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Residential Options for the Institutionalized Chronically Mentally Ill: The Impact of Psychosis on Choice

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AN ABSTRACT OF THE THESIS OF Richard James Stanek for the
Masters of Science in Psychology presented March 18, 1993.

Title: Residential Options for the Institutionalized
Chronically Mentally Ill: The Impact of Psychosis
on Choice

APPROVED BY THE MEMBERS OF THE THESIS COMMITTEE:

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Discharge planning for hospitalized chronically
mentally ill usually involves only verbal descriptions of
community residential options. Psychosis often impairs
ability to conceptualize abstract information, and quality
of the choice process may be poor without describing options
in concrete form, i.e., using written descriptions and

photographs. A random sample ($N = 90$) of Dammasch State Hospital (Wilsonville, Oregon) patient population, comprising persons diagnosed schizophrenic, schizoaffective, organic mental disorder, and bipolar, were assigned to three treatment groups, asked to rank six community residential options suited for them when they were ready to leave the hospital. The three treatment groups were presented the same set of residential options, but the manner of presentation of options was manipulated: first group received verbal descriptions, second group received verbal descriptions with placards containing printed highlights of descriptions, third group received verbal descriptions, printed descriptions, and five photographs of each type of residential option. After ranking the options, respondents were asked how difficult it was to make their choices: very difficult, kind of difficult, not very difficult. Finally, an open-ended question was asked, "What guided you in making your choices?" Respondents' social workers were asked to rank same six residential options for each respondent. Chi-square and Kruskal-Wallis tests were computed for treatment groups-by-respondents' choices for first through sixth choice with no significance found. "Difficulty of Choice"-by-treatment group analyses found no significance using Kruskal-Wallis test, and trend toward significance using chi-square. Content analysis of open-ended question, "What guided you . . ." yielded seven categories of answers, and

chi-square of "What guided you"-by-respondents' first choice of residential setting was significant. "Experience" and "Privacy and Independence" were most influential factors from content analysis, but only trends toward significance were found in chi-square, cross-tabulating them by treatment group. Since cross-tabulation of respondents'-by-social workers' choices showed no significance, six rankings were collapsed into three and significance was found for supported housing option (respondents and social workers choosing it in common third or fourth) for total sample. Other significance was found in verbal treatment group for homeless shelter (chosen in common fifth or sixth), and for supported housing (chosen in common third or fourth). Rank correlations of respondents' and social workers' choices for total sample found significant negative relationship for room and board option. Rank correlations of choices by treatment group found significant negative relationship for room and board in the verbal treatment group; found significant positive relationship for residential care facility in the verbal/written treatment group; found significant negative relationship for room and board option in the verbal/written/visual treatment group. Abstraction deficits evidently do not affect the way chronically mentally ill persons choose residential options. The chronically mentally ill also do not find choosing a residential placement any more or less difficult given the presentation

of written and visual descriptions in addition to verbal description. Given excess of "not very difficult" answers to "difficulty" question, validity of "difficulty" question to detect quality of choice process is questionable. Better outcome question may have been, "How satisfied are you with you choices?". Given distribution of respondents' and social workers' choices, compromise between independent living and residential care facility is suggested in choice of supported housing program.

RESIDENTIAL OPTIONS FOR THE INSTITUTIONALIZED CHRONICALLY
MENTALLY ILL: THE IMPACT OF PSYCHOSIS ON CHOICE

by

RICHARD JAMES STANEK

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requirements for the degree of

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INTRODUCTION

The deinstitutionalization of people from mental hospitals in the western world has required innovations of the community mental health system. Whereas the hospital had been the treatment of choice when society was confronted with the dilemma of the mentally ill person causing a public scene, such removal from the world has been recognized by many mental health professionals as a cowardly policy that ignores the civil rights of the mentally disabled. Discharge from the hospital has been a rocky and often nightmarish circumstance for persons with poor, or absent, social skills. They find themselves forced to integrate into a society which demands verbal accountability, planfulness, and goal setting, often in a complicated urban milieu. Hospital recidivism and community crises among the deinstitutionalized have stimulated mental health professionals to develop various psychosocial rehabilitation models which aim to support the relocation of these persons humanely and aid in their ongoing stability. The challenge of independent living for a population which suffers from delusional beliefs, paranoia, depression, confusion, mania, and suicidal thoughts has necessitated the development of a transitional approach to integrating the psychotic person into the community. In order to proceed ethically in aiding

the mentally ill to live in society, an understanding of the individual's frame of reference, as completely as that is possible, must be undertaken. Without such an effort, the aid rendered becomes, to one degree or another, authoritarian. That is, often the individual is directed to live in a specific locale as determined appropriate by the mental health clinician, or a program of rehabilitation is devised which prescribes particular treatment groups and levels of therapy.

In the past, psychologists have often studied human behavior through the study of the abnormal. Thus, normal behavior is understood by careful examination and successful treatment of aberrant behavior under a particular philosophical orientation to motivation and personality. Successes in treatment then support the application of a theory of human behavior to normal, healthy people. It then would seem to follow that the development and application of psychological interventions for persons suffering from mental illness should proceed under conditions that respect their autonomy and take into consideration their opinions and inclinations. Without such a premise, developing theories of human behavior cannot claim validity outside of the condition of mental illness. A status bestowed onto mentally ill persons different from that granted healthy persons would appear to be paradoxical since the intention of psychological theories and treatment is to aid the

mentally ill person in regaining healthy living and coping skills in order to feel normal and able to participate in the community. The point is, mentally ill persons should be regarded as potentially functional, normal persons, and the orientation of the mental health profession should be one of peer support, advocacy, and equality. When mental health interventions fail to successfully accommodate persons in the community, their validity as treatment philosophies should be seriously questioned.

The classical approach to mental illness is something akin to a classical medical model paradigm. The mentally ill person is treated by a professional who has in his/her possession a system of knowledge to evaluate and diagnose the troubled individual. Once the problem is identified, the professional accesses or develops a relevant treatment program and attempts to engage the individual's participation. Often the relationship is cooperative wherein the troubled individual grants the clinician the authority to guide him/her through a course of treatment aimed at relieving the internal symptoms and normalizing the external circumstances. But often the relationship becomes conflicted due to the inexact science of psychological assessment and application of limited treatment choices.

Models which involve the mentally ill population in their own treatment counters an orientation which directs and assumes the decision making tasks of the identified

patient. Many of these programs, evolving over the past three decades, have been stimulated by the large-scale discharge of mental patients in the 60's and 70's and the continued closure and downscaling of mental hospitals in the 80's and 90's. Several of these models are of interest for their common client-oriented foundation. First, the psychiatric rehabilitation model is in the forefront of involving the troubled person in developing a program which reintegrates him/her into the community at his/her own speed and in directions which the person can envision and choose as realistic. Second, a strong advocacy and empowerment movement seeks to transform the management of the identified mentally ill person in the community so that services are client-driven and the problem is framed as a lack of community resources rather than the individual's inability to function in a limited choice environment. Third, the consumer movement embraces both the psychiatric rehabilitation spirit and the advocacy empowerment political view and has designed programs which help the mentally ill through peer support.

Breaking the institutional barrier is the first step on the path of rehabilitation and recovery from a major mental illness which has resulted in admission to a mental hospital. Kincheloe and Hagar (1974) speak of the goal of therapy with institutionalized chronically mentally ill people as one of widening:

. . . the range of possibilities and options for the person, while keeping in mind a realistic view of the internal and external constraints that exist for a particular individual. Schizophrenic persons have often developed so little choice on the scale of possible choices that almost everything they do has a dysfunctional effect, with a consequent self-reinforcing spiral of deterioration. (p. 9)

In the hospital, the mentally ill person becomes progressively dependent when the environment is controlled. For example, when food is ingested, the manner of social/sexual interactions, recreational activity, curfew and sleeping times, and freedom of movement are all dictated by hospital routine. All of this contributes regressively to an already poor repertoire of community living skills, which:

. . . process then evolves more and more toward a problem of placement or disposition rather than an opportunity for change and learning. The difficulty that he and his community has with adjustment to each other seems directly related to the length of his hospitalization. (Kincheloe, et al., 1974, p. 14)

The authors stress the importance of recognizing the ecological dynamics involved in returning a person to his/her community. Programs which help the patient take into account all the people and the physical attributes of the setting which will affect and be affected by the patient minimize the chance of rehospitalization. Kincheloe, et al., write that:

In the actual selection, every effort should be made to give the client as much self-determination as possible, such as visiting suitable places so that he may choose the one most to his liking. Choice, always a crucial factor in placement, should be present in any area possible, but the therapist must make certain the choice truly belongs to the client or it should not be presented that way. (p. 81)

DEINSTITUTIONALIZATION AND RESIDENTIAL PROGRAMS

The care of the mentally ill in this country has come a long way since the decade of the 50's. Markson (1985) describes large mini-cities, self-contained within a compound of buildings and grounds where 20,000 patients lived (Pilgrim State Hospital in New York State) where the average length of stay for an individual was 1,600 days, and where the staff (from psychiatric to janitorial) to patient ratio was one to three (compared to 1.5 staff to one patient in the mental hospitals of 1980). Authors of that time describe "institutional neurosis" and "social breakdown syndrome" developing in residents of these facilities, independent of their original psychopathology, because everything that patients had in the way of material, social, and personal living resources were taken away, and survival skills atrophied from lack of use (Markson, 1985).

The call for the closing or reducing the size of mental hospitals in the early 60's had been followed with the passage of the Community Mental Health Act in 1963, but funding for a supportive residential component was not forthcoming. The hospitals discharged large numbers of their inpatients to congregate-care placements, creating what many mental health professionals claimed was but the same problem, a warehousing of mentally disabled persons,

but dispersed out in the midst of the community. It has been demonstrated that relocation of patients from mental hospitals which provide an environment of total care and dependence-building to an environment of independence with expectations that they will survive in a complicated world is doomed to failure without regular, if not daily, support and sheltering (Carpenter, 1978). Thus, transitional residences have been developed which aid the person in managing community resources, daily living needs, and personal power deficits.

Though the mental hospital census was successfully reduced by two-thirds over the period from 1965 to 1985 (Shadoan, 1985), the readmission rate had doubled, with half of those discharged coming back to the hospital within a year. Shadoan points out that follow-up funding of the Community Mental Health Center Act of 1963 was gutted at both the federal as well as at state and local levels, and in addition, the legislation did not go far enough in addressing the clinical needs of the long-term patient. "Probably no area of the community mental health movement has drawn more criticism than the lack of supervised living facilities" (Shadoan, 1985, p. 639). Faced with this dilemma, the San Francisco Bay Area community mental health programs evolved a continuum of care to support the deinstitutionalized mental patient, with three basic levels of residential treatment. At the top level, high intensity

treatment facilities involve a high professional staff to patient ratio with the aim of both placing difficult patients and also stabilizing crises in the community and preventing rehospitalization. At this level there are also halfway houses providing much structure and support for long-term community living, with little expectation of significant rehabilitation, but nevertheless stabilization in the community. The middle level of care involves the board and care home, with a low non-professional staff to patient ratio, little connection to the mental health clinic, but nevertheless playing an important role in the provision of housing that is tolerant of the bizarre behavior and problems of living so characteristic of the chronically mentally ill person. Interestingly, the third level of care involves increased programming and connection to the local mental health clinic. These facilities are cooperative living apartments, semi-independent living programs, and totally independent settings, all of which involve outreach and guidance from clinicians (Shadoan, 1985).

In the decades of the 60's and 70's the residential program of choice for the deinstitutionalized mental patient was the "halfway house". These facilities sometimes provided varying degrees of staffed support and programming, but often very little more than food and shelter. Fear arose that the continued discharge of mental patients into

the community would create an overwhelming demand for halfway house type residences, which would in turn generate an industry exploiting this need but providing only minimal transitional services, creating a "back ward" in the community. In the midst of this uncertain climate, the work of Fairweather, Sanders, Maynard, & Cressler (1969; cited in Rappaport, 1977) cast a new light on mental health aftercare in that it rehabilitated the mentally ill in the community at a fraction of the cost of hospitalization. Patients were empowered to become active in their integration into society by living in a lodge composed of their peers from hospital days. The running of the lodge was accomplished by the assistance of hospital staff who supervised the establishment of living rules and the development of a work program set up as a viable business venture. When this alternative society was established, a hands off approach ensued and the residents were expected to provide social and psychological support to each other.

Patients placed in the lodge program spent 80 percent of their time in the community for the 40 month evaluation period following discharge, compared to a control group of patients discharged to the available traditional residential programs and outpatient care who spent 20 percent of their time in the community. Rappaport (1977) summarizes another important finding of Fairweather's work, stating that:

. . . in terms of both the self-report of patients and of significant others in their life, few

differences in psychosocial adjustment between the experimental and control groups were found. The major effect of the lodge was on length of stay and productivity in the community. The major implication seems to be that the social systems in which individuals find themselves may be a much more potent factor for community adjustment than 'psychological well-being'. (p. 282)

He also points out that the most frequently stated reason by control group patients for returning to the hospital was social pressure, which reason was non-existent among lodge participants. The lodge residents tolerated and took care of their own, which strongly justifies "turning our thinking about care for chronic patients away from intrapsychic variables and toward work with significant others and the creation of settings" (Rappaport, 1977, p. 282). This study suggests that for the chronically mentally ill self-governance and autonomy created a special social status environment with access to resources and the freedom to develop strengths and abilities. Further integration into society could proceed per the individual's choice and pace, either into halfway house type facilities or independent living. A sense of ownership in the ex-patient's transition to community and the development of a status quo environment, albeit a microcosm of the community at large, promoted a sense of normality and replaced the stigma which mental illness, and especially a mental hospital history draws for society.

In Australia a similar scheme was developed to provide transition from severely institutionalized patients to the

community (Wood and Einodor, 1973). Groups of three to six patients were formed in the hospital, staff located a house in the community and rented it in the name of one of the patients, and funds were pooled and furniture and kitchen necessities purchased. Follow-up care and support was provided by the hospital for up to three hours per day, which included nursing supervision and visiting staff teaching basic skills and problem solving by example and in discussion groups. The hospital continued in the role of outpatient provider as long as the ex-patients remained in the group home. This model has advantages over board-and-care homes in that skills are pooled and prosocial behavior is encouraged and developed, daily living expenses are shared making life more comfortable on low or limited incomes, and connection with psychiatric care is secured but not invasive.

An inpatient program in Buffalo, New York parallels this concept of careful transition to the community with the development of a "quarterway house" (Mann, 1976). A separate building away from the hospital was set up in which candidates were placed who were psychiatrically stable and capable of self-monitoring their prescribed medications. Participants were given their own room, and individual treatment plans were developed which aided patients in locating housing, jobs, and public assistance. Mann (1976) explains that "treatment was aimed at overcoming the

residents' dependency needs and encouraging them to assume personal responsibility to hasten their social rehabilitation" (p. 647). The quarterway house residents conducted community meetings to facilitate the running of the program, and there were therapy groups, task groups, organized socialization activities, a sheltered occupational workshop, as well as individual counseling, all organized by the hospital staff. Once transition to the community was accomplished, continued outpatient follow-up was provided by hospital counselors, though the contact averaged only about two visits per month per ex-patient. This program appeared to be successful in that after one year of the program's operation over 100 patients had moved through the quarterway house and half of them were working in the community, with a recidivism rate of less than ten percent. The author noted that the major problem with the scheme concerned the lack of community residential resources and vocational training programs to receive the discharged patients.

Perhaps following in the footsteps of the Fairweather Lodge concept, Agnews State Hospital in San Jose, California adopted the concept of grouping patients into communities inside the hospital in preparation for discharge (Lamb, 1968). Peer groups were organized by regionalizing the hospital wards by county, which it is believed:

. . . facilitates the unit's staff establishing enduring and meaningful ties with the network of community organizations which can serve the mentally ill patient when he returns to the

community. In addition, the patient finds people on the unit from his own home community and feels less isolated. (Lamb, 1968, p. 38)

Lamb focused on a defined group, the "chronic" (hospitalized one year or more), and compared the composition of one of the regionalized wards at the beginning and end of an 18 month period, and tracked the outcomes of those patients who were discharged during that period. It was found that although there had been a 26.5% decrease in the chronic population, the longer the patients had been in hospital the less likely they were able to return to the community. In addition, the longer the discharged patients had been hospitalized, the more likely it was they were to be living in board-and-care or halfway houses. Lamb contends that the success of community living depended on the treatment and support received in the community, rather than extended preparation in hospital. Early discharge policy has been shown to prevent institutionalism and thus chronic disability, but there is a careful balance that must be struck between adequate preparation and extended stay (Lamb, 1968).

In England the concept of developing transitional housing programs near mental hospitals where day treatment support is provided is called the "hospital-hostel". Pryce (1977) describes the implementation of a rehabilitation unit specifically designed to serve as a ward for patients targeted for discharge into the community, located in an old

mansion on a 24 acre grounds. The author noted that there was an excess (half the hospital population) of potential patients for the hospital-hostel, many of whom had been involved over the previous five years in rehabilitation programs in an attempt to prepare them for discharge. The quality of care in the hospital-hostel far exceeded that of the possible community hostels (halfway houses) in nursing and supervisory care staff, and during the day the majority of patients were bussed back to the hospital for occupational and recreational programming. Pryce found that the hospital-hostels were most effective for chronic patients who had been in hospital for two years or longer, but who were not also physically handicapped or suffering extreme symptoms of mental illness. Pryce (1977) reports:

Experience over two years at the experimental hostel indicated that it would be possible to care for two-thirds of the hospital's long-stay patients outside a mental hospital, provided hostels were as well staffed as a fairly high dependency long-stay ward and there was access by bus to a day-hospital. (p. 342)

The author also points out that without adequate residential and occupational support programs in the community, discharge will result in crisis and readmission. The hospital-hostel encompasses a philosophy of social rehabilitation as key to keeping the mentally ill stable in the community, and "the *social treatment* of the handicapped requires a range of social settings, so that each individual can be placed in the social environment best suited to

maximize his performance and to minimize his symptoms and disabilities" (Pryce, 1977, p. 342). This management of the population is viewed as in the best interests of the mentally ill, with efforts at rehabilitation always possible, and social care always present.

Predischarge preparation for patients and adequate effective community services are combined in a social learning program in the state of New York called the Bayview Manor (Lieberman, Beck, & Trujillo, 1982). What was a 229-bed room-and-board facility was transformed into an inpatient social and vocational rehabilitation service offering all residents the opportunity to earn tokens redeemable for non-essential luxury-type goods and services. Tokens were earned for successful follow through with treatment plans which had been developed cooperatively between resident and staff. Lieberman, et al., (1982) write:

The token economy provided residents with both consensually acceptable motivators and rules for interacting in most areas of their lives. The skills training component taught residents how to optimize their gains within the token economy, and the social psychological component structured social relationships not covered by the token economy. (p. 42)

The study points out that in the evening once staffing levels had dropped, a different order took over in which a black market on tokens operated and behaviors encouraged during the day occurred less frequently. The attempt to manipulate social behavior through rewards did not reach all

residents, and the authors suggest that a more elaborate, tightly controlled system would be necessary to address this minority. The residential staff had some resistance to the programming, feeling that their roles had changed from caregiver to teacher. And the staff at the hospital, who continued to provide direct psychiatric care for residents at the Bayview Manor, felt that the atmosphere in the program had become negative, conditional, and more distant. Residents themselves participated actively in a community meeting to initiate and participate in program changes, as well as develop their own personal behavioral contracts. The token economy was very popular among residents, and anecdotal evidence indicated increases in self-esteem among residents. Over a year's time of tracking, less than 12 percent of the residents were rehospitalized, and 75 percent of those returned to the program within two months. The cost of housing and caring for patients in this model was a fraction of the hospital expense, though the program was not successful for younger chronic patients.

In contrast to the social learning program developed at Bayview Manor, a re-socializing program in Ontario, Canada, hoped to reintegrate patients into society by passive modeling of everyday functional activities and behaviors. But evaluation of this program showed it to be lacking in maintaining discharged mental patients in the community (Sylph & Kedward, 1977). This "approved home" program

transferred patients to private homes, an experience intended to normalize the patients' community living skills, but remained under the direct responsibility of the hospital. Following a period in the approved home, further integration into society was expected, either into independent living, or into a group or supported housing program. The approved home was compared to other levels of residential care, which included "special care" nursing and residential homes, often chosen for organically and physically impaired mentally ill individuals or for the more severely socially impaired. The authors noted that once a person was discharged into one of these special care community settings they had fewer returns to the hospital, but their social functioning deteriorated, and they had fewer and weaker contacts with family. On the other hand, the approved home residents showed improvements in social and daily living skills, and a reduction in psychotic symptoms and eccentric behavior. However, the original concept of the approved home as a transitional step back into successful independent community living was not borne out by the results as many had continuing care needs, were often rehospitalized, and were caught in a pattern of cycling back through the approved homes for numerous other attempts at community living. Sylph, et al., (1977) state:

Whatever the reasons for the inability of approved home patients to re-enter the outside society, it is clear that the approved homes have been for these patients no more of a stepping stone to the

community than special care homes are designed to be. (p. 912)

The authors conclude that the approved homes fall under the criticism other residential programs have received as being little more than alternative settings for back ward life, and that in light of this there has been the redesignation of many approved homes in Ontario as special care facilities.

A focus on the social rehabilitation needs of the institutionalized mentally ill, with attention to social interaction behaviors, was studied by Falloon & Marshall (1983). In a large residential care facility in central Los Angeles, which housed discharged mental patients, residents shared a room with another person, were provided meals, and recreational programming attempted to stimulate socialization. Residents were classified as high or low on a social interaction criterion, and then assessed on community adjustment and rehabilitation needs parameters. A year later a follow up assessment examined functioning on several social activity behaviors and attitudes, as well as noting any progress or regress in living situation or occupational status. None of the high interaction group had been rehospitalized, and most had moved on to independent living, while all of the low interaction group had remained in structured living, with a few being rehospitalized. The authors believe that the program was overstimulating for the low interaction residents, and that ". . . effective social

interaction requires more than a milieu that promotes social-contact. A minimally sufficient repertoire of interpersonal skills accompanied by adequate reinforcement for their use is crucial" (Falloon & Marshall, 1983, p. 346). They advocate an individualized psychosocial rehabilitation plan, in contrast to models which, often motivated by fiscal constraints, operate in group settings which are only beneficial to the more socially competent.

BOARD AND CARE AND IMPOVERISHED COMMUNITY LIFE

The apparent heir to the halfway house standard of the 60's was the "board and care" home, an unlicensed rooming house with a sensitivity to the population of chronically mentally ill, but providing little in the way of focused services which addressed the needs of this special population. Markson's (1985) survey of the conditions of these board and care facilities in the decade of the 70's gathered a picture of loneliness and isolation where an average day involved lying in bed, watching television, and smoking cigarettes. Few residents were regularly seen by the local mental health clinic or had any contact with relatives or friends outside the residential setting.

Markson (1985) observes that:

. . . by transferring and diverting large numbers of patients from mental hospitals into congregate, nonpsychiatric settings, we may not always have acted in their best interests. If the state hospital produced one type of iatrogenic illness, the deinstitutionalization movement may have

produced new iatrogenic strains, some of which may be as damaging. Neither the notion of right to treatment nor of least restrictive setting supports the premise that any community facility may be more appropriate than the mental hospital. (p. 53)

Research into the attitudes of the residents of board-and-care homes by Lehman, Reed and Possidente (1982) revealed a startling dissatisfaction with their living situation. Quality of life surveys were conducted on 30 large Los Angeles board-and-care homes seeking input on nine areas of the residents' community life: living situation, family, social relations, leisure activities, work, finances, legal problems and safety, health, and religion. Areas most frequently mentioned as sources of unhappiness were health, social relations, living situation and family. Under living situation, residents mentioned the lack of say in who would be their roommate, lack of choice in food, and lack of privacy. As well, respondents were asked which areas they would most like to change, and responses were consistent with the areas of dissatisfaction, with the social problems of greatest concern focused on housing difficulties, unemployment, and poor finances. Lehman's, et al., consumer-oriented perspective took the stance that:

. . . listening to what patients have to say about their lives can provide useful insights into the types of services they need and the relative importance of these services. The literature contains ample evidence that patients input in establishing treatment priorities can be essential to a beneficial outcome, particularly for chronically mentally ill persons with a multitude of problems. (p. 181)

It is concluded from this study that programs for the mentally ill need to give serious consideration to their problems of living as well as their specific psychiatric needs.

However, board-and-care homes can be designed to provide a quality of life which is stimulating, if not rehabilitating. Blaustein (1985) describes an enhanced board-and-care program in San Francisco called the Chateau Agape. The 27 bed home is privately owned, but additional staff are provided by both the state and the city to effect transition and linkage from hospital to community. Psychiatric care is provided by private psychiatrists reimbursed by state or federal medical insurance. Participation in day treatment programs in-house and by referral to the community is an expectation of continued residency, but otherwise rules of the house are minimal. Residents are chosen by the team of hospital-community staff, and the focus population has evolved towards the segment of hospitalized mentally ill termed:

. . . young adult chronic patient--the mental patient in the era of de-institutionalization, who previously would have remained in the state hospital system, but who today is discharged to the community with no skills, little ability to relate to others, impulsive and angry, refusing treatment, but medicating himself with street drugs and alcohol, and overusing the mental health system and its staff, but only from crisis to crisis. (Blaustein, 1985, p. 661)

Of the 47 residents tracked over the five year period, 75 percent had significant hospital histories. Forty-three

moved on to either other board-and-care or halfway houses, to independent living, were rehospitalized, or disappeared. Again, the cost of providing this level of support and opportunity for rehabilitation is a fraction (5 to 10 percent) of the cost of hospitalization.

Addressing the quality of life in the board-and-care facility, Trute (1986) wondered if indeed such community living represented a decentralized back ward. He cites research that emphasizes the special attention to matching ex-patients with their new living environment, and states that the role of the operator of the board-and-care facility is integral to the success of the ex-patient staying in the community. Using five different scales measuring alienation, neighbor contact, social rejection, psychiatric impairment, and social desirability, residents and operators in 27 different facilities in Winnipeg, Manitoba, Canada were sampled. Significantly, males were more alienated than females, but the social alienation of the operator was not related to the social alienation of the resident, and the attitude of the operator in regards to mental illness was not related to the level of alienation of the resident. However, the social alienation of the operator was related to the number of contacts between the resident and neighbors, as was the size of the facility, i.e., a larger facility predicated fewer neighbor contacts. Thus, "social alienation of facility operators appears to be related to

the social participation achieved by their residents" (Trute, 1986, p. 36).

The quality of care for discharged mental patients in West Germany has been studied by Kunze (1985), where the most severely symptomatic patients were found to have been placed in nursing homes, while less disabled individuals had been placed in hostels and group homes (less structured and lower staffed). Assessments of living conditions were conducted by interview on seven areas, including adequacy of outpatient after-care, social isolation, staff opinions of residents, social restrictions, unoccupied time, privacy, and poverty of possessions. Results from these interviews led the author to conclude that the most disabled ex-patients were found to be in the residences with the poorest social environment (the nursing homes). "Thus for most chronic psychiatric patients the move from hospital to residential care outside the hospital system only meant transfer from one institutionalizing situation to another" (Kunze, 1985, p. 264). Kunze cited the work of Wing and Brown (1970) who pointed out that poverty of the social environment was correlated with severity of symptoms, particularly flat affect, poverty of speech, and social withdrawal, constituting a "clinical poverty syndrome". Kunze (1985) summarizes:

It therefore appears that the relationship between mental state and institutional environment found by Wing and Brown holds equally well for an epidemiologically selected group living in various

types of community environments as it does for a selected group living in hospital wards. (p.263)

REBIRTH OF THE THERAPEUTIC COMMUNITY

In Manchester, England a program of domestic resettlement for the deinstitutionalized was developed in which long-stay psychiatric patients were rehabilitated to live with other, compatible patients in homes that were self-supporting (Soni, Soni, & Freeman, 1977). The authors suggest that "the process of institutionalization, together with the primary handicap of the illness in some cases, may have seriously and irrevocably damaged the patients' functioning as independent individuals" (Soni, et al., 1977, p. 76). The authors believed that the development of residential facilities had not kept pace with the rate at which patients were discharged from mental hospitals. A gradual diminution of the negative effects of long-term hospitalization was achieved by setting up group homes close to the hospital campus, identifying prospective candidates for discharge to these homes, and then forming inpatient quasi-family groups. These patient clusters then completed a preliminary stay at a rehabilitation unit in the hospital where practical living skills were taught in preparation for life on the outside. The person's length of stay in the hospital had no influence on the success of the group home placement, but the extent of preliminary rehabilitation, as well as psychiatric stability at time of discharge to the

group home did have a bearing on maintaining residence in the community. Soni, et al., (1977) speculate on how Wing's clinical poverty syndrome, and also Gruenberg's "social breakdown syndrome" (cited in Soni, et al., 1977) could be overcome with this community approach to social rehabilitation. An analysis of these group homes determined that successful transition to the community occurred when there was an integration of the resident into the surrounding community, which was dependent on both the tolerance of the neighborhood as well as the degree to which patients were pro-social or had been rehabilitated in hospital to community living.

Wing and Furlong (1986) have focused on the role which social disablement plays in difficulties of discharging the long-stay mental hospital population. This high-dependency group have few roots in the community via family, employment, or social network histories, and are commonly diagnosed schizophrenic. Efforts at inpatient social rehabilitation and insight-building have often been thorough, but with no improvement in social acceptability. The authors believe that the characteristics of any particular environment will have a direct effect on behavior. They focus on the quality of environmental factors as the pivotal treatment consideration for this apathetic and socially deteriorated population, stating that "the most readily influenced of the environmental factors,

both for good and harm, is the quality of social environment provided" (Wing and Furlong, 1986, p. 451).

The creation of an alternative "Community" for the dependent mentally ill is suggested, which has as its *raison d'être* the reduction of the causes of social disablement.

Wing, et al., write:

A different use of the term 'Community', explicitly with a large C, is to denote a group of people coming together because of a shared interest, in order to pursue through personal relationships and the exercise of special skills some common purpose--moral, artistic, political, or therapeutic. (p. 452)

Such a Community, The Haven, was developed in London, England. The Haven is a hostel program within the responsibility of the Friern Hospital, but located in buildings separate from the main institution. Staff and residents live in and use the same accommodations, and the mentally ill residents participate with staff in the running of the facility, including cooking, cleaning and maintenance, so that domestic management skills are gradually acquired. Graduation from the Haven Community to associated residences in the neighborhoods of the area with support links to psychiatric and rehabilitation staff is a possible further step. Particular care is centered on the individual's ability to function socially, with "numerous small advances separated by pauses for consolidation. Continuity of care is therefore vital. Ease of movement into and out of the Community is essential" (Wing & Furlong,

1986, p. 455). Residents have their own bedroom and are linked with occupational and recreational day treatment opportunities on and off site. As well, there is an on-site garden, arts center, and community center. Accommodating the needs of the intractably mentally ill and creating such a program involves the initial expenditure of healthy sums of money. But the investment of such attention to individualized treatment in a setting which makes every effort to tailor rehabilitation comes highly recommended for its visionary, humane, and civil libertarian qualities.

A discussion of the quarterway house concept in a continuum of care which aims at minimal hospital stays is presented by Ranz (1989) who has developed another kind of interim step between ward living and on-campus residency. On-campus residences provide social skills training and work opportunities on the assumption that "for more fragile or difficult patients, long-term supportive residences on hospital campuses offer a potentially better quality of life than struggling in often-hostile communities" (Ranz, p. 1191). Ranz's "Home 11" program in Orangeburg, New York, targets the difficult-to-discharge patients, 75 percent of who are diagnosed schizophrenic, before they enter the quarterway campus program. Home 11 is designed to resemble community living and allows for significantly more freedom than a hospital ward, but it also incorporates staff coverage and support that is similar to an inpatient ward.

In addition, there is an expectation that all participants in the Home 11 program will work, and a token economy functions to encourage participation in the programming. In the first year of its operation, 42 patients were admitted to Home 11, and the program successfully transitioned 12 patients into on-campus residences or into the community, while another 15 were actively working towards such a discharge. Seven of the 42 had to be returned to the hospital due to behavior problems which could not be controlled in the Home 11 environment.

Towards the goal of reducing hospitalization as the treatment of choice for unacceptable community behavior, Bedell & Ward (1989) developed an intensive community residential program in the Bronx, New York, as an alternative to commitment to the hospital. The facility provides 14 hours of psychoeducational rehabilitation activities each day focusing on social skills-building, with close supervision of each patient, and the use of physical intervention in the event of agitation or aggressive behavior. Seventy-six percent of the residents were diagnosed schizophrenic. The authors compared the outcomes of this mode of psychiatric treatment with a matched group of patients receiving typical ward care in the state mental hospital and found that the intensive residential program could stabilize and return people to the community in an average of 35 days compared to an average of 165 days in

hospital. In addition, the cost of running the intensive residential program per patient was one-third that of state hospital care, and the rate of rehospitalization also was reduced significantly in the 42 months following discharge of the subjects. This study, as in Soni, et al. (1977-78), Wing & Furlong (1986), Ranz (1989), and Bedell & Ward (1989), indicates that a reallocation of resources for well-designed, small, therapeutic communities outside of the mental hospital produce better results and save money because they stem recidivism and break hospital dependence.

Maxwell Jones' social experiments with psychiatric therapeutic communities in the 1950's are revived by Strochak (1987), a treatment philosophy which he believes contains the key to successful rehabilitation of the severely impaired chronically mentally ill. "Essentially the therapeutic community centered on the need to help the patient find a place and a social matrix to overcome the anomie of his existence" (Strochak, 1987, p. 583). The group custodial orientation, found in many mental hospitals and structured care facilities today, which has resulted in revolving-door psychiatry, is replaced by Strochak's family model, which substitutes individual treatment-oriented environments. The goal is not cure but "helping each patient find his highest level of adaptive functioning . . . offering a wide range of psychotherapeutic and psychosocial strategies from which the most appropriate interventions are

selected" (Strochak, 1987, p. 582). Such individualized attention requires a diverse staff, a secure setting, open-ended time lines, and access to the program after discharge. And central to the therapeutic community treatment philosophy is a flattening of the authority structure, which runs counter to the medical model practices in mental hospitals where diagnosis and prescription is applied to the patient population by doctors trained in brain technology. Rather,

. . . the essence of the therapeutic community is the attention that is paid to the learning and unlearning of experiences, especially those aspects requiring rethinking, reexperiencing and reappraising; real life is presented in manageable forms at a critical point in the life cycle. In today's practice, this valuable social laboratory has largely been replaced by biological labs seeking molecular causes. (Strochak, 1987, p. 584)

Levine & Wilson's study of inpatient commitment environments is cited by Strochak (1987) as foundation for his own family-model therapeutic community. It states:

The primary function of a psychiatric holding environment is the delivery to the patient of the normative services which the nuclear family customarily provides. We believe that the central configuration of such hospitals is that they serve and function *in loco familias*. Thus, a hospital should be organized in such a way as to provide for the patient the opportunity to transform or stabilize those sequelae of insults to his biopsychosocial development that have culminated in his present impairment . . . These sequelae are likely to be externalized during intensive treatment or hospitalization. (Levine, M. & Wilson, A. 1985, Dynamic Interpersonal Processes and the Inpatient Holding Environment. Psychiatry, 48, 341-357; cited in Strochak, 1987, p. 584)

The therapeutic community then involves the sharing of a common territory and purpose, that of aiding a subset of the members in their recovery from mental illness. According to Strochak, the dynamics which develop within this setting follow patterns of nuclear family functioning, and thus psychoanalytic concepts pertaining to objects of attachment and separation, and identification with significant others which fosters modeling and competition are adopted.

The physical design of the facility, located in Doylestown, Pennsylvania attempts to mimic a mini-neighborhood, with several houses laid out in a semicircle around a commons area, with living room, kitchen, dining room and bedrooms in each home. In each unit a husband and wife team, titled as family therapists, but functioning as house parents, live with the residents. Ancillary social work, nursing, and special program personnel function as surrogate siblings or role models. Each patient/resident is also assigned a primary therapist who is in charge of coordinating a meshing of medical, rehabilitative, and therapeutic interventions. Interestingly, hard-to-treat patients have been successfully treated due to the program's tolerance of deviancy and violent behavior. Strochak (1987) found:

The community utilizes the particular values, morals and strengths of family living to build ego strength and foster bonding. While psychoanalytic principles guide treatment, family systems approaches, behavior therapy, and commonsense are highly valued. The patient is held, in a

restraining sense, by the family's demand for good moral and socially acceptable behavior. (p. 587)

Likewise, in this setting the treatment staff become deeply involved in the patient's life and in effecting change. In addition, it has been found that residents adjust better to the expectations of the program if the use of psychotropic medications are decreased. In summary, the author states:

The family model is not a panacea, but it does represent certain advantages. It helps the disturbed patient find a social matrix in which he can first learn to survive. It meets the criterion of the least restrictive alternative treatment setting mandated by mental health commitment laws in many states. It individualizes treatment approaches and perhaps postpones indefinitely that day when a patient can no longer improve and therefore becomes custodial, i.e., untreatable. It conveys a dynamic hopefulness through a sense of participation with and belongingness to a surrogate-family structure rather than an institutional one. (p. 590)

ORIENTATIONS TO TREATMENT OF CHRONIC MENTAL ILLNESS

There has been a disturbing trend in the basic orientation of mental health workers towards discharge and transition of mental patients. As mentioned, the mental health profession often mimics the medical model in the delivery of care, that is, the client of mental health services is viewed as someone incapable of addressing their own problems and developing a treatment plan. Instead, the mental health professional takes charge and assesses, evaluates, and prescribes a plan of action to improve the client's predicament. But psychiatric care cannot expect to identify causes of symptoms and prescribe medicines to cure the ailment with the same confidence as physiological medicine. It is this writer's belief that the patient's mind has the potential to assess personal problems of living and apply his/her history of experiences and skills to devise a strategy for rehabilitation *with the assistance of a mental health professional*. The role of the clinician in such a scheme is to stimulate and encourage the uncovering and expression of the confused and withdrawn individual, to aid in organizing the personal resources and desires of the client, and to clarify and support the goals of the client on his/her road to community reintegration.

The psychiatric rehabilitation treatment model as espoused by Anthony, Cohen, & Farkas (1982) views rehabilitation as a "restoration process", that is, it aims "to discover and develop the patient's assets in contrast to treatment which is a direct attack on the patient's disability" (p. 84). There is relatively little focus on diagnosing an illness or addressing symptoms, but instead the client is involved in developing a functional assessment and devising interventions with which to emerge from his/her predicament of hospitalization, poverty, and/or disempowerment. Anthony's school of treatment coalesced following research that showed within one year after hospital discharge, 40 to 50 percent of psychiatric patients were returning to the hospital at least once, and that within three to five years the recidivism increased to 75 percent. Psychiatric rehabilitation positions client involvement at the center of the practice, and there is a strong emphasis on the development of an empathic and trusting relationship between therapists and their clients.

The treatment plan begins with both client and therapist discovering the client's level of functioning and identifying a living environment supportive of the client's capacity. Following this functional diagnostic phase, planning and intervention phases continue to be developed together in order to, among other necessities, prepare for attaining the desired living environment and then actually

locating and moving into the housing. Thus, among the stated principles of the psychiatric rehabilitation model is involvement of the client in all phases of the process of entering and functioning in society. In contrast to the traditional psychiatric medical model of treatment, rehabilitation is done with and not to clients. Removing the adversarial relationship which often occurs when psychiatric patients are forced into treatment, whether it be for medication or a structured living situation, the psychiatric rehabilitation model engages clients by approaching problems of living rationally, with decisions developed by the client, thus replacing the least restrictive environment concept with the principle of the most "facilitative" environment. Psychiatric patients are not warehoused and transferred from one controlled environment to another, but actually choose to move into new, more appropriate residences.

Livneh (1984), writing about psychiatric rehabilitation, describes the concrete, as opposed to abstract terminology which is used when engaging clients. As well, he notes the absence of labeling with psychiatric categories which can stigmatize and further disable the mentally ill person. Basic questions are asked pertaining to what environments the client wants to function in, with the belief that people function best when they are living in a residence of their choosing. Livneh believes that

emotional and interpersonal skills are most noticeably deficient in the chronically mentally ill population in regards to their living environments. So it only makes sense that the psychiatric rehabilitation model is directly applicable to the discharge of mental patients from hospital settings. Application of this philosophy is expanding from the community outpatient settings to the back wards in an effort to further reduce hospital populations in the face of budget cuts and increasing inpatient costs.

Yet regardless of the financial considerations which may drive the evolution of direct services for the mentally ill population, there is an ethical justification in empowering people to take a part in the planning and implementation of their rehabilitation and recovery from serious illness. Rose (1991) criticizes the social service system for its provider-driven framework, one in which the limits and needs of the services themselves determine the directions and decisions which consumers of those services must choose. Rose (1991) states:

To ignore, deny, deflect attention away from system shaping factors, or to neglect the many barriers to appropriate resources and services, betrays people whose life circumstances and vulnerability require case management. The most common form of betrayal exists in denigration of the advocacy function of case management or in its expression in co-opted or provider-driven form.
(p. 271)

Granting the service system the primary role in the consumer/services relationship results in erosion of the

psychiatric rehabilitation tenet of clients participating in the formation of their own goals and in identifying their own needs. What is at stake here is an ethical concern in clients being "seen as whole human beings living in a social context" where the "dignity of the person transcends the role of client in relation to any service provider" (Rose, 1991, p. 273).

When institutionalized persons are forced into residential settings which are undesirable, then their identity is forced into a managed role which sustains their dependency on the mental health system. Rose advocates a strong "contextualization" of community living problems, that is, the case manager or social worker presents accurate information regarding resources and assists the client in uncovering the reality of residential options, as well as other kinds of services. In addition, the case manager must aid the client in developing a new understanding about themselves which integrates the relationship of the environment with the client's self-concept in a climate of choice. Principles of psychotherapy can aid the client on the road to self-discovery in the context of community living options which he/she have explored and now have the responsibility of choosing. The role of the case manager focuses the task through a direction plan, including identification of strengths, setting of goals, identifying problems in acquiring resources, and then support for

actually moving on a decision. Overall, "the dignity, validity, and self-determination of clients precede professional convenience at all times" (Rose, 1991, p. 286).

Measures of the quality of life of the mentally ill need to be considered as the mental health system becomes ever bent on fiscal considerations and the delivery of services which yield least costly outcomes. Tantom (1988) makes a plea for considering the intractable nature of many mental illnesses and the need for a stewardship stance in the care of this population, regardless of the cost, stating, "When it comes to the distribution of resources planners must be guided as much by justice as by utility" (p. 246). He cites increasing attention in the assessment of benefit of mental health treatment to include the indirect effects of medications, programs, untreated physical disorders, and of the chronic illness itself. The values of the status quo must be tempered when evaluating the quality of life of the chronically mentally ill because recovery will often never be total, and adjustment to and acceptance of this grim reality by mentally ill persons is common. "It must be concluded that complex decision rules intervene between the appraisal of impairment and the evaluation of the quality of life, and that assessments of the quality of life must take account of them" (Tantom, 1988, p. 245).

Following the initial startling decrease in the mental hospital population in the decade of the 60's, there was, as has been mentioned, concerns that the relocation of patients into extended-care facilities such as foster homes, nursing homes, shelter-care, and board-and-care homes constituted merely a back ward in the community. Cohen and Paul (1976) cite various studies of that time revealing recidivism rates of anywhere between 20 to 75 percent within one year of discharge. They contend that what had occurred was the shifting of custodial care to locations spread out in the community, and that the potential for rehabilitation of the institutionalized mentally ill was being largely ignored. The authors believe that a 2 to 3 year period of preparation for independent community living needs to be included in a program that adequately deinstitutionalizes the long-term mentally ill and reduces recidivism significantly.

One way to transform the extended-care facilities in the community to rehabilitation centers is the incorporation of incentives in the way shelter care is funded and regulated by public agencies. In Illinois, Kohen and Paul (1976) examined the displacement of rehabilitation functions by bureaucratic inadequacies and a fiscally driven structure, and compared it to the Veterans Administration system of psychiatric care. They report:

Shelter-care homes in Illinois operate on a profit basis, rather than the simple maintenance funding for VA hospitals. However, the use of similar funding and evaluation criteria within a parallel

bureaucratic structure appears to produce a similar displacement of the rehabilitation function to that found in the VA system. In both systems displacement occurs because the criteria for funding do not provide incentive for resident improvement. (p. 586)

The authors propose a fixed base payment for residential providers who place a patient, with additional revenue offered for effective rehabilitation which is evaluated by a careful examination of resident functioning. Improvements in functioning, progression to a more independent setting, and placement of lower functioning patients would all grant higher service payments. A return to the hospital or deterioration in functioning would result in loss of the bonus funding. Various checklists and rating scales are suggested for monitoring the progress or deterioration of residents. The authors believe that residents would receive the humanitarian treatment to which they are entitled under such a scheme. However, there is in such a plan a flavor of processing and manipulation of human beings as objects out of control and in need of intrusive handling which brings up ethical concerns. In addition, the administrative process built into the clinical/residential level would seem to be adding costs.

Further evidence of a mechanical and manipulative processing of the mentally ill population is found in a rating system developed in Colorado. Shern, Wilson, Ellis, Bartsch, and Cohen (1986) studied patients who had a history in the Colorado State Hospital system and identified several

patient groups ranging from the long-term elderly institutionalized to the short-term non-institutionalized young adult chronic. By stating that "the common denominator among these clients' groups involves their need for an integrated continuum of residences and services" (Shern et al., 1986, p. 192), they have attempted to subdivide this population into types with specific community mental health needs. Hospital admission data and administration of the Colorado Client Assessment Record, which identifies psychosocial problems, is combined to form an operational definition of chronicity. Six different levels of residential care were listed as key options for patients, ranging from inpatient (hospital) setting to independent living. A committee of mental health clinicians then rated 5,017 chronically mentally ill adults who were in various of the above-mentioned residential settings and made predictions about the optimal placement for the clients. There were 3,068 clients living independently, yet only 12 percent of these were predicted by the model to be appropriate for such a setting, with 50 percent of the independent predicted to need an intensive treatment facility. Another nine percent of the independent were judged to be so dysfunctional and dangerous to themselves or others as to need an inpatient setting.

In general, the model predicted that clients should be living in structured living arrangements which fell in the

middle of the residential program continuum. The authors admit that the degree of difference between what the model predicted and what was actually found indicates a possible omission of variables considered in the placement decision. The researchers returned to the clinicians and sought a summary judgement, outside of the model, of the most appropriate placement for the client, and found that the proportion of agreement between these judgements and the predictions from the model differed substantially. The closest correspondence was found for the inpatient category, but no agreement was found for the independent living category. The authors conclude that the "model may need to be expanded to include a more complex, multivariate description of the client types" but that "a clinically meaningful typology of the CMI population exists and that the typology is systematically related to residential and service needs" (Shern et al., 1986, p. 201). Focusing on further development of a typology of mental illness with the purpose of making decisions for these people about where they should be living is troublesome. Detailed assessments, ratings, and the invention of operational definitions for these typologies will only serve to distance the mentally ill person from the treatment planning process. This population suffers from deficits in self-esteem, recurrent paranoia and suspicion, poor social skills, cognitive disorganization, and misinterpretation of reality, among

other symptoms, and will surely find such sophisticated efforts of labeling and directing their lives intrusive and impersonal. Attention must be paid to what the individual has to say about where he or she wants to live, incorporating these ideas as foundation in developing a plan for community living. The clinician must develop an alliance with the client which realistically works through the implications and implementation of a sensible placement.

Kincheloe and Hagar (1974) forsake scales and paper models for a hands-on approach to identifying and locating appropriate residential settings for hospitalized chronically mentally ill people. However, understanding what the community is for the patient, and assisting them in transitioning to the community is only the beginning of their recipe for success. Reducing or preventing rehospitalization for this population can only be accomplished with an outpatient program that incorporates the home visit as the centerpiece of the service. The typical configuration of residential options were available to discharged mental hospital patients in the Denver, Colorado area, but the authors did not depend on the level of programming or support available in the various settings to stabilize their clientele. Instead, the care providers and residents were assigned "coordinators", otherwise known as mental health therapists, who traveled to their clients' place of living. And they became involved in the same

issues that may have been otherwise brought into the clinic, but which were witnessed and processed in the actual place of their clients' experience. The authors have written extensive anecdotal accounts of the types of problems and issues which were addressed and could have only been successfully resolved, they maintain, in their clients' territory.

This overview of strategies for transitioning chronically mentally ill from hospital to community settings indicates that, rather than a lengthy preparation time removed from the community, staff times and energy should be invested in the crucial period just before and after discharge. The preparation for community life should not be too extensive in the inpatient setting, for no amount of inpatient training will substitute for the experience of learning in the actual setting what it takes to survive in society. Expectations about normalization and functioning competitively in the community should be down played in favor of the creation of alternative settings which provide the opportunity to set goals, accomplish objectives, and be rewarded for progressing into situations which satisfy the desire to be an active participant in a community. Motivating the chronic patient to become involved in the creation of their future requires adjusting the treatment orientation from a relationship that directs, manages, and decides for the patient to one that includes, empowers and

advocates for the consumer of mental health services. Attention to the social skill deficits of chronically mentally ill persons should prevent setting up patients for failure in placements which expect ready embracing of day treatment, occupational and recreational opportunities. Instead, the development and rehabilitation of prosocial behaviors should occur at the pace chosen by the resident, who is given environments which provide a non-stigmatizing, stimulating and supportive atmosphere, but reducing rehospitalization requires the continued provision of a tolerant, alternative community setting.

For many chronically mentally ill persons, totally independent living will never be possible in a society which requires adherence to particular social codes of productivity, competitiveness, confidence, and organization. Thus, it would seem more reasonable and humane to refer to these individuals as the mentally different, and grant them the right to practice their own conception of living. Such a right would require the mental health professions to work to redesign a concept for treatment which does not rehabilitate as much as nurture the mentally ill person's motivation to live. This requires both an education of society to the condition and plight of the chronically mentally ill and necessitates an adjustment about the way mental health professionals view the consumers of their services. The creation of assisted and self-managed micro-

communities would satisfy ethical concerns about denying the mentally ill their civil liberties. As well, an end can be made of the practice of removing people from the community who have become overwhelmed with the demands and expectations of a complicated world, or who have given up trying to satisfy the requirements for social approval and the attainment of personal gratification. Shutting this population away was recognized as inhumane, stimulating the deinstitutionalization movement, but programs which mainstream them into a world which challenges the hardest among us, and which has already been shown to end in rehospitalization for many of the chronically mentally ill, is equally questionable. If we pay more attention to asking the institutionalized chronically mentally ill how and where they would like to pursue living their lives in the community, then we can involve ourselves in an advocacy and empowerment orientation to treatment which serves consumers in an informed and dignified manner. More specifically, if we apply our knowledge of the chronic psychotic process to how we plan discharge with this population, then choices should culminate in successful and enduring placements in the community.

PSYCHOTIC PROCESS AND ABSTRACTION

Does the way in which residential options are presented to the chronically mentally ill make a difference in the

choice of our preference for a setting? More specifically, when discharge planning occurs, will a verbal description of a setting suffice to convey the essence of that residential option? Or is it necessary to consider problems that schizophrenic and other psychotically disordered individuals have in conceptualizing verbal descriptions into concrete ideas?

The Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised (American Psychiatric Association [APA], 1987), or DSM III-R as it is commonly referred to, describes schizophrenic thought form as overly concrete or overly abstract, often characterized by a "loosening of associations, in which ideas shift from one subject to another, completely unrelated or only obliquely related, without the speaker's displaying any awareness that the topics are unconnected" (APA, 1987, p. 188). As well, delusional thinking, another common symptom of schizophrenia, may impede coherent communication when the patient is of the belief or has the:

. . . experience that one's thoughts, as they occur, are broadcast from one's head to the external world so that others can hear them (thought broadcasting); that thoughts that are not one's own are inserted into one's mind (thought insertion); that thoughts have been removed from one's head (thought withdrawal); or that one's feelings, impulses, thoughts, or actions are not one's own, but are imposed by some external force (delusions of being controlled). (APA, 1987, p. 188)

In addition, the schizophrenic may experience "delusions of reference, in which events, objects, or other people are given particular and unusual significance, usually of a negative or pejorative nature" (APA, 1987, p. 188).

Various of the organic mental syndromes and disorders involve a thought disorder component as well, including cognitive deficits, paranoid attitudes, and delusions. Most mental hospital populations include a percentage of patients who are suffering from dementia, organic delusional syndrome, organic mood syndrome, and organic personality syndrome. Dementia is marked by "impairment in short-and long-terms memory, associated with impairment in abstract thinking, impaired judgement, other disturbances of higher cortical function, or personality change" (APA, 1987, p. 103). Organic delusional syndrome, organic mood syndrome, and organic personality syndrome cause mild cognitive impairment, with greater problems in social functioning or judgement.

Under mood disorders, bipolar (formerly manic depressive) disorder and major depression diagnoses may be accompanied by psychotic thought features. Like the organic mental disorders, the percentage of persons found in mental hospitals carrying a mood disorder diagnosis is smaller than the inpatient schizophrenic population. Bipolar type disturbances of thought occur when "sound rather than meaningful conceptual relationships govern word choice

(clanging)" and "speech may be marked by . . . flight of ideas . . . loosening of associations and incoherence" (APA, 1987, p. 215), as well as distractibility. But largely bipolar illness impairs social functioning due to symptoms of inflated self-esteem, irritability, and unceasing over-involvement with the world. In the case of major depression, there is "difficulty in concentrating, slowed thinking, and indecisiveness" as well as possible "thought insertion, thought broadcasting, and delusions of control" (APA, 1987, p. 219), and distractibility and obsessive rumination. In addition, interference in social functioning occurs, largely due to total loss of interest in most everything and an extreme sense of worthlessness.

A fourth category of common psychiatric diagnosis applied to mental hospital residents is schizoaffective disorder, which presents symptoms of both a schizophrenic and a mood disorder. Thus, persons who suffer from such a constellation of problems will inevitably be compromised in their form of thinking as well as in their social functioning.

HOSPITAL DISCHARGE PLANNING

When a mentally ill person has been stabilized in the hospital they have not been cured. Often symptoms remain, but at a less disturbing and more manageable level. There is a cognitive impairment, and social functioning is

seriously deteriorated. From a psychiatric rehabilitation and advocacy/empowerment orientation, planning for a patient's transition to the community requires the involvement of the patient from the beginning of the process. The significance of the initial planning stages of hospital discharge should be emphasized because misunderstanding or misperception of the nature of a community residential setting can set the tone for the ensuing process. If an individual, when presented choices or ideas about community living, compares what they *think* a particular option denotes with their history of community living before hospitalization, or what they have heard that option is like for their peers, a poor choice may occur. Likewise, if an individual is uncomfortable in social situations, especially when they are the focus of attention, the choice process will be compromised. Informed choices need to be optimized, and towards that end the method of presenting choices needs to be as clear, non-intimidating and as understandable to the mentally ill person as possible.

It could be argued that the importance of ensuring an optimal choice process is overstated, because as discharge planning proceeds, a poor choice could be recognized and acknowledged for what it is once the consumer visits the site. Usually such site visits occur prior to placement, and poor choices can be undone. But there is always the

need to ensure that time and resources are managed efficiently. In addition, the effects of false leads and expectations on the part of the consumer should be minimized to decrease stress and confusion. The effects of unsatisfactory explorations of misunderstood residential options on the proceeding choice(s) may very well taint the discharge process and lead to less than optimal choices.

An optimal choice may be described as one in which: (1) consumers are queried about their preferences for community living; (2) consumers are briefed on the possible residential resources available in the community; (3) consumers are assisted in understanding how their preferences intersect with available resources; (4) consumers are assisted in rating for themselves the merits of each option; (5) site visits to the top-rated options are arranged and clarification of specific concerns is provided. At this point the individual may be assumed to be informed adequately as to the nature of the residential setting and an optimal choice can be made.

When the above optimal choice process occurs without an initial accurate conceptualization of the option, poor choices will occur. Thus, attention to the challenges of schizophrenia and other psychotic disorders on the process of conceptualization of ideas and translation of abstract information to concrete information is required in planning community placement of the institutionalized chronically

mentally ill. Would it not enable a more accurate sense of the true essence of a setting if, in addition to a verbal and/or written description of the residential option, there were accompanying concrete, visual representations (photographs) of the setting?

This writer has more than five years experience working with the population of interest in this study. He is currently employed by Delaunay Mental Health Center in North Portland as a mental health therapist and service coordinator. From March 1989 to October 1992 he was employed at Mental Health Services-West in downtown Portland in the position of Dammasch State Hospital Liaison. The role involved tracking patients from the west quadrant of Multnomah County through their inpatient treatment and working with them and their hospital treatment teams on plans to transition them to the community. Prior to this position, the writer was employed by Mental Health Services-West as Residential Case Manager for 15 months. That role involved screening and interviewing patients from the state hospital who had been referred to the clinic's residential program, as well as transitioning and supporting them in their new homes after discharge.

The discharge planning process at Dammasch State Hospital begins early on during the patient's stay. The social service staff identify possible residential resources for the patient by conferring with community mental health

professionals and the family of the patient. They also consult with the rest of the treatment team about the practicality of these options for the patient. A referral to a structured residential program may be initiated when the hospital treatment team believe the patient has reached maximum benefit of hospitalization but feel that his or her living skills may not be adequate for independent living. Various programs exist to accommodate this population, including residential care facilities, adult foster homes, supported housing, and room and board homes. These options are usually discussed with the patient, but they are often presented as formulated plans or recommendations arrived at by staff who assume a role of authority about what is in the patient's best interest.

Often the treatment team has assessed the patient's level of functioning either through consulting among themselves and/or through the administration of a living skills evaluation tool. Patient input about the type of living situation into which he or she would like to move often occurs after the treatment team has made their decision. Input from the patient is sought not so much for planning as it is for approval. And the manner in which this is accomplished does not include the presentation of concrete (visual) information. All discussions and descriptions of living environments are verbal. The ensuing arrangements for site visits to residential programs are

hypothesized by this writer to be based on poorly informed decisions.

This critique of discharge planning attempts to make two points. The first point involves the patient's participation in the process. This often follows a classic medical model of professional decision making which places the patient in the role of the sick subject upon which treatment choices are performed. The mental patient is often viewed as someone incapable of participating in identifying a realistic community living plan. Hospital treatment staff assess the patient on functional scales and in conference, and then attempt to enlist the cooperation of the patient in pursuing that which the treatment staff believe to be the best choice. This writer suggests that the discharge planning process should follow instead a psychiatric rehabilitation approach as described earlier in this paper, that is, the patient and treatment team should assess the patient's level of functioning together and proceed to develop a plan which reflects the patient's capacity. A tool, which effectively presents various community living options, should be developed to stimulate planning an appropriate placement.

The second point involves the way in which descriptions of residential options are presented to the patient, whether or not it be part of a psychiatric rehabilitation model. Chronic mental illnesses such as schizophrenia, bipolar

disorder, schizoaffective disorder, and organic mental syndromes, as cited in the DSM III-R (APA, 1987), cause difficulty in the conceptualization of abstract information and a tendency to interpret information in concrete terms. In the current discharge planning process, residential options are described verbally, that is, there is the assumption that patients are able to imagine from a spoken description what the option actually would be like. Such a presentation would be challenging for anyone. It seems clear that this challenge would be amplified for the chronically mentally ill given their deficits in abstracting ability, and it would have an impact on the quality of choice in a discharge planning process which depends largely on the ability to conceptualize abstract information. If the presentation of residential options depended less on abstract information and included more concrete information, then discharge planning would more accurately reflect the patient's informed input into the process.

In this study, patients were presented residential options, and the manner in which they were presented was varied. The independent variable was the type of description of the community living option which the subject received, either: (1) verbal, (2) verbal/written, or (3) verbal/written/visual. The presentation of the description ranged across a continuum as follows:

(1) required maximum conceptualization of information
(verbal),

(2) helped organize information by committing it to
written word (verbal/written),

(3) concretized the information by providing
photographs of the actual settings described
(verbal/written/visual).

MOST ABSTRACT			LEAST ABSTRACT
VERBAL	VERBAL/WRITTEN . .	.VERBAL/WRITTEN/VISUAL	
Description	Description	Description	
(Group 1)	(Group 2)	(Group 3)	
CURRENT PROCESS			.ENHANCED PROCESS

Figure 1. Continuum of Presentation of Description.

The above figure locates the current discharge planning process, which involves a mostly abstract manner of presenting residential options, on the left end of the continuum. An enhanced discharge planning process, which takes into consideration problems with abstraction, is located on the right end of the continuum. The dependent variable was the order of choice of residential options under each experimental condition.

METHODOLOGY

RESPONDENTS

Three experimental groups were randomly assigned samples of 30 respondents each from all but three wards of the Dammasch State Hospital patient population. Respondents were not drawn from some wards of the hospital because they contained special, selected populations. The excluded wards were: a) medical ward--contained a population of severely physically as well as psychiatrically impaired persons, many of whom could not attend to the experimental task; b) self-regulatory disorders ward--contained female survivors of severe sexual, physical and/or emotional abuse, most of whom were actively struggling with these issues and not suffering from psychotic disorders; c) admissions unit--was the point of entry for all new patients, many of whom were stabilized quickly and discharged, and those who were assessed in need of longer term inpatient treatment were transferred to one of the other wards.

After respondents agreed to participate in the study, they were asked to read aloud the first paragraph of an informed consent form. If it was necessary, reading glasses were provided to the respondents. If respondents could not read the informed consent form due to poor eyesight

(uncorrectable by reading glasses) or due to illiteracy, they were administered a shortened version of the experiment to minimize possible embarrassment or other disturbance due to exclusion from the experiment. In addition, all respondents needed to be able to hear the experimenter's introduction, instructions, and verbal descriptions of the residential options, so patients who were deaf were not included in this study. These patients were ruled out by consultation with the treatment staff in advance of approaching the patient.

MATERIALS

Residential programs and opportunities for patients leaving Dammasch State Hospital and returning to live in the community approximate the variety of living arrangements found in most urban and suburban areas of the United States. For this study I chose six different types of options which covered the range of available choices: independent living (apartment or house), a homeless shelter, a supported housing program (semi-independent), a room and board facility, an adult foster care home, and a residential care facility. The residential options were ordered from least to most structured in terms of the degree of support for living. The options were ordered by assessing the relative presence of seven different criteria of structure and support. Nine Multnomah County residential case managers

and discharge planners were asked to rate the six residential options on the seven criteria. These community mental health professionals are familiar with the programming and structure found in each of these settings. Using a table similar to the one below, they were asked to mark either zero, one, or two on each criterion for each option depending on the degree of presence of that criterion. Zero signified the absence of the criterion, one: its presence at a moderate level, and two: its presence to a marked degree. Total scores for each cell for the nine professionals surveyed are listed in Table I. The mean score listed at the bottom of each column indicates the degree of structure and support found for each residential option. They have been ordered from left to right to illustrate the relative degree of structure and support. In Table I, a higher score indicates that the residence provides more in the way of supervision, structuring, and support for basic conditions of living and mental health stability. Following these ratings, each residential option was assigned an ordinal value as follows:

- 1) Independent living
- 2) Homeless shelter
- 3) Supported housing program
- 4) Room and board facility
- 5) Adult foster care
- 6) Residential care facility

TABLE I
RATINGS OF RESIDENTIAL OPTIONS
BY MENTAL HEALTH PROFESSIONALS

	Independent Living	Homeless Shelter	Supported Housing	Room & Board	Adult Foster Care	Residential Care Facility
Presence of Staff	0	8	7	9	12	16
Staff Programs	3	2	12	0	6	13
Medication Supervision	0	0	5	9	15	15
Curfews	0	7	2	6	10	12
Meals Provided	0	6	2	10	12	12
Housekeeping Service	1	3	1	7	11	13
Case Management	6	3	10	9	14	13
TOTAL	10	29	39	50	80	94
MEAN	1.111	3.222	4.333	5.556	8.889	10.444

The ranked choices for living arrangements upon discharge were recorded for each respondent as a score.

The first treatment group viewed six placards with only the residential options' *titles* printed on them, and the experimenter read a one-paragraph verbal description of approximately 50 words for each option. The second treatment group viewed six placards with the same residential titles *and* the same one-paragraph descriptions *printed* on them, and the experimenter read the descriptions for each option. The third treatment group viewed placards with the same residential titles and descriptions printed on them and *in addition*, there were five photographs accompanying each title and description. The photographs for each residential placard in this group included a view of the facility from the street, a view of the sleeping area, a view of the common sitting area, a view of the eating area, and a view of the kitchen. For this group, the researcher also read aloud the descriptions of each residential option.

There were three other possible permutations of the verbal/written/visual components which were not utilized for the following reasons. Visual presentation of the residential options, *without* verbal or written description, was not included as this provides incomplete information (lacking a description), and it would not be a realistic discharge planning tool. Visual/written presentation of the

options without verbal description was not included because the verbal information component of the description was being held constant across all three treatment groups. Also, the absence of verbal interaction and information-providing in any discharge planning process is not a realistic tool. Written presentation of the residential option, without verbal or visual description, was also not included for the above-mentioned reason that the absence of verbal information is not a realistic discharge planning tool and, as well, the presence of the verbal component was being held constant across the treatment groups.

The written and verbal descriptions of each residential option were composed as a systematic listing of attributes: the number of people typically living in the residence; whether or not bedrooms are shared with one or more roommates; whether there is a living room or common sitting area; where a resident eats; how food is prepared; whether bathrooms are shared; whether there are structured activities or programming; how medications are monitored; and whether or not there is a curfew. All of these aspects of residential setting were described in the same order.

PROCEDURE

Each respondent was approached on the hospital ward and briefed as to the nature of the study. The researcher said:

I am trying to find out the best way to do discharge planning for patients who are ready to

leave Dammasch. I'm wondering if you would look at six different types of places to live and tell me which ones would be best for you. I am not trying to get you out of the hospital, but your opinion about these different residences will help us create a better discharge planning process. Participation in this study will take about 15 minutes.

If the patient agreed to participate in the study, he or she met with the researcher in the ward's visitor's room. After the informed consent form was signed in the presence of a hospital staff witness, the witness left and six different placards representing six residential options were presented to the respondent. As each placard was presented it was placed on the table in the visitor's room and left there, until there was an accumulation of the six options lying before the respondent. The researcher then asked the respondent which of the six community living options he or she thought would be best given his or her circumstances upon discharge. This choice was removed from the array and the respondent was again asked, from those options left on the table, into which it would be best, given his or her circumstances, to be discharged to. This choice was removed from the array of placards and the process continued until the respondent had ranked the six options.

The ranking of the options was recorded on a data sheet, and the researcher then asked the respondent, "How difficult was it to make your choices: very difficult, kind of difficult, not very difficult?" A placard with this question and the multiple choice answers spelled out was

held up and handed to the respondent to consider. The answer to this question was recorded on the respondent's data sheet as well, and then the respondent was asked an open-ended question, "What was it that guided you in making your choices?" The answer to this question was recorded verbatim on the data sheet, and the interaction was complete.

The manner of presentation of options to each respondent in each group was uniform. The only difference between treatment groups was the degree of concrete information provided on the residential option placards for viewing by the respondent. Thus, confounding-by-task effects, such as unintentional differences in the way the researcher presented the options, were minimized. The respondents were alternately assigned to each treatment group until all respondents had participated. This minimized confounding-by-history effect, such as changes in hospital policy related to discharge planning, or other significant events occurring during data collection.

In order to minimize confounding-by-instrumentation effects, the order of presentation of the residential options to each respondent followed one of six sequences:

1	6	2	5	3	4
2	1	3	6	4	5
3	2	4	1	5	6
4	3	5	2	6	1
5	4	6	3	1	2
6	5	1	4	2	3

Since there are 30 respondents in each treatment group, each group had 5 respondents view the options in each of the above sequences. Use of the serial order table above guaranteed that options were presented an equal number of times in the first through sixth positions, thus evening out any position effects in the presentation of the residential options. As well, in the above sequence table, each option is followed once by each of the other options, thus controlling for first-order effects. It was not feasible to have all possible sequences presented as this would amount to 720 (6!) different sequences of the options.

After all respondents had made their choices, hospital social workers' input about appropriate residential settings for their patients was sought. The social worker is responsible for coordinating discharge plans, so each respondent's social worker was asked to rank the same six residential options for each respondent who had participated in this study. These ratings were done blind, that is, the social worker did not know what ranking the respondent had given to the options. The treatment condition to which the

respondent had been exposed was also not known to the social worker.

Basic demographic information was collected from the hospital record on each respondent, including age, gender, diagnosis, medications, and number of days in the mental hospital in the last year. This information is useful for descriptive analysis of the data, but these various conditions were *not* distributed systematically across the treatment groups. Similar demographic information was also collected for those patients who chose not to participate in the study in order to detect any selective bias in the sample.

RESULTS

CHARACTERISTICS OF THE SAMPLE

The sample included 32 female and 58 male respondents. Ages of respondents ranged from 19 to 68 years old, with the median age being 37. The respondents' ages were distributed as shown in Table II.

TABLE II

DISTRIBUTION OF AGES IN SAMPLE

Age Range	n	%
19-29 years old	15	16.7%
30-39 years old	38	42.2%
40-49 years old	20	22.2%
50-59 years old	12	13.3%
60-68 years old	5	5.6%

The psychiatric diagnoses of the respondent sample are shown in Table III.

TABLE III

DISTRIBUTION OF DIAGNOSES IN SAMPLE

Diagnosis	n	%
Schizophrenia:	34	37.8%
Schizoaffective:	23	25.6%
Organic Mental Disorders:	18	20.0%
Affective Disorders:	9	10.0%
Other:	6	6.7%

Medications were being prescribed and administered to all of the respondents. The medications are grouped by type and occurred in the proportions shown in Table IV.

TABLE IV
DISTRIBUTION OF RESPONDENTS' MEDICATIONS

Medication	n	%
Neuroleptic/Thymoleptic:	35	38.9
Neuroleptic:	24	26.7
<i>Clozaril</i> :	23	25.6
Thymoleptic:	8	8.9

Neuroleptics are medications which treat thought disorders (schizophrenia), thymoleptics are medications which treat affective disorders (bipolar, major depression), and *Clozaril* is usually only prescribed for people who suffer from a thought disorder and who have not responded to the administration of other neuroleptics. The combination prescription of a neuroleptic and a thymoleptic treats the symptom picture often seen in the schizoaffective, that of both thought disorder and affective disorder. These medications are also variously prescribed for organic mental disorders. As well, sometimes a person diagnosed bipolar may successfully be prescribed a neuroleptic medication, and a person diagnosed schizoaffective may successfully be prescribed only a neuroleptic without a thymoleptic.

In regards to length of stay at a mental hospital in the last year, the majority of respondents had been in the

hospital longer than one year. Length of stay for the respondents in the sample is shown in Table V.

TABLE V
RESPONDENTS' LENGTH OF STAY IN HOSPITAL

Period of Days	n	%
90 or less:	9	10.0
91 - 182:	15	16.7
183 - 364:	17	17.7
365 or more:	50	55.6

There were 36 patients who chose not to participate in the study. Of these, 13 were female and 23 were male. The ages of these patients ranged from 25 to 66, and the distribution of ages is shown in Table VI.

TABLE VI
DISTRIBUTION OF NON-RESPONDENTS' AGES

Age Range	n	%
25 - 29:	5	13.9
30 - 39:	13	36.1
40 - 49:	12	33.3
50 - 59:	5	13.9
60 - 66:	1	2.8

These non-respondents, by-and-large, had also been in the mental hospital longer than one year, as shown in Table VII.

TABLE VII
NON-RESPONDENTS' LENGTH OF STAY IN HOSPITAL

Period of Days	n	%
90 or less:	2	5.6
91 - 182:	5	13.8
183 - 364:	3	8.4
365 or more:	26	72.2

EQUIVALENCE OF TREATMENT GROUPS

Chi-square tests were applied to the respondent demographics-by-treatment groups to detect any systematic biases that might affect the comparisons of the treatments. No differences among the treatment groups were found by gender, age, diagnosis, medications, or length of stay in hospital. Non-respondents' demographics (only gender, age, and length of stay information was available) were included in a separate chi-square computation with the three treatment groups to detect systematic differences, but none was found.

A chi-square was also computed for respondents-by-demographic data on the first residential options choice. There were no significant patterns of first choice by gender, age, diagnosis, medications, or length of hospital stay.

The social workers who ranked the residential choices for each respondent had not been informed about which treatment group their respondents had been assigned. In

order to rule out systematic differences among the treatment groups in the way social workers ranked residential options for the respondents, chi-square tests and Kruskal-Wallis one-way ANOVAs were computed for the social workers' choices for each treatment groups-by-residential options. No significant value was found for any of the six residential options with either test, which indicated that there were no systematic differences among the groups in the way social workers ranked the residential options. Since social workers' data showed no differences among the treatment groups, this also indicated that the composition of the three treatment groups was not different from each other in any systematic way.

RESPONDENTS' AND SOCIAL WORKERS' RANKINGS OF OPTIONS

Table VIII lists the frequency of the respondents' and social workers' choices for the six residential options, for the first through the sixth choices.

Figures 2 and 3 illustrate the frequencies in Table VIII in bar graph form. Figures 4 and 5 illustrate the same data in a different way, showing frequencies of the rankings by the respondents and social workers, for each residential option.

TABLE VIII
RESPONDENTS' AND SOCIAL WORKERS' RANKINGS
OF RESIDENTIAL OPTIONS

Residential Option	Respondent		Social Worker	
<u>First Choice</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
Independent Living	42	46.7	3	3.3
Homeless Shelter	4	4.4		
Supported Housing	10	11.1	0	
Room and Board	14	15.6	10	11.1
Foster Home	9	10.0	1	1.1
Resid. Care Facility	11	12.2	17	18.9
			59	65.6
<u>Second Choice</u>				
Independent Living	13	14.4	6	6.7
Homeless Shelter	5	5.6	0	
Supported Housing	32	35.6	5	5.6
Room and Board	16	17.8	7	7.8
Foster Home	16	17.8	57	63.3
Resid. Care Facility	8	8.9	15	16.7
<u>Third Choice</u>				
Independent Living	8	8.9	2	2.2
Homeless Shelter	5	5.6	0	
Supported Housing	15	16.7	18	20.0
Room and Board	24	26.7	62	68.9
Foster Home	17	18.9	7	7.8
Resid. Care Facility	21	23.3	1	1.1
<u>Fourth Choice</u>				
Independent Living	10	11.1	3	3.3
Homeless Shelter	6	6.7	2	2.2
Supported Housing	19	21.1	55	61.1
Room and Board	14	15.6	18	20.0
Foster Home	26	28.9	8	8.9
Resid. Care Facility	15	16.7	4	4.4
<u>Fifth Choice</u>				
Independent Living	11	12.2	31	34.4
Homeless Shelter	10	11.1	45	50.0
Supported Housing	12	13.3	2	2.2
Room and Board	14	15.6	2	2.2
Foster Home	17	18.9	1	1.1
Resid. Care Facility	26	28.9	9	10.0

TABLE VIII
RESPONDENTS' AND SOCIAL WORKERS' RANKINGS
OF RESIDENTIAL OPTIONS
(continued)

<u>Sixth Choice</u>				
Independent Living	6	6.7	45	50.0
Homeless Shelter	60	66.7	43	47.8
Supported Housing	2	2.2	0	
Room and Board	8	8.9	0	
Foster Home	5	5.6	0	
Resid. Care Facility	9	10.0	2	2.2

RESPONDENT CHOICE BY TREATMENT GROUP

Chi-square and Kruskal-Wallis analyses of respondent choice-by-treatment group for each of first through sixth choices found no significant values of the statistics. However, the analysis of treatment group-by-respondents' fifth choice found a trend toward significance with the chi-square analysis, X^2 (df = 10, n = 90) = 16.57, p = .08448. Figures 6 and 7 illustrate the frequencies of the respondents' residential choices, by treatment group, for the first through the sixth choices, in bar graph form.

DIFFICULTY OF CHOICE PROCESS FOR RESPONDENT

The quality of the choice process was assessed by asking respondents the question, "How difficult was it to make your choices?" As illustrated in Table IX, respondents rated the residential choice task heavily toward "not very difficult" across all three treatment groups.

Figure 2. Respondents' and social workers' rankings of residential options (1st - 3rd choices).

Figure 3. Respondents' and social workers' rankings of residential options (4th - 6th choices).

Figure 4. Residential options as chosen by respondents and social workers (independent living, homeless shelter, supported housing program).

Figure 5. Residential options as chosen by respondents and social workers (room & board, foster home, residential care facility).

Figure 6. Residential choices of respondents by treatment group (1st - 3rd choices).

Figure 7. Residential choices by treatment group (4th - 6th choices).

TABLE IX
RESPONDENTS' RATINGS OF CHOICE PROCESS
USING THE QUESTION, "HOW DIFFICULT
WAS IT TO MAKE YOUR CHOICES?"

<u>N</u> = 90	Very Difficult	Kind of Difficult	Not Very Difficult
Tx Group			
Verbal	7	6	17
Verbal/ Written	1	11	18
Verbal/ Written/ Visual	4	5	21
TOTAL	12	22	56
Percent	13.3	24.4	62.2

A chi-square analysis of this variable, difficulty of choosing, produced a trend toward significance, X^2 (df = 4, N = 90) = 7.78, p = .0999. The Kruskal-Wallis statistic was not significant.

It was thought that eliminating the affective and "other" diagnoses from the sample would focus more accurately on the effect of inability to abstract information, since affective disorders and atypical psychoses present symptom pictures that are less impaired cognitively. When those 15 respondents were removed from the sample of 90 respondents, a chi-square analysis of treatment group-by-difficulty was not significant. A Kruskal-Wallis one-way ANOVA of treatment group-by-difficulty did not yield a significant value either.

WHAT GUIDED RESPONDENTS IN CHOOSING?

Following the question about difficulty of the choice process, a second question was posed to the respondents, "What guided you in making your choices?" A content analysis of the answers to this open-ended question yielded seven different types of answers, shown in Table X with their frequency of responses.

Chi-square tests of this variable, "What guided you", by gender, age, diagnosis, medications, and days in the hospital showed no significant values. A chi-square of "What guided you"-by-treatment group also yielded no significant value. In addition, a chi-square of "What guided you"-by-difficulty of choice showed no significance. However, a chi-square of "What guided you"-by-respondents' first choice of residential setting was significant, X^2 (df = 30, N = 90) = 44.24709, p = .04529.

Since "experience" and "privacy and independence" were the most influential factors (frequencies of 13 and 11 respectively) for choosing independent living first, a chi-square of treatment group-by-experience and treatment group-by-privacy and independence was computed. A trend, X^2 (df = 2, N = 22) = 5.545, p = .062, for the experience variable, and a trend, X^2 (df = 2, N = 17) = 5.059, p = .080, for the privacy and independence variable was found.

TABLE X
CONTENT ANALYSIS OF ANSWERS TO OPEN-ENDED
QUESTION: "WHAT GUIDED YOU IN
MAKING YOUR CHOICES?"

<u>Category of Answer</u>	<u>Frequency</u>	
	<u>n</u>	<u>%</u>
Experience:	22	24.4%
Privacy and independence:	17	18.9%
Presence of others:	14	15.6%
Impression or intuition:	11	12.2%
How choices were presented:	10	11.1%
Don't care or don't know:	10	11.1%
Wanting to leave hospital:	6	6.7%

COMPARISON OF RESPONDENTS' AND SOCIAL WORKERS' RANKINGS

Total Sample

In order to identify patterns of agreement or disagreement between respondents' and social workers' choices, respondents' rankings were cross-tabulated with social workers' rankings for each residential option. No significant chi-square values were found, but for the homeless shelter option there was a trend, X^2 (df = 10, N = 90) = 16.19341, p = .09423.

To reduce the degrees of freedom from a possible value of 25 to 4, and to avoid a small number of choices in the cells of the contingency table, the six rankings done by each group (respondents and social workers) were collapsed

into three ranks, with the first and second rank coded as first, the third and fourth rank coded as second, and the fifth and sixth rank coded as third. Another cross-tabulation of social workers' recoded rankings with respondents' recoded rankings for each residential option was computed. A significant chi-square value was found for the supported housing option, X^2 (df = 4, N = 90) = 12.57505, p = .01355. Respondents and social workers both chose this option 30 times in the middle, recoded category (either third or fourth choice). In addition, 32 times respondents chose it first or second while social workers chose it third or fourth. No other significant results were found, but trends were found for the room and board, foster home, and residential care facility options.

By Treatment Groups

When each treatment group was cross-tabulated for social workers' rankings with respondents' rankings, using the collapsed three-rank organization of the data, a significant pattern of choice was found for the homeless shelter in the verbal treatment group, X^2 (df = 2, N = 30) = 29.99999, p = .00000. Respondents and social workers both chose this option fifth or sixth 24 out of 30 times. Significance was also found for the supported housing program option in the verbal treatment group, X^2 (df = 4, N = 30) = 14.55646, p .00572. Respondents and social workers both chose this option third or fourth 9 out of 30 times.

Also, respondents chose it first or second while social workers chose it third or fourth 11 out of 30 times. In addition, a trend was found in the verbal treatment group for the residential care facility option on the collapsed choice analysis, X^2 (df = 4, N = 30) = 7.97333, p = .09256. Respondents chose the residential care facility option fifth or sixth while social workers chose it first or second 14 out of 30 times.

No significant chi-square values were found in the verbal/written treatment group on the collapsed choice analysis.

A trend was found in the verbal/written/visual treatment group for the adult foster home option on the collapsed choice analysis, X^2 (df = 2, N = 30) = 5.250, p = .07244. Social workers chose the adult foster home first or second while respondents chose it third or fourth 11 out of 30 times.

CORRELATIONS OF RESPONDENTS' AND SOCIAL WORKERS' CHOICES

To further explore the relationship between the respondents' residential choices and the social workers' choices of where they thought respondents should live, rank correlations of the choices of respondents and social workers were computed for the total sample using the Spearman correlation coefficient. Each residential option was analyzed for the number of times respondents and social

workers chose it in common first through sixth choice. A significant value was found for the room and board option, $\rho (\underline{N} = 90) = -.2163, p = .020$.

Rank correlations of the choices of respondents and social workers were computed for each treatment group using the Spearman correlation coefficient. Each residential option was again analyzed for the degree of agreement between respondents and social workers for the first through sixth choices. A significant value was found for the verbal treatment group on the room and board option, $\rho (\underline{N} = 30) = -.3555, p = .027$. A significant value was also found for the verbal/written treatment group on the residential care facility option, $\rho (\underline{N} = 30) = .3853, p = .018$. And a significant value was found for the verbal/written/visual treatment group on the room and board option, $\rho (\underline{N} = 30) = -.3754, p = .020$.

DISCUSSION

The hypothesis of the study was that the way in which residential options are presented to institutionalized chronically mentally ill makes a difference in the quality of the choice. It was expected that the distribution of the choices would be significantly different between the three treatment groups because the degree of concrete information (i.e., written descriptions, photographs) would change the understanding of the residential option. However, there was not even a trend towards difference among the treatment groups. Figure III illustrates the distribution of rankings by treatment group. The effect of the different treatment groups on choice is not demonstrated. Respondents did not choose a residential option any differently given the presentation of written, or written and visual information, in addition to a verbal description. This suggests that abstraction deficits in psychotic persons may not shape the way they make choices about where they will live when they are ready to leave the hospital. The degree of impairment in abstracting ability among psychotically disordered persons is not so severe as to compromise the processing of verbal or written information regarding residential choices in the community.

Following the presentation of descriptions of the residential options, an outcome question, "How difficult was it to make your choices?" was posed to the respondent, with three answer choices presented: very difficult, kind of difficult, not very difficult. The respondents' answers to this question were stacked heavily on the "not very difficult" choice (see Table IX), regardless of the manner of presentation of the residential options (verbal, verbal/written, verbal/written/visual). Respondents in all treatment groups indicated that the choice process was "not very difficult". Either the enhancement of the presentation of information made no difference in regards to the quality of the choice process, or the outcome variable, difficulty in choosing, as it was constructed in the design of the study, did not successfully measure different qualities of choosing given the three manners of presentation. Piling up responses under one value of the dependent variable likely reduced discrimination among the treatment groups. The variable, "How difficult was it to make your choices?", was analyzed by treatment group, and though the Kruskal-Wallis one-way ANOVA did not produce a significant test statistic, the chi-square analysis did yield a trend toward significance.

One has to wonder if the question, "How difficult was it to make your choices?", was the right question to ask in order to gauge the quality of the choice process. Given the

socially insecure personality of the psychotically mentally ill person, a question which may be perceived to reveal inadequacies or personal deficits may not be appropriate for capturing the true nature of a cognitive experience. The question, "How difficult was it to make your choices?" approaches the matter from a negative stance because the respondent is challenged to be honest about how much trouble he or she had in choosing the options. Similarly, if the question had been, "How easy was it to make your choices?", the respondent would have been answering about his or her own competency in choosing the options. In either case, a self-esteem component might enter into the answer, and, in this situation issues of insecurity and anxiety, heightened by psychosis, could have played a part in 62.2% of the answers being "not very difficult".

In addition, the Dammasch State Hospital population is 76% composed of individuals who have been court committed. They have been judged to be incapable of taking care of themselves in society, or a danger to themselves or to others. Many of them have been at the mental hospital for years and some are dependent on it, but many others, both long and short-term patients, want to leave and return to society. They know they are at the hospital because they have not lived up to the expectations of society, and they know that they are being observed. When someone, such as the researcher, comes into their world and talks to them

about their choices for living arrangements on the outside, there is, no doubt, a host of ideas and emotions conjured up. And it is likely there will be the motivation to present to this researcher a picture of capability and readiness, and not disability or ambivalence, when they are queried about the degree of difficulty they had in choosing a place to live from a set of options.

A different question to detect the quality of the choice process would have been, "How *satisfied* are you with your choices?". Posing the question this way avoids introduction of a personal power deficit component into the answer about the quality of the choice process. The question is more neutral in regards to the cognitive performance of the respondent. A report about the personal experience of the respondent in regards to the manner of presentation of the options is gained, without arousing suspicion that competency is questioned. The question, "How satisfied are you with your choices?", is an opportunity for the respondent to speak his or her mind, to evaluate the researcher on his project, to be given a voice rather than to be once again probed and evaluated. If the question had been "How satisfied are you with your choices?", perhaps the trend toward significance on the difficulty-by-treatment group analysis would have been significant on a satisfaction-by-treatment group analysis.

Following the question about difficulty, an open-ended question was asked, "What was it that guided you in making your choices?". Cross-tabulation with the respondents' first choices indicated that "experience" and "privacy and independence" guided the respondents in making their first choice independent living. The respondents chose independent living 46.7% of the time as their first choice. The data suggest that they knew what the range of options was like from past experience, as 24.4% indicated that experience was what guided them in making their choices. And they also had an idea of what they were looking for in the community (that is, privacy and independence) as another 18.9% indicated privacy and independence was what guided them in making their choices. In addition, another 15.6% indicated that "presence of others" guided them in their choosing. If this is combined with the "experience" and "privacy and independence" answers, 58.9% of the respondents were informed and focused about their own disposition in regards to discharge planning. This could be a partial explanation of there being no significant difference between the treatment groups.

Though this research did not demonstrate a difference among the treatment groups in the way respondents chose residential options, there were some other interesting details revealed in the results. Discharge planning and successful residential placements for the chronically

mentally ill may be enlightened by some of the data. The ongoing dilemma for social workers in mental hospitals is building insight into patients regarding their ability, or lack of ability, to care for themselves independently in the community. Patients' histories in the community, and the hospital's observations of the patients' living skills in rehabilitation programs, lead most social workers to the conclusion that independent living is unrealistic. The social workers' rankings of the residential settings most appropriate for respondents in this study bear this out. The most structured of community residential settings, residential care facilities, were chosen first by social workers 65.6% of the time. And the second most structured setting, adult foster care home, was chosen first 18.9% of the time. These two choices, when combined, amount to 84.5% of the social workers' first choices. The respondents, on the other hand, spread their choices of the residential care facility and the adult foster care home across the rankings. This likely prevented the cross-tabulation of respondents'-by-social workers' rankings from showing a significant negative relationship for the residential care facility option.

By contrast, independent living was chosen first by social workers 3.3% of the time, while respondents chose it first 46.7% of the time. The lack of agreement between patients and social workers can result in a stalemate in

discharge planning, and patients remain in the mental hospital because they will not cooperate with a structured residential program placement. A compromise needs to be reached if further deinstitutionalization is to occur.

When the six rankings were collapsed into three, some significant relationships were found between respondents' and social workers' choices. For the verbal treatment group, the homeless shelter option, on a chi-square analysis of social worker-by-respondent ranking, showed a significant agreement of choice. This option was chosen in common fifth or sixth 24 times ($N = 30$). It is concluded that this option is not realistic for either respondents or social workers when discharge planning utilizes only a verbal description of options.

The supported housing option, in the chi-square analysis of social worker-by-respondent ranking, showed a significant agreement of choice both for the verbal treatment group and for the three treatment groups combined. For the verbal treatment group, this option was chosen in common 9 times ($N = 30$) by both respondents and social workers as third or fourth choice. For the total sample, this option was chosen in common 30 times ($N = 90$) as either the third or fourth preference, and it was chosen 32 times ($N = 90$) by respondents as first or second preference while social workers were choosing it third or fourth.

The supported housing option is a program which resembles independent living in many ways, but which incorporates community mental health outreach and support on a regular basis. Residents are expected to keep their own apartment, cook their own meals, and monitor their own medications, and an apartment manager with mental health experience lives nearby and oversees the security and order of the building. This program manager also serves as a resource in problem solving, crisis management, and counseling support. In addition, a skills trainer visits the tenants of the program individually at least once a week and helps with housekeeping and culinary skills. There is also a recreation room where residents can gather to watch movies, listen to music, stage potlucks, and socialize.

This semi-independent arrangement, though preferred more often by respondents than social workers, offers a compromise which could be agreeable to both parties in the discharge planning stalemate. In order for it to be more realistic for the hospitalized chronically mentally ill person and agreeable to hospital treatment staff, perhaps there could be an enhancement of the services provided without changing the atmosphere of autonomy. By enhancement is not meant transfer of responsibility for daily living activities to mental health staff. Residents in this program would still need to prepare their own meals, keep their own apartment clean, and manage their own medications.

But the addition of community mental health staff in more frequent visits and more hands-on activities in cooking, medication education, and community building activity, would guarantee supervision without being controlling. Some residents would need more help in managing their own apartment or remaining stable, but a mix of more and less skilled residents would lend itself to peer support and modelling. Coordination of linkage between residents could be handled by the program manager, who would also serve as a fail safe to the mental health clinic when a resident needed special support or attention. Community projects would be a natural extension of this arrangement, such as gardening, recycling, physical plant maintenance, and recreation. It is supposed that, with time, these supported housing projects would become more autonomous and less dependent on the mental health clinic for outreach.

When it comes to identifying the residential option which is least agreeable for patients and social workers on a case-by-case analysis, it appears that the room-and-board is the option to avoid. The rank correlations of the respondents' and social workers' choices for the total sample found a significant negative correlation for room-and-board. When rank correlations of respondents' and social workers' choices were computed for individual treatment groups, a significant negative correlation for room-and-board was found for the verbal treatment groups and

for the verbal/written treatment group. It seems that regardless of the way this option was presented to respondents, it was not a placement which was agreeable with what social workers thought was appropriate.

The only positive significant correlation between rankings of respondents and social workers was found in the verbal/written treatment group for the residential care facility. Given the skewed distribution of the social worker choices towards first choice for the residential care facility, and the generally unfavorable regard which respondents had for it, a significant correlation within this treatment group indicates that the option looks better on paper than it sounds or than it actually appears in a photograph. Residential care facilities are the most structured of all the options presented, and are the most widespread of the highly structured placements available in the community. They resemble the hospital culture in their degree of controlling the activities of daily living, and certainly have a place in the panorama of services. Some patients have become so institutionalized as to be helpless without the provision of prepared meals, monitored medications, and life-structuring regulations. For these dependent persons, rehabilitation will require an elaborate and intensively staffed daily treatment program. With the fiscal crunch in the new era of austerity in public programs, priorities will likely postpone the implementation

of the rehabilitation of the severely dependent, and placement in the community, albeit in highly structured basic maintenance programs, will suffice. For those other individuals that have reached maximum benefit in the mental hospitals and who want to live autonomously, mental health professionals have a responsibility to accommodate them creatively on their own terms.

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APPENDIX A

EXAMPLES OF PLACARDS

Display for Verbal Treatment Condition

Display for Verbal/Written/Visual Treatment Condition

APPENDIX B

VERBAL NARRATIVES OF RESIDENTIAL DESCRIPTIONS

RESIDENTIAL CARE FACILITY

- 6 to 16 residents
- facility managed by paid staff
- share bedroom with roommate(s)
- shared living room for visiting and watching television
- shared dining room for eating meals together
- food prepared by program staff
- bathrooms shared
- occasional structured activities
- medications dispensed by paid staff
- evening curfew

ADULT FOSTER CARE HOME

- 2 to 5 residents
- owner of home lives with residents
- bedrooms sometimes shared with roommate
- shared living room for visiting and watching television
- shared dining room for eating meals together
- food prepared by foster home owner
- bathrooms shared
- no structured activities provided
- medications dispensed by foster home owner
- evening curfew

SUPPORTED HOUSING PROGRAM

- 4 to 15 residents
- program manager lives in nearby apartment
- residents live in their own apartment
- apartments have a bedroom, living room, kitchen, bathroom
- some furnishings and kitchen utensils provided
- meals prepared by resident
- housekeeping duties carried out by residents
- skills trainer helps organize household and teach cooking
- medications managed by the resident
- no curfews

ROOM AND BOARD

- 5 or more residents
- facility supervised by owner or staff person
- bedroom shared with a roommate
- common area for visiting or watching television
- common dining room or hall
- meals provided by owner or paid staff
- bathroom shared
- no structured activities provided
- medications managed by the resident, or by staff by request
- no curfews

HOMELESS SHELTER

- up to 50 people may stay here
- shelter managed by paid staff
- residents sleep in bunk room with others
- common day room area for visiting, watching television
- meals provided by kitchen staff
- residents line up for food tray, eat in day room
- bathroom shared
- no structured activities provided
- medications managed by resident
- evening curfew and early morning wake up

INDEPENDENT LIVING

- individual private apartment
- no supervision
- could be shared with roommate
- includes at least one bedroom
- also has living room, kitchen, bathroom
- resident responsible for own furnishings and kitchen utensils
- meals prepared by resident
- no structured activities provided
- medications managed by resident
- no curfews

APPENDIX C

RESPONDENT DATA SHEET

RESPONDENT'S DATA SHEET

Respondent's Name: _____ Ward _____

(cut here after participation in study for anonymity)

Respondent Number: _____ Gender: _____ Age: _____

Diagnosis: _____

Medications and Dosages: _____

Number of days in mental hospital in last year: _____

First Choice: _____

Second Choice: _____

Third Choice: _____

Fourth Choice: _____

Fifth Choice: _____

Sixth Choice: _____

How difficult was it to make your choices?

Very difficult _____

Kind of difficult _____

Not very difficult _____

What was it that guided you in making your choices?

Treatment Group:

Verbal _____ Verbal/Written _____ Verbal/Written/Visual _____

APPENDIX D

SOCIAL WORKER DATA SHEET

SOCIAL WORKER'S DATA SHEET

Patient's Name: _____ Ward _____

(to be cut by researcher for anonymity after data collected)

For the above-named individual, please rank the following community residential options from best (1) to least (6) suited as a discharge placement, given his or her current circumstances.

Independent living _____

Homeless shelter _____

Supported housing program _____

Room and board _____

Adult foster care _____

Residential care facility _____

(If necessary, please refer to residential options descriptions.)

(To be filled out by researcher)

Respondent number _____

APPENDIX E

INFORMED CONSENT FORM

INFORMED CONSENT FORM

I, _____, agree to take part in this research project on the way discharge planning occurs for patients when they are ready to leave Dammasch Hospital.

I understand that the study involves considering six different descriptions of living arrangements in the community. The six options will be described to me in the visitor's room on the ward. I understand that the researcher wants to know which one of these living options I would choose as the best choice for me, given my circumstances, when I am ready to leave the hospital. He will then ask me to continue choosing the next best placement until I have ranked all six. After the researcher has recorded my choices, he will ask me how difficult it was to make the choices, and my part in the study will be over.

Rick Stanek, the researcher, has told me that the purpose of this study is to learn how to plan for successful discharge of patients when they are ready to leave the hospital. I understand that a discharge plan is not being made for me at this time. I may not receive any direct benefit from taking part in this study, but the study may help to increase knowledge that may help others in the future.

Rick Stanek has offered to answer any questions I have about the study and what I am expected to do. He has promised that all information I give will be kept confidential and that the names of all people in the study will remain anonymous. I give him permission to look at my hospital chart to record my age, psychiatric diagnosis, medications, and number of days in the hospital so far. If I have questions about the study later on, I can contact him through my social worker.

I understand that I do not have to take part in this study, and that I may stop participation at any time during the study. If I choose not to participate in this study, this will in no way affect my treatment at, or discharge from, the hospital.

I also understand that participation in this study is not an actual discharge plan for me; it is only a response to the researcher's questions.

I have read and understand the above information and agree to take part in this study.

Date: _____

Signature: _____

Date: _____

Witness: _____