# Characteristics of Participants and Nonparticipants in a Drop-in Center Program for the Chronically Mentally Ill

Written by

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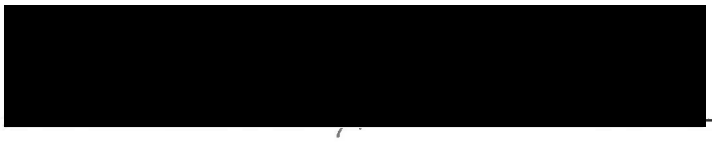
in Fulfillment of Requirement for

Masters in Nursing

1982

Approved:



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This study was supported by a
traineeship from the United States Public
Health Service Grant Number 2 ALL NU00250-05.

Acknowledgments

A special thank you goes out to the many people who have provided me with support and encouragement through the consuming effort of this study.

To Mary Kay King for her initial guidance in the early stages of this project in its infancy, thank you for the moments of encouraging my thoughts in more creative directions.

To Beverly Lauck, thank you for the conception of this project, the opportunity for my work on this project, and the hours of support and supervision through this project.

To the North/Northeast Mental Health Clinic staff, for all the warmth and encouragement in my efforts, thank you.

To my colleagues in the emergency room, thank you for the endless support and understanding lended to me, and especially the compassion given me during the efforts of completing this study.

To Beverly Hoeffer who perpetuated the creative thinking and development of this study by her contributions, her insightful directiveness, her supportive guidance, and her willingness to be available to me through the course of this study, thank you.

To all the friends and family who patiently accepted

all my time constraints and demands, who provided the most valuable of emotional supports to me in the birth of this study, and who stood by willing to share in the laughter and tears along the way, thank you.

To Larry, Deb, and Kat, for your endless love and encouraging support, I thank you. I am grateful for all the moments and the minutes you listened to me and comforted me. I especially thank you for the love and caring you shared with me as I completed this study.

To Dennis, for the nurturing, the support, the listening, the laughter, the tears; for all these things and more, I thank you. These special gifts you have shared on the road to the completion of this study have made it a joyous process.

Table of Contents

Figures



Appendix

# Chapter I

## Introduction

### Scope of the Problem

According to a 1981 report, there are between 1.7 million to 2.4 million people in the United States who are considered chronically mentally ill (Goldman, Gattozzi & Taube, 1981). A chronic condition may be characterized by a long duration of illness which also includes periods of wellness disrupted by exacerbation of acute symptoms and secondary disabilities (Goldman et. al., 1981). Chronic mental illness is not only determined by the disturbances of cognition which interfere with the individual's ability to assume functioning in life roles (e.g., work, school, family, and community), but also by affective disorders which interfere with the same. Additionally, chronic mental illness is also determined by the number of previous hospitalizations for the treatment of a mental disorder (Bigelow, 1972). This report conveys information hinting at clinical, socioeconomic, ethnic and cultural heterogeneity of this population but does not address any of the special problems or needs of this population.

In 1978, a consumer, a man with a history of chronic mental illness, identified the needs of the chronically mentally ill to an A.P.A. conference. Among those needs

described were specific issues related to support and socialization: for those who can't work is the need for a place to go, a place to be expected daily, a place where they can be with people like them and do things that are meaningful to the individual self and others; a place in the community which he feels helps him remain in the community or helps him get out of the hospital; a need to be with other people, to talk and do things with, and be themselves with (Peterson, 1978).

Talbott (1980), in his review of the process of deinstitutionalization to make recommendations for a public policy on the chronically mentally ill, again addressed these same issues of support and socialization. He describes the need for programs which emphasize skills of everyday living, assistance in developing meaningful daytime and evening activities, and assistance in developing social contacts and socialization.

More specifically, these needs for support and socialization must be defined by each single catchment area for their population. The North/Northeast catchment area serves about 117,000 people, including 18,500 blacks, one of the largest concentrations of an ethnic minority in the state of Oregon. This concentration amounts to 84% of the total black population of Multnomah County. The percentage of blacks treated in the clinic is 25-28%

of the total clinic population. This is seen as consequent to the clinic's geographic location in the heart of the black community. The clinic itself is located in the catchment area containing a vast majority of the black people living in Oregon. Thus, the clinic serves a population which has two influencing care factors: chronic mental illness and ethnocultural factors.

In 1980, two assessment projects were conducted in the North/Northeast catchment area of Multnomah County, to establish the need for special services for the chronically mentally ill. Both these assessments reflected an absence of strong social networks and the need for socialization as a priority for the chronically mentally ill population served by the clinic, especially for minority clients.

The first, a six month 'minority concerns' project (Pittman & Taylor, 1980), assessed the needs of the black chronically mentally ill clients, utilizing a community member familiar with the area. She conducted interviews with the clients and community members. Her data were correlated with the data from the clinic demographic data compiled by the clinic psychiatrist and a group of client volunteers from the graduated work program. The second (Lauck, 1980), a needs assessment, was conducted by the Clinical Specialist in Psychiatric Nursing.

The assessment prioritized the needs of the 408 active clients receiving services from the North/Northeast Primary Care Project mental health component. Of these, 181 were assessed to need structured recreation and leisure time activities in conjunction with daily social support.

The result of these two projects was the identified need for a socialization program that could meet some of the unique needs of minority clients, as well as for the chronically mentally ill clients served. This need for social contact was also supported by this writer's informal observations of clients at the clinic over a six month period.

The clinic staff determined that the form this socialization would take would be a drop-in center. The drop-in center was seen to be a vehicle to help the chronically mentally ill have the direct benefit of access to socializing with others, recreation, and structured leisure time, and the indirect benefits of an expanded social network.

## Purpose of the Study

The purpose of the study is to provide information about the clients who utilize the drop-in center to assist in evaluation and further program planning by the Northeast Primary Care Project staff.

In a general review of the literature, socialization (access to others for socializing), and recreation were identified as essential for maintaining the chronically mentally ill in the community (Cohen & Sokolovsky, 1978, Hammer, et. al., 1978, Masnik, 1971; Talbott, 1980). Making the community more like 'home' for the chronically mentally ill may be accomplished by assisting the chronically mentally ill in broadening their base of support, expanding and developing networks, personal and resource, and helping them to sustain their social networks. It has been shown that with more available variety in services, clients demonstrated improved utilization of services. It has been demonstrated that if services are located in the area of need, they are regarded as more accessible and are more efficiently utilized by the chronically mentally ill. Given the above, it would seem that with the community seeming more like 'home,' if needed services such as socialization opportunities are available in the community as they are in the hospital programs, the chronically mentally ill would demonstrate reduced admission rates to the larger institutional settings. The literature also supports the idea that the effects of a broader base of social support will reduce the rate of hospitalization for the chronically mentally ill (Hammer, Makiesky-Barrow & Gutwirth, 1978); improve the individuals' social network

by expanding their range of contacts (Cutler & Beigel, 1978); reduce their use of other services; and increase the participation of the local community by involvement in volunteer services (Saunders, 1979).

The clinic location in the Albina core area provides it with a large minority population, and its services are generalized to the chronically mentally ill. Windle, Neal and Zinn (1979) identified that nonwhites were served more with indirect services such as consultation and education to the natural helper networks. The need for these services has always existed, and now too existed the need for access to socializing and recreation as confirmed by the needs assessment and the minority concerns project. It was decided that a drop-in center would be developed as a direct service, funded by a clinic grant. The drop-in center program also has access to additional supervision.

The Program

Potential participants of the drop-in center include 600 chronically mentally ill clients served by the area mental health agencies: North/Northeast Mental Health Clinic and The Center for Community Mental Health Day Treatment Center program. Subjects studied came from referrals from the North/Northeast Mental Health Clinic.

The drop-in center is intended to provide recreation and access to socializing for the chronically mentally ill

persons at risk of rehospitalization. Two groups were identified as potential activity center clients: those over age 55, who tend to be isolated; and younger, more active clients between the ages of 18-35, who spend time on the streets or 'hanging out.' Primary attention is given to meeting the needs of clients who function poorly in structured settings, but do respond to low stress, supportive environments.

With North/Northeast Mental Health Clinic providing services to the highest percentage of catchment area clients in Multnomah County, maintaining a 25-28% black population, it is expected that the drop-in center would have a similar proportion of black and white participants.

The drop-in center is located in the core Albina area, at a church four blocks from the mental health clinic. The drop-in center will focus on the special needs of minority clients by recruiting minority member volunteers and by providing culturally relevant activities. A client committee has been established and is to have a 25% minority membership to work with the staff from the clinic in developing ongoing program needs for the minority clients as well as for the chronically mentally ill clients.

The drop-in center uses the meeting room of the church which has access to bathroom and kitchen facilities. There are tables and chairs in the central area with additional

comfortable seating available. A radio is available for music. It is in operation for five hours on each of four days during the week. The staff consists of a program director and community volunteers. A wide variety of table games are available as well (e.g., puzzles for individual or small group construction). Also available are a crafts class, hygiene education, and a weekly outing. Clients can participate in cooking Thursdays' lunch and in special baking projects of snacks. Coffee and snacks are available daily.

To facilitate accessability, the drop-in center is free of restrictive entrance criteria and screening procedures, with people being able to do just that, 'drop in.'

Linkage of the drop-in center with the community mental health clinic is accomplished through the director and client representatives participating in the program planning meetings, in close cooperation with the drop-in center coordination committee.

As a result of previous sampling over the first four months of the drop-in center program functioning, it was found that the drop-in center served 34 clients; male participants were served more than female participants, with young adult black males served more frequently; all but 3% were single or divorced, and the 3% was one client who was separated. Eighty-two percent of the client

participants carried a diagnosis of Schizophrenia (Chronic Undifferentiated Type or Paranoid Type), and 20% were also diagnosed as Mentally Retarded/Developmentally Disabled. Other information found from reviewing client records showed black males at highest risk of rehospitalization due to a higher incidence of hospitalization in the previous year, 1980.

Significance of the Study

The importance of gathering information about the clients using the drop-in center program lies in its application in continued program development addressing the needs of support and socialization for the chronically mentally ill. The study provides information related to the influence of demographic variables, additional treatment variables, and distance factors as a base for program planning, implementation, and evaluation. The information may provide guiding parameters for comprehensive rehabilitation programs to meet the needs of the chronically mentally ill more effectively.

Historically, nursing has made a commitment to the care of the chronically mentally ill, reflected in their long time involvement with this population. In hospitals, nurses have been focused on assisting these clients in all areas of activities of daily living from basic grooming to leisure time activities, planning with staff and assisting

in the implementation of care. Becoming involved in planning and consulting to innovative comprehensive rehabilitation programs, such as a drop-in center, will expand the parameters of nursing to utilize more of the professionals' skills for the total client and maintenance of the client's community tenure.

## Problem Statement

The problem addressed in this study is: of those clients referred to a drop-in center program for the chronically mentally ill, what factors differentiate participance from nonparticipance.

# Chapter II

## Review of the Literature and Conceptual Framework

The review of literature will address the concept of a drop-in center (history and research), discuss the history of the provision of services to the chronically mentally ill in the community including a drop-in center program or similar programs, and the influence of socio-economic and minority factors. Additionally, concepts relevant to this study will be discussed. Finally, research questions will be posed and terms defined as they relate to this study.

## Historical Perspectives of the Concept of a Drop-in Center

Historically, socialization and recreation were seen as invaluable in the treatment of the chronically mentally ill. The "total push" method, as described by Myerson and Tillotson in 1939, focuses on treatment in the days before the development and introduction of antipsychotic medications. Exercise was seen to promote improved circulation and general health. Recreation was provided with a wide range of activities, both active and passive, for the stimulation and socialization of clients. Results of the total push method showed great benefits in encouraging improvement in patients and in minimizing the deterioration of their regressed clients. Improvements were seen in better contact with reality; enhanced social responsiveness;

increased activity, skill and coordination; improved mood and affect; and some improvements in physical status.

The move toward the use of antipsychotic medications was expected to solve the problems of management of the chronically mentally ill. Only after twenty years did professionals address the fact that medications were not solving the problem. Their clients continued to live in the revolving door syndrome, with frequent readmission to state institutions. The revolving door syndrome was one of the consequences of the process of deinstitutionalization which left most chronically mentally ill clients in a life with impoverished living conditions, unable to feel at 'home' in the community, perpetuating their return to the institutions which provided the security of having their basic needs met, e.g., food and shelter, and contact with others in a non-threatening setting.

Because of staff hopelessness regarding the repeated hospitalization of the chronically mentally ill (Slavinsky, Tierney & Krauss, 1976), and not knowing what else to do, little else beyond medication checks was done for these clients. This was reinforced by the difficulty these clients have in achieving and tolerating closeness (Masnik, 1971). It seemed that something more specialized, such as a means of encouraging socialization was needed for the treatment resistant chronically mentally ill population (Patti-

son & Elpers 1972, Talbott, 1980). This population accumulates in the community mental health clinics secondary to their poverty status and low income (Bassuk & Gerson, 1980); and use a large share of treatment facilities, often times resisting all treatment attempts excepting medications. Their opportunities for socialization are restricted to their medication checks with the doctor or therapist. This is due to the nature of the lack of funds so they can participate in community activities, and due to lack of staff knowledge about intervening with their special problems such as limited social networks (Pancoast, Froland & Collins, 1980).

Professionals eventually combined two areas of recognized need: socialization and recreation. Several programs were developed to incorporate both functions. Examples include the "coffee and ..." medication groups where clients come to a group for the dispensing of medications, and are asked to wait in an environment which is designed to provide low key stimulation and opportunities for social interactions with others. A group such as this was seen to utilize staff time more effectively and provide more control over the course of treatment (Masnik, 1971).

Another program is "the lounge" program, whose purpose was to promote an atmosphere of warmth while unthreatening,

still able to promote growth (Parras, 1974). As an informal unstructured setting, it was accepting and stimulating as a place where people were able to feel natural, and encouraged to be themselves. Like the "coffee and ..." group, "the lounge" program was free to be accepted or rejected by the client. "The lounge" was seen as capable of expanding and enriching existing inpatient and community services, serving as a steppingstone for hospitalized patients to outpatient services. It can be modified or utilized as a less formal outpatient day treatment service (Black, 1976); and it can provide linkage to other community based resources, demonstrating a more coordinated network of services (Parras, 1974).

In a review of mental health manpower trends, Pattison and Elpers (1972), identified the development of "informal community contact programs" where clients could interact casually with volunteers for human contact. These programs were to be coordinated and operated by indigenous community workers. In their review, they also described the downfall of some of these indigenous worker programs (e.g., lack of opportunity for professional development) and recommend future directions for the training of paraprofessional workers.

Only recently does the literature address the building of networks beyond that provided by professionals in

caring for the chronically mentally ill. Increased involvement of neighborhoods has been the most significant area explored by professionals: Volunteer Community Groups (Denner, 1974); folk networks and volunteer support networks (Cutler, 1979); and neighborhood projects for primary prevention (Saunders, 1979). The neighborhood networks can provide assistance in identifying high risk populations and services available, and suggest needed services. The neighborhood networks are comprised of community members who have no vested interest in controlling the chronically mentally ill, but rather serve as natural helpers in a volunteer support network (Cutler, 1979; Saunders, 1979).

It is anticipated that the participation of neighborhoods will increase awareness and community involvement for the general population and for the chronically mentally ill, with the community mental health clinic in a liaison based role. Generally, citizen involvement occurs on three levels: neighborhood participation; participation on the center's advisory board; and membership in the center's consumer committee which reviews and recommends needed services (Saunders, 1979).

Other innovative approaches utilize the educational model. The educational model is generally used for the teaching of the basic skills of everyday living to the chronically mentally ill. Lamb (1976), describes the uses

of the educational model in an educational setting or a non-institutional setting, with clients as students enrolled in courses taught by credentialed teachers. This idea was adapted by Cutler and Beigel (1978) in the program entitled "Community Organization for Personal Enhancement" (C.O.P.E.). This program was designed to enhance the social networks for the chronically mentally ill living in the community. Stein, Test and Marx (1975, 1978) also identified useful gains in community survival for clients participating in a program for 'Training in Community Living."

More recently, drop-in centers are being considered as resources for providing opportunities for socialization and recreation. These take a social rather than an individual emphasis. These programs offer an 'in vivo' site of treatment to enhance learning of skills and generalization of the learning to the clients' environment (Peterson, 1978; Schwartz, 1971; Test & Stein, 1976, Test, et al., 1975). Also, these programs increase the visibility of the chronically mentally ill in the community. By indirectly changing the attitudes of the volunteers participating in these programs and their extended networks, the programs hopefully will increase the tolerance of, the interest in, and the concern for the more visible chronically mentally ill (Cutler & Beigel, 1978). David's Harp in Portland is a good

example of the community church-based drop-in center, whose purpose is to assist the chronically mentally ill in developing a broader based network of support (Cutler, 1978).

Additional research by Pancoast, Froland and Collins (1980) suggests that mental health professionals identify and work with the complementary roles of formal and informal supports. They further offer examples of approaches and suggestions about the professional role. Included are: personal network interventions, volunteer linking programs, mutual aid networking, neighborhood helper programs, and community empowerment projects.

Socio-Economic and Minority Status Factors

The literature has identified a great need for mental health services for the poor, minorities, and the socially isolated (Balch, 1974; Clark, 1959; Cohen & Sokolovsky, 1978; Cutler, 1979; Hammer, et. al., 1978; Jaco, 1954; Slavinsky, et. al., 1976). Research supports that these people have difficulty obtaining such services on their own, and that they need professional intervention just to receive the service, let alone establish a support network (Balch, 1974; Cohen & Sokolovsky, 1978; Cutler, 1979; Hammer, et. al., 1978; Parras, 1974; Williams, et. al., 1980).

Two studies indicate that in order to be utilized, centers such as a drop-in center must be located within the area of the greatest need and readily available without

restrictive entrance criteria (Hussaini & Mathis 1979; Windle, et. al., 1979). This is further identified by Talbott (1980) as a necessity for effective program outcome that enhances the community tenure of the chronically mentally ill. Another main factor supported by two studies is that chronic clients, regardless of race, are likely to become more involved when there is a wide range of services made available, and when the network of services is broader (Dawkins & Dawkins, 1978; Cutler, 1979).

Research on Measurement of Outcomes

In measuring program success it would seem that the readmission rates to hospitals would be the most easily measured variable. Readmission rates to hospitals have been identified in the literature as one of the primary measurable criteria for determining the success of community programs (Budson, 1977; Hammer, 1963-64; Strauss & Carpenter, 1977; Talbott, 1980; Wolkon, et. al., 1971). Other outcomes which are certainly more difficult to measure include: increased insight, decreased anxiety, alleviation of symptoms, improved ego strength, and the facilitation of social function. These outcomes are similar to the outcomes of the total push method described by Myerson and Tillotson (1939) for chronic patients in an inpatient setting.

A review of the literature identifies very poor progress in follow-up studies providing data that can be gene-

ralized and compared, let alone trace the movement of discharged clients through mental health facilities and living situations after their release from hospitals (Bassuk & Gerson, 1978). It is further identified that many studies appear inconsistent in their results, relative to differences of populations observed and other methodological choices.

The difficulty in general with research on schizophrenia (a major chronic mental illness) is the absence of universally applicable characteristics of schizophrenia (Hammer, et. al., 1978). One of the methods being considered and developed is the use of network analysis for the study of the schizophrenic population to determine characteristics of that population. Such an analysis would identify special needs for services required by that population (creation of predictor variables), and establish criteria to measure program effectiveness for the various direct and indirect services employed to serve this population. All this would be done to determine outcome variables. Network analysis can be operationalized to mean the analysis of links or relationship sets which define the network boundaries for the individual.

Hammer, Barrow, and Gutwirth (1978) identify the use of network variables as permitting systematic comparable studies of individuals in their social contexts. This approach is seen to better control for cultural variations

in such factors as: family composition and role definitions; the range of socializing agents; and other cultural differences.

Cohen and Sokolovsky (1979) identify that most research in the area of network analysis has been done with families and that only a few have clinical relevance. They further identify that there have been only a few studies considering the desirability of using network analysis as an adjunct to treatment, and that these lack "scientific rigor" characterized in other models or approaches.

Hammer (1963-64) identified that the number of contacts in an individual's network was influential in the rehospitalization of schizophrenics. Based on her findings, Hammer, et. al., (1978) discussed the roll of sociocultural factors in schizophrenia, specifically the impact of social environment. Pattison and Elpers (1975) identified the importance of "quasi-families" in expanded networks for the chronically mentally ill adjusting to the community. Cohen and Sokolovsky (1978) attempted to convert the network approach into a network analysis tool and tested it in a single-room occupancy study examining social network variables, psychopathology, and rehospitalization. Their results opposed the results of Hammer (1963-64) and Pattison, et. al., (1975). Although they had a better research design in terms of more rigorous methodology (density and

degree were expressed mathematically for measuring quantitatively), the tool was only applied in single room occupancy settings. Not all chronically mentally ill people live in these single-room-occupancies, and the tool has not been generalized to or been tested in other living situations. These studies use a social network approach but demonstrate opposite outcomes.

Cutler (unpublished) provides a five segment design model for understanding the impact of social networks in his guide for community mental health practicioners and board members in working with the chronic patient. In his description the network is divided into five segments: PERSONAL, the most immediate segment of persons who provide emotional and instrumental support for the individual; SOCIAL, those persons who provide emotional support to the individual as in natural friends, neighbors, school mates, and distant relatives; RECREATION, the segment which focuses on the need for involvement in activities where the expected outcome is for an enjoyable experience; PRODUCTIVE ACTIVITIES, which refers to the work segment or how one contributes to their world in a meaningful way; and SERVICES, the segment which constitutes the formal care giver network. It was this design which influenced and guided the needs assessment conducted by the Clinical specialist in Psychiatric Nursing (See Appendix A).

The purpose of a drop-in center would be to provide resources for socialization opportunities. A drop-in center provides the setting to promote augmented folk networks (which would be identified in the SOCIAL segment), to provide social and interpersonal support, and generally provide the rudimentary network base for the SOCIAL segment (Cutler & Beigel, 1978).

In summary, the review has covered the circularity of the issues concerning support and socialization from pre-antipsychotic medication periods through post-deinstitutionalization periods. The literature has identified the need for access to socializing with others and recreation as essential for maintenance of the chronically mentally ill in the community. Making the community more like 'home' for this population may be accomplished by providing access to opportunities and settings for socialization and recreation, and structured leisure activities in addition to the more formal services. Combining formal and informal services may directly or indirectly assist the chronically mentally ill in broadening their support base, while expanding and developing networks. It has been shown that with more available variety in services, clients demonstrate improved utilization of services. It has been demonstrated that if services are located in the area of needs, they are regarded as more accessible and are more efficiently utilized by

the chronically mentally ill. Given the above, it would seem that with the community seeming more like 'home,' if needed services such as socialization are available in the community as they are in the hospital, the chronically mentally ill would demonstrate reduced admission and re-admission rates to the larger institutional settings.

## Research Questions

For the purpose of this study then, certain questions have been posed:

1. On what demographic variables do participants and nonparticipants in a drop-in center program differ?
2. On what treatment program variables do participants and nonparticipants in a drop-in center program differ?
3. What is the relationship between participation and nonparticipation in a drop-in center program and readmission to the hospital?

## Definition of Terms

Chronic Mental Illness: a condition characterized by a long duration of illness which also includes periods of wellness disrupted by exacerbations of acute symptoms and secondary disabilities. Chronic mental illness is not only determined by disturbances of cognition which interfere with the individual's ability to assume functioning in life

roles, but also by affective disorders which interfere with same (Bigelow, 1972; Goldman et.al., 1981).

Drop-in Center: a place where people are free to do just that, 'drop in.' It is a low key, non-threatening environment which is also supportive and stimulating. There is structure provided by the director and contact with other persons provided by participants and volunteers. It is a source of socialization and leisure time activities.

Participation: Participation on a regular basis will be determined to be attendance at the center one or two times per week. On each day of the week there are other structured services at the mental health clinic the clients already utilize: Monday-Prolixin Group; Tuesday-Graduated Work Group; Wednesday-Lithium Group and Chronic Problem Solving Group; and Thursday-Socialization Group. This means that clients are at the clinic on each day for specific formal services and could easily access the drop-in center four blocks away. Just dropping in is accepted, regardless of the amount of time spent. Exceptions include: physical illness, holidays, hospitalization, director's vacation, and jail incarceration.

# Chapter III

## Methodology

### Design

The study is a retrospective study of the chronically mentally ill clients associated with a drop-in center, using pre-existing data. The study is descriptive in nature.

### Subjects

The population from which the sample is drawn consists of clients referred or introduced to the drop-in center program from the Northeast Mental Health Clinic. All clients who fit the above stated criteria were included in the study which consists of all clients who were referred or introduced to the drop-in center program from January 1, 1981 through December 31, 1981.

Of the 90 clients referred or introduced to the drop-in center program, 58% (n=52) were male and 42% (n=38) were female. In terms of ethnicity, 46% (n=41) were white and 54% (n=49) were black. The clients ranged in age from 19.5 years to 71 years with a mean age of 37.4 years and a median age of 34.4 years.

From the needs assessment conducted in May 1980, it was determined that 181 clients could benefit from a drop-in center program. The program outcome objectives anticipate that 75 chronically mentally ill clients would be introduced to the program in the first year of operation.

The drop-in center was in operation for 51 weeks, a total of 156 days from January 1, 1981 through December 31, 1981.

Data Collection Instrument

The instrument used for data collection from clients' records at the mental health clinic was a Client Information Form, (See Appendix C). The items contained in this instrument were chosen to gain demographic information regarding clients who participate in the drop-in center program and those who do not (items 1-5); diagnosis (item 6); distance to the program which might influence access and type of living situation (item 7); additional treatment variables which may facilitate participation in the program or influence the readmission to the larger institutional settings (items 8 and 9); the number of previous hospitalizations and hospital days for the years 1980 and 1981 to identify any changes in the patterns of using the larger institutional settings (item 10); the total number of days in attendance at the drop-in center from January 1, 1981 through December 31, 1981 excepting the days the center was not open as on holidays, vacation, snow days (item 11); and the number of times incarcerated in jail in 1981 with jail identified as another place a client may have been detained preventing attendance (item 12).

Data Collection Procedure

Access to the specified subject population was addressed with the Clinical Specialist, who brought the issue of access to the team meeting for approval. A letter of confirmation was obtained from the Clinic Director, confirming access to the records of the specified subject population (see Appendix B).

Information regarding clients and their attendance was obtained from the drop-in center where the director records daily attendance. Once the list of subjects was obtained, the researcher reviewed the client records at the mental health clinic to record the necessary pre-existing data.

Confidentiality was assured as the researcher was the only person with access to the data and all data was coded. There were no risks to the subjects involved in the study.

Analysis of Data

This study delineates the characteristics of clients who participated in a drop-in center program and those who did not. Frequencies were derived for each varialbe. Cross-tabulations were obtained for age, sex, ethnicity, marital status, income, diagnosis, type of living situation and distance to the drop-in center. Income was collapsed into three categories. Age was computed on the basis of June 1981. Comparisons were made between all demographic variables, additional treatment variables, and hospitalization variables at four levels of participation; and for the core group (n=9)

with the remaining group (n=81). A Student's t-test was used as a test of proportions to test for differences in group means with significance set at the $\leq$.05 level. A oneway ANOVA uas used to further assess the variability within and between the groups. Significance was set at the $\leq$.05 level. A Pearson's Correlation was obtained to determine the relationship between: medicine changes and hospitalizations (the number of times hospitalized and the number of days spent in the hospital); additional treatments and days in attendance at the drop-in center; and participation and the change in hospitalization (the number of times admitted and the number of days spent in the hospital). Significance was set at the $\leq$.05 level. Chi square was used to analyze the cross tabulations involving nominal data with significance set at the $\leq$.05 level.

# Chapter IV

## Results of the Study

This chapter presents a discussion of the results of this study which describes the participants and nonparticipants of a drop-in center for the chronically mentally ill. After a critical review of the frequency data, the sample was broken down into 4 major groups. GROUP I (n=23) attended one time at the drop-in center and are classified as nonparticipants. GROUP II (n=25) attended the drop-in center 2-6 times and are classified as infrequent participants. GROUP III (n=27) attended the drop-in center 7-24 times and are classified as frequent participants. GROUP IV (n=15) attended the drop in center 25-133 times and are classified as regular participants. A core group (n=9) was delineated from GROUP IV as subjects who attended the drop-in center at least once per week.

### Research Question One

> On what demographic variables do participants and nonparticipants in a drop-in center program differ?

The demographic variables treated include: age, sex, ethnicity, marital status, income, diagnosis, living situation type and distance to the drop-in center. Each variable will be discussed separately.

#### Age

The range of ages was from 19.5 years to 71 years,

calculated from the date of birth to June 1981. The mean age was 37.4 years, and the median age was 34.4 years. A more detailed breakdown of age can be seen in Figure 1.

There were no significant differences between the four groups based on age of the subjects ($p=.49$).

Sex

Of the 90 subjects, 58% (n=52) were male and 42% (n=38) were female. Table 1 presents a contingency table of the four groups based on gender.

There were no significant differences between the four groups based on gender ($chi^2=6.15$, $p=.1045$). However, although not statistically significant, males tend to more frequently participate than females.

Ethnicity

The ethnic composition of the sample included 46% (n=41) white subjects and 54% (n=49) black subjects. There were no significant differences between the four groups based on ethnicity ($f=2.10$, $p=.55$).

Marital Status

For the sample, 6% (n=5) of the subjects were

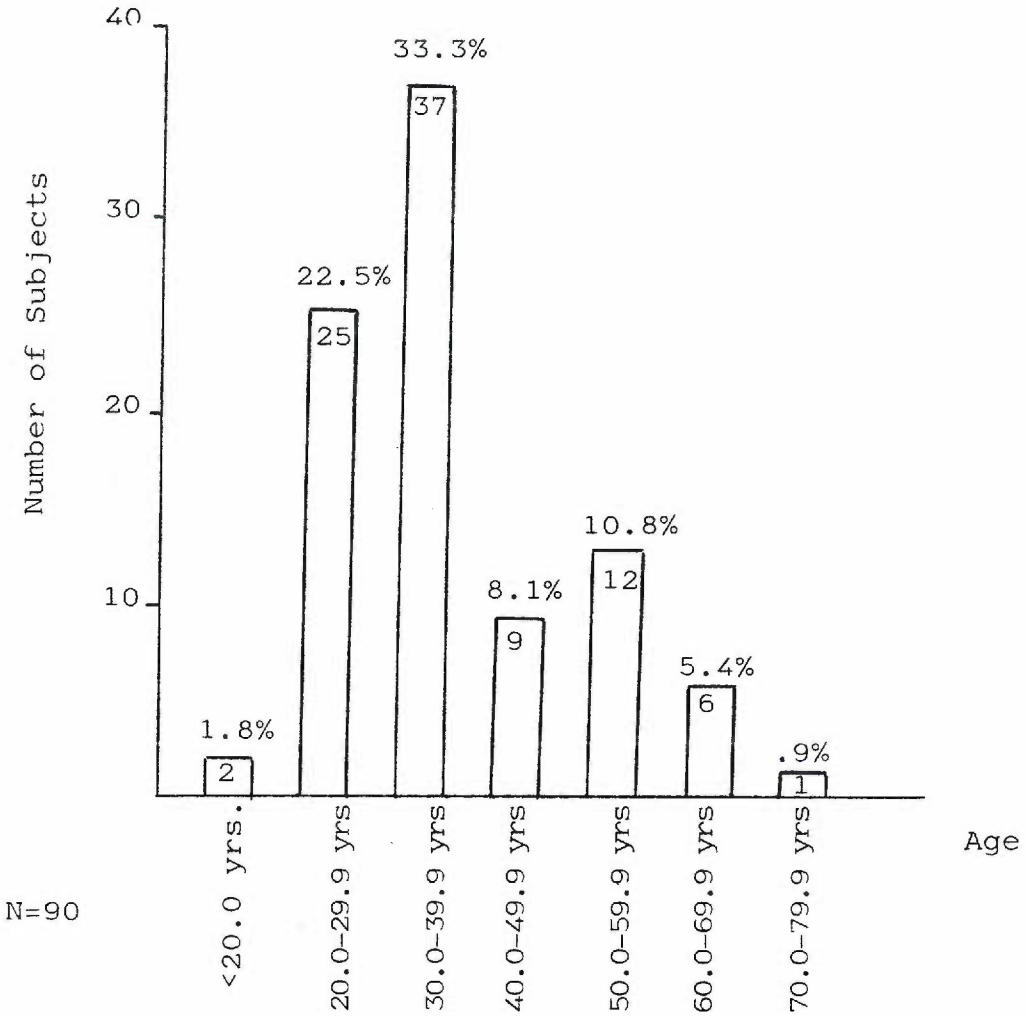



Figure 1. Age distribution for participants and nonparticipants in a drop-in center program for the chronically mentally ill.

Table 1

Gender Composition for Four Levels of Participation in a Drop-in Center Program

| Level of Participation | Gender | |
|---|---|---|
| | Male | Female |
| Non-participation | 10 | 13 |
| Infrequent participation | 12 | 13 |
| Frequent participation | 19 | 8 |
| Regular participation | 11 | 4 |
| Total | 52 | 38 |

$chi^2=6.15$, $p=.10$

married, 64% (n=58) were single, and 30% (n=27) were either divorced or separated. There were no significant differences between the four groups based on marital status ($chi^2$9.64, p=.38).

Income

The range of income for the sample was less than $3,000 to $9,999 annually. Of the sample, 41% (n=52) made less than $3,000 annually; 24% (n=27) made from $3,000 to $3,999 annually; and 10% (n=11) made from $4,000 to $9,999 annually (see Figure 2). There were no significant differences observed between the four groups based on income ($chi^2$=10.7, p=.77).

Diagnosis

A review of the subjects' charts revealed eight diagnostic categories: Schizophrenia, Chronic Undifferentiated Type; Schizophrenia, Paranoid Type; Borderline Mental Retardation; Latent Schizophrenia; Schizoaffective Disorder; Manic-Depressive Illness; Involutional Paranoid State; and Substance Abuse. Figure 3 presents the frequency of each of the eight diagnoses. The most frequent diagnoses include: Schizophrenia, Chronic Undifferentiated

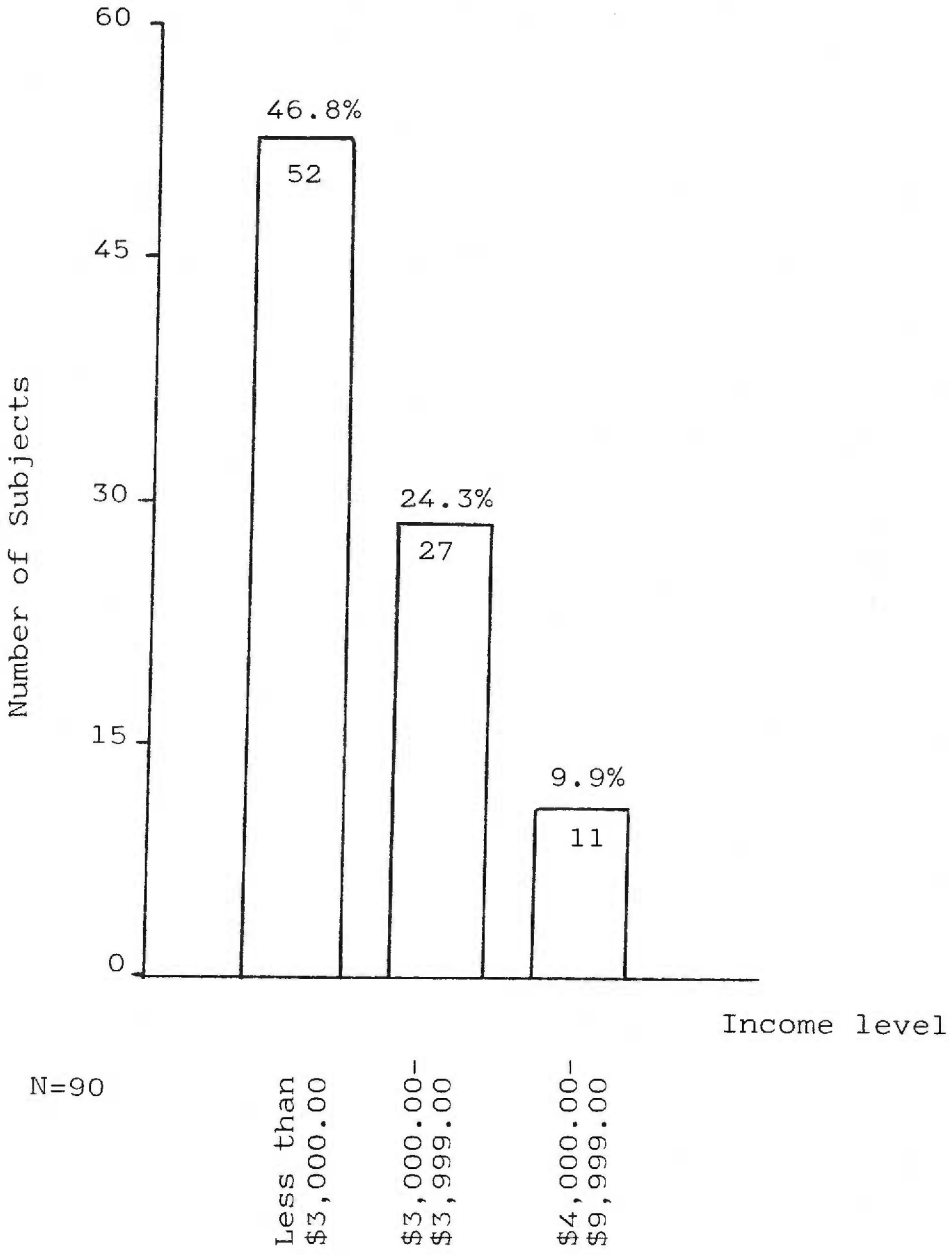



Figure 2. Income distribution for participants and non-participants in a drop-in center program.

type, 43% (n=39); Schizophrenia Paranoid type, 49% (n=44); Borderline Mental Retardation, 16% (n=14); and Substance Abuse, 14% (n=13). Figure 4 presents the number of diagnoses per subject as some subjects had multiple diagnoses. The range of the number of diagnoses was 1-4 listed in the individual chart. There were no significant differences between the four groups based on the type of diagnosis or the number of diagnoses for each subject [(p=.29), (p=.45), (p=.43), (p=.91), (p=.22), (p=.44), (p=.32), (p=.54), and (p=.99)], respectively, for each diagnosis and for the number of diagnoses.

Living Situation Type and Distance

Twenty-seven per cent (n=24) of the subjects lived in a private residence, 38% (n=34) lived with family, and 36% (n=32) lived in a room and board setting. No significant differences were found for the four groups based on the type of living situation ($chi^2$=5.45, p=.48).

The range of distance to the drop-in center from the living situation was three blocks to 200 blocks. The mean distance was 23.9 blocks, and the median distance was 19.2 blocks. There were no significant differences between the four groups based on distance (p=.45). However, it was

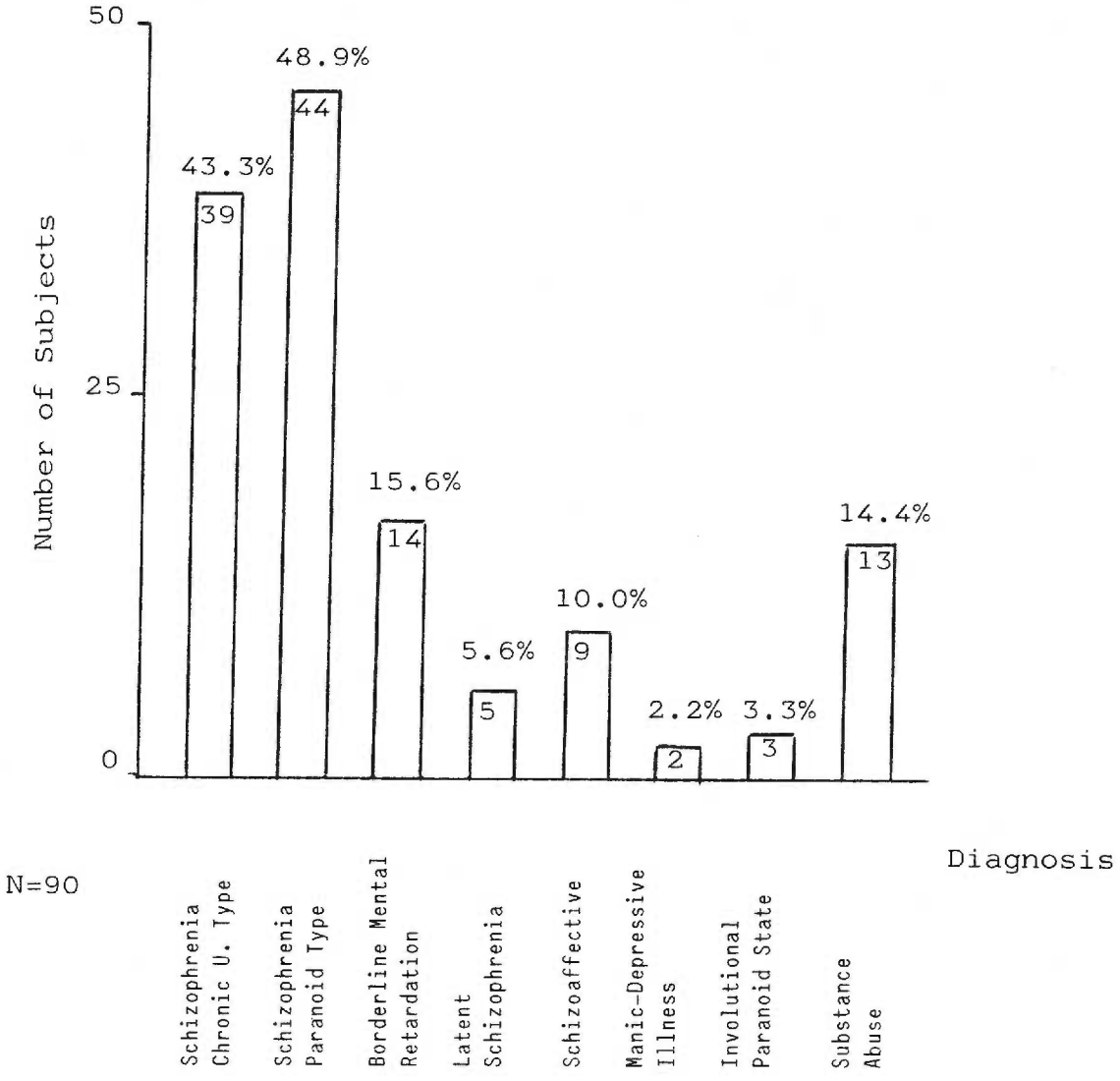
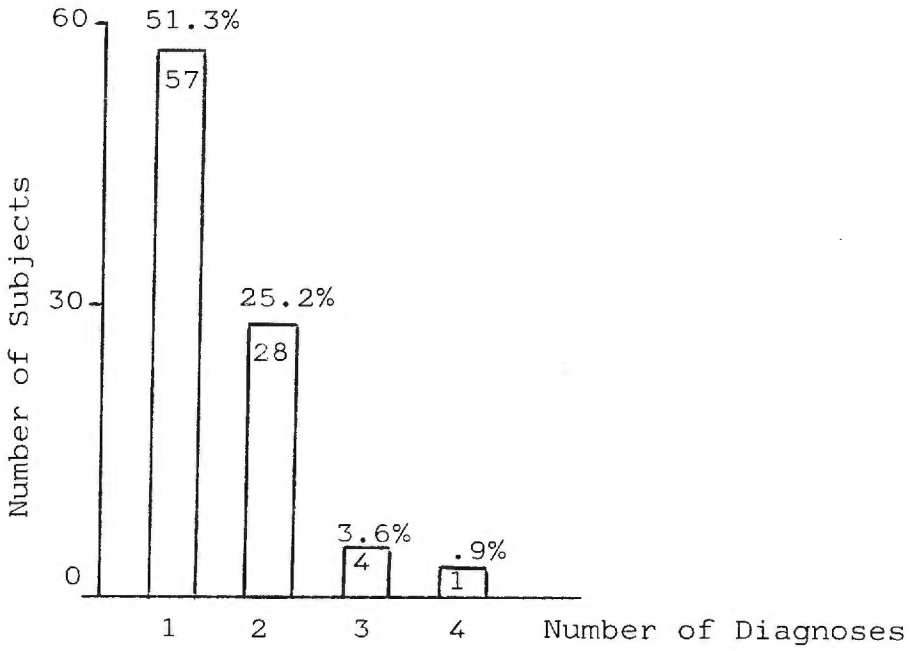



Figure 3. Distribution frequency of diagnosis for participants and nonparticipants in a drop-in center.




N=90

Figure 4. Distribution for the number of diagnoses per subject.

noted that the member of the core group lived at a closer mean distance of 14.8 blocks while the remaining subjects lived at a mean distance of 21.5 blocks. But, a Student's t-test indicated no significant differences between the four groups based on distance (t=.18, p=.45).

### Summary

There were no significant differences found based on demographic variables for participants and nonparticipants in a drop-in center program for the chronically mentally ill. The data suggest a trend for a greater portion of the participants to be male.

## Research Question Two

> On what treatment program variables do participants and nonparticipants in a drop-in center program differ?

Additional treatment variables measured include: medication, changes in medications, and additional treatment groups which are conducted at the mental health clinic. Each category will be presented individually.

### Additional Treatment Groups

As stated previously, the mental health clinic conducts several treatment groups: Prolixin Group, Graduated Work Group, Lithium Group, Chronic Problem Solving Group, and Socialization Group. These groups are adjuncts to chemotherapy. Overall, the two most frequent treatments received by subjects were: Medications, 96% (n=87),

and Prolixin Group, 56% (n=50). Figure 5 presents the frequency of each additional treatment.

As with diagnosis, subjects may also receive more than one additional treatment. The range of additional treatments is from no additional treatments to four additional treatments. For the sample, 49% (n=54) had at least two additional treatments, 25% (n=28) had one additional treatment, and 7% (n=7) had more than two additional treatments (see Figure 6). No significant differences were found between the four groups based on the type or number of additional treatments [(p=.44), (p=.74), and (p=.56), respectively] for each additional treatment variable and the number of additional treatments.

A Pearson's Correlation was performed to determine the relationship between the days the additional treatment groups are conducted at the mental health clinic and the days in attendance at the drop-in center. Significant differences were found for those subjects who attended the graduated work group and their participation on Tuesday ($r$=.27, p=.004); Wednesday ($r$=.18, p=.04); and Thursday ($r$=.19, p=.03).

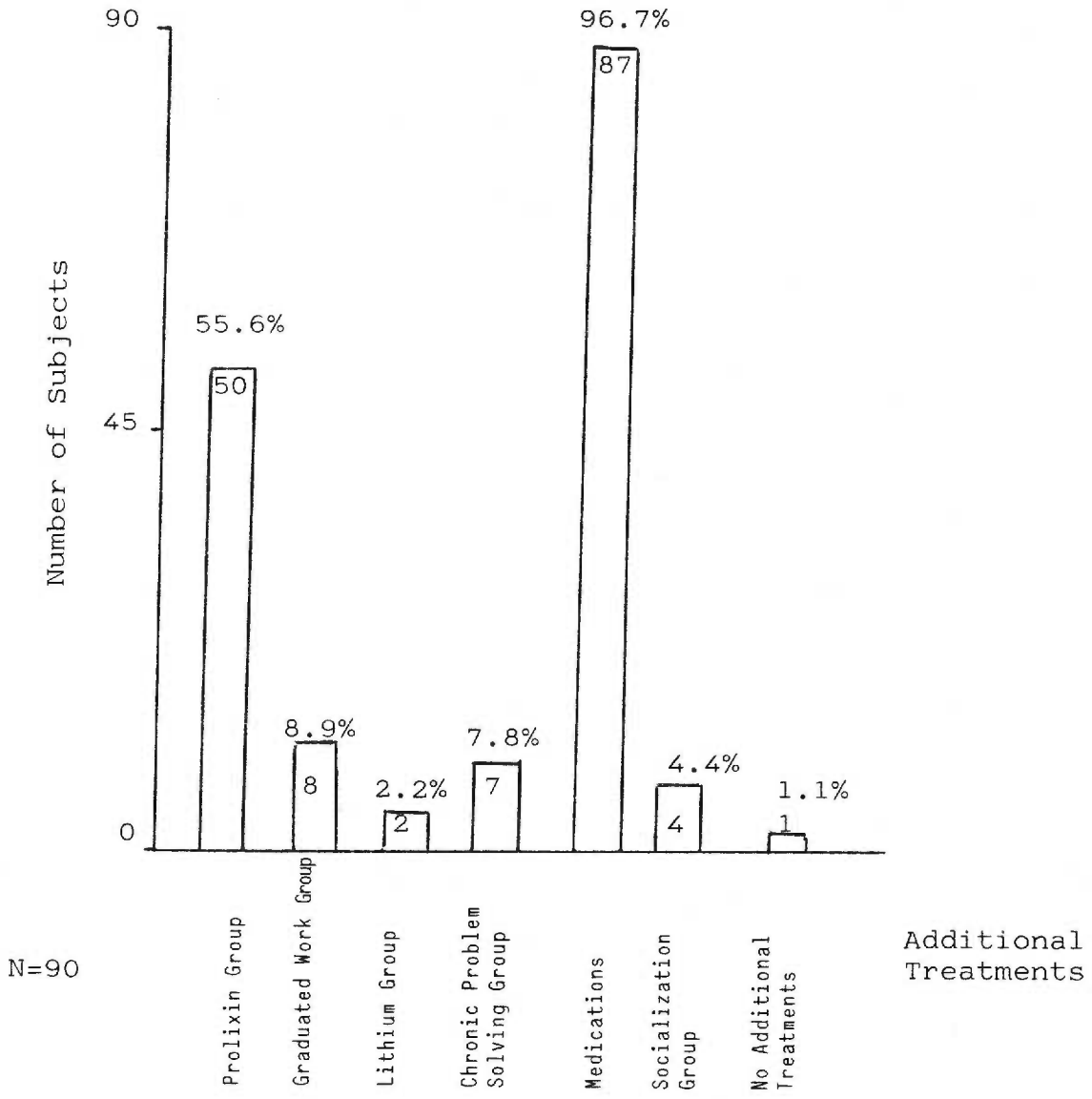



Figure 5. Distribution frequencies for additional treatment program variables.

Medications

Only neuroleptic medications were measured. For the sample, 84% (n=76) had medication changes and 16% (n=14) had no medication changes. The range of medication changes (increases, decreases, or new medication added) was from one to ten changes. Figure 7 presents the number of medication changes experienced by the subjects.

Increases in medications had a range of one to four increases. For the sample, 29% (n=26) had one medication increase and 20% (n=18) had two to four increases.

Decreases in medication had a range of one to four decreases. For the sample, 22% (n=30) had one decrease; 26% (n=23) had two decreases; and 16% (n=14) had three to four decreases.

There was a range of one to five new medications added. For the sample, 18% (n=16) had one new medication added; 14% (n=13) had two new medications added; and 6% (n=5) had three to five new medications added. There were no significant differences between the four groups based on the number or type of medication changes [(p=.22), (p=.59), (p=.65), (p=.59), and (p=.60), respectively] for no medication changes, number of

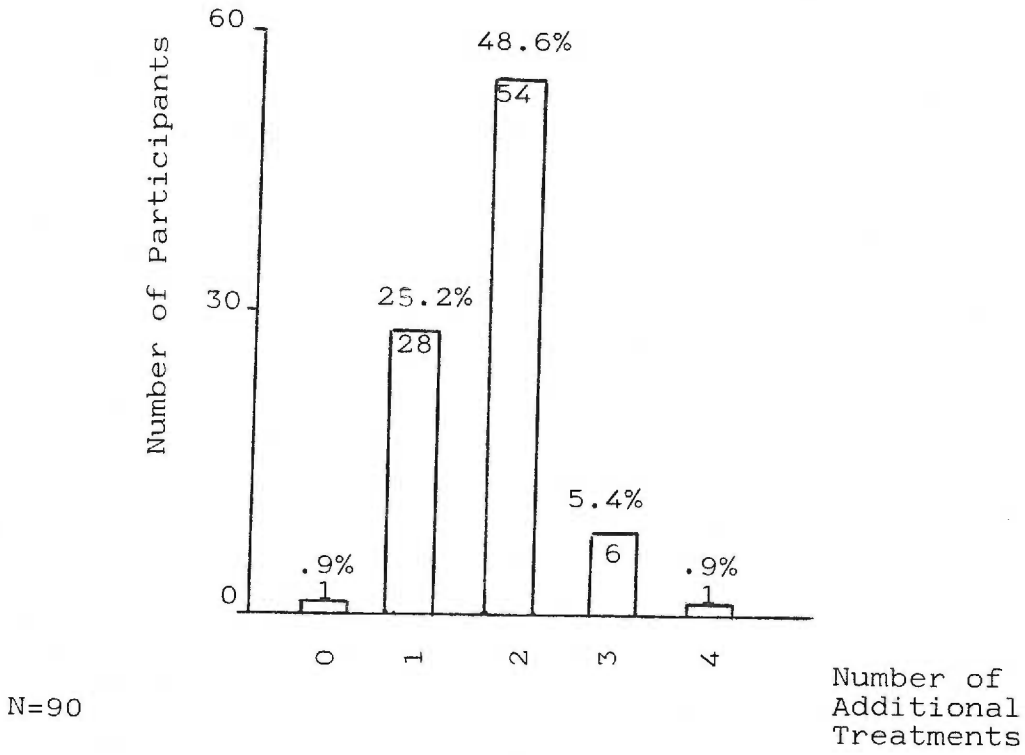



Figure 6. Distribution for the number of additional treatments per subject.

decreases, and new medications added.

Medication variables were correlated with hospitalization variables using a Pearson Correlation. There was no significance in the relationship of medication changes in changing the number of hospitalizations or the number of days spent in the hospital ($r$=-.05, p=.29) and ($r$=-.02, p=.41), respectively.

Summary

There were no significant differences based on additional treatment program variables for participants and nonparticipants in a drop-in center program for the chronically mentally ill. The data does show that subjects attending the graduated work group also regularly attended the drop-in center on Tuesday, Wednesday and Thursday significantly more when compared with the remaining subjects.

Research Question Three

> What is the relationship between participants and nonparticipants in a drop-in center program and readmission to the hospital?

The range of hospitalizations for 1980 was no hospitalizations to six hospitalizations. For the sample, 56% (n=50) had no hospitalizations, 27% (n=24) had one hospitalization

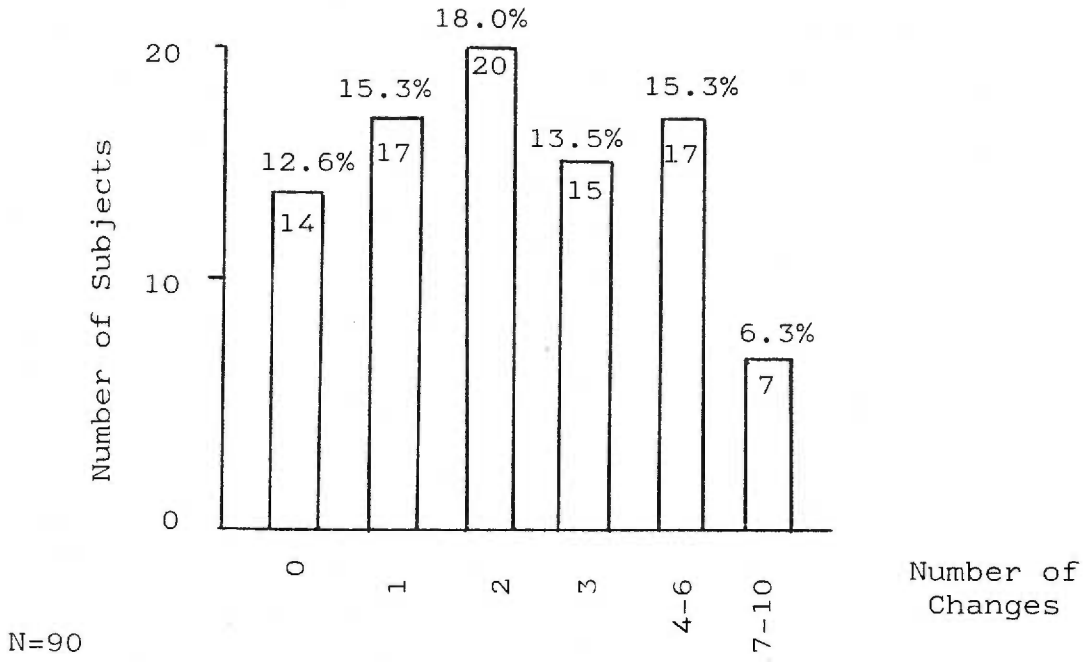



Figure 7. Distribution of medication changes.

and 18% (n=16) had two or more hospitalizations in 1980. The range of hospital days in 1980 was from one to 185 days with a mean of 30 hospital days.

The range of hospitalizations for 1981 was from no hospitalizations to four hospitalizations. For the sample, 64% (n=58) had no hospitalizations, 20% (n=18) had one hospitalization, and 16% (n=14) had two or more hospitalizations in 1981. The range of hospital days in 1981 was from six to 212 days, with a mean of 25 hospital days.

New variables of hospitalization change and hospital days change were created to reflect the difference for 1980 compared to 1981 (Hospitalizations in 1980 minus Hospitalizations in 1981, and Hospital days in 1980 minus Hospital days in 1981). Figure 8 presents the new variable of change in the number of hospitalizations, while Figure 9 presents the new variable of change in the number of hospital days.

There were no significant differences in participation for the four groups based on the change in the rate of hospitalization ($f=-1.2$, $p=.29$), or in the change in hospital days ($f=.25$, $p=.86$).

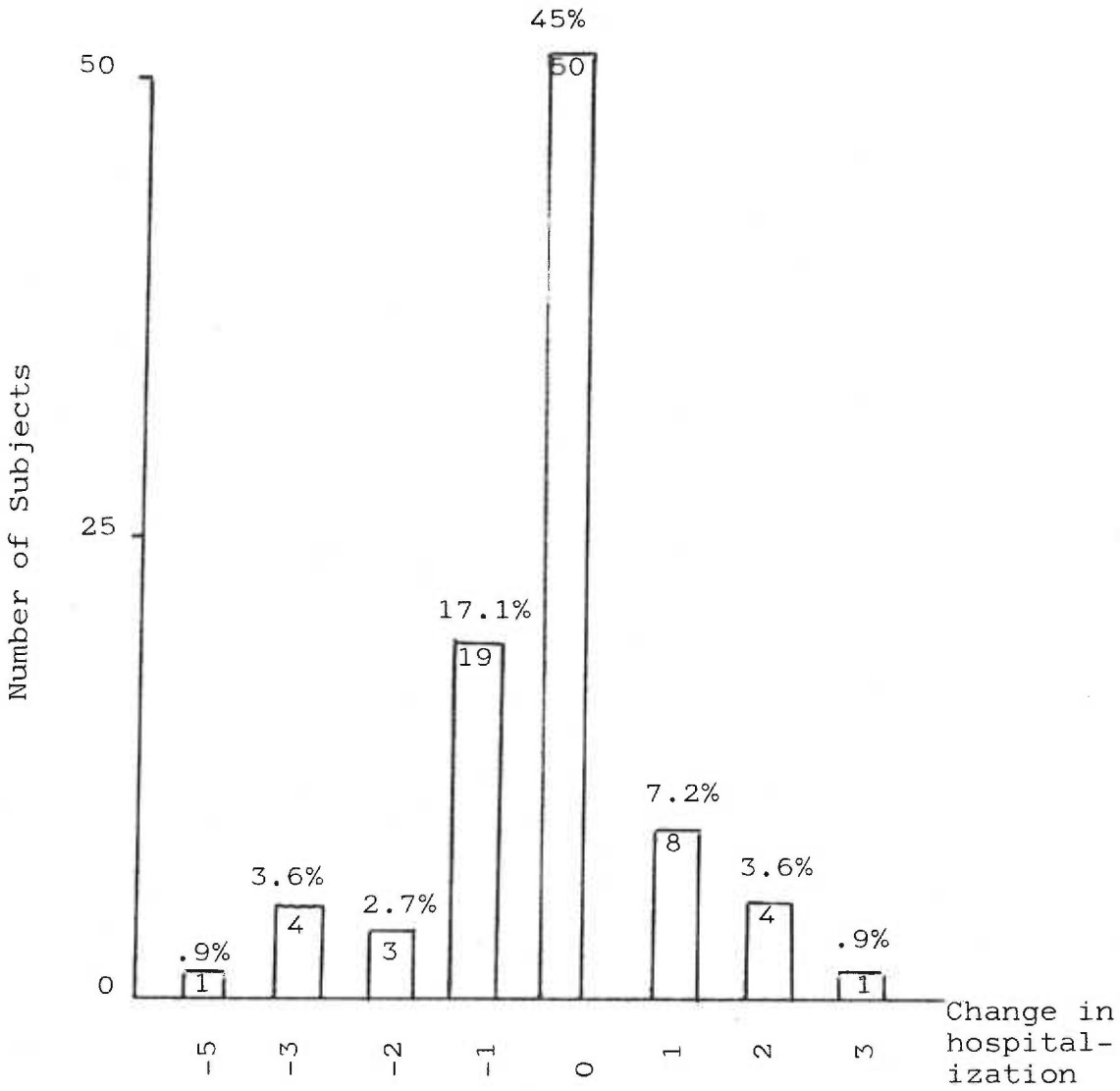
Jail incarcerations were measured as one other exception preventing participation in the drop-in center. The range of incarcerations was no incarceration to four incarcerations. For the sample, 87% (n=78) were never incar-

cerated, 10% (n=9) were incarcerated once, and 3% (n=3) were incarcerated four times. There was no significant differences found between the four groups based on the number of incarcerations, (f=.80, p=.41).

The relationship between participation and hospitalization was examined using a Pearson's Correlation. No significant relationship was found for participation and change in the number of hospitalizations or hospital days ($r$=-.05, p=.29) and ($r$=-.02, p=.41), respectively.

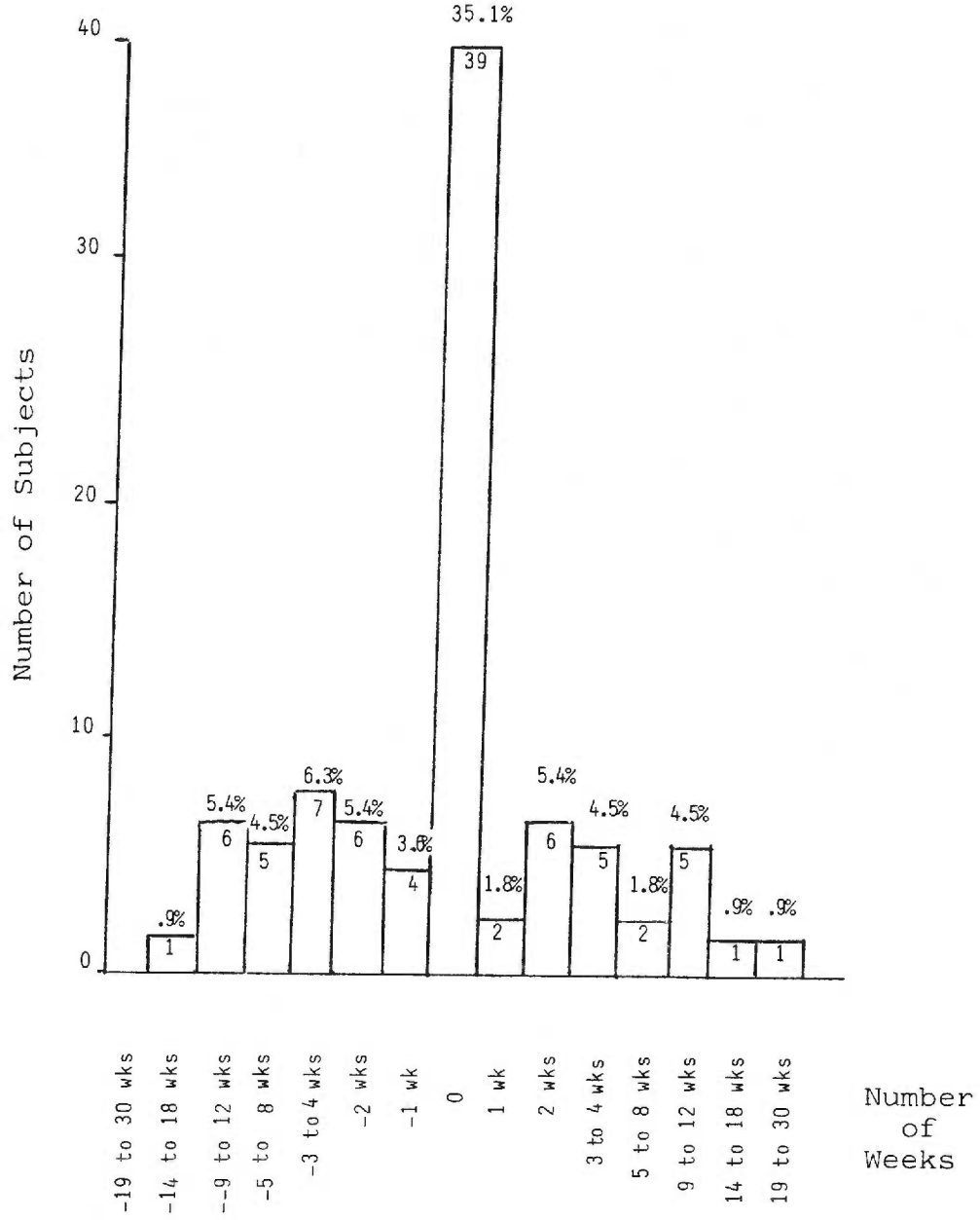
Summary

There was no significant relationship between participation and change in the readmission to hospitals or length of stay for participants and nonparticipants in a drop-in center for the chronically mentally ill.




N=90

Figure 8. Distribution of the change in hospitalization from 1980 to 1981.




N=90

Figure 9. Distribution of change in hospital days by weeks.

# Chapter V

## Discussion

For each of the three research questions, a discussion of the findings and limitations of the study are presented. The chapter concludes with a discussion of the implications for nursing practice and suggestions for further research.

### Discussion of Findings for Research Question One

Research question one was concerned with the differences in demographic variables for participants and nonparticipants. In general, the sample is a younger one, male, single, and relatively poor. Most of the subjects are diagnosed as suffering from schizophrenia and tend to live with family or in a room-and-board setting. However, there were no significant differences found for age, ethnicity, income, diagnosis, type or distance of living situation for frequency of participation. Although there was no significant difference found for gender, a trend for males to participate more was noted. Also noted was a trend for the core group to live closer to the drop-in center than for the remaining subjects.

The profile of those attending the drop-in center does fit the critical target populations the drop-in center sought to serve, i.e., young male clients who generally have poorly structured schedules with time spent 'hanging around' in stores or on the streets. This group was seen as at highest risk for poor community tenure with frequent readmissions to

the hospital.

A trend for increased participation by males was noted. This conflicts with the findings of other studies in the literature which report gender is not a significant predictor of attendance (Anthony & Buell, 1973); or that males tend to drop out of treatment more than females (Winston, Parbes, Papernick, Breslin, 1977). While the trend for males participating is in a positive direction, the specific reasons are unknown. Perhaps a program like a drop-in center with its acceptance of just 'dropping in,' appeals to these young males who previously were 'hanging around' in the community. Perhaps females enjoy a more structured social contact, thus finding participation in a less structured program less desirable. Also, females may have concerns about the safety in travelling to the drop-in center due to its location and may have concerns about the social response from males at the drop-in center. One would need to interview the females and confirm that these are issues.

Finally, one would need to interview those over 60 to find out why they are not participating and what they would need to increase their participation at the drop-in center.

Consistent with the findings on other surveys of the chronically mentally ill (Tessler, Bernstein, Rosen, Goldman, 1982), the majority of subjects were single. One could assume this was a function of the chronically mentally ill population having great difficulty in achieving the closeness or tolerating the intimacy required by marriage or a long term inter-

personal relationship. Another study (Winston, et. al., 1977) identifies a trend for single persons to not participate in or follow through with general aftercare treatments when compared with married persons. However, it seems that single persons can and do tolerate the lower stress opportunities for socialization that a drop-in center can provide.

The client population is relatively poor with 88% of the subjects having an income of less than $3,999 annually. Most of the subjects receive these dollars through Welfare or S.S.I.. With limited incomes, these persons have little financial capacity to be involved in or participate in more 'normalized' social activities (i.e., eating in a restaurant, going to a movie) which require funds. Also, the skills of managing funds often is limited. These people can benefit from the access to some recreation and crafts activities provided at the drop-in center without depleting their already minimal funds.

Ninety-two percent of the subjects were diagnosed as having a major mental illness, specifically schizophrenia. As described earlier, these people have difficulty tolerating closeness and social interaction, and may be at risk for social vegetation in the community. A smaller group is diagnosed as having borderline mental retardation. This group also experiences difficulty in tolerating social situations and social contact. Additionally, 14% of the subjects have problems with substance abuse which may contribute to increasing dysfunctional behavior and legal consequences due to impaired judgment and cognition. All

these people will experience difficulty in their interpersonal relating skills and could benefit from a low stress opportunity for socialization that a drop-in center provides.

The majority of subjects live with family or in room-and-board settings. One-fourth of the sample lived in private residences. It was found that there are no group homes in the area. So, clients generally have living situations which provide some social contact and provide limited supervision, as living with a family or in a room and board setting does not necessarily guarantee higher levels of supervision and structure.

Distance did not significantly affect participation. It does seem that members of the core group tend to live closer to the drop-in center. Distance should have been more predictive of participation, but is not significant in the findings. Distance may be confounded as a variable by clients use of the clinic for additional treatment groups and then going only an additional four blocks to the drop-in center. In addition, transportation may be an issue. Lack of transportation may decrease the ability to participate. Some of the clients were transported by room and board operators to the clinic or the drop-in center, while others had to come on foot or by bus.

The findings of this study are consistent with other

studies in that demographic variables are poor predictors of participation and that other possible characteristics (e.g., motivation) must be investigated.

Discussion of Findings for Research Question Two

Differences in additional treatment variables for participants and nonparticipants was the concern of research question two. In general, medications and one additional treatment group were the frequent therapeutic tools used at the mental health clinic. No significant differences were found for additional treatment variables of specific treatment groups, and medications (including changes in medications), except for subjects participating in the Graduated work Group. These subjects participated in the drop-in center program on Tuesdays, Wednesdays, and Thursdays significantly more than subjects participating in other specific treatment groups.

It was thought that clients already attending the specific treatment groups on particular days at the mental health clinic would more readily access the drop-in center only four blocks away. However, the data indicate that participation was not dependent on the day of the week. One could identify the relative health of those persons participating in a Graduated Work Program as a step towards more stable integration in the community and advancement to more productive contribution in the community. Hence, these

persons may be better able to follow through on participation based on a higher level of daily function.

The intent of the Graduated Work Group is to assist clients in adjusting to a structured routine which would be similar to one found in a work or educational setting. The ability of these persons to tolerate structure and social contact may be enhanced by their participation in a drop-in center program. The drop-in center also gives them a place to be expected daily, (as in a job), an expressed need for the chronically mentally ill (Peterson, 1978).

Medication is a primary treatment tool, with 87% of the subjects receiving some type of neuroleptic chemotherapy. For the purpose of this study, medications and changes in medications were measured primarily to account for their contribution in affecting community tenure and possible influence in the return to the hospital.

The findings indicate no significant relationship of medication adjustments in changing the number of hospitalizations or hospital days, or in participation in the drop-in center. The study does not, however, address the relationship between patient compliance with medications and participation in a drop-in center program. In sum, additional treatment variables are not significant predictors of participation or nonparticipation in a drop-in center program. However, there may be some association between participation in the graduated work group and tolera-

tion for the activity of the drop-in center.

Discussion of Findings for Research Question Three

The relationship between participation and nonparticipation in a drop-in center program and readmission to the hospital are addressed in research question three. The findings suggest that there was no significant relationship between participation or nonparticipation and change in the rate of admission to the hospital or the length of stay in the hospital. However, there is a serious methodological flaw which may account for this. The data is skewed as a limitation from not measuring the date of entrance to the drop-in center program. In sum, the data cannot answer the question.

Before the drop-in center program was available, many clients experienced a lonely lifestyle with limited opportunities for social contact and often returned to the hospital because they were bored, lonely, and felt more accepted within the hospital by others with similar problems. With the purpose of the drop-in center being the provision of opportunities for socialization and recreation, one would anticipate a broadening of social supports and opportunities, and consequently, a reduced need for hospitalization or shorter stay in the hospital. However, it should be noted that 69% or the majority of the sample was not rehospitalized in 1981, although how it relates to participation in the drop-in center is unclear.

Limitations

There are several limitations inherent in this study. Initially, participation was described as attendance to the drop-in center one or two times per week, assuming the center was avilable fifty weeks per year (two weeks out for the director's vacation). After critical review of the frequency data, the sample was broken down to include four levels of participation: nonparticipation, infrequent participation, frequent participation, and regular participation. These adjusted categories were developed because of historical factors endured by the drop-in center in the first year of operation. These historical factors account for the three changes in the location of the center, and the three changes in the directorship of the drop-in center. This disruption of frequent location change and director change may have added to early program instability. Clients may have been hesitant to participate in the drop-in center until the program was more settled.

Also important to note is that the drop-in center was initially open only three days per week for three hours each day. This may have deterred participation for those clients who needed longer hours structured. By October, the program had expanded to a full four days per week, in operation five hours each day. Participation on Thursdays then

was much less than for the other days.

Because of the investigation of a number of variables, the study would need to be replicated to determine significance based on gender as more than a trend. Also, because of group size and extreme values obtained on variables for the core group compared to the remaining subjects, the use of a Student's t-test and oneway ANOVA were invalid for some comparisons as the data defied the basic assumptions demanded for these statistical analyses.

As discussed previously, data on participation itself may have been confounded by not identifying the date of entrance to the drop-in center program. Without point of entrance identified or measured, the accuracy of estimating or identifying participants is under question. In future studies, measurement of the date of entrance to the program is recommended to more accurately determine the level of participation.

## Implications for Nursing Practice

With the lack of support for the predictive nature of demographic variables or additional treatment variables, nursing may need to identify other factors such as clients' motivation or their perception of the nature of the program in order to increase participation in the center. Following the identification of high risk clients, and referral of those clients, the nurse may want to accompany the client

on their first visit, or arrange for a volunteer from the program to meet with the client. This may enhance participation for those clients who have great difficulty in tolerating interpersonal contact, or who tend to drop out of other treatment programs.

The nurse may assist the client in problem-solving transportation problems to reduce the chances of this issue decreasing participation. An assessment of the client's perceptions of the drop-in center and support issues in the community may provide information for program evaluation and planning to design program in line with client needs. Nursing's involvement in on-going follow-up chemotherapy regimes with the chronically mentally ill provides an additional opportunity to be supportive of client's participation in a drop-in center program.

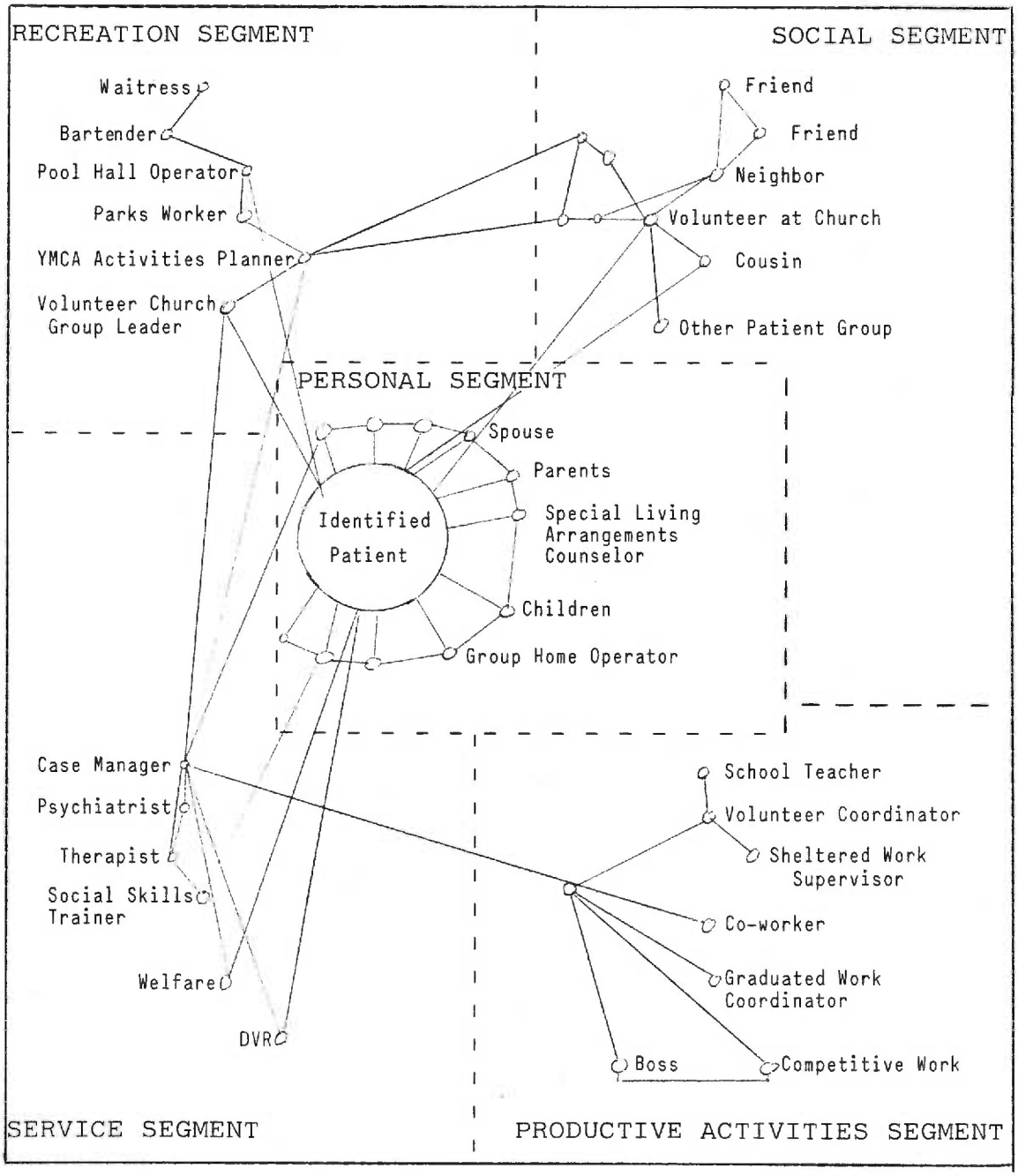
Furthermore, nursing can assist the community to understand and support the drop-in center concept. As a consultant to room and board operators, nurses may encourage their assistance in influencing clients to assess the service or to transport them on occasion. Nurses have an opportunity to educate the community about this unique aftercare program in addition to their other services, and invite the community members to volunteer at the drop-in center.

## Recommendations for Further Study

As the study finds no clearly significant predictors in demographic and additional treatment variables, other possible factors must be investigated. Specific suggestions include designing a descriptive study that focuses on clients' perceptions about the drop-in center program, i.e., what they like and dislike about the program and what factors influence their attendance. Additionally, network analysis studies may be undertaken to identify if participation in a drop-in center program expands the individual's social network. Other studies might focus on changes in medication utilization patterns and hospital utilization patterns as a function of increased participation in a drop-in center program. Finally, the study should be repeated now that the drop-in center is more stable, given the possible effects of the first year's disruptions and changes.

Appendix A: Augmented Folk and Service Support Network for the Long Term Patient

(Adapted from Cutler 1978)



# Appendix B

MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
COMMUNITY HEALTH SERVICES DIVISION
5022 N. VANCOUVER AVENUE
PORTLAND, OREGON 97217
(503) 248-5183

DONALD E. CLARK
COUNTY EXECUTIVE

TO: WHOM IT MAY CONCERN SUBJECT: Chris Maghrak

FROM: Thomas L. Milne DATA: September 28, 1981
District Health Director

Ms. Chris Maghrak has been given approval by me to use Mental Health client records to conduct research associated with her graduate thesis work. The focus of her thesis is on evaluating mental health care received by clients at the Northeast Primary Care Center (5022 N. Vancouver, Portland, Ore) and to review outcomes of that care.

The requirements which I have imposed in granting permission to use client records are the following:

1) That a copy of the research design be provided to me in advance of the study;

2) That the research design ensure client confidentiality; and

3) That a copy of pertinent findings be shared with me.

dt

cc: Gene Taylor, M.D.
Billi Odegaard, Director

# Appendix C

## Client Information Form

Instructions: Use one form for each subject. Complete form with information found in subject's records.

1. Record Birthdate. Month_____ Year_____

2. Record Sex. Male = 1
   Female = 2

3. Record Ethnicity. White = 1
   Black = 2
   Other = 3

4. Record Marital Status. Married = 1
   Single = 2
   Divorced = 3
   Separated= 4

5. Record amount of annual income.

   Under $3,000 = 1
   $3,000-$3,999 = 2
   $4,000-$4,999 = 3
   $5,000-$5,999 = 4
   $6,000-$6,999 = 5
   $7,000-$7,999 = 6
   $8,000-$8,999 = 7
   $9,000-$9,999 = 8
   $10,000-$14,999 = 9
   $15,000 and over=10

6. Record diagnosis as listed in chart.

   Schizophrenia Chronic Undifferentiated Type = 1
   Schizophrenia Paranoid Type = 2
   Borderline Mental Retardation = 3
   Latent Schizophrenia = 4
   Schizoaffective Disorder = 5
   Manic Depressive Illness = 6
   Involutional Paranoid State = 7
   Substance Abuse = 8

7. Record: a. type of living situation:
   Private residence = 1
   Resides with family = 2
   Room and Board = 3
   Group Home = 4

b. Distance of the living situation; count the distance on a map of the city by short city blocks - _____.

8. Record all additional treatments:

| | |
|---|---|
| Prolixin Group | = 1 |
| Graduated Work Group | = 2 |
| Lithium Group | = 3 |
| Chronic Problem Solving Group | = 4 |
| Medication | = 5 |
| Socialization Group | = 6 |
| No additional treatments | = 7 |

9. Record Neuroleptic medication changes:

a. No medication changes. _____
b. Number of medication changes. _____
Number of increases. _____
Number of decreases. _____
c. New medication added. _____

10. Record: a. Number of Hospitalizations in 1980. _____
b. Number of Hospital days in 1980. _____
c. Number of Hospitalizations in 1981. _____
d. Number of Hospital days in 1981. _____

11. Record the total number of days in attendance at the drop-in center and the days of the weeks.

TOTAL _____
Monday _____
Tuesday _____
Wednesday _____
Thursday _____

12. Record the number of incarcerations in jail in 1981. _____

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## Abstract

This is a retrospective study which describes the characteristics of the chronically mentally ill participants and nonparticipants of a community mental health clinic 'drop-in' center program from January 1, 1981 through December 31, 1981. The subjects for the study are those clients referred to the drop-in center program from the community mental health clinic. The study focuses on examining demographic variables, diagnosis, distance to the program from the living situation as well as the type of living situation, additional treatment variables and medication changes, to determine if there are differences between participants and nonparticipants of a drop-in center program, and if there is a relationship between the degree of participation and admission or readmission rates to the hospital. This is a descriptive study using pre-existing data obtained from daily attendance records at the drop-in center, and clients' charts from the community mental health clinic. Demographic characteristics and additional treatment variables were found to be insignificant predictors of attendance. A trend for males to participate more frequently was noted, and for members of the core group to live closer to the drop-in center. There was no significant relationship between participation in the drop-in center program and the rate of hospitalization or the length of hospital stay.