

Annotated Bibliography
Continuing Care Rotation

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aftercare

Christenfeld R, Haveliwala YA. Patients' views of placement facilities: a participant-observer study. *American Journal of Psychiatry* 1978 Mar, 135(3):329-32

Cutler DL, Tatum E. Networks and the chronic patient. In: Cutler DL, ed. *Effective aftercare for the '80's*. New Directions in Mental Health Services 1983;19:13-22

Dickey B, Gudeman JE, Hellman S, Donatelle A, Grinspoon L. A followup of deinstitutionalized chronic patients four years after discharge. *Hospital and Community Psychiatry* 1981;32:326-303

Goering P, Wasylenki D, Lancee W, Freeman SJJ. From hospital to community: six-month and two-year outcomes for 505 patients. *J Nerv Ment Disease* 1984;172(11):667-73.

[authors' abstract] the authors have completed a large descriptive study of the system of psychiatric aftercare in Metropolitan Toronto. This article describes the relevant 6-month and 2-year postdischarge outcome in each of five aftercare components for 505 subjects in a traditional system of service delivery. Provincial hospital, research institute, and general hospital subgroups are compared.

For the total group, recidivism and employment rates are similar to those found in previous studies. Symptoms and distress levels are high. Considerable numbers of subjects live in inadequate and unsatisfactory housing. Social isolation, inadequate income, and difficulties with instrumental role functioning are persistent problems with little improvement between 6 months and 2 years postdischarge. Differences among the subgroups vary according to type of outcome and, for the most part, can be explained by differences in the characteristics of the patients served by the three types of inpatient treatment settings.

These findings provide additional information about serious deficiencies in discharge planning and aftercare service delivery that is focused primarily upon the treatment of illness. the authors conclude that a more balanced system of aftercare requires a shift in resources to rehabilitation programs in the community.

Linn MW, Caffey EM, Klett CJ, Hogarty G. Hospital vs community (foster) care for psychiatric patients. *Arch Gen Psychiatry* 1977 Jan;34:78-83

[authors' abstract] The aim of this study was to determine the effectiveness of foster care preparation and placement. Five hundred seventy-two patients were randomly assigned to foster care preparation (experimentals) or continued hospitalization (controls). they were studied before assignment, at placement of experimental subjects, and four months later regarding social functioning, mood, activity, and overall adjustment. Hospitals averaged two months preparing experimental subjects, resulting in 73% placed in foster care. Little change was observed between referral and placement. However, four months after placement, experimental subjects were significantly improved over controls, particularly in social functioning and adjustment. After four months, 88% of foster care subjects were in the community. Findings suggest that attention should be given to selection criteria, that lengthy preparation may be unnecessary, and that foster care is superior to hospitalization for patients who cannot return to their own homes.

Stein LI, Test MA. Use of special living arrangements: a model for decision-making. *Hosp Community Psychiatry* 1977;28:608-10

community psychiatry

Caton CLM. The new chronic patient and the system of community care. *Hospital and Community Psychiatry* 1981;32:475-8

Chacko RC, ed. The chronic mental patient in a community context. American Psychiatric Press, Washington DC 1985

Group for the Advancement of Psychiatry. The chronic mental patient in the community, New York: GAP, 1978

Gudeman JE, Dickey B, Rood L, Hellman S, Grinspoon L. Alternative to the back ward: the quarterway house. *Hospital and Community Psychiatry* 1981;32:330-4

Hewitt S, Ryan P. Alternatives to living in psychiatric hospitals - a pilot study. *British Journal of Medicine* 1975 14:65-70

(From Borus & Hatow, 1978): "A ... study ... of ninety patients in London, seventy-seven percent of whom were schizophrenic, examined the theory that the rehabilitation process begun in the hospital can be completed in a prescribed period of time in a halfway house and that there can be a continual flow of patients from hospital to halfway house and then out into the community. They found that not only was there a small number of severely disturbed patients who had lengthy stays in halfway houses but there was also a much larger number of relatively well-functioning schizophrenic patients who stayed for long periods in halfway houses. These people were often working, taking their medications, and having few major symptoms. The authors reported that the relatively well-functioning group found the halfway house a social environment that helped maintain them at their current plateau of recovery. The living facility staff provided many things that families would normally provide; for example, the staff would make sure that medications were given, they would wake patients up in the morning to make sure they got to work, and they would be interested in the patients and what they were doing. There were also economic incentives to staying in a halfway house. Given the small amount of money these people earned, the only alternative living situation was in an isolated room. Hewitt and Ryan conclude that halfway houses should be considered part of the long-term treatment of schizophrenia in the community rather than as only transitional facilities, and that their long-term use does not signify failed rehabilitation because they provide a social environment that helps maintain a high level of functioning."

Hollingshead AB, Redlich FC. Social class and mental illness: a community study. Wiley Publications, New York 1983

Lamb HR. The new asylums in the community. *Archives of General Psychiatry* 1979 Feb;36:129-34

Lamb HR. Maximizing the potential of board and care homes. In: Budson R, ed. *New directions in mental health services: issues in community residential care* 1981 Sep;11: San Francisco; Jossey-Bass

[****H. Olders' comments] A sensitive article which describes the very real value that foster homes have for chronic mental patients, In the author's words, "The persons in this environment have come to what one might call 'adaptation by decompression'. They have found a place of asylum from life's pressures but at the same time a place where there is support, structure, and some treatment, especially in the form of psychotropic medications."

Not all is roses, however. There are problems, especially for those patients who are aware of the emptiness of their lives. The author argues that adequate funding and monitoring are essential to have high-quality providers and facilities.

Linn MW, Caffey EM, Klett CJ, Hogarty G. Hospital vs community (foster) care for psychiatric patients. *Archives of General Psychiatry* 1977 Jan, 34:78-83

Segal SP, Aviram U. The mentally ill in community-based sheltered care. New York: Wiley, 1981

Test MA, Stein LI. Practical guidelines for the community treatment of markedly impaired patients. *Community Mental Health Journal* 1976;12:72-82

White HS. Managing the difficult patient in the community residence. In: Budson R, ed. *New Directions for mental health services: issues in community residential care* 1981 Sep;11. San Francisco; Jossey-Bass

[H. Olders' comments] A practical guide to dealing with problem patients in residential treatment programs. The author identifies seven different types of difficult patients: assaultive, paranoid, medication-refusing, entitled, medically ill, over- or under-involved with family, suicidal, and the community provocateur. Unfortunately, the methods the author describes are frequently based on the fact that in these types of settings, the patient who will not respond to limit-setting can be asked to leave the residence. We often don't have this flexibility.

deinstitutionalization

Bachrach LL, ed. *Deinstitutionalization*. San Francisco: Jossey-Bass, 1983

Bachrach LL. Asylum and chronically ill psychiatric patients. *American Journal of Psychiatry* 1984 Aug;141(8):975-8

[author's abstract] The decision to change the primary locus of care for chronically ill psychiatric patients from the state mental hospital to the community has often set off a chain reaction of consequences. Notably, reducing the role of institutions has frequently resulted in destroying needed sanctuary for some patients. The author discusses the

relationship between deinstitutionalization and the function of asylum and examines the relevance of three planning principles - functional equivalence, cultural relevance, and potential trade-offs, - to the need of chronically ill psychiatric patients for asylum.

Bassuk EL, Gerson S. Deinstitutionalization and mental health services. *Scientific American* 1978 Feb;238(2):46-53

Borus JF. Deinstitutionalization of the chronically mentally ill. *New England Journal of Medicine* 1981;305:339-42

Braun P, Kochansky G, Shapiro B et al. Overview: deinstitutionalization of psychiatric patients - a critical review of outcome in American studies. *Am J Psychiatry* 1981;138:736-49

Goldman HH, Adams NH, Taube CA. Deinstitutionalization: the data demythologized. *Hospital and Community Psychiatry* 1983;34:129-34

Gralnick A. Build a better state hospital: deinstitutionalization has failed. *Hospital and Community Psychiatry* 1985 Jul;36(7):738-41

[author's abstract] The author cites increasing numbers of chronic, homeless, and neglected mentally ill people as evidence of the failure of deinstitutionalization and community care to live up to their promise to reduce chronicity, the need for long-term hospitalization, and even mental illness itself. He believes the state hospital system, despite having been maligned and nearly destroyed, has great therapeutic potential. It could provide extended care to acutely ill patients before they become chronically ill; restore the ability to pinpoint responsibility for patient care, which has been lost under community care; and provide a stimulating academic environment conducive to research into treatment of the mentally ill.

Jones K. Scull's dilemma. *British Journal of Psychiatry* 1982;141:221-6

Scull, a sociologist, has studied mental health services (or, as sociologists put it, the social control of madness). He has written two books: "decarceration", about the inadequacies of community care in Britain and the U.S., and "Museums of Madness", about the evils of institutional care in British asylums in the 19th century. The dilemma is: if it is wrong to get patients out of the mental hospital, and wrong to keep them in, what are we to do with them?

The author, while deploring the excessive rhetoric of Scull, argues that what he has to say is worthwhile. Unfortunately, there are no easy solutions, but one often overlooked aspect of deinstitutionalization is that there is now no longer anything uniform to serve as a standard, against which performance can be measured.

Lamb HR. What did we really expect from deinstitutionalization. *Hospital and Community Psychiatry* 1981;32:105-9

Mercier C, Harnois GP. L'hôpital psychiatrique: d'hier à demain. *Revue canadienne de psychiatrie* 1986 Feb;31:35-43

[authors' abstract] Une enquête réalisée dans un hôpital psychiatrique de la région montréalaise révèle que, malgré la

désinstitutionnalisation, le séjour à long terme représente toujours une modalité importante d'utilisation des lits. Pour une partie des bénéficiaires, l'hôpital demeure un lieu de séjour permanent, soit dès après la première admission, soit qu'ils s'y sédentarisent après une carrière d'admissions multiples. Pour les patients inscrits en externe, le retour à l'hôpital est quasiment inévitable et pour des séjours prolongés.

Les services de l'hôpital sont ainsi en grande partie mobilisés par les mêmes patients usagers à long-terme. Si bien qu'il ne peut offrir de services aux autres établissements et jouer son rôle de deuxième ligne. Situation frustrante pour les partenaires du réseau, en même temps que jugée sans issue, vu l'absence de ressources adéquates pour cette clientèle dans la communauté. L'une des fonctions premières de l'hôpital psychiatrique apparaît ainsi de combler les lacunes du réseau des services. A ce titre, son expertise dans le domaine de l'intervention auprès des patients psychiatriques chroniques ne doit pas être négligée. Vu la situation actuelle, on doit aussi considérer que la mission des services de deuxième ligne ne peut être précisée qu'une fois évalué ce que la communauté elle-même peut assumer en termes de prise en charge des patients psychiatriques chroniques.

homelessness

Bassuk EL. The Homelessness problem. *Scientific American* 1984 Jul;251(1):40-5

Bassuk EL, Rubin L, Lauriat A. Is homelessness a mental health problem? *American Journal of Psychiatry* 1984 Dec;141(12):1546-50

[authors' abstract] Seventy-eight homeless men, women and children staying at an emergency shelter were interviewed. The vast majority were found to have severe psychological illnesses that largely remained untreated. Approximately 91% were given primary psychiatric diagnoses: about 40% had psychoses, 29% were chronic alcoholics, and 21% had personality disorders. Approximately one-third had been hospitalized for psychiatric care. The authors discuss the relationship of mental health policy to the homeless and suggest that shelters have become alternative institutions to meet the needs of mentally ill people who are no longer cared for by departments of mental health.

Morganthau T, et al. Abandoned: well-meant reforms have shattered our system for treating the chronic mentally ill - and left thousands of them to scrape by in the streets. *Newsweek* 1986 Jan 6:14-9

[H. Olders' comments] A scathing attack on the process of deinstitutionalization combined with the abolition of long-term involuntary commitment in producing a large number of homeless mentally ill.

epidemiology

Bland RC. Long term mental illness in Canada: an epidemiological perspective on schizophrenia and affective disorders. *Canadian Journal of Psychiatry* 1984 Apr;29:242-6

[author's abstract] Canadian national data on psychiatric illness are combined with results from outcome studies to derive figures for the incidence, expectancy, prevalence, prevalence of marked disability, use of institutions and loss of the work force as a result of schizophrenia and affective psychoses. It is hoped that this can be of assistance in planning services and that it will stimulate more direct research into the nature and the scope of the social, psychiatric and economic impact of these illnesses.

[H. Olders' comments] The author provides useful definitions of incidence, expectancy (or morbid risk), prevalence, and life prevalence. A surprise was the high expectancy for schizophrenia in Canada: 2.1% for males, and 1.7% for females. Regarding outcome, about 30% of schizophrenics have an 'unfavourable' or 'very unfavourable' outcome, while only 15% of manic-depressive or recurrent depressive patients had such outcomes. For each schizophrenic in an institution, there are four others who are disabled and require support in the community.

Elpers JR, Crowell M. How many beds? an overview of resource planning. *Hospital and Community Psychiatry* 1982;33:755-61

Hirsch SR. Psychosocial factors in the cause and prevention of relapse in schizophrenia. *British Medical Journal* 1983 May 21;286:1600-1

families

Anderson CM. The psychoeducational family treatment of schizophrenia. *New Directions in Mental Health Services* 1981;12:79-94

Anderson CM, Hogarty GE, Reiss DJ. Family treatment of adult schizophrenic patients: a psychoeducational approach. *Schizophrenia Bulletin* 1980;6:490-505

Barrowclough C, Tarrier N. 'Psychosocial' interventions with families and their effects on the course of schizophrenia: a review. *Psychological Medicine* 1984;14:629-42

[****H. Olders' comments] A worthwhile review of what has been tried.

[authors' synopsis] Recent interest in the way social factors influence the course of schizophrenia has led to attempts to monitor and manipulate these factors. A number of studies have now been conducted in which a psychosocial intervention has been employed in an attempt to prevent relapse after discharge from hospital. These studies are reviewed with an emphasis on their methodological adequacy and on the nature

of the intervention used. Recent studies have demonstrated a positive result for psychosocial interventions used in combination with neuroleptic medication. However, analysis of these studies does not allow us to conclude that we can identify the 'active ingredients' in these psychosocial treatment regimes. Although there is cause for optimism, further investigation is required.

Bernheim KF;Lehman AF. Working with families of the mentally ill. W.W. Norton, New York 1985.

[***** H. Olders] [jacket notes] This book is a practical guide to integrating educational, behavioral and supportive techniques to assist families in helping their chronically ill relatives as well as themselves. These families must cope with a variety of problems, such as the heavy and often unpredictable demands of their ill member, the pain of lost dreams and expectations, and the bureaucratic complexity of the mental health system. However, with proper guidance and counseling, they can become the professional's most valued allies in treatment of patients with schizophrenia and major affective disorders.

This is a practical, psychoeducational approach, with special emphasis on the "nuts and bolts" of counseling families. The authors show how the family clinician can develop a cooperative, respectful relationship with family members, educating them about the symptoms, causes, and treatments of such illnesses as schizophrenia, helping them develop strategies to deal with both day-to-day problems and the long-term implications of the disease, and offering emotional support as needed. This book will be invaluable to all mental health professionals working with the chronically mentally ill and their families in hospitals, clinics and outpatient settings. Both professionals and trainees will find here a new model of compassionate care, essential as families are enlisted as allies in the treatment of chronic mental illness.

Boyd JL, McGill CW, Falloon IRH. Family participation in the community rehabilitation of schizophrenics. *Hospital and Community Psychiatry* 1980;32:629-32

Brown GW, Birley JC, Wing JK. Influence of family life on the course of schizophrenic disorders: a replication. *British Journal of Psychiatry* 1972 121:241-58

(From Borus & Hatow, 1978): "About schizophrenics who leave the hospital and come home to environments where the relatives are very emotionally expressive and demanding. These patients have a higher rate of relapse than patients that come home to cooler, slightly more distant families."

Creer C, Wing JK. Living with a schizophrenia patient. *British Journal of Hospital Medicine* 1975 Jul;P 73-82

(From Borus & Hatow, 1978): "A ... fascinating article ... describes what it is like to live with a schizophrenic relative. They interviewed eighty families in Great Britain who had schizophrenic family members living in their homes, to try to understand both the patients' behaviors and the relatives' coping skills. Two primary types of patient behaviors disturbed the families. First were social withdrawal behaviors, including diminished interpersonal interaction, slowness at tasks, lack of conversation, few interests, and self-neglect. A much lesser amount of obvious disturbed or socially embarrassing behavior was also reported, such as restlessness, pacing, delusions, patients talking to themselves, and odd posturing. ... The relatives' reactions included ... anxiety ... depression and guilt ... frequent anger, and a lot of frustration. Creer and Wing felt

that these were very appropriate responses to the behaviors of these patients. ... The authors found that relatives remembered and valued professionals who had given them information and who had been interested in their plight. ... The authors conclude that by providing what we already do know - explaining medications, discussing how to provide the proper stimulation to prevent either withdrawal or relapse - and by being more available to relatives, we can be very helpful to them directly and help them be helpful to their patient relatives."

Doane JA, Falloon IRH, Goldstein MJ, Mintz J.
Parental affective style and the treatment of schizophrenia. *Arch Gen Psychiatry* 1985 Jan;42:34-42

[authors' abstract] In a randomized controlled study, the affective style (AS) of parents of schizophrenics in clinic-based individual treatment groups and home-based family treatment groups was compared prior to treatment and again three months after treatment had begun. Affective style is an index reflecting the quality of the family emotional climate, measured from face-to-face discussion. Pretherapy and posttherapy measures of negative AS were significantly predictive of relapse within the nine-month treatment period for patients in individual treatment. In addition, for both treatment groups, a negative AS pattern at posttherapy reassessment was significantly associated with decreased patient social functioning, reduced ability of the family to absorb the family intervention, and lowered capacity of the family to cope with everyday family stresses. The results suggest that AS is an important intrafamilial attribute, with implications for treatment strategy and planning.

[H. Olders' comment] Note that Affective Style (AS) differs from EE in that EE is based on attitudes expressed to an interviewer in the patient's absence, while AS is coded from remarks made to the patient by the parent during actual face-to-face discussions.

Falloon RH, Boyd JL, McGill CW et al. Family management training in the community care of schizophrenia. *New Directions in Mental Health Services* 1981;12:61-77

Spiegel D, Wissler T. Family environment as a predictor of psychiatric hospitalization. *American Journal of Psychiatry* 1986 Jan;143(1):56-60

[authors' abstract] The Family Environment Scale scores and demographic characteristics of 108 discharged psychiatric patients were used to predict outcome at 3 months and 1 year. Higher ratings of family expressiveness predicted fewer days of rehospitalization, especially among schizophrenic patients. Higher family cohesion scores predicted better family-rated patient adjustment. The patients were more likely to rate themselves as better adjusted if they had higher incomes, lived with parents rather than a spouse, and came from families with less emphasis on independence. Family environment was a better predictor of rehospitalization than baseline rating of clinical status, indicating the importance of family support in the community adjustment of chronic patients.

[H. Olders' comments] This article is easy to criticize as a presentation of what may be a good piece of research. For example, the authors do not include data for actual outcomes, eg how many were rehospitalized, or for how long. This would have provided a better picture of patient chronicity and would allow us to assess the clinical, as opposed to the statistical, significance. The authors also fail to tell us whether or not the non-rehospitalized patients were included in the statistical analysis. This could make a big difference in the statistical significance of the reported findings.

Vaughn CE, Leff JP. The influence of family and social factors on the course of psychiatric illness. *British Journal of Psychiatry* 1976 129:125-37

(From Borus & Hatow, 1978): The authors "found that a combination of maintenance medication therapy and a reduction of face-to-face contact with highly emotional or critical relatives could prevent relapse in nearly every case."

miscellaneous

Amdur MA. Death in aftercare. *Comprehensive Psychiatry* 1981;22:619-26

Bassuk EL, Gerson S. Chronic crisis patients: a discrete clinical group. *American Journal of Psychiatry* 1980;137:1513

[from Bell,] This study of psychiatric patients who made repeated visits to an emergency room in a general hospital focuses on their nonproductive interaction with the caregivers from whom they seek help. The authors suggest interventions based on an understanding of their help-seeking-help-rejecting behavior.

Cutler DL. Clinical care update: the chronically mentally ill. *Community Mental Health Journal* 1985 Spring;21(1):3-13

Lamb HR. Roots of neglect of the long-term mentally ill. *Psychiatry* 1979 Aug;42:201-7

Lehman AF, Ward NC, Linn LS. Chronic mental patients: the quality of life issue. *American Journal of Psychiatry* 1982 Oct;139(10):1271-5

McGlashan TH. Predictors of shorter-, medium-, and longer-term outcome in schizophrenia. *American Journal of Psychiatry* 1986 Jan;143(1):50-5

Mosher LR. Italy's revolutionary mental health law: an assessment. *American Journal of Psychiatry* 1982 Feb;139(2):199-203

[author's abstract] The Italian Parliament passed a comprehensive, community-oriented mental health law in May 1978 that called for dramatic changes. The author details these changes, which include the requirements that no new patients be admitted to large state-run hospitals, that these hospitals be gradually phased out, that patients not be involuntarily hospitalized in these facilities, and that community-based facilities for prescribed geographical areas be established. He also describes the historical context for the law's passage and its effects on Italy's mental health system so far. On the basis of 7 months' observation, he feels that the law is being successfully implemented.

Rosenhan DL. On being sane in insane places. *Science* 1973 Jan 19;179:250-8

Sheehan S. *Is there no place on earth for me?*
Houghton Mifflin, Boston 1982

This journalistic account of the life history of a chronically schizophrenic woman reveals the nature of the mental health care system in the U.S., including changes initiated by the community mental health movement. The frustration of the patient and her family as they try to find help is clearly communicated to the reader.

Stein LI, Test MA. Alternatives to mental hospital treatment. New York: Plenum Press 1975

Talbott JA, ed. The chronic mental patient: problems, solutions, and recommendations for a public policy. American Psychiatric Association, Washington DC 1978

Talbott JA. The chronically mentally ill: a look at the past five years with an eye to the future. *Psychosocial Rehabilitation Journal* 1983;VI(3):13-21

Talbott JA. The chronic mental patient: five years later. Grune & Stratton, Orlando, Florida 1984.

Watt DC. Mental hospitals and community care: a discussion paper. *Journal of the Royal Society of Medicine* 1986 Sep;79:538-40

[H. Olders' comments] This brief paper looks at the history of deinstitutionalization in the U.K. It reports on an inpatient rehabilitation program at St. John's Hospital in Aylesbury, where 44 patients were placed into a free-standing, self-contained unit for a two-year training programme based on behavioural, social-learning principles which incorporated cooking, budgeting, and a period of independent living in a flat attached to the unit prior to discharge. The types of patients considered unsuitable for such a program included elderly, infirm, or disabled patients; those suffering from presenile dementia (including brain damage) and the majority of the new long-stay patients who were too behaviourally disruptive to be included.

Watt JA, El-Guebaly N. The chronic mental patient: the position of the Canadian Psychiatric Association. *Canadian Journal of Psychiatry* 1981 Nov;26:494-301

model programs

Bachrach LL. Overview: model programs for chronic mental patients. *Am J Psychiatry* 1980 Sep;137(9):1023-31.

[author's abstract] Model programs for chronic mental patients may be viewed from four perspectives: evaluation of individual programs, commonalities in successful programs, generalizability and reproducibility of specific programs, and relevance of model programs to problems of service delivery in mental health systems. Although successful model programs share certain common structural elements, such programs cannot be readily reproduced or generalized. Having limited value for the problems of service delivery in mental health systems, model programs are best seen as experimental efforts,

not as solutions. Strategies for translating model-derived knowledge into systems-related action are needed.

psychopharmacology

psychosocial treatments

Brady JP. Social skills training for psychiatric patients, I: concepts, methods, and clinical results. *Am J Psychiatry* 1984 Mar;141(3):333-40

Brady JP. Social skills training for psychiatric patients, II: clinical outcome studies. *Am J Psychiatry* 1984 Apr;141(4):491-7

Greenberg DJ, Scott SB, Pisa A, Friesen DD. Beyond the token economy: a comparison of two contingency programs. *J Consulting & Clinical Psychology* 1975;43(4):498-503

[authors' abstract] To determine whether the addition of milieu principles to a contingency program increases its effectiveness, the investigators compared two treatment programs in a mental hospital: (a) a social learning or token economy approach and (b) a combined social learning and milieu approach in which patients were given increased decision-making responsibilities, group pressures were used, and both were integrated with response-contingent management. Because the patients in the combined social-learning/milieu program spent significantly more days out of the hospital during the 1-year experimental period, the authors concluded that that program was more effective than the token economy in promoting the generalization of adaptive in-hospital behavior to community settings.

Gudeman JE, Shore MF. Beyond deinstitutionalization: a new class of facilities for the mentally ill. *New England Journal of Medicine* 1984 Sep 27;311(13):832-6

The authors discuss the deinstitutionalization program in Massachusetts, with particular reference to the experience of the Massachusetts Mental Health Centre, which is responsible for an urban catchment area of 200,000 population, and has had no state hospital backup since 1971. It looks after almost all the former state hospital back ward patients who formerly resided in the center's catchment area. Since 1981, the center has had 2 day hospitals, each treating 40 to 50 patients (avg stay 28 days); a 30-bed intensive care unit (10 days average length of stay), and a 35-bed "inn" to temporarily house day-hospital patients (avg stay 21 days). There are 200 nursing-home places, and 20 special psychiatric-geriatric nursing-home places. The total hospital-residential care serves about 500 patients daily.

The above length of stay figures do not include 30 patients (ie 6%) who stay in the facility continuously, despite an average of 5 years' exposure to a full range of treatments. The authors believe that these patients would be better served in

specialized-care facilities, because of unremitting symptoms and flagrant behavioral disabilities. The patients fall into 5 groups:

I. Elderly, demented, and behaviorally disturbed. These would require containment and supportive care (3/100,000 population).

II. Mentally retarded and psychotic. These require re-education and behavioral modification in a low-stimulus environment (3/100,000).

III. Brain-damaged, assaultive pts. These need containment and supportive (including medical) care (1.5/100,000).

IV. Psychotic and assaultive, suicidal, or obstreperous. Need secure, long-term setting (2.5/100,000).

V. Chronically schizophrenic, disruptive, and endangered, with behavior unacceptable in most settings. Need a structured milieu (5/100,000).

Such specialized treatment settings could consist of 25 to 30 bed units, grouped on one or more campuses, to serve regional or state needs, with a total facility size not exceeding 150-200 pts. There should be stringent preadmission screening; specialized treatment programs for each type of patient (see article for details); multidisciplinary staffing; units could be on grounds of state hospitals, etc.; should be affiliated with an acute-care psychiatric unit for emergency backup; careful attention to political matters because of anxiety about re-institutionalization; pilot programs should be tried.

Gunderson JG. Defining the therapeutic processes in psychiatric milieus. *Psychiatry* 1978 Nov;41:327-35

This paper looks at psychiatric inpatient milieus using five functional variables: containment, support, structure, involvement, and validation. Using such functional variables is superior to using descriptive variables in articulating discrete therapeutic intentions and activities, and thus can help conceptualize and clarify milieu programs for patients. Each variable has its advantages and disadvantages for different patients and staff, as well as for different institutional needs. The article is useful in providing a brief but logical and well-structured introduction to the concepts behind "milieu therapy", for readers with an understanding of patient types and psychodynamics.

Klein DF. Psychosocial treatment of schizophrenia, or psychosocial help for people with schizophrenia? *Schizophrenia Bulletin* 1980;6(1):122-30

[author's abstract] Mosher & Keith (1980) ... conclude that we know more about the effectiveness of psychosocial treatment than is generally acknowledged and that there is consistent evidence of its effectiveness.

This comment takes issue with these conclusions. The methodological and substantive limitations of the various studies are discussed. Our conclusion is that researchers studying the efficacy of psychosocial treatment have contributed little in the way of demonstrated facts and even less in affirming the value of psychosocial treatment for schizophrenia. Far more good research is needed. We should recognize that current policy decisions rest on personal opinion rather than on demonstrated fact.

Lamb HR. Treating the long-term mentally ill. Jossey-Bass Publishers, San Francisco 1982 (Call No. WM 30.6 L218t 1982)

Mosher LR, Gunderson JG. Group, family, milieu, and community support systems treatment for schizophrenia. In: Bellak L, ed. Disorders of the schizophrenic syndrome. New York: Basic Books 1979;:399-452

Mosher LR, Keith SJ. Research on the psychosocial treatment of schizophrenia: a summary report. *American Journal of Psychiatry* 1979 May;136(5):623-31

[authors' abstract] The authors present an overview of research on psychosocial treatments for schizophrenia. Findings from studies of five therapeutic approaches - individual psychotherapy, group psychotherapy, family therapy, milieu therapy, and community support systems - are discussed in detail. The usefulness of each type of therapy is critically assessed on the basis of available data from controlled outcome studies. The authors make recommendations regarding high-priority areas to be addressed in future studies of psychosocial treatment.

Mosher LR, Keith SJ. Psychosocial treatment: individual, group, family, and community support approaches. *Schizophrenia Bulletin* 1980;6(1):10-41

Murphy HBM, Engelsmann F, Tchong-Laroche F. The influence of foster-home care on psychiatric patients. *Archives of General Psychiatry* 1976;33:179-83

Paul GL, Lentz RJ. Psychosocial treatment of chronic mental patients: milieu versus social-learning programs. Harvard University Press, Cambridge, Massachusetts 1977 (Call No. WM 428 P324)

Rotgers F. Relapse prevention: strategies for maintaining behavior change. *Carrier Foundation Letter* 1985 Jun, #108, The Carrier Foundation, Belle Mead, NJ 08502

[H. Olders' comments] This article reviews the relapse process as applied to alcohol and drug abuse, and details a model presented by Marlatt in 1980. The five stages of the relapse process and the corresponding points of intervention can be thought of as applying also to relapse in chronic mental illness: for example, the fifth stage, the meaning of a single relapse for the patient (does a single slip indicate lack of willpower, an incurable disease, or that relapses are inevitable?), the same mental process may be used by the patient who needs to visit the emergency room after discharge. Return to a high-EE family could also be viewed as relapse, for a patient who has gone through a trying process of separation-individuation. The first stage, exposure to a "high risk" situation, is paralleled for the young chronic patient who is subject to peer pressure to discontinue medications, or to use street drugs to self-medicate. Other relapse-type situations could include losing a job, failing or dropping out of school, or being kicked out of a foster home or apartment. The types of behavioral interventions suggested by the author could be useful as part of supportive therapy (whether group or individual) with chronic mental patients.

Weisbrod BA, Test MA, Stein L. An alternative to mental hospital treatment: III. Economic cost-benefit analysis. *Arch Gen Psychiatry* 1980;37:400-5

Zanditon M, Hellman S. The complicated business of setting up residential alternatives. *Hospital and Community Psychiatry* 1981;32:335-9

day hospitals

Gudeman JE, Shore MF, Dickey B. Day hospitalization and an inn instead of inpatient care for psychiatric patients. *New England Journal of Medicine* 1983;308:749-53

Gudeman JE, Dickey B, Evans A, Shore MF. Four-year assessment of a day hospital-inn program as an alternative to inpatient hospitalization. *Am J Psychiatry* 1985 Nov;142(11):1330-3

[authors' abstract] The authors report on a new system of care in which all patients who require psychiatric hospitalization are admitted to a day hospital with an inn and an intensive care unit. Data on use of services, length of stay, recidivism, security, medical emergencies, staff accidents, and seclusion and restraint over a 4-year period suggest that the new delivery system provides care which is at least as effective as the previous system of care. Evidence is presented that the new system offers certain advantages, including less seclusion and restraint, fewer episodes of escape, and substantial cost savings.

inpatient treatment

Almond R. Issues in milieu treatment. *Schizophrenia Bulletin* 1975 Summer, 13:12-26

Caton CLM. Effect of length of inpatient treatment for chronic schizophrenics. *American Journal of Psychiatry* 1982;139:856-61

Davis C, Glick ID, Rosow I. The architectural design of a psychotherapeutic milieu. *Hospital and Community Psychiatry* 1979 Jul;30(7):453-60

The authors describe the design principles and philosophies they followed in the remodeling of an inpatient unit in a university psychiatric hospital (Langley Porter in San Francisco). The involvement of all levels of staff in planning is recommended. The article includes a good bibliography for architectural design of psychiatric units.

Diamond RJ. The role of the hospital in treating the chronically disabled. *New Directions for Mental Health Services* 1979;2:45-56

[author's conclusion] The problem of when to hospitalize a psychiatric patient is clearly influenced by a wide variety of variables beyond the patient's current symptom level and such influences, far from being "extraneous", are actually appropriate and important. The attempts previously made in the literature to specify the criteria for hospitalization have largely ignored these factors, as well as the issue of how to fit the hospital into whatever system of mental health care is available in the community. The decision to admit, then, is part

of a complex decision about treatment strategy that must include consideration of what kinds of help the patient needs, what resources are available (throughout the community both in and out of the hospital), what the attitudes and customs of the community are, and how the community will react to and tolerate the patient's behaviour. Psychiatric hospitalization is socially and psychologically costly to the patient and can often be replaced by more efficient community alternatives if the proper resources are available.

Glick ID, Hargreaves WA. *Psychiatric hospital treatment for the 1980's*. Lexington MA: Lexington Books;1979

Glick ID, Klar H, Braff D. When should chronic patients be hospitalized? *Hosp Community Psychiatry* 1984;35:934-6

Gomez EA, Ruiz P, Langrod J. Multidisciplinary team malfunctioning on a state hospital unit: a case study. *Hospital and Community Psychiatry* 1980 Jan;31(1):38-40

A case study of an 80-bed inpatient unit in the Bronx, with 60% Hispanic, 35% Black, and 5% white patients, and 54 unit staff (10/12 white professionals, and no white paraprofessionals). When a new chief of service began, he found the unit in administrative chaos, with a severely demoralized staff. Staff counseling, staff meetings to increase motivation, attempts to increase individual supervision, administrative sanctions, sensitivity therapy (groups) for staff all failed. Finally, a questionnaire revealed that paraprofessional staff were alienated by not having their job functions defined, by their feeling of not receiving the training they needed, and by feelings of job insecurity. These staff also felt under pressure to give psychotherapy to their patients, for which they were untrained.

This led to a special inservice training program focussed on the paraprofessional staff, to provide basic explanations of what therapy was all about, and to provide expertise in developing individualized treatment plans. Patients' psychological, physical, social, and rehabilitative needs were discussed.

A followup one year later showed that aggressive behaviours (fights, firesetting, suicide attempts, escapes) had been reduced considerably.

Gravel GB, Boyer R, Lamontagne Y. Attitude des malades chroniques envers l'hôpital psychiatrique. *L'Encéphale* 1984;X:39-44

[authors' summary] Three hundred chronic mental patients participated in a survey to evaluate their attitudes towards the 2000 bed hospital where they were staying. The mean duration of the actual hospitalization was 12.1 years and most patients (77.9%) suffered from schizophrenia or other psychoses. On the whole, results show a relatively high level of patients' satisfaction. Single, non psychotic and self-sufficient patients who have not been hospitalized many times and do not want to leave the institution are more inclined to be positive towards the psychiatric milieu. The authors report that participation of chronic mental patients in a survey can be reliable and give helpful suggestions in relation with the evaluation of psychiatric care and the improvement of the quality of life in state hospitals. They conclude that it will always be difficult to discharge satisfied patients without offering the same support and community services that they find in a state hospital.

Johnstone EC, Owens DG, Gold A, Crow TJ, Macmillan JF. Institutionalization and the defects of schizophrenia. *British Journal of Psychiatry* 1981;139:195-203

Mattes JA, Rosen B, Klein DF. Comparison of the clinical effectiveness of "short" vs. "long" stay psychiatric hospitalization: II. Results of a 3-year posthospital followup. *J Nerv Mental Dis* 1977;165:387-94

Mohelsky H. The mental hospital and its environment. *Canadian Journal of Psychiatry* 1982 Oct;27(6):478-81

Oldham JM, Russakoff LM. The medical-therapeutic community. *Journal of Psychiatric Treatment and Evaluation* 1982;4:347-53

Describes an acute inpatient service which borrows some therapeutic community principles and applies them in a modified way to a traditional medical model for inpatient treatment. An emphasis on diagnosis, the use of individual therapy, the prescribing of medications, the use of ECT, the presence of locked doors, and the use of seclusion and restraint would be part of such a model. The modified therapeutic community principles would include: (a) modified and selective information sharing, individually tailored to each patient's needs; (b) modified patient government, serving a liaison and advisory function between staff and patients; (c) modified group therapy requiring all staff to attend and observe; (d) modified community meetings chaired by staff in a highly structured manner with a carefully planned agenda; and (e) clear hospital identification nameplates (indicating professional discipline) to be worn by staff at all times. At the same time, the staff members would wear street clothes rather than medical uniforms.

Sacks MH, Carpenter WT Jr. The pseudotherapeutic community. *Hospital and Community Psychiatry* 1974;25:315-18

A pseudotherapeutic community is defined as "... a psychiatric unit that subscribes to a particular treatment philosophy, but covertly functions in ways contradictory to the expressed belief ...". This occurs in five situations: (a) absence of a therapeutic standard, (b) assignment of irresponsibility, (c) the antitherapy leader, (d) absence of therapeutic leadership, and (e) a pathogenic environment - an environment "created and maintained by patients attempting to meet the staff's simultaneous expectations of responsibility and irresponsibility".

Talbott JA, Glick ID. The inpatient care of the chronically mentally ill. *Schizophrenia Bulletin* 1986;12(1):129-40

This excellent article provides a comprehensive, although brief, review of what is known about the treatment of chronic mental patients. In spite of its title, it considers outpatient settings as well. A very selective review of the literature is used to highlight the points that psychotherapy is not essential for inpatient treatment of chronic schizophrenia, but is essential in outpatient care; group therapy is more effective than individual treatment; drugs alone are not sufficient to prevent relapses; a highly structured, organized, expectant milieu that stresses adaptive skills, while suppressing symptoms and maladaptive behavior, is helpful in hospital treatment of chronic schizophrenia; a highly organized resocialization-relearning program, with a behavior treatment orientation (eg token economy), enables chronic schizophrenics to stay in the

community much longer than those receiving milieu therapy or traditional State hospital care; alternatives to hospital treatment, whether home care, family treatment, day hospital care, residential nonhospital treatment, or community-based community support, are as, if not more, effective than inpatient treatment in reducing symptomatology, rehospitalization, interpersonal difficulties, and vocational disablement; the cost of high quality community care, while quite high, is a bit less than hospital care plus traditional followup; there are no data to support the use of hospitalization instead of outpatient treatment for most of these patients; the drawbacks of hospitalization, often overlooked, include the financial costs, potential harm to patient self-esteem and role functioning, and conditioning of patients to use and depend on the hospital to deal with crises. With regard to length of hospitalization, the authors feel that most patients requiring inpatient settings can be effectively treated in relatively short-term settings, so long as day treatment and supportive residential treatment are readily available.

Indications for hospitalization include: reevaluation of diagnosis and functioning of chronic patients; re-equilibration of medication; to effect changes in treatment plans: when a patient cannot be optimally managed as an outpatient; if treatment that is not available in community settings is required (eg ECT); to deal with transference crises or countertransference problems; detoxification from alcohol or drugs; "respite care".

Inpatient treatment includes the following elements: evaluation/assessment (the authors stress that, since withdrawal, depression, and lack of spontaneity are common to chronic schizophrenia, chronic affective disorders, chronic institutionalization, and organic mental conditions, these differential diagnoses must be considered from the start); medication; psychotherapy; family treatment/psychoeducation; instruction in skills of everyday living; vocational rehabilitation; and socialization. Finally, discharge planning should begin at admission, and should include provision for psychiatric care, medical care, housing, socialization and social rehabilitation, vocational rehabilitation and work, income, and continuity of care. The authors also briefly discuss long-term hospitalization, and the need for asylum and how it can be met.

All in all, this article can be highly recommended to anyone seeking a well-reasoned approach to dealing with chronic mental illness, by two leaders in the field.

Wing JK, Brown GW. Social treatment of chronic schizophrenia: a comparative survey of three mental hospitals. 1961 Sep

[authors' summary] The clinical condition of samples of chronic female schizophrenic patients in three mental hospitals was assessed by means of standard interviews, and rating scales completed by ward sisters. Information on the restrictiveness of the ward routine, the way the patient's day was organized, her personal possessions, and the nurses' opinions of her, was also systematically gathered. After due allowance had been made for differences in distribution of age, length of stay, and social class (occupation of father), marked differences still remained between the groups. A consistent pattern emerged. At Hospital A, where the main emphasis of care was on the long-stay patient, there was least clinical disturbance and most personal freedom, useful occupation, and optimism among the nursing staff. At Hospital C, where reform had not progressed so far, there was most clinical disturbance among patients and least personal freedom, useful occupation and optimism. Hospital B was intermediate in most respects. Alternative explanations are considered and it is concluded that there is good preliminary evidence that social conditions in a mental hospital do influence the mental state of schizophrenic patients. It will be necessary to show an improvement in patients in Hospital C, as the social regime there changes, in order to confirm these results.

rehabilitation

Anthony WA. The principles of psychiatric rehabilitation. University Park Press, Baltimore, Maryland 1980 (Call No. WM 30 A635p 1979)

[from Unger, 1982] This book fully explores the current state of the art of psychiatric rehabilitation and the further steps it will be taking. It integrates and refines findings from interrelated fields to provide an empirical rationale for the techniques and principles presented in the Psychiatric Rehabilitation Practice Series.

The book is a recommended resource for inservice trainers, college professors, and interested professionals. It gives background to the skills presented in the videotape series and suggests results that can be expected from use of these skills.

Anthony WA (ed). Rehabilitating the person with a psychiatric disability: the state of the art. Rehabilitation Counseling Bulletin 1980;24 (entire special issue)

[from Unger, 1982] This first section of this issue overviews essential components of a rehabilitation approach as well as current national developments. The second section describes how various aspects of the rehabilitation model have been implemented in a variety of rehabilitation and mental health settings. The final section describes some innovative rehabilitation treatment and training programs that have been developed in the past decade.

Anthony WA, Buell GJ, Sharratt S, Althoff MF. The efficacy of psychiatric rehabilitation. Psychology Bulletin 1972;78:447-56

Anthony WA, Cohen MR, Farkas M. A psychiatric rehabilitation treatment program: can I recognize one if I see one? Community Mental Health Journal 1982;18:83-96

[from Unger, 1982] Ten essential ingredients of rehabilitation programming are presented for use in discriminating between programs that are rehabilitation oriented and programs which are rehabilitation in name only. These ten ingredients can serve as a guide for the continued development of community-based settings which attempt to provide comprehensive rehabilitation programming.

Anthony WA, Cohen MR, Vitalo R. The measurement of rehabilitation outcome. Schizophrenia Bulletin 1978;4(3):365-83

Anthony WA, Farkas MA. A client outcome planning model for assessing psychiatric rehabilitation interventions. Schizophrenia Bulletin 1982;8(1):13-38

[from Unger, 1982] Skill training, drug therapy, and community support strategies are the three primary intervention techniques used by practitioners attempting to rehabilitate severely psychiatrically disabled clients. This article describes a comprehensive client outcome planning model that encompasses both the intended and unintended effects of an intervention and that extends beyond such traditional outcome measures as recidivism, clinical relapse, and employment. In addition, data collection strategies and

instruments capable of measuring a broad range of possible outcomes are described. A comprehensive model has the advantage of encouraging a researcher to consider during the design of the research the specific outcomes that will and will not be affected by an intervention. Furthermore, such a model discriminates between process and outcome variables, limits the scope of the implications derived from the research data, and encourages the researcher to assess both the positive and negative effects of the rehabilitation intervention.

Beard JH. Psychiatric rehabilitation at Fountain House. In: Meislin J, ed. Rehabilitation Medicine and Psychiatry. Charles C. Thomas, Springfield Illinois 1976

Beard JH, Malamud TJ, Rossman E. Psychiatric rehabilitation and long-term rehospitalization rates: the findings of two research studies. Schizophrenia Bulletin 1978;4(4):622-35

Beard JH, Propst RN, Malamud TJ. The Fountain House model of psychiatric rehabilitation. Psychosocial Rehabilitation Journal 1982 Jan;5(1):47-53

Fidler GS. Design of rehabilitation services in psychiatric hospital settings. Ramsco Publishing, Laurel, Maryland 1984

Unger KV, Cohen MR, Cohen BF. The skills of psychiatric rehabilitation videotape series: User's guide. Centre for Rehabilitation Research and Training in Mental health, Boston University, 1982.

(Douglas Hospital has the user's guide, audio-visual library catalogue no. VC 31A, and the accompanying videotape, VC 31).

[from the user's guide] The Skills of Psychiatric Rehabilitation Videotape Series was produced to demonstrate with real clients some of the skills practitioners use in the psychiatric rehabilitation approach. The series can be used as part of an introductory presentation for professionals in mental health or related fields, for board members of mental health agencies, for funding sources, lay groups or clients and family members. The videotape series can also be used to demonstrate some of the key principles and skills of psychiatric rehabilitation for preservice and inservice training.

The series was designed to introduce some of the major principles of psychiatric rehabilitation and to demonstrate some of the major skills. The first videotape of the series, "Introduction to the Psychiatric Rehabilitation Approach," summarizes the major principles in a lecture by Dr. William Anthony. The remaining three videotapes, "Exploring a Vocational Goal," "Personalizing Skill Strengths and Deficits," and "Teaching a Skill", demonstrate major skills used in the approach through a practitioner-client interview.

The user's guide is designed to help presenters utilize the videotape series. It reviews the major teaching points for each of the four tapes and suggests topics for discussion. A complete teaching presentation is provided for each videotape. The first section of the guide consists of material that will assist the presenter; for each videotape, there is information about the content of the tape, a presentation goal, and identification of what the presenter can expect the viewers to know after the presentation. Questions and topics for discussion are included. There are transcripts for each tape, indicating the places to stop the tape to make teaching points. The guide also includes an annotated bibliography.

teaching

Bloom J, Cutler DL, Shore JH. Training psychiatrists to work with community support systems for chronically mentally ill persons. *American Journal of Psychiatry* 1981;138:98-101

Carkhuff RR. The art of helping IV. Amherst: Human Resource Development Press, 1980

[from Unger, 1982] This book has been used to teach skills to more than 100,000 helping professionals. It is straightforward, clearly written, and well illustrated for use by trainees in developing interviewing skills. Included are attending skills, responding skills, personalizing skills, and initiating skills. The book is designed to be used by helpers in schools, colleges, and mental health, industry, and home settings.

Carkhuff RR, Berensen DH. The skilled teacher. Amherst: Human Resource Development Press, 1981

[from Unger, 1982] In this resource book, the authors provide readers with a practical systems approach for developing teaching skills. The skills are presented using all the principles of effective teaching and learning: a Facts-Concept-Principles-Objective-Steps approach to content development; a Review-Overview-Presentation-Exercise-Summary approach to lesson planning; a Tell-Show-Do approach to teaching delivery; a Personalized Initiative approach to interpersonal skills.

A review of the relevant literature including the authors' own research is presented for each of the teaching skill areas. The book concludes with the TLC system, a teacher-based system that emphasizes the teacher as developer, planner, manager, programmer, and helper.

Cutler DL, Bloom JD, Shore JH. Training psychiatrists to work with community support systems for chronically mentally ill persons. *American Journal of Psychiatry* 1981;138:98-101

Faulkner LR, Rankin RM, Eaton JS Jr, Kinzie JD. The state hospital as a setting for residency education. *Journal of Psychiatric Education* 1983;7:151-66

Lurie HJ, producer. Changing attitudes toward the chronically mentally ill: discussion leader's guide. Educational Development for Psychiatric Educators Project (EDPE) of the American Psychiatric Association, July 1981.

Mayo J, Gabel R, Carvalho R. Planning for the future in psychiatric training: the place of the chronic care program. *Comprehensive Psychiatry* 1982;23:1-8

Shore JH, Kinzie JD, Bloom JD. Required educational objectives in community psychiatry. *American Journal of Psychiatry* 1979;136:193-5

Stanton AH, Schwartz MS. The mental hospital: a study of institutional participation in psychiatric illness and treatment. Basic Books, New York 1954

A searching study of the mental hospital in which the authors showed the impact of the environment and the staff on the manifest pathology of the hospitalized patients.

young chronic patients

Caton CLM. The new chronic patient and the system of community care. *Hospital and Community Psychiatry* 1980 Jul;32(7):475-8.

This is a one-year study of 119 new chronic patients entering treatment in New York City between 1977 and 1979. The authors found 5 suicides in the study group; 35 patients had contact with the criminal justice system (25% arrest rate); only 17% complied fully with the prescribed treatment plan during the postdischarge year, and the one-year rehospitalization rate was 58%. Only 27% worked during the study year. Forty-two % lived with their families, 24% in single-room-occupancy hotels, and 28% lived alone in their own apartments.

The authors conclude that institutionalization is not the factor resulting in chronicity; even though "state of the art" community programming was used, there was an excessively high rehospitalization rate, poor treatment compliance, and high level of symptomatology. There is a need to develop innovative approaches to engage patients in long-term maintenance treatment. Suicide may be a more significant problem than crime.

Pepper B, Kirshner M, Ryglewicz H. The young adult chronic patient: overview of a population. *Hospital and Community Psychiatry* 1981;32:463

[from Bell RW,] Based on a study of nearly 300 patients, 18 to 35 years old, the authors provide a beginning description of the characteristics of this emerging subgroup of the chronically mentally ill.

Platman SR, Booker TC. The new long-term patient in the public mental hospital: a follow-up. *American Journal of Psychiatry* 1984 Jun;141(6):794-5

[authors' abstract] Of the 270 patients who had been hospitalized at least 1 year in Maryland public psychiatric facilities in 1976, 15% remained 7 years later. The authors' data provide evidence that a new long-term population is not accumulating in Maryland.

Schwartz S, Goldfinger S. The new chronic patient: clinical characteristics of an emerging subgroup. *Hospital and Community Psychiatry* 1981;32:470

[from Bell RW,] The authors describe their impressions, based on 2 years' clinical work in a general hospital, of the characteristics of younger chronically mentally ill patients. They analyze the interaction of this patient group with present treatment resources and make recommendations for future development of treatment resources.