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Community care for the chronic mentally ill is marred, and perhaps jeopardized by the "dumping" of former patients into unprepared communities. A "revolving door" hospital admissions policy—usually associated with dumping—is also thought to undermine patient care. While such criticisms may seem justified in terms of the ideals of community care, further consideration should be given to specifying those factors that determine the responsiveness of community services to the needs of former patients and to the actual role of brief hospitalization in the patient's community care. It may be that for some patient groups, the "revolving door" facilitates better community care.

Research on the care of the chronic mentally ill has focused on factors that determine a patient's return to the mental hospital and factors related to an increase in the time a chronic patient spends in the community between hospitalizations. Little effort has been directed toward an understanding of the continuing role of community-based services as social supports for the chronic patient. Perhaps because the mental hospital has served as a long-term, life-encompassing residence, we are unaccustomed to examining the adequacy of community services that must promote the social and psychiatric well-being of former patients, who have need for far more than bed and board.

As part of a larger study of community care (1), data were collected on the nature of the service system and social context experienced by nonretarded ex-mental patients between 18 and 65 years of age living in community care facilities in California. Using survey sample methods, 499 residents living in 234 sheltered care facilities in 157 census tracts were interviewed, as were the operators of these facilities. This article sum-

# Community Care and

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marizes the results of several substudies that sought to determine the responsiveness of human services to the needs of former hospital patients and the effect of rehospitalization on these former patients in community care facilities.

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## The Responsiveness of Community-Based Services

Two substudies sought to determine the responsiveness of community-based services. The first focused on the sheltered care facility as a mediator between its residents and the service community. Findings, reported in detail in Segal and Aviram (1), show that services go to those who make the greatest demands for them. Facility operators who were involved in the community were more likely to get services for their residents than operators not so involved. Operators who had contact with other operators, whose residents had been in the hospital in the last year, and whose residents had been picked up by the police were more likely to use services. Better educated operators, who saw services as helpful, were more likely to make use of them.

# Human Service Responsiveness

Steven P. Segal, Ph.D.

Facility operators who saw themselves as more of a parent than a caretaker to the former patient showed a more professional treatment orientation and tended to run a more professional facility. Such operators entered the sheltered care business because of past professional experience with the resident group. Their professional attitude toward sheltered care was reflected in the characteristics of the facility. Larger facilities, as well as those characterized by their operators as having a hotel, boarding house, or commune atmosphere (as opposed to a family or home environment) were more likely to use community services extensively.

Thus, a client's receipt of services is a function of the facility operator's willingness to scream loudly, of his/her demands on the community, and of the composition of the resident group. A troublesome group tends to draw attention to itself.

The second substudy used a discriminant function analysis to examine the responsiveness of community-based services from the perspective of the individual client. Efforts were made to determine which individual, facility, and community characteristics (the latter two describing the individual's social context) could best distinguish between sheltered care residents receiving psychotherapeutic care and those not receiving

such aid. Since meaningful distinctions could not be made for the population as a whole, the sample was divided into subgroups on the basis of age and sex. While men were as likely to receive treatment as women, significant differences were associated with age: In the younger age group (18-33) 46.2 percent received treatment; in the middle-aged group (34-49) 29.9 percent received treatment; and in the older age group (50-65) 21.3 percent received treatment. We must ask whether the low utilization rate of the 50-65-year-old group is because older residents have traditionally been underserved by mental health professionals (2) or because they need less treatment. Given the isolated and often empty lives of many older residents, it appears that the former explanation is more likely.

Not only were older residents less likely to be in treatment but also to have significantly fewer therapeutic contacts when in treatment. Fifty-nine percent of the young residents in treatment received it once a week or more, while only 38 percent of the middle-aged group and 28 percent of the older group received treatment as frequently. Younger residents were also more likely to receive aid from different types of helpers: They not only saw psychiatrists but were also likely to see psychologists, social workers, and psychiatric nurses. In

general, men received treatment from more varied types of helpers than did women.

In order to determine whether different factors facilitate or hinder the process of getting help, six discriminant function analyses were completed within each age group by gender. Individual characteristics indicative of personal independence, such as socioeconomic status and external social integration, were found to be crucial in determining treatment status for young and middle-aged men as well as for young and older women. Individuals with higher status and higher levels of external integration received more help. Facility and community characteristics, such as orientation toward acute service delivery, were important factors in service provision for middle-aged women; fortuitous placement in a treatment-oriented environment did the same for older men. Regardless of age, factors discriminating females who received help from those who did not described an environment that encouraged the open expression of personal problems (3). Factors discriminating males who received help from those who did not described the need to maintain social appearances in the facility, for example residence in a facility where treatment was thought to be socially desirable.

### **The Role of the Mental Hospital in the Patient's Social Context**

Having looked at characteristics that influence the responsiveness of human services to the needs of the sheltered care population, it now seems important to consider the effect of rehospitalization on the former patient's life. While influenced by "market" factors such as bed space, previous research has shown that return to the hospital is often associated with the manifestation of bizarre symptomatology (4, 5). The question raised in this substudy was somewhat different from those raised in previous research: Rather than asking what leads an individual to the hospital, the concern here was with the implications of the individual's experience of rehospitalization for his/her life situation upon return to the community.

Twenty-five percent of the sheltered care population had been rehospitalized within the past year. While the sex of the resident did not seem to distinguish between those who had and those who had not recently been admitted to mental hospitals, recently rehospitalized residents were most likely to be young: Forty-one percent were between 18 and 33, 25 percent between 34 and 49, and 33.5 percent between 50 and 65.

In viewing the relationship between chronicity and rehospitalization, consideration of the number of rehospitalizations for the young and middle-aged residents, as well as the amount of time spent in hospitals for older

residents, is necessary. These figures can be taken as measures of chronicity which relate age to changes in the mental hospital system. In the past, chronic patients were held in the hospital for long periods of time; today they are readmitted to the hospital for brief stays in a revolving door pattern.

Data indicate that young and middle-aged rehospitalized residents were more likely to be chronically involved with the mental hospital system than were residents of similar age who had not been rehospitalized in the past year. While 69 percent of young residents readmitted to the hospital within the study year had had four or more previous hospitalizations during their lifetime, only 31 percent of the young sheltered care residents who had not been readmitted to a mental hospital in the past year had had so many. Figures for the middle-aged group were 33 percent and 13 percent respectively.

Although chronicity contributed to the rehospitalization of young and middle-aged residents, such was not true for older rehospitalized patients in this study, who had spent significantly less time in state mental hospitals than had their age-mates who were not rehospitalized. Sixty-seven percent of readmissions in the older age group had spent less than a year in the hospital, while only 23 percent of the non-readmissions had been hospitalized for so brief a time. The fact that older rehospitalized residents are less chronic/more acute than the non-rehospitalized group is probably a function of the latter's tractability and the perception by mental health professionals that this group is less promising and less interesting.

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A discriminant function analysis by the author distinguished individual, facility, and community characteristics that differentiated the life situations of sheltered care residents rehospitalized during the past year from those not rehospitalized. Only residents hospitalized more than once during their lives were considered.

On the whole, rehospitalization improved the social resources available to the chronic patient by enhancing the quality of his/her post-hospital environment. Older chronic patients who had been rehospitalized, for example, were more likely to have services available to them in their current living situations than those who had not been rehospitalized. Similarly, middle-aged and older residents who had been rehospitalized were more likely to be living in desirable sheltered care facilities; that is, in programmatically oriented group homes and therapeutic community facilities.

Younger patients, too, were likely to be living in higher quality facilities. Because findings show that rehospitalized residents were significantly less likely than non-rehospitalized residents to have lived in their post-hospital environment for more than a year, it seems that those in the rehospitalized group were placed in different facilities following hospitalization. A tentative conclusion that can be drawn from these findings is that rehospitalization may improve the post-hospital environment of the *chronic* mentally ill by precipitating a constructive change in placement which improves the resident's access to treatment and supportive resources. The revolving door may have some incidental benefits.

## Conclusion

Results of these substudies address the responsiveness of human services in several ways: The findings imply a necessity to involve the sheltered care provider

in the service network if service delivery is to be guaranteed. Many facility operators respond constructively to community complaints, and such complaints seem to motivate them to draw on community services. Also, it would be useful to provide educational programs for facility operators to increase their understanding of the process of seeking help for residents. These findings emphasize the importance of the relationship between the character of the facility and the availability of treatment. For example, women are more likely to seek help in an environment that encourages personal expression; enhancing that quality of the setting is likely to stimulate women to seek help there. On the other hand, efforts should be made to reduce the importance of social appearances as a contingency for men to receive help since the facility that presents the best public picture is not always best for the resident. A concerted effort must be made to aid older individuals in community care. They have traditionally been underserved and should not continue to be ignored by the mental health professions.

When help takes the form of hospitalization it must be recognized that the overall effect may be positive. Hospitalization is usually for no more than 72 hours, during which treatment is likely limited to providing a respite from crisis, updating medication, and revising plans for community support. For the sheltered care resident, an episode of rehospitalization may trigger the provision of attention that ties him/her to a resource pattern necessary for the maintenance of social functioning. While it seems important to develop community-based resources that could assume some functions of a hospital ward, return to the hospital should not always be discouraged. In our current system of care, brief hospitalization may have redeeming outcomes.

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