Abstract

Assessment of outcomes in community support systems for chronic mental patients is associated with a number of difficulties, including the lack of an operational definition, the need to study synthesized programs as approximations to organic community support systems, and severe methodological deficits within existing studies and in cross-study comparability. Although outcome studies indicate that community support programs show some apparent advantages in the treatment of patients, treatment gains are limited and tenuous. Moreover, interpretation of study results must be tentative because of methodological and programmatic limitations. Improved program evaluation and impact evaluation procedures are necessary to assess the efficacy of community support systems both in enhancing patient care and in providing solutions for the problems associated with deinstitutionalization.

In 1971, the National Institute of Mental Health (NIMH) sponsored a conference on mental health planning and community organization at the University of Missouri. The proceedings of that conference were published in a good-sized volume and then, like the proceedings of many conferences, consigned to a shelf. Recently I came across those proceedings and discovered, buried in the appendices, a paper that discusses the objectives and functions of outcome assessment in community-based mental health services (Stumpf 1973). Several purposes of outcome assessment are developed, and these may be paraphrased as follows: adding generally to the field of knowledge concerning an intervention or treatment approach; evaluating the degree to which the objectives of a given program using that intervention are being accomplished; re-evaluating the validity of the objectives of the intervention; and providing feedback, through the recycling of information, to initiate systems modifications.

The first of these purposes of outcome assessment is to broaden the base of knowledge. The second purpose, assessing a particular program’s outcomes and their implications, falls within the purview of traditional program evaluation. Schulberg (1977) refers to this function as the “assessment of performance.” It inquires into what tangible outcomes may be attributed to a given program’s efforts by measuring the effects of specific actions in that program on a finite target population.

The last two purposes of outcome assessment, re-evaluating the validity of objectives and providing feedback for systems change, are related to what Schulberg (1977) calls “the assessment of adequacy.” They deal with the extent to which a specific program contributes to the solution of a community’s problems and thus view program outcomes from a global perspective. This approach has been referred to elsewhere as “impact evaluation” (Bachrach 1980b) in order to differentiate it from more traditional program evaluation techniques.

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The present article departs from this conceptualization of the functions of outcome research. It will discuss the major findings of systematic studies in a variety of community-based programs, the methodological difficulties limiting those studies, and the more global systems implications of community support interventions. The target population consists of persons with chronic mental disorders—particularly those diagnosed as schizophrenic—who have illnesses of such persistence and severity that, without special supports, they are "unable to maintain a stable adjustment to community life" (Test and Stein 1978, p. 351).

**Background**

Two recent overview articles, one by Test and Stein (1978) and one by Braun et al. (1981), intensively analyze the existing literature on community support programs. Each overview summarizes the results of some 30 controlled studies. The exact number of programs involved depends on how many times one counts a specific program that has been modified and restudied. Both of these articles describe and distill the research results in a narrative format. The piece by Braun and his colleagues also provides, in tabular form, precise comparisons of such details as study design, sample size, diagnostic and demographic characteristics of study group, control situation (e.g., long- vs. short-term hospitalization), specific outcomes assessed, and duration of study period.

These two overviews are so thorough and insightful that I shall make no further attempt to analyze individual community support programs. Anyone wishing to review the outcomes of a particular experimental effort is referred to these excellent summary articles. Instead, I shall use these articles, as well as other relevant literature, as the basis for a more consolidated analysis of the outcome research and its implications.

The internal validity of outcome studies in community support programs—i.e., whether the conclusions presented flow logically from the data collected—is highly variable. Some of the studies are quite meticulous in their methodologies, have excellent designs, and avoid unwarranted conclusions. Other studies vary in their methodological adequacy and often present results that are difficult to confirm.

Much more serious, however, is the fact that the research shows relatively little cross-study comparability. Although individual studies may be credible, the corpus of research has extremely limited generalizability. The result is that, while considerable effort has been expended on the systematic study of community support interventions, very little evidence can be adduced concerning the efficacy of the sum of these interventions. There are two major reasons for these restrictions on generalizability. One is conceptual and definitional: We do not as yet have a clear delineation of what community support systems are and so must approach the task of evaluating them inferentially. Secondly, differences in study design and populations assessed in the existing research, as well as methodological weaknesses in individual studies, make it very difficult to compare results and to generalize across studies.

Nonetheless, some limited generalizations can be made. Before I present these results and evaluate them, however, I should like first to discuss the conceptual difficulties inherent in attempting to study outcomes in community support systems.

**Characterizing a Community Support System**

The term community support system has been variously defined (Task Panel 1978). With specific reference to chronic mental patients, the definition most widely used for program planning purposes is that proposed by NIMH. That definition and its implications are discussed in an article by Turner and Shifren (1979).

According to the NIMH conceptualization, a community support system for the chronically mentally ill is a "network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (Turner and Shifren 1979, p. 2). In an attempt to standardize this definition NIMH has described 10 basic criteria for identifying community support systems for this population.

Such a system must, first, have a mechanism for identifying persons in need and the ability to "reach out to offer appropriate services to those willing to participate" (Turner and Shifren 1979, p. 3). It must, second, offer patients assistance in applying for and obtaining such entitlements as disability income and other benefits. Third, it must offer 24-hour crisis assistance in "the least re-
strictive setting possible" (Turner and Shifren 1979, p. 4) (although restrictiveness is not precisely defined). Fourth, it must provide psychosocial rehabilitation services for the target population. Fifth, services must have indefinite duration and potentially be available for individual patients' lives.

Sixth, the system must provide adequate medical and mental health care for patients. Seventh, it must include backup support for family, friends, and community members in order to minimize the burden imposed by the long-term care of chronically disabled individuals. Eighth, the system must engage and involve concerned community members in such a way as to maximize the contribution of natural helping networks, self-help groups, and voluntary community organizations in caring for the target population. Ninth, the system must operate so as to protect patients' rights and ensure that their civil liberties are not denied them. And, finally, the system must provide for the involvement of family—the socialization and maintenance of individuals—but they also strive, by providing the means and motivation for patients to participate in society, to afford these individuals the gemeinschaft life experiences and extended kinship supports that are identified as the essence of social networks (Pattison et al. 1975, 1978; Budson and Jolley 1978; Garrison 1978; Task Panel 1978; Beels 1979; Froland et al. 1979).

Definitional Difficulties

Now, this description of community support systems, while comprehensive and detailed, lacks the specificity of an operational definition. It cannot, as it stands, be used to locate existing community support systems. What standards shall we use for ascertaining a given program's validity as a "true" community support system? How much of each of the 10 criteria is needed for a particular effort to qualify? Must all 10 criteria be present, or only some of them, and in what mix? If resources are limited, who, among the most seriously ill, must be served? Must a given program serve all persons with chronic mental disorders who live within a defined geographic area, or only some of them, and, if only some, which ones? These are only a few of the many questions that are unanswered by the existing definition.

Although the difficulties associated with confirming the existence of community support systems with this definition are sufficient for us to conclude that we cannot know whether such programs actually exist, the literature contains descriptions of a number of programs that appear to qualify. Such efforts include the very noteworthy Fountain House program in New York City (Beard 1978; Beard, Malamud, and Rossman 1978); the Training for Community Living program in Madison, Wisconsin (Test and Stein 1976; Stein and Test 1979); the Southwest Denver community mental health program; (Polak and Kirby 1976; Polak 1978); the Places for People program in St. Louis, Missouri (Anonymous 1976; Sandall, Hawley, and Gordon 1975); and the Sacramento County (California) mental health system (Barter 1975; Sacramento County 1977; Barter 1978; Langsley, Barter, and Yarvis 1978; Langsley and Yarvis 1978). It must, however, be emphasized that these various programs cannot be readily established as "true" community support systems—not because of any inherent lack in the programs themselves, but rather because the criteria for identifying them as community support systems lack specificity.

The question of whether community support systems exist ex-
cept as an ideal concept notwithstanding, it is my strong feeling that localized initiatives that reflect the sense of the NIMH conceptualization, even if they depart from the literal description in some particulars, do in fact exist and that they are not at all limited to the well-known programs just enumerated. I have heard numerous such programs enthusiastically described at conferences in a variety of “show-and-tell” presentations.

Even more importantly, the existence of programs that fulfill the substance of the NIMH criteria makes sense intuitively. One might go so far as to guess that these kinds of programs exist wherever chronic mental patients are successfully and humanly served, whether in the community or in a hospital setting. This generalization makes sense not only because of what we know about the needs of persons with chronic mental disorders but also because of what is more generally known about human behavior (Task Panel 1978). An eloquent statement by Stein (1979, p. vii) conveys the rationalization that underlies this argument in its position that chronic mental patients are “no different from the rest of us in needing a [social] support network to maintain themselves in their environment. Unfortunately, however, their emotional disabilities are so serious and persistent that, without special help, they are unable to develop and maintain such a network.” As a result, Stein maintains, long-term psychotic patients generally do poorly when they live in the community without the benefit of specially developed supports.

But it is a long way from intuition to scientific assessment, and the argument that community support systems exist because effective treatment cannot take place in community settings without them is circular. More specific knowledge is needed.

Since we lack objective means for reaching consensus as to what constitutes a “true” community support system, we cannot approach the task of assessing outcomes directly but must instead contrive to do so inferentially. Moreover, assessment of community support system outcomes can only be performed if the programs that we study are themselves organized and conducted according to experimental design. They must, in short, be bona fide research efforts that allow for the objective assessment of outcome.

There is, in fact, a class of planned community-based programs for chronic mental patients that fulfills both of these criteria. Referred to by Braun et al. (1981, p. 736) as “experimental alternatives to hospital care,” these programs, according to reports of their operation, appear to be in accord with the NIMH criteria for community support systems. Moreover, they serve as the foci of research efforts that are documented in such a way as to make objective evaluation feasible.

These experimental alternatives to hospital care generally fall under one of two formats. Either they exist as alternatives to mental hospital admission—i.e., they take the place of, and serve in lieu of, placement on hospital rolls; or they exist as “aftercare” programs for patients already hospitalized. In some instances these aftercare programs are planned—in accord with the concept of continuity of care (Bachrach 1981)—as community-based extensions of care after a patient’s hospital stay has been concluded. In other instances, the patient is deliberately released to the community before his hospital treatment is deemed completed, because the community alternative is in place and is believed to be—in line with the doctrine of the least restrictive alternative (Bachrach 1980a)—a better place for him to reside.

Organic vs. Synthesized Community Support Systems

It cannot be emphasized too strongly that assessment of outcomes in these community-based experimental alternatives to hospitalization is not the same thing as assessment of outcomes in bona fide community support systems. The former merely approximate the latter. Because these are two separate entities, I should like, for purposes of this discussion, to distinguish between “organic” and “synthesized” community support systems.

Organic community support systems emerge as answers to a community’s perceived needs and are highly idiosyncratic responses to local problems. Every organic community support system is a unique entity because it reflects the problems and the culture of the community in which it is found. Typical of these enterprises are the Open Door in Barrington, Rhode Island (Carroll 1980); the Way Station in Frederick, Maryland (Mortensen 1980); 62 Barre Street in Montpelier, Vermont (Washington County 1980); Mountainhouse in Asheville, North Carolina (Anonymous, undated); St. Luke’s House...
in Montgomery County, Maryland (Dearden and Petersen 1980); the Day Treatment Program in Angelina County, Texas (Anonymous 1979a); Cedar House in Oneida, New York (Straussman 1980); and Westside Lodge in San Francisco (Harris 1979).

My impression, based primarily on oral descriptions of these programs but reinforced by a number of site visits and occasional pamphlets, flyers, and articles, is that they are generally located in communities where resources are so scarce that residents have little choice but to deal directly with deinstitutionalized patients. Often, though not necessarily, these are rural or isolated communities where the chronically ill are highly visible, and there is little in the way of woodwork into which they can fade (Bachrach, in press). The use of social pressures to encourage civic and church groups to join in the support effort is not at all rare in these programs.

Organic community support systems may occur as "response[s] of the private sector to failures of the medical and social welfare systems to provide adequately for the needs of patients" (Mosher and Keith 1980, p. 35). Or they may operate with partial or total state and/or local government backing. Not infrequently, they combine the sum of public and private resources available in a given area. Indeed, these programs are generally characterized by a pragmatism so fundamental that funding structures are quite unpredictable. Money is taken from wherever it can be obtained, even if the amount is small and the duration of the financing is uncertain. Sometimes a local "angel" funnels resources into the program, and, when this occurs, it provides encouragement to the staff and reinforces the generally positive psychological milieu that seems to be a hallmark of these programs. Indeed, an optimistic outlook tends to persist in organic community support systems in spite of constant preoccupation with the program's survival.

Personnel in organic community support systems generally take great pride in their efforts and exhibit a deep concern for patients' needs. Goals tend to be expressed in terms of patients' overall welfare rather than measurable outcomes. It is not surprising that these programs typically lack an experimental approach. Workers tend to be more concerned with the day-to-day problems of service provision and with the effort of assuring program survival than with testing hypotheses about treatment interventions.

Organic community support systems, in sum, represent the means that some local communities have developed for coping with their own deinstitutionalization needs.

I recognize that in this conceptualization I have perhaps idealized organic community support systems as pristine, patient-oriented entities that are unencumbered by territorial disputes and bureaucratic demands. If this description is a bit idealistic, however, it still has the virtue of serving as an ideal type against which to measure synthesized community support systems—i.e., the experimental alternatives to hospitalization that serve as approximations to these organic community support systems.

Synthesized community support systems have neither the spontaneity nor the uncertainty of the programs that they simulate. They are interventions planned to test hypotheses, to elaborate on the conditions under which selected variables have specific outcomes. By contrast, organic community support systems are relatively spontaneous and free of the effects imposed by artificial experimental conditions and the categorical personnel and service requirements that frequently accompany them. This does not, of course, mean that the synthesized programs are poor ones, and my differentiating them from their organic counterparts is in no sense pejorative. Quite to the contrary, many synthesized community support systems are widely perceived as highly commendable and desirable alternatives to hospital placement in those communities where they exist (Stein and Test 1978; Talbott 1981). A number of these programs originally started out as organic programs and only later, after they were recognized as having special value in the delivery of services to chronic mental patients, were given supplemental funding earmarked for research purposes.

It should be noted that, in actual operation, both organic and synthesized community support systems usually limit their enrollments in some way. With finite resources available to a given program, some method of assigning priorities, either explicit or subtle, is generally used. Some programs disallow patients with a particular problem in living, such as substance abuse or severe acting out behavior, and these patients are systematically eliminated because of their potentially deleterious effects within the
program's milieu or on community relations. Other patients may be excluded from the synthesized programs because they do not fit the requirements of the experimental design.

Research Findings

In the absence of research findings on organic community support systems, it is possible to look instead at those from synthesized programs. The major substantive findings on outcomes in these latter programs, as summarized in the Test and Stein overview, are as follows:

1. Community-based programs that have been planned as alternatives to hospital admission for the care of persons suffering from chronic mental disorders can, in fact, serve that purpose effectively. Given programs that are directed toward individual patient care (as opposed to dumping), it is altogether possible to substitute community-based efforts for hospital care with results that are not worse than hospital care and are generally beneficial to the patients enrolled in them. Community-based programs that show positive results are typically characterized by high staff-to-patient ratios and appear to benefit from funding patterns that assure, at least for the duration of the study, their optimal and continuing operation.

It may be noted that the actual number of experimental programs planned as alternatives to hospital admission, as reported in the literature, is quite small. Test and Stein, who include certain nonresidential day hospital programs in this category, count a total of 10 experimental alternative to hospital admission programs; while Braun et al., who exclude day hospitals, count only seven.

2. Most synthesized community support systems, instead of serving as alternatives to hospital admission, exist as experimental substitutes for traditional hospital care, specifically as aftercare efforts for patients previously hospitalized. These programs also appear to achieve generally favorable results but only so long as they are characterized by individual programming, adequate financing, and favorable staff-to-patient ratios. Experimental evidence supports the view that synthesized community support systems can be instrumental in substantially reducing rehospitalization rates for patients. However, while these programs are generally known to reduce readmissions, they do not altogether prevent them. Even where aftercare is provided, large numbers of patients drop out of treatment, and these individuals frequently return to hospitals.

3. There are relatively few differences reported in the symptom levels of chronic mental patients treated in experimental synthesized community support systems and in in-hospital control programs. In both kinds of settings, the "usual course" is an "early reduction in symptomatology" followed by a "levelling off as long as persons remain in treatment" (Test and Stein 1978, p. 360).

4. Research conducted to date is inconclusive as to whether care in synthesized community support systems results in improved psychosocial functioning among chronic mental patients. A number of individual studies reveal no significant differences in psychosocial functioning as between patients enrolled in hospitals and those who are cared for in community settings. However, the literature does suggest that, in those community-based programs that include a "very intensive intervention targeted specifically toward the psychosocial area" (Test and Stein 1978, p. 360), distinctly positive outcomes are discernible. Test and Stein (1978, p. 360) thus conclude that "modest gains in psychosocial functioning in the community can be achieved... through direct and intensive intervention in specific activities of daily living in the community with gains being sustained as long as treatment lasts," and there is a strong implication that direct interventions must be aggressively pursued if the advantage is to continue.

It may be noted parenthetically that a major benefit of providing social skills training in synthesized community support systems is their in situ advantage. There is general agreement that accomplishments gained in environments other than those where patients will ultimately reside are inadequately generalized to "real life" situations (Wallace et al. 1980). Accordingly, if patients are to be discharged to the community, training for community living is most appropriately conducted after hospital release.

5. Consumer satisfaction with treatment appears to be greater among patients cared for in synthesized community support systems than among those placed in hospitals. Although some studies of individual programs claim a variety of successful outcomes beyond these several general results, the points just enumerated appear to constitute the bulk of generalizable out-
comes in the various synthesized community support systems studied by Test and Stein (1978), and the conclusions of Braun et al. (1981) essentially concur. Braun et al. conclude their review of substantive findings with the observation that “selected patients managed outside the hospital in experimental programs do no worse than and by some criteria have psychiatric outcomes superior to those of hospitalized control patients” (p. 747). These authors do note, however, that where differences between the two groups are observed, they tend for the most part “to favor the experimental group, particularly with respect to hospital readmissions and, in a number of instances, with respect to independent functioning” (p. 747).

**Methodological Problems**

It must be noted that even these modest outcomes attributed to synthesized community support systems in the two overview articles do not exist in a vacuum. These outcomes should be perceived as effects only partially attributable to support system milieu because of the simultaneous operation of numerous other variables such as drug treatment, talking therapies, patients’ demographic characteristics and institutional histories, and the like (Bland and Orn 1977; Strauss and Carpenter 1977). Because of such difficulties, Mosher and Keith (1980) contend that research into the outcomes of community care for chronic mental patients is “flawed.” A number of critiques, less comprehensive in scope than the two overview articles, but productive of penetrating analyses of the state of the art, accordingly echo the tentativeness and caution expressed by Test and Stein (1978) and by Braun et al. (1981).

A first source of methodological concern revolves around the absence of clearly stated program goals. Existing studies generally fail to specify the goals of the programs whose outcomes they are assessing, and this failure makes it difficult to assess the degree of fit between the program’s philosophy and its outcomes (Bachrach 1974). The failure to specify program goals in research reflects a more generalized failure to be specific about the goals of the programs themselves.

The importance of precision in goal setting for program planning is discussed in a report on California’s mental health system (Teknekron 1977) that isolates several desiderata in service planning, such as having patients reside in the community, minimizing hospitalization, maximizing patients’ independence, and curing, or eliminating, mental illness. If the first two of these goals, living in the community and minimizing hospitalization, are basic to a program’s aims, the patient’s mere presence in the community provides sufficient evidence of a successful outcome. But if the last two of these goals, maximizing independence and eliminating mental illness—goals about which some investigators are quite pessimistic (Lamb 1981; Zusman and Lamb 1977; Hansell 1978)—are to be pursued, the evaluation of outcomes becomes infinitely more complicated.

Thus, the absence of explicitly stated program goals, a serious methodological problem, more basically represents a major flaw in program design, one that reveals a fundamental lack of direction that very likely interferes with the provision of services. In this instance, methodological and service delivery deficits appear to be linked.

In the absence of clearly stated program goals, it is not unexpected that a second major source of methodological concern about the assessment of outcomes in synthesized community support systems is the general absence of adequate indices of outcome. The most widespread outcome measure used in studies of community support interventions is recidivism or rehospitalization.

Anthony, Cohen, and Vitalo (1978) support the use of recidivism as an outcome measure, not only because this criterion provides a data link to previous studies, but also because it is easily standardized, has face validity as a measure of program success, and has traditionally served as a standard for program planning and development. An early study by Lehrman (1960) concurs in this judgment.

These advantages notwithstanding, a number of authors have questioned the preponderant use of recidivism as an index of program success (Rosenblatt and Mayer 1974b; Bachrach 1976b; Strauss and Carpenter 1977; Stein and Test 1978; Smith and Smith 1979; Mosher and Keith 1980; Braun et al. 1981). Taube (1974) demonstrates that rehospitalization may be an artifact of the institutional history of a given program’s patient population. Aggregate readmission statistics for a program reflect the number of people at risk for rehospitalization and, since number of prior hospitalizations is one of the best pre-
dictors of recidivism (Weinstein, DiPasquale, and Winsor 1973), a program's success in keeping patients out of the hospital will be affected by the degree to which its enrollment is weighted with multiply hospitalized individuals.

Recidivism is also known to be a correlate of a variety of other variables, such as length of hospital stay, administrative policies concerning readmission, out-of-hospital living arrangements available to the patient, and emotional climate within the patient’s family (Buell and Anthony 1975; Rosenblatt and Mayer 1973; Weinstein, DiPasquale, and Winsor 1973; Rosenblatt and Mayer 1974b). Relying on recidivism as the major outcome variable in community support programs is thus, at best, a questionable practice.

Once again, there is a parallel for this methodological deficit in the area of service delivery. In the absence of adequate outcome indices, a program that relies on rehospitalization rates to measure success may easily make community tenure its major de facto goal.

Third, when outcome measures other than recidivism are used in studies of synthesized community support systems, their adequacy is not clearly established (Gottesfeld 1976; Test and Stein 1978; Braff and Lefkowitz 1979; Docherty et al. 1980). This situation is hardly surprising. In the absence of explicit goals, even accepted instruments will produce results whose meaning is difficult to assess.

Outcome criteria used in studies of community support programs are numerous, diverse, and largely unstandardized and include such specific events as psychiatric symptomatology; psychosocial functioning as measured by residential stability, social autonomy, role performance, employment, social functioning, and the like; and patient satisfaction. Of these measures the most valid instruments, according to Test and Stein (1978), are those that deal with symptomatology. Other instruments currently used are something less than satisfactory, according to these investigators, and the “major need in standardizing research in community treatment is the development of a sensitive instrument to measure community adjustment” (p. 361).

In short, if effective outcome research is to be performed, it is necessary not only to state program goals with exactness but also to take care to use measures that reflect progress in the attainment of those particular goals. Once again, the failure to do so in studies of synthesized community support systems reflects potential program deficits and says, in effect, that caregivers have not developed effective ways of telling whether their interventions make any difference.

A fourth difficulty attending the measurement of outcomes in synthesized community support systems derives, as suggested earlier, from the absence of methodologies to assess the interactive effects of patient care techniques. Since outcome research in community-based mental health efforts generally suffers from the existence of “multiple interventions, either concurrent or sequential” (Klein 1980, p. 122), it is necessary to use measures and statistical techniques that permit us to extract from a complex field of variables the precise ways in which specific interventions or treatments affect patient status. It is also important to know something about the combined effects of interventions (Carpenter 1979). This, after all, is what outcome research is all about.

One specific and very troublesome area of concern is the confounding nature of drug treatments. It is suggested by a number of investigators (Braun et al. 1981; Goldberg 1980; Rose 1979; Schouler 1980; Schulz 1980) that drugs may account for a substantial portion of the apparent success of synthesized community support systems in the treatment of chronic mental patients. To control for this and other interactive effects, it is necessary to have what Coulton and Solomon (1977) refer to as “rigorous research design” that “allows an investigator to know, with a stated degree of certainty, that changes in the dependent variable are due to changes in the independent variable” (p. 4).

Without this, we have only “very partial answers” (Klein 1980, p. 122) to specific questions concerning outcomes.

Fifth, it is difficult to assess the outcomes of synthesized community support systems because study groups tend to be inadequately standardized with respect to their diagnoses, degree of psychopathology, symptomatology, institutional history, and other patient characteristics (Goldberg 1980; Gottesfeld 1976; Carpenter 1978). When patients with a wide range of characteristics are thus indiscriminately used in the conduct of research, comparability of results across studies is hard to achieve, and it is very difficult to “resolve contradictory findings and identify those patient characteristics that may predict respon-
The problem they discuss is present even within an exclusively psychotic patient population, which itself tends to be quite heterogeneous in functional level, symptom level, and rehabilitative potential (Lamb 1981). Rabkin (1980), for example, discusses widespread variations in level of premorbid adjustment even among patients diagnosed exclusively as schizophrenic.

Since patients vary so widely in their history of coping with social and occupational situations, it is reasonable to expect outcome studies to control for patient characteristic variables. But assessments of outcome in synthesized community support systems widely fail to take this confounding factor into consideration, and both intra- and interstudy comparisons in outcomes are rendered extraordinarily difficult.

Finally, the variable of time is subtly associated with a variety of problems in assessing outcomes in synthesized community support systems. Carpenter (1979) suggests that, ideally, data should be gathered at four different times in outcome studies: at a point preceding the treatment intervention, at the beginning of the treatment period, at the conclusion of the treatment period, and at some followup date after the treatment period. But this kind of systematic study is rare in outcome assessments of community support programs.

Even when attempts have been made in individual studies to collect longitudinally valid data, there is so little uniformity across studies that generalizability is severely limited (Bachrach 1976b). Results of interventions in these studies are assessed variously at time intervals ranging from several months to 5 years (Braun et al. 1981). The problem goes beyond the need to allow sufficient time for interventions to have their desired effects, a situation that concerns some investigators (Mosher and Keith 1980). It extends to the need for consensus about what to expect from programmatic interventions and reflects a widespread and basic uncertainty about when to begin to look for effects.

In summary, the study of outcomes in synthesized community support systems is limited by an array of methodological difficulties, including the absence of clearly defined program goals, reliance on recidivism as the major outcome measure, use of other outcome measures whose validity has not been established, the absence of methodologies sufficiently sophisticated to account for interactive effects, the lack of standardization in study groups, and the failure to ground research with "an appropriate definition of the time frame" (Schooler 1980, p. 133) in which effects may be sought.

The most important thing about these methodological deficits is that they represent something more than limitations in research design. I have pointed out a number of instances in which they also reflect basic uncertainties in the art and science of delivering community-based services to patients with chronic mental disorders. Fuzziness in program design and program direction begets fuzziness in investigation. The methodological shortcomings discussed here are thus, in the most basic sense, program shortcomings. Failures in setting goals, defining outcome criteria, controlling for interactive effects, and making judgments about the
time in which those effects should become apparent are as much deficits in program design as in methodology. And deficits in program design ultimately tend to affect patient care.

Therefore, I would supplement the reports of qualified success in synthesized community support systems with the somewhat more cynical view that what looks like success may, unfortunately, be no more than a reflection of the hopes and ego involvements of the programs’ investigators (who also are often the programs’ caregivers and administrators). The most certain conclusion we can draw from the data reported so far is that we do not really know very much about outcomes in these programs beyond the fact that, given adequate service structures and resources, they are not harmful to patients. Assessment of outcomes in these programs is premature and is too frequently biased in a number of ways. These interventions may be very good for their respective target populations. Or they may be of little consequence, even though our intuitions tell us that this is unlikely.

For more detailed assessments to be conducted, there must be both improved methodologies and better-integrated program designs. At present, we know neither what to look for nor how to look for it in our efforts to assess program success.

Impact of Synthesized Community Support Systems

I should like now to shift the focus of this article, in keeping with the purposes of outcome assessment as detailed in the introduction, and examine outcome research in synthesized community support systems from a totally different point of view. Since outcome assessment is relative to program objectives, it behooves us to ask what the general objectives of these programs are.

Although we have seen that specific patient care goals tend to be inadequately delineated in these synthesized community support efforts, there is far more certainty about broad program objectives. A review of the literature reveals the existence of two closely related, though distinguishable, kinds of program ends. One set of objectives is patient-oriented and is concerned with improving direct patient care. The second is systems-oriented and is related to enhancing the humanitarian goals of the deinstitutionalization movement—namely, reversing those dehumanizing influences that are generally thought to be part and parcel of institutional care (Bachrach and Lamb, in press). A major clue to the importance of this second class of objectives is provided in the statement by Schulberg (1979, p. 1433) that NIMH’s recent community support initiative is “being heralded by some as the solution to the ills of deinstitutionalization.”

The rationale for conducting outcome research in synthesized community support systems parallels these two kinds of program objectives. Individual controlled studies covered in the two overview articles represent attempts at traditional program evaluation, as described in the literature of that field (Zusman and Ross 1969; Markson 1975; Arthur D. Little 1976), with the express purpose of testing specific patient care techniques. Beyond this evaluative purpose, there is a second manifest reason for studying synthesized community support systems. It is thought that the study of these programs will elucidate problems associated with community-based treatment for the target population and that the knowledge derived can then be used to plan program strategies—in short, to provide feedback for improving the community-based system of care (Schulberg 1979).

It is possible that the first of these two outcome study objectives can some day be accomplished—that methodological deficits can be contained in such a way that controlled studies of synthesized community support systems will eventually yield viable program evaluations. I would contend, however, that even if these studies were to be conducted rigorously, they still could not be used for the purpose of assessing the problems of deinstitutionalization. A wholly different kind of approach from that followed in traditional program evaluation is required to study solutions to the multitude of problems attending deinstitutionalization. What is needed is a framework that asks systems-relevant questions, one that permits the kind of impact evaluation that is necessary for effective policy formulation (Bachrach 1980h).

Impact evaluation is distinguished by the kinds of questions it poses. Instead of looking inward to the workings of individual programs as does traditional program evaluation, impact evaluation typically looks outward and asks, “So what?” It thereby focuses on the broader implications of programs for the delivery of services to the
total population of persons with chronic mental disorders. By using events in the external world as yardsticks, impact evaluation possesses an element of reality testing that is of particular importance in service planning for chronic mental patients, in view of the fragmented nature of mental health systems and the undisciplined, and frequently discriminatory, manner in which programs are often developed (Bachrach 1976a; Barter 1980; Beck 1979; Bradley 1976; Cramer 1978; Hansell 1978; Karwan, LoCicero, and Rasul 1980; Kirk and Therrien 1975; Raffo and Brody 1980; Rose 1979; Scherl and Macht 1979; Talbott 1979; Tarail 1980; U.S. General Accounting Office 1976; Williams, Bellis, and Wellington 1980).

That traditional program evaluation and impact evaluation serve different ends and require different methodologies is illustrated in a recent U.S. General Accounting Office (1978) report on the Veterans Administration personal care home program. Program evaluations reveal that this model effort of foster care placements for chronic mental patients, which is now nearly 30 years old, is highly successful in meeting the personal care needs of its enrollees. But impact evaluation is necessary to tell us that many more patients qualify for care in these homes than are actually served there. With impact evaluation we know that qualified patients tend instead to be hospitalized for such systems reasons as insufficient funding, unavailability of enough suitable community-based facilities to meet demand, lack of adequate commitment to the program from the VA central office, and patient and/or family resistance to out-of-hospital placements.

Unless specific impact questions are asked, individual programs run the risk of going off into their own orbits with little meaning for the complex and diverse needs of the total population of chronically mentally ill persons. Preoccupation with traditional program evaluation is, in fact, potentially dangerous because it holds the possibility of deflecting our attention from the severe and often unremitting problems that have been widely identified as serious issues inhibiting successful deinstitutionalization programming (Bachrach 1976a; Bassuk and Gerson 1978; Group for the Advancement of Psychiatry 1978; Halpern et al. 1978; Scherl and Macht 1979). In this connection, I would agree strongly with the assertion by Braun et al. (1981, p. 748) that, "given the magnitude of the social policy change entailed by deinstitutionalization and the two decades that have elapsed since it was put into motion, it is astonishing that so little productive effort has been put into evaluating the effects of the policy."

Avoiding the tendency to concentrate on effects in isolated programs instead of total systems is, in fact, the basis of systems theory as described in a recent article in Science (Miser 1980). According to Miser (1980, p. 209), the basic tenet of systems theory is that any given system is "merely a subsystem in a larger system—indeed, one of ever widening conglomerations of systems." Thus, for example, "a regional blood-collection and -distribution system supports the hospitals of its region, which are part of the nation's health care system" (p. 209). Systems theory holds that "the purposes of the subsystems are subservient to the purposes of the larger systems of which they are parts" (Miser 1980, p. 209).

To paraphrase Miser, community support systems for the chronically mentally ill are subsystems within the mental health system which, in turn, is a subsystem that is partially within the general health care system and partially within the human services system. The purposes of community support efforts must in this sense be perceived as subservient to the purposes of deinstitutionalization, the major policy focus of the mental health system. If we wish to assess the outcomes of deinstitutionalization in order to change that policy and/or its implementation, we must look not to effects in isolated programs but rather to effects in the mental health system itself.

In this connection it is worth noting that experimental efforts necessarily differ from mental health systems in a number of critical ways. Mental health systems must serve all who are in need, not only persons who happen to fit in with some predetermined experimental criteria. Mental health systems must, in fact, serve even those who show little hope of improvement, although experimental programs may be very selective in their admission policies. Although experimental programs can, and in accord with their scientific aims should, focus their resources on a selected group of patients, mental health systems must deal with competition from different kinds of patients with a variety of disabilities. In short, experimental programs are generally too limited in concept to serve as
testing grounds for the outcomes of deinstitutionalization.

Problems In Evaluating Deinstitutionalization

There is some reason to question whether it is even possible to assess the outcomes of deinstitutionalization because such an effort must necessarily entail tremendous complexities in both conceptualization and methodology (Bachrach and Lamb, in press). I would submit, however, that it is time to find out. We must attempt to supplement the traditional program evaluation efforts that are used for assessing outcomes in experimental programs with more extensive impact analyses. Although the need for impact evaluation has been known for some time, it is only recently that the literature has even begun to reflect the kinds of questions that need to be asked (Gaver 1976; Holder 1977; Stratas, Bernhardt, and Elwell 1977; Barter, McMahan, and Froland 1978; Boyd and Henderson 1978; James 1978; Bachrach 1979; Barrow, Gutwirth, and Schwartz 1979; Talbott 1979; Barter 1980; Stratas and Boyd 1981) and methodological approaches are still being developed.

I shall devote the remainder of this article to a discussion of several broad issues that are relevant to impact analysis in deinstitutionalization and that are essentially overlooked by the existing research into outcomes of synthesized community support systems. I have selected for this purpose four specific but interrelated areas of major systems concern in deinstitutionalization programming. These include inequitable priority setting within the mental health system; the failure to address the needs of all segments of the heterogeneous population of chronically mentally ill individuals; the limited relevance of a rehabilitation focus for all portions of the target population; and difficulties in placing certain kinds of patients within the mental health system.

Inequitable Priority Setting

If chronic mental patients are to be provided with adequate care, they must have access to the service system and its component parts. What this means, in effect, is that these patients must be acknowledged as the rightful recipients of whatever services the system has to offer. However, there is some evidence that chronic mental patients are discriminated against by the service system. In the community, for example, in lieu of adequate care they may be placed in residential facilities of questionable standards. They may, or may not, receive medication; and other forms of treatment are even more rare (President's Commission 1978).

That these conditions prevail is ironic. Originally, community mental health services were intended to eliminate the need for mental hospitals through the development of noninstitutional alternatives for the most seriously ill. Simultaneously, patients were to be released to the community, and the need for new admissions to these facilities was to be gradually eliminated: The nation would be served by a network of community mental health settings that would provide a wide variety of services for individuals with severe and persistent mental disabilities.

However, even though the "basic mission" of deinstitutionalization was originally to provide community-based treatment for the most seriously ill, "only limited aspects of the original conception have been implemented," and "the interest of most workers has gone off in other directions" (Zusman and Lamb 1977, p. 889). Community mental health today focuses largely on the treatment needs of the "healthy but unhappy," and the needs of the most seriously ill tend to be given low priority. Thus, Miller (1977, p. B1) writes of an "inverse system of care," in which "the most trained and skilled clinicians deal with the most articulate, interesting and likely to succeed clientele," while the existence of those patients most in need is largely ignored.

The net result of these inequities is discussed by Halpern et al. (1978) who describe the "irrelevance" of community care for the most disabled and draw the parallel that "expecting the chronically mentally ill patient to use the current mental health system is like expecting a paraplegic to use stairs. . . . The chronic long-term mentally ill person can't use the current mental health system because it's oriented toward people who have motivation, who have the capacity to develop insights, to change behaviors, to accommodate through socially acceptable behaviors" (p. 19)—characteristics not generally descriptive of persons with chronic mental impairments.

Nor is it realistic to think that these particular patients will themselves bear responsibility for initiating and perpetuating their own treatment in community set-
Virtually all services were given in institutions and deaths, so that provisionally as the result of new admissions and deaths, many remained in state mental hospitals, where many remained for the rest of their lives. This essentially static population pool changed primarily as the result of new admissions and deaths, so that providing care was relatively simple. Virtually all services were given in a single physical setting, and the various services needed by the target population could, at least potentially, be readily effected.

Deinstitutionalization has, however, broadened the geographic base of the target population, so that the chronically mentally ill now possess a variety of institutional and demographic histories (Bachrach 1978). Part of the target population consists of hospital discharges, and it is very difficult to deliver adequate services to two somewhat diametrically opposed subgroups of this population—those who are highly visible as they go again and again through the revolving doors of the service delivery system, and those who become virtually invisible (i.e., “fall through the cracks”) as they exit from the doors of institutions and become, for all intents and purposes, lost to the service delivery system.

Although patients discharged from mental hospitals are most often associated with the term “deinstitutionalization,” they in fact make up only a portion of the target population and are by no means the only chronically ill persons affected by the movement. Another group within the target population consists of never-hospitalized individuals who probably would have been institutionalized several decades ago and who, as the direct result of deinstitutionalization policies and practices, represent an ever-increasing percentage of the target population (Lamb and Goertzel 1977; Pepper et al. 1980). The medical, psychiatric, and social service needs of these individuals are very different from those of the ever-hospitalized.

Moreover, deinstitutionalization has also affected the provision of services for a number of patients who, despite deinstitutionalization efforts, continue to utilize state hospitals. These include the hospitals’ “old long-stay,” “new long-stay,” and “short-stay” patients (Bachrach 1978; Shore and Shapiro 1979).

A study by Dorwart (1980, p. 338) at a state hospital in Massachusetts confirms that the residue of patients treated in hospitals today tends to have distinctively different demographic histories and needs that have been “accentuated by deinstitutionalization.” These patients tend to exhibit acute psychotic symptoms, to be dangerous to themselves or others, to require intensive care, and to lack social skills. It is likely that the continuing diversion of resources toward the expansion and improvement of community-based services may work to the detriment of these patients, whose special needs require the financing of well-organized, well-staffed in-hospital programs (Ashbaugh and Bradley 1979).

All of these different groups of chronic mental patients should be regarded as the legitimate beneficiaries of planning efforts that are intended to improve patient care in this era of deinstitutionalization. At a time when financial constraints make it necessary to be as parsimonious as possible, we are thus faced with the task of arranging a multitude of services for a variety of patient populations in numerous settings. This is a systems problem of the first order and one that is not customarily considered in the evaluation of outcomes in synthesized community support systems. Because they are concerned with only a...
small portion of the target population of deinstitutionalization, these experimental programs fail to provide direction in planning services for the majority of persons with chronic mental disorders and thereby minimize the needs of that major-ity.

**Limits of Rehabilitation**

The Test and Stein (1978) overview reports that the modest gains in rehabilitation and psychosocial functioning made by some patients in experimental programs as the result of caregivers’ very direct and continuing interventions are tenuous and will probably be sustained only so long as direct treatment continues. I believe that this rather discouraging finding is overshadowed by a situation that may appear to be even more pessimistic.

Within the target population of chronic mental patients there are individuals who are unlikely to show appreciable gains in skills accomplishments regardless of how direct and sustained the interventions may be (Abbott 1978; Hansell 1978; Lamb 1979; Stern and Minkoff 1979). These are patients who do not stand out as program “successes,” and discussions of their needs are notable for their general absence from the literature. According to Lamb (1981), it is highly probable that for the majority of chronic mental patients rehabilitation, as measured by competitive employment, high levels of social functioning, and a general return to the mainstream of society, is simply not a realistic program goal. To the extent that these patients show any responsiveness to treatment at all, their achievements tend to be so imperceptible that they cannot be assessed by the conventional criteria employed for assessing outcomes in rehabilitation. Nonetheless, most synthesized community support systems continue to place heavy emphasis on rehabilitation, skills development, and the preparation of patients for activities of daily living; and such emphasis is considered to be essential, if not absolutely basic, to the development of community support systems (Turner and Shifren 1979).

This emphasis has the latent function of reinforcing the notion that all patients have equal rehabilitation potential, and caregivers are apt to behave as if this were the case. A recent study of admissions of chronic mental patients to a community-based facility in California, for example, reports that staff members frequently have difficulty in acknowledging the existence of patients whose rehabilitation potential is limited. This study asserts that staff predictions of patients’ outcomes systematically exceed their ability to respond to treatment interventions—a situation that leads to caregivers’ unwillingness to accept the concept of limited goals and to difficulties in caring for poor-prognosis patients (Solomon et al. 1980, p. 116).

Rossi (1978, p. 581) aptly points out that a delivery system “can simulate success by delivering treatments to individuals who are most likely to recover.” Hence, so long as synthesized community support systems are designed to measure program success in rehabilitative terms, there is a serious risk of forgetting that it is sometimes necessary to measure success in some other way and that it is appropriate to use alternative goals for some patients. In fact, it is incumbent upon us to develop separate outcome measures for maintenance-level patients, measures that rely on other criteria—such as patients’ responsiveness to environmental stimuli, or their personal comfort.

Unfortunately, however, the widespread emphasis on rehabilitation in synthesized community support systems predisposes us to place disproportionate emphasis on skills achievement, so that we tend to overlook alternative, but less dramatic, indices of humane and compassionate patient care in program planning.

**Placement Difficulties**

While some patients with chronic mental disorders are inappropriately placed in particular service facilities for political or financial reasons, or simply because appropriate community alternatives are not available to them (Sheehan and Craft 1975; Lund 1976; Booker 1977; St. Elizabeths 1977, 1979; Anonymous 1979b; Colen 1979; Faden and Goldman 1979; Fowler 1980), there are other patients for whom there appears to be no ready niche in a community-oriented system of care. This is an issue that has recently begun to surface in the literature, and it concerns patients whose needs are somehow anachronistic, or at least out of tune with current service delivery modes.

There are probably several varieties of these patients who “do not fit.” Frequently, they are people whom Neill (1979, p. 209) describes as “blacklisted ‘difficult’ patients . . . whose presence engenders strong negative feelings.”
among treatment staff. Bean et al. (1979) refer to them more generally as "system misfits." Bassuk and Gerson (1980, p. 1513), who have encountered such patients in the psychiatric emergency ward of an urban general hospital, describe them as individuals "who, despite persistent efforts to engage them in ongoing treatment, keep returning to the emergency ward" where they comprise a familiar revolving-door population. Lamb (1980, p. 137) refers to these emergency service regulars as "psychiatric hobo[es]."

Closely related to, or part of, the problem of patients who do not fit in the service system are two other placement problems. One concerns patients whose preference and/or need for either long- or short-term hospitalization is not accommodated (Simon 1965; Spiegel and Keith-Spiegel 1969; Rosenblatt and Mayer 1974a; Colen 1977; Smith and Smith 1978). Subtle clues to the dimensions of this particular problem are provided in two studies of the reasons that former patients visit those wards in general hospitals where they were once hospitalized. Kramer and Rubinson (1978, p. 302) report that these visits frequently reflect either "meaningful relationships with staff members and other patients" or "continuing treatment needs of various kinds." Similarly, Gruber, Brown, and Mazorol (1978, p. 734) write that visits by former patients represent a "response to real but unarticulated needs that are not being met by the mental health system" and that "while hospital readmission is commonly thought to indicate failure, it may be better to look on the brief hospital admission as an episode of temporarily increased dependency in the course of a long-continuing disability."

A second related problem involves the inappropriate placement of patients in the criminal justice system. Although Steadman and Ribner's (1980) study of criminal offenders in New York State concludes that deinstitutionalization practices and revisions in mental health commitment practices probably have not altered the composition of prison populations appreciably, Stelovich's (1979, p. 620) study in Massachusetts concludes that there is a "population of deinstitutionalized patients, who, lost to follow-up, [drift] into the legal system and [land] in prison." Whitmer's (1980) observations concur with the latter view.

In any case, a number of writers (Anonymous 1979c; Modlin 1979; U.S. General Accounting Office 1979; Anonymous 1980; Kaufman 1980; Nunes 1980) appear to agree that psychiatric services in prisons are generally less than optimal, and the implication is clear that at least some of the more seriously psychiatrically ill inmates would profit from more appropriate placement in service settings where the level of psychiatric care is consistent with their needs.

Robbins et al. (1978) assert that the number of patients who lack a place in the mental health system appears to be increasing as the result of deinstitutionalization practices. Yet, there is little in the literature on experimental community support programs that can shed light on this systems problem. Synthesized community support systems indeed appear to exhibit what almost amounts to a complacency in addressing placement questions. For the most part, each individual experimental program is described in the literature as if it represents one of two dichotomous choices, hospital care being the other. The notion of a range of placements for patients with a range of needs is very much played down in that literature.

**Implications**

The problems just discussed—in equitable priority setting, failure to address the entire target population, disproportionate emphasis on rehabilitation, and placement difficulties—may be seen as direct, if unanticipated, consequences of implementing deinstitutionalization policies and practices. Although they are by no means the only problems that attend deinstitutionalization, I think that they are particularly useful in illustrating the failure of synthesized community support interventions to deal with systems issues. They show that important conceptual work remains to be done in deinstitutionalization planning and that this cannot be accomplished by studying synthesized community support systems per se.

In the light of the serious problems that still surround deinstitutionalization, synthesized community support systems, unfortunately, may even appear to be guilty of oversights, irrelevancies, and deflections. This is, of course, an unfair indictment. Most of the caregivers and administrators associated with these programs are undoubtedly concerned with giving the best possible care to their patients and with testing the efficacy of their interventions.
in a scientific manner. They almost certainly have no grandiose wish to solve the problems of deinstitutionalization.

The trouble is not in these several programs per se but rather in the confusion, by policy makers and systems planners, of these programs with mental health systems. Outcomes in these subsystems are obviously not the same as outcomes in the greater mental health system. And outcome measures that are appropriate for one are not suitable for the other.

Conclusions and Recommendations

The foregoing discussion leads logically to several summary conclusions and recommendations.

First, we must confront our conceptual and definitional problems so that interventions in the community treatment of chronic mental patients may be placed in perspective. To the extent that organic community support systems exist in reality, each is a local and idiosyncratic method of dealing with the problems of the chronically disabled and, as such, is unique. Hence, we may look to them to provide us with broad guidelines in service planning, but their generalizability is severely limited. They lack experimental specificity and cannot be replicated.

Second, it is possible to deal with some issues in community support programming by investigating outcomes in programs set up as experimental alternatives to hospitalization. Although these programs differ from organic community support systems, they may serve as substitute laboratories. These programs may be viewed as synthesized community support systems in that they appear—insofar as it is possible to make such a determination given an essentially nonspecific definition—to honor the various criteria used in determining community support systems as promulgated by NIMH.

Third, outcome studies of the effects of synthesized community support systems on chronic mental patients show these efforts to be at least as effective as in-hospital programs in some particulars of patient care, and more effective than in-hospital programs in others. However, the documented benefits of these programs are modest and tentative. What advantages do accrue to patients as the result of their enrollment in these programs are apparently of a temporary nature and appear to be sustained only so long as direct and aggressive interventions by program staff are pursued. It must be recognized also that the methodological problems associated with assessing outcomes in synthesized community support systems are sufficiently serious to warrant only the most cautious acceptance of these results.

Fourth, outcome research in synthesized community support systems is best suited to matters concerning patient care techniques—questions about the specific treatments and environmental circumstances that most effectively meet the needs of specific categories of patients. Research directed toward these kinds of questions should continue, and new directions should be encouraged. It is essential that immediate efforts be launched to minimize the extensive methodological difficulties that now confound such research. New and more valid outcome measures are needed, as are more rigorous study designs that would foster improved cross-study comparability.

Fifth, because patient-centered investigations may deflect attention from the broader policy questions surrounding deinstitutionalization, they should be supplemented with other kinds of outcome research. Outcome studies of synthesized community support systems largely ignore, or are irrelevant to, the global problems of deinstitutionalization. Accordingly, we would be well served by attempting to investigate the outcomes of deinstitutionalization more directly.

One approach that holds promise lies in the application of systems theory. According to Miser (1980), systems theory asks questions that involve the critical examination of the social purposes of an intervention, that explore alternative ways of achieving goals, and that estimate the “impacts of various courses of action” (p. 145). Systems theory is implicitly interdisciplinary and comprehensive in its approach (Weiss 1967; Marmor 1975; Holder 1977; Engel 1980; Stratas and Boyd 1981).

The literature is now just beginning to explore some systems issues that must be resolved if deinstitutionalization efforts are to meet with success, and chronic mental patients are to be cared for humanely in community settings. Bradley (1976) shows, for example, that deinstitutionalization involves both program development objectives, such as establishing a system of community-based care, and program termination objectives, such as phasing out institutional
care. The two objectives need not necessarily be met simultaneously, and it is possible to vary the speed and completeness with which each is implemented. But because strong partisan views have prevailed, and because economic resources are scarce, these two potentially autonomous processes have become linked, and scholars like historian David Rothman are quoted as saying that "there is good reason to believe that deinstitutionalization and State mental hospitals cannot coexist" (Sargent 1980). The implication here is clearly that disengagement from institutional care must be total and immediate.

Systems theory would permit the theoretical and practical separation of these two objectives, so that priorities could be set and intermediate goals could be effected. In fact, Bradley (1978) provides a most insightful discussion of the steps that must be followed in making critical choices in the formulation of public policy. She writes:

Since all ends and needs are not equal or equally met, these choices must be among competing priorities and should be closely tied to political and fiscal exigencies. . . . [A plan for effecting changes in policy] when viewed in this light forms the impetus for change and bridges the gap between ideology and implementation. [p. 52]

Although the service delivery options being tested in synthesized community support systems may hold the key to future planning for direct patient care, they are not immediately translatable into public policy decisions. They represent but one kind of needed outcome study and must be supplemented by impact analysis in order for the deinstitutionalization movement, and its overall benefits and limitations for persons with chronic mental disorders, to be assessed completely and objectively.

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The National Institute of Mental Health (NIMH) Center for Studies of the Mental Health of the Aging, in collaboration with the Center for Studies of Schizophrenia, will be sponsoring an open conference on Schizophrenia, Paranoia, and Schizophreniform Disorders in Later Life to be held at The Jack Masur Auditorium, National Institutes of Health Campus, Bethesda, Maryland, June 7-9, 1982. The conference will focus on two major populations: (1) individuals diagnosed schizophrenic in early adulthood who are presently entering old age; (2) individuals who have experienced the first onset of symptoms in later life.

Although schizophrenia has traditionally been studied as a psychiatric disorder with onset in early adulthood, there exists little systematic knowledge regarding the changes in course, treatment, or prognosis of this disorder which accompany advancing chronological age. Moreover, numerous questions remain regarding the viability of diagnostic classifications such as "paraphrenia," or "late-onset schizophrenic states." The reliable distinction of such disorders from paranoid states and from progressive dementias and other forms of cognitive impairment associated with advancing age require further systematic attention.

The conference will focus on:

• Stimulating increased interest in these substantive areas.
• Reviewing the state of the art.
• Specifying precise substantive recommendations to NIMH for research program development.

If you have worked clinically with either one or both of these populations and would be interested in sharing your research perspectives on these issues with us, we would be pleased to hear from you. Empirical data regarding epidemiology, assessment, differential diagnosis, biological, or sociocultural parameters of illness, and treatment modalities are especially welcome. Please address your correspondence to:

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