-Crofts, 1968.

Rog, Dennis J. and Rausch, Harold L. "The Psychiatric Halfway House: How Is It Measuring Up?" Community Mental Health Journal, XI (Summer, 1975), 155-62.

- Ruckwardt, Marylyn. "Day Treatment Programs in California." Unpublished report, Oregon Mental Health Division, 1972.
- Sandall, Hilary; Hawley, Timothy; and Gordon, Gloria. "The St. Louis Community Homes Program: Graduated Support for Long-Term Care." American Journal of Psychiatry, 132 (June, 1975), 617-22.
- Shean, Glenn. "A Social Learning Approach to Community Living for Chronic Mental Patients." Proceedings of the 81st Annual Convention of the American Psychological Association, VIII (1973), 455-6.
- Silverstein, Max. Psychiatric Aftercare. Philadelphia: University of Pennsylvania Press, 1968.
- Slinger, Geraldine. "Day Treatment." Unpublished report, Oregon Mental Health Division, 1970.
- Stein, Leonard I; Test, Mary Ann; and Marx, Arnold J. "Alternative to the Hospital: A Controlled Study." American Journal of Psychiatry, 132 (May, 1975), 517-22.
- Task Force on Aftercare. "Transitional Mental Health Services for the Chronic Mentally Disabled Client." Unpublished report, Mental Health and Mental Retardation Board of Montgomery County, Dayton, Ohio, 1975.
- Task Force on Community Mental Health Program Components. "Developing Community Mental Health Programs: A Resource Manual." Unpublished report, Massachusetts Department of Mental Health, May, 1975.
- "Washington County Comprehensive Mental Health Plan," 1975-76.
- Wechsler, Henry. "Halfway Houses Differentiated." Mental Hygiene, XLV (1961), 65-76.
- Weiner, Leonard; Becker, Alvin; and Friedman, Tobias T. Home Treatment: Spearhead of Community Psychiatry. Pittsburgh, University of Pittsburgh Press, 1967.
- Williams, Frank; Hawley, Timothy; Sandall, Hilary; Goodwin, Sharon. "Transitional Living Environments: A Program Design and Case Study." Paper presented at the Annual Meeting of the National Council of Community Mental Health Centers, Washington, D.C., 1975.
- Zusman, Jack. "Some Explanations of the Changing Appearance of Psychotic Patients." Evaluating the Effectiveness of Community Mental Health Services. Edited by Ernest M. Gruenberg. New York: Milbank Memorial Fund, 1966.

APPENDICES

	<u>Page</u>
APPENDIX A: SAMPLE QUESTIONNAIRES	106
APPENDIX B: RESULTS OF PATIENT QUESTIONNAIRES	113
APPENDIX C: RESULTS OF PROFESSIONAL QUESTIONNAIRES	135
APPENDIX D: LETTER TO STATE MENTAL HEALTH DEPARTMENTS	136
APPENDIX E: RESPONDENTS TO REQUESTS FOR INFORMATION FROM STATES	137
APPENDIX F: GROUP HOME PROPOSAL: GLENN MAYNARD, PUBLIC WELFARE	140

APPENDIX A

SAMPLE QUESTIONNAIRES

Patient Questionnaire

The Mental Health Division is trying to improve services for people who are leaving hospitals. To better understand your needs, we would appreciate your answers to the following questions.

ID#	1-3
1. Age at last birthday	4-5
2. Sex 1__male 2__female	6
3. Marital status 1__single 2__married 3__cohabiting 4__separated 5__divorced 6__widowed	7
4. Were you admitted 1__voluntarily 2__by court	8
5. What was the last grade you completed in school?	9
6. Occupation (specific)	10
7. Do you have a physical disability that limits the kind of work you can do? 1__yes 1__no	11
If yes, please describe condition	12
8. Are you receiving treatment for any medical problems? 1__yes 2__no	13
If yes, please describe condition	14
9. Number previous psychiatric hospitalizations ____	15-16
10. Length of time since last hospitalization ____	17
11. Where were you last hospitalized? _____	18
12. Have you answered this questionnaire before? 1__yes 2__no	19
13. Why are you here this time?	20
14. Where were you living before this hospitalization? (check all that apply) 1=most recent 2=bet. hosp. 3=dna	
a. home with parents	21
b. with siblings	22
c. with spouse	23
d. with children	24
e. with spouse and children	25
f. with roommate(s)	26
g. alone	27
h. room and board	28
i. group home	29
j. halfway house	30
k. other, describe	31

15. If 14h,i,j are not checked: Have you lived in a group home , halfway house, or room and board situation in the last 10 years? 1__yes 2__no	32
16. If resident has lived in a group arrangement within 10 years:	
a. Was it 1__room and board 2__group home 3__halfway house	33
b. Was your room 1__private 2__shared	34
c. How much of your daily time was scheduled? 1__none 2__ 3__half 4__ 5__all	35
Mostly scheduled by 1__manager 2__self 3__other,who?	36
d. Were you responsible for any household chores?	
housecleaning 1__yes 2__no	37
shopping 1__yes 2__no	38
cooking 1__yes 2__no	39
dishwashing 1__yes 2__no	40
other, what? 1__yes 2__no	41
How much supervision did you have for these chores? 1__none 2__ 3__half 4__ 5__total	42
e. Were you responsible for personal tasks?	
caring for room 1__yes 2__no	43
caring for clothes 1__yes 2__no	44
grooming 1__yes 2__no	45
other, what? 1__yes 2__no	46
How much supervision did you have for these tasks? 1__none 2__ 3__half 4__ 5__total	47
f. were there regulations regarding	
smoking 1__yes,reasonable 2__yes,unreas 3__no	48
drinking 1__yes " 2__ " 3__no	49
hours 1__yes " 2__ " 3__no	50
visitors 1__yes " 2__ " 3__no	51
other, what? 1__yes " 2__ " 3__no	52
g. How often did you participate in social activities? 1__never 2__occasionally 3__ 4__fairly 5__very often often	53
Was participation 1__self-initiated 2__mandatory 3__both 1 & 2 4__dna	54
h. How often did you participate in recreational activities? 1__never 2__occasionally 3__ 4__fairly 5__very often often	55
Was participation 1__self-initiated 2__mandatory 3__both 1&2 4__dna	56
i. Were you taking medication? 1__yes, self-administered 2__yes, other-administered, who? 3__no	57

j. Were you involved in psychotherapy? 1__yes 2__no	58
If yes, 1__individual 2__group 3__1&2 4__other,?	59
If yes, was psychotherapy received 1__on site 2__community agency	60
k. Did you have vocational counseling? 1__yes 2__no	61
l. Did you have vocational training? 1__yes 2__no	62
m. Did you have a job? 1__full-time 2__part-time 3__sporadic 4__no job	63
n. Did you have help with	
money management 1__yes 2__no	64
using buses 1__yes 2__no	65
shopping 1__yes 2__no	66
other, what? 1__yes 2__no	67
17. How many children do you have?	68
How many children are dependent on you?	69
18. Were you taking medication before this hospitalization? 1__yes, self-administered 2__yes, other admin 3__no who?	70
19. What was your source of financial support prior to hospitaliz? 1__employment 2__family 3__welfare 4__SSI 5__disability insurance 6__other, what?	71
20. In thinking about a living situation which would best meet your needs:	
a. Would you like it to be 1__more permanent 2__more temporary 3__dont know	72
b. Would you like to live with family? 1__yes 2__no 3__depends Is this possible? 1__yes 2__no	73
c. Would you like to live with other people (not family)? 1__yes 2__no 3__depends Why?	74
	75
d. Would you like to live with other people who have been hospitalized? 1__yes 2__no 3__depends 4__dna Why? ID#__	76
	1-3
	4
e. How many people would you like to live with?	5-6
f. Would you prefer a 1__private 2__shared room	7

g. How much of your time would you like scheduled (for you)? 1__none 2__ 3__half 4__ 5__all	8
h. Would you help with household chores? 1__yes 2__no 3__depends	9
i. Would you take responsibility for personal tasks? 1__yes 2__no 3__depends	10
j. Would you be willing to have some regulations regarding smoking 1__yes 2__no drinking 1__yes 2__no hours 1__yes 2__no visitors 1__yes 2__no	11 12 13 14
k. How much would you like to participate in social activities? 1__never 2__occasionally 3__ 4__fairly 5__very often often	15
l. How much would you like to participate in recreational activ? 1__never 2__occasionally 3__ 4__fairly 5__very often often	16
m. Would you like to have psychotherapy? 1__yes 2__no	17
n. Would you like to work? 1__yes, full-time 2__yes, parttime 3__yes, sporadically 4__no	18
If yes, how soon would you like to find work?	19
o. Would you like vocational counseling? 1__yes 2__no	20
p. Would you like vocational training? 1__yes 2__no	21
q. Would you like help with money management 1__yes 2__no using buses 1__yes 2__no shopping 1__yes 2__no other skills, what? 1__yes 2__no	22 23 24 25
r. Would you prefer to live in a 1__downtown area 2__rural 3__residential 4__suburban 5__other, where?	26
s. Are there things we haven't discussed which are important to you in considering a living arrangement? What?	
ID Hospital where administered 1__D 2__WF 3__P	75
ID Date administered	76-80

The Mental Health Division is interested in improving community resources for ex-mental patients. A study of post-hospital living arrangements for MED patients is currently in progress. The study's target population is adult (age 18-65) ex-patients, with mental and emotional disturbances. People who require special nursing care for medical problems, or who have alcohol and drug problems, or who are mentally retarded or developmentally disabled, are not included in the current research. The study's long-range goal is to facilitate successful community adjustment of the target population, which can be crudely defined as decreasing psychiatric hospital readmission rates.

To better understand the needs of this group of people, we would greatly appreciate your answering the following questions, based on your professional experience. Thank you.

I. Identifying information:

Name _____
 Position _____
 Agency _____

1-2

3-4

5-6

II. Using the chart provided, please rate each item on its importance in facilitating successful community adjustment.

	not imp.	some what imp.	moder- ately imp.	fair- ly imp.	very imp.	
1. Individual privacy						7
2. Living with other people						8
a. Living with people who have had mental problems						9
b. Living with people who have not had mental problems						10
3. Social contact with people who have had mental problems						11
a. Social contact with people who have not had mental problems						12
b. Social contact with family						13

	Importance in successful community adjustment					
	not imp.	some what imp.	moder- ately imp.	fair- ly imp.	very imp.	
4. Having individual's time structured (ie. meals, day treatment, sheltered work-shops, etc.)						14
a. Involving individual in planning own schedule						15
5. Opportunity for participation in social / recreational activities (parties, clubs, sports, etc.)						16
6. Opportunity for participation in educational / cultural activities (adult ed courses, movies, museums, etc.)						17
7. Employment (part or full time) for those able to work						18
a. Vocational counseling						19
b. Vocational training						20
8. Socialization and training in the following areas:						
a. money management						21
b. use of public transit						22
c. meal planning						23
d. grocery shopping						24
e. cooking						25
f. dishwashing						26
g. housekeeping/cleaning						27
h. grooming						28
i. personal shopping						29
j. household maintenance tasks						30
9. Psychotherapy						31
10. In group living arrangements, how important is individual participation in development of house rules (ie. hours, smoking, drinking, visitation)						32
11. Comfortable, attractive facility						33

III. What other factors are critical in successful community adjustment for this group of MED adult ex-patients?

IV. Please add any comments or suggestions regarding planning of living arrangements for MED adult ex-patients.

THANK YOU VERY MUCH FOR YOUR COOPERATION !!

APPENDIX B

RESULTS OF PATIENT QUESTIONNAIRE

Note: The following abbreviations are used throughout this appendix:

DSH - Dammasch State Hospital
 WP - Woodland Park Mental Health Center
 P - Providence Medical Center
 PDT - Providence Medical Center Day Treatment Program

Demographic Data: Tables I through XV present demographic information of the 51 patients interviewed in this study.

TABLE I

AGE

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
18-25	4	17	8	29	12	24
26-35	7	29	7	26	14	27
36-45	5	21	4	15	9	18
46-55	5	21	4	15	9	18
56-65	3	13	4	15	7	13
TOTAL	24	100	27	100	51	100

TABLE II

SEX

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Male	11	46	7	26	18	35
Female	13	54	20	74	33	65
TOTAL	24	100	27	100	51	100

TABLE III
MARITAL STATUS

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Single	7	29	13	48	20	39
Married	5	21	4	15	9	18
Cohab- itating	1	4	0	0	1	2
Separated	3	12	6	22	9	18
Divorced	6	25	3	11	9	18
Widowed	2	9	1	4	3	5
TOTAL	24	100	27	100	51	100

TABLE IV
ADMISSION

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Voluntary	18	75	26	96	44	86
Committed	6	25	1	4	7	14
TOTAL	24	100	27	100	51	100

TABLE V
EDUCATION LEVEL

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
0	2	9	0	0	2	4
1-6	0	0	1	4	1	2
7-8	3	12	1	14	4	8
9-10	3	12	3	11	6	12
11-12	8	34	11	40	19	36

13-14	4	17	6	22	10	20
15-16	3	12	5	19	8	16
17+	1	4	0	0	1	2
TOTAL	24	100	27	100	51	100

TABLE VI

PHYSICAL DISABILITY WHICH LIMITS ABILITY TO WORK

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Yes	3	12	7	26	10	20
No	21	88	20	74	41	80
TOTAL	24	100	27	100	51	100

TABLE VII

CURRENTLY RECEIVING MEDICAL TREATMENT

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Yes	1	4	2	7	3	6
No	23	96	25	93	48	94
TOTAL	24	100	27	100	51	100

TABLE VIII

NUMBER OF PREVIOUS PSYCHIATRIC HOSPITALIZATIONS

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
1-2	11	47	19	70	30	58
3-4	6	25	3	11	9	18
5-6	1	4	5	19	6	12
7-9	3	12	0	0	3	6
10+	3	12	0	0	3	6
TOTAL	24	100	27	100	51	100

TABLE IX
MONTHS SINCE LAST HOSPITALIZATION

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
0-1	3	12	8	29	11	21
2-3	4	17	4	17	8	16
4-5	5	21	6	22	11	21
6-8	1	4	3	11	4	8
9-12	1	4	3	11	4	8
13-18	1	4	0	0	1	2
19-24	3	12	2	8	5	10
25-36	0	0	1	4	1	2
36+	4	17	0	0	4	8
Don't know	2	9	0	0	2	4
TOTAL	24	100	27	100	51	100

TABLE X
PLACE LAST HOSPITALIZED

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Dammasch	20	83	1	4	21	41
Woodland Park	0	0	14	52	14	27
Providence	0	0	9	32	9	18
Veterans' Hos- pital	2	9	0	0	2	4
Oregon State Hospital	1	4	0	0	2	4
Holladay Park	0	0	1	4	1	2
Out of State	1	4	2	8	3	6
TOTAL	24	100	27	100	51	100

TABLE XI
NUMBER OF CHILDREN

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
0	10	42	14	52	24	48
1	3	12	4	16	7	14
2	6	25	2	8	8	16
3	3	12	4	16	7	14
4-6	2	9	2	8	4	8
TOTAL	24	100	26	100	50	100

TABLE XII
MEDICATIONS BEFORE HOSPITALIZATION

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Yes, Self-administered	19	79	16	59	35	69
Yes, Other-administered	1	4	2	8	3	5
No	4	17	9	33	13	26
TOTAL	24	100	27	100	51	100

TABLE XIII
SOURCE OF INCOME BEFORE HOSPITALIZATION

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Employment	4	17	11	42	15	29
Family	3	12	6	22	9	18
Welfare	5	21	3	11	8	16
Supplemental Sec. Inc.	4	17	2	7	6	12
Other	8	33	3	11	11	21
Welfare + SSI	0	0	2	7	2	4
TOTAL	24	100	27	100	51	100

TABLE XIV
LAST RESIDENCE

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Home						
-with parents	1	4	4	15	5	10
-with siblings	1	4	00	0	1	2
-with spouse	2	8	3	11	5	10
-with children	1	4	1	4	2	4
-with spouse & children	1	4	2	7	3	6
-with roommates	1	4	4	15	5	10
-alone	8	34	10	37	18	35
Room & Board	4	17	2	7	6	11
Group Home	1	4	0	0	1	2
Halfway House	0	0	0	0	0	0
Other	4	17	1	4	5	10
TOTAL	24	100	27	100	51	100

TABLE XV
GROUP LIVING SITUATION IN LAST 10 YEARS

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Yes	13	54	5	19	18	35
No	11	46	22	81	33	65
TOTAL	24	100	27	100	51	100

Group Living Experiences: Tables XVI through XXXIII present responses of the 18 patients in the sample who had had group living experience some time during the last ten years.

TABLE XVI
TYPE GROUP ARRANGEMENT

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Room & Board	9	70	3	60	12	67
Group Home	2	15	0	0	2	11
Halfway House	2	15	2	40	4	22
TOTAL	13	100	5	100	18	100

TABLE XVII
TYPE ROOM

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Private	3	24	1	20	4	22
Shared ⁴	10	76	4	80	14	78
TOTAL	13	100	5	100	18	100

TABLE XVIII
AMOUNT OF TIME SCHEDULED

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
None	4	30	1	20	5	28
One-fourth	5	40	3	60	8	44
One-half	0	0	0	0	0	0
Three-fourths	2	15	0	0	2	11
All	2	15	0	0	2	11
TOTAL	13	100	5	100	18	100

TABLE XIX
TIME SCHEDULED BY

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Manager	2	15	3	60	5	28
Self	7	54	1	20	8	44
Does not apply	4	31	1	20	5	28
TOTAL	13	100	5	100	18	100

TABLE XX
CLIENT HOUSEHOLD RESPONSIBILITIES

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Housecleaning						
Yes	5	40	4	80	9	50
No	8	60	1	20	9	50
TOTAL	13	100	5	100	18	100
Shopping						
Yes	4	31	1	20	5	28
No	9	69	4	80	13	72
TOTAL	13	100	5	100	18	100
Cooking						
Yes	3	24	1	20	4	22
No	10	76	4	80	14	78
TOTAL	13	100	5	100	18	100

TABLE XXI

AMOUNT OF SUPERVISION FOR HOUSEHOLD CHORES

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
None	8	60	3	60	11	61
One-fourth	2	16	1	20	3	17
One-half	3	24	1	20	4	22
TOTAL	13	100	5	100	18	100

TABLE XXII

CLIENT PERSONAL RESPONSIBILITIES

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Cleaning own room						
Yes	11	84	5	100	16	89
No	2	16	0	0	2	11
TOTAL	13	100	5	100	18	100
Caring for clothing						
Yes	10	76	5	100	15	83
No	3	24	0	0	3	17
TOTAL	13	100	5	100	18	100
Grooming						
Yes	13	100	5	100	18	100
No	0	0	0	0	0	0
TOTAL	13	100	5	100	18	100

TABLE XXIII

AMOUNT OF SUPERVISION FOR PERSONAL TASKS

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
None	10	76	5	100	15	83
One-fourth	2	16	0	0	2	11
One-half	1	8	0	0	1	6
TOTAL	13	100	5	100	18	100

TABLE XXIV

HOUSEHOLD REGULATIONS

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Smoking						
Yes, reasonable	3	24	2	40	5	27
Yes, unreasonable	1	8	0	0	1	6
No	9	68	3	60	12	67
TOTAL	13	100	5	100	18	100
Drinking						
Yes, reasonable	7	54	4	80	11	61
Yes, unreasonable	0	0	0	0	0	0
No	6	46	1	20	7	39
TOTAL	13	100	5	100	18	100
Hours						
Yes, reasonable	6	46	2	40	8	44
Yes, unreasonable	2	16	1	20	3	17
No	5	38	2	40	7	39
TOTAL	13	100	5	100	18	100

Visitors

Yes, reasonable	2	16	1	20	3	17
Yes, unreasonable	1	8	0	0	1	6
No	10	76	4	80	14	77
TOTAL	13	100	5	100	18	100

Other Regulations

Yes, reasonable	1	8	1	20	2	11
Yes, unreasonable	0	0	0	0	0	0
No	12	92	4	80	16	89
TOTAL	13	100	5	100	18	100

TABLE XXV

PARTICIPATION IN SOCIAL ACTIVITIES

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Never	5	38	2	40	7	39
Occasionally	4	30	3	60	7	39
More than occasion	1	8	0	0	1	6
Fairly often	1	8	0	0	1	6
Very often	2	16	0	0	2	10
TOTAL	13	100	5	100	18	100

TABLE XXVI

PARTICIPATION IN RECREATIONAL ACTIVITIES

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Never	8	62	2	40	10	55
Occasionally	4	30	3	60	7	39
Fairly often	1	8	0	0	1	6
TOTAL	13	100	5	100	18	100

TABLE XXVII
TAKING MEDICATIONS

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Yes, Self-administered	7	54	3	60	10	55
Yes, Other-administered	4	31	1	20	5	28
No	2	15	1	20	3	17
TOTAL	13	100	5	100	18	100

TABLE XXVIII
IN THERAPY

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Yes	5	38	2	40	7	39
No	8	62	3	60	11	61
TOTAL	13	100	5	100	18	100

TABLE XXIX
IN IN THERAPY, MODE

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Individual	3	60	1	50	4	57
Group	1	20	0	0	1	14
Both	1	20	1	50	2	29
TOTAL	5	100	2	100	7	100

TABLE XXX
WHERE THERAPY RECEIVED

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
On site	1	20	0	0	1	14
Community agency	4	80	2	100	6	86
TOTAL	5	100	2	100	7	100

TABLE XXXI
RECEIVED VOCATIONAL ASSISTANCE

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Vocational counseling						
Yes	2	15	1	20	3	17
No	11	85	4	80	15	83
TOTAL	13	100	5	100	18	100
Vocational training						
Yes	2	15	0	0	2	11
No	11	85	5	100	16	89
TOTAL	13	100	5	100	18	100

TABLE XXXII
EMPLOYMENT

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Full-time	0	0	2	40	2	11
Part-time	3	23	0	0	3	17
Unemployed	10	77	3	60	13	72
TOTAL	13	100	5	100	18	100

TABLE XXXIII
RECEIVED ASSISTANCE WITH DAILY TASKS

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Money management						
Yes	0	0	1	20	1	6
No	13	100	4	80	17	94
TOTAL	13	100	5	100	18	100
Using public transportation						
Yes	1	8	2	40	3	17
No	12	92	3	60	15	83
TOTAL	13	100	5	100	18	100
Shopping						
Yes	0	0	1	20	1	6
No	13	100	4	80	17	94
TOTAL	13	100	5	100	18	100

Ideal Situation: Tables XXXIV through XLVII present the opinions of the entire sample of 51 patients regarding their aftercare needs and desires.

TABLE XXXIV
BEST LIVING SITUATION

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
More permanent	17	71	14	52	31	60
More temporary	1	4	10	36	11	22
Don't know	6	25	2	8	8	16
No response	0	0	1	4	1	2
TOTAL	24	100	27	100	51	100

TABLE XXXV
WOULD LIKE TO LIVE WITH OTHER PEOPLE

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Like to live with family						
Yes	7	29	7	26	14	27
No	16	67	16	59	32	63
Depends	1	4	4	15	5	10
TOTAL	24	100	27	100	51	100
Possible to live with family						
Yes	7	29	4	15	11	22
No	9	38	9	33	18	35
Maybe/Does not apply	8	33	14	52	22	43
TOTAL	24	100	27	100	51	100

Like to live
with others

Yes	10	42	15	55	25	48
No	8	33	4	15	12	24
Depends	6	25	7	26	13	26
No response	0	0	1	4	1	2
TOTAL	24	100	27	100	51	100

Like to live with
other ex-patients

Yes	7	29	4	15	11	22
No	11	46	12	44	23	45
Depends	5	21	10	37	15	29
Does not apply	1	4	1	4	2	4
TOTAL	24	100	27	100	51	100

TABLE XXXVI

IDEAL NUMBER IN LIVING SITUATION

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
0	4	17	2	8	6	12
1-2	7	29	12	43	19	36
3-4	3	13	4	15	7	14
5-6	1	4	3	10	4	8
7-9	1	4	1	4	2	4
10-13	3	13	0	0	3	6
13+	1	4	0	0	1	2
No preference	1	4	1	4	2	4
Don't know	2	8	2	8	4	8
No response	1	4	2	8	3	6
TOTAL	24	100	27	100	51	100

TABLE XXXVII
ROOM PREFERENCE

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Private	14	59	22	80	36	70
Shared	6	25	2	8	8	16
Depends	1	4	0	0	1	2
No preference	2	8	1	4	3	6
Don't know	1	4	0	0	1	2
No response	0	0	2	8	2	4
TOTAL	24	100	27	100	51	100

TABLE XXXVIII
AMOUNT OF TIME SCHEDULED

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
None	15	63	14	51	29	56
One-fourth	5	21	4	15	9	18
One-half	1	4	6	22	7	14
Three-fourths	3	12	2	8	5	10
No response	0	0	1	4	1	2
TOTAL	24	100	27	100	51	100

TABLE XXXIX
WILLING TO ASSUME RESPONSIBILITY

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Household chores						
Yes	22	92	24	88	46	90
No	2	8	1	4	3	6
No response	0	0	2	8	2	4
TOTAL	24	100	27	100	51	100
Personal tasks						
Yes	24	100	25	92	49	96
No response	0	0	2	8	2	4
TOTAL	24	100	27	100	51	100

TABLE XL
WILLING TO HAVE REGULATIONS

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Smoking						
Yes	6	25	16	59	22	43
No	15	63	9	33	24	47
No response	3	12	2	8	5	10
TOTAL	24	100	27	100	51	100
Drinking						
Yes	8	34	18	66	26	51
No	13	54	7	26	20	39
No response	3	12	2	8	5	10
TOTAL	24	100	27	100	51	100

Hours						
Yes	7	29	9	33	16	31
No	13	54	16	59	29	57
No response	4	17	2	8	6	12
TOTAL	24	100	27	100	51	100
Visitors						
Yes	3	12	11	40	14	27
No	17	71	14	52	31	61
No response	4	17	2	8	6	12
TOTAL	24	100	27	100	51	100

TABLE XLI

WANT TO PARTICIPATE IN RECREATION

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Never	7	29	2	8	9	18
Occasionally	10	42	6	22	16	30
More than occasion	1	4	8	29	9	18
Fairly often	4	17	5	18	9	18
Very often	1	4	4	15	5	10
No response	1	4	2	8	3	6
TOTAL	24	100	27	100	51	100

TABLE XLII

WANT TO PARTICIPATE IN SOCIAL ACTIVITIES

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Never	2	8	1	4	3	6
Occasionally	7	29	10	37	17	32
More than occasion	2	8	6	22	8	16
Fairly often	9	39	4	15	13	26
Very often	3	12	3	11	6	12
No response	1	4	3	11	4	8
TOTAL	24	100	27	100	51	100

TABLE XLIII

WANT PSYCHOTHERAPY

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Yes	17	71	20	73	37	72
No	7	29	4	15	11	22
No response	0	0	3	12	3	6
TOTAL	24	100	27	100	51	100

TABLE XLIV

WANT TO WORK

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Yes, full-time	12	50	8	29	20	39
Yes, part-time	6	25	12	44	18	35
No	6	25	4	15	10	20
No response	0	0	3	12	3	6
TOTAL	24	100	27	100	51	100

TABLE XLV
WANT VOCATIONAL ASSISTANCE

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Vocational counseling						
Yes	7	29	15	55	22	43
No	17	71	10	37	27	53
No response	0	0	2	8	2	4
TOTAL	24	100	27	100	51	100
Vocational training						
Yes	6	25	16	59	22	43
No	17	71	9	33	26	51
No response	1	4	2	8	3	6
TOTAL	24	100	27	100	51	100

TABLE XLVI
WANT ASSISTANCE WITH DAILY TASKS

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Money management						
Yes	7	29	9	33	16	31
No	16	67	16	59	32	63
No response	1	4	2	8	3	6
TOTAL	24	100	27	100	51	100
Using public transportation						
Yes	4	17	6	22	10	20
No	20	82	19	70	39	76
No response	0	0	2	8	2	4
TOTAL	24	100	27	100	51	100
Shopping						
Yes	4	17	6	22	10	20
No	20	83	19	70	39	76
No response	0	0	2	8	2	4
TOTAL	24	100	27	100	51	100

TABLE XLVII

AREA PREFER TO LIVE

	DSH		WP, P, PDT		TOTAL	
	f	%	f	%	f	%
Downtown	5	21	3	11	8	16
Rural	5	21	6	22	11	21
Residential	10	42	10	36	20	39
Suburb	1	4	4	15	5	10
No preference	1	4	1	4	2	4
No response	2	8	3	12	5	10
TOTAL	24	100	27	100	51	100

APPENDIX C

RESULTS OF PROFESSIONAL QUESTIONNAIRE

	Very important f %	Fairly important f %	Moderately important f %	Somewhat important f %	Not important f %	No response f %	TOTALS f %
Individual privacy	4 13.3	10 33.3	10 33.3	5 16.7	0 0	1 3.3	30 99.9 *
Living with other people	14 46.7	9 30.0	3 10.0	2 6.7	0 0	2 6.7	30 100.1
Living with people who have had mental problems	1 3.3	1 3.3	6 20.0	8 26.7	12 40.0	2 6.7	30 100.0
Living with people who have not had mental problems	3 10.0	3 10.0	7 23.3	5 16.7	10 33.3	2 6.7	30 100.0
Social contact with people who have had mental problems	1 3.3	5 16.7	8 26.7	9 30.0	5 16.7	2 6.7	30 100.1
Social contact with people who have not had mental problems	5 16.7	12 40.0	5 16.7	4 13.3	2 6.7	2 6.7	30 100.1
Social contact with family	11 36.7	10 33.3	3 10.0	3 10.0	1 3.3	2 6.7	30 100.0
Having individual's time structured (i.e., meals, day treatment, workshops, etc.)	14 46.7	6 20.0	6 20.0	2 10.0	0 0	1 3.3	30 100.0
Involving individual in planning own schedule	20 66.7	7 23.3	0 0	2 6.7	0 0	1 3.3	30 100.0
Opportunity for participation in social/recreational activities	16 53.3	11 36.7	1 3.3	1 3.3	0 0	1 3.3	30 99.9
Opportunity for participation in educational/cultural activities	11 36.7	7 23.3	8 26.7	2 6.7	1 3.3	1 3.3	30 100.0
Employment (full- or part-time) for those able to work	18 60.0	5 16.7	3 10.0	2 6.7	0 0	2 6.7	30 100.1
Vocational counseling	13 43.3	9 30.0	4 13.3	2 6.7	1 3.3	1 3.3	30 99.9
Vocational training	12 40.0	8 26.7	6 20.0	2 6.7	1 3.3	1 3.3	30 100.0
Socialization and training in the following areas:							
Money management	14 46.7	8 26.7	5 16.7	2 6.7	0 0	1 3.3	30 100.1
Use of public transportation	14 46.7	7 23.3	5 16.7	3 10.0	0 0	1 3.3	30 100.0
Meal planning	7 23.3	5 16.7	8 26.7	8 26.7	1 3.3	1 3.3	30 100.0
Grocery shopping	7 23.3	4 13.3	11 36.7	6 20.0	1 3.3	1 3.3	30 99.9
Cooking	6 20.0	5 16.7	8 26.7	9 30.0	1 3.3	1 3.3	30 100.0
Housekeeping/cleaning	6 20.0	7 23.3	6 20.0	9 30.0	1 3.3	1 3.3	30 99.9
Grooming	9 30.0	10 33.3	7 23.3	2 6.7	0 0	2 6.7	30 100.0
Personal shopping	6 20.0	9 30.0	9 30.0	4 13.3	1 3.3	1 3.3	30 99.9
Household maintenance tasks	4 13.3	8 26.7	7 23.3	6 20.0	1 3.3	4 13.3	30 99.9
Psychotherapy	2 6.7	11 36.7	9 30.0	4 13.3	2 6.7	2 6.7	30 100.1
In group living arrangements, how important is individual partici- pation in development of house rules	12 40.0	9 30.0	4 13.3	5 16.7	0 0	0 0	30 100.1
Comfortable, attractive facility	4 13.3	8 26.7	14 46.7	3 10.0	0 0	1 3.3	30 100.0

APPENDIX D

LETTER TO STATE MENTAL HEALTH DEPARTMENTS
MENTAL HEALTH DIVISION

DEPARTMENT OF HUMAN RESOURCES

309 SW. FOURTH AVENUE • • PORTLAND, OREGON • • 97204

ROBERT W. STRAUB
 GOVERNOR

J. D. BRAY, M.D.
 Division Administrator

DEPARTMENT OF
 HUMAN RESOURCES

CLEIGHTON PENWELL
 Director

DIVISIONS
 Children's Services
 Corrections
 Employment
 Health
 Mental Health
 Special Programs
 Vocational Rehabilitation
 Welfare

December 1, 1975

Dear Mental Health Administrator:

I am one of three graduate Social Work students at Portland State University who are conducting an exploratory study for the Oregon Mental Health Division on the needs of ex-mental patients in this area. We are particularly interested in the living situations of ex-patients and how this affects both recidivism rates and successful re-entry into the community. It is our belief that there is a direct correlation between post-hospital living situations and community adjustment or readmittance.

Our study will include a needs assessment based on interviews with patients and mental health professionals, a survey of existing resources, both here and elsewhere, and conclude with recommendations. As part of our exploration of existing resources, we are contacting state mental health associations for information in this area. We would appreciate any information on group homes, halfway houses, or other living situations for ex-psychiatric patients that you could share with us. Possibly you have already undertaken this investigation in your state or have established successful post-hospital environments that would serve as models for other areas. We would greatly appreciate your assistance and will gladly share our conclusions with you in return.

Thank you for your cooperation.

Kathleen McCarthy
 School of Social Work
 Portland State University
 P.O. Box 751
 Portland, Oregon 97207

APPENDIX E

RESPONDENTS TO REQUESTS FOR
INFORMATION FROM STATES

James V. Laney
Community Programs Chief
State of Alabama
Department of Mental Health
502 Washington Avenue
Montgomery, Alabama 36104

Mrs. Alice Molholm, ACSW
Director, Social Service Department
Little Rock Hospital
4313 West Markham Street
Little Rock, Arkansas 72201

David Winfrey
Regional Coordinator
Division of Mental Health
4150 South Lowell Boulevard
Denver, Colorado

Myron Rockmore, ACSW
Director, Psychiatric Social Service
Department of Mental Health
90 Washington Street
Hartford, Connecticut 06115

Tom Earles, Chief
Supportive Living Unit
Division of Mental Health and Mental Retardation
47 Trinity Avenue, S.W.
Atlanta, Georgia 30334

Patricia Kawaa, R.N.
State of Hawaii
Department of Mental Health
P.O. Box 3378
Honolulu, Hawaii 96801

Director
State of Maine
Department of Mental Health and Corrections
State Office Building
Augusta, Maine 04330

Mary R. Love
Director of Community Residences
Department of Mental Health
190 Portland Street
Boston, Massachusetts 02114

Timothy Hawley
Program Evaluation Specialist
Missouri Department of Mental Health
St. Louis State Hospital
5400 Arsenal Street
St. Louis, Missouri 63139

Patricia D. Johnson
Assistant Administrator
New Mexico Department of Hospitals and Institutions
Community Services Division
505 Don Gaspar Avenue
Santa Fe, New Mexico 87503

Robert Gilson
Associate Program Analyst
Department of Mental Hygiene
44 Holland Avenue
Albany, New York 12229

William E. Thomas, Ph.D.
Chief, Adult Services
Division of Mental Health Services
325 North Salisbury Street
Raleigh, North Carolina 27611

Elizabeth K. Stern, ACSW
Transitional Service Program Administrator
State of Ohio
Department of Mental Health and Mental Retardation
2929 Kenny Road
Columbus, Ohio 43221

Sandra Holoka
Consultant for Community Placement Programs
Bureau of Mental Health Programs
Health and Welfare Building
Harrisburg, Pennsylvania 17120

Dennis E. Angelini, Ph.D.
Assistant Director for Mental Health
Department of Mental Health, Retardation, and Hospitals
Division of Mental Health
600 New London Avenue
Cranston, Rhode Island 02920

William S. Hall, M.D.
State Commissioner of Mental Health
South Carolina Department of Mental Health
P.O. Box 485
2414 Bull Street
Columbia, South Carolina 29202

Adolf Supak
Administrative Resident for Mental Health Services
Texas Department of Mental Health and Mental Retardation
Box 12668, Capitol Station
Austin, Texas 78711

Isabel M. Aird
Information Director
Department of Mental Health and Retardation
P.O. Box 1797
Richmond, Virginia 23214

W.E. Lehman
Program Administrator
Bureau of Mental Health
Community Services Division
P.O. Box 1788
Olympia, Washington 98504

APPENDIX F

GROUP HOME PROPOSAL: GLENN MAYNARD, PUBLIC WELFARE

INTRODUCTION

One of the responsibilities of a Public Welfare service worker is the development and implementation of alternate community care plans for M.E.D. clients. This involves planning and implementing social services with individuals being discharged from psychiatric facilities as well as those already in the community who are involved in a community mental health program. Frequently, the central portion of this process is the locating of an appropriate living situation. Those clients who are placed in a living situation appropriate to their need seem to be far more successful at remaining in the community. The most difficult individuals to place are the young adult mental health patients. Frequently, these people are placed in room and board settings which provide no social services; individual apartments; or in Group Foster Homes which have mixed populations of mentally ill, mentally retarded, and aged residents. When a young adult is placed in one of these settings, the common result is that the person either shows no improvement and remains dependent, or a crisis develops around the unmet need and the person is re-hospitalized.

PROBLEM

It appears that this group of young adult M.E.D. clients have a specific set of needs which are not being met by the existing resources in the Portland area. Discussions with other service workers and social workers at local mental health facilities support this idea. Individuals within this group are being placed in living situations which are inadequate to their needs. The consensus of opinion is that there is a great need for a treatment oriented group home which would meet the needs of young adult M.E.D. clients.

BACKGROUND

While it was generally agreed that this group exists and that their needs are not being met, there was no specific information about the group or what their needs are. Therefore, an attempt to identify this population and their needs was launched. Additionally, an assessment of the level of community support for a program aimed at meeting these needs was made.

The initial step was the development of a criteria by which to identify the population (attachment #1). Next, the catchment area was defined as the area usually thought of as Southeast Portland. Geographically, the area extends from East Burnside on the north to the county line on the south and from the Willamette River on the west to 82nd Avenue on the east. Within this area are located Woodland Park Mental Health

Center, an acute psychiatric care facility and Portland Adventist Hospital, which also provides inpatient and outpatient services through Mt. Tabor Personal and Family Services. Located adjacent to this area and serving many residents within these boundaries is Providence Medical Center, which provides both inpatient and outpatient mental health services. The area is also served by a Multnomah County Mental Health Clinic.

The next step was to make contact with the mental health facilities serving this area. The purpose of these contacts was two-fold: how many people did they see who met the screening criteria previously established and what is the level of support for the establishment of a facility to serve these individuals.

In response to the request for specific numbers of clients fitting this criteria, Providence Medical Center and Portland Adventist Hospital each estimated that they would have four clients per month needing these services. Woodland Park Mental Health Center provided concrete statistics. During the month of November 1975 the social service department at the hospital worked with fourteen clients who fit the criteria and who were not placed in an appropriate living situation. Additionally, there were another five clients receiving services through the Southeast Portland Adult Services Program who were also in need of these services. This amounts to a total of twenty-seven individuals during November 1975 who met the criteria and who were receiving mental health services in the Southeast Portland catchment area.

Secondly, these contacts indicated a high level of support for the establishment of a program to meet the needs of young adult M.E.D. clients. Providence Medical Center, Portland Adventist Hospital and Woodland Park Mental Health Center each wrote letters in support of such a program. Additionally, seven members of the medical staff at Woodland Park Mental Health Center expressed a willingness to serve as consultants to such a program (attachments #'s 2, 3, 4, 5, 6).

CONCLUSIONS

This investigation shows that there is a significant group of mental health patients in the 18-35 year-old range whose need for a treatment oriented living situation is not being met. Although the data collected is extremely limited, it does demonstrate that such a group exists and what needs should be met in a living situation. It should be pointed out that the data collected represents only a small portion of the Portland Metropolitan area. No statistics are included from Dammasch, UOHSC, Holladay Park Hospital, Multnomah County Mental Health Clinics, or any other Public Welfare Division Branch Office. Therefore, the data collected is only indicative of a much larger group of individuals in the metropolitan area.

The results of inadequate living situations for these individuals are

that they remain dependent for longer periods of time and recidivism is much higher due to lack of services. The ultimate result of this is that the overall cost of caring for an individual under present conditions is much higher than if the person were in an appropriate living situation. The cost of caring for a person in a state institution is approximately \$1100/month. The cost of care in a private hospital is approximately \$150/day. The cost of maintaining a person in the community would be less than half the cost of institutionalization.

Finally, it has been shown that there is a high level of community support for a program to meet the needs of young adult M.E.D. clients. The mental health facilities within the catchment area, as well as psychiatrists and psychologists in private practice have stated their support for such a program. A program to provide an appropriate living situation for this group would work well with existing mental health programs and would substantially improve the overall effectiveness of service to this client population.

PROPOSAL

A private non-profit corporation should be established to develop and administer a group care home with the following purpose: "to provide residential services in support of and as an adjunct to existing community mental health services, to facilitate the return of young M.E.D. institutionalized adults to the community, and to provide an alternative to institutionalization."

The facility would be staffed by an administrator, a program coordinator, a cook, and house managers. Residents would be individuals who meet the previously established screening criteria (attachment #1). Additionally, the residents should have the potential to live independently in the future. While it is not necessary that the person be potentially economically independent, they should have the potential to live and maintain themselves in their own apartment.

Therapeutic services would be provided in three ways. First, it is assumed that residents would be involved in a community mental health program or under the treatment of a psychiatrist or psychologist. Community mental health programs and private practitioners can provide counseling and medication services to residents. Secondly would be therapeutic services within the home. These would fall into the areas of socialization, development of self-care skills, emotional support, and supervision of medication. The staff of the group care home would work closely with psychiatrists, psychologist, and community mental health program staff. Services within the home would complement those being provided by private practitioners or community mental health programs, so that the therapeutic needs of the residents were being met. Thirdly, psychiatrists and psychologists would work with the group home in a consultative capacity. They would be involved in assessing a potential resident's suitability for the program, planning the program

and services offered in the home, and providing inservice training for staff. They would also be available to consult with staff regarding individual residents.

The above proposal is an outline of a suggested program model. The actual program would be developed in much greater detail by the board of directors, providing that funding sources for the operation of such a facility exist.

SCREENING CRITERIA FOR M.E.D. GROUP CARE HOME

- I. Receiving or potentially eligible for SSI, OSIP, or GA.
- II. 18 through 35 years old.
- III. Being discharged from a psychiatric
current community mental health patient.
- IV. Need for one or more of the following services:
 - A. Supervision of medication
 - B. Supervision of behavior
 - C. Development of self-care skills
 - D. Socialization
 - E. Emotional support

woodland park mental health center

1400 southeast umarilla streer
portland, oregon 97202
telephone 503/234-5353

145

December 17, 1975

Mr. Glenn Maynard
Public Welfare Division
Multnomah County- Southeast
P.O. Box 14785
Portland, Oregon 97214

Dear Glenn,

As a social worker in a psychiatric setting, I have become very aware of a lack of living situation resources which are available for people leaving an acute care setting and returning to the community. Often patients are forced into returning to the same setting which may have been a precipitating cause in their need to seek help or to a setting which doesn't provide the emotional support that is so important after hospitalization. Many of our patients lack financial resources and are referred to welfare for assistance and help with living arrangements. Although a great deal of time and energy may be spent trying to make appropriate arrangements, the resources are often not available within the community.

For the purpose of statistical information regarding housing, social services tracked those patients who were referred for structured living situations during November. We received 19 referrals. Of those 19, 12 were diagnosed psychotic. Six of them were women between the ages 18-30 with the median age of 21½. The remaining 13 male patients ranged in age from 18-48 and their median age was 35. The following indicates their financial resources: general assistance - 10; SSI - 3; Social Security Disability - 2 and private - 3.

Of the patients referred, 2 patients were transferred to Dammasch State Hospital and one was transferred to the University of Oregon Medical School. Three patients went to appropriate room and boards and four were discharged to relatives awaiting placement. The remaining patients were advised to seek a structured living situation but chose other alternatives.

In November the Social Service department sent a memo to our 19 member medical staff briefly describing that Public Welfare was investigating the possibility of sponsoring a group care home for young adults discharged from psychiatric hospitals. In the memo we also asked the doctors if they would be willing to be a consultant should funding be available and a group care home established. Recognizing the need for such facilities, seven psychiatrists and psychologists indicated interest in being involved.

Having seen the lack of available resources in the community I certainly see the value of establishing a group home and hope that this information and the support that our doctors are willing to give lends some support to your efforts in establishing another resource.

Sincerely yours,

Kathy Kato

Kathy M. Kato, ACSW
Director of Social Services

PROVIDENCE¹⁴⁷
MEDICAL CENTER

700 N.E. 47TH AVENUE PORTLAND, OREGON 97213 PHONE (503) 234-8211

13 November 1975

Glen Maynard
Department of Human Resources
Southeast Branch PWD
4520 S. E. Belmont
Portland, Oregon 97215

Dear Mr. Maynard:

I am writing at this time to support your efforts in proposing the establishment of a group care facility in the Portland area.

As a private practitioner of psychiatry in Portland and as the Associate Director of Mental Health Services at Providence Medical Center, I am certainly aware of the tremendous lack of such care facilities within our community. We are all interested in assuring adequate care and follow-up for those patients who need such services following discharge from psychiatric patient facilities. I can assure you from my experience that any success in increasing the number of this type of facility within our community would be greeted with enthusiasm and active use by those people requiring such services.

Sincerely,

W. D. Zieverink, M. D.
Associate Director
Mental Health Services

mg

PROVIDENCE¹⁴⁸
MEDICAL CENTER

700 N.E. 47TH AVENUE PORTLAND, OREGON 97213 PHONE (503) 234-8211

November 11, 1975

Mr. Glenn Maynard
Service Worker
Southeast Branch
Multnomah County Public Welfare
4520 S.E. Belmont
Portland, Oregon 97215

Dear Glenn,

I was very pleased to hear that you are pursuing the establishment of a group care facility for men and women, age 18 to 35, recently discharged from psychiatric facilities.

As you know Providence Medical Center has a 19 bed, acute, short-term psychiatric unit. For many of the patients we treat, the post-discharge placement is critical in maintaining the gains made during hospitalization and to further the growth of the individual. This demands a living situation that goes beyond mere provision of food and shelter but ideally offers a program geared to the needs of the individual offering structure, support, supervision and encouragement.

My understanding is your proposed facility would offer such a program. I heartily endorse your endeavor. Rarely does a week go by that we are not forced to make an unsatisfactory placement because there are inadequate programs available. I would estimate that our program places about 50 persons a year that could use a facility such as the one you propose.

We wish you the best of luck in your pursuit and if we can assist you in any way please let us know.

Sincerely,

Dorothy Bateman, ACSW
Social Worker,
Mental Health Services

December 18, 1975

Mr. Glen Maynard
S.E. Welfare Branch Office
PO Box 14785
Portland, OR 97215

Re: GROUP CARE HOME

Dear Mr. Maynard:

This letter is in response to your request that we share our experience regarding efforts to place mental health in-patients in appropriate post-hospital living situations and the problems encountered in doing so. I'm happy to comply with your request because our experience confirms a fact that there are significant inadequacies both quantitatively and qualitatively re living facilities for post-hospital mental health patients. There are a limited number of good room and board facilities in the south-east and northeast portions of the city and group homes specializing in mental health are virtually non-existent.

On the average we have three to four young adult and adult mental health patients per month who because of personal problems or family environment would benefit by being in a treatment oriented group home. At best we are able to place these individuals in room and board facilities that frequently are inadequate to meet the individuals needs. A significant number of patients can not handle an independent living situation but need supervision of medication and behavior, and require assistance in developing self-help skills in a supportive living environment. The problem becomes even greater if a patient has inadequate financial backing to pay for good care. Hospital readmission rates are high because patients are placed in inadequate living situations. We believe that these patients would have remained in the community had they initially been placed in qualified group home settings.

Mt. Tabor Personal and Family Services

300 S.E. 10th • Portland, OR 97214 • 525-1234

Mr. Glen Maynard
December 18, 1975
page 2

Without question there is a need in the Portland area for group homes that offer a quality care program in mental health and Mt. Tabor Personal and Family Services with Portland Adventist Hospital certainly support your endeavor to establish such a facility.

Sincerely,

Robert Wolgamott, M.D., Psychiatrist
Director of Mt. Tabor Personal and Family Services

Ed Kasner, M.S.W.
Director of Social Work Department
Portland Adventist Hospital

cja

19 November 1975

Glen Maynard
Department of Human Resources
Southeast Branch PWD
4520 S. E. Belmont
Portland, Oregon 97215

Dear Mr. Maynard:

Ms. Dorothy Bateman, psychiatric social worker at Providence Medical Center, has brought to my attention that you are applying for a grant to establish a group care facility for patients who have recently been discharged from a psychiatric inpatient facility. I am writing this letter to support your proposal.

Having been involved in psychiatric treatment primarily of an inpatient nature in Portland since 1969, I have been deeply concerned about the dearth of such facilities in the Portland area. We have made great strides in improving the quality of short-term inpatient care, but we have not made equal strides in providing partial care and group home facilities that approach our level of technical sophistication in 1975. I would support your proposal for the following reasons: (1) There are simply not enough facilities of this nature in the Portland area. (2) We see substantial numbers of patient who could be managed without being admitted if they had an appropriate facility in which to live. Your group home concept sounds like it would nicely fill that need. Hospitalization can frequently be reduced in length if a person could go to such a home for a period of time following hospitalization. (3) Such a facility would be a nice complement to a day treatment program such as we have at Providence Medical Center. A significant number of patients could be treated at that program during the day and live at the group home at night. Cost of our day treatment program is currently one-third the cost of inpatient treatment on a per diem basis; since

Mr. Maynard

2

19 November 1975

many patients would not need to come to the program five full days per week, the actual cost of day treatment would fall more in the range of one-fifth to one-tenth that of inpatient hospitalization. The cost of a group home would be minimal compared to the difference between inpatient and day treatment costs.

Please let me know if we at Providence Medical Center can do anything else to be supportive of your proposal. It would greatly enhance our ability to provide high quality medical care in a way that would be likely to reduce recidivism and help the patient make a good adjustment to a semblance of productive life.

Sincerely yours,

Kent E. Neff
Kent E. Neff, M. D.
Director
Mental Health Services

mg