ISRAEL ZWERLING

AFTERCARE SYSTEMS

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Aftercare Systems

Israel Zwerling

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Chapter 38

AFTERCARE SYSTEMS

Introduction

The principal locus of treatment for the psychotic patient in the United States has, since 1955, been shifting from inpatient to outpatient facilities. This may be documented in terms of the briefer median duration of inpatient stay, the declining average daily census of mental hospitals, or the increasing numbers of outpatients on the rolls of hospital outpatient services. Over the same period, admissions to mental hospitals have increased, largely because of the high rate of readmissions. Table 38-1 shows the relevant data for the mental hospitals operated by the New York State Department of Mental Hygiene as an example.

The modal career of patienthood has been altered, in parallel with these changes, from extended or life-long institutionalization punctuated by brief stays in the community, to extended residence in the community punctuated by brief periods of hospitalization. It is not directly in the province of this chapter to attempt an analysis of the sources of this change; it seems clear that effective psychoactive drugs, the altered organization of the service-delivery structures of the hospitals, and the burgeoning of community psychiatry programs, all inextricably interrelated, have been central to this shift in focus from inpatient to outpatient treatment (Zwerling, 1965). It is by no means suggested that no further problems confront a hospital staff faced with an acutely psychotic patient, but the more pressing challenge now in the treatment of this patient is the stabilization of his recovery and his maintenance in the community after discharge.

Table 38-1. Admissions and Readmissions in New York State Mental Hospitals, 1955-1972

	Year			
	1955	1960	1965	1972
Average daily census	92,165	89,334	85,172	53,598
Median duration of stay	211	not available	75	43
Total admissions	21,931	27,152	35,254	31,258
Percent readmissions	27.2	32.8	35.5	60.6
Readmission index*	180.3	213.1	198.7	161.8

*Number of readmissions per 1000 discharges

There is no dearth of reports of aftercare efforts, but only few substantive conclusions may be drawn, because of the inadequate data reported. To begin with, the greatest number of studies by far are either cross-sectional or cover a brief period of follow-up time; quite clearly, the need in dealing with chronic disability is for long-term longitudinal research.

Second, most reports use rehospitalization as the sole criterion for the success or failure of the effort described. This is questionable, for one reason, because hospitalization is so highly dependent upon extraneous factors (e.g., the availability of beds and of alternative treatment facilities, and the tolerance of the family and community for deviant behavior). For another, they fail to differentiate a fully functioning, socially active expatient from a totally dependent recluse in the back room of the home of a tolerant family; both would be equally tabulated as "not rehospitalized." Third, the number of factors which may be presumed, or have been demonstrated, to play significant roles in determining post hospitalization adaptation is quite large. Few studies have been able to control variables adequately and/or study a sufficiently large sample so as to provide compelling correlational data between one particular treatment variable and outcome. It is therefore not surprising that, with a few exceptions which will be noted, for virtually every study demonstrating a significant advantage to the inclusion of a particular component of an aftercare system, other studies report that the same component offers no significant advantage, or may even he a disadvantage.

General Issues

Central to an analysis of aftercare systems is a formulation of the goals of aftercare. This, in turn, requires some conceptualization of the disability which led to the hospitalization. If psychosis is perceived as essentially an intra-organismic organic process, rather different expectations of the posthospital course and different treatment concerns would prevail than if it is seen as the consequence of an imbalance of intrapsychic forces and counterforces, or as a product of intrafamilial or sociocultural disequilibria. Confronted with the need to account for the grossly deranged behavior of a psychotic patient, one can take any position along a broad range between two extremes. At one end of the range of explanations, one can assume that the behavior is the product of a disordered organism, neurochemically or psychologically incapable of satisfactory adaptation to any expectable environment. Alternatively, at the other extreme, one can assume that the behavior is the response of an essentially normal organism to a noxious environment, much as one would expect a *normal* liver bathed in a high-alcohol, low-protein, low-vitamin environment, sooner or later, to undergo fatty degeneration and ultimately to become cirrhotic. The implications of these polar positions for the appropriate scope of the work of a psychiatrist are quite different. While nobody would expect an internist, e.g., to attempt to treat a patient with cirrhosis while the diseased liver continued to be bathed in the same noxious environment, one still is challenged occasionally about the appropriateness of a psychiatrist in a program concerned with jobs, schooling, housing, welfare, recreation, and the like. It is quite evident that these polar views are not mutually preclusive, that both diathesis and stress (both psychological and socio-cultural determinants) may be expected to be implicated in the occurrence of psychotic behavior, and that a psychiatrist undertaking the operation of an aftercare program must be prepared to direct therapeutic efforts to whatever system level appears critically disordered and amenable to intervention.

There is a considerable body of evidence which indicates that aftercare programs can indeed be effective in reducing the incidence of rehospitalization in a population of discharged patients (Anthony, 1972; Davis, 1972; Keil, 1970). A handful of studies report, separate from or in addition to this criterion, a more desirable level of social activity and a generally improved quality of life as correlates of successful aftercare programs. Cassell et al. (1972), in a two-year follow-up study of 458 patients discharged after a minimum of two years of continuous hospitalization, point out that the financial cost to the community of maintaining these patients out of the hospital is less than half the cost of hospital care. Whatever the criteria employed, there is consistency in the finding of greater success in an experimental program than in no program, or in a minimal program. Some general observations may be extracted from these studies, before attempting to describe and assess some of the specific tactics of aftercare systems.

1. A number of studies report an initial period of high success, with a subsequent decrease in improvement rate and a narrowing of the gap between experimental and control subjects (Davis, 1972; Davis, 1969; Levenstein, 1966).This would seem to

suggest a kind of Hawthorne effect to be operative, and underscores the importance of such factors as the enthusiasm of the providers of service and their attentiveness and dedication to their patients, as well as perhaps the awareness of the patients that they are in a special program.

2. Perhaps related to the above observation is the consistency of the report of success when high expectations of patients' performance are built into the design of the aftercare program. Darley and Kenny (1971) have coined the term "the Queequeg syndrome" to describe the self-fulfilling character of the prophecy of the family and community that the discharged patient is chronically ill and cannot be held responsible for himself. This is not, of course, to suggest that unrealistic demands for performance are likely to be helpful to chronic patients; Schooler et al. (1967), indeed, in describing the composite picture of their successful one-year post discharge patient, state: ". . . his functioning is not at the level expected of members of the community. He appears to satisfy the expectations of his own family and himself by virtue of their realistically low level."

3. There is substantial agreement that extended hospitalization, generally defined as more than two uninterrupted years in an institution, is associated with a poor prognosis in aftercare programs (Hansell, 1971; Paerregaard, 1971; Paul, 1969). Since the long-term patients tend to be disconnected from family and community even before hospitalization and may be assumed to suffer from a more severe degree of

mental illness, it is simplistic to account for this finding solely on the basis of the social breakdown syndrome (Gruenberg, 1967). It is likely that the desocializing process of a total institution, the alienation from family and community, and the greater severity of illness all are implicated in the difficulty of effecting a stable equilibrium in the community for patients discharged after long periods of hospitalization. It should be emphasized that the observed relationship, while it applies to duration of hospitalization, does not appear to apply, within parallel time units, to alternative modes of treatment; Lamb and Goertzel (1972) observe . . growing evidence that whatever treatment is given or not given during 24-hour hospitalization is not related with post-hospital community tenure or level of instrumental functioning."

4. There is a generally expressed sensitivity to the problem of whether a discharged patient is really in the community, as well as to the converse problem of the burden on the family and community. Lamb and Goertzel (1971) caution against the assumption that a patient discharged to a boarding home is in the community; many family-care homes are in effect small satellite wards of the hospitals from which the patients were discharged. The seemingly self-evident criterion of contact with nonpatients and participation in nonpatient activities, while useful, must in turn be applied with caution since, as will be reviewed below, there are reports of successful aftercare programs built around the tactic of forming a small patient group while in the hospital and discharging the group as a unit into a house or apartment;

contacts and activities may then remain limited to intragroup relationships for some time. An assessment of the effects of all the component elements of a total prescription for aftercare upon the process of normalization, i.e., of rejecting the identity of parenthood and acquiring a primary identity as a citizen without stigmatization, must be a central consideration in the design of an aftercare program.

5. There is considerable disagreement concerning the optimal locus of aftercare services. Jansen (1970) cautions against mental hospitals operating halfway houses on their premises; Black and Benney (1969) and Keil (1970) similarly argue for rehabilitation centers to be separated from hospitals. At the same time Hott (1971) reports strikingly good results from establishing an aftercare clinic on the ward at Bellevue Hospital in New York City from which patients were discharged; his rationale, directly contrary to the fears of the above cited contributors that in-hospital aftercare services tend to keep patients seeing themselves as patients, is precisely that "Return to the original ward as a visitor to the Follow-Up Program lets the patient enjoy the prestige of his new status, increases his self-esteem, and helps to establish his self-image of health" (Hott, 1971, p. 225). Crary and Kirts (1971) report a similar program in Los Angeles. Pechan (1971) describes a successful halfway house on his ward, while Lamb and Goertzel (1972) report a study in which patients discharged to a transitional day hospital improved significantly when they were scheduled so as not to mix with the inpatient population. Silverstein (1968) comments that the mental hospitals in Pennsylvania provide half of all

aftercare services themselves; he cautions that "It should be kept in mind that no research has established that community-based services are more effective than hospital-based services for the seriously mentally ill" (1968, p. 53. It may of course be that the locus of the aftercare effort is of minor significance in determining its effectiveness, compared with other qualities of the effort; it may, indeed, be helpful to some patients to have a graded range of services extending from the hospital itself to full participation in community life.

6. A review of the literature leads compellingly to the conclusion that, even with the most effective programs devised, considerable disability may be expected in the greatest number of patients. Anthony et al. (1972), after reviewing an extensive body of the literature, suggest as a baseline against which experimental programs may be tested, that standard programs show 40 to 50 percent of discharged patients returning to the hospital within a year of discharge, and 20 to 30 percent working at that time. The data reported by Schooler et al. (1967) are representative of the better studies: of 299 patients discharged from an initial, larger cohort of newly admitted schizophrenic patients, and in the community one year following discharge, 41 percent had been rehospitalized during the year (the number not discharged at all, and the number discharged, rehospitalized and back in the community at the time of the one-year follow-up, are not given; the percentage of the original cohort of patients discharged and out of the hospital a year after discharge is certainly below 50 percent). Of this

> population of 299 successful patients, only 11 percent were described functionally "as good as the average person in the community," and only 58 percent were employed. It should be emphasized that these data concern an acutely ill patient population continuing to reside in the community a year after discharge; Paul (1969), citing five studies of chronic patients, offers the disheartening summary that ". . . the probability of release and community stay after two years continuous hospitalization is reported to be about 6 percent, without change in this century."

These observations suggest the critical importance of defining the goal of an aftercare system. If mental illness is perceived exclusively in the simplistic and absolute model of infectious disease, the likelihood is that unrealistic goals of total cure will be set, and inappropriate and ultimately destructive efforts will be made to force patients to perform at levels of functioning far above their capabilities. More will be said to this point after a review of the factors of significant relevance to the effectiveness of aftercare systems.

Residence

There is wide agreement that the most compelling determinant of success or failure in the posthospital adaptation of a patient is the nature of the residence to which he is discharged. Schooler et al. (1967) suggest that this factor actually precedes the hospitalization; they write: "The single fact about the patient which contributed the most to the evaluation of his present [i.e., one year postdischarge] functioning was his prehospitalization family type . . . Patients who lived in conjugal settings were more likely to be performing successfully in the work role on all four measures of work performance. Over-all functioning was also higher for these patients." Freeman and Simmons (1963), initially exploring the hypothesis that the family’s tolerance for deviance was the critical factor in the posthospitalization course of a patient, found four interrelated variables significantly related to whether the patient was rehospitalized or still in the community a year after discharge: work, social participation, instances of bizarre behavior, and the extent to which the patient represented a management problem to his family. Brown et al. (1962) demonstrated that patients who were discharged to relatives with whom they were involved in highly emotional relationships, most particularly to the homes of their parents, were most likely to suffer a relapse of florid symptoms and require rehospitalization. In a recent, more careful study, Brown et al. (1972) employed a parameter they term "expressed emotion," composed essentially of a combination of the number of critical comments made about the patient, the presence or absence of expressions of hostility to the patient, and expressions of dissatisfaction about the patient. Not surprisingly, a significant relationship was demonstrated between families with *high expressed emotion* and the relapse of patients discharged from hospitals to these families;

conversely, marked warmth expressed to patients without *emotional over-involvement* was associated with a very low rate of relapse. Miller (1967) has similarly demonstrated that, while in general patients returning to a conjugal home show a lower rate of rehospitalization than those returning to a parental home, there is a significantly better outcome when there is an absence of marital conflict than when conflict is present.

A number of alternative hypotheses at rather different systems levels have been proposed to account for these findings. Brown et al. (1972) suggest that the high physiological arousal potential of schizophrenic patients make a socially and emotionally intrusive environment a double-edged risk: the patient may overreact and become floridly psychotic, or may attempt to defend against psychotic disorganization by social withdrawal, a process he cannot control and which may therefore proceed to a state of psychotic isolation. Sanders (1972) suggests a more complex social process in which the labeling of a patient as "mentally ill" changes his status from that of a sick patient to that of a chronic patient, with the inevitable expectations of recurrence; the rejecting family, which emphasizes disability, is then an alternative less desirable than the hospital, in which his role as chronic patient provides acceptance and even status. Whatever the nature of the forces at work, it is abundantly clear that no aftercare system can ignore the matter of the residence to which the patient is discharged. Some approaches to this issue have included family therapy, halfway houses, hostels and family care programs, and Fairweather lodges (see below).

Family Therapy

There is burgeoning literature on family therapy, but few studies are immediately relevant to aftercare programs. A thoughtful summary of the outcome of family therapy of schizophrenia has recently been contributed by Massie and Beels (1972). Langsley et al. (1969) demonstrated the resounding advantage of intensive family-crisis therapy in lieu of hospitalization; six months after the initial episode, only half the number of patients in the group treated initially by family-crisis therapy had been hospitalized, as compared with the number of patients treated initially by hospitalization who were rehospitalized. In a later study, Langsley et al. (1971), reporting on the same patient population, found that after eighteen months there were no differences in hospitalization rates between the two groups. Friedman et al. (1965) describe, in detail, family therapy in four cases, two of which were quite successful. Lurie and Ron (1970) report success with an aftercare program for young adults in which the patient met with a patient group and the parents with a separate couples group for three months before patients and parents began meeting together in activity groups and, after a year, in a joint camping experience. Esterson, Cooper, and Laing (1965) describe a program in which forty-two schizophrenic patients were treated exclusively by family therapy while in the hospital and in three family sessions during the year following discharge; only 17 percent required rehospitalization.

Weiner et al. (1967), on the other hand, suggest caution concerning the effectiveness of family therapy as a treatment modality for a population of chronic mental patients. Their book describes in detail the development of the Home Treatment Service at Boston State Hospital as an effort which . . . "kept the patient in his natural habitat where his allies in the community could contribute to his support, prevented the disruption of family, community or occupational ties, and obviated the stigma of referral to a hospital" (1967, p. xv). However, they go on to note, . . . "when home services were first started, there was a growing interest in family dynamics and family treatment. Home-service personnel undertook some family treatment, wherein the entire family was seen regularly, usually once a week. Although much could be learned by the therapist about family dynamics, results did not justify the enormous amount of time spent in this kind of therapy. Motivation among family members varied greatly, and it was quite easy for a member to avoid a treatment session by being out of the house, by being asleep, by drinking too much beer, etc. Some families claimed that the topics which came up were disturbing enough to upset family life for the rest of the week." In later phases, this type of family treatment was discontinued. Actually, in these later phases, the home services became a triage and crisis intervention unit; they comment, concerning their shift from "home treatment" to "community management" that ". . . long-term or intensive home treatment has the same drawbacks as long-term outpatient psychotherapy, namely, an enormous expenditure of professional time and energy" (1967, p. 22).

It must be kept in mind that *treatment of the family* is not as definitive a process as, say, *treatment with phenothiazines.* The range of therapeutic tactics in, and of conceptual approaches to, family therapy is extremely extensive (Group for the Advancement of Psychiatry, 1970), and outcome studies of this modality are as unsatisfactory as are evaluations of individual psychotherapy. It appears, however, that the capability of intervention at the level of the family system is a vital component of an aftercare system. The data concerning the impact of family behavior and family attitudes on recurrence of symptoms are quite compelling. A measure of face validity to focusing on such family behaviors and attitudes in treatment is lent by the fact that virtually every report of a comprehensive aftercare system includes family therapy as part of the treatment armamentarium.

Halfway Houses

Since the family so frequently represents an emotionally disturbing setting for a newly discharged patient, and since the gap between the dependent role of cared-for patient and a fully independent community role is for many patients unmanageably wide, a kind of in-between facility inevitably suggests itself. It thus seems surprising that halfway houses have been so slow in developing in the United States; there were only two in 1950, and ten in 1960 (Glasscote, 1971). The number has been increasing rapidly, as has the literature describing their role in aftercare programs. Two excellent and informative surveys of halfway-house practices have been published (Glasscote, 1971; Rappaport, 1971).

Glasscote offers the following definition: "A halfway house for the mentally ill is a nonmedical facility specifically intended to enhance the capabilities of people who are mentally ill, or who are impaired by residuals of or deficits from mental illness, to remain in the community, participating to the fullest possible extent in community life" (1971, p. 11).

Typically, a halfway house has a capacity of between twenty and twenty-five residents, though they range from four to 200. Most limit their services to the mentally ill, often to the exclusion of patients with alcoholism, drug addiction, and sex deviations. Most are intended to function only as transitional facilities, and impose a restriction on the length of stay; the average appears to be from four to six months. They may, however, also serve as a long-term or even a permanent placement for patients incapable of more independent community living. In some instances—data are lacking, but the impression of this writer is that almost all halfway houses are used in this way to a minor degree—they serve also as an alternative to hospitalization. As transitional facilities, halfway houses have been significantly instrumental in shortening the duration of hospitalization for patients no longer in need of hospitalization, while waiting for a suitable residence to be located, or for the resolution of intrafamilial conflicts too severe to permit discharge to the parental or conjugal home. A hoped-for side effect is the role a halfway house can play in educating a community to accept former mental patients (Jansen, 1970).

A number of issues and problems are related to the use of halfway houses. Walter Barton’s caution of a decade ago, as quoted by Glasscote, unfortunately remains true today: "No proof appears to be on record from past experience that the halfway house is worth the expense . . . Tentative findings suggest that the number of patients who succeed and fail in the community after release from the mental hospital is not very much different if they go to a halfway house or to board in the community" (Glasscote, 1971) Studies of halfway houses tend to report only the outcome of the patients admitted, and do not offer outcome data for alternative, matched populations not afforded a halfway-house placement. Patently, a very cautious and conservative selection process, limiting intake to patients with the best prognosis, would yield quite different outcome data from a study of a randomly selected group of discharged patients, or from a group deliberately chosen to test the applicability of a halfway house for patients with a poor prognosis.

As was noted above, there is a generally expressed preference for the sponsorship of a halfway house by other than a hospital, to avoid creating a facility which is nothing more than a community-based annex of the hospital. Closely related is the problem of staffing; there is general support for a nonpsychiatric, and even a nonprofessional, staff, again, to avoid creating an extension of the hospital. Debates on this issue seem really to miss the critical point about halfway houses; it is as though a halfway house was located by a mathematical determination at precisely a point half-way—(in distance? in dependent status? in proportion of time spent with nonpatients as against patients?)—between the hospital and the community, and the issue was to define the properties of that specific point. The halfway house as a *concept* is better seen as a *range* than as a *point.* At the Bronx State Hospital, for example, many patients begin their return to the community through a brief pre-discharge stay on a *hotel ward,* a virtually unstaffed ward on which the patients are almost completely responsible for their own daily programs; one might see this as a one-eighth-way house. Two of the hospital units utilize a traditional halfway house. Many patients subsequently move to apartments leased and furnished indirectly by the hospital; one might see this as a three-quarter-way house. The degree of contact with hospital staff appropriate for one point along the range from hospital to community would be quite inappropriate for another point in this range, and to debate the merits of a total spectrum of available residential facilities with a single set of criteria is really without purpose.

Perhaps the most critical variable in the functioning of a halfway house in an aftercare system is the ambience established with regard to the expected competence of the residents. Jansen (1970) has described the alternative sets of attitudes, i.e., the *low-expectation* halfway house, where staff may underestimate the capabilities of patients, take responsibility for their care, and assume a parental role to patients, and a *high-expectation* halfway house, where each patient is expected to make the maximal contribution to his own and to other patients' recovery. Apte (1966) has described the failure of low-expectation halfway houses to rehabilitate and return patients to the community. Wilder et al. (1968) have described a high-expectation halfway house, with moderately favorable outcomes for patients. Baganz et al. (1971), demonstrated the effectiveness of a halfway house established in a community YMCA, with minimal staffing; the exceptionally favorable outcome may simply reflect the prerequisite for admission, namely, that the patient have a job in the community.

Relatively little has been written about family-care and foster-home placements for discharged patients, though a considerable number of such dispositions are made by mental hospitals. Lamb and Goertzel (1971) raise the concern that patients in such settings are frequently not truly in the community at all, but occupy what is in effect a one-room back-ward annex of the hospital. Anthony et al. (1972) point out that such placements tend in actuality to be transitional; only 20 to 30 percent of patients placed in foster homes are still there after a year. Campbell (1971) found a group of patients discharged to hostels to show greater ability in self-care and independent functioning than a group remaining in the hospital; however, on retesting a year later, the hospital group showed significant progress, while the hostel patients showed none at all. Unless there is continued involvement of patients in a program of follow-up care and treatment, there is little reason to expect emotional growth, or even the sustained capacity to cope with the pressures of community life, in the setting of a foster-home placement.

Fairweather Lodges

In the view of this writer, the most promising addition to the resources available to an aftercare system with regard to the residence of discharged patients is the practice, first, of the establishment of small patient groups in the course of hospital treatment, and second, the discharge of these patients, *as a unit,* to a house, apartment, or other residence in the community. The most thorough study reported to date of this kind of effort is that of Fairweather et al. (1969), at the Palo Alto VA Hospital. They studied a group of seventy-five chronic patients who were moved into a motel (the "Lodge") after a four-week planning period in the hospital, devoted to discussing the potential problems they would face in the community and the possible solutions to these problems. Except for an occasional visit by a staff member on a specific mission, the lodge was completely organized and operated by the patients. Jobs as janitors and gardeners in the community were taken by lodge units, rather than by individual patients; the work responsibilities of a patient indisposed and incapable of working for a brief period could then be assumed by other lodge members, so that the job would not be lost. The living and working arrangements, such as who would do the marketing, the cooking, the bookkeeping, etc., essential for maintaining the lodge, and who would cover which outside jobs, were established by group meetings of lodge residents. The results were extremely impressive: in the first six months, 65 percent of the lodge group remained out of the hospital and 50 percent were employed full-time during this period; in contrast, in a carefully matched control group, 24 percent remained out of the hospital and only 3 percent worked for the full six-month period. The differences between the two groups remained strikingly significant over the thirty-month follow-up period. What is of greatest interest is that there were no significant differences in psychopathological symptoms between the two groups when the patients were studied individually; the symptoms ceased to be disabling in the setting of the lodge. The social structure of the lodge permitted the evolution of an extremely effective system of mutual supports, in which the disability of any one patient, which might have rendered him incapable of coping in the community if he were living alone, could be made up for by others in the group.

Variants of this approach abound, with differing numbers of patients, different patterns of heterogeneity or homogeneity with regard to age, sex and diagnosis, and with different types of residential settings. Reference was made above to the pattern used at the Bronx State Hospital since 1966. Because of the concern of many patients that they may suffer recurrences, they are reluctant to undertake long-term leases on apartments and to purchase furniture. A nonprofit philanthropic corporation, the *Pibly Fund,* undertook to actually lease the residences, pay for the furniture, and collect the rent. Groups of three to six patients, recovered from acute psychotic episodes and disconnected from their families and communities, are brought together on a section of a minimally staffed "hotel ward;" patients are usually, but not always, of one sex and of a narrow age range. When the group is felt ready for discharge they, along with a representative of the Pibly Fund, search out an apartment, purchase furniture, and move out of the hospital. Initially there are daily staff visits to the apartment, but these are rapidly reduced until the new pseudo-family is completely on its own. A total of 106 patients were discharged from the hospital in this fashion to eleven apartments from 1968 to 1972.

Vocational and Social Rehabilitation

Black and Benny" define rehabilitation as ". . . an all-out, concerted, dynamic process involving the use of a variety of professional and technical skills and a variety of community resources to help handicapped people achieve the maximum functioning of which they are capable" (Black, 1969, p. 735). Glasscote et al.(1971) differentiate rehabilitation from treatment on the basis that the latter represents a direct attack on the disabilities of a patient, while the former represents an effort to identify and exploit the patient’s assets to the end of providing the best possible community role; they note: ". . . such facilities as halfway houses to live in, sheltered workshops on special job placements to work in, and social clubs to socialize in are in essence rehabilitating, while after-care clinics and day hospitals are in essence treating" (Glasscote, 1971, p. 15). The matter of a residence *to live in* has been reviewed in the preceding section; the two remaining areas—places *to work in* and *to socialize in*—constitute the principal remaining components of rehabilitation programs in aftercare systems.

In a culture in which, as in the American middle class, a *doing* rather than a *being* value orientation is so dominant (Kluckhohn, 1961), the role of work is preeminently determining of both the way an individual is perceived socially and, pari passu, the way in which he values and identifies himself. It is therefore not surprising that work and training for work have played a prominent role, starting from the earliest programs for the care of the mentally ill. Work for patients was a fundamental component of *moral* *therapy,* and work status has continued to be a criterion for assessing outcome in all studies of aftercare systems which go beyond the simple tabulation of rehospitalizations. Formal programs of *occupational therapy* for the mentally ill were first introduced after World War I; initially limited to diversionary craft training, they began in the early 1930s in England to approximate normal working conditions, and the term "industrial therapy" began to replace "occupational therapy" (Black, 1969) *Work-for-pay* units and sheltered workshops are now a standard component of comprehensive rehabilitation programs, both for inpatients and in aftercare systems. They serve a range of functions, including prevocational screening, vocational training and evaluation, and ego-strength assessment; in addition, for those patients whose disabilities render them incapable of securing and maintaining work in the competitive labor market, they may serve to provide permanent employment. The settings vary; they may be located in a hospital or clinic, or they may be independent. They range from simple bench-type assembly jobs to complex industrial operations which provide training and supervision for a number of semiskilled occupations. A detailed description of a large-scale program, including a stepwise summary of its development and implementation has been contributed by Winick (1967).

Just as was noted above to be the case with halfway houses, the widest and firmest conviction prevails concerning the positive value of vocational rehabilitation, despite the total lack of evidence demonstrating the advantages of such programs in a hospital or an aftercare system. Silverstein (1968), reporting on a sample of the 10,500 patients discharged annually from Pennsylvania state mental hospitals, modified his prestudy hypothesis about the need for a network of vocational training centers and sheltered workshops when he found that ". . . less than 20 percent of the total patients released might have unmet needs in the vocational field." Crisswell (1967), in a summary of projects supported by the U.S. Vocational Rehabilitation Administration, reported that regardless of the retraining procedures used, from 60 to 80 percent of discharged mental patients return to the hospital; of those who remained in the community, 67 percent required continued professional contact. Anthony et al. reviewed a half-dozen studies of work therapy programs and similarly concluded that: ". . . work therapy alone does not increase the patient’s probability of remaining in the community or obtaining employment" (1972, p. 450). Nevertheless, a number of principles enjoy a near unanimous consensus among writers (Black 1969; Glasscote, 1971), e.g., that vocational rehabilitation efforts should begin as early in the hospitalization as possible; that the work provided should be real work, in a real work atmosphere and at real wage levels; and that a widely varied range of jobs should be available in order to provide channels for the diverse talents and interests expectable in a random group of patients.

The situation with regard to social rehabilitation is, again, that without substantive supporting evidence, the widest consensus accepts firmly the value of programs which attempt . . to teach the clients in a variety of ways such things as how to groom themselves appropriately, how to ride on buses, how to get to events on time, how to shop for food, how to plan and cook a meal . . . even if he is still persuaded that his head is full of wires or that his body is full of microphones" (Freeman, 1963). A growing network of freestanding socialization centers has developed, which include, among those best known in the United States, Fountain House in New York City, Thresholds in Chicago, Council House in Pittsburgh, Portals in Los Angeles, Horizon House in Philadelphia, and Hill House in Cleveland. Landy (1960), in an early article, predictive of the concern with social learning and role modeling which was to increase almost explosively during the ensuing decade, called attention to the ways in which the acculturation process of the already socialized patient differs from the socialization of the child: "No matter how deprived he might have been, no matter how asocial a warped socialization may have rendered him, he is not simply facing life *de novo."* Social rehabilitation, in his view, is then a process through which a range of role models serve to provide for the *relearning* of socially appropriate adult-role behaviors. The staffing and activity patterns of socialization centers and patient social clubs depend upon the particular resocialization goals of the program. For example, attitudes of hopefulness, respect, approval, patience, and lack of censure are more important than traditional professional skills if the goal of a center is to develop in patients the capacity for establishing friendships and to provide opportunities for feeling accepted. Hansell and Benson (1971) provide a detailed description of a highly structured aftercare program designed to restore social skills to very long-term hospitalized patients. Bill (1970) reports success with a social club for discharged patients run by volunteers, and David (1971), and Allodi et al. (1972) describe socialization programs organized entirely by coordinating existing community agencies.

A study of an innovative rehabilitation program operated as a school, in which 106 patients attended as full-time students for three months, was conducted by Bauman (1974). The formal curriculum included remedial education (reading, arithmetic, and English), vocational counseling, homemaking skills, familiarization with public transportation and points of interest around the city, and local and national political issues. The faculty was entirely nonprofessional. A careful review of the extensive body of data indicates that both at graduation and at a six-month follow-up review there were significant improvements in social and vocational skills; although no clinical services were offered, there was also a decrease in symptomatology. In the nine-month study period following discharge, 23.4 percent of the students were rehospitalized. At the time of graduation, 22 percent were considered ready for employment, and virtually all of these patients did find jobs, but six months later only half of these patients were working. The data are even more sobering when it is recognized that the 106 patients represented those of the 198 discharged patients who were referred to the program; thirty-four were rejected as too severely ill, and fifty-eight who were accepted either refused to participate or dropped out immediately after beginning.

Specific Treatment Modalities

Studies of the effectiveness of alternative treatment approaches tend not to differentiate between results obtained with an inpatient population and results obtained in an aftercare program. The assumption implicitly made is that a treatment plan which is effective in equilibrating an acutely psychotic inpatient is equally effective in maintaining this equilibrium after the patient is discharged. This is a rather shaky assumption; the degree of control of the total environment of the patient in the hospital is of a totally different order from that in the community, and it is risky to predict the impact upon patients of drugs, individual psychotherapy, vocational and social counseling, and family and group therapy in the context of community life on the basis of their effectiveness in the hospital.

It is abundantly clear that antipsychotic drugs must play a central role in the hospital treatment of chronic psychotic patients (May, 1969). Particularly impressive evidence, because their study was not directed primarily at demonstrating the value of the drugs, was supplied by

Pasamanick et al. (1967) who reported that 77 percent of the patients in a drug-plus-home-care program remained in the community throughout the two-and-one-half years of their study, as against 34 percent in the placebo-plus-home-care program. However, there are disquieting findings which raise doubts about automatic and universal prescription of drugs to all aftercare patients. Brown et al. report that "Drug taking does relate to outcome, but only modestly, and just fails to reach statistical significance . . . drugs appear to have no effect on patients living with relatives rated low on EE, suggesting that medication might serve mainly to protect patients who live with relatives showing a high EE" (1972, p. 25). While the greater value of drugs in the setting of a hostile family may appear reasonable enough, it is difficult to understand this finding in relation to the demonstration of the effectiveness of drugs in the presumably nonhostile, low "EE" (expressed emotion) environment of a hospital (May, 1968). It is even more difficult to account for the finding by Schooler et al. (1967), in a careful one-year follow-up study of a cohort of 299 discharged schizophrenic patients, that "Patients who received placebo treatment in the drug study [i.e., during hospitalization] were less likely to be rehospitalized than those who received any of the three active phenothiazines." (1967, p. 991). The same investigators, reporting about the same patients, also note that "Patients who received phenothiazines and/or psychotherapy after discharge to the community were less likely to be rehospitalized than those who did not." Their efforts to account for the former finding lack conviction, i.e., they suggest that the additional six weeks in the average duration of hospital stay of placebo-treated patients, resulting from the fact that they improved less than the drug-treated patients, led to some "special quality in care, treatment or concern" on the part of the staff. It has not been this writer’s experience that patients who fail to respond to treatment evoke special care from the ward staff.

The role of psychotherapy in aftercare is even more problematic than that of drugs. May, who makes short shrift of any applicability of psychotherapy at all to the hospital treatment of schizophrenia (May, 1968), nevertheless urges all efforts to support the patient and his family at the time of discharge and immediately afterwards (May, 1969). Safirstein (1971) describes an aftercare clinic in which psychotherapy is clearly the principal treatment modality, and while no study known to this writer proposes psychotherapy alone as an effective treatment approach to chronic psychotic patients, there have been a number of reports of psychotherapy in combination with pharmacotherapy. The most carefully controlled of these studies was reported by Grinspoon et al (1968); they demonstrated that, over a two-year period, psychotherapy alone, although conducted by experienced therapists, was without any salutary effect, whereas psychotherapy in combination with phenothiazines was effective in reducing psychotic symptomatology. These authors make the observation that, with only one exception in the placebo population, patients not receiving drugs gave no indication of having established any meaningful relationship with their therapist, whereas patients receiving drugs gave clear evidence that their therapist was important to them. It would appear, contrary to the concerns of some that drugs result in a *chemical strait-jacketing* of patients and their inaccessibility to psychotherapy (Szasz, 1957), that in fact appropriate chemotherapy renders patients who are otherwise unreachable, accessible to psychotherapy.

A crucial difficulty in the evaluation of a program of psychotherapy is the lack of specificity in the variable being evaluated, and this is even more problematic in assessing milieu therapy. May (1968), in a study which demonstrated that milieu therapy was the least effective and, next to psychotherapy alone, the most expensive way to treat hospitalized schizophrenic patients, reports the number of visitors, the number and changes of ward staff and patient population, the number of staff meetings, and a monthly rating of the ward climate (noise level, patient demands on staff, destructive and constructive behavior, interstaff conflict, and the adequacy of the physical surroundings). The contrast between this simplistic assessment of a milieu and, e.g., that of Edelson (1970) could hardly be overstated. May argues that his concern was to provide a milieu which could realistically be replicated in most public mental hospitals; perhaps he is then comparing a fully adequate, sophisticated drug program with a naive and grossly inadequate milieu program. There are, in any event, few studies of milieu therapy in aftercare programs. Guy et al. (1969) report a study of 137 patients discharged randomly into a drug-therapy program or into a day hospital in which patients were afforded both drugs and a carefully devised milieu. In two global judgments, on "severity of illness" and on "degree of improvement," there was a significant advantage to the milieu-plus-drugs program, particularly in the population of schizophrenic patients. However, the rehospitalization rate over the year of the study was the same for the two groups; the drugs-alone group showed a significantly shorter duration of treatment, and, perhaps not really baffling, the drugs-plus milieu group showed a *worsening* of sexual problems (which one might expect to have been brought into focus in discussions at the day hospital).

A particularly significant recent innovation in the treatment of hospitalized mental patients has been the application of learning theory to the clinical alteration of behavior. A growing literature (Atthave, 1968; Ayllon, 1969) reports the effectiveness of a token economy pattern of reinforcing desired responses and punishing undesirable behaviors in reducing bizarre acts and increasing adaptive role performance. There are, however, obvious problems in organizing such programs in community settings; Paul, after summarizing the impressive results in inpatient studies, observes about social-learning therapies that, "Like milieu therapy, the greatest weakness to date has been the failure to include provision for community support and follow-up" (1969, p. 89).

Criteria for determining which patients will respond to drugs and/or individual, family, or group psychotherapy do not exist; indeed, some writers (Levenstein, 1966) underscore the unreliability of predictors of success or failure in alternative treatment approaches. Given the complexity of the interaction among the biological, psychological, familial, and sociocultural determinants of well-being and illness, it is unlikely that firm and dependable criteria for prescribing a treatment regimen for a patient in an aftercare program will emerge in the foreseeable future. It would appear more reasonable to expect that an aftercare system with a broad range of available treatment approaches would be more effective than one with limited therapeutic options.

A Perspective on Aftercare Services

Reference was made earlier to the importance of defining the goals of an aftercare system in a manner consistent with a conceptual approach to mental illness as a manifestation of disturbance at some one or several particular system levels, such as biological, psychological, interpersonal, familial, or sociocultural. Intertwined with but separable from these essentially etiological alternatives is a spectrum of service models, ranging from those— especially medical—models which aspire to *cure* the *illness,* to those—especially educational—models which aspire to *teach* more gratifying adaptational techniques. Patently, the service model, as well as its goals, must be consistent with the conceptualization of the illness of the patients being served, and it is in this context that the issue of models and goals requires explication. What is here proposed is an etiological approach at multiple systems levels, a service model which makes provision for intervention at each level, and the goal of achieving the optimal adaptation for each patient.

The establishment of a service-delivery system, which provides for intervention at several systems levels in the interest of securing optimal functioning of a patient, is hardly strange to medicine. Indeed, a cardiologist would likely be subject to malpractice charges if he did not combine drug, diet, exercise, and lifestyle prescriptions for his patients. Yet, somehow, there appears to persist in the approach of the traditional psychiatrist the expectation that, given only the proper kind and dosage of drugs and/or psychotherapy, all patients should be capable of being cured. One reflection of this is the series of dichotomies noted throughout this report and about which debates continue, namely, an in-hospital versus a community base for an aftercare clinic, high-expectation versus low-expectation programs, a medical model versus a social competence model. All these are not seen as equally necessary options in a broad range of resources for the mentally disabled or handicapped, but as mutually exclusive alternatives. It is a tragic miscarriage of an unrealistic drive to make everyone as functional and independent as we are. A more realistic and humane perspective starts with a view of human behavior as the product of a complex interaction between a biological organism and its psychological apparatus, in the matrix of a family system, within a hierarchy of sociocultural forces and counterforces. When the product of this interaction is of a specified order of deviancy and/or disability, it constitutes *mental illness,* and the goal of treatment may then be more realistically defined in terms of readjusting those elements of the complex interaction which are available to intervention in such fashion as to diminish the degree of deviancy and disability. This view acknowledges the existence of a range of levels of ability and of disability along the spectrum of mental illness, much as we acknowledge a range of levels in other spectra of human variability, and suggests the necessity for a corresponding range of social modalities to provide for the broad spectrum of abilities and disabilities.

There are inescapable consequences to this perspective, perhaps more profound than are immediately apparent. If we accept the likelihood that every instance of psychosis has biological, psychological, and sociocultural determinants, and if we accord equally to the psychotic patient as we do to those of us who are not identified as mad the right to solve his problems as best he can, we are committed to an aftercare system which provides (1) the full range of biological, psychological, and social therapies; (2) the full range of levels of vocational, residential, social, and recreational opportunities, through which a patient may move towards greater autonomy and independence, *or at any of which a patient may rest as optimal for him for* *whatever length of time;* and (3) the fullest coordination of all component elements of the aftercare system, to insure the availability of all to each patient, and to provide continuity of care as a patient moves through the different available levels in the system. Glasscote states the issue in terms of ". . . what we believe to have become a commitment to the mentally ill: not just the privilege but the right to live in the community, and to have as good a life there as possible" (1971, p. 28). Freeman spells out these implications more concretely: "Posthospital service must be dynamic, supervised, and affiliated with other health units without restrictions to the flow of people. Posthospital care means the availability of care as long as needs exist, to the full measure of services, available for the full duration of life" (1971, p. 128). We can continue to evaluate aftercare programs against a set of arbitrary and demonstrably unrealistic criteria of *success* and *failure*, at an awesome cost in human suffering, or we can utilize our experience as a guide to the establishment of a range of residential, vocational, treatment, and socialization resources adequate to provide for the identified needs of perhaps the most oppressed of all our minority groups, the chronically mentally ill.

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