COMMUNITY ADJUSTMENT
OF
CHRONIC PSYCHIATRIC PATIENTS
DROPOUTS VS. NON-DROPOUTS

Nabil Moh'd Marshood

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ABSTRACT

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This study examined the chronic psychiatric patients who were referred to Fountain House for psychosocial rehabilitation. Differences between the dropouts vs. the non-dropouts were tested. Applying a longitudinal design and using discriminant analysis, it was found that 70% of patients dropout over a period of six months; and that patients' personal characteristics as well as service variables are predictors of dropout and community adjustment.

Although issues of collecting follow-up data on the dropouts were inherent, it was possible to identify patterns of adjustment for the non-dropouts. It was found that patients who stay longer in a rehabilitaion setting, attend therapy, and comply with medication had better adjustment levels than others. This led to the conclusion that comprehensive long-term treatment is more effective than other single specialized model of treatment.

Theories of milieu therapy, ego psychology, and empirical research pertaining to adjustment and dropout provided a rationale for developing this study, its conclusions, and its recommendations. One recommendation

to emerge from this study is that deinstitutionalization should be perceived as a step in the rehabilitation process rather than as a goal by itself.

This study concludes that it is possible for chronic psychiatric patients to adjust to the community, but only if all elements of the system work as a complementary unit in which inpatient and aftercare facilities are integrated around the goals of rehabilitaion and independent living. The application of milieu therapy based upon sound social work philosophy, research, and methods is essential for the promotion of the adjustment process and reduction of the dropout rate in aftercare facilities

Continuation of research and committment for long-term, comprehensive treatment will meet the scientific and clinical challenges for dealing with those patients who are "difficult to reach." A second recommendation is that in addition to the usual concern with patient adjustment to services, there is a need to be concerned with the adjustment of services to patients.

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CHAPTER I

INTRODUCTION

Zilboorg and Henry (1969) extensively describe the historical development of the treatment of mentally disabled people. In their review, it is obvious that the pattern of care throughout history is characterized by periods of hospitalization and community care. The notion of community care is not a new or recent creation. An organized conceptual framework of emphasis on deinstitutionalization and dehospitalization was introduced in 1955 along with the practical model of "aftercare programs," which intends to promote patient's independent living and community adjustment. With the advent of tranquilizing drugs and antidepressants, more active and innovative treatment modalities and an optimistic treatment climate, hospitalizations are now shorter and the number of chronic patients is remarkably smaller, despite the increasing number of admissions (Hertz, 1976). At the same time many long-term hospitalized patients have alarmingly high readmission rates-- a "revolving door" syndrome of discharge and readmission (Hertz, 1976). Hertz supports his statements and observation on Wren's (1973) statistics which concludes that in New York State 28% of those patients discharged from state mental hospitals in recent years were readmitted within six months of their release, and up to 50% are expected to be readmitted eventually.

The significance of the "aftercare" programs turns out to be one of the major emphasis of mental health services. Patients are usually discharged to an aftercare facility unless they refuse to accept the referral.

Thus, the treatment of mentally disabled persons should be an integrated effort of hospitals, aftercare facilities, and the community. Regardless of the efforts made by professionals, patients are discharged to the community with the expectation of being able to adjust to it. However, Anthony (1972) states that most types of inpatient treatment improve patients' in-hospital behavior, but research does not indicate that these approaches can individually effect post-hospital adjustment, which in turn suggets gaps in discharge planning, and in integration efforts.

However, "aftercare" is used in psychiatric literature to describe the total treatment program for the psychiatric patient after discharge from the hospital. It encompasses all patients and all programs. It includes pre-discharge readiness and planning, post-hospital residential arrangements, resocialization techniques, vocational and social rehabilitation services, and professional care for all patients released from a psychiatric hospital (Hertz, 1976). Statistics reveal the wide varity of "discharged mental patients." Weinstein, DePasquale, and Winsor (1973) found that in New York State, excluding facilities for narcotic addicts, there were 41,531 patients discharged from state mental hospitals in the year ending March 31, 1971, with 40% of them diagnosed as schizophrenics.

Hertz (1976), in his analysis of the "aftercare" concept and system(s), states that historically aftercare has been with us for hundreds of years in many forms. The family placement custom in Geel, Belgium, for

example, dates back to the seventeenth century. Yet, it has only been since 1955, with hundreds of thousands of patients being discharged to their home communities, that there occurred a world-wide shift in treatment emphasis from hospital to community (Ryan, 1969). Prior to that time, with long-term hospitalization the rule, patients were not uncommonly hospitalized to the end of their lives. Understandably, community facilities for released patients were rare.

The shift in treatment emphasis seems also a shift from private to public concern, voluntary to legislative, remedial to preventive. In England the Mental Health Act of 1959 stressed the need for preventive and aftercare facilities and sheltered workshops in the community (Sharpe, 1972). The Federal Community Mental Health Center Act of 1963 in the United States stressed the return of treatment responsiblity to the local communities (McGarry & Kaplan, 1973).

The need for community aftercare facilities is now recognized worldwide. In England, Sharpe (1972) noted advances in treatment methods necessitated by the change from custodial to progressive patient care. Therapeutic communities, preventive therapy, and resocialization techniques are being actively pursued in Italy (Scarzell, 1970). There are aftercare programs in Poland (Trefor, 1972) and in Russia (Babayan, 1969). All developed countries have some aftercare services, and many developing countries have experimental programs (Lin, 1968).

Yet, despite the need, aftercare facilities have developed slowly. In 1961 the Final Report of the Joint Commission on Mental Illness and Health reported that "aftercare services for the mentally ill are in a primitive state of

development almost everywhere." In the United states, the report noted, there were at that time only nine half-way houses, less than two dozen day hospitals, eight rehabilitation centers, seventy ex-patient clubs, and foster-home services for discharged patients in less than one-quarter of all the states. However, since then, further developments have taken place, quantitatively and qualitatively.

The described development and trends raise many questions regarding the efficacy of aftercare facilities and the standards of community adjustment which are used to judge the adjustment of patients in their community. This study focuses on some of these aspects of community adjustment of a selected group of chronically mentally ill patients.

CHAPTER II

CONCEPTUALIZATION OF RESEARCH QUESTIONS AND GOALS

The demand for better aftercare facilities and the concern of officials, patients, and relatives alike have shown that there are many basic unanswered questions, both new and old, concerning aftercare and community adjustment. What happens to those discharged patients for whom no special treatment provisions are made? How many stay out of the hospital and for how long? If they remain out, how well do they function and what is the course of their illness? Among those who decompensate, are there any high risk periods? Why do they decompensate? Does aftercare influence the course of the illness or the chance of readmission? If so, are there any aftercare programs that are particularly effective? Which are not?

The focus of this study is on social and psychiatric rehabilitation services in general, and Fountain House in particular. The goal is to verify some of the assumptions and hypotheses that could relate to community adjustment of chronic patients. The main questions are:

1. What is community adjustment of chronic mental patients? What are the criteria used to measure it? How valid and reliable are these measurements?

2. How does involvement in Fountain House programs and utilization of its services affect community adjustment?
3. What are the differences between dropouts and non-dropouts from the program in regard to community adjustment and other demographic characteristics?
4. Who drops out from Fountain House and at what point in time of the program?
5. What are the changes that may take place in patient's patterns and level of adjustment due to participation in the program?
6. What are the types of causal associations that could be used to explain community adjustment? More specifically, variables such as family and social network, involvement in Fountain House program, medical history and hospitalization(s), involvement in treatment, and compliance with medication are the main variables that will be explored.
7. What happens to patients who drop out? Do they return to Fountain House? Are they rehospitalized even after the application of outreach methods? Are they employed?

Based on these question, the goals of the study are:

1. What are the characteristics of Fountain House patients who achieve a satisfactory community adjustment?
2. Identify the relationships between different variables that may lead to significant variance in community adjustment.

In short, this study intends to examine the community adjustment of dropouts as compared to non-dropouts from a psychiatric rehabilitation

program where the rationale is multiple in nature:

1. Practical--What is done and what could be done in the field of psychiatric rehabilitation services, in general, and of Fountain House, in particular?
2. Theoretical--What is the added contribution of this study to the knowledge that already exists, especially in reference to the construct of community adjustment and to the concepts of "Therapeutic Community," "Milieu Therapy," and "Ego Psychology"?

CHAPTER III

RESEARCH SETTING

Fountain House

This chapter is based on Beard's (1976) extensive description of Fountain House. Fountain House is a nonprofit, voluntary organization established in 1948 for the purpose of facilitating the community adjustment of psychiatric patients following their discharge from public and private mental institutions. Its founders were a small group of mental patients at Rockland State Hospital and two volunteers from the community, Elizabeth K. Schermerhorn and Hetty H. Richard. They held the belief that many of the obstacles confronting patients who are attempting to rebuild their lives in the community could be overcome, or at least alleviated, if the patients could come together, share their problems, and be encouraged to provide one another with help and assistance.

Originally known as the WANA Society, an acronym for " We Are Not Alone," vigorous and successful efforts were made to hold patients meetings in mental hospitals, in rooms made available by churches and by the YMCA, in coffee shops or cafetereas and, (when weather permitted), on the steps of the New York Public Library at 42nd Street and Fifth Avenue. A one-page tract, tightly printed on both sides, was distributed widely on hospital wards and at community meetings to welcome the newcomer--who

would be known as a "member" and not as a "patient"--and to reaffirm the commitment of WANA to provide aid and assistance to mental patients so that they could leave the hospital, find a place to live, secure assistance from public welfare, find emploment and alleviate their feelings of lonliness, isolation, and alienation.

Each month the membership of WANA grew, along with increasing support from the professional community and from private citizens, whose interest and financial support made possible not only the creation of a sustaining organizational structure but also the purchase of a "brownstone" in the spring of 1948 which would serve as a permanent clubhouse for the WANA membership and its expanding club activities. The home-like, noninstitutional quality of the "brownstone", located on West 47th Street in the Times Square area of New York City, was fully in keeping with the non-clinical atmosphere which the new organization wished to convey and provide to all of its members. Also, the renewing quality of a small fountain on the patio of the clubhouse suggested that a new name, one such as "Fountain House," would not identify the special reasons for which the organization was established and which brought its membership together.

Rehabilitation Services

Over the past 25 years the original objectives of Fountain House determined the design of the rehabilitation services which have been developed. In brief, all of the services of the agency relate to a cluster of community adjustment problems which typically confront psychiatric patients, usually diagnosed as schizophrenics, who have either spent many years in mental hospitals or undergone multiple hospitalizations, and who have been unable to achieve or maintain a successful social and vocational adjustment in the community.

Over the past decade, increasing numbers of such patients have been discharged to the community, greatly reducing the population of state mental hospitals. The transition, however, from hospital to community is one which is causing major concern throughout our nation. Articles in major newspapers, from New York to Los Angeles, are bringing to the attention of the public the plight of the severely mentally ill when placed in the community. Unemployed and financially dependent, they live in housing which is often grossly inadequate. Medical care and supervision are frequently lacking, social isolation is severe, and simple social-recreational opportunities are almost totally absent.

Adverse reaction, often organized and at times militant, arises when there is heavy concentration of the mentally ill in a small neighborhood area where large numbers of patients live in boarding houses or in hotels. Such accommodations are viewed as a poor substitute for mental institutions, particularly when peculiar and bizarre behavior is observed by the public.

Understandably, the question is asked, "Should not the mentally ill be placed in psychiatric hospitals where they can receive the care and treatment they require?"

At issue, of course, is the need to provide rehabilitation facilities within the community, so that the severely disabled mentally ill can develop their potential for community living. Various rehabilition models, such as Fountain House, have been developed to guide and assist in the achievement of this objective. However, financial resources must be available. There must be a strong commitment to the view that the severe disablitity of the mentally ill is due in large measure not only to the process of illness but to a host of factors external to the patient factors which can either intensify or minimize disability.

A Program of Reaching Out

Rehabilitation services at Fountain House are not confined to the clubhouse facility or to the programs it operates in commerce and industry. For example, when patients are re-hospitalized, contact is maintained through hospital visits and regular mailings. Similarly, when individuals suddenly withdraw from the facility or become "dropouts" shortly following intake, reaching out efforts, through home visits by both staff and members, are promptly initiated. In almost all instances it is found that the sudden withdrawal of a member is not a decision to reject the service but, rather, an inability to become an active participant. Home visits are almost always welcomed and usually lead to the individual's re-entry.

Members of Fountain House have clearly demonstrated that they

can be extremely effective in conducting home and hospital visits. In so doing they illustrate the significant role which patients themselves can play in the delivery of mental health services. In view of the magnitude of the need, the program emphasized reliance upon participation of patients as well as professional staff. Through such efforts, needed rehabilitation services will be provided to disabled individuals who would otherwise remain in the community without assistance.

The Apartment Program

The primary reason for the establishment for an apartment program in 1957 was the direct need by many members of Fountain House for more decent and adequate housing. There were patients at Fountain House who, while still in the hospital, were coming to the clubhouse during the day and returning to the hospital at night, having no home to return to. There were also members who lived with their families in suitable housing but whose community adjustment was impaired due to the family environment. And there were many members who lived in lonely single rooms, often in deteriorated tenement buildings, where the weekly rental fee was low, usually provided by the Deparment of Social Services.

The apartment approach of Fountain House was simply to secure a lease of its own, decorate and furnish the apartment through contributions from the community, and then make the apartment available to two or three Fountain House members who could share the modest monthly rental as well as day-to-day housekeeping tasks.

The apartment program, therefore, served those members who could not secure a lease on their own because of unemployment, a lack of

references, and impaired self-confidence. In a Fountain House apartment, however, two or three members could live together. By pooling their limited resources, members could attain more adequate housing than they otherwise could by living alone. Over the years, some forty apartments have been established throughout New York City, and 90% of the annual rental cost is assumed by the member residents. The remaining 10% deficit is a result of occasional vacancies. Members may remain in the apartments as long as they wish and, if they prefer, may take over the lease from Fountain House when it expires.

The apartment is not viewed as a significant therapeutic experience in and of itself. The purpose is simply to provide more decent housing at minimal expense. The apartment program, however, is conducted as an integral part of rehabilitaion services, not as an isolated program, unrelated to the larger rehabilitative environment. Each week apartment residents and staff hold small group meeting, often in each other's apartments, to discuss housekeeping problems or other difficulties which require attention.

By design, each apartment provides accomodations for an overnight guest so that patients still in the hospital can visit Fountain House on an overnight basis and be introduced to the rehabilitative environment prior to discharge. As increasing numbers of psychiatric patients are leaving hospitals, the need for more adequate housing is of crucial importance. An arrangement whereby patients can share an apartment, closely related to a mental health or rehabilitative facility, not only provides better housing to the returning patient, but also facilitate the individual's involvement in needed rehabilitative services.

The Prevocational Day Program

There are many tasks which need to be performed each day at Fountain House in operating the clubhouse, and the participation of each member is not only needed but reflects the basic philosophy underlying "membership" at Fountain House. Regardless of the level of disability, it is believed that each member has a contribution to make, one which will be valued and appreciated by the others. The opportunities to contribute are many and vary with respect to the tasks as well as to the levels of responsibilities which are assigned.

In brief, the day program has been structured around those activities which clearly reflect essential clubhouse functions. For example, a cleaning service is not utilized at Fountain House. From a prevocational point of view, it is believed extremely helpful for members and staff to assume responsibilities for the day-to-day cleaning and household tasks and to do so by working together, side-by-side. A great deal of housekeeping has to be done, particularly in the new five-story clubhouse which was dedicated in 1965. There are many stairways and halls, a large living room, a library, and a dining room which also serves as an auditorium. There is a full-floor snack bar and an outdoor patio. Administrative areas are also part of the clubhouse, and all the members and staff in administration share in housekeeping responsibilities.

Another prevocational activity relates to the buying, preparation, and serving of food, either in the snack bar or in the dining room, where some 250 noon-day meals are prepared and served each day. In another area, the many and varied clerical needs of the clubhouse are handled.

Members assume responsibility for the busy switchboard. A daily newspaper and a monthly magazine must be prepared. Reports need to be typed and mimeographed, and there is much correspondence to be handled each day.

Members and staff also operate a thrift shop around the corner from Fountain House, working together on the truck, picking up donated merchandise, sorting and pricing in the small warehouse and, in the shop itself, selling directly to the public.

Other day program opportunities include welcoming new members and visitors at the front door and giving tours through the facility. There are also costs to be checked, member deposit and loan accounts to be handled, and apartment rental payments to be received. Attendance records must be maintained, and help is needed for research calculations and bookkeeping procedures. The IBM keypunch and sorting machines must also be operated.

At Fountain House such activities are viewed as ideally suited for the prevocational rehabilitation of the severely disabled psychiatric patients. All of the tasks need to be done, and they could not successfully be completed without the help and assistance of day program members. The staff greatly appreciates the significant contribution which members in the day program make, and recognition is expressed in many ways. Both staff and members become engaged in a process where important shifts begin to occur with respect to their concept of disability. Staff become more aware of the social and vocational potential of the disabled psychiatric patient, while the individual member discovers personal abilities and talents which

lead to greater social effectiveness and more meaningful work productivity.

In structuring the activities of the day program, staff are organized into six smaller groups or units, each consisting of four to six workers. The units are differentiated on the basis of their responsibility for specific activity areas (i.e., the thrift shop, the snack bar, the clerical office, the kitchen-dining room, administration and education, and research). Each unit has rehabilitative responsibility for a group of members, ranging from fourteen in the administrative area to one hundred twenty-eight in the clerical office. In essence, each unit is a smaller Fountain House, having its own resposibilities for each of the services provided by the agency. In addition to operating its own day program area, each unit maintains apartments in the community, provides transitional employment in industry, reaches out to dropouts or re-hospitalized members, and also takes reponsibility for a portion of the evening and weekend social-recreational program.

In summary, the activities performed in the day program are done by members and staff working together. They have selected activities which have a clear relationship to the basic operations and functions of the clubhouse. Members are encouraged to explore and choose the activity area which is of interest to them and to assume a level of responsibility which can be successfully handled. In most cases, members view their participation at Fountain House as a natural process. They are members of a club, and as members of a club, they voluntarily provide help and assistance. They do not usually view themselves as undergoing an organized, consciously directed rehabilitation process. For many, Fountain House assumes the role of an extended substitute family.

Transitional Employment

Each weekday approximately 200 Fountain house members go to work, on a half-time basis, in some 44 New York City business firms. There are well-known deparment stores, such as Sears, Macy's and Alexander's. Some work in banks--Manufacturers Hanover, Chemical Bank, and Chase Manhattan; others in life insurance companies such as Royal Globe, Mutual of New York, and Equitable; and others in advertising companies--Benton and Bowles and Young and Rubicam. There are also a number of smaller firms such as stationery stores and messenger services which employ the members. Transitional employment in all of these firms is either on an individual or a group basis. All members receive the prevailing wage scale, and the total annual earnings in 1974 for members who worked approximated $400,000.

In the securing of job placements, it was not necessary to first engage in an educational process. Fountain House simply sought entry-level employment, usually jobs where the employer normally experiences a high turnover. The arrangement with the employer was not complicated. A job position would remain filled, being rotated among members of Fountain House every four to six months. Normal production standards would be maintained, and other job requirements would be met. A staff worker would first perform the job for a few hours or a few days, and on group placements a staff member would always be present with the ten to twelve members on placement. Little difficulty was found in securing such job oppoutunities from commerce and industry.

As indicated, in initiating a new job placement, a staff worker first

performs the job before a member goes on placement. In order to thoroughly understand the requirements which must be met when a member is placed, all of the staff including the secretarial and administrative personnel assume this responsibility from time to time. As most transitional placements represent entry-level employment, requiring little training or skill, the staff usually is able to learn the job quickly and to secure the approval of the employer to proceed with the new placement. There have been some instances, however, where it was necessary to assign a second or third staff worker before the employer was assured that the staff was capable of doing the job satisfactorily.

By design, a staff person in each of the six rehabilitation units not only initiates job placements but is given continuing responsibility for their management and supervision. The implications of this procedure are very specific: The worker who initiates a placement tends to want it to succeed. A more personal sense of responsibility is taken in maintaining good relationships with the employer. The worker also wants to orient properly and train the new member going on placement to maximize job success. As the worker has personally performed the job and has direct access to it, prompt on-the-job assistance can always be provided to the member whenever difficulties arise.

Most importantly, as replacements are regularly needed to maintain an individual or group position, the staff person may have to serve as a replacement when vacancies occur. This generally is a new experience for the staff person as well as for the member, who all too often has come to view himself as vocationally disabled and is not used to the idea of being

needed to fill a real job.

For a member to be successful when s/he goes on a job placement, it is essential that basic work habits, the ability to accept supervision and to get along with others, and the motivation to try transitional employment be strengthened as much as possible. There is no formula to accomplish these objectives. Certain factors are present, however. In the prevocational day program, the member receives a great deal of support and encouragement. It is a positive environment, one which utilizes and appreciates whatever help and assistance the member is able to offer. The member is given recognition and approval for participation and for the development of better work habits.

Members already on transitional employment serve as examples to fellow members and play a major role in motivating others to undergo the experience of being employed in a normal place of business. Through group discussions and videotape presentations, they are able to discuss openly those aspects on the job which are of special concern. The "boss" is described, as well as other employees, the work performed is outlined in detail, and special features such as free meals, paid holidays, and other such benefits are also stressed.

Members on placement are also able to help reduce the newcomer's fear of failing on a job placement. At Fountain House, a job failure does not result in a member's isolation and rejection. Many members go on to three, four, or even more placements before achieving independence in employment. Failure is considered as a step one must often take in overcoming disability.

Vocational difficulties are not viewed solely as a condition which resides within the psychiatric patient. It is believed that many are due to factors external to the patient, the removal or modification of which will increase and enhance the individual's vocational adjustment. In the field of physical rehabilitation, it is clear that architecture, for example, can either retard or facilitate the mobility of the physically disabled, as does the presence or absence of various prosthetic devices.

Similarly, many barriers exist in society which not only prevent the psychiatric patient from making a productive contribution but are largely responsible for the patient's designation as being vocationally disabled. The ability to pass a job interview, for example, is not necessarily correlated with the patient's ability to perform a job satistactorily. Transitional employment in commerce and industry is an example of a social device which circumvents a series of barriers which all too often prevent employment of many psychiatric patients who have the capacity to perform gainful employment. The creation of additional social devices can further remove other barriers which currently prevent the return to productive employment of mental patients defined as vocationally disabled.

A Social and Recreational Program

On Wednesday, Thursday, and Saturday evenings and Sunday afternoons, some 200 to 300 Fountain House members attend the clubhouse for social and recreational purposes. The program presents a variety of opportunities with respect to individual needs and interests. The living room is a place to sit by oneself or to chat with others. Reading is available in the library, and many members enjoy the music room. The snack bar is

always open and is extremely popular, and a cup of coffee can still be had for five cents. The game room is favored for bridge, pinochle, chess, and checkers, and the television room is usually filled.

More organizational activities are also provided such as the poetry group, the sewing class, the dramatics club, the cooking class, and the current events group which meets in the classroom. Photography is popular, and a well-equipped darkroom is available. The choral group meets on Wednesday evenings and the creative writing group on Thursdays. Movies, as well as hobby talks by staff, members, and visitors are regularly scheduled. On Saturday nights there is usually a dance, with live music being provided by volunteers from the community or by the small Fountain House combo. The dramatic groups presents its plays in the spring and fall, and the member talent show is greatly enjoyed by all. Free tickets are available weekly to members for Broadway shows, the Philharmonic, the opera, and other cultural and entertainment events. As Fountain House is open throughout the year, holidays become special events, especially Thanksgiving, when the staff and their families assume responsibility for serving some 300 full-course dinners to the membership.

The evening social programs of Fountain House serve various groups of members. For some, it is an initial point of entry into the rehabilitation process, frequently leading to full-time involvement in the vocationally-oriented day program. For those who are fully employed, it represents an important sustaining influence, particularly when full-time employment is first secured and the member is abruptly separated from the day program. Most of the members who are active in the day program look

to the evening recreational activities as a primary source of pleasure and relaxation. Also welcomed are those members who have made a marginal adjustment in the community and are unemployed and financially dependent, but who reject involvement in more intensive rehabilitation efforts.

Evenings at Fountain House are also an ideal time to hold various kinds of weekly group meetings. On Thursday evenings, meetings are held for members who live in Fountain House apartments. On Wednesday evenings, members on transitional employment come together to have dinner and to meet in small groups to discuss their work experiences, and similar meetings are held for those members who are nearing the point of independent, full-time employment. Small group meetings are also held for members who have just obtained jobs on their own. It is essential, therefore, that the work schedules of staff include assignments in the evening program if contact is to be maintained with members whose lives have become more independent and who are no longer available for day-time involvement.

In summary, Fountain House is open seven days a week, throughout the year, so that members may prepare for independent employment during daytime hours and enhance their social adjustment on evenings, weekends, and holidays. The evening program enables many of the members to alleviate their frequently intense feelings of social isolation and alienation and is, therefore, an important component of the rehabilitation service of Fountain House. The objectives of the clubhouse are compatible with treatment objectives (Beard et al., 1982). The goal is to maximize the

abilities of patients to manage their lives, to minimize the social isolation and sense of loss induced by mental illness, and to aid them in reclaiming their self-esteem and sense of competency. These are the goals where the underlying philosophy is that "chronic patienthood does not necessarily follow from chronic illness" (Fraser & Jackson, 1983).

CHAPTER IV

LITERATURE REVIEW

Fountain House is a rehabilitation facility that performs its functions toward the social and vocational adjustment of patients, where the majority of the population served are chronic schizophrenic adults.

Psychodynamic interpreters of schizophrenia emphasize intrapsychic conflicts and problems in ego. Sullivan (1947,1953) emphasized parent-child relationships which prevent the development of "self esteem" and the "me feeling." Wolman (1966,1970,1973,1976) proposes a socio-psychological theory in which schizophrenia is perceived as an "escape for survival," which is a process of downward adjustment in an irrational struggle to stay alive.

Regardless of the many variants of psychodynamic theories of schizophrenia, these theories emphasize a weakness of the ego, where it is unable to withstand the pressures of superego and/or id forces. (Wolman, 1976; Hartmann, 1964). Thus the main goal in treatment of schizophrenia is to strengthen the ego of the personality and/or to reduce stress. The varying approaches to achieve this have resulted in differing schools of thought in the field of psychotherapy.

The operational modes of Fountain House are congruent with this goal. By creating interrelated, cohesive programs, the interaction between

patients themselves and between patients and staff is structured and directed toward strengthening the ego of members in order to facilitate their social adjustment. Fountain House, then, is operating under the theoretical notions of milieu therapy (therapeutic community) and ego psychology.

Therefore, in this review of the literature, the focus is on the following areas:

1. Basic Theories underlying the Fountain House model:
    a. Milieu Therapy and Therapeutic Community
    b. Ego Psychology
2. Review of the concept "Social (Community) Adjustment," definitions, measurement, and empirical studies; and
3. The dropouts definitions, measurement, and empirical studies.

Basic Theories

Milieu Therapy and Therapeutic Community

In a historical review of milieu therapy, Rioch and Stanton (1983) commented that there have been, at least since 1793 when Pinel released the patients from their chains (Greenblatt, 1965; Schwartz & Swartzburg, 1976), psychiatrists who have focused on the milieu as a potentially powerful therapeutic or pathogenic force. One of the most decisive breaks with custodialism in the United States was undertaken by Harry Stack Sullivan at the Sheppard and Enoch Pratt Hospital (Greenblatt, 1965). Sullivan paid particular attention to the selection of nurses and attendants and all other staff members, and worked chiefly with them rather than with the patients themselves.

In his work Sullivan viewed the therapist as a "participant observer" (Hall & Lindzey, 1978), and developed the notion of "interpersonal theory of psychiatry," that stimulated other psychiatrists and social scientists to carry on research related to this area. However, in his paper, "The modified psychoanalytic treatment of schizophrenia" (1931), Sullivan showed that the large impact of psychoanalytic theories on the treatment of schizophrenia has been modified and mediated through ward personnel and "milieu therapy" rather than being carried by the small number of psychiatrists and analysts directly to the patients. In Sullivan's milieu, the recovery rate, as measured by return to work or work of young, first break male schizophrenics, was reported to be better than 85%. This

continued at this level for several years after Sullivan himself had left (Greenblatt, 1965).

Greenblatt (1965) also reports different studies that show the unique effectiveness of milieu therapy as compared to other modalities of treatment, including chemotherapy. He states that "there seems to be growing consensus that the combination of the medication and milieu tharapy is more effective than either alone" (p. 54).

An active milieu then is an environment in which the staff personnel is vastly more stimulating than in the usual custodial situation; where the patients are better dressed, and better behaved; where the therapeutic climate is optimistic; and where interaction and planned activities are the order of the day (Greenblatt, 1965). The poverty, darkness, inertia, and lethargy of the custodial ward, and the staggering shortage of staff, is sharply contrasted by bright, decorated, home-like wards. A feeling of buoyancy and hope is transmitted through the presence of a full staff of doctors, nurses, social workers, occupational therapists, and psychologists, who surround the patients with their therapeutic enthusiasm. There also is an active teaching and research program.

The awareness and involvement of social scientists is in fact that the hospital setting is a social system that has an effect on patients' behavior and the outcome of their illness. This view has enhanced the trend of manipulating the social factors in the setting in the direction of improving patients' reactions and recovery.

The treatment of psychiatric patients has undergone major changes. From a punitive approach, in which patients were confined with chains to

the era of "moral treatment" which made it possible for the medical profession to develop the medical model of treatment. The introduction of insuline coma and electroconvulsive therapy generated some therapeutic optimism.

It was not until theoretical principles elucidated by the growing disciplines of social psychology and anthropology, reinforced by the practical experiences of World War II, led to a rethinking of the basic concepts of hospital care that change began to appear (Schwartz and Swartzburg, 1976). Major studies in this respect were that of Stanton and Schwartz (1954) in which they described a hospital as a total culture in which staff and patients interact within single social system, where events in one area affect all others. Also Goffman (1961) vividly described the devastating effects of the mental hospital as an organized institution upon the patients.

The increased number of studies in this respect, lead to the conclusion "that if the social structure was capable of exerting a profound antitherapeutic effect upon patients, then by utilizing the principles developed by social scientists, a social structure could be created which would have a therepeutic effect upon patients." This became to be known as a "therapeutic milieu or community" (Schwartz & Swarzburg, 1976).

Maxwell Jones (1962), a pioneer in the field, described the therapeutic community as an attempt to utilize the institution's total resources, especially the staff and other patients in an attempt to help the sick individual. To accomplish this, it was deemed necessary to establish open communication and to eliminate the hierarchical system of authority so

that patients and staff could examine what they were doing and how it affected them and others.

Schwartz and Swarzburg (1976) report different studies that show the effectiveness of these principles in different settings including state, military, and general hospitals. They also state that the advances made in psychopharmacology made it possible to manage disturbed patients in an open setting, and by reducing agitation, enabled the patient to participate in the milieu. Again, this conclusion supports the notion that the combination of medications, with therapeutic milieu (community), is more effective than either one of them in the treatment of mentally ill patients (Greenblatt, 1965).

Programs emphasizing milieu therapy with a therapeutic community model as their core have been developed throughout the country. Although these parameters have been established in diverse settings, including state hospitals, veteran's hospitals, military hospitals, general hospitals, mental health centers, and private psychiatric centers, they share many features in common (Schwartz & Swartzburg, 1976): Some of the main features are:

1. The ward should avoid an institutional appearance and should be so designed that small group interactions and a sense of community are fostered.
2. An open-door policy.
3. The purpose is to foster a sense of self-reliance in the patient and to discourage tendencies toward regression.
4. The message to the patient is that s/he must assume at least a partial responsibily for his/her behavior and functioning even in

the face of very real psychopathology.

5. The hope is that the appeal to the so-called "healthy part of the patient's ego" enhances dignity and promotes trust and a sense of collaboration between patient and staff.
6. Patients are introduced, upon entry to the program, to the expectations of the ward culture, by both staff and other patients.
7. The value of open-communication is stressed by discouraging secrets and encouraging shared decisions.
8. Patients are asked to assume responsibility not only for themselves but also for their fellow patients. They may be asked to aid in the care of more disorganized patients which, in turn, leads to group interaction and a tendency for peer assessment.
9. Enhance the sense of community by encouraging patients to comment on each other's behavior, pathology, and life difficulties.
10. All events and interactions that take place on the ward are discussible and become grist for the treatment process.
11. The closer the actual functioning of a particular milieu approaches its stated value system, the more effectively these values can be used in treating patients.

Despite the aforementioned common features, Jones (1962) has pointed out that there is no one ideal model of a therapeutic community. Mesnikoff (1964) defined therapeutic milieu as a protective setting in which

the patient's behavior patterns, as revealed in relationships in the hospital, may be observed, studied and utilized for treatment. The functions, data gathering and therapeutic are concurrent and coordinated (p. 891). In his work, he discussed the operating model of therapeutic milieu as it has been developed at the New York State Psychiatric Institute, Columbia-Presbyterian Medical Center. He provides clinical evidence to the effectiveness of milieu therapy and proposes that treatment in such setting may be divided into three phases: (1) Adjustment to the hospital, (2) Dilineation of the patient's adaptive responses, and (3) Ego growth and its relation to the environmental structure.

In addition to their proponents, therapeutic communities have generated a fair amount of criticism. They have been criticized for holding to a unitary concept of the treatment of the patient, regardless of the clinical problem, with a resulting loss in the diversity and flexibility needed for a varied patient population (Schwartz & Swartzburg, 1976).

In their work, Schwartz and Swartzburg (1976), present a number of studies that discuss the criticism of therapeutic community. Some studies focus on problems of role-blurring and role-confusion; others question the ability of disorganized acute schizophrenics to participate meaningfully in group interactions. It also has been criticized for encouraging prolonged hospitalization for patients who could have been treated just as adequately in crisis intervention or brief treatment wards. Other criticism has focused on such issues as permissiveness, lack of lockable doors, and avoidance of the practice on consensus medicine.

Whatever the impact of therapeutic community and milieu therapy,

there are concepts developed to improve the inpatient modality. Thus, the question becomes clear--whether or not these theories, concepts, and principles relate to intermediate facilities, to day hospitals, to community mental health centers, to rehabilitation programs, to social clubs, and to other forms of aftercare programs? Again, Schwartz and Swartzburg (1976) conclude that the theoretical basis of therapeutic community could be applicable in aftercare facilities.

Fountain House, in its operation, relies heavily on the theoretical basis of therapeutic community and milieu therapy; and almost all the principles are practically applied at Fountain House.

The theoretical notion of this review is that therapeutic community and milieu therapy, independent of the variance in practical models, have a positive impact on treatment of chronic mentally ill patients, whether the structure is applied in a hospital setting or an out-patient setting. The question, however, relates to the type of patients who benefit from this system. In other words, what are the characteristics of those who benefit from milieu therapy and a therapeutic community?

Ego Psychology

This section is not a detailed review of ego psychology but, rather, it is a presentation of basic concepts that relate directly to the notion of milieu therapy.

The concept of ego is formulated differently by various authors such as Hartmann, White, Erikson, and others, but there is a core of common meaning in each of them. First, ego is conceived as an

interdependent combination of emergent abilities and conflict-born elements. Second, the development of the ego is commonly regarded as occurring through a series of crises. These crises appear to occur whenever the emergent skills and developing powers of a child need to be controlled, elaborated or enhanced in order for him/her to be considered a normal member of the culture. When these crises occur, the equilibrium of a child's personality and the system around him/her is partly upset. The resolution of crisis will lead to the ego development and organization (Cumming & Cumming, 1962). At the same time, the ego is enhanced, the child gets increasingly diverse types of roles. Thus, the ego is strengthened because the child has internalized a new set of interrelationships and increased his/her power of discrimination between him/herself and the environment (Cumming & Cumming, 1962).

Hall and Lindzey (1978) state that the most striking development in psychoanalytic theory since Freud's death is the emergence of a new theory of the ego-referred to as ego psychology. Freud's theory served as a basic theoretical framework for some psychoanalytic theorists to enhance the role of the ego in the total personality. The leader of the new ego theory was Hienz Hartmann.

Hartmann (1953, 1964) being the leader in the field, recognized a "conflict free portion" of the ego, which is a part that is developed from the natural endowment of the individual and is not dependent on the id for its existence. This portion is considered to be the individual's native competences. He believed that instrumental tasks were performed under the direction of this portion (Cumming & Cumming, 1962). Hartmann also

realized the impact of the enviroment on ego emergence and states that it (environment) governs the details of the emergent qualities. Thus, when all the emergent capacities (e.g., thoughts, perception, intuition, motor development, etc.) are taken together, they form the conflict-free structure of the ego whose function is known as "executive."

Erik Erikson (1950), took off from Hartmann and recognized the importance to the individual of variations in the situation and, therefore, addressed himseif to the problem of ego developing in a society. He concluded that the development of "ego identity"--an essential ingredient of the intact and healthy ego--requires a "successful alignment" of basic drives, individual endowments and the situations. That is, of the impulse of life, the synthetic and executive portions of the ego, and the opportunities in the situation. Erikson was the first one to give equivalent value to the environment, he added to the idea of ego adaptation a further idea of "ego feeling." Cumming and Cumming (1962) state that when Erikson speaks of "sense," he contributes the specific idea of ego identity producing a feeling of appropriateness and satisfaction or even euphoria, whereas ego diffusion is experience unpleasantly as a disjunction beween self and society.

This notion of adaptation is slightly different from that of Hartmann. For Hartmann, the way the person comes to perform in a wide-variety of situations is usually known as "adjustment" or "adaptation." This adaptation not only symbolizes continuity because it is the act of accepting the situation created by past generation, but it also contributes to the situation and, thus, changes the environment. In this sense, Cumming and Cumming (1962) state that adaptation is a two-way process in which

the individual recognizes him/herself to accommodate to the milieu and, at the same time, influences that milieu.

This brief review of basic concepts and theories of ego psychology allows us to make the linkage between milieu and action through adaptation or adjustment process. Cumming and Cumming (1962) support this by stating that developments in ego psychology provided a further theoretical base for milieu therapy.

Social (Community) Adjustment Definitions and Measurements

In this section, the notion of social adjustment will be discussed in general, but also there will be an effort to implement the concept to a practical measurable formulation that will contribute to the development of social adjustment scale of chronic schizophrenics. The theoretical notion of adjustment was discussed in the previous section where it is perceived as an outcome of interaction between the ego and the milieu.

Maxwell Jones (1962) uses the concept "adjustment" to indicate the degree to which the patient has successfully coped with the demands of reality--successfully, that is, by the conventional standards of Western society. He states that adjustment may be measured in a number of different behavioral areas and in a number of ways in each area. This implies that accurate measurement of adjustment requires development of multiple-large number of indices.

Weissman (1975) states that the concept of social adjustment was defined to include both personal and social functioning. Personal functioning relates to the individual's feelings about self and self-directed behaviors. Social functioning concerns the individual's interactions with society and his/her ability to perform socially expected roles.

The American Psychiatric Association (APA, 1980) differentiates between "adaptation" and "adjustment," where both are used in most of the literature interchangeably. Thus, adaptation refers to fitting one's inner needs to the environment while adjustment is a more functional, often

transitory, alteration or accommodation by which one can adapt him/herself better to the environment. This distinction relates to Weissman's distinction between personal and social functioning where the personal functioning could be considered as an adaptation, and the social functioning as an adjustment. In this study the focus will be on the latter.

Hence, social adjustment is broadly defined as the interplay between the individual and the social environment. Weissman (1975) states that the major roles any individual assumes may be a function of psychopathology. While there is overlap beween symptoms and social adjustment, they may also be relatively independent (e.g. some person can function relatively well, although symptomatic, and others may function poorly, although asymptomatic). Symptoms are primarily a reflection of internal psychological or physical states that may have consequences in social relations. Social adjustment is a reflection of the patient's interactions with others, satisfaction, and performance in roles which are more likely modified by previous personality, cultural, and family expectations, Weissman continues to note that there is a debate about independence of symptoms and social adjustment. A resolution requires that they be measured separately and as accurately as possible. This will allow for the identification of different subgroups that may require different therapeutic interventions.

Jones' (1965) concept of social adjustment is a functional one, and is measured independently of symptoms. Despite the need for multiple large numbers of indices, he found through factor analysis that it is possible to talk about "general adjustment" of patients.

The concept of "social adjustment" suggests differentiation between various cultures and social structures. Therefore, I will refer to the concept of "community adjustment" where the focus should be on particular community standards and norms. Although there is overlap between social adjustment and community adjustment, they could be measured independently. People could adjust to a certain community, but not to the general society, and others could adjust to the general social norms, standards, and expectations, but not to a particular community.

Katz and Lyerly (1963) note when we talk about adjustment our grasp of the concept is limited to our current arbitrary standards and understanding of mental health. These standards are set by clinicians who have the responsibility for determining how mentally ill the patient is, and how s/he is functioning in the community. Therefore, clinical judgment is to be seriously considered in empirical research. At the same time, the ambiguity of definition and the shades of difference among users of the concept are indications that consensus about the meaning of adjustment is still very much beyond our present grasp. Clinicians and personality theorists are likely to change with regard to their conceptions of adjustment, and the definition is likely to be modified as understanding of the factors underlying mental health increases. They conclude that although "adjustment" as a concept has been in common usuage among clinicians for a long time, it is by no means unambiguous in meaning, nor is it necessarily acceptable as a goal in treatment to all therapists.

Literally, adjustment has to do with "bringing into proper relation behavior to circumstances or oneself to one's environment; to free from

differences or discrepancies; to bring to a satisfactory state so that parties are agreed" (Webster, 1960). Katz and Lyerly (1963) state that this is the clearest and most psychologically satisfying description of the concept (p. 506).

Adjustment by its definition is, however, a positive concept and implies the need to look for positive signs of coming to more satisfactory terms with the environment and with oneself. In setting out to measure it in severely disturbed people, an attempt was made to include both its indirect and direct manifestations and, at the same time, to keep within a definition which is necessarily highly operational.

Grasha and Kirschenbaum (1986) presented the concepts of adjustment and adaptation on a continuum labeled, "The Adaptation Continuum," (p. 7) comprised of three categories in which adaptation involves a range or continuum of relatively ineffective to highly effecting responses to meet the challenges of daily living; therefore they use the concepts of maladjustment, adjustment (adaptation) and competence to distinguish between different points on the adaptation continuum. Thus, adaptation is defined as the overall ability to cope successfully with the challenges that change produces in people's lives; while adjustment is defined, as one category of that continuum, and refers to the actions people take to at least "get by" or even adequately to handle the demands of their environment. Accordingly, maladjustment as one extreme of the continuum, refers to poor adaptation and competence, as the other extreme, refers to creative ways used to meet the challenges of life.

Based on previous discussion, it is obvious that measurement of

the concept is more ambiguous, and necessitates the foundation of standarized criteria which is highly debatable theoretically and clinically. Weissman (1975) reviews 15 methods and scales that are presumably measuring social adjustment which meet certain criteria for scale assessment. She states that there is still considerable room for scale development, that none of the reviewed scales will stand as the final instrument, and that there is also a strong need for standardization of methods between studies.

These debated and ambiguous methods of measurement intensify the multi-dimensional notion of social adjustment and increase the need for widely accepted criteria. Paykel et al. (1971) discuss the various dimensions of social adjustment and state that few empirical investigations in this regard have been done and that most social adjustment scales have evaluated functioning in terms of role areas such as work adjustment, marital adjustment, social and leisure adjustment. They state these studies ignore the possibility of consistent patterns of abnormality across roles. By applying factor analysis, they found six factors (dimensions) that cut across role areas, and provide an alternative conceptual framework for describing the social adjustment (maladjustment) of patients. The factors are: (1) Work performance, (2) Interpersonal friction, (3) Inhibited communication, (4) Submissive dependency, (5) Family attachment, and (6) Anxious rumination.

They found that patients were significantly distinguished from normal controls by scores on all six factors, which appeared to summarize a diverse range of social maladjustments of patients. They added that these

dimensions may be more suitable for observing patterns of change and measuring the effects of psychotherapy of other treatment.

As mentioned earlier, acceptable criteria in measuring social adjustment are obviously needed for practical clinical reasons and for research evaluation purposes.

> Katz and Lyerly (1963) state: "the concept of social adjustment is partially congruent with that of mental health and, thus, the absence of mental health does not necessarily produce maladjustment. However, the concept of mental health is highly complicated, and its definitions are as numerous and diverse as the various schools of personality theory. There are probably some minimal criteria acceptable to all schools, but for the most part "ego strength," "self-actualization," and "individuation" have meanings which are highly colored by the values of the theories they represent and are not easily defined or commonly agreed upon characteristics of mental health." (p. 506).

They found that the absence of gross signs of psychopathology is one of the minimal goals upon which all schools can agree.

In their work Katz and Lyerly (1963) also discussed several methodological considerations in measurement and scale construction of social adjustment, and concluded by developing specific operational definitions of adjustment and social behavior:

> Clinical adjustment-- This is freedom from symptoms of psychopathology as manifested in a patient's complaints and social behavior. Psychopathology can be manifested in the form of psychiatric symptoms, in disturbances in social behavior, in physical complaints, in ways of behaving toward him/herself, in work habits, in short, in all aspects of the patient's current living. The clinician bases his/her judgment of extent of psychopathology on symptoms manifested by the

patient during the interview, on symptoms inferred on the basis of interview behavior, and on the information s/he has been able to gather from other sources on the patient's symptomatic behavior in the community. S/he is, of course, not only concerned with extent of psychopathology, but also with the quality or type of psychopathology. Measures of psychopathology should provide, then, information both on amount and types of symptomatology.

Adequate social functioning-- Performance of occupational, self-care, social, community and home responsibilities, and the level of free-time activities which would be expected of the patient in terms of his/her social role are relevant.

Social adjustment-- The parties most concerned with the patient's condition and activities in the community are satisfied with his/her level of functioning.

Personal adjustment-- The patient is comfortable (i.e., not distressed by symptoms) and is satisfied with his/her manner of functioning in the work, social, and home areas.

Social behavior-- The quality of the patient's social behavior as manifested in the relative strengths of tendencies to relate in characteristic ways to other people; the comparison of such dimensions as withdrawal, hostility, and independence as these tendencies are expressed in his/her general behavior.

Anthony and his associates (1972), in their evaluation of the

efficacy of psychiatric rehabilitation programs, state that "procedures designed to rehabilitate the psychiatric patient have been evaluated by using a variety of criteria, including recidivism, posthospital employment, hospital discharge rate, and hospital adjustment." (p. 447). They selected in their study two criteria-- recidivism and posthospital employment-- and concluded that there is a definite need for the continued use of specific outcome criteria so that the comparative effectiveness of various psychiatric rehabilitation procedures can be meaningfully evaluated.

Fountain House, being a psychiatric rehabilitation facility, developed a descriptive, nominal scale known as the "Categories of Community Adjustment" (Appendix A) for the purposes of measuring outcome of rehabilitation activities. It is an instrument to facilitate the follow-up process in determining the status of any of their participating members at any point in time. The scale is based on information obtained by the Fountain House staff about their members. Although it deals with community adjustment it does not have ordering notions. Any effort to do so is inferred and based on value judgment.

To summarize this section, it is obvious by now that the literature is inconsistent in its definitions and measurement of the concept "community adjustment." This, in turn, creates problems of reliability and validity of the available scales. Some of the scales measure the concept in its psychopathological notion. Their main question, then, is how the patient is doing in terms of his/her level of functioning in the community. Others focus on the question of what the patient is doing in the community.

Neither type of scale will stand up as a final and absolute measure

of the concept. Combining both questions in one standardized criterion is a task for future research.

The emphasis on personal and social adjustment directed this study in using two scales:

1. **Categories of Community Adjustment (COCA):** Developed by Fountain House; provides us with a descriptive, functional pattern of patient.
2. **Symptom Check List = SCL - 90:**

   This is a self-report out-patient psychiatric rating scale, Derogatis, Lopman & Covi (1973), oriented toward symptomatic behavior of psychiatric out patients, composed of 90 items (Appendix B section 4), which are categorized, based on factor analysis (Appendix C) into 9 (nine) factors; as follows:

   1. Somatization
   2. Obssessive-Compulsive
   3. Interpersonal sensitivity
   4. Depression
   5. Anxiety
   6. Hostility
   7. Phobic anxiety
   8. Paranoid ideation
   9. Psychoticism

The application of those two scales (COCA and SCL-90) is a unique development in this type of research, and considered to be a major

contribution of this study to the field of mental health in general, and rehabilitation of psychiatric patients in particular.

Empirical Studies in Respect to Community Adjustment

In an attempt to review empirical findings that may account for explaining variance in community adjustment of chronic schizophrenics, it is found that the literature focuses mainly on: (a) family settings and social support network utilization of psychiatric rehabilitation programs; (b) combinations of drugs; and (c) sociotherapy. On the other hand, not much emphasis was found on demographic variables such as age, sex, and ethnicity, residence, socioeconomic status, employment history, and psychiatric history. There is no emphasis on the relationship between dropout from psychiatric programs and community adjustment.

Family and Social Support

Clark (1967) found that improvement is associated with the patient being hopeful about therapeutic change and interacting with people who support this attitude. That is to say that therapeutic improvement is most likely when elements in the patient and his/her social network are congruent and directed towards improvement. Clark states that his findings are consistent with the theory and also in their relation to therapeutic community. He emphasizes that family and friends have a significant effect on patient improvement.

Froland et al. (1979) state that most studies on social support in mental health indicate that social support networks influence whether one is recognized or defined as ill or under stress, and can satisfactorily adjust to

community life. Froland et al. argue that what is lacking is more understanding of how the social ties available to mental health clients may contribute to their community and social adjustment. In comparing different groups in this respect, they found that family ties are the major source of support for all groups except the hospital group. Further, they found that different levels of individual adjustment are significantly associated with the relative emphasis given to support resources. Individuals giving relatively greater emphasis to either family or professional contacts also report less psychological distress and more stability in the help they feel available to them. Relatively greater emphasis on friends or relatives and acquaintances is associated with having experienced more change in the network and reporting greater psychological distress.

Lukoff et al. (1984), in their extensive study of life events, familial stress, and coping in the developmental course of schizophrenia, found that socioenvironmental factors seem to predict the onset of schizophrenic episodes in vlunerable persons. They state that stressful life events have been found to cluster in the 3 to 4 week period preceding a schizophrenic episode in some patients. In addition, they relate that within the family environment, hostile, critical, and emotionally over-involved attitudes toward the patients by relatives have been found to be related to relapses. They also found that many schizophrenic patients seem to be deficient in the coping skills required to remediate the losses brought on by life events or to deal effectively with stressful relatives.

Freeman and Simmons (1958) argue that there is considerable evidence that improved functioning is not a necessary requisite for "success"

(i.e., remaining in the community). They found that level of performance is correlated with family setting (parental vs. conjugal); that is, patients who are husbands are almost exclusively concentrated on the high side of performance and conversely, patients who are sons cluster on the low side. Other studies, such as Kaplan et al. (1977) and Lin et al. (1979), emphasize the importance of social support as protective of health and that social support is negatively related to psychiatric symptoms. Although the empirical studies in this respect are consistant, they fail to explore the relationship of their findings in regard to family and social support systems to the dropout phenomenon.

Utilization of Psychosocial Rehabilitation Services

Keith and Matthews (1982) report that psychosocial rehabilitation services owe their inception to a group of patients who organized in the late 1940's to meet what they considered their important but neglected need for rehabilitation. These services respond directly to negative symptoms and deficits in interpersonal competence in the schizophrenic population. In general, these services have been initiated when positive symptoms have resolved, but as in physical rehabilitation, it is now apparent that such efforts should begin early in the treatment process.

The overall goal is to re-integrate the psychiatrically disabled patient into the community by maintaining and augmenting whatever level of functional independence s/he has been able to achieve. Rehabilitation has generally focused on social support, independent living, and vocational skills. Results of research on the chronic patient population underline the

populations need for rehabilitation programs.

An extensive review of the findings of Anthony and his associates (1978) showed baseline readmission figures of 30% to 40% after six months, 35% to 50% after one year, and 60% to 75% after three to five years. As for employment, most studies indicate only a 10% to 30% rate of independent employment at follow-up regardless of the time period studied.

To date, little controlled comparative research has been carried out on the impact that comprehensive psychosocial rehabilitation services have on the high rates of recidivism and unemployment. Beard and his associates (1978) reported on a five-year follow-up study that clients of Fountain House who received an active outreach program for the initial two years had significantly lower rehospitalization rates at one, two, and five years than control subjects, (Experimental subjects had Fountain House services available, while controls did not; additionally, experimental subgroups received systematic reaching out service). Those Fountain House clients who were hospitalized spent 40% fewer days in the hospital than did the rehospitalized control subjects. The data also indicate that the more contact the patients had with the program the less likely they were to be rehospitalized.

In another study, Beard et al. (1983) reported a low rate of re-hospitalization and a high rate of employment for experimental subjects (Fountain House population) as compared to the controls. Other research on psychosocial rehabilitation programs focused on services provided by aftercare clinics. These clinics, which usually offer some form of therapeutic or casework contact in addition to medication have been shown

to reduce readmission rates (Anthony et al., 1972).

Wolkon and Tanaka (1966) found in their evaluation study of Hill House members that the greater the involvement of the clients in the program the less the rehospitalization.* Involvement was measured by attendance rate and type of termination from the program. Also, known individual characteristics did not explain the reasons for rehospitalization.

It the studies discussed above it was found that rate of attendance has different effects on chronic versus non-chronic patients. In general, aftercare treatment is most effective with those chronic patients who maintain a continuing relationship with the program. These studies do not differentiate between dropouts and non-dropouts in term of their pattern of adjustment.

Compliance with Medication and Psychosocial Treatment

In an extensive review of literature by Greenblatt et al. (1965), they found that:

1. In experimental designs, experimental groups (those receiving psychotropic medication) improved significantly in comparison with control groups.

2. In follow-up studies, relapse rate was significantly higher for those groups given placebos as compared to those receiving medication. Hospitalization rates of chronic schizophrenic patients being followed in an

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* Hill House is a social rehabilitation center for released psychiatric patients located in Cleveland, Ohio.

outpatient clinic were significantly lower for those receiving medication as compared to those receiving placebos.

3. Different studies comparing hospital census before and after the introduction of psychotropic medication conclude that it is impossible to estimate the contribution of medication to the release rate, and there were no significant differences in the median lengths of stay in hospitals.

4. The combination of medication with psychotherapy is more effective than either modality alone.

5. Greater consensus is found regarding the effectiveness of combination of drugs with occupational therapy, and drugs with milieu therapy.

Hogarty and his associates (1974a) found in their two-year study that:

1. Medication is more effective in forestalling relapses than placebos (80% relapse rate for the placebo and 48% for the drug treated group).
2. Medication is effective for both sexes, but the size of difference is significantly greater for women than men.
3. There is no significant effect of sociotherapy during the entire treatment period, but it did reduce releases among those who survive in the community for six months after hospital discharge.

In their study on adjustment of non-relapsed patients, Hogarty and his associate (1974b) also found that among patients in the community those treated with combined medication and sociotherapy adjust better than those taking medication alone.

In comparing the effects of medication and differing modalities of psychotherapy, Paykel et al. (1971) state that several authors have emphasized the need for multiple assessment measures in studies of the outcome of psychotherapy. Medication has usually been regarded as primarily directed to symptom relief, and symptom measures may be adequate to assess outcome of treatment with medication. The aim of psychotherapy is not directed to improvement in those aspects of patients' interpersonal relationship, effectiveness, and satisfactions which are included under the general rubric of social adjustment. They cite studies which indicate that psychotherapy has an effect on social effectiveness more than on symptomatic discomfort.

Gibbons et al. (1984) indicate that dropout and failure to take medication appear to be causes of the relatively high prevalence of psychosis.

In this review there was no attempt to make a distinction between the different types of medication and different modalities of treatment. The variations are large and the effects may vary accordingly. However, it is noticed that these studies suffer from lack of consistent standardized criteria of therapeutic outcome.

Nevertheless, the issue of compliance with the treatment plan (medication and psychotherapy), could be considered as a variable that may explain variance in community adjustment and in dropout from Fountain House. This issue was discussed by Kane (1983), who highlights the importance of compliance, especially in outpatient settings, in affecting patient's adjustment.

This study will focus on these questions as they may explain differences between dropouts and non-dropouts and pattern of community adjustment.

The Dropouts

In this section, the focus will be on reviewing some of the empirical relevant literature that deals, directly or indirectly, with those who drop out from psychiatric treatment in general and psychiatric rehabilitation in particular. This review will allow us to generate hypotheses that compare dropouts versus non-dropouts from Fountain House. There is no systematic study that compares those two groups although the issue of dropouts received considerable attention. Almost all studies reviewed acknowledge the difficulty of obtaining reliable information on the dropouts.

Levinger (1960) makes the distinction between discontinuance rate and dropout rate, where continuance and discontinuance do not merely indicate the number of dropouts, and that continuance in treatment is not necessarily predictive of improvement. Yet, he argues, that the "degree of success" (i.e., improvement) can only be measured for these cases which continue contact with the agency, and discontinuers are automatically excluded from consideration in such samples.

Loeb and Scoles (1968) state that the sizeable percentage of clients who make initial agency visits and prematurely drop out of programs before receiving adequate assistance is an area of concern to many social service and mental health agencies.

Albers and Scrivner (1977) postulate that most attrition research has focused on dropping out shortly after once the patient has arrived at the clinic. However, they note that attrition (discontinuance) has not received adequate attention although it has been estimated that as few as 5% of the thousands annually seeking mental health services enter into and eventually complete a prescribed treatment program. This state of affairs not only has enormous professional, clinical, and economic consequences for the management and operation of clinics but also raises important questions as to the extent to which clinics are adequately meeting the needs of communities. Most of the literature notes that the continuation or termination of the process of appraisal is not well understood (Albers & Scrivner, 1977).

The drop-out problem appears to be even more serious and prevalent in the field of psychiatric rehabilitation. In a study of 1,216 cases referred to a mental health clinic, Garfield and Kurtz (1952) found that between 30% and 65% of the patients dropped out before completing treatment. Pfouts, Wallach, and Jenkins (1963), in a study of 218 consecutive referrals to an adult psychiatric outpatient clinic, state that only 13% of actual community referrals were seen in therapy for more than five visits. Beard, Pitt, Fisher, and Goertzel (1963), in a controlled study of Fountain House's rehabilitation services, point out that some 65% of their experimental group members made fewer than four visits to the agency.

This increasing evidence on the size and seriousness of the problem was one of the basis for developing this cohort prospective study.

In an attempt to conceptualize the dropout issue, several studies

have been done. Perlman (1960) labels the person who fails to return after one or two interviews the "case of the third man."

Albers and Scrivner (1977) discuss the need for a theoretical framework for understanding appraisal and the development of definitions about what may constitute attrition. They developed a conceptual model of the appraisal process, following which they reported and classified studies that explain attrition. From this process they argue that numerous personality, interpersonal, and social components can affect attrition. Such variables are: (a) the frequency, amount, and nature of previous sources of help, (b) socioeconomic factors, (c) the perceived attributes of both the problem and the sources of help, (d) situational variables, (e) the individual's values, beliefs, attitudes, cogniitions, and motivations, and (f) interactions with the environment, especially significant others. It is clear that there is not any single factor that will differentiate all those who seek psychiatric care from those who do not. They found that studies about attitudes toward mental health contribute to the explanatory factors in the individual's decision to continue or discontinue the appraisal process, In addition, they found that referral structure studies and accessibility are also useful for interpreting attrition.

Ripple (1955) proposes a different model, in which she states that the client's use of case work service is determined by his/her motivation, capacity, and the opportunities afforded him/her both by his/her environment and by the social agency from which s/he seeks help.

Sullivan, Miller, and Smelser (1958), in a study of outpatient psychotherapy, classified predictive factors into three groups: (a) charac-

teristics of the patient, (b) characteristics of the therapist, and (c) situational variables.

Frank and his associates (1957) considered possible answers in terms of two general headings--personal attributes of patients and aspects of the treatment situation.

Based on these studies, Levinger (1960) concluded that the patient's continuance in treatment is a function of variables in the following five areas: (1) Patient's personal attributes, (2) Patient's current environment, (3) Helper's personal attributes, (4) Helper's current environment, and (5) Characteristics of the patient-helper relationship.

Most of these conceptual studies focus on personality attributes of clients, of helper, and on their interaction. The studies are based on outpatient psychotherapy models, where it is found that these factors have differentiating effect more than in other types of treatment. Therefore, there is no systematic study that could give a comprehensive understanding of those who drop out from social and vocational rehabilitation programs.

However, in reviewing correlational studies, Loeb and Scoles (1968) found that demographic factors failed to differentiate dropouts from active clients, and that both contact approaches (telephone and home visit) were equally successful and resulted in returning 38% of the dropouts to an active status.

Wolkon and Tanaka (1966) found that the greater involvement in the rehabilitation service for released psychiatric patients the less the rehospitalization.

Beard et al. (1963) support this finding in their study of the effect

of rehabilitation services on rehospitalization and community adjustment. Experimental subjects were admitted to Fountain House programs and given differential rehabilitation services; the control group was referred to other community services. The investigators concluded that rehabilitation services of Fountain House were an influence in helping the experimental subjects survive in the community. They also found that a "higher percentage of experimental subjects than control subjects were able to assume employment. Relating employment to rehospitalization, it is seen that, although rehospitalizations were prevented in the experimental group, the rehospitalized experimentals had approximately the same employment rate as the non-rehospitalized subjects in the control group." (p. 709).

Viewing the effects of the Fountain House programs at the end of one year in terms of rehospitalization and employment, it was found that the largest subgroup of the control group (34.7%) consisted of subjects who were rehospitalized and never worked, compared to 21.3% for experimentals. The largest subgroup of the experimental group (43.9%) consisted of subjects who were non-rehospitalized and employed, compared to 32.6% for the controls. (p. 709). These findings suggest the effectiveness of the rehabilitation services on experimental subjects in terms of their ability to survive in the community.

Kogan (1957), in his study of short-term cases in a family agency, found that about 30% were considered to be "unplanned closings" (dropout) and that there was a difference between the type of presenting problems of both groups. He found that the closed cases on a planned basis presented economic and concrete problems while the unplanned closed cases

presented problems of family relationships or personality adjustment. The latter also appeared to be more resistant to follow-through in therapy. Both groups were judged by workers to be helped by the contact, but considered the clients in the planned closings had been helped to a greater extent. Kogan also found that despite the fact that there was evidence from follow-up that improvement of the problem situation or inability on the part of the client to continue because of reality based factors, in the majority of instances the worker tended to attribute client discontinuance to lack of interest or resistance to participation. This finding suggests that research of dropout populations may be influenced by the value judgment and bias of the researcher, who might assume negative outcomes.

However, consistant with Loeb and Scoles' findings, Kosloski et al. (1977) found in their archival study that descriptive characteristics such as age, income, and treatment latency had no significant correlations with either absenteeism or attrition from mental health centers.

CHAPTER V

RESEARCH METHOD

Integration and Rationale

An integrative perspective is needed here to emphasize that the reviewed literature in the previous chapter could be perceived conceptually and practically in the field of psychosocial rehabilitation of psychiatric patients. Rehabilitation is the mechanism through which the ego and environment (milieu) are put together to produce a new outcome in terms of patients' adjustment. The empirical research does not provide a comprehensive understanding of the interaction between both and on the various components of the process.

The continuing dispute regarding deinstitutionalization (Brown, 1980, 1982; Deleon, 1982; Kaswan, 1982; Okin, 1978; Robbins, 1982) and the increasing evidence of the correlation between mental illness and the homeless population (Arce et al., 1983; Fustero, 1984; Jones, 1983; Lipton et al., 1983) raise the assumption that there is a pathway between deinstitutionalization and homeless through attrition or dropout. This, in return, reflects on community adjustment of patients, and intensifies the theoretical and practical significance of this study. Thus, the conceptual model under investigation in this study is a multivariate correlational one which is schematically presented in figure 5.1.a.

Figure 5.1.a:
Schematic presentation of conceptual model.

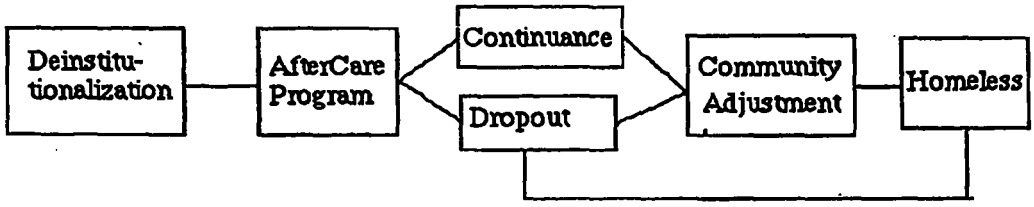


Figure 5.1.a

This model presents the process in which patients are discharged from psychiatric hospitals, and referred to aftercare programs, but their length of stay will vary. Categorically, patients are classified into dropouts vs. those who continue in the program (non-dropouts). It is hypothesized that length of stay in the program is directly related to community adjustment. Dropouts will tend to achieve poor community adjustment and eventually to become homeless.

A comprehensive longitudinal study is needed to assess relationships among the components of this model. The research setting (Fountain House), the design of this study, and the data will be limited to the following components (figure 5.1.b):

Figure 5.1.b :
Application of the conceptual model to the research project.

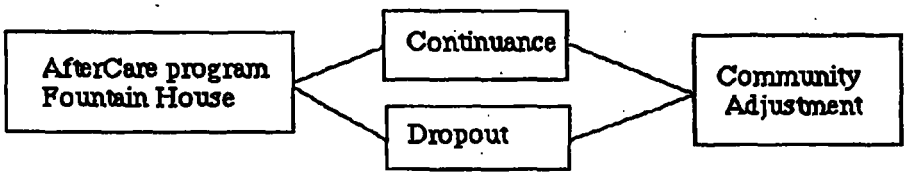


Figure 5.1.b

The outcome to be measured is the level of community adjustment of two groups: (1) dropouts, and (2) those who continue to utilize Fountain House's services. This model raises, by its nature, many questions concerening the differences between the two groups. The literature does not give us satisfactory answers to many of those questions, especially to those which relate to engagement in treatment (therapy), compliance with medication, social network, ethnicity, socioeconomic, and other demographic variables. Additionally, this model recognizes the difficulty in collecting accurate data on the dropouts unless a follow-up study is completed.

Knowledge of these relationships should enhance clinical judgments in terms of clients' needs in Fountain House. One might argue that this model posits a causal relationship between continuance with Fountain House and improved level of functioning. However, as Levinger (1960) suggests, continuance or discontinuance with the program could be evidence of success in establishing the client-worker relationship, but it is not necessarily predictive of improvement. Levinger (1960) also reports the findings of other studies (Blenker, 1954; Katz et al. 1958) which indicate that the distinguishing variables between continuance and discontinuance do not differentiate similarly between successful and unsuccessful cases. Persons staying a short time may "improve" more than those staying a long time.

Thus, the rationale of the study is derived from the significance of the dropouts as compared to non-dropouts from Fountain House in regard to their community adjustment. This issue generates two major questions:

1. What are the predictive factors of dropout? In other words, what are the distinguishing variables between dropouts and non-dropouts?
2. What is the effect of dropout on community adjustment of psychiatric patients?

The rehabilitation services of Fountain House are composed of a three stage process: (a) Intake, (b) Orientation, and (c) Day Program. Dropout may occur at any stage in the process. It is important to estimate the dropout rate at each stage of the process. Determining the relationship between stage of dropout and community adjustment will enhance our clinical and administrative decisions and improve our service delivery system. In other words, this study is a way of opening new gates for new concepts of treatment on various levels.

In addition, the fact that Fountain House has no definite criteria for termination makes it a type of system which encourages a lower rate of dropout but imposes difficulties in measuring client's improvement.

Hypothetical Framework

The discussion in the previous section raises the main questions of this study:

1. Who are the dropouts?
2. When do they drop out (at what stage)?
3. What is the dropout rate?
4. What is the level and pattern of community adjustment for

the dropouts and non-dropouts?

5. How do the activities of Fountain House affect the dropout rate and community adjustment?

Based on these questions, the literature, and the goals of this study, many hypotheses could be generated. The following variables/factors were selected:

1. Demographic variables
2. Social network and social support system
3. Psychiatric history
4. Compliance with out patient treatment
5. Compliance with psychiatric medication
6. Degree of psychiatric symptomatology
7. Involvement in Fountain House program

The purpose of the hypotheses is to examine whether these independent variables are related to community adjustment and dropout.

1. Community Adjustment

The "Categories of CommunityAdjustment Scale" (COCA) is the chief instrument used in the follow-up study in this investigation. It is a nominal scale which is used to categorize the member's status at Fountain House. Further research is needed to assess significant differences between the scale categories. Most new members entering Fountain House are placed into category #3 (Prevocational Day Program). Further refinement of the scale is needed to observe significant movement from one category to another and to provide further differentiation of members' adjustment. For

this reason, three new variables were added to the scale:

a. Level of performance-- with values of very good, good, fair, and poor.

b. Unit selection-- the type of work in which members will be engaged. The values of this variable are based on the active units of Fountain House, which are:

   1. First Floor - Reception
   2. Dining Room - Kitchen
   3. Research
   4. Clerical
   5. Snack Bar
   6. Third Floor - Day Treatment

c. Weekly rate of actual attendance of member at his/her unit.

These additions to the scale measure changes in level of functioning not only by movement from one category to another but also within the same category.

2. Dropout

The term dropout is defined as a voluntary leaving from the program at any point in time within the first six months following intake. It is measured by the member's length of stay in the program.

According to the scale (COCA), most dropouts will be classified as "lost" or "in community reach out." This categorization might be misleading because it does not necessarily imply poor level of adjustment.

The following are dimensions of dropout which will be studied:

a. Length of stay

b. Dropout vs. non-dropout

c. Attendance at orientation program

Hypotheses

Operational definitions of the variables will be presented in this section describing the research method and measurement.

A. Demographic Hypotheses

Demographic variables (age, sex, ethnicity) will be used to describe the populations. The following hypotheses are to be tested:

1. AGE: Young members tend to drop out more frequently than older members. The assumption is that young patients are not afffected yet by chronicity factors. They will tend to utilize Fountain House as a means of gaining employment in the open market rather than viewing Fountain House as a terminal position.

2. SEX: Females tend to drop out more frequently than males. The assumption is that females may be affected by outside factors (e.g., home responsibilities, pregnancy, children, etc.) more than males.

3. ETHNICITY: White members tend to drop out less

frequently than do members of minority groups. The assumption is that majority groups (white) tend to maximize their utilization of services.

B. Social Network and Social Support System:

It is hypothesized that members with stronger social suppport systems tend to have longer periods of stay in Fountain House and have higher levels of adjustment. Variations within the social network (types of social network) will also be tested. The assumption is that strong social networks will reduce rehospitalization by encouraging patients to attend aftercare programs.

C. Psychiatric History:

Members with higher numbers of psychiatric hospitalizations will stay longer in Fountain House. Additionally, these members will have poor level of adjustment. In other words, patients who are more affected by chronicity of hospitalization tend to be more dependent upon social services and less functional.

D. Compliance with Out Patient Treatment:

The higher the compliance of patients with their psychiatrists and their therapists, the longer they will stay in the program. These patients will have a higher level of community adjustment.

E. Compliance with Prescribed Psychiatric Medication.

High compliance with prescribed psychiatric medication has a positive effect on length of stay and on level of community adjustment. The assumption is that psychotropic medication reduces the symptomatology and thus fosters better adjustment.

F. Degree of Psychiatric Symptomatology (SCL-90)

The more severe the psychiatric symptoms, the shorter the length of stay. Patients of this group will have a lower level of adjustment.

G. Involvement in Fountain House Program

This variable relates to the initial contact and beginning stages of involvement in Fountain House. It is broken down into three elements:

1. Familiarity/Previous Contact with Fountain House:

   The hypothesis is that members who have had previous contact with Fountain House tend to drop out sooner from the program.

2. Expectations from Fountain House:

   The more expectations from Fountain House, the longer they tend to stay and the better their community adjustment.

3. Attendance at Orientation Program:

   Patients who have full-time attendance at the orientation program will stay longer and adjust better.

Research Design

Due to the nature of population, the structure of Fountain House, and the time involved in assessing dropout and community adjustment, a decision was made to investigate the type of questions and hypotheses of this study by developing a longitudinal design. Subjects were recruited to the study on intake and every one was followed for six consecutive months. The baseline data on this cohort was collected during the period of April 1985 to September 1985. New members who came for intake filled out the intake application and were referred right after to the research department to participate in the study. The subject was interviewed in most cases by an active member of the research department who directed the new patient for the research project and helped him/her to fill out the questionnaire. Sixty subjects were generated during that period of time. A 40-50% dropout rate was anticipated.

Longitudinal empirical investigation of these questions should provide systematic answers to several clinical, policy, and research issues.

The outcome to be measured is the level of community adjustment of both groups, the dropouts vs. the non-dropouts. The literature, as mentioned earlier, does not give us satisfactory answers to many questions, especially to those that relate to engagement in treatment, compliance with medication, family setting, ethnicity, and other socioeconomic and demographic variables.

It is essential to emphasize the following points, as they reflect, and further justify the administration of longitudinal and follow-up designs:

1. Huge gaps in our knowledge do exist, particularly in reference to identification of dropouts and their level of functioning.
2. Need for standardized measures of community adjustment.
3. Empirical studies that focus on effectiveness and efficiency of mental health services mostly rely on data obtained on those who continue with the program. It is highly significant to point out that valid measurement of effectiveness should rely on adequate and reliable comparisons of the two groups (dropouts vs. non- dropouts). The lack of standardized measures of improvement, and the lack of reliable data on the dropouts impose certain constraints on statistical inference and valid generalization.
4. Effectiveness of mental health services is measured in most cases by reducing the rate of admissions and the length of stay in state hospitals. Effort is not made to develop standard criteria for improvement and social functioning. Institutionalization or deinstitutionalization should be perceived as an integral part of rehabilitation efforts, rather than a separate entity.

However, it is important to highlight some of the main issues that prevent researchers, and agencies from applying long-term designs:

1. Longitudinal and follow-up designs are lengthy and expensive.
2. Collection of data requires cooperation and long-term

commitment of various elements of the agency: Administrative, clinical, and all other elements involved in patients' activities and welfare.

3. Most agency elements are to be trained on an ongoing basis and made aware of the project and its goals. Accordingly, stability in the agency structure is required for a long period of time.
4. Resistance to cooperate with the researcher is a critical issue because, in most cases, staff members are required to carry the research responsibilities beyond and in addition to their heavy schedules and regular daily activities.

This project is an attempt to contribute to an understanding of some of the timely questions concerning mental health. It is the assumption that mental health issues are complex and simple methodology will not be sufficient to give valid and reliable answers.

Instruments and Data Collection

Data collection was a lengthy process that involved different elements in the program, started in April 1985 and completed in March 1986. It was composed of two major stages:

1. Intake interview (Appendix B)
2. Follow-up data (Appendix D)

Intake Inerview

Data were collected on intake on every new applicant to Fountain House. The purpose was to have baseline data on every subject. The intake instrument was developed based on given literature, and the type of hypotheses stated in previous chapters. Modifications to the instrument were introduced in two consecutive steps: the research staff of Fountain House and selected members of same department. The final instrument included the following set of explanatory independent variables:

1. Demographic Variables:

   Age Education

   Sex Employment

   Ethnicity

2. Familiarity with Fountain House:

   Previous contact with Fountain House

   Referral source to Fountain House

   Expectations from Fountain House

3. Social Network and Social Support System:

   Type of living arrangements

   Present functioning status

   Income, sources and number of dependents

   Marital status

   Number and age of children

   Number and age of siblings

   Number of friends

   Current living status of parents

Distance in time from parents, children, siblings and friends

Frequency of contact with neighbors, friends, and family members

In addition, a list of possible social network members was given attached to 8 (eight) types of needs. Patients were asked to choose all applicable members from the following list:

1. Parents
2. Siblings
3. Spouse
4. In-Laws
5. Children
6. Other Relatives
7. Friends
8. Neighbors
9. Fountain House
10. Co-workers or Employer
11. Other Agencies
12. Other

The eight needs were:

1. Emegency need to borrow sugar or salt at dinner time.
2. Needing someone to watch your house while you are away and report any incidents to proper authorities.
3. Needing someone to take care of your household needs while you are sick in bed for two weeks.
4. Being sick in hospital, whom you want to visit you?
5. In emergency situation, having no money and needing a room to stay where would you go?
6. Needing someone to take care of your bills, due to long illness in hospital.

7. For your favorite free time activities, where would you go?
8. In case you feel low and want someone to talk to and make you feel better, where would you go?

After completing all these set of questions, patients were asked to rate, in general, the degree of help they think they are receiving from the same list of network members. Degree of help varied on a scale of 1 to 4 as follows:

1. Very helpful
2. Helpful
3. Not too helpful
4. Not helpful at all

Conceptualization, formulation, and measurement of social support system were developed based on personal consultation with Professor Litwak and his theories (Litwak 1981). The dimensions to be tested were:

1. Availability of social support network
2. Proximity of social support network
3. Use rate of social support network
4. Psychiatric History:
    1. Hospitalization for psychiatric reasons
    2. Age of first hospitalization
    3. Total number of hospitalization times
5. Compliance with Psychiatrist and Therapist:

This section was developed based on literature, Davis, (1967, 1968) Bush & Osterwicz (1978). Similar questions were asked separately about psychiatrist and therapist using the following dimensions:

1. Recommendations offered
2. Recommendations accepted
3. Recommendations followed

Using the above three dimensions, the questions related to the frequency of sessions and compliance with the following recommendations:

1. Psychiatric medication
2. Other medication
3. Health issues
4. Work and rehabilitation
5. Personal habits (smoking, drinking, etc.)
6. Family situation
7. Other recommendations

Then they were asked to rate the relationships with their psychiatrist and therapist as follows:

1. Rate of relationship
    1. Very good
    2. Good
    3. Fair
    4. Poor
2. How often do you follow their recommendations:
    1. None of the time
    2. Very seldom
    3. Less than half the time
    4. Most of the time
    5. All the time

3. How helpful they are to you:
    1. Very helpful
    2. Helpful
    3. Not too helpful
    4. Not helpful at all

A separate question about compliance with prescribed psychiatric medication was asked, alternative possible responses were:

1. All the time as prescribed
2. Most the time as prescribed
3. Half the time as prescribed
4. On occasion as prescribed
5. Never as prescribed

6. Symptomatology - (SCL-90)

Symptom check list including 90 items was administered, Deragotis, Lipman & Lino (1973); Dinning & Evanse (1977).

7. Diagnosis:

Data were collected from records based on DSMIII 1980

8. Attendance at Orientation Programs:

Data were collected from records.

To administer this questionnaire, a training session was held with Fountain House staff from intake and research departments. Agreement was reached that new members would complete their intake procedure for Fountain House and they would be referred to the research department in order to respond to the questionnaire. An interview and complete training was given to Fountain House active members in the research department to

assist subjects in answering the questions. In addition other staff members and this researcher took part in administering the instument. The average length of time took for each subject to complete the instument was between 45-60 minutes. Subjects complained that the instrument was "too long, and too personal." The first stage of intake interview was completed on sixty subjects during the period from April 1985 to September 1985.

Follow-up Stage

Every subject was followed for 6 (six) consecutive months by the researcher starting two weeks after intake. Two weeks are enough time to allow a member to complete the orientation program and start in the day program unit that s/he chose .

Data that were collected every two weeks thereafter included the following (appendix D):

1. Unit selected (assigned):
    1. First Floor - Reception
    2. Kitchen - Dining Room
    3. Third Floor - Day treatment
    4. Research
    5. Clerical
    6. Snack Bar
2. Categories of community adjustment (COCA)
3. Level of performance for relevant categories: 1. Very Good 2. Good 3. Fair 4. Poor
4. Attendance of member at the program.

These items were given to the unit supervisor who was familiar with the subjects and their activities. The supervisors were not familiar with the research design and methodology.

In case of dropout, a follow-up was performed. A number of efforts were made to reach each dropout. These efforts were made by the researcher, the unit supervisors, and an active member who was in charge of reach out. It was decided to stop the follow-up search when enough evidence was obtained on those members who were lost in the community. The follow-up process started in September 1985 and ended at the beginning of March 1986.

To sum up, it was evident that the research methodology was complicated, lengthy, and expensive, but it provided enough data to compare patterns of adjustment and to distinguish between the dropouts and the non-dropouts. The cooperation of Fountain House staff and members is to be commended.

CHAPTER VI

ANALYSIS OF DATA: RESULTS AND FINDINGS

Descriptive Statistics and Operational Definitions

The collected data did not allow for all independent variables to be included in the analysis. Missing data, unreliability, and sample size were factors which affected the analysis process. Accordingly it required redefinition and regrouping of some of those variables. The following is a presentation of all independent variables in their final definition and frequency distributions.

Demographic and Socioeconomic Variables

Table 6.1 presents main characteristics of the subjects, it indicates that the majority are white males with average age of 36 years (median = 34). It also indicates that most of the subjects have high school and/or college education, 97% of them are unemployed and 97% are single, and financially dependent on welfare system. Their average length of unemployment is 44 months, with a range of 2-96 months, and their average monthly income is $272.0, median = $307.0 (17% reported having zero income).

Their living arrangements also vary; the majority of them live by themselves, with friends, or families, and 25% are living in institutions and group homes.

Table 6.1 Demographic and Socioeconomic Variables-Frequency Distribution

Variable	Category	N	%
Sex	Male	35	59.3
	Female	24	40.7
Age	18 - 30	20	34.5
	31 - 50	33	56.9
	51 - 67	5	8.6
Ethnicity	White	39	67.2
	Minority	19	32.8
Education	Less than high school	18	31.0
	High school	18	31.0
	More than high school	22	37.9
Source of income	Family	5	8.3
	Social sources	43	71.7
	Unknown	12	20.0
Income level	None	8	17.0
	1 - 300	16	34.0
	301 - 500	17	36.2
	501 - 700	6	12.8
Living arrangement	Family	16	30.2
	Institution	13	24.5
	Self	24	45.3

Looking at cross-tabulation of every two variables (demographic and socioeconomic) and using X^2 chi-square test, the analysis revealed that the association between ethnicity and level of income is statistically significant ($X^2 = 10.853$, D.F = 3, $P < 0.0125$) (appendix E). It is found that white subjects have significantly higher level of income as compared with the income of minority groups. In addition no significant differences were found between sources of income and

ethnicity; using crosstabulation of income level by source of income controling for each ethnic group, independently, the X^2 test revealed to be nonsignificant ($P > 0.05$).

Psychiatric History

The psychiatric history and characteristics of the subjects are presented in table 6.2.

Table 6.2 Psychiatric History - Frequency Distribution

Variable	Categories	N	%
Hospitalization	Yes	53	88.3
	No	7	11.7
Diagnosis	Schizophrenia	47	78.3
	Other	13	21.7
Number of times hospitalized	None	7	11.6
	1-5	31	51.7
	6-10	22	36.7
Length of stay in hospital (months)	None	7	11.7
	1-10	23	38.3
	11-96	30	50.0

Data collected from medical records indicated that 78% are diagnosed with chronic schizophrenia, and 22% are diagnosed with other psychiatric illnesses. However, the majority (88%) indicated having history of previous hospitalizations for psychiatric reasons. The average age of their first hospitalization is 24 years, which indicates that patients became sick in their early life. Patients repeated their admissions on the average 6 times.

These figures are indications of long standing chronicity since early ages with multiple number of psychiatric hospitalizations.

Social Network

The data collected on all variables relating to social network were not sufficient to allow for analysis of different types of social network and different kinds of help. The effort to build a scale identifying the type of network by the type of help needed turned to be unreliable. This should be a challenge for further research with a larger sample size. However, table 6.3 presents the availability of four sources of network and their frequencies. This table indicates that patients turn for help in the following order: families, social agencies, friends, and neighbors.

Table 6.3 Availability of Social Network: Type and Frequency Distribution

Type of Available Network	Available		Not Available		Total	
	N	%	N	%	N	%
Family	49	81.7	11	18.3	60	100.0
Social agencies	40	66.7	20	33.3	60	100.0
Friends	35	58.3	25	41.7	60	100.0
Neighbors	24	40.0	36	60.0	60	100.0

Table 6.4 presents the number of available social network which is a composition of the previous components in table 6.3. It presents the frequency distribution by number of available network sources for each patient.

The categories in table 6.4 represent any combination of items

in table 6.3. Thus category "none" means, social network is not available, while category "4" means four sources of network are available. It was found that the majority of patients have between 1 - 3 (one to three) sources of network; (mean = 2.5, SD ± 1.08, median = 3).

Table 6.4 Number of Available Network Sources - Frequency Distribution

Total Sources Available	N	%
None	1	1.7
1	13	21.7
2	14	23.3
3	21	35.0
4	11	18.3
Total	60	100.0

This is an indication that participants in the project had many sources of support available for their use.

Compliance With Out Patient Treatment

The data in table 6.5 indicate whether patient is in psychiatric treatment, with psychiatrist or therapist, compliance with medication, and frequency of sessions with psychiatrist and therapist.

Although a majority of subjects (72%) attend treatment with a psychiatrist, only 40% of them actually maintain weekly sessions. In contrast, 83% of those who have a therapist (53%) actually maintain weekly sessions. This difference in frequency of sessions may be explained by differences in treatment modalities. Finally 92% (N = 35) reported compliance with their prescribed medication.

Table 6.5 Out Patient Treatment - Type and Compliance

Variable	Category	N	%
Attending treatment with psychiatrist	yes	43	71.7
	no	17	28.3
Frequency of sessions with psychiatrist	once a week	14	40.0
	once every 2 weeks	7	20.0
	once a month	14	40.0
Compliance with medication	all time as prescribed	35	92.0
	most the time	3	8.0
Attending treatment with therapist	yes	30	52.6
	no	27	47.4
Frequency of sessions with therapist	once a week	19	82.6
	once every 2 weeks	4	17.4

Symptom Check List (SCL-90)

The administration of the SCL-90 to the subjects revealed that (table 6.6) the majority of the subjects scored low on scale from 0 to 4. At least 70% of them reported that symptoms either do not bother them or they are bothered only "a little bit". Almost nobody scored 4 (i.e. extremely bothered by the symptons) and about 12% - 30% scored 2 or 3 (symptoms bothered them moderately or quite a bit).

Examining every factor separately it was found that 26% of the subjects scored 2 = Moderately bothered by the symptom of paranoid ideation. These findings indicate that subjects are not bothered by

Table 6.6 SCL-90 - Severity of Symptomatology- Frequency Distribution

Symptom	Severity of symptoms * 0	1	2	3	4	total
Somatization	2	48	6	1	-	57
	(3.5)	(84.2)	(10.5)	(1.8)	-	(100.0)
Obsessive compulsive	6	40	7	2	-	55
	(10.9)	(72.7)	(12.7)	(3.6)	-	(100.0)
Interpersonal sensitivity	5	37	10	3	-	55
	(9.1)	(67.3)	(18.2)	(7.3)	-	(100.0)
Depression	5	36	10	4	-	55
	(9.1)	(65.5)	(18.2)	(7.3)	-	(100.0)
Anxiety	5	41	6	3	-	55
	(9.1)	(74.5)	(10.9)	(5.5)	-	(100.0)
Anger/hostility	18	31	5	-	1	55
	(32.7)	(56.4)	(9.1)	-	(1.8)	(100.0)
Phobic-anxiety	12	36	7	-	-	55
	(21.8)	(65.5)	(12.7)	-	-	(100.0)
Paranoid ideation	9	29	14	3	-	55
	(16.4)	(52.7)	(25.5)	(5.5)	-	(100.0)
Psychoticism	6	39	9	1	-	55
	(10.9)	(70.9)	(16.4)	(1.8)	-	(100.0)

* Severity of symptoms:

0 = Not bothered at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Extremely

psychiatric symptomatology, which could be explained either by the fact that the majority of patients are on medication, which reduces the intensity of symptomatology, or by the fact that on intake to a psychosocial program, the patient is expected to perform adequately

and to be sympton free. The fact that patients scored relatively high on paranoid ideation corresponds with the fact that the majority are diagnosed: chronic schizophrenia - paranoid type.

Reliability analysis of the SCL-90 factors is presented in table 6.7. The figures indicate that all factors revealed to be highly reliable and were included in the analysis. The additional scales of the SCL-90* were removed from the analysis.

Table 6.7 SCL-90 - Reliability Coefficients

Factor	# items	N	Reliability Alpha	Standardized Alpha
Somatization	12	21	.90	.90
Obsessive/ compulsive	10	43	.90	.85
Interpersonal - sensitivity	9	46	.85	.85
Depression	13	45	.93	.92
Anxiety	10	47	.83	.82
Anger/hostility	6	51	.76	.77
Phobic anxiety	7	49	.82	.83
Paranoid ideation	6	47	.78	.78
Psychoticism	11	49	.83	.82

To examine the validity of the SCL-90 it is recommended to administer it on larger samples of patients in different psychosocial rehabilitation programs, however, the correspondence of clinical diagnosis with SCL - 90 scores on paranoia provided an indication of its validity.

* Additional scales, part of the original SCL - 90 and measuring things other than the list in table 6.7, include the following: poor appetite, over eating, trouble falling asleep, awakening in the early morning, sleep that is restless or disturbed, thoughts of death or dying, and feelings of guilt.

Involvement With Fountain House

Initial involvement with Fountain House was measured by the following three variables:

1. Previous contact with Fountain House
2. Expectations from Fountain House
3. Attendance at Orientation Program

Table 6.8 presents frequency distribution for these variables. Figures in this table indicate that the same percentage (73%) had no previous contact with Fountain House and attended the orientation program. This suggests that all new members did attend the orientation program.

Table 6.8 Involvement with Fountain House

Variable	Categories	N	%
Previous contact with Fountain House	yes	16	26.7
	no	44	73.3
Expectations from Fountain House	stay out hospital	22	37.3
	vocational	17	28.8
	social	12	20.3
	residential	8	13.6
Attendance at orientation program	yes	44	73.3
	no	16	26.7

The majority of patients (45%) were referred to Fountain House by their social workers, 15% by their psychiatrists, 10% by

themselves, and 8% by their families.

Patients had four major expectations, listed by order they include: to stay out of hospital, help in vocational areas, help in their social life, and help in residential issues. Achievement of these expectations requires extended periods of help and continuation of patients in the program; thus it is expected that patients who have these expectations will have low rate of drop out.

The following is a breif summary of main characteristics of the subjects presented in this descriptive section:

1. Majority are white, male, average age of 36 years with high school and/or college education. Patients are unemployed, financially dependent on social welfare sources, low income, most of them live by themselves or with their families.

2. White patients have significantly higher income than do minority patients.

3. Majority are diagnosed to have chronic schizophrenia, who had multiple number of hospitalizations for long periods of time.

4. In reference to their social network, patients mostly rely for help, listed in order, on families, social agencies, friends and finally, neighbors. It was found that the majority are utilizing more than one source of social network.

5. Majority of patients are attending out patient treatment with psychiatrist or therapist. The frequency of their therapy sessions is higher with the therapist.

6. Majority of patients reported taking their psychiatric medication as prescribed.

7. Concerning their symptomatology, the SCL-90 scale, was administered. Patients scored low (0 or 1) on all factors with the exception of paranoid ideation.

8. Majority of patients attended the orientation program, had no previous contact with Fountain House, and presented many expectations of their future involvement in the program.

Dropouts vs. Non-Dropouts

This section will try to answer the main questions of this project, i.e. what are the characteristics of those who dropout from Fountain House? When do they drop out? and What is their dropout rate?

It was found that only 30% (N = 18) completed the six months follow up; thus 70% (N = 42) dropped out during this period. This finding should lead to many questions about the program and its approach to patient retention.

Table 6.9 indicates that the majority of patients drop out immediatly after intake, and that a decrease of the dropout rate is observed over time. Thus concluding, as expected, that the initial stages of involvement in Fountain House are very significant in determining the length of stay.

Table 6.9 Dropout Rates Within the First Six Months After Intake

Length of stay (months)	N	%	Cumulative %
0	24	40.0	40.0
1 - 3	13	21.7	61.7
4 - 5	5	8.3	70.0
Completed 6 months	18	30.0	100.0
Total	60	100.0	

Demographic and Socioeconomic Variables

Table 6.10 presents the frequency distribution of the subjects, dropouts and non-dropouts, on the several demographic and social network variables.

Table 6.10 Demographic and Social Netwok Variables by Dropout vs Non-Dropout

		Dropout= less than 6 months		Non-dropout completed 6 months		Total	
		N	%	N	%	N	%
Sex *	male	28	80.0	7	20.0	35	100.0
	female	13	54.2	11	45.8	24	100.0
Age	18 - 30	13	65.0	7	35.0	20	100.0
	31 - 50	24	72.7	9	27.3	33	100.0
	51 - 67	3	60.0	2	40.0	5	100.0
Ethnicity	white	27	69.2	12	30.8	39	100.0
	minority	14	73.7	5	26.3	19	100.0
Education	<high school	15	83.3	3	16.7	18	100.0
	high school	12	66.7	6	33.3	18	100.0
	>high school	15	68.2	7	31.8	22	100.0
Source of income	family	2	40.0	3	60.0	5	100.0
	public sources **	32	74.4	11	25.6	43	100.0
Income	none	6	75.0	2	25.0	8	100.0
	1 - 300	13	81.3	3	18.7	16	100.0
	301 - 500	12	70.6	5	29.4	17	100.0
	501 - 700	3	42.9	4	57.1	7	100.0
Living arrangements	family	10	62.5	6	37.5	16	100.0
	institute	8	61.5	5	38.5	13	100.0
	self	18	75.0	6	25.0	24	100.0
Social network	1	10	71.4	4	28.6	14	100.0
	2	12	85.7	2	13.3	14	100.0
	3	12	57.1	9	42.9	21	100.0
	4	8	72.7	3	27.3	11	100.0

* $X^2 = 4.48163$, D.F. = 1, P = 0.03

** Public sources: SSI, SSD, welfare etc.

The figures in this table indicate that the majority of dropouts are white, males, their age group is 31 - 50, their education is distributed almost equally within the three groups (less than high school , high school or more than high school), most of them have income of $1 - $500 a month, their main source of income is public sources (welfare, SSI, SSD etc.), and live on their own (by themselves). Most of them have 2-3 sources of available social network.

Compared to the non-dropouts, the majority are white, females, from age group of 31-50, with education of high school or more, who are dependent mainly on public sources of income, their income level $301-$700 per month, who live mainly with family or by themselves, and have 3 sources of social network .

However these differences turned out to be not significant except with gender. Contrary to the hypothesis, male patients drop out more than females. It was found that 80% (N = 28) of the males drop out as compared to 54% (N = 13) of the females. Also 68% of the dropouts are males while 61% of the non-dropouts are females. The same significance level was reached when the dropout variable was broken down into months length of stay (X^2 = 6.59882, D. F = 2, P <= 0.0369). Fifty-one percent of the males drop out within zero time (right after intake) as compared to 25% of the females. At that stage 75% of the dropouts are males. Also among those who remained 1-3 months 23% of the males dropout, and constitute 67% of total dropouts. Fifty-eight percent of the females remain in the program for 4-6 months.

Psychiatric History and Compliance With Treatment

Table 6.11 presents the differences between the dropouts and non-dropouts in reference to psychiatric history and compliance with treatment.

Table 6.11 Psychiatric History and Compliance with Treatment by Dropout vs Non-Dropout

		Dropout		Non-Dropout		Total	
		N	%	N	%	N	%
Diagnosis	Schizophrenia	35	74.5	12	25.5	47	100.0
	Other	7	53.8	6	46.2	13	100.0
Hospitalization*	Yes	40	75.5	13	24.5	53	100.0
	No	2	28.6	5	71.4	7	100.0
Times hospitalized**	None	2	28.6	5	71.4	7	100.0
	1-5	23	74.2	8	25.8	31	100.0
	6-10	17	77.3	5	22.7	22	100.0
Length of stay ***	None	2	28.6	5	71.4	7	100.0
in hospital (mons)	1-10	15	65.2	8	34.8	23	100.0
	11-96	25	83.3	5	16.7	30	100.0
Have psychiatrist	Yes	30	69.8	13	39.2	43	100.0
	No	12	70.6	5	29.4	17	100.0
Sessions with	once/week	9	64.3	5	35.7	14	100.0
psychiatrist	once/2 week	6	85.7	1	14.3	7	100.0
	once/month	10	71.4	4	28.6	14	100.0
Take medications	All times	25	71.4	10	28.6	35	100.0
	Not as prescribed	1	33.3	2	66.7	3	100.0
Have therapist	Yes	22	73.3	8	26.7	30	100.0
	No	17	63.0	10	37.0	27	100.0
Sessions with	once/week	13	68.4	6	31.6	19	100.0
therapist	once/2 week	3	75.0	1	25.0	4	100.0

* $X^2 = 6.4767$, D.F.= 1, P = 0.01
** $X^2 = 6.5348$, D.F.= 2, P = 0.04
*** $X^2 = 8.51129$, D.F.=2, P = 0.01

The following variables were found to have a significant effect on dropout:

1. Hospitalization: 76% of those who have been hospitalized dropped out and 95% of the dropouts have been hospitalized .

2. Number of times hospitalized: most of those who have not been hospitalized 71% (N = 5) did not drop out, and the majority of those who have been hospitalized dropped out (76%). Also the highest rate of drop out was for those who have been hospitalized 1-5 times (74%) and (77%) for those with 6-10 times of hospitalizations. Thus the higher the number of admissions to psychiatric hospitals, the most likely to drop out.

3. Length of stay in hospital: The same pattern repeated itself, the figures indicate that the longer the patient stays in psychiatric hospitals the more likely for him/her to drop out. Sixty-five percent of those who remained 1-10 months and 83% of those who remained 11-96 months dropped out.

These findings point out, not as expected, that severe chronic patients are more likely to drop out as compared to the less severe chronic patients. Further confirmation was reached when the association between hospitalization and length of stay in Fountain House was tested. Forty-three percent of those who bave been hospitalized drop out right after intake, twenty-five percent within 1 - 3 months, and thirty-two percent within 4-6 months. Eighty-six percent of those who have not been hospitalized remained in the program for 4-6 months ($X^2 = 7.66788$, D. F =2, P= 0.0216).

Symptomatology - SCL-90

As mentioned previousely, the majority of the subjects did not score high on the SCL-90 scale, but when the association between all scale factors and dropout was tested, using X^2 test, it was found that paranoid ideation had a significant effect on drop out ($X^2 = 8.80302$, D.F. = 3, P = 0.03) (Appendix F). Thus congruent with the hypothesis, the higher the paranoid symptomatology, the more likely for the subjects to drop out. Other factors were not statistically significant.

Involvement with Fountain House

This factor measures the effect of the following variables on dropout from Fountain House:

1. Past membership at Fountain House (yes/no).
2. Expectation from Fountain House (vocational, residential, social, stay out of hospital).
3. Attendance at orientation program (yes/no).
4. Unit selected for patients' rehabilitation program (research/ clerical, kichen/snack bar).

Table 6.12 revealed (using the X^2 test) that the differences between the dropouts and the non-dropouts were nonsignificant. However, attendance at orientation program was statistically significant in explaining the length of stay at Fountain House ($X^2 = 7.91373$, D.F = 2, $P < 0.0191$). It was found that 69% of those who did not attend the orientation program dropped out immedialy after intake. And 25% remained in the program for 4-6 months. While 30% of those who attended the orientation dropped out

within 1-3 months, and 43% remained for 4-6 months. This could be explained by the fact that many of those who drop out right after intake do not attend the orientation program. This leads to the conclusion that the or-

Table 6.12 Involvement with Fountain House by Dropout vs. Non-Dropout

		Dropout		Non-Dropout		Total	
		N	%	N	%	N	%
Past membership at Fountain House	Yes	13	81.3	3	18.7	16	100.0
	No	29	65.9	15	34.1	44	100.0
Expectations	Vocationl	12	70.6	5	29.4	17	100.0
	Residential	4	50.0	4	50.0	8	100.0
	Social	8	66.7	4	33.3	12	100.0
	Stay out of hospital	18	81.8	4	18.2	22	100.0
Attend orientation	Yes	14	60.9	9	39.1	23	100.0
	No	12	75.0	4	25.0	16	100.0
Unit selection	Research/ Clerical	14	60.9	9	39.1	23	100.0
	Kitchen/ snack bar	9	60.0	6	40.0	15	100.0

ientation program is effective in maintaining patients for longer periods of time, but it is highly important to develop new plan for those who drop out right after intake prior to attending the orientation program.

Correlational Analysis

Correlations were obtained in order to measure the association and direction of selected continuous independent variables with length of stay at Fountain House.

The figures in table 6.13 indicate that age of first psychiatric

hospitalization is significantly associated with length of stay. This is a positive correlation which indicates that the younger the age of first psychiatric hospitalization the shorter the length of stay. Other variables in this table are not significantly associated with length of stay which further validates the previous cross tabulation analysis.

Table 6.13 Correlation Values of Selected Independent Variables with Length of Stay at Fountain House.

Variable	N	r	P
Age	58	-0.07	0.62
Income	48	0.13	0.36
Social network	60	0.18	0.17
No. times hospitalized	52	0.08	0.57
Age first hospitalized	50	0.32	0.02*
Length of stay in hospital	51	0.08	0.58
Somatization	57	-0.03	0.84
Obsessive Compulsive	55	0.03	0.81
Interpersonal Sensitivity	55	-0.01	0.93
Depression	55	-0.00	0.99
Anxiety	55	-0.02	0.91
Anger-Hostility	55	-0.04	0.77
Paranoid Ideation	55	-0.03	0.85
Psychoticism	55	-0.08	0.56

* $P < 0.05$

However, it is important to mention the negative association of the SCL - 90 factors (excluding obsessive-compulsive) with length of stay. Although the correlations are very low and statistically non signficant, they still indicate a consistant direction. That is, the more severe the symptomatology, the shorter the length of stay.

Community Adjustment

Patients who dropped out from Fountain House were not included in this analysis. Data are not available and a follow-up study is required to reach out and locate them in the community. The Categories Of Community Adjustment scale (COCA) used by Fountain House was not reliable enough to collect data on those patients. Data of this kind requires extra time and resources of Fountain House staff, and/or researcher.

Therefore, in this project, it is not feasible to analyze differences between dropouts and non-dropouts in reference to their community adjustment. The focus is on those patient who maintained themselves in Fountain House and measuring variance in unit selection, weekly rate of attendance at their unit, and level of performance. Special attention will be given to Categories Of Community Adjustment scale.

1. Unit Selection

The main units selected by patients were:

1. Research
2. Clerical
3. Kitchen
4. Snack bar

Due to sample size and dropout factor it was necessary to regroup the units into :

1. Research and Clerical
2. Kitchen and Snack bar

The distribution of patients (N = 38) among these two units was: 60% in the research/clerical units and 40% in the kitchen/ snack bar units.

Cross tabulation between choice of unit at different points in time did not show any variance, that is patients remained in their selected units (if they did not drop out) for all the six months period of follow-up.

Table 6.14 presents the variables which are significantly associated with unit selection.

Table 6.14 Values of X^2 for Variables Significantly Associated (P < 0.05) With Unit Selection

Variable	N	X^2	DF	P < 0.05
Ethnicity	37	6.27544	1	0.01
Income	29	9.15535	3	0.03
Paranoid ideation	34	8.79764	3	0.03

The figures identify that ethnicity , income level, and paranoid ideation make significant difference in unit selection. It was found that patients who chose the research/clerical unit are predominantly white, with higher income, and more paranoid as compared to those who selected the kitchen/snack bar units.

2. Weekly Rate of Attendance at Fountain House

The average days of every member's attendance at Fountain House over 6 months was calculated. (Mean = 3.6 days/week, SD ± 0.23, and median = 4.0). The weekly average attendance was classified into three groups: (1) 0 = zero days per week (2) 1 - 3 days per week

(3) 4 - 5 days per week..

Table 6.15 presents the independent variables which are significantly associated, using X^2 test, with weekly rate of attendance.

Table 6.15 Values of X^2 for Variables Significantly Associated (P< 0.05) with Average Weekly Attendance at Fountain House.

Variable	N	X^2	DF	P < 0.05
sessions with therapist	17	10.3162	4	0.04
Somatization	35	35.0034	4	0.00
Obsessive-Compulsive	33	22.9960	6	0.00
Interpersonal sensitivity	33	16.7568	6	0.01
Depression	33	15.4580	6	0.02
Anxiety	33	20.0357	6	0.00
Anger-hostility	33	33.8518	6	0.00
Paranoid Ideation	33	35.0186	6	0.00

The main findings of this table are:

1. Patients who maintain high frequency of sessions with their therapist (once a week) have higher weekly rate of attendance at the program as compared to those with low frequency of sessions.

2. Symptomatology (SCL - 90)-- it was found that the factors of somatization, interpersonal sensitivity, depression, anxiety, anger-hostility and paranoid ideation have an impact on patients' attendance at the program. That is, the more severe the symptoms the lower the rate of weekly rate of attendance. This trend is reversed for patients bothered by obsessive compulsive symptoms.

These differences, in respect to the symptomatology factors, could

be attributed to the nature of the symptom itself. That is, obsessive compulsive symptoms are motivating factors for performance, while other symptoms are motivators for social isolation and withdrawal.

These findings do not suggest that high frequency of therapy sessions eliminates symptoms. Rather it is consistant with the previous interpretation stating that severe symptomatology underlies social isolation including withdrawal from therapy session.

3. Level of Performance

Patients' level of performance is a scale composed of four degrees :

(1) very good (2) good (3) Fair (4) Poor

Patients were rated by the unit supervisors on biweekly basis for six months of the follow-up. The average level of performance was calculated. Due to the dropout factor, it was necessary to collapse the categories into two groups :

1. Good (including very good and good)
2. Poor (including fair and poor)

The frequency distribution of patients (N = 37) among these two groups was: 68% good and 32% poor.

Table 6.16 presents the variables which had significant effect on explaining the variance in level of performance. Congruent with the hypotheses, the figures in this table indicate the following:

1. Frequency of therapy sessions is significantly associated with level of performance. That is patients who had a high frequency of therapy sessions (once a week) with their therapist had a good level of performance.

Table 6.16 Values of X^2 for Variables Significantly Associated (P< 0.05) with Level of Performance

Variable	N	X^2	D.F	P < 0.05
Frequency sessions with therapist	16	8.12308	2	0.02
Weekly rate of attendance	37	16.9675	1	0.00
Dropout	37	7.27162	1	0.01
Length of stay	37	76.43348	2	0.04

2. Weekly rate of attendance at Fountain House is significantly associated with level of performance. Thus patients who had a high rate of weekly attendance had a good level of performance.

3. Length of stay at Fountain House and drop out are significantly associated with level of performance. Patients who drop out (less than six months) have poor level of peformance as compared to the non-dropout. Also, the longer patients remain in the program, the better their level of performance.

However, it is important to note that the validity of level of performance is questionable because it was rated by a staff person who may have associated good performance with attendance at the program. That is, there may have been a "halo" effect.

Correlation Analysis

Correlation analysis was applied to examine the association between all continuous independent variables and (a) Level of performance, and (b) Weekly rate of attendance. The main result is that all correlations were statistically not significant (P > 0.05), excluding that the anger-

hostility factor was found to have a negative significant correlation with weekly rate of attendance (N = 33, r = -0.39, P <= 0.03). This finding indicates that the higher the anger, the lower the weekly rate of attendance at the program. This finding could be attributed to the nature of the emotional component of anger and the associated defense mechanisms of avoidance or denial.

Categories of Community Adjustment (COCA)

Data on COCA were collected on the subjects as part of the follow-up process. Table 6.17 presents (using X^2 test) the variables that were significantly associated with COCA. As expected, the following were the main findings:

Table 6.17 Values of X^2 for Variables Significnatly Associated ($P < 0.05$) with COCA

Variable	N	X^2	D.F	$P < 0.05$
Dropout	60	15.83899	6	0.02
Length of stay	60	31.90059	12	0.00
Attend. orientation	60	16.59497	6	0.01
Rate weekly attendance	38	22.09719	8	0.01
Level of performance*	32	12.86465	6	0.05

* Significant only three months after intake

1. COCA is significantly associated with drop out from Fountain House. It was found that non-dropouts were classified in the "prevocational day program " category while the dropouts were classified in the "lost" category.

2. COCA is significanly associated with length of stay at Fountain House. It was found that patients who had shorter lengths of stay were classified in the "lost" or "in community out reach" categories, while those who had longer periods of stay were classified in the "prevocational day program".

3. COCA is significantly associated with attendance at orientation

program. Those who attended orientation were classified in the "prevocational day program" category, and those who did not attened orientation were classified as "lost".

4. COCA was also significantly associated with weekly rate of attendance at Fountain House. Those with high rate of attendance were classified in "prevocational day program" category, while those who did not attend or had low rate of attendance were classified in the "lost" or "in community out reach" categories.

5. Cross tabulation analysis between COCA at different points in time with any of the dependent variables turned out to be not significant, except with level of performance three months after intake. It was found that patients who rated good were mostly in "prevocational day program" or "transitional employment", while those who scored poor were in the "lost", "in community out reach", or "misceleneous" categories.

6. Cross tabulation analysis between COCA at different points in time (i.e. after orientation, after three months, and after six months) revealed the following:

a. COCA after orientation with COCA three months later is not statistically significant. Same result was revealed between COCA after orientation and six months later.

b. However, COCA - three months is significantly associated with COCA - six months. This indicates that changes were happening in the "prevocational day program", "lost", and "in community out reach" categories. These changes provide evidence that measurement of change on COCA "scale" is dependent on long periods of time.

7. COCA is not significantly associated with unit selection.

The clearest findings are the association between COCA and drop out, and the lack of variance among the COCA itself over time. To help understand these results, it is suggested to examine the COCA scale as a classifying instrument on a continuum of functionalism which will generate these major groups:

a. Functional group-- includes:
    1. Independent employment
    2. Transitional employment
    3. Pre-vocational Day Program
    4. School and other rehabilitation program
b. Non-Functional group-- includes:
    1. Miscellaneous
    2. Physical illness
    3. In hospital for psychiatric reasons
c. Unknown-- includes:
    1. In community out reach
    2. Lost.
d. Deceased.

The unknown group requires special clarification. It is the policy of Fountain House to reach out for patients who dropout and to classify them as "lost" only after enough effort was made to reach out and re-enter patients back to the program. However, the difference between both categories "lost" and "in community out reach" did not contribute to the

understading of those patients. Also, it was found that there was no return of patiens from the dropouts to Fountain House, which may suggest that patients were initially classified in the reach out category, and few weeks later were classified as lost.

Table 6.18 presents the frequency distribution of patients over periods of time -- after orientation, three months later, and six months later. The figures indicate that the majority of patients were classified mostly in either functional or the lost groups. It also indicates that the functional category decreases over time, while the unknown category increases.

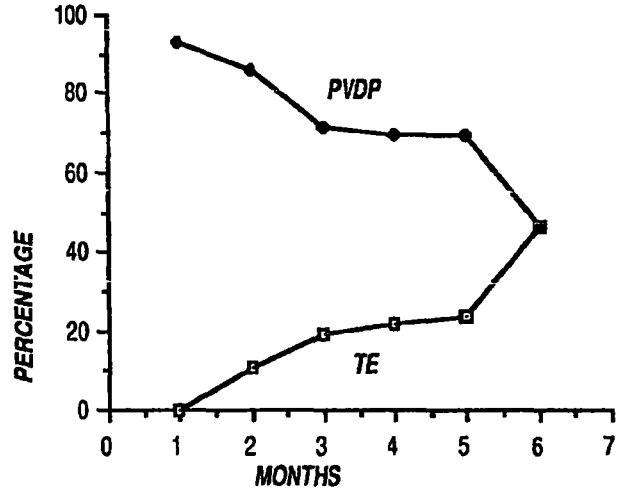
Table 6.18 Frequency Distribution of COCA over Three Periods of Time.

Category after orientation	Time 1		Time 2 3 months		Time 3 6 months	
	N	%	N	%	N	%
Functional	30	50.0	26	43.3	15	25.0
Non functional	6	10.0	1	1.7	-	-
Unknown	24	40.0	33	55.0	45	75.0
Total	60	100.0	60	100.0	60	100.0

Examining the functional group, (identical to the non-dropouts), it was found that patients moved mostly from "prevocational day program" category into "transitional employment". Out of the 30 subjects at time 1, 93% were found to be in "prevocational day program". The remaining 7% were classified in "independent employment". While at time 2, sixty-nine percent were found to be in "prevocational day program", 8% in "independent employment", and 19% in "transitional employment". At

time 3, forty-nine percent were classified in the "prevocational day program", and 47% in the "transitional employment". Figure 6.1 indicates the gradual decrease of the "prevocational day program" category and the gradual increase in the "transitional employment" category over six months of follow-up. This significant increase in the "transitional employment" category is very meaningful and indicates the effectiveness of Fountain House programs for non-dropouts.

Figure 6.1 : Comparison of "prevocational day program" with "transitional employment" over six months at Fountain House.



PVDP = Prevocational Day Program
TE = Transitional Employment

The non-functional group had only few patients (10%) at time 1

and 1.7% at time 2, and none at time 3. Two thirds (67%) of these patients were found to be either in psychiatric hospitals, or were placed in the "miscellaneous" category.

It was found that the majority (84%) of the unknown group were classified in "Lost" category at time 1, 97% at time 2, and 98% at time 3. The remaining uknown patients were placed in "in community out reach" category.

The decrease of the "in community out reach" category (16% , 3%, 2%) over three periods of time is significant, and indicates that patients were initially placed in that category and gradually moved into the "Lost" category.

This finding, in addition to the fact that within the six months of follow-up there was no re-entry of patients raises important questions regarding the effectiveness of the reach out program, and the reliability of COCA scale in characterizing the dropouts.

Whatever the case, hence COCA is a categorical scale, measurement of change is conditioned by change of category, but not by change within the same category. Since patients may remain in the same category for a long period of time, it is important to include additional measuring instruments to indicate changes within the same category.

Discriminant Analysis

Discriminant analysis is applied to test the predictive combined effect of certain independent variables on classification of patients. The dependent variable is required to be a categorical variable. The objective of using this analysis is to identify the discriminating effect of different independent variables grouped in a functional structure called domains.

The dependent variables selected for this analysis are:

1. Length of stay at Fountain House (Dropout vs. Non-Dropout).
2. Unit selection (Research/Clerical vs. Kitchen/Snack Bar)
3. Level of performance (Good vs. Poor)

The selected independent variables were grouped into four domains, as follows:

Domain #1: Sex, age, ethnicity, income

Domain #2: Psychiatric hospitalization, paranoid ideation, compliance with medication, frequency of sessions with psychiatrist, and frequency of sessions with therapist.

Domain #3: Sex, age, ethnicity, income, psychiatric hospitalization, and paranoid ideation.

Domain #4: Psychiatric hospitalization, paranoid ideation, compliance with medication, frequency of sessions with psychiatrist, and having a therapist.

Those variables were selected due to their statistical significance in the previous analysis, or their theoretical importance, and focus on the following three dimensions:

Demographic dimension:

- Ethnicity
- Sex
- Age
- Income

Psychiatric background:

- Psychiatric hospitalization
- Paranoid ideation

Treatment dimension:

- Compliance with medication
- Frequency of sessions with psychiatrist
- Frequency of sessions with therapist
- Have a therapist

The four domains were analysed seperately with each of the three dependent variables (appendices G-1, G-2, G-3). The outcome of this analysis provided information about the relative impact of each independent variable in every domain, also about the combined impact of that domain on classifying patients. As a result, the significant variables were combined to structure additional discriminant domain (Domain #5, appendices G-1, G-2). Different structures of this domain were composed to classify for length of stay and unit selection, presented as follows:

Dependent Variable	Domain #5
Length of stay	sex, income, hospitalization, compliance with medication
Unit selection	sex, income, hospitalization, compliance with medication, ethnicity, and frequency of sessions with psychiatrist

Nie, et al (1975) and Kerlinger & Pedhazur (1973) discuss the discriminant analysis model. The following is a definition of the main statistical concepts used in this analysis:

1. Standardized Canonical Discriminant Domain Coefficient: It represents the relative contribution of its associated variable to that domain. The sign of the coefficient (+ or -) merely denotes whether the variable is making a positive or negative contribution. The interpretation of these coefficients is analogous to the interpretation of beta weights in multiple regression, that is standardized regression coefficient.

The standardized values of either coefficient do not enable one to estimate Y values in the original row value units, but they are more convenient to use in a number of contexts. They enable one to simplify the linear regression equation since the constant A (the Y intercept) is always equal to zero and therfore can be omitted. In addition when there are two or more independent variables measured on different units, standardized coefficients may provide the only sensible way to compare the relative effect on the dependent variable of each independent variable. Moreover a standardized coefficient is quite readily transformed to its unstandardized counterpart if the standard deviations for the original X or Y are available.

2. Wilk's Lambda: It is an inverse measure of the discriminating

power in the original variables which has not yet been removed by the discriminant domains - the larger the Lambda is, the less information remaining.

3. Canonical Correlation Square Value (R^2_c):

The canonical correlation is a measure of association between the single discriminant function (domain) and the set of (g-1) dummy variables which define the g group memberships. It tells us how closely the function and the group variable are related, which is a measure of the function's ability to discriminate among the groups. Canonical Correlation Squared is inter- preted as the proportion of variance in the discriminant function (domain) explained by the groups.

4. Eigenvalue: Is a measure of the relative importance of the domain. The sum of the eigenvalues is a measure of the total variance existing in the discriminating variables.

5. Proportion of Correct Classification: By classification is meant the process of identifying the likely group membership of a case when the only information known is the cases values on the discriminating variables. by classifying the cases used to derive the domains in the first place and comparing predicted group membership with actual group membership, one can empirically measure the success in discrimination by observing the proportion of correct classifications.

Results of the Discriminant Analysis

The results of this analysis are reported under the headings of every

dependent variable. Appendices G-1, G-2, and G-3 provide full statistical data of this analysis. However, the following pages include the discriminating power of every domain as it relates to every dependent variable; as well as the specefic independent variables which reached the level of statistical significance ($P < 0.05$).

1. Length of Stay at Fountain House (Dropout vs. Non-Dropout)

Table 6.19 represents the classifying power of all domains applied to discriminate between dropouts vs. non-dropouts.

Table 6.19 Classifying Power of all Domains Applied to Discriminate Between Dropouts and Non-Dropouts

Domain	%Classified	R^2_c	Eigen-value	Wilk's Lambda	X^2	DF	P
1	63	0.18	0.21	0.83	7.966	4	0.09
2	89	0.74	2.73	0.27	5.919	5	0.31
3	79	0.30	0.44	0.69	13.508	6	0.04
4	76	0.30	0.44	0.69	9.004	5	0.11
5	67	0.20	0.26	0.80	10.043	4	0.04

The figures in this table indicate that domain #3 was significantly powerful in its discriminating effect on length of stay, and correctly classified 79% of the cases. Similarly, domain #5 has a significant combined effect on length of stay and correctly classified 67% of the cases.

Thus, one can conclude that combinations of demographic, psychiatric, and treatment variables (appendix G-1) have significant effect on length of stay. That is the dropouts are mostly males, with low income, who have been hospitalized for psychiatric reasons, and not compliant with medication.

2. Unit Selection (Research/Clerical vs.Kitchen/Snack Bar)

Table 6.20 represents the discriminating power of all domains applied to classify between patients who selected the research/clerical units vs. those who selected the kitchen/snack bar units. The figures in this table indicate that domain #1 had a significant effect on classifying patients by their unit selection, and correctly classified about 80% of the cases.

Table 6.20 Classifying Power of all Domains Applied to Discriminate Between Patients by their Unit Selection

Domain*	%Classified	R^2_c	Eigen value	Wilk's Lambda	X^2	DF	P
1	79	0.35	0.53	0.66	10.145	4	0.04
3	76	0.28	0.39	0.72	6.617	6	0.36
4	90	0.28	0.39	0.72	5.149	5	0.40
5	86	0.58	1.33	0.43	20.302	6	0.002

* Domain #2 has insufficient data, unable to compute.

Additionally, domain #5 had a significant effect on unit selection and correctly classified 86% of the cases. The major contribution, as measured by the standardized canonical coefficient, was attributed to ethnicity and frequency of sessions with psychiatrist. Thus concluding (appendix G-2) that unit selection is determined mostly by ethnicity, having a therapist, and frequency of sessions with psychiatrist. That is, patients who selected the research/clerical units were mostly white, had a therapist and maintained high frequency of sessions with their psychiatrist.

3. Level of Performance (Good vs. Poor)

Table 6.21 represents the discriminating power of all domains applied to classify patients according to their level of performance at their selected rehabilitation units.

Table 6.21 Classifying Power of all Domains Applied to Discriminate Between Patients According to their Level of Performance

Domain	%Classified	R^2_c	Eigen-value	Wilk's Lambda	X^2	DF	P
1	58	0.08	0.09	0.92	2.314	4	0.68
2	100	0.99	130.47	0.01	12.197	5	0.03
3	67	0.12	0.13	0.89	2.687	6	0.85
4	71	0.19	0.24	0.81	2.714	5	0.74

The figures in this table indicate that domain #2 has a significant discriminating power on patients' level of performance, and correctly classified 100% of the cases. The major contribution was significantly attributed to frequency of sessions with the psychiatrist (Appendix G-3). Hence other variables were not statistically significant, it is reasonable to conclude that the higher the frequency of sessions with the psychiatrist, the better the performance.

Summary of Discriminant Analysis

Table 6.22 presents the classification outcome of the discriminant analysis and shows the characteristics of the groups which were analysed.

Table 6.22 Classification Outcome for Length of Stay, Unit Selection, and Level of Performance

Dependent and discriminating variables		Classification groups and characteristics	
1.	Length of Stay	Dropout	Non-Dropout
	Sex	male	female
	Income	low	high
	Psychiatric hospitalization	yes	no
	Compliance with medication	no	yes
2.	Unit Selection	Research/Clerical	Kitchen/Snack Bar
	Ethnicity	white	minority
	Have a therapist	yes	no
	Frequency of sessions with psychiatist	high	low
3.	Level of Performance	Good	Poor
	Frequency of sessions with psychiatrist	high	low

Information in this table indicate that level of performance is determined mostly by treatment variables, while unit selection is determined mostly by a combined effect of demographic variable (ethnicity) and with treatment variables, and that length of stay is determined by a combined effect of demographic variables, psychiatric background, and treatment variables.

It is evident from this analysis that treatment variables made a significant effect in their power to explain the variance in patients' community adjustment and their length of stay at rehabilitation facility.

Summary of Main Findings

The following is a list of all the statistically significant findings:

A. Length of Stay at Fountain House (Dropout vs.Non- Dropout).

1. The highest percentage of dropout occurs right after intake and gradually leads to a cumulative amount of 70% over a period of six months.
2. Male patients drop out more than female patients.
3. Dropouts have relatively lower income as compared to non-dropouts.
4. Psychiatric hospitalization makes a significant effect on length of stay. It is more likely for patients who have been hospitalized to drop out, as compared to those who have not been hospitalized. In addition, the higher the number of psychiatric hospitalizations, the shorter their length of stay. And the longer their hospital stay, the more likely for them to drop out.
5. Paranoid ideations have significant effect on length of stay. The more severe the paranoid symptomatology, the more likely for patient to drop out. Other SCL - 90 factors had no significant effect on length of stay.
6. Patients are more likely to drop out if they do not attend the orientation program.
7. Compliance with medication has an effect on drop out.

It is more likely for patients to drop out if they are not compliant with their psychiatric medication.

B. Unit Selection

Unit selection was mostly associated with the following variables:

1. Ethnicity: white patients tend to select the research/ clerical units as compared to minority groups who are more likely to select the kitchen/snack bar units.
2. Income: Patients with high income tend to select the research/clerical units, while low income patients are more likely to select the kitchen/snack bar units.
3. Paranoid ideation: It is more likely for patients who were more bothered with paranoid symptoms to select the research/clerical units. While patients who were less bothered by paranoid symptoms tend to select the kitchen/snack bar units.
4. Frequency of sessions with psychiatrist: Those who had a high frequency of sessions tend to select the research/ clerical units as compared to those who maintained a low frequency of sessions and tend to select the kitchen/snack bar units.

In this regard, it is important to note that ethnicity was significantly associated with income (appendix E), it was found that income had no significant effect in the discriminant analysis. This may be explained by the

small sample size, and the weight of the standardized cononical coefficient of ethnicity (appendix G-2).

C. Weekly Rate of Attendance

Variance in patients' weekly rate of attendance at Fountain House was mostly associated with the following variables:

1. Frequency of actual visits to the therapist: The higher the frequency of therapy sessions, the higher their rate of attendance at Fountain House.
2. Symptomatology (SCL - 90) made a significant effect on attendance. In this respect, two types of symptoms were found:
    a. It is more likely for patients with symptoms that promote isolation and social withdrawal; i.e.interpersonal sensitivity, depression, anxiety, anger-hostility and paranoid ideation to have a low weekly rate of attendance at the program.
    b. It is more likely for patients with symptoms that promote perfection; i.e. obsessive-compulsive to have a higher weekly rate of attendance at the program.

D. Level of Performance

Patients' level of performance at their selected units at

Fountain House was mostly associated with the following variables:

1. Frequency of sessions with therapist: The higher the frequency of therapy sessions, the better their level of performance.
2. Frequency of sessions with the psychiatrist: The higher the frequency of sessions, the better their level of performance.
3. Length of stay at Fountain House: The longer they stay at Fountain House, the better their level of performance.

E. Categories of Community Adjustment (COCA)

1. Variance in COCA was associated with the following variables:
    a. Length of stay (dropout vs. non-dropout)
    b. Weekly rate of attendance
    c. Level of performance
    d. Unit selection
2. It was also found that "Transitional employment" category increases over time, while the "prevocational day program" category decreases.
3. Assessment of the COCA scale suggested revision, reconstruction of the scale, and the inclusion of measuring instruments for performance within the same category.

The Findings in Perspective

The findings clearly point out that severe chronic patients drop out, while the less severe non-chronic patients succeed to improve their level of performance through effective service utilization.

It is evident that chronicity is a contributing factor to dropout and to poor level of adjustment. At the same time, it is important to note that service variables, such as poor outreach program, complicated-formal intake procedures, ethnic differentiation, and non-comprehensive treatment modalities are equally significant in explaining the high dropout rate.

Questions are raised regarding the contributing factors to this outcome; the effectiveness, adequacy, and appropriateness of Fountain House modality to the treatment of chronic psychiatric patients. Thus concluding that patients' personal characteristics as well as service variables, related to Fountain House delivery system, are major predictors of dropout and community adjustment.

CHAPTER VII

DISCUSSION AND IMPLICATIONS

Dubin (1978) in his discussion of theory building makes the distinction between outcome propositions and process propositions. He argues that process propositions deal with explanation of social phenomena and the interaction between the units of the system (theory, model), while outcome propositions deal with prediction of social phenomena. In his notions of precision* and power** paradoxes (p. 23-27), he maintains that powerful explanation is not contingent on having both propositions in existence at the same time.

The lack of an adequate theory of schizophrenia and mental illness, and the lack of unified (standardized) measures and indices of community adjustment affect, directly or indirectly, the research process in these areas, and limit the researchers' ability to deal with outcome propositions. Most empirical research in this field in particular, and other social services in general, deal with process propositions.

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* **Precision paradox** = We can achieve precision in prediction without any knowledge of how the predicted outcome was produced.

** **Power paradox** = We can achieve powerful understanding of social behavior without being able to predict its character in specific situations.

This study, being not different from other research projects in social work, identified several process propositions that could be implemented in mental health field in general and psychosocial rehabilitation programs in particular. However, if this study added to the confusion of understanding community adjustment of chronic psychiatric patients, it is certainly not the intention, but it is because the subject matter and its units are complex.

The literature (Ch. IV) provided theoretical concepts which may explain patients' inability or ability to perform and also may suggest intervention strategies. They do not present powerful (in statistical sense) and measurable predictions with exact (or approximate) precision. Homans (1967) states that this is a typical characteristic of the nature of social sciences.

Social work, as one area of social sciences, is not free from this problem. However, the core focus of the social work profession to deal with general concepts of behavior and social services, presents a unique linkage of theroretical assumptions about the behavior of both elements (clients and services). The interrelationships between client variables with service variables are linked together and generate new outcomes. This study assumes that the variable "community adjustment" is a reflection of that linkage and does not stand as an abstract entity by itself. Its validity is contingent on strong powerful connections of both sets of variables. Therefore, the variable "dropout" is highlighted to indicate a weak linkage of both sets of variables.

The following discussion will address the social work concepts of

service provision, availability, access, and utilization as they relate to Fountain House's goal to provide quality of care and to promote independent living of deinstitutionalized patients.

The effort was made to follow a cohort of patients who were referred to Fountain House which is considered to be one of the leading psychosocial rehabilitation programs, and stands as a model for other programs in this and other countries (e.g., Egypt, Sweden, Pakistan). The study's main focus was on the client identified by H. Perlman as "the case of the third person..." (i.e., the dropout).

The high rate of dropout raises many legitimate questions about service effectiveness, availability, and utilization. The question of why patients do not utilize available services is an important and relevant to issues of planning and making of social policy. This study provides evidence that availability and accessibility of service are necessary and important steps in the process of service provision, but not sufficient to ensure service utilization.

The answer given very often relies on individual characteristics and patient's inability to utilize the services. However, Mills (1959) suggests that American culture has developed a peculiar tendency to adjust to symptoms of particular, troublesome conditions rather to explore the full range of conditions and their causes. Consequently, he argues, we seem more willing to pursue psychological adjustment than social or structural change. In his words, "Many great public issues as well as many private troubles are described in terms of 'the psychiatric' - often, it seems, in a pathetic attempt to avoid the large issues and problems of modern society."

(p. 12). We have failed, Mills says, to keep an eye on the economic issues and on the major institutions of our society. Therefore, the discussion here will focus on two arguements: patient's inability to utilize available services and the underlying themes and philosophy of mental health services.

The argument concerning service utilization suggests that patients may not effectively utilize available services because of their personal characteristics and idiocencracy. In this respect it is discussed from two perspectives: (a) the differences between the two groups (dropouts and non-dropouts), (b) the differences between the subgroups among the non-dropouts. The main variables found to make a significant difference in identifying the dropout group were discussed in chapter VI. However, it is important to present the profile of the dropout patient which is: male with paranoid ideations, who has been previously hospitalized, with low level of income, noncompliant with psychiatric medication, and did not attend the orientation program offered by Fountain House.

In addition, symptomatology in general found to have significant impact on service utilization if measured by weekly rate of attendance, and suggests the distinction between two types of symptoms:

a. Symptoms that promote social isolation and social withdrawal i.e., depression, anger-hostility, paranoid ideation.
b. Symptoms that promote social performance i.e., obsessive-compulsive features.

These distinctions make a major contribution to clinical and research practice in understanding the association of symptomatology with the adjustment of psychiatric patients.

These individual characteristics impose difficulties on the individual patient to effectively utilize Fountain House services and to utilize these for an extended period. The mechanism to address these issues has been constituted through individual and group psychotherapy or counseling which found to be effective. This study provides evidence in this direction, in which patients who attended therapy had better levels of performance and higher rate of attendance. However, other mechanisms are required to address the issue of effectiveness of therapy for the dropout patients.

The other perspective of service utilization relates to the significant association between ethnicity and unit selection, It may suggest that white and minority patients are different in their vocational choices; or that ethnic disintegration is an underlying social issue at Fountain House, or in other mental health services as well. In addition, other service variables such as poor outreach program, fragmented aftercare facility, and complicated intake procedures have negative effect on service utilization. These are important issues with significant implications to clinical practice and policy making, and require immediate attention, examination, and planning for proper mechanisms to alleviate their potential impact.

The second argument to be made refers to the philosophy and structure of the mental health system. Patients are discharged from psychiatric hospitals to the community with referral to Fountain House or other aftercare services. Certain patients do not maintain themselves in the program. Three possible options for this type of patient are presented: The first one is to return to a psychiatric hospital for readmission and constitute the revolving door phenomenon. The second option is to go out and

wander in the streets without goal or direction and constitutes the main element of the homeless population. The third option is to achieve a certain level of independent living and constitutes a component of the successful rehabilitated groups. It is logical to expect that the majority of patients tend to "select" one of the first two alternatives. Therefore, the most relevant question to be raised concerns the effectiveness of deinstitutionalization.

The deinstitutionalization trend is based on a belief in patients' ability and community willingness and ability to co-exist. This belief system was a major force in promoting the movement of community mental health centers, rehabilitation programs, and wide range of aftercare activities. It is obvious however, that not every referred patient will follow through with the treatment plan, thus creating a gap between deinstutionalization and community adjustment.

The deinstitutionalization process was enhanced due to underlying ideologies and belief system rather than to an empirical validation of this concept. Effectiveness was measured by the "believers" mainly, by reducing rate of admission and length of stay in state psychiatric hospitals, but not by patients' ability to function outside the hospital setting. For the deinstitutionalization to succeed it should be perceived as one component of the rehabilitation process. It is the commitment of social services, hospitals, rehabilitation centers, residential facilities, and all other aftercare components to coordinate a comprehensive program in which aftercare activities and inpatient treatment are to be considered on a continuum of treatment and complementary components rather than a categorical system. If patients "fall within the cracks" as claimed by many professionals, it is

because the system is built with cracks. Segal (1983) makes this argument very clear when he states "...a true system of community care is needed rather than one that simply emphasizes the moving of people out of institutions into the community without proper social supports. The planning of activities for discharged patients should be an essential element in the system..." (p.439).

Additional element of this argument is the philosophy behind service provision: comprehensive system vs. project system. A project philosophy could be cost-effective but not necessarily comprehensive. While comprehensive philosophy requires long term commitment of policy makers, clinicians, and researchers to be flexible enough to meet the needs of every individual client, and to motivate patients to take an active part in the process of their independence. Projects on the other hand are short term, have limited set of goals and resources, which consequently might create a diffusion of resources and clients.

Additionally, the practice of segregating treatment programs: rehabilitation programs from psychotherapy or counseling. These two professions should complement each other, but de facto they operate as separate entities. The main goal of patients' treatment is psychosocial rehabilitation , and all other activities should operate toward that direction. This study provides evidence that frequency of therapy sessions is positively associated with attendance and performance, and indicates that patients who received comprehensive treatment had a better level of adjustment.

To conclude this argument, comprehensive and massive long term

treatment is the ideal rehabilitation model for psychiatric patients. This is a system which will ensure sense of security, sense of belonging, and sense of goal and direction. A fragmented treatment system does not serve these objectives and continues to jeopordize the effectiveness of deinstitution-alization.

The independent living movement, found to be very successful in the rehabilitation of physical disabilities, was promoted to counteract the consumerism movement, and to set "independence" as a higher goal. Patients and all treatment elements share the same goal and thrive toward rehabilitation as the main mechanism to enhance self-esteem and independence.

In mental health, however, the goals are diffuse, the system is wide open, and the patients are not an active part in the decision making process. Recently self help groups have emerged, but still have no clear direction, and set their main efforts in generating acceptance and cooperation among their own members and of the system. (Mental Health Association in New Jersey, 1985).

Consumerism has a different connotation when compared with independent living. It represents marketing philosophy in which the systems' goals (services) are the patients' alternatives, thus limiting their options and promoting dependency on the system. In contrast, the independent living movement thrives for independence, in which patients are important part of the system and have an active role in making decisions about their options.

One may argue that physical disability is different from mental

illness. That is, mental illness is more likely to have a negative impact on patients' social skills and interactions; thus it is more likely for those patients to withdraw and isolate themselves.

This raises the need for psychiatric patients and the mental health system to pursue a unique and special notion of independence. It is an independence within the system, in which rehabilitation as a goal should be contingent on long term commitment of comprehensive treatment philosophy and patients' complete participation.

Social work is a profession which assumes and deals with psychosocial factors, it stresses the extent to which the clients' situation results from social and general environmental influences. These factors should be combined with individual psychological/emotional influences to achieve a correct perspective on the clients' situation. Social work is designed to help both individual and society to evolve via the social democratic system.

The apparent over-emphasis by mental health professionals, including social workers, on individual and group therapy for psychiatric patients is widespread. This results, intentionally or unintentionally, in the neglect of the other aspects, methods, and philosophies of social work.

An active and massive community organization approach is required if one is to address the issue of dropouts and community adjustment. Biklen (1983) and Kramer (1983) provide an extensive discussion, models, and practice of community organization processes. Practical models of legal advocacy, community education, self-help and patient participation, negotiations, lobbying and action research , all these

are necessary elements that could be utilized to promote patients' care, independence, and rehabilitation. They also could be utilized to pursue the help needed for communities to adjust to psychiatric patients. Coexistence of both the community and patients, in a democratic system, is dependent on process of exchange and influence between them. Community organization is there to facilitate that process.

CHAPTER VIII

STRENGTHS, LIMITATIONS, AND RECOMMENDATIONS

It is evident, as has been pointed out throughout this study, that while research in the mental health field is complicated in terms of its strengths and limitations, it frequently leads to policy recommendations. The goals of this chapter are to identify strengths and limitations of this study, and to provide policy recommendations.

Strengths and Limitations

1. Research Design

As a longitudinal follow up design, this project provided enough evidence in identifying the dropout patients and suggesting patterns of community adjustment. It also was a powerful tool in collecting enough data about their characteristics. This was a unique research design which attempted to explore patients' adjustment to Fountain House programs. The difficulties inherent in this type of design are the following:

a. High expenses in time and financial resources. Follow-up on the dropout group required extra time and finances which were unavailable.

b. Requirement for continuous cooperation of staff at the agency. The staff at Fountain House was for the most part

very cooperative, but at times it was perceived by many members as an additional load they were asked to carry beyond their regular assignments.

c. Attrition from the program constituted attrition from the research project. This affected the amount and quality of data collected in the follow-up phase, that is, on the community adjustment of dropouts.

2. Research Instrument

The intake questionnaire was intended to collect reliable information, however, the problems encountered were the following:

a. The questionnaire was lengthy with many details, and required on the average 45 to 60 minutes of patients' time.

b. Patients had the choice of responding to the questionnaire or asking for help. Most of them chose the "self rating" procedure which affected the reliability issues, especially in the area of social network and compliance with treatment.

c. Due to sample size and missing data, many items had to be regrouped into categorical variables which imposed restrictions on the statistical analysis.

3. Statistical Analysis

When applying discriminant analysis, as well as any other regression models, one should be concerned with two major issues: sample size and multicollinearity (Kerlinger & Pedhazur, 1973). In this study the

issue of small sample size limited the project's ability to provide answers to all its original questions. However, the multicollinearity issue did not present a major problem because of lack of correlations among the independent variables.

Recommendations

The limitations of the study do not eliminate its power in contributing to knowledge in social work, mental health areas, and to program policies and activities. Chapter VII provided a baseline for practical recommendations, as follows:

Policy Recommendations

Reduction of the dropout rate, improvement of community adjustment, and service utilization could be achieved by implementing the following procedures:

1. Intake procedure should involve the referring agent and if possible, family members.
2. Awareness of diagnosis and symptomatology is an important factor. Special effort is needed for paranoid patients.
3. Awareness of gender differences is also an important factor. Special attention is needed for male patients.
4. Patients are to be introduced to the different rehabilitation units at Fountain House on intake. This will allow them to select their future activities and make the proper connections with the staff and members of that unit.

5. Strengthen the outreach program to include home visits, phone calls and letters.
6. Medication and psychotherapy are to be an integral part of the rehabilitation programs at Fountain House.
7. Development of self help groups at Fountain House to connect with other self help groups in society and in the community.
8. Special attention and programs are needed to define the direction and policy goals concerning patients' unit selection. It is important for Fountain House to address the issue of ethnic integration among its various rehabilitation programs and to develop the proper mechanisms to implement that policy.

Recommendations for Future Research:

1. Evaluation research is needed to assess the effectiveness of Fountain House units of rehabilitation.
2. Follow-up research on the dropout groups from aftercare facilities is needed to identify patterns of community adjustment.
3. Assessment of dropout from other aftercare facilities is needed to identify patterns of dropout and community adjustment.
4. Revision and reconstruction of COCA scale as a continuation of the efforts to achieve standardized scale for community adjustment.

5. Evaluation of the process of unit selection by patients: ethnic disintegration and type of symptomatology are issues for future research.
6. Scales of community adjustment, performance, social network, and compliance with treatment need to be developed.
7. Further research is needed to assess the deinstitutionalization process. Decision and policy making should be based on empirical findings rather than political and value judgement.
8. Mental health system and community mental health centers are in need of continuous and follow up research to evaluate effectiveness of patients' integration in the community. At the same time, further research is needed to identify and assess community resources and willingness to reintegrate chronic psychiatric patients. Questions to be addressed include: Who is to be released back to the community? What type of community? What type of social network?
9. Psychiatric-epidemiological research is needed to assess distribution of psychiatric patients in the community, and to identify correlations of diagnosis and symptomatology with age, gender, ethnicity, and social network.
10. Efforts are to be made to develop theories on schizophrenia and mental illness. Available theories are not satisfactory

because they do not lend themselves to empirical research, and causal analysis.

Practical Recommendations for Fountain House

The following recommendations are presented to highlight the important role of Fountain House. Implementation of those suggestions may reduce the dropout rate, improve patients' level of performance, and improve Fountain House delivery system.

1. It is recommended to realize the discripancies between the agency's goals of serving chronic psychiatric patients and the reality in which non-chronic, white patients constitute the majority of those who utilize its services.
2. Hence the highest dropout rate occurs right after intake and in the first few months thereafter, it is recommended to implement revisions of the intake and orientation procedures, to reverse them, and finalize the intake requirements during and after the completion of the orientation program.
3. Fountain House is to be concerned over the ethnic discripancies among its various rehabilitation units, and to initiate an integration policy to be implemented through special group and orientation activities.
4. Fountain House is to expand its model and to further add treatment services of medication and psychotherapy to its current rehabilitation activities. Chronic patients are in need of combined comprehensive treatment model with

commitment for a long-term intervention.

5. Fountain House is to improve and upgrade its outreach program. It is recommended to develop new programs with new vision to include the family and the referring agency; and to apply various activities of contact through phone, home visits, and written correspondence.
6. Finally, it is recommended to revise the COCA scale to adequately construct reliable measures of performance.

CHAPTER IX

CONCLUDING REMARKS

In conclusion, it is important to highlight the main issues and concepts of this investigation.

The first group of concepts relate to social policy concerning deinstitutionalization, aftercare programs, and independent living. The issues were examined from the perspective of the dropouts, and the community adjustment of chronic psychiatric patients. This study concludes that the deinstitutionalization trend should be dependent on comprehensive philosophy and practice of aftercare programs. In addition, aftercare programs should pay more attention to the goals of rehabilitation and independent living, which accordingly, will enhance patients' community adjustment. The author agrees with the statement that "Freedom to be sick, helpless and isolated, is not freedom..." (Reich, 1973, p. 912).

Accordingly, one of the main recommendations is to promote the community organization process combined with comprehensive treatment models, to include: rehabilitation, psychotherapy, sociotherapy medication, and milieu therapy. Patients who received comprehensive treatment were more functional, had higher rate of attendance, and improved their level of performance.

The second issue refers to the research design and the statistical methods. The longitudinal design started at the intake stage enabled the researcher to have enough baseline data on all subjects including the

dropouts. This study provides evidence that there is a way to reach the dropouts from the mental health system, and to promote evaluation research by comparing dropouts vs. non-dropouts. This study, for the lack of resources, did not provide enough follow-up data on dropouts, but it certainly helped to identify this group and identify certain patterns of variations among chronic psychiatric patients. Additionally, the data allowed for the use of discriminant analysis as a statistical method to produce patterns of relationships between different sets of variables. The conclusion is that longitudinal and follow-up research are essential in mental health system, and that discriminant analysis is an effective procedure in social sciences research.

The last point to be made, my personal **epilogue**, is to emphasize that continuation of research and commitment for long-term, comprehensive treatment will meet the scientific and clinical challenges for dealing with those who are "difficult to reach". This study suggests that in addition to the usual concern with patients' adjustment to services there is a need to be concerned with the adjustment of services to patients.

The research experience I have gained from this study enhanced my professional skills, knowledge, and confidence as a clinician as well as a researcher. The combination of both (i.e. social research and clinical practice) should be promoted, hence it is the greatest achievement of all.

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APPENDIX A

Categories of Community Adjustment-- An Operational Definition

#	Category	Definition
1	Independent employment	Members in this category are gainfully employed, maintaining independent jobs of their own.
2	Transitional employment	Members who are going to work each day on a transitional employment placement in commerce and industry.
3	Prevocational day program	This category is for those members who are receiving prevocational training in the day program and who are not in the independent employment or transitional jobs.
4	School and other rehabilitation programs	This category is for those members who are actively involved in other rehabilitation facilities, or are participating in other kinds of training programs including academic work in educational institutions.
5	Miscellaneous	This category is utilized for member on vacation, or pregnancy leave or members engaged in home responsibilities, such as caring for a sick relative.
6	Physical illness	Members who are physically ill, either at home or in the hospital and, therefore, are not able to be actively involved in other categories of adjustment.
7	In community/Reach out	Members who have withdrawn from the program, are isolated in the community, unemployed and not involved in any known rehabilitation, education, or training programs, and not in hospital. Members are not placed in this category until they have been absent from the clubhouse for two consecutive weeks.

Appendix A (continued)

Categories of Community Adjustment-- An Operational Definition

#	Category	Definition
		The "reach out" component of this category's designation indicates that these members are considered to be in need of reach out services, such as phone calls and visits from the clubhouse.
8	In hospital for psychiatric reasons	This category is used for members who are in the hospital for psychiatric illness on a 24-hour a day basis and thus are not available for rehabilitation and/or work experiences.
9	Deceased	
10	Lost	This category applies to members for whom the clubhouse has no information.

Note: If a member holds two categories, always classify member in the lower number category, the exception being that individuals in categories 3 and 4 will always be classified in category 4.

APPENDIX B

Intake Interview-- Questionnaire

Instructions

This Questionnaire is composed of four different sections, there is no right or wrong answers. You have the choice to answer the questions by yourself or ask for help. Also you may take break for a few minutes and come back to complete it.

Your cooperation is highly appreciated. Your answers may help us to have better understanding of the members' needs at Foutain House.

Section I

1. Are you familiar with Fountain House programs?
    1. Yes
    2. No

2. Have you been a member in Fountain House in the past?
    1. Yes
    2. No - Please skip Q. # 3

3. If yes, when, for how long each time, and why did you leave?

Date of Previous Contact	Length of Stay	Reason for leaving

4. This time, who referred you to Fountain House?
    1. No one/self
    2. Psychiatrist

3. Social Worker
4. Therapist not social worker or psychiatrist
5. Family
6. Friends
7. Fountain House members
8. Patients in hospital
9. Media/TV/Newspapers
10. Other, specify _____

5. Do you plan to attend the orientation program?
    1. Yes
    2. No, why_____
    3. Undecided

6. Do you plan to attend the Day Progam?
    1. Yes
    2. No, why _____
    3. Undecided

7. In what areas do you expect Fountain House to help you? (Check all applicable)
    1. Vocational employment
    2. keep self busy
    3. Residential
    4. Make friends
    5. Stay out of hospital
    6. Other_____
    7. None
8. If you do not plan to attend the orientation and/or the day program, do you have other plans?
    1. Yes, what_____
    2. No
    3. Do not know

9. How old are you? _____

10. Sex
    1. Male
    2. Female

11. Ethnicity:
    1. white
    2. Black
    3. Hispanic
    4. Asian
    5. American Indian
    6. Other_____

12. How far did you go to school?
    1. Less than high school
    2. High school - graduate
    3. High school - non-graduate
    4. College - graduate
    5. College - non-graduate
    6. Other _____

13. What degree did you obtain?
    1. None
    2. High school diploma
    3. Vocational diploma
    4. Academic degree _____
    5. Other _____

Section 2

INSTRUCTIONS

Following are questions about your social status and social relations. There is no right or wrong answer. Some questions have more than one answer. Please choose the answers that best describe your situation.

1. Type of living arrangement
    1. Live with parents
    2. Live with spouse
    3. Live with friends (rent outside Fountain House)
    4. Fountain House resident
    5. Live by myself outside Fountain House
    6. Group home
    7. Institution (Boarding Home, Nursing Home, etc.)
    8. No place to live (live in street)
    9. Other _____

2. Are you employed at present time?
    1. Yes, what job _____
    2. No, procede to Q # 6

3. How long have you been in your present job? _____

4. How many days you are supposed to work per week?_____

5. How many days do you actually work per week? _____

6. What other jobs did you do in the past? _____
    _____
    _____

7. If unemployed, how long have you been unemployed in the present time? _____

8. Are you attending school or vocational program at the present time?
    1. Yes, ____full time student
        ____part time student
    2. No, procede to Q # 11

9. What type of school you are attending at present time?
    1. High school
    2. Vocational school
    3. College
    4. Special ed.
    5. Other _____

10. What degree/diploma you are preparing for?
    1. High School Diploma
    2. Vocational Diploma
    3. BA/BS in _____
    4. Attend school not for degree

11. What are your doing at present time, (check all applicable)
    1. Employed
    2. Student
    3. Homemaker
    4. Retired
    5. other _____

12. What are your current sources of income?
    1. Wage
    2. SSI
    3. SSDI
    4. Public assistance
    5. AFDC
    6. Family, who _____
    7. Other _____
    8. None

13. What is your past month's income? $ _____

14. How many dependents on your income (including self)? _____

15. What is your marital status?
    1. Married
    2. Divorced
    3. widow
    4. Seperated
    5. Single, never been married
    6. Other

16. Do you have children?
    1. Yes, how many? _____ Children ages ___ ___
       ___ ___
       ___ ___
    2. No, procede to Q # 19

17. How far do your nearest child(ren) live away from you?
    1. Live in same house
    2. Live in same block
    3. They live 2-5 blocks away
    4. They live 6-10 blocks away
    5. Other _____

18. How long does it take your children to ge to you?
    1. Nearest child _____ hours/minutes
    2. Far-away child _____ hours/minutes

19. Are your parent(s) still alive?
    1. Yes, who both, mother, father
    2. No, procede to Q # 22

20. How far do your parents live away from you?
    1. Live in same house.
    2. Live in same block
    3. They live 2-5 blocks away
    4. They live 6-10 blocks away
    5. Other _____

21. How long does it take your parents to get to you?
    _____ hours/minutes

22. Do you have siblings (brothers & sisters)
    1. Yes, how many _____ Ages of siblings ___ ___
       ___ ___
       ___ ___
    2. No, procede to Q # 25

23. How far do your siblings live away from you?
    1. Live in same house
    2. Live in same block
    3. They live 2-5 blocks away
    4. They live 6-10 blocks away
    5. Other _____

24. How long does it take your siblings to get to you?
    1. Nearest brothers/sisters _____ hours/minutes
    2. Far away brothers/sisters_____ hours/minutes

25. how many friends fo you have (not acquantences)? _____
26. How often do you meet or talk with your friends?
    1. Daily
    2. Twice a week
    3. Once a week
    4. Once every two weeks
    5. Other _____

27. How long does it take your friends to get to you?
    1. Near friend _____ hours/minutes
    2. Far friend _____ hours/minutes

28. How often do you talk (discussions, share mutual concerns, etc.) to your neighbors?
    1. Daily
    2. Twice a week
    3. Once a week
    4. Once every two weeks
    5. I do not talk to my neighbors
    6. Other _____

29. How far does the neighbor(s) you talk to, live away from you?
    1. Same block
    2. They live 2-5 blocks away
    3. They live 6-10 blocks away
    4. More than 10 blocks away
    5. Other _____

30. How long does it take your neighbor to get to you (the one you talk with)?

    _____ hours/minutes

31. In case you need an emergency loan of sugar or salt while having your dinner, whom would you go to: (Check all applicable)
    1. Parents
    2. Siblings
    3. Spouse
    4. In-laws
    5. Children
    6. Other relatives

    _____

    7. Friends
    8. Neighbors
    9. Fountain House
    10. Other agencies _____
    11. Co-worker or employer
    12. Other _____
    13. No one

32. In case you are away from your house and want someone to watch your house and report any emergency incidents (e.g., breaking in, fire, etc.,) to the appropriate authorities (police, fire dept.) whom would you ask? (Check all applicable)
    1. Parents
    2. Siblings
    3. Spouse
    4. In-laws
    5. Children
    6. Other relatives

    _____

    7. Friends
    8. Neighbors
    9. Fountain House
    10. Other agencies _____
    11. Co-worker or employer
    12. Other _____
    13. No one

33. In case you are sick in bed for 2 weeks and want someone to take care of your household needs (clean house, shopping, prepare meals, etc.,) whom would you ask? (Check all applicable)

1. Parents	7. Friends
2. Siblings	8. Neighbors
3. Spouse	9. Fountain House
4. In-laws	10. Other agencies _____
5. Children	11. Co-worker or employer
6. Other relatives	12. Other _____
_____	13. No one

34. In case you are sick and in the hospital, whom would you ask to visit you? (Check all applicable)

1. Parents	7. Friends
2. Siblings	8. Neighbors
3. Spouse	9. Fountain House
4. In-laws	10. Other agencies _____
5. Children	11. Co-worker or employer
6. Other relatives	12. Other _____
_____	13. No one

35. In case of an emergency situation, you need a room to stay in for a while, and do not have enough money to rent one, where would you go? (Check all applicable)

1. Parents	7. Friends
2. Siblings	8. Neighbors
3. Spouse	9. Fountain House
4. In-laws	10. Other agencies _____
5. Children	11. Co-worker or employer
6. Other relatives	12. Other _____
_____	13. No one

36. In case you are sick in the hospital for a long time, and you want someone to cash your checks, pay your bills and take care of your finances, whom would you ask? (Check all applicable)

1. Parents	7. Friends
2. Siblings	8. Neighbors
3. Spouse	9. Fountain House
4. In-laws	10. Other agencies _____
5. Children	11. Co-worker or employer
6. Other relatives	12. Other _____
_____	13. No one

37. For your favorite free time activities, where would you go? (Check all applicable)

1. Parents	7. Friends
2. Siblings	8. Neighbors
3. Spouse	9. Fountain House
4. In-laws	10. Other agencies _____
5. Children	11. Co-worker or employer
6. Other relatives	12. Other _____
_____	13. No one

38. In case you feel low and want someone to talk to and make you feel better, where would you go? (Check all applicable)

1. Parents	7. Friends
2. Siblings	8. Neighbors
3. Spouse	9. Fountain House
4. In-laws	10. Other agencies _____
5. Children	11. Co-worker or employer
6. Other relatives	12. Other _____
_____	13. No one

39. In general, rate the degree of help you think you are receiving from the following people:

	Very helpful	Helpful	Not too helpful	Not helpful at all
1. Parents	1	2	3	4
2. Siblings	1	2	3	4
3. Spouse	1	2	3	4
4. Children	1	2	3	4
5. In-laws	1	2	3	4
6. Friends	1	2	3	4
7. Neighbors	1	2	3	4
8. Fountain House	1	2	3	4
9. Co-worker or employer	1	2	3	4
10. Others _____	1	2	3	4

Other comments about your social relations?

_____

_____

_____

_____

Section 3

MEMBER'S SELF REPORT

INSTRUCTIONS

Following are questions about your hospitalization and about your relationships with your psychiatrist and your therapist. There is no right or wrong answer, some questions may have more than one answer. Please choose the answer(s) that best describes your condition.

HOSPITALIZATION(S)

1. Have you ever been hospitalized for psychiatric reasons?
    1. Yes
    2. No, procede to Q # 4

2. At what age was the first time you went to a hospital for psychiatric problems?_____

3. Since then, how many times did you go to a hospital for psychiatric reasons, and for how long did you stay each time?

Approximate date	Approx. Length of Stay (in months)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Last time _____	_____

RELATIONSHIP WITH PSYCHIATRIST

4. At present time, do you have a psychiatrist?
   1. Yes
   2. No, why _____
   for No stop here, peocede to Q # 18

5. How often are you supposed to visit your psychiatrist?_____

6. How often do you actually visit your psychiatrist?_____

7. When was your last visit to your psychiatrist office?
   1. On _____
   2. Do not remember

8. When is your next visit to your psychiatrist?
   1. On _____
   2. Do not remember
   3. I have to call and reschedule

9. What suggestions and/or advice were recommended by your psychiatrist? (check all applicable)
   1. Psychiatric medication (include renewal),what___
      _____
   2. Other medication, what _____
   3. About health issues (diet) _____
   4. About your work and rehab. _____
   5. Your personal habits (smoking, drinking, etc.) _____
      _____
   6. Your family situation _____
   7. Other _____
   8. None

10. What recommendations did you accept (check all applicable)
    1. Psychiatric medication
    2. Other medication
    3. Health issues
    4. Work and rehab.
    5. Personal habits
    6. Family issues
    7. Other _____
    8. None

11. What recommendations did you actually follow and how often?

Recommendations followed	How often
1. Psychiatric medication	_____
2. Other medication	_____
3. Health issues	_____
4. Work and rehab.	_____
5. Personal habits	_____
6. Family issues	_____
7. Other _____	_____
8. None	

12. What recommendations you are not following and why?

Recommendations not followed	Why
1. Psychiatric medication	_____
2. Other medication	_____
3. Health issues	_____
4. Work and rehab.	_____
5. Personal habits	_____
6. Family issues	_____
7. Other _____	_____
8. None	

13. How often do you take your prescribed psychiatric medication?
    1. All the time as prescribed
    2. Most the time as prescribed
    3. Half the time as prescribed
    4. On occasions as prescribed
    5. Never as prescribed

14. In general, how would you rate your relationship with your psychiatrist?
    1. Very good
    2. Good
    3. Fair
    4. Poor

15. In general, how often fo you follow your psychiatrist's recommendations?
    1. None of the time
    2. Very seldom
    3. Less than half the time
    4. Most of the time
    5. All the time

16. In general, how helpful is your psychiatrist to you?
    1. Very helpful
    2. Helpful
    3. Not too helpful
    4. Not helpful at all

17. Other comments about psychiatrist _____

_____

_____

RELATIONSHIP WITH THERAPIST

18. Do you have a therapist/counselor outside of Fountain House Staff?
    1. Yes
    2. No, why _____

    If No stop here, peocede to next section (section 4)

19. What is your therapist's profession?
    1. Social worker
    2. Psychologist
    3. Psychiatrist
    4. Counselor
    5. Other _____
    6. Do not know

20. How often are you supposed to visit your therapist?_____
21. How often do you actually visit your therapist?_____

22. When was your last visit to your therapist's office?
    1. On _____
    2. Do not remember

23. When is your next visit to your therapist's office?
    1. On _____
    2. Do not remember
    3. I have to call and reschedule

24. What suggestions/advise were recommended by your therapist? (check all applicable)
    1. Psychiatric medication (include renewal),what_____
    _____
    2. Other medication, what _____
    3. About health issues (diet) _____
    4. About your work and rehab. _____
    5. Your personal habits (smoking, drinking, etc.) _____
    _____
    6. Your family situation _____
    7. Other _____
    8. None

25. What recommendations did you accept (check all applicable)
    1. Psychiatric medication
    2. Other medication
    3. Health issues
    4. Work and rehab.
    5. Personal habits
    6. Family issues
    7. Other _____
    8. None

26. What recommendations do you actually follow and how often?

Recommendations followed	How often
1. Psychiatric medication	_____
2. Other medication	_____
3. Health issues	_____
4. Work and rehab.	_____
5. Personal habits	_____
6. Family issues	_____
7. Other _____	_____
8. None	

27. What recommendations you did not follow and why?

Recommendations not followed	Why
1. Psychiatric medication	_____
2. Other medication	_____
3. Health issues	_____
4. Work and rehab.	_____
5. Personal habits	_____
6. Family issues	_____
7. Other _____	_____

28. In general, how would you rate your relationship with your therapist?
    1. Very good
    2. Good
    3. Fair
    4. Poor

29. In general, how often do you follow your therapist's recommendations?
    1. Never
    2. Very seldom
    3. Less than half the time
    4. Most of the time
    5. All the time

30. In general, how helpful is your therapist to you?
    1. Very helpful
    2. Helpful
    3. Not too helpful
    4. Not helpful at all

31. Other comments about therapist_____

_____

_____

APPENDIX D

Follow-Up Form

This is a follow up form to be administered when ever a change is in effect, or at least once every two weeks, starting right after orientation, to be filled by the unit supervisor.

1. Member is assigned to the following unit:
   1. First floor - reception
   2. Kitchen - dining room
   3. Research
   4. Clerical
   5. Snack bar
   6. Third floor - day-treatment

2. Specify member's category and rate his/her performance when applicable.

	Categories	Rate of performance
1.	Independent employment	1. V. Good 2. Good 3. Fair 4. Poor
2.	Transitional employment	1. V. Good 2. Good 3. Fair 4. Poor
3.	Prevocational day program	1. V. Good 2. Good 3. Fair 4. Poor
4.	School & other rehab. program	1. V. Good 2. Good 3. Fair 4. Poor
5.	Miscellaneous	
6.	Physical illness	
7.	In community reach out	
8.	In hospital for psychiatric reasons	
9.	Deceased	
10.	Lost	

3. Describe the tasks that member is doing in this category:_____

4. For categories 1.2.3.4 only:

   Attendance at program:

   Expected_____ Actual_____Days/week

5. For categories 5.6.7.8 only:

   Do you (staff person) keep in touch with member?

   1. No, Why _____
   2. Yes, How and how often
      a. Visits_____
      b. Phone _____
      c. Other_____

6. For dropouts

   Why member is not attending Fountain House?_____

   _____

   Other comments: _____

   _____

APPENDIX E

Monthly Income by Ethnicity

Income	Ethnicity white	minority	total
None	2	6	8
	25.0	75.0	17.0
	6.1	42.9	
1 - 300	12	4	16
	75.0	25	34.0
	36.4	28.6	
301 - 500	13	4	17
	76.5	23.5	36.2
	39.4	28.6	
501 - 700	6	-	6
	100.0		12.8
	18.2		
Total	33	14	47
	70.2	29.8	100.0

$X^2 = 10.85835$ D.F = 3 P < 0.0125

APPENDIX F

SCL-90 by Dropout (DO) & Non-Dropout (N.DO)

	SEVERITY OF SYMPTOMS								
SYMPTOMS	Not at all		A little bit		Moderately		Quite a bit		Total
	DO	N.DO	DO	N.DO	DO	N.DO	DO	N.DO	
Somatization	2	-	31	17	5	1	1	-	57
	(3.5)	-	(54.4)	(29.8)	(8.8)	(1.8)	(1.8)	-	(100)
Obsessive-Compulsive	6	-	27	13	4	3	2	-	55
	(10.9)	-	(49.1)	(23.6)	(7.3)	(5.6)	(3.6)	-	(100)
Interpersonal-Sensitivity	5	-	25	12	7	3	2	1	55
	(9.1)	-	(45.6)	(21.8)	(12.7)	(5.6)	(3.6)	(1.8)	(100)
Depression	5	-	24	12	7	3	3	1	55
	(9.1)	-	(43.6)	(21.8)	(12.7)	(5.6)	(5.6)	(1.8)	(100)
Anxiety	5	-	27	14	4	2	3	-	55
	(9.1)	-	(49.1)	(25.6)	(7.3)	(3.6)	(5.6)	-	(100)
Anger hostility	14	4	21	10	3	2	1	-	55
	(25.6)	(7.3)	(38.2)	(18.2)	(5.6)	(3.6)	(1.8)	-	(100)
Phobic-Anxiety	10	2	23	13	6	1	-	-	55
	(18.2)	(3.6)	(41.8)	(23.6)	(10.9)	(1.8)	-	-	(100)
Pranoid-Ideation**	9	-	16	13	11	3	3	-	55
	(16.4)	-	(29.1)	(23.6)	(20.0)	(5.6)	(5.6)	-	(100)
Psychoticism	6	-	25	14	7	2	1	-	55
	(10.9)	-	(45.6)	(25.5)	(12.7)	(3.6)	(1.8)	-	(100)

* Scale is composed of five degrees, the highest one is "Extremelly". Subjects did not receive any score in this degree; thus it is not reported.

** $X^2 = 8.80303$, DF = 3, $P < 0.032$.

APPENDIX G-1

Discriminant Analysis for Length of Stay at Fountain House (Dropout vs. Non-Dropout)

Domain	Variable	Standardized CDC *	Wilk's Lambda	F	P
1	Sex **	0.64	0.90	4.76	0.03
	Age	-0.47	0.99	0.43	0.52
	Ethnicity	0.14	1.00	0.32	0.86
	Income	0.72	0.92	3.60	0.06
2	Hospitalization	1.4	0.75	2.33	0.17
	Paranoia	-0.18	0.99	0.71	0.94
	Compliance with medications	0.63	0.75	2.33	0.17
	Sessions with psychiatrist	-0.99	0.82	1.58	0.25
	Sessions with therapist	-0.14	0.99	0.93	0.77
3	Sex	0.57	0.92	3.67	0.06
	Age	-0.22	0.99	0.17	0.68
	Ethnicity	0.15	0.99	0.27	0.61
	Income **	0.70	0.89	4.73	0.03
	Hospitalization **	0.76	0.90	4.23	0.04
	Paranoia	-0.14	0.99	0.43	0.84
4	Hospitalization	0.71	0.93	1.97	0.17
	Paranoia	0.11	0.99	0.15	0.70
	Compliance with medications **	0.80	0.86	4.42	0.04
	Sessions with psychiatrist	-0.006	0.99	0.16	0.69
	Have therapist	0.65	0.95	1.33	0.26
5	Sex	0.65	0.95	2.27	0.14
	Income	0.38	0.97	1.34	0.25
	Hospitalization	0.89	0.92	3.78	0.06
	Compliance with medications	-0.44	0.99	0.41	0.53

* Standardized Canonical Discriminant Coefficient

** $P < 0.05$

APPENDIX G-2

Discriminant Analysis for Unit Selection (Research/Clerical vs. Kitchen/Snack Bar)

Domain	Variable	Standardized CDC *	Wilk's Lambda	F	P
1	Sex	0.23	0.98	0.59	0.45
	Age	0.57	0.94	1.56	0.22
	Ethnicity **	0.82	0.73	9.56	0.005
	Income	-0.24	0.94	1.43	0.24
2	Hospitalization				
	Paranoia		Insufficient data		
	Compliance with medications		to compute function		
	Sessions with psychiatrist				
	Sessions with therapist				
3	Sex	0.30	0.98	0.49	0.49
	Age	0.57	0.93	1.82	0.19
	Ethnicity **	0.56	0.83	4.86	0.04
	Income	-0.29	0.98	0.52	0.48
	Hospitalization	-0.17	0.94	1.58	0.22
	Paranoia	-0.28	0.93	1.66	0.21
4	Hospitalization	-0.37	0.98	0.13	0.74
	Paranoia	-0.60	0.78	1.72	0.24
	Compliance with medications	0.13	0.98	0.13	0.74
	Sessions with psychiatrist	1.01	0.87	0.88	0.39
	Have therapist **	0.05	0.36	10.80	0.02
5	Sex	-0.18	0.99	0.40	0.53
	Income	0.06	0.95	1.38	0.25
	Hospitalization	-0.64	0.92	2.48	0.13
	Compliance with medications	-0.41	0.93	1.90	0.18
	Ethnicity **	0.32	0.72	10.33	0.003
	Sessions with psychiatrist **	1.24	0.65	14.61	0.001

* Standardized Canonical Discriminant Coefficient

** $P < 0.05$

APPENDIX G-3

Discriminant Analysis for Level of Performance (Good vs. Poor)

Domain	Variable	Standardized CDC *	Wilk's Lambda	F	P
1	Sex	-0.52	0.98	0.58	0.45
	Age	0.45	0.97	0.85	0.37
	Ethnicity	-0.29	0.97	0.94	0.34
	Income	0.51	0.97	1.06	0.31
2	Hospitalization	-1.80	0.78	1.43	0.29
	Paranoia	9.20	0.95	0.28	0.62
	Compliance with medications	5.33	0.88	0.71	0.44
	Sessions with psychiatrist**	5.42	0.44	6.43	0.05
	Visits to therapist	6.58	0.54	4.29	0.09
3	Sex	-0.99	0.94	1.53	0.23
	Age	0.26	0.99	0.31	0.59
	Ethnicity	0.26	0.99	0.27	0.61
	Income	0.29	0.99	0.22	0.65
	Hospitalization	-0.20	0.99	0.18	0.89
	Paranoia	0.72	0.99	0.31	0.58
4	Hospitalization	0.52	0.91	1.47	0.24
	Paranoia	-0.02	0.99	0.78	0.98
	Compliance with medications	-0.57	0.91	1.54	0.23
	Sessions with psychiatrist	0.34	0.91	1.57	0.23
	Have therapist	-0.23	0.97	0.44	0.52

* Standardized Canonical Discriminant Coefficient

** $P < 0.05$