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Factors Affecting SSI Support for Sheltered Care Residents With Serious Mental Illness

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The complexity of Supplemental Security Income (SSI) regulations and procedures allegedly inhibits eligible persons with serious mental illness from obtaining and retaining support. This study examined factors affecting continued SSI support among 393 sheltered care residents with serious mental illness ten years after an initial positive eligibility determination. At follow-up between 1983 and 1985 of 225 cohort members, 182 were receiving SSI benefits, 28 were eligible for SSI due to their low income but were not receiving benefits, and 15 were income-ineligible. The financially needy were most likely to receive SSI support for longer periods of time, and the most severely disturbed spent the least amount of time on SSI. Income-eligible nonrecipients were likely to be young, transient patients using emergency room services as opposed to receiving outpatient counseling.

The Supplemental Security Income (SSI) program with adjunctive benefits from Medicaid and food stamps

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is the single most important source of support for persons with serious mental illness living in the community. Of 4.1 million persons receiving SSI in 1985, almost two-thirds were entitled because of a disability. One-third of the disabled group suffered from a mental disorder (1,2). Certainly this dependable source of income has eased the acceptance of deinstitutionalized mentally ill persons by their families and the general public.

The SSI program has, however, attracted controversy. The low level of basic federal benefits and the wide variation in state supplementary plans are concerns generally raised (3). Critics argue that because of the program's complexity, applicants with serious mental illness have great difficulty participating (4,5) and are therefore systematically barred from program benefits. To support this argument, critics cite the multilayered, complicated, and often endlessly protracted SSI adjudication process (6). They point to poor and often erratic administrative guidelines for evaluation that have resulted, especially in the early 1980s, in numerous inappropriate benefit terminations and discontinuances (7).

This study evaluates the experiences of persons with serious mental illness living in sheltered care facilities in 1973 whose initial determination of SSI eligibility was made when the program was initiated in 1974. How did significant aspects of the individual's condition affect his or her continued SSI support? Of particular concern were the effects of the person's resources, living arrangement, mental disturbance, and transience and whether the person was a young adult male.

The study contrasts three groups at follow-up: SSI recipients, those who were eligible for SSI due to their low incomes but were not receiving benefits (referred to below as income-eligible nonrecipients), and those who were ineligible for SSI benefits. It was hypothesized that members of the latter group would have more resources than those in the other groups, that is, that they would be more frequently employed and more educated and have stronger informal support systems. They were also expected to have more stable living arrangements and to be less mentally disturbed. Income-eligible nonrecipients were expected to be younger, more frequently male, more transient, and more mentally disturbed than those in the other two groups (8,9) and to have a service utilization pattern similar to that of young chronic patients (8,10).

Given the study focus on the inability of the most severely disturbed individuals to participate in the SSI administrative process, it was hypothesized that regardless of group membership at follow-up, those with initially severe or no evidence of psychological symptoms would have spent less time on SSI than those with mild and moderate symptomatology. The severely symptomatic were expected to have spent less time on SSI because of being unable to fend for themselves in the SSI process. Asymptomatic persons would have spent less time on SSI because of ineligibility due to an absence of mental disability indicators.

It was hypothesized that more transient sample members would also have spent less time on SSI regardless of group membership because transiency increases the likelihood that the Social Security Admin-

istration (SSA), unable to deliver checks, will terminate the case. The time a person spent on SSI was expected to be more dependent on mental disturbance than on transience since only those who were most severely disturbed would allow their transience to interfere with their financial support.

Methods

Sample. The study reported here followed up 393 persons with serious mental illness who were first interviewed in 1973 when they were living in sheltered care facilities, such as board-and-care facilities, family homes, halfway houses, and psychosocial rehabilitation facilities. The original cohort was representative of all persons in California in 1973 between the ages of 18 and 65 who had serious mental illness and lived in sheltered care facilities (11,12).

Of the original cohort of 393 persons, 360 (91.6 percent) were located at follow-up between 1983 and 1985. Among that group, 270 (68.7 percent) were alive, and 90 (22.9 percent) were confirmed dead. Thirty-three (8.4 percent) were not located. There were no significant differences between those who were located and those who were not in age, gender, ethnicity, marital status, or functional status (both psychological and social) in 1973. Of the 270 people located alive, 253 (93.7 percent) agreed to be interviewed and 17 (6.3 percent) refused. Outpatient and inpatient records were obtained for the 253 sample members from mental health facilities and the SSA. Valid interviews were obtained from 234 sample members, 225 of whom had unambiguous Social Security histories.

Social Security and the sample. Of the 393 persons in the original cohort, 191 (49 percent) were receiving SSI benefits at follow-up; 117 cases (30 percent) had been terminated, 64 due to the recipient's death and 53 for other reasons. The SSA found no record of 49 cases (12 percent). Social Security numbers were not available for 36 persons, and they were not followed up. Counting persons whose cases were terminated for reasons other than death and

those for whom no records were found, a total of 102 members of the original cohort (30 percent) were not associated with SSI at follow-up.

Our analysis was limited to those cohort members who completed interviews at follow-up and whose Social Security status could be unambiguously documented. Thus the follow-up sample consisted of 182 of 191 persons currently receiving SSI benefits and 43 persons who were clearly not receiving benefits. In nine cases, the sample members themselves or their relatives or sheltered care providers reported that they were receiving benefits, but such payments could not be confirmed with the SSA, and these cases were not included in the analysis.

Analyses. Two analytic procedures were used to address the hypotheses. For specific tests of hypotheses with a clear direction, results are reported as significant if *p* values did not exceed .10 in a two-tailed test. We first compared the three groups at follow-up—182 recipients, 28 income-eligible nonrecipients, and 15 who were income ineligible—using chi square analysis and analysis of variance. The independent variables in the analyses are listed in the left-hand column of Tables 1 and 2. The dependent variable is SSI status at follow-up.

The second analytic approach used ordinary least squares regression to test the relative importance of mental disturbance and transiency in predicting the total number of months an individual received SSI between 1973 and follow-up. The number of months on SSI, which was obtained from SSA records, was the dependent variable, and two measures of mental disorder and two measures of transiency were the independent variables. The analysis controlled for four factors demonstrated to be related to time spent on SSI: age in 1973, health status in 1973, level of social functioning in 1973, and the amount of time in a mental hospital or unit between 1973 and follow-up.

Measurement. The Brief Psychiatric Rating Scale (BPRS), initially developed in 1962 and used extensively in drug trials with psychiatric patients (13,14), was used to assess

the severity of mental disturbance in 1973 and at follow-up. Each BPRS item was rated on a 7-point scale ranging from 0, no symptoms, to 6, extremely severe symptoms. The internal consistency of the BPRS was found to be high in both 1973 ($\alpha=.79$) and 1983 ($\alpha=.86$). The interrater reliability of the BPRS (available only for the 1973 study), based on joint interviews by a psychiatrist and a psychiatric social worker, was also high ($r=.9$) (15).

Two variables measuring different degrees of mental disturbance in 1973 were created from BPRS item scores. For the first variable, asymptomatic persons were coded 1, and those with mild, moderate, or severe symptoms were coded 0. For the second variable, persons with severe symptomatology were coded 1, and asymptomatic persons or those with mild or moderate symptoms were coded 0. For the chi square analysis, we compared the asymptomatic persons with all others in both 1973 and at follow-up. Both of the 1973 BPRS variables were used in the regression to predict months of SSI support between 1973 and follow-up.

The severity of mental disturbance was also measured by the amount of time in a psychiatric hospital or unit between 1973 and follow-up and the number of times in a psychiatric hospital or unit before 1973. Both measures were used in the chi square analyses. Only the number of times admitted before 1973 was used in the regression as an indicator of mental disturbance. Because the amount of time in a psychiatric hospital between 1973 and follow-up was likely to be related to the time a person received SSI in the same period—given restrictions on payments to those in public institutions—this variable was used as a control variable in the regression model.

Primary discharge diagnoses for each episode of inpatient care were obtained from psychiatric records for 201 persons for whom we had valid interviews. The 201 persons had 1,159 inpatient episodes, and diagnoses were obtained for 1,038 (89.5 percent) (Segal SP, unpublished study, 1985). A modal lifetime diagnosis—that is, the most frequently

Table 1
Demographic characteristics, resources, and living arrangements in 1983 of 225 persons who were living in sheltered care facilities in 1973 and eligible for SSI benefits, by 1983 SSI status

Characteristic	1983 SSI status			Test statistic	df	p (two tailed)
	Recipients (N=182)	Income-eligible nonrecipients (N=28)	Income-ineligible persons (N=15)			
Age (%) ¹				$\chi^2=18.24$	6	.005
65 and over	26.4	14.3	53.3			
55 to 64	26.4	21.4	13.3			
45 to 54	20.3	21.4	0			
30 to 44	25.8	39.3	33.3			
Gender (%)				$\chi^2=3.69$	2	ns
Male	48.9	64.3	66.7			
Female	51.1	35.7	33.3			
Education (years)				F=.34	2,128	ns
Mean number	10.8	11.3	11.4			
Additional, 1973 to 1983 (%)	16.9	39.3	20.0	$\chi^2=7.63$	2	.02
Employed (%)	10.4	10.7	33.3	$\chi^2=6.93$	2	.03
Informal support system (%)						
Family	83.5	89.3	93.3	$\chi^2=1.52$	2	ns
Friends	63.2	60.7	80.0	$\chi^2=1.85$	2	ns
20 or more hours of contact per week	18.0	32.1	33.3	$\chi^2=6.4$	2	.04
Married	5.0	10.7	20.0	$\chi^2=5.83$	2	.05
Living arrangement (%) ¹				$\chi^2=13.33$	4	.009
Community	28.6	35.7	46.7			
Sheltered care	61.5	35.7	33.3			
Institution	9.9	28.6	20.0			
Mean number of residences, 1973 to 1983 ²	3.4	5.8	4.2	F=3.56	2,200	.03

¹ Total percentages for recipients and income-eligible nonrecipients are less than 100 due to missing data.

² Scheffé range test indicated that income-eligible nonrecipients were significantly different from the other groups.

recorded diagnosis—for each sample member was determined from these data. This diagnosis was used as indication of the severity of mental disturbance in the group comparisons.

Transience was defined by the number of residential moves a person made in the year before the 1973 interview and the number of moves made between then and follow-up. The variables were constructed from residential histories based on self-report and archival record data.

Age, social function, and health status in 1973 and time in a psychiatric hospital between 1973 and follow-up were used as controls in the multivariate regression model. In 1973 the External Social Integration Scale (ESIS) was used to assess the social functioning of sheltered care residents. The ESIS measures the extent to which an individual participates in and makes use of the community in a self-initiated manner (15). Va-

lidity information on the ESIS is available from the author ($\alpha=.95$) (Segal SP, unpublished study, 1985).

The Physical Symptom Scale (PSS) used to measure health status includes six symptoms: clogging or fullness in the head or nose, shortness of breath, trembling hands, sour stomach, headaches, and feeling weak all over (16–18). The scale's validity was supported by the finding that residents who reported having consulted a physician about any of the six symptoms assessed in the scale also reported that the physician usually attributed the symptom to physical illness. Another finding that supported the scale's validity was that the scale scores successfully distinguished sample members at follow-up who reported an increase in the number of days spent in bed in the past two weeks, poor self-assessed health status, and nine major health problems.

Results

Demographic characteristics. As shown in Table 1, the age distributions of the three groups were significantly different from one another ($\chi^2=18.24$, $df=6$, $p=.005$). SSI recipients were evenly distributed among all age categories. Those ineligible for SSI were older; 53.3 percent were age 65 or over. Income-eligible nonrecipients were younger; 39.3 percent were between the ages of 30 and 44. Only 14.3 percent of the latter group were 65 and over. No significant gender differences were observed between the groups.

Resources and SSI. No significant group differences were found in mean years of education. Income-eligible nonrecipients, however, received more additional schooling in the years between 1973 and follow-up than the others ($\chi^2=7.63$, $df=2$, $p=.02$). Although their recent additional education might lead to the

Table 2
Mental disturbance and service utilization of 225 persons who were living in sheltered care facilities in 1973 and eligible for SSI benefits, by 1983 SSI status

Characteristic	1983 SSI status			Test statistic	df	p (two tailed)
	Recipients (N=182)	Income-eligible nonrecipients (N=28)	Income-ineligible persons (N=15)			
Brief Psychiatric Rating Scale (BPRS), 1973				$\chi^2=1.55$	2	ns
No symptoms (%)	26.4	32.1	40.0			
Some symptoms (%)	73.6	67.9	60.0			
BPRS, 1983				$\chi^2=6.37$	2	.04
No symptoms (%)	52.8	54.2	86.7			
Some symptoms (%)	47.2	45.8	13.3			
Months psychiatrically hospitalized, 1973 to 1983 ¹	4.9	16.8	5.5	F=4.42	2,149	.01
N psychiatric hospitalizations before 1973	3.0	3.0	2.4	F=.26	2,176	ns
Service utilization, 1983						
In counseling (%)	57.7	60.7	33.3	$\chi^2=3.58$	2	ns
Type of primary counselor (%)				$\chi^2=17.70$	6	.007
Psychiatrist	89.3	76.5	40.0			
Psychologist	2.9	11.8	0			
Social worker	5.8	5.9	40.0			
Other	1.9	5.9	20.0			
Type of primary agency (%)				$\chi^2=14.72$	6	.03
Private counselor	53.8	17.6	40.0			
Clinic	25.8	41.2	0			
Hospital outpatient unit	3.2	17.6	20.0			
Other	17.2	23.5	40.0			

¹ Scheffe range test indicated that income-eligible nonrecipients were significantly different from the other groups.

conclusion that this group had more employment potential, eligible nonrecipients and recipients were significantly less likely than the ineligible group to have paid jobs outside residential placements ($\chi^2=6.93$, $df=2$, $p=.03$). The employment income of the ineligible group was apparently a major reason for their ineligibility.

A majority of the persons in all three groups had informal support systems, including family members, friends, and acquaintances. Compared with SSI recipients, members of both nonrecipient groups were more likely to be married ($\chi^2=5.83$, $df=2$, $p=.05$) and to have had more than 20 hours of contact with family and friends during the two-week period before their follow-up interview ($\chi^2=6.4$, $df=2$, $p=.04$). The results indicate that those who had more informal support were less likely to be on SSI. Family and friends might be a source of financial support for both nonrecipient groups.

Living arrangements and SSI.

As shown in Table 1, a greater proportion of both nonrecipient groups lived in community and institutional settings than in sheltered care ($\chi^2=13.33$, $df=4$, $p=.009$). Of the 28 eligible nonrecipients, four lived in state mental hospitals or county jails and thus did not receive SSI benefits because they were inmates of public institutions. It was also possible that another person in this group, a resident of a halfway house rehabilitation facility, did not receive SSI for that reason. Another four eligible nonrecipients lived in Medicaid-covered nursing homes; the cumbersome procedures for a \$25 monthly allowance, the maximum payment allowable in such settings, could have discouraged application.

The transient living situations of some eligible nonrecipients also prevented them from receiving SSI benefits. For example, two cases were terminated because addresses were unknown and checks were returned to the SSA. The eligible nonrecipients changed residences more fre-

quently than those in the other groups ($F=3.56$, $df=2,200$, $p=.03$). The number of moves for eligible nonrecipients ranged from one to 42 between 1973 and follow-up; for recipients the range was one to 20, and for ineligible persons it was one to eight.

Mental disturbance. No differences were found in the diagnostic composition of the three groups. Among the 182 SSI recipients, 117 (64.3 percent) had a diagnosis of schizophrenia or paranoid schizophrenia. Twenty-one (75 percent) eligible nonrecipients had one of those diagnoses, as did ten (66.7 percent) persons in the ineligible group ($\chi^2=9.23$, $df=10$, $p=.51$).

As shown in Table 2, the 1973 BPRS ratings for the three groups did not differ significantly. At the time of the follow-up interview, however, persons in the SSI-ineligible group were significantly more likely than those in the other two groups to evidence no symptoms of mental disturbance ($\chi^2=6.37$, $df=2$,

$p=.04$). SSI recipients and eligible nonrecipients were equally likely to exhibit some symptomatology.

The groups' history of psychiatric hospitalization adds perspective to their differences in mental disability. Eligible nonrecipients spent significantly more time (mean \pm SD=16.9 \pm 30.1 months) between 1973 and follow-up as psychiatric inpatients than those in the recipient group (mean \pm SD=4.9 \pm 12.7 months) and ineligible group (mean \pm SD=5.5 \pm 15 months) ($F=4.42$, $df=2,149$, $p=.01$). Given that the amount of time spent hospitalized for psychiatric illness is a fairly reasonable indicator of the severity of disability, eligible nonrecipients appear to have been more disturbed than those in the other two groups. In addition, their longer period of hospitalization indicates that they were less likely to continue to receive SSI than the other groups. Other things being equal, this result is probably due to reluctance to complete the procedures necessary to obtain the \$25 maximum monthly SSI payment for residents of public institutions.

Service utilization. As shown in Table 2, no significant group differences were found in the proportion of those who were receiving psychosocial counseling at follow-up. But among those who received such counseling, the type of primary therapist and the type of primary agency differed significantly. A majority of SSI recipients and eligible nonrecipients were seeing psychiatrists, whereas those who were ineligible to receive SSI tended to see social workers as often as psychiatrists ($\chi^2=17.70$, $df=6$, $p=.007$). A greater proportion of recipients and those in the ineligible group saw private counselors, whereas more eligible nonrecipients went to clinics and hospital outpatient units ($\chi^2=14.72$, $df=6$, $p=.03$). The utilization of clinics and hospital outpatient units by a relatively more transient population and the utilization of private counselors by a relatively more stable population conform to current patterns of mental health care utilization.

Predicting months on SSI. Table 3 presents our model for assessing the relative importance of mental

Table 3

Multiple regression analysis of factors predicting the number of months spent on SSI between 1973 and 1983 by 160 persons who were living in sheltered care facilities in 1973 and eligible for SSI benefits¹

Variable	Unstandardized regression coefficient	SE	Beta	p (two tailed)
Predictor variables				
Mental disturbance				
No symptoms as measured by Brief Psychiatric Rating Scale (BPRS) in 1973	-11.25	6.17	-.14	.07
Severe symptoms as measured by BPRS in 1973	-26.03	11.56	-.17	.03
N psychiatric hospitalizations before 1973	-2.16	1.13	-.16	.06
Transience				
N changes of residence between 1973 and 1983	-.56	.65	-.09	ns
N changes of residence in year before 1973 interview	-2.68	2.15	-.10	ns
Control variables				
Age in 1973	-.38	.25	-.13	ns
N symptoms as measured by Physical Symptom Scale in 1973	-.13	2.20	-.00	ns
External Social Integration Scale score in 1973	-3.03	3.11	-.08	ns
Months psychiatrically hospitalized between 1973 and 1983	-.03	.02	-.19	.04

¹ $R^2=.16$, $F=3.21$, $df=9,150$, $p=.001$. Complete data not available for every sample member

disorder and transience in predicting the number of months an individual received SSI between 1973 and follow-up. The findings indicate that all three measures of mental disorder were negatively associated with the amount of time a person received SSI. Persons with more psychiatric hospitalizations before 1973 and those with severe symptoms in 1973 were likely to have spent less time on SSI between 1973 and follow-up.

Based on the model's predictions, those who were severely symptomatic in 1973 would have spent 26.03 fewer months on SSI between 1973 and follow-up than those who were asymptomatic or moderately disturbed in 1973. The asymptomatic group would also have spent less time on SSI—11.25 months less, based on the model's prediction—than those who were moderately disturbed. None of the indicators of transience were significant predictors. The only control variable found to be significantly associated with

time spent on SSI was the amount of time spent in a mental hospital between 1973 and follow-up.

Discussion

Although our conclusions must be tempered by caution given the small sizes of two of the groups, some consistent patterns were found. The age, transience, and degree of mental disturbance of eligible nonrecipients appear to confirm current beliefs that the SSI program has not served young chronic patients as efficiently as older, more stable ones. There was no evidence of intentional discrimination against these young transient patients by the SSI system. Yet simple administrative requirements, such as reporting changes in address and complying with recertification, apparently prevented severely symptomatic and transient sample members from applying for SSI. The hypothesis that there would be more men among the eligible nonrecipients was not confirmed.

A rather unexpected finding was the large proportion of eligible nonrecipients (35.7 percent) who lived in sheltered care facilities. This unexpected finding might be attributable to the strength of their informal support network in comparison to the SSI recipients. It is possible that those who spent more time in contact with family and friends received financial support from them, but this finding cannot be verified from our data.

The social and economic environments of eligible nonrecipients appeared to be more heterogeneous than those of other group members. Some eligible nonrecipients were probably supported by their families and friends, but this support was not likely for some others in this group given their extreme transience.

The effects of education and employment history were not straightforward. The capability of working outside the home did not appear to be related to SSI status at follow-up. Most sample members had scant work histories, and thus the differences among the groups, if any, could not be viewed as very meaningful. A significantly higher proportion of ineligible persons, however, worked for pay, and their earnings, in addition to other work- or service-related benefits, seemed to be the major reason for their not receiving SSI benefits.

Eligible nonrecipients had longer periods of hospitalization between 1973 and follow-up. BPRS scores of eligible nonrecipients and recipients indicated that persons in both groups were more disturbed than those in the ineligible group. Given that these findings are fairly reasonable indicators of the degree of mental disability, the results confirm the hypothesis that eligible nonrecipients are at least as severely disabled as recipients and most likely more disabled. The fact that eligible nonrecipients spent more time in psychiatric hospitals than the other two groups was certainly a hindrance to their continuous association with the SSI system. In the process of finding their way through community residences, institutions, and hospitals, sicker people are more likely to have a harder time abiding by the

complex eligibility rules and thus are likely to be kept out of the SSI system.

The findings of our multivariate model predicting total months on SSI support the hypotheses that reduced SSI income between 1973 and follow-up was primarily due to the severity of mental disorder rather than the transience that it may have precipitated.

Conclusions

Results show that the SSI program has made clear discriminations between those who are eligible and those who are not eligible, not only in the amount of income and resources that they have but also in their mental disability. Error in the system occurs at the extreme of mental disorder, in cases in which those who are eligible for benefits and not on SSI are at least as severely disturbed as SSI recipients, if not more so.

Severe symptomatology and a longer period of time spent in psychiatric hospitals predicted a shorter period of time on SSI. This prediction held even when ineligibility due to time spent in institutions was taken into account. Because hospitals are frequently involved with persons in the eligible nonrecipient group, discharge planning must place a greater emphasis on the goal of obtaining and maintaining SSI benefits. Most disturbing is the fact that in the eligible nonrecipient group are the young transient patients who, as expected, were using hospital emergency rooms instead of receiving counseling and support in the more stable environment of sheltered care.

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References

1. Social Security Administration: Fast facts and figures about Social Security. *Social Security Bulletin* 49:6-19, 1986
2. Social Security Administration: Program and demographic characteristics of SSI

- recipients, December 1985. *Social Security Bulletin* 50:23-58, 1987
3. Schultz JH: Origins, experience, and unresolved issues in the SSI program: a ten-year overview. Report of the Senate Special Committee on Aging. Washington, DC, US Government Printing Office, 1984
4. Segal SP, Baumohl J, Johnson E: Falling through the cracks. *Social Problems* 24: 387-400, 1977
5. Anderson JR: Social Security and SSI benefits for the mentally disabled. *Hospital and Community Psychiatry* 33: 295-298, 1982
6. Social Security Administration: Disability Evaluation Under Social Security. DHEW pub (SSA) 79-10089. Washington, DC, Department of Health, Education, and Welfare, 1979
7. Okpaku S: A profile of clients referred for psychiatric evaluation for SSDI and SSI: implications for psychiatry. *American Journal of Psychiatry* 142:1037-1043, 1985
8. Schwartz S, Goldfinger S: The young adult chronic patient and the care system: fragmentation prototypes. *New Directions for Mental Health Services*, no 19:23-35, 1983
9. Thompson EH: Variation in the self-concept of young adult chronic patients: chronicity reconsidered. *Hospital and Community Psychiatry* 39:771-775, 1988
10. Pepper B: A public policy for the long-term mentally ill. *American Journal of Orthopsychiatry* 57:452-457, 1987
11. Segal SP, Aviram U: The Mentally Ill in Community-Based Sheltered Care: A Technical Supplement on Study Methodology, 1972-1977. Berkeley, University of California, School of Social Welfare, 1977
12. Segal SP, Silverman C, Baumohl J: Seeking person-environment fit in community care placement. *Journal of Social Issues* 45:49-64, 1989
13. Overall JE, Gorham DR: The Brief Psychiatric Rating Scale. *Psychology Reports* 10:799-812, 1962
14. Rhoades HM, Overall JE: The semi-structured Brief Psychiatric Rating Scale interview and rating guide. *Psychopharmacology Bulletin* 24:101-104, 1988
15. Segal SP, Aviram U: The Mentally Ill in Community-Based Sheltered Care: A Study of Community Care and Social Integration. New York, Wiley, 1978
16. Langner TS: A 22-item screening score of psychiatric symptoms indicating impairment. *Journal of Health and Social Behavior* 3:269-276, 1962
17. Seiler LH: The 22-item scale used in field studies of mental illness. *Journal of Health and Social Behavior* 14:252-264, 1973
18. Wells JA, Strickland DE: Physiogenic bias as invalidity in psychiatric symptom scale. *Journal of Health and Social Behavior* 23:235-252, 1982