FRANCIS J. BRACELAND

REHABILITATION

American Handbook of Psychiatry

Rehabilitation

Francis J. Braceland

e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 5* edited by Silvano Arieti, Daniel X. Freedman, Jarl E. Dyrud

Table of Contents

Rehabilitation

> The task of medicine is to promote health, to prevent disease, to treat the sick when prevention has broken down, and to rehabilitate the people after they have been cured. These are highly social functions and we must look at medicine as basically a social science (1943, p. 241).
>
> Henry E. Sigerist

To rehabilitate the people after they have been cured" is indeed, as Sigerist says, a highly social function, but it is more than that—it is an essential part of treatment and it has a quality of genuine altruistic concern about it. There are differences of opinion as to the best definition of rehabilitation. Everyone seems to know what it is, yet it is difficult to define. Its underlying philosophy is clear, however, and we defined it earlier as: Based upon humanitarian and practical considerations it is the inherent right of each individual to participate in society to the fullest extent of his capabilities and the advantage to society of his being as self-reliant as possible.

Of itself, the word means to clothe again, and by extension, it means to invest again with some right authority and proper regard for oneself. The semantic meaning is also inherent in the philosophy of rehabilitation, which in essence holds the human being to be entitled to the privilege of his humanness. If disabled, he has the right to be a complete person again and to

be restored as much as possible to usefulness and dignity in the world of his fellows.

Thus the form of rehabilitation considered here deals essentially with the restoration of a handicapped individual to a higher level of personal, social, and occupational functioning. Modern psychiatry has a vital role to play in bringing this about. It can give physicians, nurses, and rehabilitation workers the tools to understand the person and to learn the meaning of his presenting symptoms and their emotional overtones. Thus prepared, no physician is likely to neglect the human aspects of the patient or slight his dignity or his human wants and needs.

Howard Rusk (1963), one of the prime movers in the rehabilitation field, expressed a basic rehabilitation principle when he said of persons handicapped by physical disability:

> A man with a broken back has not been rehabilitated if we spend four months teaching him to walk but leave him with such anxiety that he will not go out of the house. And if we meet this objective and then send him home to a fourth floor walk up apartment where he is a prisoner in his own room the rest of his life, we have done him no great service. Until we have found him a job which he can do we have not fulfilled our responsibility.

By the same token, when a patient is discharged from a mental hospital today he frequently is not entirely recovered. He is referred to community

facilities with the expectation that he will be helped through his posthospital problems and set on the path to employment and independence. This expectation is not always met. Lonely, anxious, fearful, and ashamed, someone will have to see that he gets to the community center, assuming that one is operative. Someone, also, will have to see that he takes his medication and that he does not withdraw and isolate himself, particularly if he has no home or has worn out his welcome in it.

The patient's return to the community, therefore, is fraught with danger. Not uncommonly, he is fearful of relapse. Unless we in psychiatry keep all of these factors in mind and make provisions for follow-up and rehabilitative care, we have done him no great service and have not fulfilled our responsibilities either. Hence the need for inpatient and outpatient rehabilitative care of many descriptions.

History

The history of efforts to rehabilitate the mentally ill and to restore them to a higher level of personal, social, and occupational functioning goes well back into the ages. Various methods were tried—some worthwhile, some unless, some humane, some inhumane—but modern psychiatry began with *moral treatment,* which was, in essence, rehabilitation. It was practiced by those who had compassion on the mentally ill and saw them as members of

the human family, victims of illness and misfortune, rather than the prey of demons.

By means of moral treatment, attempts were made to bring those of the patients' faculties which remained sound to bear upon those which were diseased. It emphasized the value of occupation, education, and social influences, and operated in an atmosphere of high expectation. Early, the moral therapists reported excellent results in cases of recent illness, and though less optimistic about chronic illness they occasionally could announce a restoration to health.

It is interesting that in the past, when the patients were discharged to their homes after hospitalization, stress was laid upon the saving grace of work as a rehabilitative measure. Eli Todd, in 1830, wrote in terms quaint and poignant to a family of a patient about to be discharged from his Hartford Retreat:

> . . . I cannot too strenuously urge the advantage and even the necessity of his being engaged in some regular employment which shall hold out the promise of moderate but fair compensation to his industry and prudence.

Freud, at a much later date, voiced the same sentiments in his *Civilization and Its Discontents* (1930): "Laying stress upon the importance of work has a greater effect than any other technique of living on binding the individual more closely to reality."

Work is equally important in rehabilitative efforts today, and though the so-called "Protestant work ethic" is at the moment under a cloud according to the avant-garde and the young radicals, it nonetheless remains as an important rehabilitative measure. In our civilization, work is what men live by. Man works to earn the necessities of life, to secure its comforts, and to provide for his family. Work helps still the feelings of inferiority that unconsciously beset us. It gains us parity with our fellow men and the acceptance of the community; thus its importance to everyone, well and sick men alike. No matter how humble the task, it dignifies our daily lives. By means of it man may work off his aggressive impulses and ward off his profound feelings of insecurity and helplessness. With work man earns more than a stipend—he earns his self-respect.

We are interested in work here because of its rehabilitative potential. Glasscote and his colleagues would say, however, that while this emphasis on employment is fine, some people are not able to work, they are too old or frail, or too disordered mentally; but they state that this in itself does not necessarily mean that they must be hospitalized. "With some help they can meet the day to day demands of community living without harm to self or others" (Glasscote, 1971). Olshansky thinks the role of worker is the easiest one for expatients to fill, it is the most structured. Also, he thinks, even some of the sickest ex-mental patients are able to work. Olshansky asks: Why do expatients work? (1) To acquire self-esteem in their identification as workers

and in functioning in an approved adult role (becoming self-supporting is important in our culture); (2) work is a way of shedding patienthood; (3) work provides a means of denying illness and avoiding the threat of hospitalization—"it proves wellness;" and (4) work provides an opportunity to have something to do (Olshansky, 1968).

Moral Treatment

In our country it was the advent of private mental hospitals in the first few decades of the nineteenth century that showed the way to improve the lot of the badly treated and poorly understood mentally ill patients. The method practiced was known as *moral treatment.* Moral treatment had never been defined, because—as Bockoven, an authority on the subject, stated—its meaning was self-evident, i.e., "compassionate understanding treatment, even for those whose illness was thought to be due to willful and excessive indulgence in the passions" (Bockoven, 1956). Unfortunately, the fine balance which permitted moral treatment to flourish in those early decades was later to be disturbed as large numbers of impoverished mental patients arrived from foreign lands and inundated the hospitals. Moral treatment perished in that flood. It raised its head cautiously again in new guises, in recent times in the form of "milieu therapy;" but the excitement it created in the early nineteenth century has never been recaptured. The cult of incurability gradually made its appearance and for a long time the public forgot about its

sick citizens incarcerated in large monolithic institutions.

As mental hospitals grew larger, more numerous, and more crowded with chronic cases, moral treatment had to be abandoned. Beyond protecting itself against acts of the insane, society took little but a remotely horrified interest in the mentally ill. It was believed that once the doors of the asylum closed upon a patient, he would never emerge again. This belief was well founded because the patient's illness was usually chronic by the time he was committed.

There were cautious modifications of this outlook early in this century as dynamic psychiatry was making its way upon the scene, but even then little could be done about overcrowded, understaffed, and isolated institutions. It was not until the 1940s that any real hope was kindled. This was the time that insulin shock and convulsive therapies appeared upon the scene. Like all new therapies, they brought with them exaggerated hopes which, while never quite completely realized, did encourage physicians and roused psychiatrists from their discouraged attitude.

World War II Developments

The holocaust of World War II brought new insights into the treatment of the physically and mentally ill. New rehabilitative efforts arose perforce. Men with spinal and head injuries, heretofore given up as lost, were brought

under treatment, achieved a modicum of recovery, and the modern science of rehabilitation of the sick and injured was initiated. Psychiatry benefited by the fact that for the first time large numbers of clinicians were in the field and in bases throughout the world accompanying the fighting men. The value of drug-facilitated abreaction was learned at the time, as was the value of immediate first-aid treatment for emotional disorders administered close to the front lines. This proved later to be of great value in the Korean War episode, and it greatly reduced the number of psychiatric casualties who returned as invalids. Group therapy, necessary because of the large number of patients requiring treatment, began to prove its value.

Several other events in World War II indicated that the mentally and emotionally disordered could under necessity respond well to the stresses of their environment. When the German army invaded France, a substantial number of patients at Charite-sur-Loire left the hospital without permission and were able to find lodging and employment for themselves. In England at Croyden Hospital (Jaeggi, 1963) bombs demolished the structure and material to repair it was not to be found. The patients were adrift, but there were none of the dramatic consequences that might have been anticipated. These and other incidents led British psychiatrists to embrace the concept of the open-door hospital and to play a leading role in the therapeutic community movement.

The concept of "therapeutic community" soon found wide acceptance and was featured in the Third Report of the Expert Committee on Mental Health of the World Health Organization, published in 1953. Its implementation was already apparent in the statistics of some hospitals before the tranquilizing drugs came into general use in 1955, which is usually cited as the year of revolution in patterns of psychiatric care. It was also the year which marked the real beginning of the declining annual statistics for the mental hospital population, as it did for the greatly diminished incidence of disturbed and regressive behavior. In that same year, the United States Congress passed a Mental Health Study Act directing a Joint Commission to make recommendations for a national mental health program. The final report of the Joint Commission on Mental Illness and Health in 1961 then inspired the new movement toward Comprehensive Community Mental Health Centers advocated by President Kennedy in his message of February 1963.

In England, meanwhile, continuity of care, community-care, and aftercare programs also received official endorsement in the Mental Health Act of 1959. For the notion of chronic mental patients, which is ambiguous and which lifts responsibility from society, was substituted the notion of the mentally handicapped which implies a positive factor in the person invalided by a mental illness.

Thus, the philosophy of treatment of psychiatric patients has changed. There is increased emphasis on community care as compared to hospital care, a leaning toward social definitions of mental disturbances, as well as intrapsychic definitions on the strengthening of the continuity of care and the rewarding of innovative as opposed to traditional programs. The development of social rehabilitation programs for ex-mental patients is one of the outcomes of this changing philosophy.

Mental health leaders today also teach the philosophy that mental illness is an episode in life, rather than a person's manifest destiny, and hospitalization is, therefore, also an episode and one which should be kept to a minimum. The patients' rehabilitation is, or should be, a continuous process in, as well as out, of the hospital, and the patients should move in graded steps from one transitional setting to the next until recovery.

All too often the mental hospital presents a highly abnormal social structure. The view is prevalent that it is improper to rely primarily on diagnostic labels in treating and releasing patients; nor is it always proper to keep the patient in the hospital until he has lost all his symptoms. As soon as the florid symptoms are suppressed or under control, it may be advisable to return him to the community, provided, of course, that aftercare services are available. Patients who can be saved should not be overlooked in the chronic population of the hospital either. A goodly number of these patients no longer

belong in the hospital; if possible, they should be weaned from their dependent way of life and made self-supporting. An underlying assumption seems to be that society soon will have to raise its threshold of tolerance for deviant behavior, like it or not. These are the present-day trends; whether they will prove to be wise or otherwise remains to be seen.

Rehabilitation in psychiatry, therefore, has broad connotations unfortunately, often somewhat vague. The various definitions given generally reflect the doctrines of their proponents. Commenting upon the diversity of definitions, Freeman and Simmons were able to find one basic agreement, namely, that the successfully rehabilitated patient is one who is able to live in a nonmedical setting at a level of occupational and social performance comparable with that of other adults in the community (1963).

Rehabilitation further implies that there is a need to remove or reduce a handicap. It is only when the individual retains vestiges of his illness that care needs be taken, lest he find security only in his return to the hospital. Not only must he cope with the end product of his illness, but his family and friends must be able to tolerate his foibles. It is upon this that his tenure in the community depends. Failure to adjust satisfactorily only too often means the beginning of the "revolving-door" readmissions to the hospital.

Treatment versus Rehabilitation

It is difficult to draw a sharp line between treatment and rehabilitation in mental disorder. Treatment is directed toward the symptoms leading to distressing or socially upsetting behavior, while rehabilitation emphasizes those social and vocational skills that diminish the liabilities and obscure the handicap. Treatment aims at correcting the illness, whereas rehabilitation aims at restoring the patient to his social and employment roles.

Greenblatt views rehabilitation from the standpoint of total treatment, and under psychological rehabilitation he includes measures that reduce or remove disruptive anxieties and neutralize intrapsychic conflicts (1963). Walter Barton finds no sharp line between treatment and rehabilitation since they proceed simultaneously from the beginning; but he does make the distinction that treatment is directed toward the primary problems, whereas rehabilitation emphasizes readjustment and the development of social and vocational skills that diminish the liabilities and overcome the handicap (Barton, 1962).

Barton is critical of the activities program of many public hospitals and believes that preparation for real life is not made possible through a program of handicrafts and games. The fact that unskilled laborers and working class men predominate among state hospitalized patients makes it necessary that a more practical type of program be instituted. "The change to a useful work program and to a leisure time schedule likely to be practical later on," he

notes, "should come as early in the program of therapy as the patient can manage it" (Barton, 1962).

As the patient prepares to leave the protection of the mental hospital for the uncertainty of a sometimes rejecting and hostile world, he must be well prepared for the difficulties he will encounter. This is why the program should start early and continue throughout his hospital stay. Failure brings risk of isolation and loneliness, and perhaps accelerates his early return to the secure but unnatural protection of institutional life.

Maxwell Jones says that rehabilitation is the attempt to provide the best community role which will enable the patient to achieve the maximum range of activities compatible with his personality and interests and of which he is capable (1952). Bellak and his associates submit that the major task of rehabilitation is the reconstruction of the patient's ego strength so that he can be made mentally fit and ready for work and able to cope with the emotional and interpersonal factors in starting and continuing the job (Bellak, 1956). One of the major purposes of rehabilitation is to restructure object relationships to help the patient adapt more realistic and objective ways of thinking and acting and to acquire useful social and occupational skills.

In-Hospital Rehabilitation

Necessarily, the prime purpose of mental hospitals and the main reason

for their existence is the treatment of patients who are mentally ill. Were it not for this, there would be little reason for their being. There is no reason to list here the illnesses treated in these hospitals, nor the methods of treatment involved. Suffice it to say that the overall efficacy of treatment plans depends to a large extent on the atmosphere of the individual hospital and the interpersonal and intergroup transactions which take place within. Studies of mental hospitals have revealed the crucial roles which leadership and individual workers play.

Russell Barton has identified a syndrome among hospitalized patients characterized by apathy, withdrawal, resignation, and loss of individuality. Contributing factors to this *institutional neurosis* are loss of contact with the outside world, enforced idleness, authoritarian staff, loss of personal possessions, oversedation, depressing surroundings, and loss of prospects for the future. A therapeutic atmosphere can only be created by what Barton calls "people concepts" (happiness and comfort of patients, morale and efficacy of staff and personnel); these should be as important as "object concepts" (number of beds, number of doctors, etc.; 1963).

In a conference in 1970 on rehabilitation of the mentally handicapped, Donald Miles (Hospital and Community Psychiatry, 1971) presented evidence for and against basing rehabilitative efforts in hospitals rather than in the community. In favor of hospital-based rehabilitation programs are (1) space

available as the census lowers; (2) the population of the hospitals is homogenous and the program can be tailored to fit; and (3) adequate clinical and support facilities are readily available. Against hospital-based rehabilitation programs are (1) the patient's behavior in the community cannot be predicted from his hospital behavior since coping behavior does not transfer readily to the community; (2) patients' stay in hospitals is usually not long enough to learn adaptive behavior; and (3) Miles believes that not all patients are helped by certain rehabilitation programs. Others agree with him and opt for more workshops and incentive programs in the community. Whatever opinions may be expressed, one thing is certain, namely, due to the inexorable march of time, and hopefully progress, *the scene has changed markedly since the late 1960s and rehabilitative efforts on a large scale have shifted and still are shifting to programs based in the community.*

The Therapeutic Community

The therapeutic community concept is an important factor in the treatment of in-hospital patients. Its importance is lessened only by the above mentioned present-day rapid discharge from hospitals to community programs. In other words, the present-day trend seems to be more toward short-term crisis oriented therapy in the hospital, rather than to longterm rehabilitative efforts. The value of the short-term hospital stay, if that is all that is required, is obvious.

The therapeutic milieu[1] is based upon a number of interacting factors and made essential by the fact that in the old hospital regimes patients lost their identities and their individuality, and thus were reduced to anonymity. The first necessary step to correct this was to establish a good relationship among people, beginning with the hospital director and filtering down through the staff and the various hospital employees. The possibilities of rehabilitation are lessened by inadequate liaison between different members of the treatment team, particularly between the professional staff and the employees who are on the wards with the patients most of the hospital day. The therapeutic possibilities of the nursing staff are only now being recognized fully. Their potentialities were always known, but generally too little use was made of their skills. Each encounter between nurses, aides, and patients, like those of the physician, can be either psychonoxious or psychotherapeutic.

The possibilities inherent in these various forms of social therapy received their greatest impetus in and following World War II. They rested upon the observation that certain types of emotional ills were the result of disturbed interpersonal relations and operated upon the belief that the culture of a hospital or a ward could be used deliberately to assist the individual by group experiences and social influence. The medium used is frequent group meetings, made up of ward doctors, nurses, social workers, occupational therapists, the patients themselves, and everyone involved in

their care. The group meets daily in open discussion to informally consider ward happenings, personal grievances, personal relationships, tensions, and misunderstandings. The preservation of the patient's dignity is thus bolstered. He is given to understand that he is important and responsible, and that he can be trusted. Personal problems and misbehavior are treated as communal responsibilities and are analyzed and interpreted, usually in psychodynamic terms. A consensus then is sought so that difficulties can be resolved by group influences and pressures. The way the ward operates is influenced greatly by these group meetings and they constitute the main area for the interchange between patients, physicians, and caretaking personnel.

Necessarily, the staff must meet on its own and a certain amount of unity of approach is required. Physicians and nurses are expected to assign rehabilitative measures and duties to the various categories of helpers and the staff should be taught to deal with its own anxieties. Though the physician is usually in charge at staff meetings, reliance must be placed on the nursing staff for transmission of the culture or group climate of the unit.

The preservation of the patient's individuality is thus an extremely important characteristic of the therapeutic community. The day is past when idle, neglected, uncared for patients may be confined in locked wards. This is intolerable. To deprive patients of their small personal possessions and reduce them to nonpersons is to alienate them further from society. All too

often in the past the only thing the patient was left with was his delusional system. The patient must be recognized as a person, not a case, and his self-esteem must be cultivated if he is not to withdraw.

It stands to reason that in a well-run hospital most patients can handle themselves properly and that only a few require to be behind locked doors. Symbols of incarceration, high walls, iron bars, and keys jangling have done more harm than good in the past.

The rehabilitation process depends upon sustained living experiences with people who are mature, kind, and understanding, and who do not reject the patient. Over-permissiveness is as destructive as over-protectionism, however, not only because of its malign influence on morale but also because it is not proper preparation for what the patient will encounter when he leaves the hospital.

Thus, the therapeutic community is a reasonable situation in which activities abound and where diversification is sufficient to interest persons of different bent. Helpfulness and understanding are the watchwords, responsibility and initiative are expected and respected. It is necessary to present most patients with simple steps en route to more complicated ones, with a reliable work program as the ultimate goal.

Other In-Hospital Activities

Upon admission to the hospital, the patient's interests and potentialities should be assessed. The change to a useful work program and to the constructive use of leisure time likely to be helpful in the future should come as early as possible. All too often the patient has no avocation and, perhaps just as frequently, he is not interested in his daily work either. To encourage him to develop a new interest or to take new interest in old skills is an early and important step in the rehabilitation process.

The continuing education of young patients who are hospitalized is of the greatest importance to prevent further widening of the distance between them and their peers outside the hospital walls. Toward this end, several first-class hospitals have opened regularly established high schools in which the patients are enrolled as bona fide students, attend classes, receive grades, and are granted credit toward a high school diploma and college admission. This is a remarkable step forward. The patients learn while being helped with their emotional problems, and education becomes a valuable part of their therapy.

Correspondence courses for adults, some leading to college or industrial-school credits, are also in vogue. State and municipal education authorities are usually anxious to help. These courses are in addition to programs of music, art, handicrafts, theatre, and reading which have long proven their value, as every mental hospital director can attest. Some patients

discover that they have hidden talents or skills and developing them improves their personal image and advances their recovery.

Patients who exhibit special skills are often enlisted to help teach others, and thus may acquire a new status which in itself is therapeutic. Volunteers can help in the teaching of dramatic arts, music, shop work, and in conducting discussion groups; their particular value often lies in the fact that patients see them as people from outside the hospital, not part of the paid establishment, who think enough of them to come in and give of their service.

It has long been recognized that idleness is demoralizing, but earlier forms of occupational therapy were often dull and stultifying. Patients either tired of them soon or did them mechanically, simply passing time without therapeutic benefit. All of this is now seen in a different light. Interesting work therapy, which relieves tension and anxiety, serves, in addition, to increase socialization and fulfills certain instinctive drives. It caters to the needs for activity and has the possibility of bringing recognition and approval.

More and more, as the length of hospital stay in the acute admissions group is shortened, patients progress rapidly from the ward and occupational therapy shop into real situations. En route, they should learn proper attitudes toward authority, turn their attention to personal appearance, and, under the acceptance and approval of their teachers, acquire new respect for

themselves. The chronically ill require much longer periods before a satisfactory work level is reached.

In many hospitals work programs are instituted in conjunction with industrial firms. The patient is put on employee status and held to acceptable standards of performance. The patients thus employed in English hospitals receive rates of pay comparable to those outside of the hospital. In our own country the rates are lower, but are sufficient for the patient to pay something for his "board and keep" and even retain some earnings. The prestige that accrues to these patient employees is ego building and eventually the skills learned may help secure employment when the patient leaves the hospital.

Landy and Griffith, in a study of employer receptivity toward psychiatric patients, observed that when the patient does not have to find his own job and it is secured for him, he either fails to get the job or to hold it (1958). Readiness to hold a job, therefore, may be judged by the degree of initiative the patient shows in looking for work. One department store manager in a New England town informed a hospital staff member that he "would not know what to do without the help of the hospital patients at Christmas time." Interestingly, some of these patients never worked for wages before.

Rehabilitation in the Community

Let us consider the following statement from the report of the Joint

Commission (Joint Commission on Mental Illness and Health), published in 1961:

> . . . aftercare and rehabilitation [are] essential parts of all services to mental patients and various methods of achieving rehabilitation should be integrated in all forms of services. Among these services should be day hospitals, night hospitals, aftercare clinics, public health nursing services, foster family care, convalescent nursing homes, rehabilitation centers, work services, and ex-patient groups. . . . It is important that rehabilitation be regarded as a part of a comprehensive program of patient services in which each and every member of the mental health team has a part to play. [pp. 270-271, 272]

Transitional Stages

In the present progressive climate in psychiatry, the prospects for the patient's recovery from mental illness are viewed with much greater optimism than ever before. As patients leave the protective environment of the hospital there is frequently a need for an intermediate, or transitional stage in the form of partial hospitalization. Night and day hospitals were instituted for this purpose.

We have already considered the night hospital in relation to the patient's extra-mural employment while still an inpatient. The day hospital is one step further on the recovery path. In addition to its role as an alternative to full hospitalization, the day hospital is an excellent aftercare rehabilitation facility. In it the patient can reap the benefits of continued psychiatric care

and at the same time maintain ties with family and the community. These adjunctive rehabilitation units have grown in popularity since the 1960s. Most good hospitals have such facilities, and, in addition, independent day hospitals, not linked to a mother institution, have appeared on the scene. Such installations also seem to fit naturally into the general hospital and psychopathic institute picture.

One important stimulus to the growth in numbers of these facilities is the fact that in order to qualify for federal funds granted by the Department of Health, Education and Welfare under the Community Mental Health Centers Act of 1963, each center must include provisions for a day-care facility. This provision understandably has caused a noteworthy increase in the number of such facilities. Day care has by now become firmly established in various countries throughout the world as a significant psychiatric service, and in several countries, beside our own, provision for them has been written into the law.

The first modern psychiatric day hospital is said to have been organized by M. A. Dzhagarov in Moscow in 1933. Most of the Western World heard about the concept, however, through the establishment of a facility in Montreal by Ewen Cameron in 1947, and by Joshua Bierer in England in 1948 at the Institute of Social Psychiatry.

Glasscote (1969) notes that British clinicians wished that the professions in the United States ". . . would adopt the English practice of delineating day programs as either day hospitals or day care." He quotes the British psychiatrist, Douglas H. Bennett, who states that "a day hospital is a program in which every form of treatment that could be provided in a psychiatric hospital is available, while a day center is independent of a hospital and provides social and occupational services plus limited medical supervision."

Bierer, who launched the day-hospital movement in England, had different ideas. He would limit the term "day hospital" to independent structures which were hospitals in their own right—not a part of another institution—and which would admit every kind of patient. It would replace the mental hospital in his scheme and provide every kind of treatment available to modern psychiatry. These definitions and requirements did not meet with wide support either in England or in the United States.

No matter what the connection with other institutions or lack of them might be in this country, Kramer (1967) sees certain issues of universal concern in their operation, albeit to varying degrees. These, he states, "include short-term versus long-term care; the degree of administrative control over admissions; staff initiative versus patient initiative; and finally the collaboration between the staff of the day care center unit and the

psychiatric inpatient service in the hospital to which it is affiliated.

. . . The unit's approach to these issues will give shape to its program and determine its function in the community." He sees a critical requirement for the successful operation of these units to be a quick and easy access to an inpatient bed when the need for it arises.

As to treatment procedures in day-care facilities, they differ markedly in accordance with the governing philosophy, the size, and the location of the units. All provide, in some fashion, medical treatment, psychiatric care, occupational therapy of some sort, socializing activity, and various other routines. Whatever their particular approach may be, the primary task of the unit is to create a therapeutic milieu so that the environment of itself may be of benefit to all the patients concerned.

As to the results of treatment in these centers, there is no doubt that they provide an easy transition to life in the outside world for some patients. The general belief is that this is one of their primary functions. The value to the patient in maintaining community ties as a rehabilitative measure is definite. The answer to the question whether partial hospitalization is better than full hospitalization depends upon the patient, the illness, and the availability of first-class centers and hospitals.

In a controlled study concerned with day versus inpatient

hospitalization, Herz and his colleagues report that for those patients for whom both treatments are equally feasible clinically, newly admitted patients from the catchment area were randomly assigned to either day or inpatient facilities. In the evaluation, including measures of psychopathology and role function seen at follow-up intervals, the authors found clear evidence of superiority of day treatment on virtually every measure used to evaluate the outcome (Herz, 1971). Glasscote and his associates warn that it is "important to recognize that day treatment may denote either a service unit or element, or merely a patient status." The latter is the case, he says, when day patients come into the inpatient service and join the program taking place there (1969).

Halfway Houses

As the rehabilitative efforts for patients with emotional disorders have reached further into the community since World War II, there has been an impressive increase in the number of community residences known as halfway houses. These transitory residential centers serve to meet the needs of patients discharged from mental hospitals for a temporary residence in which to make a readjustment to social life and employment in the community. They attempt to maintain a climate of health rather than illness and to develop and strengthen normal capacities and responsibilities.

Though the British began with their "hostels" in the last century, there were only about ten halfway houses in the United States in 1960. When Raush and Raush made their survey in 1963, there were approximately forty (1968). When Glasscote, Gudeman, and Elpers made their survey in 1969, 128 were located, more than half of them having been established from 1966 to 1969 (1971, p. 1). They believed that this new locus for serving the mentally ill, "considered little more than a curiosity a decade ago, carries the promise of becoming a major consideration in the continued redirection of mental illness services during the years immediately ahead."

While there have been a number of definitions of halfway houses in the past decade, Glasscote and his colleagues propose one of their own:

> A halfway house for the mentally ill is a nonmedical residential 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. 1).

(They say "nonmedical residential facility" meaning that the medical involvement "should be only of consultative and backup nature" in the venture.)

Halfway houses are not always welcomed with enthusiasm by the residents of various communities. Local officials and citizens do not quite know how to regard them. Their initial reaction is frequently unfavorable.

Town meetings, zoning laws, and citizens' groups have been called into play to keep out these "unwarranted intrusions on neighborhoods" which, the residents are sure, would lessen the value of their property or even endanger their personal safety and that of their children. Much depends, of course, upon the way in which the concept of these houses is presented to the neighboring citizens. With diplomacy and tact, the citizens can be brought to see that the centers will be community assets and opportunities to help restore sick fellow citizens to health at less cost and with less human suffering than if they would be consigned to large state hospitals. The ideal situation, of course, would be to have a nonprofit house or hostel with a board made up of interested citizens. The patients' stay in halfway houses varies from a few months to a year or more and depends upon many factors. Most see them as way stations in which residents are gradually prepared to live in the community independently.

It used to be necessary to keep patients in state hospitals, even after their symptoms had abated, because there was no other place for them to go. Now a number of these individuals can be treated in day centers while they live in halfway houses. This should be a slow and painless way of returning to a full life in the community. Some centers, under lay auspices, include ranches and farms in rural settings where work projects, outdoor living, and planned recreational programs are offered. Glasscote and his group believe that these centers could also offer a more or less permanent placement for people who

no longer need be in hospitals yet have no potential to live in the community or be employed without special supports. As a good example, they mention Cobble Hill Center in Brooklyn (Glasscote, 1971, p. 22).

The typical community halfway house, however, is either a large, old house donated for the purpose, or even a boarding house already in operation. Generally, it will be staffed by employees, some acting as house parents, or even an interested and altruistic owner. Ordinarily the house is operated on a nonprofit basis, the staff is relatively constant, and decisions regarding policy and changes in policy are made within the group. For the most part there are no written laws but consensual rules are in force. Any infractions of the rule are usually handled by group pressure, but if necessary a staff member intervenes. Most of the halfway houses place a time limit of a few months up to a year upon their residents but this is not strictly enforced. Hopefully within the time mentioned, the residents will have made strides toward establishing some form of independent living.

The unfortunate aspect of the halfway house concept is the small number of patients that they can accommodate. Even if all of the more than 200 halfway houses accepted only mental patients, and if each one accommodated fifteen patients (many accommodate fewer), there still would be only a small fraction of the more than half-million patients still in psychiatric facilities who could be accepted, when ready, for a trial outside

the hospital. The big contradiction in this statement is to be found in the fact that not all of the large number of patients in the hospitals would be capable of living in these community houses and another large number would not need this transitional facility.

As to the programs followed, there are no set standards and each differs according to its purpose, its census, and its staff personnel. Some are high expectation centers (Wiler, 1968) where the residents must work or attend a class; others are of intermediate expectation with residents enrolled in a day program or in some way active in the community. The objection to liaise-faire centers with no program lies in the fact that they are in danger of becoming "mini state hospitals."

A variant of the halfway house is the use of subsidized apartments for recently discharged psychiatric patients. The best known and the first psychosocial rehabilitation center to be established in the United States is Fountain House in New York City (Fisher, 1960). It is one of the largest installations of its kind; another is Horizon House in Philadelphia. Both offer comprehensive programs. From its attractive six-story headquarters in mid-Manhattan, Fountain House provides an impressive array of social, vocational, and residential services to many hundreds of persons with a history of mental illness, in a program that operates every day of the year (Glasscote, 1971).

Begun modestly by expatients in the early 1940s due to their mutual needs, Fountain House soon attracted the attention of altruistic individuals and the center has grown apace. Eventually, after a successful fund-raising campaign, the present headquarters were constructed at a cost of approximately two million dollars. Its various units are supervised by social workers and visited by volunteers. There is a day center and a program of transitional paid employment, and it has helped its residents by reaffirming a sense of belonging and of being needed. Staff members participate side by side with the residents in all of the daily happenings and events which are comparable to those which take place in the household of a normal family. The staff is not interested in the patient's pathology or in their background, but rather "in teaching them what they need to know and giving them the supports they need to work with, to live in the community and to have a decent kind of life" (Glasscote, 1971).

In Philadelphia, Horizon House is a combination residence and day center. Council House in Pittsburgh is a unique facility in that it does not have a residence of its own but rather it utilizes a variety of community facilities. It began modestly in 1957 as an ex-patient club and it has grown substantially ever since. Its purpose has remained the same, however—namely, to provide educative and membership experiences to patients who have had serious mental illnesses. There are a variety of other residential houses and clubs for discharged patients where professional workers give supportive counseling

and assist residents in finding employment. There are also residences in which expatients live with those who have not had mental illnesses; for example, a house in Cambridge, Massachusetts, which accommodates expatients and volunteer Harvard and Radcliffe students.

Not all observers are sure of the usefulness of halfway houses, and admonitory voices have been raised by some knowledgeable individuals. Walter Barton is among those who wonder whether these way stations are really worth the expense entailed. Data so far available does not show a significant difference between the rehabilitative successes of the halfway houses and the programs associated with direct placement in the community (Barton, 1962). Admittedly, however, this situation is hard to evaluate. In the balance, at the present moment, the houses seem to the casual observer to be worthwhile.

Russell Barton warns of the danger of developing chronic hostel patients and wonders whether the size of the hostel is apt to become a compromise between what is clinically desirable and what is economically expedient, with the hostels eventually proving to be "white elephants" (1963). Cooper and Early warn that the patients, unless care is taken, may simply exchange one institution for another. They believe the stop should be only one of *transition* en route to a normal life (1963). It does seem, however, that the hostels are on the way to accomplish the purpose for which they

were organized. It seems likely, also, that halfway houses will continue to grow in number, not only because of the help, the protection, and the transitional steps which they offer, but also because of the fact that at the moment state and mental hospitals in general are in disfavor.

Occupational Rehabilitation

Community programs for occupational rehabilitation are provided for in the United States under the federal-state rehabilitation system, job placement agencies of various sponsorship, and the sheltered workshop programs. In 1971 the National Association of Sheltered Workshops estimated that of the 1300 workshops in the United States, one thousand accept people with a mental-illness diagnosis, but that relatively few are for mental patients exclusively. Unfortunately, there is even evidence that a number of workshops have resisted the acceptance of mental patients for a variety of reasons.

Exclusionary activities in sheltered workshops, as far as mental patients are concerned, are unfortunate, for many patients might do well to participate in all activities. They offer an orientation to work, and with work as we have seen comes the acceptance of an individual which he needs badly. The earning of money and the example of others laboring under difficulty seem to help patients who have been confined to mental hospitals; it is estimated that

approximately one-third of them can eventually become self-supporting. Ideally the workshop should be structured to approximate the work set-up in the normal world in work hours and in at least partial reward of the workers.

Altro workshops in New York, a part of the Rehabilitation Center for Chronic Relapsing Illnesses, began admitting psychiatric patients nearly a decade ago. There the mental patients are mixed with the physically handicapped and a cadre of normal employees, including supervisors and instructors. Host to approximately fifty psychiatric patients, on any given day, the workshops are in close collaboration with Rockland State Hospital, the New York Departments of Mental Hygiene and State Education, along with the Office of Vocational Rehabilitation.

The largest of the workshops appears to be the one connected with the Brockton Massachusetts Veterans Administration, which was started in 1961. Called Chirp (Community Hospital Industry Rehabilitation Program), it offers a diversified program of sheltered work and educational and manual arts therapies. It is based on the principle of most such endeavors and its purpose is also to make transition to autonomous community life easier for the patients. The patients are paid and a diversified group with varying diagnoses takes part in the program. The concept has spread to other veterans hospitals and the working conditions are similar to those in factories in normal life. In the first four years, 1400 patients went through the program; only 115 had to

be readmitted to hospitals (Winick, 1967).

Special workshops are also run by the Goodwill Industries. First established in 1902, this is probably the largest national network of such endeavors. All 141 workshops of the national programs now accept people who have a history of mental illness. Although in 1969 the Goodwill Industries estimated its workshops were servicing about 24,000 people per day and restoring 7000 of them to the competitive labor market, they were unable to estimate the portion of those serviced and restored who were mental patients.

It is a special advantage of the sheltered workshop, according to Russell Barton, that it tests work capacity without estranging the employer who is, of necessity, concerned primarily with production and profit rather than with public and social welfare.

Expatients Clubs

Expatients clubs, which have come into prominence since 1937, also serve as a transitional rehabilitation resource between the hospital and life at home and in the community. Originally formed by the patients themselves, some hospitals followed suit and organized comparable clubs as part of their rehabilitation programs. It is difficult to even estimate the number of such clubs or the numbers formed by hospitals, citizen groups, or the patients

themselves. Most of the clubs are supported by the members dues and whatever outside assistance they can muster.

The largest and perhaps the oldest of these organizations is Recovery, Inc., which was organized by Abraham Low of Chicago in 1937. It has perhaps 5000 members in various categories and exists in approximately twenty-five states. These groups are intensely loyal to the precepts laid down by their founder and to one another. Undoubtedly this form of socialization and group spirit does a great deal of good for the club members.

Bierer in London inaugurated a therapeutic social club in 1938 and believed it to be an important step in the direction of the therapeutic community. Run by a committee elected by the patients, the club is an integral part of the treatment program of London's Marlborough Day Hospital, with the psychiatrists serving as advisors. A number of similar clubs sprang up in small towns, and subsequently comparable therapeutic social clubs for outpatients were opened in the London area.

The same situation obtains in the United States. Many expatients clubs are based in small cities. All seem to have the same function, but some are directed toward the purpose of particularly helping schizophrenics, while others are for older age groups. It is impossible to estimate the number of these clubs. One famous club was Club 103, attached to the Massachusetts

Mental Health Center, which has now given way to Wellmet Houses, run by students and other interested parties with a minimum of supervision.

Much depends upon the leadership and the orientation of these clubs. Well directed, they are potentially helpful in overcoming the isolation and the loneliness of the members and in preparing them to meet the stresses of everyday life. Should they fall into the hands of paranoid leaders or under the control of a "hard-core" group of expatients, however, there is bound to be trouble. Such groups lose their usefulness by quarreling with authorities and with one another.

Foster Family Care

The practice of placing mental patients in selected foster homes is an ancient rehabilitation practice that remains valid in the twentieth century. The philosophy of family care is based upon humanitarian, economic, and rehabilitative considerations. It is assumed that chronically ill patients may live a more normal life in a foster home than in a mental hospital, that foster family care serves as a bridge to eventual community placement, and that it is less costly than hospital care and reduces the overcrowding in mental hospitals.

Foster family care started in Gheel, Belgium, centuries ago, and today a large segment of Gheel's inhabitants are mental patients. Some work and

show little evidence of illness; others are obviously ill. These patients are visited regularly by a nurse and are returned to an inpatient center when treatment of some kind becomes necessary. Germany and France use the foster home plan on a limited basis; Norway uses it extensively. In the Netherlands a program of foster care centered around an active treatment program in a day hospital, which also serves as an inpatient 100-bed unit, is conducted in the rural community of Beilen (Barton, 1961).

Foster family care in the United States goes back very far; in colonial times some communities auctioned off distracted persons to the lowest bidder to be "boarded" and put to work. Flagrant abuses emerged from this practice and it had to be given up. In many cases it amounted to bondage. In recent times the foster home plan has been used to some extent, especially in the state of New York, but only since the 1960s has its growth been noticeable.

The selection of a foster home depends on the presence of a desirable domestic atmosphere, with benevolent parent figures, harmonious and cooperative relationships, and the apparent tranquility and cheerfulness of a home which can withstand emergencies. A patient should not be placed above his social level or in a home with standards of order and neatness much different from his own. Unsuitable for foster home care are problem patients, such as the aggressive and potentially violent, the suicidal, the sexually

deviant or alcoholic, and others with nuisance characteristics. According to Walter Barton (1961), one social worker can carry about forty patients in family care. Home visits may be made by the psychiatric nurse, in which case the social worker may specialize in selecting homes, training the caretakers, and placing patients ready to move from foster family care elsewhere. Patients remain under the medical supervision of the hospital. In some programs the services of a local physician are engaged for routine medical attention.

The results of foster family care are encouraging. Although many patients have to be returned to the hospital, many are able to remain in the community, with a substantial proportion moving on to full independence. Unfortunately there are a number of barriers to the expansion of these programs, such as a shortage of space in the modern family home, an economy in which taking in boarders no longer has much appeal, and a scarcity of professional workers to develop the program.

Family Care

In the present climate of administrative psychiatry patients are returned to the community whenever and as fast as possible. As soon as florid symptoms are suppressed or under control, the discharge apparatus is set in motion. Even among the chronic cases, candidates for release are found by

enthusiastic rehabilitators. The justification for discharge is often based upon social grounds but it is often done without much foresight. Hospitals presently seem to be vying with one another for the record of the shortest patient stay possible.

Symptoms have improved (with or without) treatment, to the degree that patient behavior is, more or less, socially accepted. In many cases, however, the original illness is still present and unless conditions after discharge are favorable, the patient is likely to relapse. A major problem in rehabilitation is the fact that most patients return to the environment in which they broke down in the first place. In other words, most patients go back to families, frequently before either patient or family are ready or properly prepared.

That the family of the patient should be involved in certain aspects of the treatment process is an opinion that has wide support, but until recently little implementation. Ideally, a family diagnosis should be made at the time of admission of the patient so that an effort can be made to deal with troublesome conflicts and attitudes. Experience shows the value of group therapy in this area.

Earlier it was generally agreed that work with groups of mothers and sons or daughters was usually successful, but work with husbands and wives

was found to be somewhat more difficult. The better hospitals have changed markedly. When family or marital difficulties are the problem the social worker sees the spouse or parent regularly while the physician treats the patient. This is particularly efficacious for it prepares the other family members for the return of the patient involved.

Heretofore it was the duty of the social worker to maintain contact with families while a member was hospitalized in order to make early release feasible and successful. Patients should be referred to the appropriate community and other health and welfare resources even before release. Patients on maintenance chemotherapy are in need of medical follow-up. This brings the family doctor or the local psychiatrist into the picture if they are available; if not, some form of outpatient mental health facility is indispensable.

These facts bring to light several changes in recent years which are not always to the benefit of the patients and one or two which might be helpful. First, many social workers have changed their orientation and are now practicing psychotherapists. Secondly, in England (Tripartite Committee, 1972) and in the United States, hospitals are being emptied too rapidly. In both countries patients are being discharged quickly and told to apply to their local community mental-health services. Unfortunately many of these centers are not quite prepared for a large influx of patients who are only partially

recovered.

In both countries psychiatrists in general favor community care but are of the opinion that the mental hospitals should not be phased out until these centers are properly prepared to take care of the patients who will accrue to them.

Aftercare community mental health resources, although rapidly increasing, are still inadequate to take care of the problems arising out of the transformation of patterns of psychiatric care. The family care emphasis is moving some observers to the conservative position.

According to Wing, it is far from true that schizophrenic patients, after a long stay in a hospital, can be easily resettled in the community even when extensive social services are available (1964). Short-term patients also present serious problems. Investigation of a series of schizophrenic patients released from London mental hospitals after four months, showed that only 27 percent were free of symptoms at the time of their discharge, while 34 percent were actively deluded. A year later 56 percent of the discharged patients showed clinical deterioration and 43 percent were readmitted to the hospital usually after a sudden emergency involving police, firemen, neighbors, and the general public. Half of the patients for whom drugs were prescribed failed to take them, and half of those who found work were

dismissed or left after a short time. These facts were reported in the 1960s but there is no reason to believe that the situation has changed. In fact, it is compounded by the population explosion.

The British Tripartite Report in 1972, notes that "Community care has been a popular slogan for the past decade. Indeed, the operation of a system of community care is seen by some enthusiasts as a panacea, even as a cure for chronic schizophrenia. . . . The subsequent development has been uneven and decisions have been taken based more upon intuition than on knowledge, research, and experience."

This is not only an important mental health problem but it is one with ethical and moral connotations. Families will do what they can do to put up with a disturbed patient, but when that patient is the mother of small children the situation assumes serious proportions.

These same problems exist in the United States. The mental hospital census *is* declining and this is to be applauded, but where are the patients going? Is this simply the transfer or concealment of a serious problem? Every thinking person will agree that hospitalization in a mental institution is not an ideal situation and that community care is highly desirable, but the fact that many discharged patients often will neither take their medication nor seek out community care is not considered. To rehabilitate patients, someone must

be responsible to see that they receive proper attention. As one instance of this problem, George H. Wolkon, the resident director of Hill House in Cleveland, states that "two-thirds of the patients referred from psychiatric hospitals to a post-hospital rehabilitation center did not follow through on the referral" (204 patients chose not to follow through on a referral total of 312 [1970]).

Rapid or premature discharge of patients without adequate provision for aftercare or without regard to facilities for resettlement is irresponsible and likely to damage the whole policy of the open door in mental hospitals. A follow-up of discharged patients shows that altogether too large a percentage of them is re-hospitalized within a year.

One cannot help but bring to mind that before mental hospitals were established the mentally ill were the responsibility of the community and sick people wandered through the towns and ended up in jails, garrets, and poorhouses. It was for this reason that state hospitals were built, and to give patients better care. Now it does seem as though these institutions are failing in their duty as they are being pressured to rapidly discharge the patients. Mayer-Gross warned a generation ago that incautious discharge of the mentally ill can have tragic repercussions on the family (1958).

Without doubt the community mental-health program has opened new

vistas of hope for the mentally ill, but we must be mindful of the hazards of wishful thinking. The good mental hospital will be the backbone of the cure and the rehabilitation effort for a long time to come, for there will always be patients whose recovery will take longer than they, their doctors, the family, or even Blue Cross find convenient.

Addendum

It is written that he who neglects the lessons of history will be fated to repeat its errors. As this report is being written, the rehabilitation efforts for mentally ill patients is deteriorating in a number of states, both large and small. The same may be said of the situation in England (Tripartite Committee, 1972) where a crusade is underway to denigrate the mental hospitals with the intent of phasing them out. Presently their plans call for the extremely low ratio of mental illness beds of 0.5 per thousand population. In the United States the same situation is found though not as dramatically. These aims would be admirable were all the community centers properly prepared and staffed to receive the mentally ill, but unfortunately very few are thus prepared and some others are in a sorry state.

Originally the community centers were conceived to furnish mental health service to a segment of the population which was unable to afford private care and for whom psychiatric service was generally not available.

That some of the centers have deviated from their original purpose is of no concern to us here. The fact remains that these centers have the potentiality for being excellent treatment and rehabilitative agencies, and a number of them are already accomplishing that purpose. Since their inception these centers have been heavily dependent upon the Federal Government for financial support, especially for staffing. The outlook for future Federal support is bleak and should this support be withdrawn altogether, it is impossible to conjecture what will happen to community centers. Some will undoubtedly weather the storm but others will just as surely disappear. Undoubtedly the general and the private hospitals will in some way move into the breech and our advances in treatment and rehabilitative methods will not be lost no matter under whose auspices they will be given.

It is clear that delivery systems for all health services will undergo major reorganization in the near future. Robert Gibson states: "The needs are of such magnitude that all health resources must be drawn in if we are to meet them. Excellence will have to remain the watchword if they are to be viable components of the reorganized system" (1971).

With this statement all can agree, since an emotionally ill person has the right to be rehabilitated and restored as much as possible to usefulness and dignity in the world of his fellows.

Bibliography

Barton, R. "The Psychiatric Hospital," in Freeman and J. Farndale, eds., *Trends in the Mental Health Services,* pp. 156-163. New York: Macmillan, 1963.

Barton, W. E. *Administration in Psychiatry.* Springfield, Ill.: Charles C. Thomas, 1962.

Barton, W. E. and W. T. St. John. "Family Care and Out Patient Psychiatry," *Am. J. Psychiatry,* 117 (1961), 644-647.

Bellak, L., ed., *Handbook of Community Psychiatry and Community Mental Health.* New York: Grune & Stratton, 1964.

Bellak, L., B. J. Black, A. Lurie et al. "Rehabilitation of the Mentally 111 through Controlled Transitional Employment," *Am. J. Orthopsychiatry,* 26 (1956), 285-296.

Black, B. J. *Guides to Psychiatric Rehabilitation.* New York: Altro Health and Rehabilitation Services, 1963.

Bockoven, J. S. "Moral Treatment in American Psychiatry," *J. Nerv. Ment. Dis.,* 124 (1956), 167-194, 292-321.

Cooper, A. B. and D. F. Early. "Evolution in the Mental Hospital," in H. Freeman and J. Farndale, eds., *Trends in the Mental Health Services,* pp. 79-86. New York: Macmillan, 1963.

Fisher, S. H. "The Recovered Patient Returns to the Community," *Ment. Hyg.,* 42 (1958), 463-473.

Fisher, S. H., J. H. Beard, and V. Goertzel. "Rehabilitation of the Mental Hospital Patient: The Fountain House Program," *Int. J. Soc. Psychiatry,* 5 (1960), 295-298.

Freeman, H. E. and O. G. Simmons. *The Mental Patient Goes Home.* New York: Wiley, 1963.

Freeman, H. and J. Farndale, eds., *Trends in the Mental Health Services.* New York: Macmillan, 1963.

Freud, S. *Civilization and Its Discontents.* New York: Cape and Smith, 1930.

Gibson, R. W. "The Private Psychiatric Profile 1971," *Am. J. Psychiatry,* 127 (1971), 1395-1397.

Glasscote, R. M. *Rehabilitating the Mentally Ill in the Community: A Study of Psychosocial Rehabilitation Centers.* Washington: The Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1971.

Glasscote, R. M., J. E. Gudeman, and R. Elpers. *Halfway Houses for the Mentally Ill,* p. 1, 22. Washington: The Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1971.

Glasscote, R. M., A. M. Kraft, S. M. Glassman et al. *Partial Hospitalization for the Mentally Ill: A Study of Programs and Problems.* Washington: The Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1969.

Greenblatt, M. "Rehabilitation of the Mentally Ill," in A. Deutsch and H. Fishman, eds., *Encyclopedia of Mental Health,* Vol. 5, pp. 1737-1747. New York: Watts, 1963.

Greenblatt, M., D. J. Levinson, and G. L. Klerman. *Mental Patents in Transition.* Springfield, Ill.: Charles C. Thomas, 1961.

Herz, M., J. Endicott, R. L. Spitzer et al. "Day versus Inpatient Hospitalization—A Controlled Study," *Am. J. Psychiatry,* 127 (1971), 1371-1382.

Hospital and Community Psychiatry. "Conference Report: Conference on Rehabilitation of the Mentally Handicapped, Sept. 24-25, 1970, Philadelphia," 22 (1971), (4)-(6).

Jaeggi, F. "Aspects sociologiques de l'hospitalisation et de revolution des psychoses chroniques," *Encephale,* 52 (1963), 97-166.

Joint Commission on Mental Illness and Health. *Action for Mental Health.* New York: Basic Books, 1961.

Jones, M. *Social Psychiatry, a Study of Therapeutic Communities.* London: Tavistock, 1952.

Kramer, B. "Day Care: A Phase of Partial Hospitalization," in A. M. Freedman and I. Kaplan, eds.,

Comprehensive Textbook of Psychiatry, pp. 1300-1302. Baltimore: Williams & Wilkins, 1967.

Landy, D. and W. D. Griffith. "Employer Receptivity toward Hiring Psychiatric Patients," *Ment. Hyg.,* 42 (1958), 383-390.

Mayer-Gross, W., J. A. Harrington, and A. A. Baker. "Breaking up the Mental Hospital," *Lancet,* 2 (1958), 697-698.

Olshansky, S. "The Vocational Rehabilitation of Ex-psychiatric Patients," *Ment. Hyg.,* 52 (1968), 556-561.

Overholser, W. "The Volunteer in Psychiatric Rehabilitation," *Ment. Hyg.,* 45 (1961), 163-166.

Raush, H. L. and C. L. Raush. *The Halfway House Movement: A Search for Family.* New York: Appleton-Century-Crofts, 1968.

Rennie, T. A., T. Burling, and L. E. Woodward. *Vocational Rehabilitation of Psychiatric Patients*. New York: Commonwealth Fund, 1960.

Rusk, H. "Rehabilitation," *Abbott Tempo* (Publication of Abbott Laboratories), 3 (1963), 3.

Sigerist, H. E. *Civilization and Disease*, pp. 229-244. Ithaca, N.Y.: Cornell University Press, 1943.

Todd, E. Unpublished Letter 1830, at the Institute of Living Archives, Hartford, Conn.

Tripartite Committee. *The Mental Health Service after Unification, Mental Health in a Unified National Health Service.* Report with the authorization of the Royal College of Psychiatrists, the Society of Medical Officers of Health, and the British Medical Association, p. 8. London: Tripartite Committee, 1972.

Wolkon, G. H. "Characteristics of Clients and Continuity of Care into the Community," *Comm. Ment. Health J.,* 6 (1970), 215-221.

Wiler, J. F., M. Kessel, and S. C. Caufield. "Follow up of a High Expectation Halfway House," *Am. J. Psychiatry,* 124 (1968), 1085-1091.

Wing, J. K. "Rehabilitation of Psychiatric Patients," *Br. J. Psychiatry,* 109 (1963), 635-641.

Wing, J. K., E. Monck, G. W. Brown et al. "Morbidity in the Community of Schizophrenic Patients Discharged from London Mental Hospitals in 1959," *Br. J. Psychiatry,* 110 (1964), 10-21.

Winick, W. *Industry in the Hospital, Mental Rehabilitation through Work.* Springfield, Ill.: Charles C. Thomas, 1967.

World Health Organization, Expert Committee on Mental Health. *World Health Organization Technical Report Series no.* 73. Geneva: World Health Organization, 1953.

Notes

1 Terms such as milieu therapy or administrative therapy are occasionally used interchangeably with that of therapeutic community. There is no one ideal pattern and a number of forms are permissible, provided the general principle of patient participation in the therapeutic process is honored.