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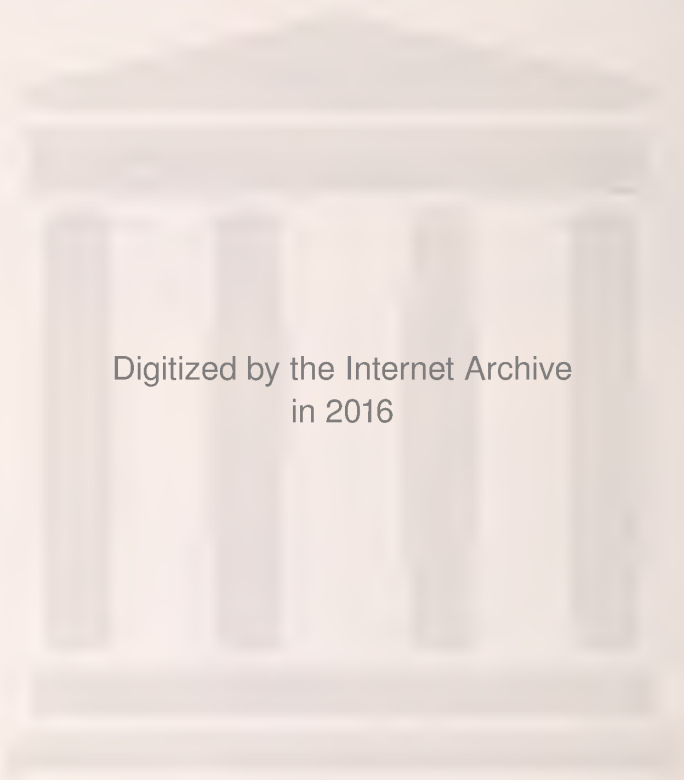

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THE COMMUNITY MENTAL HEALTH CENTER IN URBAN CRISIS

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In the "long, hot summer" of 1967, New Haven was one of many American cities to suffer a violent upheaval in black neighborhoods. The episode was particularly traumatic because it shattered the illusions of harmony in the city. Many organizations, in addition to local and state agencies, had a part in initiating, escalating, and controlling the events. in New Haven. The Connecticut Mental Health Center (CMHC) and other health, welfare, and antipoverty agencies were unable to intervene effectively in the initial stages of the upheaval or to bring about a negotiated, nonrepressive resolution of the conflict. State police were called in to reestablish "order."

More significantly, virtually nothing could be done to deal with the underlying causes of the crisis. The CMHC had begun operation in July 1966, and during the first year the majority of its time and resources were devoted to inpatient and outpatient treatment programs. Although community involvement was a stated goal of the Center, the commitment had been controversial. There was no over-all plan for involvement, and efforts to develop a community arm were limited and fragmented. One small unit offered clinical and administrative consultation to schools and

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community agencies. Another unit, engaged in a program of comprehensive care for a defined catchment area, provided an additional thrust into the community.

The events of August brought into sharper focus the need to define the Center's future role in the community. In the Fall of 1967, the CMHC Executive Committee established a Committee on Community Functions, with a mandate to inquire into the August upheaval and the part the CMHC played in it and to recommend ways of improving the Center's capability to take part in constructive community change. The membership of the Committee was diverse in discipline, race, organizational status, and theoretical perspective; it included the director of nursing, a day hospital aide who was a resident of the black community, a social worker in charge of the community program on the catchmented unit, a community psychologist, two social psychologists, and a sociologist. The group completed its study in January 1968 and presented the following report:

REPORT OF THE COMMITTEE ON THE COMMUNITY FUNCTION OF THE CMHC

In the New Haven crisis of August 1967, the Mental Health Center intervened in various useful ways. However, our resources were limited and we played only a small part in the overall event. We could be of some use in the Hill, which is part of the Unit III catchment area, but we did nothing in other neighborhoods where, as it turned out, the damage in material costs was even greater. The less material costs have not been assessed. We also played virtually no role with the City government, police, and other City-wide agencies as the crisis unfolded.

In the last six months, the urban situation in New Haven, as nationally, has become more serious. At the national level the Viet Nam War has led to a drastic cutback on the war on poverty and other efforts to modify the social problems of which the summer civil disturbances are an expression. More than this, the "disturbances" are being regarded by the Federal Government not in socioeconomic and psychological terms but as a problem in crime control to be dealt with primarily by police-military methods. If this approach also predominates within the New Haven community, the role of the Mental Health Center will be seriously limited. We

will be able to do very little either to avert a violent crisis or to deal with the crisis as it evolves.

In this Committee's view, planning the Connecticut Mental Health Center's role in future riots should not receive the highest priority. Our most constructive efforts now, and in the months to come, should go to developing an integrated community program and a strategy for preventive and rehabilitative services. These services would be provided (a) at the *neighborhood* level, (b) in various *institutions* such as the schools and other community agencies, and (c) at the *city-wide* level through the City government, police, and so on. In its preventive aspects a community program would seek to facilitate change in the institutional and environmental conditions that breed massive alienation, apathy, and powerlessness among the poor, black as well as white.

Specifically, what should the Connecticut Mental Health Center do to define, develop, and support an effective community program? The specific goals, modes of intervention, and resources of such a program are yet to be developed. We have no blueprint to offer but we shall present a point of view and a number of recommendations.

Historical Background

To provide a context for considering the present needs of the Connecticut Mental Health Center, we shall review briefly the initial planning and the mandate with which it began. The Connecticut Mental Health Center was conceived and planned in the late 1950's and early 1960's. The planners had two major aims: first, to build an institution along the most modern lines; and second, to create an innovative organization that would continue to develop new models and to be a pacesetter in the mental health fields. The emphasis on innovation was central in the planning.

The conception of a modern institution in 1960 reflected the state of the mental health field at that time. Psychoanalysis and dynamic psychiatry held a predominant position in American psychiatry. Psychotherapy was the major treatment modality in clinics and teaching hospitals. The initial convergence of psychiatry with social science had led in the 1950's to research on the social psychiatry of the hospital and to the development of the hospital as a therapeutic community. Efforts were

made to democratize the hospital structure, to use the social milieu as a therapeutic modality, to utilize family and group therapy, and to develop new roles for nurses, aides, psychiatrists, psychologists, and others. A major push was made toward decreasing the barriers between hospital and community by means such as partial hospitalization, use of volunteers, building hospitals within the cities rather than in isolated areas, follow-up services for discharged patients in their transition to community life, half-way houses, home treatment services, psychiatric units in general hospitals, emphasis on voluntary admission, and so on.

The concept of the *State* mental health center emerged in this climate of change during the 1950's. It is based on two main ideas. First, a single facility provides multiple clinical services to patients, including inpatient, outpatient, day hospital, and the like. Second, the barriers between clinical facility and outside community are reduced. However, the State mental health center is primarily concerned with the clinical care of the individual patient. It has only a minimal responsibility to the outside community. This model was well illustrated by the Massachusetts Mental Health Center (established in 1955), the Fort Logan Mental Health Center (1961), and certain private centers such as Menninger and Austin Riggs.

The Connecticut Mental Health Center was initially conceived within this model, that is as a Mental Health Center for the State of Connecticut. However, between the initial conception of the Connecticut Mental Health Center around 1960, and its birth in 1966, a new historical development occurred in American society and in the mental health field. In society, the change was symbolized by the new visions and programs of the Kennedy administration--the war on poverty, the struggle for civil rights, the legislation for numerous programs in health, education and welfare, the effort to deal with massive social problems by systematic programs of social change. A new political, economic and cultural climate evolved.

The CMHC As A Community Mental Health Center

Within the mental health field, the 1960's have seen the emergence of community mental health as a new point of view, involving a new sense of responsibility to the community as well as new concepts, programs and

techniques of community involvement. As of 1966, the 1960 plans for the Connecticut Mental Health Center were no longer as modern and as innovative as they had been initially.

If the Connecticut Mental Health Center is to fulfill its mandate as an innovative, pacesetting organization, it must seek not only to develop improved models of inpatient and outpatient care, but it must also develop its community function with imagination and excellence. This means that it must form a conception of itself as a *community* mental health center and implement this conception fully. The distinction between a State mental health center and a community mental health center is of crucial importance.

The early development of the Connecticut Mental Health Center, since July 1966, reflects the historical developments noted above. We proceeded first and most smoothly with clinical programs for which existing models were well-established. First, the outpatient programs, the day hospital, and the inpatient wards. The Emergency Treatment Service, based on newer concepts of crisis intervention, took a little longer but was integrated without great difficulty. The formation of the Consultation Service has gone more slowly. The first chief has only recently been appointed and the staff is still incomplete. The functions of this service and its relation to the clinical units are yet to be settled and given a basis in formal policy. Unit III (the catchmented unit) has from the start been identified as our major arm in the community. However, the great bulk of its time and resources are devoted to its inpatient and outpatient programs rather than to its community program.

At the same time, important steps have been taken toward strengthening our ties to the community. A major early step was the policy decision that the Center will not serve the entire state but will take metropolitan New Haven as its extended community. While not crucial in itself, this facilitates further efforts to clarify the responsibilities of the Center for a defined population. Also, the Center early obtained a federal grant to provide comprehensive mental health care for a specific catchment area (West Haven and The Hill). Having a catchment area is another significant step toward the acceptance of responsibility, not just for single patients but for the health needs of a population. It leads to the development of programs by which Center staff move outside the walls of our building, learn about the character and problems of our community,

assess its needs, and utilize various modes of intervention to create social conditions conducive to mental health. There are other, related developments which break down our encapsulation within the walls of our building and lead to various kinds of community involvement.

Where do we go from here? In our opinion, it is necessary to develop a more balanced and systematic overall program, with greater attention to the community aspects. To facilitate planning in this direction, we have prepared an outline of the multiple components of a community mental health center (see Table 1). We distinguish three major components: (a) *Intra-mural programs* which are carried out within the offices and wards of the mental health center building; (b) *Boundary programs* which are carried out at the interface of the hospital and the community, but which involve the staff minimally in community life; (c) *Extra-mural programs* which are carried out within the community and which require, to different degrees, that staff regard the community as a locus of and a partner in mental health work.

(See Table 1 on next page)

TABLE 1

THE MULTIPLE COMPONENTS OF A COMMUNITY MENTAL HEALTH CENTER

I. Intra-mural programs: carried out within the organization's walls. Inpatient wards. Day Hospital. Outpatient Clinic. ETS: 72-hour stay. Diagnostic evaluation; referral. Teaching and Research. The focus here is almost exclusively on the provision of clinical services to patients.

II. Boundary programs: at the interface of Center and community. Family treatment. Teaching and Research. Volunteers, visitors. ETS 30-day follow-up. The focus is still mainly on clinical services, but there is more flow of clinical staff into the community, and of community members (volunteers, family, etc.) into the Center.

III. Extra-mural programs: movement of staff into the community.

A. Public Relations

Education regarding the nature, work, and philosophy of the MHC.

B. Provision of clinical services in community

1. Direct care to patients

Home treatment. Half-way House. Group Therapy in Community. Referral Center.

2. Indirect clinical services

Case-oriented consultation with other institutions regarding their treatment function. In-service training of treatment staff.

C. Preventive programs

1. Programs oriented toward individual change. Change of individual attitudes, feelings, skills: family life education, sex education, teachers, industry, mental hygiene.

2. Programs oriented toward institutional change

Police, courts, schools, government agencies and programs, intervention in enduring community conflict and acute community crises. Major issue: What roles and modes of intervention are most functional under different social conditions. Examples: mediator, negotiator, catalyst, advocate.

D. Teaching and Research in each of the above.

The historical developments of the past twenty years are in the direction from purely intra-mural to boundary to extra-mural programs. In our view all three of these major components are necessary and legitimate parts of the community mental health center. The Center is incomplete and limited if it lacks major effort in any of these areas. However, the proper proportions will vary from place to place and guidelines to the optimal mix do not exist.

The most problematic aspect of the community program seems to be the one listed under III-C-2; namely, preventive programs oriented toward institutional change. This component requires a commitment to engage in social action of various kinds. It also requires that we extend our theoretical horizons. Our present theories are primarily in the realm of psychodynamics, psychopathology, and interpersonal relations. They need to be broadened to include an understanding of groups, institutions, communities, and society as a whole, including its political and economic aspects. This extension of theoretical perspective is necessary if we are to fulfill the mandate of a community mental health center.

The community services of the Connecticut Mental Health Center have been developing in fragmented, unrelated ways. In the absence of formal policies and an organizational structure geared for community programming, we can respond only to requests of the most noncontroversial kind. As these requests multiply, and as ideas and projects are generated within the Center, we need a rational basis for establishing goals and priorities.

RECOMMENDATIONS

In our opinion it is imperative that the Center's community activities increase and be integrated into a more unified program. In establishing such a program several tasks are involved. We need first of all to define the nature and components of our community function. Second, we need to define the place of the community program within the structure of the Center. Third, this program must have strong leadership, staff, resources, and explicit responsibilities. Finally, we need a policy framework which will guide the development of this program and will provide a mandate for the development of specific activities.

Specifically the Committee Recommends That:

1. Current community work and commitments should be presented at the total Connecticut Mental Health Center staff meetings for a discussion of our current status.

2. The constraints and supports which affect our activities in the community should be acknowledged and discussed openly. These stem from the Department of Psychiatry, New Haven politics, internal Connecticut Mental Health Center conflicts, the State Department of Mental Health, the medical school, and so on.

3. The Connecticut Mental Health Center should be capable of intervening in various ways in the community. More needs to be known about the various kinds of intervention and their applicability under different social conditions. Three broad categories should be experimented with and evaluated: (a) Neutral mediator; (b) Catalyst: instigator of actions by others; (c) Advocator: initiator of actions and programs aimed to stimulate social and institutional change.

4. Now that the present Committee and the Committee on Structural Reorganization have made their reports, a decision regarding the reorganization of the Connecticut Mental Health Center should be made promptly. We recommend that a Division of Community Services be established, with a Director whose organizational status is equivalent to that of the Clinical Director.

5. We recommend that a Planning Group for Community Services be appointed. It should be comprised of staff members who have major interest in, and responsibility for, community services. The Group would consult with other staff and members of the community in their planning efforts. Its tasks are: to develop a strategy for approaching the community; to define program priorities; and to address itself to related training, research, and service questions.

COMMITTEE ON THE COMMUNITY FUNCTION
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In the course of its work, the Committee found itself moving increasingly from the initial focus on the August 1967 disturbance to a more general analysis of the history and functions of the community mental health center. Structural change seemed essential if the CMHC was to extend its activities beyond the intramural provision of clincial services to a more genuine involvement in the community.

Acting upon the Committee's recommendations, the CMHC appointed a task force to study possible goals, programs, and requirements for the proposed organizational change. In July 1968, the Community Division of the CMHC was formally instituted under the leadership of William Ryan, Ph.D.

Although the Committee studied only the Connecticut Mental Health Center, the program it recommended offers a broad framework that may help other organizations struggling with similar issues.

INDIVIDUALIZED TREATMENT: A PROBLEM IN INSTITUTIONAL CARE

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The responsibility for providing care to a wide variety of people with widely different problems is a significant feature of large public mental health institutions. The challenge is met, in part, by programs based on special groupings such as diagnosis (e.g., an alcoholism program) or age (e.g., a children's program or an adult psychiatric program). Within such groupings, however, the norms established for patients' behavior and response to treatment reflect a standard treatment program designed to meet the needs of a "standard" patient. For some patients these norms are contrary, or at best irrelevant, to their problems and needs.

This paper examines the individual treatment needs of patients admitted to an adult psychiatric program in a state hospital. Although the material is presented in light of my experience at the Fort Logan Mental Health Center, the problem is universal, and I believe the solutions discussed could apply to any mental health institution.

The Clinical Setting

The Adult Psychiatry Division at Fort Logan comprises nine clinical teams, each composed of approximately twenty staff persons. The Center's catchment area covers Denver and its adjacent counties. Each treatment team is assigned a geographical portion of the catchment area and receives from it all cases of severe mental illness requiring more than outpatient care or short-term crisis intervention. The caseload includes acutely psychotic and neurotic patients who respond to intensive intervention, chronically disturbed patients who may require months or

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years of intensive treatment, patients with character disorders who have not responded to other programs or who come directly from a law enforcement agency, and retarded or senile patients who require appropriate placement with another agency. Providing adequate treatment for this diverse group is a basic problem for each team.

Treatment Philosophy

The Center's Adult Psychiatry Division teams seem to have similar cultures and similar expectations of patients. The treatment programs are oriented toward patients who will benefit from, and respond to, a short-term, intensive, counter-dependent program, followed by supportive outpatient care or community placement.

When patients come to the Center, they enter into a treatment approach termed "therapeutic community." The concept of the therapeutic community has been widely described in recent years (1, 2, 3, 4), and only a summary of some fundamental ideas is required here. The "community" of patients and staff form the therapeutic agent, with treatment focused on the relationship of the patient with the total group. Through the "group culture," as expressed in the expectations of behavior, the meetings and activities, and the governmental organization and rules, each patient forms a relationship with the "community." He brings to that relationship his long-standing patterns of behavior and his current anxieties and symptoms. Interaction between the patient and the group is expected to result in improved social functioning and a lessening of psychiatric symptoms.

The therapeutic community approach is appropriate and beneficial for many of Fort Logan's adult patients but, in my opinion, not for all. To maintain its cohesiveness, the community may demand conformity of behavior at the expense of the needs and freedom of an individual patient. At some point, the community of staff and patients together must determine what is in the best interests of a particular patient. Is it more important to maintain cohesiveness by forcing him to attend daily meetings that may be irrelevant to his treatment or to excuse him and risk loosening group control over other patients who need to be pushed to participate?

The Misfits

Patients who do not fit readily into the therapeutic community model can be described in four general categories:

1. *The patient for whom placement is the only realistic goal.* Typical of those for whom no benefit can be anticipated from the Fort Logan program is the patient who requires nursing home care or who must be deported to his state of legal residence. The team usually resents such a patient, not because he presents management problems, but because he occupies a bed, often requires extra administrative work, and is not an appropriate candidate for the program.

When there are several "placement" patients in a unit at the same time, the team finds it not only difficult to tolerate their lack of involvement but also difficult to determine the extent to which these patients should participate in a program that does not meet their needs.

2. *The patient who fails the program.* A patient may participate in the prescribed activities for the prescribed period of time without showing the improvement necessary to return to the outside community. He may be actively resistive to change, and, by his resistance, may become a problem. This is the patient who, in the traditional state hospital organization, would be transferred from the intensive treatment unit to the continued treatment unit after about three months.

If the culture expects a quick response to treatment, the failure of a patient to respond is often seen as defeat. The staff and other patients tend to withdraw from the patient in discouragement and anger instead of revising their expectations and continuing on a long-term basis. It may be that the day-to-day stimuli of the program should be less intensive for this patient. Further, if the patient cannot adapt to group social controls for the necessary period of time, he may need a setting with more physical controls, i.e., locked doors.

3. *The patient who can return to the community after a relatively brief period of intensive therapy, but who might benefit from additional long-term psychiatric treatment.* A personal disappointment in my work on a Fort Logan team has been the failure to keep some patients in a long-term therapy relationship in the hope of changing their basic characterological make-up. The patient who seems amenable to this type of treatment usually is younger and more intelligent than the norm. He is

less "set in his ways" or indicates an intense frustration with his current adjustment and, consequently, a willingness to risk some changes. The team culture has difficulty supporting these goals, however, because of the dominant value of brief treatment and the strong fear that the patient will become dependent upon the hospital. To make a characterological change, the patient would have to become dependent upon the hospital, at least to a degree, and possibly for more than a few weeks of 24-hour care. Team emphasis on counter-dependence may prevent the patient from forming a group relationship deep enough to permit changes of which he is capable. Thus, the dominant group norms interfere with an optimum treatment program. In such cases, the team should not withdraw from the patient or allow him to withdraw from the team; rather, the team should be willing to shift its approach and its expectations and to commit itself to remain involved with the patient for an indefinite period of time.

The short-term, intensive orientation of the program is almost self-perpetuating because of the rapid turnover of patients. Often an intense treatment relationship between the staff and a particular group of patients is thwarted by the arrival of additional acutely disturbed patients who displace the other patients by demanding the attention of the staff and the group. At this point, the displaced patients may either withdraw from therapy and return to the community or remain in treatment but partially withdraw from the group. In either case, both they and the group cease to struggle with their behavior. The number of patients who can become involved in the community through community meetings seems to be limited, and the somewhat uncontrolled admission rate often forces patients to withdraw prematurely from active involvement.

For a few patients, a form of long-term characterological therapy has seemed to occur over the course of several admissions. The patient who withdraws prematurely from treatment on his first hospitalization may return to treatment ready to look more closely at the reasons for his recurrent difficulties. In these cases, contrary to common opinion, rehospitalization may not be a failure.

4. *The patient with a character disorder.* A fourth group of misfits in the Fort Logan program are individuals who are neither psychotic nor neurotic in symptomatology, but who come to the hospital as a result of their manipulative, acting-out behavior. The patient with a character disorder is usually young, often has a criminal record, and often engages

in alcohol or drug abuse. Frequently, he is difficult to work with under any circumstances, and the inflexibility of the Fort Logan program seems to create additional difficulties.

Again, expectations and the treatment program are established with psychotic or neurotic patients in mind. Both the staff and other patients are more comfortable with the psychotic or neurotic patient, have less difficulty understanding him, and are more willing to work with him. The team tends to see the patient with a character disorder as unmotivated or as an unsuitable candidate for psychiatric treatment, and the team tends also to have less tolerance of his acting-out behavior. It is easy to confuse an appropriate confrontation technique for helping a patient recognize and understand his behavior with the inappropriate approach of setting limits that he cannot meet and that subtly maneuver him out of treatment. The acting-out psychotic often evokes increased sympathy and investment on the part of both the patients and the staff, but the patient with a character disorder is often scapegoated and rejected. The whole question of whether the latter patients can be treated in the same program with neurotic and psychotic patients needs review. In what way should expectations for patients with character disorders differ from those for psychotics or neurotics?

DISCUSSION

The problem of individualizing treatment in a program that encompasses a wide variety of patients cannot be solved categorically, but in many instances the problem can be modified.

A mental health facility should avoid ideological decisions that establish one treatment approach as superior to any other and that unnecessarily limit the available choices for treating any given patient. In its first few years of operation, Fort Logan erred in assuming that individual psychotherapy was generally less effective than a therapeutic community approach or, at least, that the two approaches were incompatible in the same program. The opposite, and equally unjustified, belief of many facilities assumes that "real treatment" occurs in individual psychotherapy and that the benefits of a milieu approach are secondary. Only time and resources, not ideology, should limit treatment choices.

Fort Logan teams have assumed in many cases that group activities are superior to individual activities. For example, when one team decided to include small group psychotherapy in the treatment program, all patients were required to participate. Small group wasted the time of those patients for whom it was not suitable and reduced its effectiveness for those who could benefit. The same problem occurs in all parts of the program--group psychotherapy, workshop, occupational therapy. A therapeutic community program balanced between group-oriented and individual activities would maintain a cohesive, functional community of patients and staff. A patient should be made to feel that he is both a valued part of the community and a respected individual with distinctive needs and wishes.

Part of the teams' standard expectations of patients is a standard approach to specific kinds of problems; for example, suicidal gestures, inattendance, or lateness on the part of patients. Often an approach that seems to be effective on one occasion is employed in all similar cases with no more than cursory evaluation. Forgotten are the reasons behind the individual patient's behavior. Constant effort is needed to understand individual behavior in a dynamic way and to tailor proven approaches to a specific patient.

If the foregoing statements sound glib, I have misled the reader. The greatest obstacle to individualizing treatment is our collective ignorance of what constitutes effective treatment, how to determine the appropriate program for a given patient, and how to evaluate the effectiveness of an approach once undertaken. We must achnowledge our ignorance and reevaluate our established conclusions--not an easy task.

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PSYCHIATRIC TEAMS: A SELF-EVALUATION

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In a previous paper (1) the authors developed the theme that there is little theoretical agreement about many aspects of psychiatric teams and that exploration and testing at the empirical level are needed. This paper presents empirical data derived from a questionnaire designed to test five hypotheses. The questionnaire was intended to first learn the extent of professed team membership among hospital employees and then to obtain information about ideas held regarding requirements for membership, team structure, team leadership, supervision of team members and freedom of members to participate in team functions. Almost all of the questionnaire items were forced choice; only a few open-ended questions were included. The objective was to obtain responses from employees who considered themselves members of psychiatric teams. The investigators did not provide a definition; thus, membership in a psychiatric team was self-defined by each respondent.

The pretested, self-administered questionnaire was distributed to 634 staff members and trainees of the Veterans Administration Hospital at Topeka, Kansas. Only subjects whose occupations or work assignments placed them in close proximity to psychiatric patients were selected. Two hundred thirty-eight questionnaires were returned, with 148 respondents identifying themselves as members of one or more teams. Eighty-two respondents indicated they did not consider themselves team members; seven did not make codable responses. Almost all psychologists, psychiatrists, and social workers returned the questionnaire and professed team membership. Only a small percentage of the housekeeping

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staff returned the questionnaire and none professed team membership. Less than half of the night nursing staff responded, and the majority of those who did indicated non-team membership. Previous study (2) has indicated that non-respondents tend to be unfamiliar with the subject matter, and, in this study, it was assumed that most of the non-respondents were not members of a psychiatric team.

RESULTS

Team Membership

The first hypothesis tested was: Claimed membership on the psychiatric team is related to education, authority, or work assignment.

The hypothesis was partially confirmed; data showed as education increased, the tendency to consider oneself a team member increased, with the notable exception of the nursing aides, who ranked near the bottom on education but near the top on profession of team membership.

The eight occupations represented were rank ordered by years of education necessary to meet the entrance requirements of each occupation, and these ranks were compared with the ranked percentages of each occupational group professing team membership. (see Table 1).

Trainees and staff members claimed team membership in equal proportions, about 70% in each group. Only 53% of those who identified themselves as administrators also considered themselves members of a team. The administrator is more likely to be concerned with communications or problems within a single profession or occupation.

Only 28% of the night shift claimed team membership compared with 64% of those on day, afternoon, or rotating shifts. Individuals working on the night shift may be less likely to claim team membership because they rarely come into contact with social workers, psychologists, and PM & R staff. Psychiatrists work on the late shift only on an emergency basis.

How do individuals attain membership? The respondents clearly indicated that the element of choice is largely lacking and that team membership is determined, for the most part, by work assignment or profession. Seventy-nine per cent reported they achieved membership in one or the other of these ways.

TABLE 1

RELATION OF EDUCATIONAL RANK TO PROFESSED TEAM MEMBERSHIP

Profession or Position	Educational Rank	Number Responding	Number Claiming Membership	Professed Team Membership % of Number Responding	Rank
Psychiatrist	1	24	23	96	1
Psychologist	2	8	6	75	4
Social Worker	3	11	9	82	3
PM & R*	4	40	24	60	6
Nurse	5	36	26	72	5
Registrar**	6	39	12	31	7
Aide	7	58	48	83	2
Housekeeper	8	22	0	0	8
Total		238	148		

r = .619

*Physical Medicine and Rehabilitation (PM & R) included corrective, educational, industrial, and manual arts; occupational, physical, recreational, and speech therapists. Completion of standard college training is a requisite for employment in any of these positions.

**Registrar staff included the ward and clothing clerks on all psychiatric units. Responses indicated a clear split, with the ward clerks professing team membership and the clothing clerks denying membership.

Team Structure

The second hypothesis was: Team members are unaware of the structure, i.e., the membership, purpose, and organization of teams.

The hypothesis was not confirmed. However, especially interesting was the finding that the professions or occupations with lower educational requirements (nurse, aide, registrar, and PM & R) more often than the group with higher educational requirements (psychiatrists, psychologists, and social workers) reported that their teams had an explicit statement of purpose.

Membership. When asked the size of their psychiatric team, just over half (53%) of the respondents described their team as relatively large, i.e., composed of ten or more members. About one-fourth (27%) of the respondents stated their team had nine or less members. The remaining respondents (20%) failed to answer this question.

Most respondents identified themselves with one or two distinct teams. Relatively few respondents claimed more than four team memberships, and these tended to be psychiatrists assigned to more than one ward.

Knowledge of purpose of teams. One hundred and four (70%) of the respondents said their team had developed a statement of purpose. However, when the seven occupational groups studied were dichotomized into upper and lower levels, 84 (76%) of the 110 lower level members reported an explicit purpose, compared to only 20 (52%) of 38 in the upper levels.

(See Table 2 on page 73)

TABLE 2

STATEMENT OF PURPOSE COMPARED TO OCCUPATION

Has Your Team Developed An Explicit Statement of Purpose?	Physical Medicine and Rehabilitation Staff, Nurses, Nursing Assistants, Clerical Staff	Psychiatrists, Psychologists, Social Workers	Total
Yes	84	20	104
No	12	18	30
No response	14	---	14
	110	38	148

$x^2 = 19.086$, $p > .001$

The difference between upper and lower groups may be related to and partially explained by an additional finding. Responses to the question, "What is the profession or occupation of your team leader?" suggested that there are two sets of teams operating at this hospital: one set led by a psychiatrist, with psychologists, social workers, and PM & R's as members; the other set led by a nurse, with aides and secretaries as members (see Table 3). This finding suggested that the nurse and her team tend to be task-oriented, and that specificity of purpose is related to the explicit nature of these tasks.

(See Table 3 on page 74)

TABLE 3

OCCUPATION ASCRIBED TO TEAM LEADER BY PROFESSIONAL GROUPINGS

Occupation of Team Leader	Cluster 1*	Cluster 2**	Total
M.D.	47	19	66
R.N.	2	39	41
Other	10	9	19
No Answer	3	19	22
Total	62	86	148

$x^2 = 55.512$, $p > .001$

* Cluster 1 is composed of PM & R, Psychology, Psychiatry, and Social Work.

** Cluster 2 is composed of members of the Registrar division, R.N.'s, and aides.

Organization of teams. In this study all professions or occupations except one (housekeepers) were represented on the team. Only three (2%) team members said there were professions or occupations represented on their team that should not be represented. The data showed that 108 (73%) subjects agreed with the statement, "Everyone who works with patients in any capacity is a member of a psychiatric team."

Team Leadership

The third hypothesis was: Leadership of the team is determined primarily by professional affiliation.

The hypothesis was confirmed. It was found that team leadership accrued most often to psychiatrists and nurses. The pattern of leadership-membership suggested there were two sets of teams in this hospital: one led by the psychiatrist with the social worker, psychologist and PM & R

staff as members, and one in which the nurse is the leader with the aide and secretary (registrar) as members (see Table 3).

Of the 148 respondents, 66 (44%) said the profession of their team leader was psychiatry or medicine; 41 (27%) said a nurse was their team leader; 20 (14%) said their leader was some other professional or that leadership was shared or rotated and 20 (14%) gave no answer or indicated their team had no leader. The failure of PM & R members to impute team leadership to nurses suggests rivalry between the two professions.

A possible difference between the professions in Cluster 1 and Cluster 2 is the amount of immediate and continuous contact each has with patients. Members of Cluster 2 see patients throughout the day while those of Cluster 1 tend to see patients on an irregular basis. As a corollary, the respondents were asked if they thought that the physician should always be the leader of the team. The results were substantially the same, i.e., 68 (46%) agreed, 74 (50%) disagreed, and 6 (4%) did not answer.

Supervision of Team Members

The fourth hypothesis was: There is uncertainty among team members as to whether they are supervised by their profession or by the team.

The hypothesis was not confirmed. One hundred thirty-six (92%) respondents answered yes to the question of having a supervisor, When asked, "Is your supervisor a member of your profession?", 114 (77%) answered yes, 21 (14%) answered no, and 13 (9%) did not answer. Ninety-nine (67%) said their supervisors were not members of their team.

In answer to the question, "Are you supervised by the team and also by your profession or occupation?", 90 (61%) reported dual supervision; 44 (30%) did not have dual supervision. In response to the statement, "The psychiatric team provides better supervision to its members than does the individual profession," 95 (64%) agreed; 47 (32%) disagreed. Agreement with this statement suggests a conflict in loyalty between the team and the profession and this may be a source of conflict for the individual or an opportunity to avoid supervision. (1)

Participation in Team Functions

The fifth hypothesis was: The individual's freedom to participate in team functions is unrelated to his education, authority, and work assignment.

The hypothesis was confirmed. Of the 148 team members, 142 (96%) said they felt free to contribute to the team and 104 (70%) said the team "uses my talents fully." Freedom to disagree with other team members was expressed by 139 (94%) of the team members and 126 (85%) felt free to disagree with the team leader. The team members agreed remarkably well that they share knowledge and learn from each other. Apparently, when an individual feels he belongs to a team, some universal rights accompany this membership regardless of education, authority, or work assignment.

There was enough agreement among team members on the following three statements that one may take them as common assumptions when speaking of psychiatric teams. The statements are: (1) Members of the professions bring their knowledge to the team meetings, and the team meeting is essentially an interchange of information. (130 (88%) agreed.)

(2) The information about patients that I bring to team meetings is carefully considered by most other members of the team and is utilized in making decisions about those patients. (130 (88%) agreed.)

(3) The psychiatric team should offer an opportunity for each team member to learn something about what each of the other members are doing. (142 (96%) agreed.)

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VARIABLES RELATED TO VISITING RATE OF HOSPITALIZED MENTAL PATIENTS*

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In recent years, community interaction has played an increasingly important role in the philosophical concepts of rehabilitation and treatment programs for mental patients. It is believed that visitors to hospitalized patients not only aid the patient's therapeutic progress, but by maintaining his connections with the outside world, facilitate his readjustment to family and community after discharge (3, 4).

Few data are available on the incidence of visitors, the reasons for visiting or not visiting, the types of patients receiving visitors, or the effects of visitors upon patients' response to treatment. Results from studies in this field have not been consistent; some (1, 2, 4, 6, 7) have indicated that the frequency of visiting decreases with increased length of hospitalization. Archese (1), Rose (6), and Groth, et al., (4) found also that visiting frequency decreased as age of the patient increased. Other reports (2, 7) have shown no relationship between age of patient and visiting frequency. Investigating the relationship of the patient's sex to visiting frequency, Evans and Bullard (2) found that females were visited more often than males.

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Several studies have sought to determine whether the distance between home and hospital influenced the number of visitors a patient received. Groth, et al. (4), studying a hospital population in a sparsely populated area, found that as distance from the hospital increased, the number of visitors decreased. Archese and Sommer (1, 7), investigating more populated areas, found no relationship.

PROCEDURE

The present study was designed to compare visiting frequency with the variables of the patient's age, sex, religion, marital status, socio-economic status, educational level, diagnosis, rural or urban residence, total number of admissions to a mental hospital, admission status (voluntary or involuntary) of the most recent admission, length of most recent hospital stay, total time hospitalized in all admissions, and distance between the patient's residence and the hospital.

The subjects were 155 patients at the Wyoming State Hospital, randomly selected from four counties of varying locations within the state. Data were taken from the patients' medical charts and the hospital's visiting records for the period from June 1, 1963 to December 21, 1964. Visiting frequency was converted into a visiting ratio, i.e., mean number of visits per month of hospitalization. A chi square analysis was then computed between all independent variables and visitor ratio (Table 1). Except for the factor of distance, the variables were represented among the four counties such that all counties could be treated as one group statistically.

(See Table 1 on page 53.)

TABLE 1

CHI SQUARES FOR INDEPENDENT VARIABLES RELATED TO VISITOR RATIO

INDEPENDENT VARIABLES	df	X^2
Distance of patient's residence from hospital	6	37.117****
Rural-urban residence	2	7.940**
Diagnosis	3	14.921***
Type of admission	4	15.889**
Age of patient	6	21.797***
Length of current admission	6	29.282****
Number of admissions per patient	4	12.514**
Total time hospitalized	6	29.452****
Socioeconomic status	4	3.058
Education level	2	2.924
Sex of patient	2	2.006
Religion	2	3.716
Marital status	6	9.369
Number of children	2	7.674*(median test)

* $p < .05$
** $p < .02$
*** $p < .01$
**** $p < .001$

RESULTS AND DISCUSSION

The variables found to be related significantly to visiting rate were distance, rural-urban residency, diagnosis, admission type, age, length of hospitalization for current admission, total number of hospital admissions, total time spent in a mental hospital, and number of children.

Distance. Patients from a radius of 50 miles (the approximate area of the county housing the Wyoming State Hospital) received significantly more visits than those residing between 330 and 460 miles from the hospital. However, variations within the 330 to 460 miles did not appear to affect visitor frequency. These findings were consistent with those of Archese (1), Sommer (7), and Groth, et al. (4). Groth, et al., also reported an abrupt decline in visiting frequency beyond a 500-mile radius from the hospital.

Rural-urban residency. Patients from rural areas had both a higher frequency of visits and a lower frequency of no visits than did urban patients. A possible explanation for this finding might be the different environmental and social influences in rural and urban cultures. The rural culture seems to give rise to strong family and companionate ties that result in frequent visits to a hospitalized member of the family and community. Perhaps the members of a rural family are also more interdependent than those of an urban family.

Diagnosis. There was a significant relationship between diagnosis and frequency of visits; as the severity of disorder increased the frequency of visits decreased. It would seem that visitors to patients with less severe mental disorders not only deem their visits more rewarding to the patient but also have more hope of the patient returning home.

Admission status. Patients admitted voluntarily received more visits than patients admitted by a Physician's Certificate or other involuntary means, perhaps because an involuntary admission involves a degree of coercion and, thus, may represent tensions between a patient and his family. It also seems possible that voluntary admission procedures reflect the financial ability to initially transport the patient to the hospital (the State of Wyoming provides transportation for involuntary patients) and, consequently, greater financial ability to subsequently visit the patient.

Number of admissions. As the total number of admissions per

patient increased, visiting frequency increased. Relating the number of admissions to length of time in the hospital may explain this result. Of the 44 first-admission patients who received no visits, 31 had been hospitalized for more than five years; most of these had been hospitalized for more than 20 years. Patients with several hospitalizations could be expected to be less disturbed and to have been with relatives during the time between admissions. If the patient's absences were only intermittent, one would expect interpersonal relationships to be stronger and, therefore, visiting to be more frequent. If continued community contact with patients is regarded as a desirable goal, this finding lends some support for rapid treatment and discharge of patients in spite of the risk of subsequent readmission.

Age, total time in the hospital, and time during current admission. Generally, visiting frequency decreased as the patient's age increased. Although length of time in the hospital was a basic factor in rate of visits, length of time during the current admission was a more crucial factor than total time in the hospital. As noted previously, patients whose total time spent in a hospital was divided into several admissions received more visits than patients who were hospitalized continuously for an equal amount of time.

Socioeconomic status. No significant relationship was found between frequency of visits and the patient's socioeconomic status. This unexpected finding is perhaps explained by the inadequate sampling of socioeconomic class in this study. Hollingshead and Redlich (5) noted that mentally disturbed patients from high social classes were primarily treated at private clinics and hospitals, whereas patients from middle and lower classes were predominately treated in state-supported hospitals. It seems, then, that if other conditions are equal, the patients in a state institution have an equal chance of receiving visits.

Education. No relationship was noted between frequency of receiving visits and a patient's educational level. Patients who had completed between one and eight years of schooling received no more visits than those who had finished the ninth grade or above. The limited sample size prohibited more than a dichotomic catergorization; a more heterogeneous classification of educational levels might have shown a difference. It may also be, however, that increased knowledge of the dynamics of mental illness has little effect upon visiting frequency.

Sex. Although females tended to be visited more frequently than males, the difference was not significant. The reason for this finding, which is not congruent with previous studies, was not determined from the data and further study would be necessary to explain the discrepancy.

Religion. A comparison between visiting frequency and patients of Catholic, Protestant, and Mormon religions revealed no significant relationship. This may be due to the fact that family ties that would influence visiting are a function of the culture as a whole rather than of religious belief.

Marital status. No association existed between marital status and visiting rate. Rose (6) found that the mother was the most frequent visitor to hospitalized patients and the same circumstance may account for the lack of association in this study. Further, for unmarried patients, frequent visits of the mother compensated for the absence of a wife.

Number of children. Married patients with children received more visitors than married patients with no children. However, patients with four or more children tended to receive fewer visitors than patients with three or less children. Perhaps the expense and difficulty of providing care for the children influenced the decrease in visiting to patients with large families. If so, community organizations could contribute immensely to the mental health program by providing child care services.

CONCLUSIONS AND RECOMMENDATIONS

If community contact with hospitalized mental patients is believed to facilitate recovery, it is important to find means of increasing interaction between the patient and the community. Perhaps patients could benefit from more frequent and extended home visits or convalescent leaves. Although the variable of convalescent leave was not studied, the medical records showed a greater number of visits to patients who were permitted home visits than to those who were not.

Increased interaction between the patient and the community might be achieved through an education program by the hospital for families of hospitalized patients, particularly families of psychotic patients. Such an educational endeavor could emphasize the large proportion of cases in which the patient's chances of remission are favorable, offer practical

suggestions for coping with problems that might arise during a patient's home visit, and stress the potential benefit to patients and families in maintaining close contact through both home visits and visits to the patient at the hospital. Routine reports to families about the patient's status might establish closer liaison between the institution and the patient's family and home community.

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FAMILY CARE AND POST-DISCHARGE COMMUNITY ADJUSTMENT*

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The development of a comprehensive approach to mental health problems has emphasized the use of community resources in the treatment of the mentally ill. Family care, in particular, has been used increasingly to help mentally ill persons find patterns of life in a family setting compatible with their individual needs (5). Placement in a family care home is no longer seen as the epilogue of unsuccessful therapy but as a possible prologue to the patient's return to independent functioning.

Morrissey (6) described three current uses of family care: (a) *intermediate placement* to provide temporary living arrangements for patients who are ready to move into the community, seek employment, and establish independent living situations; (b) *interim treatment placement* for patients who complete an adequate period of institutional therapy but need additional treatment experience in a home situation before moving into the community; and (c) *resident placement* for patients who, because of the chronic or irreversible nature of their illnesses, cannot be expected to experience further progress in intensive treatment and who require permanent and protected living arrangements.

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Perhaps because of the past tendency to view family care primarily as a resource for long-term placement, most outcome studies on family care have considered only the adjustment of patients within the placement homes (1, 4, 7). Little attention has been given to measuring the usefulness of family care as a means of moving the patient toward better social functioning in the community. This study sought to assess the influence of family care upon the patient's adjustment in the community after discharge.

The research was conducted in cooperation with the Fort Logan Mental Health Center, Denver, Colorado, which initiated its family care program in 1962. Although the hospital makes some use of resident placements, it stresses family care as a primary resource for intermediate and interim treatment. The center's over-all philosophy of fostering patients' self-responsibility and growth in meeting the obligations of family and community life and its use of family care as an active treatment modality provided an ideal basis for the evaluative work undertaken.

The follow-up study had five objectives:

(a) To determine the current employment, family, and community adjustments of discharged patients who had experienced family care.

(b) To obtain the patient's current perspective of his adjustment prior to admission to Fort Logan and his appraisal of his current level of functioning.

(c) To categorize the goals of family care placement specified by the staff of Fort Logan for individual patients.

(d) To explore the patient's perspectives of his family care experience.

(e) To identify the characteristics of discharged family care patients who were rehospitalized at the time of the study.

METHOD

Instruments

The research project was designed to obtain information on

selected characteristics of the total patient sample and then, through personal interviews or information from relatives, to further study the patients who were able to remain in the community after discharge. To gather the desired data, three documents were designed by the research team:

(a) The *Fort Logan Record Schedule*, to record the personal, social, and psychiatric data tabulated by Fort Logan at the time of the patient's admission and during his course of treatment. This information was obtained for the total study sample.*

(b) The *Personal Interview Schedule*, for information about employment and vocational training, community and family adjustment, health and social services, and the patient's perspective of his family care experience. A pre-test to determine the appropriateness of the Personal Interview Schedule did not result in any significant alteration of content; therefore, the data gathered were included in the study.

(c) The *Relative's Questionnaire*, concerning the patient's current level of functioning, to be sent to the relatives or friends of patients who could not be interviewed.

Subjects

A total of 289 patients at Fort Logan experienced one or more family care placements between May 1962 and September 1966. The population selected for study consisted of all patients (N = 141) who, at some time during treatment, had been placed in family care and who had been discharged from the hospital prior to July 1, 1966.

Procedure

The research team first determined which of the 141 patients were rehospitalized at Fort Logan (N = 25) at the time of the study (January

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1967); the remainder (N = 116) were assumed to be in the community. A letter that explained the study and requested a personal interview was sent to the latter group. The research staff then telephoned the patients to arrange interviews. Table 1 shows the results of the initial inquiries.

TABLE 1

LOCATION OF STUDY POPULATION AS OF JANUARY 1967

Located		
Not rehospitalized; interviewed		33
Not rehospitalized; not interviewed		
Patient moved away	15	
Refused interview	7	
Imprisoned	1	
Incompetent	1	24
Rehospitalized; not interviewed		
At Fort Logan	25	
At other facilities	16	41
Deceased		3
Not located		40
Total		141

If a patient could not be reached or if he refused to be interviewed, a close relative was sought to complete the Relative's Questionnaire. A completed questionnaire was obtained for 21 of the 24 patients not interviewed and not rehospitalized. Patients found to be rehospitalized at Fort Logan or another facility received no further inquiry.

The loss of 24 potential interviews raised questions concerning the validity of the study, but comparing the potential group with the inter-

viewed patients on demographic and psychiatric variables from the Fort Logan Record Schedule revealed no significant differences except in marital status. In the non-interviewed group, the number of single persons was disproportionately low (N = 8), and the number of divorced persons was disproportionately high (N = 14). Because the two groups differed only on this variable, the interviewed group was considered representative.

RESULTS AND DISCUSSION

The entire sample was used in the initial descriptive analysis of the demographic and psychiatric data from the Record Schedule. There were 71 male subjects, and 70 female; the group was predominantly Caucasian, single, and Protestant. The mean age was 41.4 years, with a range of 18 to 81 years. The mean years of education was 11.0, but years of education completed ranged from zero to 17 years. Unskilled and semiskilled workers represented a large part of the sample, and the data indicated relatively poor employment records prior to admission.

The majority of the patients were admitted on a voluntary basis, and 117 had been admitted only once as of July 1, 1966. However, by January 1967, 17 of this group had been rehospitalized. For most of the sample, length of hospitalization was from one month to two and one-half years; 20 patients had longer stays, and 13 of these were among the 41 rehospitalized at the time of the study. Over half of the population had diagnoses of schizophrenia at the time of admission. Family care placements generally lasted from one month to one year. The majority of referrals to family care were intermediate or interim treatment placements, and most of the sample experienced only one placement.

The results of the data analysis of the Personal Interview Schedules and the Relative's Questionnaires, 54 records in all, are presented within the framework of the study's five objectives.

1. *Employment, Family, and Community Adjustment*

The first objective sought to determine the current employment, family relationships, and community adjustment of the discharged patients.

Current employment. Thirty-eight of the 54 patients were considered

employable. Six housewives and four persons over 65 years were excluded, and in six cases no information was given. Table 2 shows the distribution of occupations and employment status.

TABLE 2

CLAIMED OCCUPATION PRIOR TO ADMISSION
BY EMPLOYMENT STATUS SINCE DISCHARGE

Occupation	Employed Full Time	Part Time	Unemployed	Total
Executive & Major Professional			1	1
Business Managers & Lesser Professional	1		4	5
Administrative & Minor Professional	3			3
Clerical, Sales & Technicians	4		3	7
Skilled Manual Work		1		1
Machine Operator & Semi-skilled	2	1	4	7
Unskilled	2		8	10
Students*			3	3
None			1	1
TOTAL	12	2	24	38

*Students were assumed to be preparing for eventual employment: therefore, they were not eliminated from the employable population.

The number employed increased from two at the time of admission to 14 at the time the post-discharge data were collected. Ten of the 14 stated that they had been experiencing job difficulties before admission; thus, the Fort Logan program may have been a constructive rehabilitative force for them. Five other patients had had a period of employment after discharge. Only one of these gave a positive reason (quitting to go to school) for terminating employment. The relationship between time in family care and employment or unemployment was not statistically significant.

The two patients who had been employed at admission and three who had been temporarily unemployed returned to their former jobs. Although for some of the others the level of employment was lower than the claimed occupation at admission, most of the employed reflected positive attitudes about their jobs.

Information about income was fragmentary. Six of the full-time employed reported their monthly incomes, which ranged from $160 to $500, averaging $318. Fifteen of the unemployed responded, showing an average income of $122 per month. Sources of income for the unemployed were about equally divided between social security benefits and public assistance; in a few cases, income was supplemented by families.

In spite of the increase in employment after discharge, almost two-thirds of the patients were not employed. Most had had job problems before hospitalization; eight had not held any job during the two years preceding admission, and ten had changed jobs three or more times during that period. Their reasons for not working reflected lack of motivation or continued mental health problems.

It was particularly interesting that of the nine patients with more than high school education, six were unemployed. Although none of the unemployed listed employer prejudice as a reason for not getting a job, this may be a greater detriment to expatients seeking positions of high responsibility than to those eligible for less demanding jobs.

Unskilled laborers predominated in the unemployed group, and fewer of them had received vocational training during treatment. The unskilled person is rapidly becoming superfluous in our society; thus, one might assume that the unskilled person with a record of hospitalization for mental illness would be even more handicapped in occupational opportunity than his nonhospitalized counterpart. In view of this, perhaps the

applicability of the Fort Logan vocational training program to the unskilled worker should be re-evaluated.

Of the 24 employable patients with diagnoses of "schizophrenic reaction" or "paranoid schizophrenia," only six (25%) were currently employed. Since this percentage was markedly lower than the combined employment rate (58%) in the other diagnostic categories, schizophrenia may be the most incapacitating illness. If the percentage of schizophrenics among all Fort Logan patients is as high as it was for the study sample, it might be of interest to the Center to examine further the relative potentiality for employment in this diagnostic category.

Family adjustment. The majority of the interviewed respondents said that their relationships with family and friends were satisfactory following discharge from Fort Logan. Some of the responses suggested that the Center played a helping role in this aspect of their adjustment. The Center's emphasis on involving families in treatment and providing opportunities for group interaction may encourage the continuing use and development of socialization skills. The ease with which patients said they readjusted to friends and family also may indicate increased community acceptance and understanding of mental patients and their problems, although they may not have encountered the same degree of acceptance among employers.

Community adjustment. Although most respondents reported satisfactory personal relationships, few indicated participation in organizations or clubs. Leisure activities reflected the respondents' preference for passive, non-interactional pastimes involving one or two friends at most. In view of the group activities that patients experience at Fort Logan, it was interesting that more patients did not become involved in groups after discharge. Two basic speculations may account for the lack of involvement: First, community resources may have been lacking or, if existing, unaware of the patient's needs. Second, the patient may not have had the interest, the knowledge, or the ability to seek out community groups on his own.

2. *The Patient's Perspective of His Adjustment*

The second objective of this study concerned the patient's present perspective of his physical and emotional health prior to

admission to Fort Logan and his appraisal of his current level of functioning.

In the interviewed group, 29 patients considered themselves in fair, good, or excellent physical health. However, 13 were taking medication for "emotional problems," and 11 were receiving some type of professional counseling. Seventeen patients reported improvement in the areas that had troubled them at admission, and the majority credited the improvement to treatment at Fort Logan. Some patients said that their problems were unchanged but that after treatment they had felt better able to cope with their difficulties.

Relatives of patients not interviewed were not asked about the patient's physical condition, only whether he was known to be receiving help for emotional problems. Eleven of the 21 were reported to be adjusting satisfactorily, so it was assumed that these patients had no major physical problems. Seven of the 21 patients were receiving professional counseling.

In assessing community functioning, the perspective of patients may be markedly different from that of relatives. Most of the patients whom the staff discharged as "ready to return to the community" agreed that they were, but relatives tended to disagree. In four of nine instances in which non-interviewed patients were considered ready for discharge, relatives reported that the patient had not adjusted well.

The fact that only 17 of the 33 interviewed patients reported improvement and that only 11 of the 21 not interviewed were reported to be adjusting satisfactorily may indicate a need to provide greater assistance to the discharged patient in using counseling resources.

3. *Goals of Family Care*

The third objective of the study was to identify the goals of family care placement specified by the staff of Fort Logan for the total sample of 141 patients.

Reasons for referral. In a majority of cases, the researchers extracted from the Medical Record Transfer Notes the staff statements under the heading, "Reasons for Family Care Referral." If no reasons were given, or if transfer notes were missing from the record, the research team reviewed the general information from the medical record and

attempted to infer the basis for referral. The team next classified the reasons according to Morrissey's (6) categories--intermediate placement, interim treatment placement, or resident placement.

Because the decisions required of the researchers limited this section of the study, an independent classification of the same data by the Fort Logan chief of Patient Services was used to check the reliability of their judgments. A consensus on classification was reached in 109 cases. Table 3 shows this distribution, and in the remaining 32 cases, the classifications made by the research team and by the chief of Patient Services.

TABLE 3

REFERRAL CLASSIFICATION

Classification	Consensus Distribution	Differences	
		Research Team	Chief, Patient Services
Intermediate placement	27	11	0
Interim treatment	37	4	18
Resident placement	35	16	6
Unclassifiable	10	1	8
Totals	109	32	

In the cases in which the judges disagreed on the reasons for referral, frequently the *needs* of the patient were cited (e.g., "needs firm control"), but the *intent* of the placement in terms of projected outcome was not stated.

Intent of family care placement. In establishing the family care program, the staff at Fort Logan placed primary emphasis on providing a

therapeutic experience and preparing the patient to return to the community. "Transition from the hospital to family care is not for the purpose of providing custodial care for one who is sick, but rather an opportunity for further rehabilitation and family living." (5)

In spite of policy intent, almost one-third of family care referrals were predicated on the need for resident placement, with little or no formulation of an eventual goal of returning to the community. Possibly there were discrepancies between administrative goals for family care and staff expectations for the patient. That is, in making a referral to family care, the administrative staff may have considered the patient incapable of rehabilitation, while family care sponsors and other staff members assumed that eventual return to the community was the primary goal. The research team believed, therefore, that the staff should re-examine the goals of the family care program for this significantly large group of patients.

4. *Patients' Perspectives of Family Care*

The patients' feelings about family care experiences were predominantly positive. The most frequently mentioned recommendations for changes in the program were for better patient preparation prior to placement and for more activities while in family care.

Twenty-six of the interviewed group stated that they had looked forward to going into family care, although 13 said they had no clear idea of why they were doing so. Most of the patients did not consider themselves involved in the choice of a home to the degree specified in Fort Logan policy statements. Fourteen said that they had not had the opportunity to choose between two or more homes.

Twenty-one preferred living in a home with other patients and felt that it gave them greater opportunities for socialization and sharing experiences. This seemed inconsistent with the solitary nature of the family care activities that occupied most of their time, i.e., reading, watching television, and "just sitting around." Only 12 patients reported that they went out of the home on trips, drives, or excursions with their sponsors or other patients. Most of the group helped with household chores and spent some other time with family care sponsors, but primarily at home.

An additional recommendation for fewer group meetings at Fort Logan was of special interest in view of the study finding that very few patients participated in organized activities in the community. Was the nature of group meetings at Fort Logan such that the patient did not perceive the experience as preparing him for a participant role in group activities in the community? If, for example, such meetings focused primarily upon "talk therapy" and emotional problems, should they be expanded to involve the patient in experiences that would seem more directly transferable to community groups?

5. *Factors Associated with Rehospitalization*

Because the rehospitalized patients were not interviewed, no information was obtained about their impressions and experiences during the period between discharge and readmission. For those readmitted to Fort Logan, 24 items of personal, social, and psychiatric information from the medical records were analyzed. Only these were found to be significantly associated with rehospitalization: marital status; length of hospitalization; number and duration of family care placements; reasons for referral to family care; and reasons for discharge.

Marital status. Patients who were divorced, separated, or widowed had a significantly lower rehospitalization rate than either the single or married patients. Possibly "significant others," particularly marital partners, were unable to help discharged patients consolidate the progress made at Fort Logan. Further, marital problems may have contributed to rehospitalization. It was recommended, therefore, that these "significant others" be involved as soon and as thoroughly as possible in the patient's treatment and in the planning for his return to the community.

Length of hospitalization; number and duration of family care placements. Patients who stayed in the hospital less than one year had a greater chance of remaining out of the hospital. Similarly, a shorter length of time in family care and fewer placements were associated with remaining in the community. Two implications could be drawn from these associations. First, perhaps the patients who required only short hospitalization and a brief period in family care to achieve an adequate adjustment in the community were "healthier" to begin with. Second, increased length of hospital time and family care may contribute to

the formation of an "institutional" personality dependent on the relative security of these environments.

Reasons for referral. Rehospitalization was less likely for patients who were referred to family care for specific therapeutic purposes than for those who were referred for resident placement or for unknown reasons. This supported the desirability of designating therapeutic goals for family care referral.

Reasons for discharge. Patients discharged by the Fort Logan staff as *improved* or as having received *maximum benefit* had a significantly greater chance of remaining out of the hospital than those patients discharged for *lack of cooperation in treatment* or as having been *transferred to another institution or to private* care.

Fairweather (2) has suggested that the chronically mentally ill person may attempt to solve his problem of marginality in the community by "becoming apathetic and assuming no responsibility at all." Hence, the mental patient who seems to adjust well in the stabilized social system of the hospital may fail completely in his attempt to find new roles in the community social system.

The patients rehospitalized at Fort Logan experienced more than one placement in family care, spent more time in family care, and had the longest hospitalization. Is it possible that the goal of independent living for the chronically mentally ill is unrealistic? Is family care or some other protected living arrangement as far as some mentally ill patients can be expected to go in the community? If the rehospitalized group had, in fact, only marginal capacity for independent functioning, consideration should be given to developing ways to maintain patients outside the hospital in satisfying, but protected, environments.

Fairweather (3) reported one method of maintaining the chronically mentally ill in the community in a personally satisfying and productive capacity: the successful organization of hospitalized chronic psychotics into a group with high cohesiveness and decision-making ability. The patients were then moved into a residence in the community, where they made the daily decisions involved in caring for themselves--buying food, cooking, and housekeeping. Later, with the assistance of hospital staff, the group established a janitorial service that furnished employment for the members. Fairweather concluded that these patients were able to remain in the community because

their intradependent group situation provided social contacts, companionship, and employment.*

CRITIQUE

The purpose of this study was to measure the influence of family care upon the patient's adjustment in the community after discharge. The data offer good exploratory material, but the lack of a control group limited the study.

The outcome of family care placement could have been measured more effectively if there had been a non-family-care control group and a family care group, with similar specific variables enumerated for each group. If differences occurred between the two groups, the next step would be to analyze the variables among the three placement categories in the experimental group to determine if differences among categories accounted for the differences between the family care group and the control group.

The usefulness of this report lies in the questions it raises pertinent to program evaluation and change, e.g., in the areas of job training, preparation for family care, and the goals of family care placement, and the suggestions it offers for developing comparative measures.

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A PILOT FOLLOW-UP STUDY OF ALCOHOLISM PATIENTS

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A follow-up study of a sample of the first 1000 patients treated in the Alcoholism Division at the Fort Logan Mental Health Center was conducted to assess the major difficulties that might be encountered with a large-scale study and to evaluate the progress of patients after treatment. Other studies (1,2,3) have reported that the major problems in follow-up studies were locating patients, defining criteria for progress, and relating progress to the specific treatment programs the patients received. These studies also found that the recovery rate was highest among higher socio-economic groups, that little change occurred from a psycho-social or economic standpoint following treatment, and that only five to twenty per cent of patients treated maintained total sobriety up to one year. Most studies did not use a random selection of patients and those that did found difficulty in getting a sample large enough for statistical analysis.

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David Berman, M.D., formerly Attending Physician of the Alcoholism Division at Fort Logan, collaborated in gathering data for this study.

†The Alcoholism Division offers a two-week, intensive treatment program using didactic techniques such as films, lectures, and activity and verbal therapies, followed by on-going outpatient group therapy.

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METHOD

The first 1000 patients admitted to treatment were sent letters asking if they would be willing to participate in a follow-up study. Two hundred eighty persons (28%) replied, most in the affirmative. Every tenth patient of the 1000 was then selected to be interviewed. Forty-one of these 100 patients could not be located even through registered letters, police and missing person records, and phone contacts with relatives. Of the remaining 59, 5 had died, 27 did not consent to an interview, and 27 agreed to be interviewed. Appointments were arranged to provide an interval of at least two years between interview and the subject's first admission.

RESULTS

The sample interviewed differed from the original population in having a higher mean age (47 years versus 42 years) and a smaller proportion of females (15% versus 18%). This, added to the smallness of the group, makes it difficult to consider the 27 patients interviewed a representative sample of the first 1000 admissions. Nevertheless, information about a number of specific areas can be summarized as follows:

Sobriety Following Treatment

Sixteen (59%) of the patients were sober for a period of six months or more sometime following admission, and five of this group (18.5%) remained completely sober from the time of admission to the program to the time of interview--more than two years. In the drinking histories taken at the time of admission, none of the 27 patients indicated a sobriety period of more than three months during their previous years of intensive drinking. More than half reported that their longest period of abstinence had been less than two weeks. At the time of interview, 16 of the 27 patients were sober, 8 were obviously drinking, and 3 possibly drinking.

Employment and Productivity

Table 1 suggests a positive relationship between sobriety at the time of interview and employment.

TABLE 1

EMPLOYMENT STATUS BY LENGTH OF SOBRIETY

Status	Sobriety				
	Less than 6 months	6 to 12 months	1 to 2 years	2+ years	Total
Employed	4	2	2	5	13
Unemployed	7	5	2		14
Total	11	7	4	5	27

Of the 13 employed, 11 had full time, permanent jobs. Two in this group were drinking, and 11 were not. Of the 14 unemployed, 9 were drinking.

Twelve of the 13 employed said their jobs were satisfactory, and all except two noted either the same or better work habits following treatment. There was no significant change in income after treatment compared to before.

Prior Treatment and Hospitalization

Sixteen of the 27 patients had been treated elsewhere before coming to Fort Logan. For ten subjects, Fort Logan was their first effort at receiving help. Ten of the group had been hospitalized at some time between admission into treatment at Fort Logan and the time of interview, and 6 of these had sought help prior to coming to Fort Logan. Of the 9 patients who stayed sober more than a year, 7 had help prior to coming to Fort Logan. (See Table 2.)

TABLE 2

PRIOR TREATMENT STATUS BY LENGTH OF SOBRIETY

Status	Sobriety: Less than 6 months	6 to 12 months	1 to 2 years	2+ years	Total
Prior help	4	5	3	4	16
No prior help	7	2	1	1	11
Total	11	7	4	5	27

Social and Interpersonal Relationships

Length of sobriety seemed to influence overall improvement in interpersonal relationships after treatment. Twenty of the 27 patients felt that their work associations had improved or remained the same, and five of these believed there was much improvement. One person indicated his work relationships had worsened.

For 22 patients, there had been no change in marital status or in relationships with friends or drinking companions during the two years after treatment. Two of the 3 who lived alone had maintained complete sobriety. Of the 7 who lived with spouses and children, presumably younger patients, five reported less than six months' sobriety since treatment. (See Table 3.)

TABLE 3

LIVING ARRANGEMENTS AND LENGTH OF SOBRIETY

Status	Sobriety: Less than 6 months	6 to 12 months	1 to 2 years	2+ years	Total
Living with:					
Spouse & Children	5	1	1		7
Spouse only	2	3	1	3	9
Others	4	2	2		8
Living alone		1		2	3
Total	11	7	4	5	27

Use of Other Resources

In all, 17 of the 27 patients attended Alcoholics Anonymous after treatment--11 of those who had six months to two years or more of sobriety and 6 of those with less than six months' sobriety. Six of the 17 joined A.A. after treatment.

Patients' Reactions to Alcoholism Program

All except one of the patients felt that they were helped by the treatment program at Fort Logan, with more help ascribed to the lectures and group therapy than to individual counseling.

DISCUSSION

The results of this pilot work were similar to those of the studies cited with one exception: 33% of this study sample, compared to 5% to 20% in the other studies, maintained sobriety for a year or more. The 27 patients interviewed could not be considered representative of the first 1000 admissions, nor could the information obtained be considered

conclusive. However, there appeared to be a positive relationship between improvement following treatment and several factors: the extent to which help was sought prior to treatment at Fort Logan, being employed, living alone or with a spouse only (versus spouse and children), and participation in Alcoholics Anonymous. A positive relationship also was indicated between length of sobriety and improvement of interpersonal associations. Basic social-economic structures (income, marital status) did not seem to change. The apparent mobility of the 41% who could not be located suggested that alcoholics may be markedly alienated persons.

Some of our other work has shown that alcoholics differ noticeably in drinking symptoms, socio-economic status, and personality dimensions. Preparation for a follow-up study based on this multidimensional model of alcoholism is in preparation.*

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The Fort Logan Mental Health Center is Colorado's second state hospital. Currently serving almost half the population of the state, its organization follows as much as possible the recommendations of the Joint Commission on Mental Illness and Health. Concepts of milieu therapy are strongly utilized, with emphasis on expansion of professional roles and the involvement of the patient's family and his community in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. Approximately one-half of its patients are admitted directly to day care, and evening care is offered. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient from the time of admission through all phases of treatment.