RUDOLF H. MOOS

EVALUATING TREATMENT ENVIRONMENTS

The Quality of Psychiatric and Substance Abuse Programs

SECOND EDITION, REVISED & EXPANDED

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Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 1997 by Transaction Publishers

Published 2017 by Routledge
2 Park Square, Milton Park, Abingdon, Oxon OX14 4RN
711 Third Avenue, New York, NY 10017, USA

Routledge is an imprint of the Taylor & Francis Group, an informa business

Library of Congress Catalog Number: 96–38940

Library of Congress Cataloging-in-Publication Data

Moos, Rudolf H., 1934–
Evaluating treatment environments : the quality of psychiatric and substance abuse programs / Rudolf H. Moos. — 2nd ed., rev. and epanded.
p. cm.
Includes bibliographical references and index.
ISBN 1–56000–294–8 (alk. paper)
1. Psychiatric hospitals—Evaluation. 2. Substance abuse—Treatment—Evaluation. 3. Mental health services—Evaluation. I. Title.
[DNLM: 1. Mental Health Services. 2. Substance Abuse Treatment Centers. 3. Mental Disorders—therapy. 4. Outcome and Process Assessment (Health Care) WM 30 M694e 1996]
RC439.M75 1996
362.2'068'5—dc20
DNLM/DLC
for Library of Congress 96–38940
CIP

ISBN 13: 978-1-56000-294-9 (hbk)

To my mother and father,
who told me I could
and
to Jean Otto,
a soul at rest

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Preface to the Original Edition

This book presents a new approach to the comparison and evaluation of treatment environments. I call it a social ecological approach with some misgiving, because new terms may lead to confusion as well as to clarification. But I believe that the basic focus and organization of this work are unique. I offer a new way of measuring and changing treatment environments, and I describe how to link these environments' characteristics to patients' adaptation and psychosocial functioning.

In brief, social ecology is concerned with the environment and how people adapt to it. The field deals with both the physical and the social environment. I define social ecology as the multidisciplinary study of the relationship between the physical and social environment and individuals' cognition and behavior. Primarily concerned with the assessment and development of optimum human milieus, social ecology provides a distinctive "point of entry" into relevant clinical and applied problems. As I see it, it combines basic research approaches with a dedication to resolving common human problems. For me, the quality of life for patients and staff in psychiatric treatment settings is as significant as the objective empirical and statistical results.

The social and behavioral sciences are now as ever in a state of rapid development. Certain of these developments have influenced me most. In my clinical work I quickly found that I could not understand, much less predict, the behavior of my patients in settings other than my office. Even a decade ago the research literature and my colleagues had convinced me that this was a common problem. I was dissatisfied then with trait conceptualizations of personality, much as others are now. I felt that behavior was influenced by situational and environmental forces to a much greater extent than was commonly recognized, at least by psychologists.

About six years ago I became convinced of the importance of developing new methods by which to understand the environment. I felt that more knowledge about the environment would enhance an assessment of the impact of environments on human behavior. My overall aim is to identify environments that promote opportunities for personal growth, simultaneously enhancing both physical and psychological well-being.

Two thrusts of this work are most important to me. First, research is utilized in a practical, applied manner. Our work illustrates not only that relatively "hard-nosed" objective research can be made interesting and informative to patients and staff, but also that they can use it to improve their treatment climate. In this sense the aim of our work is to improve the quality of life for patients and staff in treatment programs and, by extension, for individuals participating in a range of other environments.

Second, the distinctive conceptual and theoretical overviews that grew out of the empirical work should help to stimulate further work in this area. Most important, there are common underlying patterns in a wide range of social environments, and the different methods researchers have used to study human environments can be categorized into six broad types. My hopes and my fears are one: that this work and these concepts will encourage and stimulate their own replacement.

The most distinctive features of this book include: (1) the use of similar techniques for assessing the treatment environments of hospital and community programs on common dimensions; (2) the explicit emphasis on both subjective (i.e., satisfaction, morale, helping behavior) and objective (i.e., dropout, discharge, and community tenure rates) effects of treatment programs; (3) the emphasis on the clinical utility of evaluation data about programs as an aid to teaching, to planning new and innovative approaches to treatment, to identifying trouble spots, and to successfully helping patients and staff change their own social environments; (4) the preparation of guidelines for the development of more useful and more complete program descriptions; (5) an emphasis on cross-cultural applications and comparisons of treatment programs, with particular relevance to treatment programs in the United States and the United Kingdom; and (6) an integration of relevant research approaches in other institutions into the literature on treatment environments.

My intellectual debts are too heavy and too numerous to detail. My bibliographic citations give a limited idea of those who have most strongly influenced my thinking. The initial research was supported by NIMH Grant MH16026 and MH8304, by NIAAA Grant AA00498, and by Department of Veterans Affairs medical research funds. The work profited from active collaborations with Marvin Gerst, Peter Houts, Edison Trickett, and Jack Sidman. These individuals provided a rich, stimulating source of new ideas and ever-present challenges. Gordon Adams facilitated the early phases of work; Marilyn Cohen, Diane House, Susan Lang, Eleanor Levine, Martha Merk, Chris Newhams, Phyllis Nobel, and Karl Schonborn each completed many essential tasks. Jim Stein, Bill Lake, and Bernice Moos coordinated the computer analyses.

During the last two years of the project, Marguerite Kaufman, Jean Otto, Charles Petty, Paul Sommers, Robert Shelton, and Penny Smail carried out the bulk of the detailed work. David Mechanic and Richard Price read and competently criticized a draft of the first edition of the book. Their comments helped me improve and clarify several chapters. Marion Langenberg typed the initial chapter drafts, Susan Glebus and Marcia Insel typed the second drafts, and Louise Doherty and Susanne Flynn typed and organized the final drafts.

David Hamburg, Chair of the Department of Psychiatry and Behavioral Sciences at Stanford University, deserves special recognition. For more than a decade he provided the supportive social milieu in which this work flourished. George Coehlo luckily recognized the potential of the work and was instrumental in helping me obtain initial funding.

Bernice Moos contributed to the compilation and statistical analysis of the data. Without Bernice, Karen, and Kevin, I might unhappily have finished this book somewhat sooner. They interrupted me, teased me, annoyed me, infuriated me, gumbled and gamboled—and thereby brought me joy.

Rudolf H. Moos
July 1973

Preface to the New Edition

When I wrote the preface to the first edition of this book I did not imagine that, after twenty-three years, I would be revising and updating the material. But, as luck and chance have it, many of the ideas I set out then are important and timely now. There is renewed focus on the overall quality of mental health care, on the process of care, and on the connections between the process and outcome of care.

The procedures we developed to assess the treatment environments of hospital and community programs have been widely applied in the United States and in other countries. As described here, they have been used to monitor and improve treatment programs, to assess the adequacy of program implementation, and to understand the determinants and outcomes of specific aspects of treatment environments.

The conceptualization of three underlying sets of treatment climate dimensions—that is, relationship, personal growth, and system maintenance dimensions—has been used widely to describe specific treatment programs and to contrast hospital with community programs and psychiatric with substance abuse programs. It also provides a framework to help integrate findings on the differential outcomes of treatment programs and on the results of client-program matching.

Over the past two decades, my research in this area was supported by NIMH grant MH28177, NIAAA grants AA02863 and AA06699, and Department of Veterans Affairs medical research funds. Most recently, the research and preparation of this manuscript were supported in part by the Department of Veterans Affairs Health Services Research and Development Service and Mental Health and Behavioral Sciences Service.

Elizabeth Burnett conducted bibliographic searches and expertly abstracted many publications, some of which were quite long and complex. She developed a practiced eye for finding and succinctly summarizing key points; she also provided valuable help with editorial

tasks. Molly Kaplowitz conducted statistical analyses on new data that were drawn from Christine Timko's sample of psychiatric and substance abuse programs. The findings obtained from these data, which are described in chapters 7 and 8, enhance the current relevance of the work.

Bernice Moos contributed to the statistical analyses reported here; more important, she provided the social climate in which I flourished. Fortunately for me, after more than three decades, she is still coping effectively.

Rudolf H. Moos
July 1996

1

Understanding Treatment Programs and Outcomes

Three assumptions guide our approach to understanding psychiatric and substance abuse treatment programs and their outcomes. First, in order to examine the influence of treatment programs on patients' adaptation, we need systematic ways to measure the key aspects of the treatment process. Although most behavioral scientists endorse the idea that both personal and environmental factors determine behavior, evaluation researchers have typically conceptualized the treatment program as a "black box" intervening between patient or staff inputs and outcomes. Thus, these programs often are assessed only in terms of broad categories, such as the level of care provided or whether they accept patients with severe psychiatric disorders. To enrich understanding of these settings, we describe some useful ways to measure program characteristics; these measures enable us to identify specific aspects of treatment programs and to analyze their influence on patients' in-program and community adaptation.

Our second assumption is that although treatment programs for psychiatric and substance abuse patients are diverse, a common conceptual framework can be used to evaluate such programs, and doing so has several advantages. The framework allows us, for example, to identify similar processes occurring in different types of programs and to specify the extent of environmental change an individual experiences when moving from one type of setting to another, such as from a hospital to a community facility.

Our third assumption is that more emphasis should be placed on the process of matching personal and program factors and on the connec-

tions between person-environment congruence and patients' outcomes. To understand the influence of treatment programs more fully, we need to examine the selection processes that affect how patients are matched to programs. We also need to focus on how treatment environments vary in their impact on patients who differ in their level of impairment and the chronicity and severity of their disorders. Although researchers have recognized the complexity of person-environment transactions, empirical work has not adequately reflected the multicausal, interrelated nature of the processes involved.

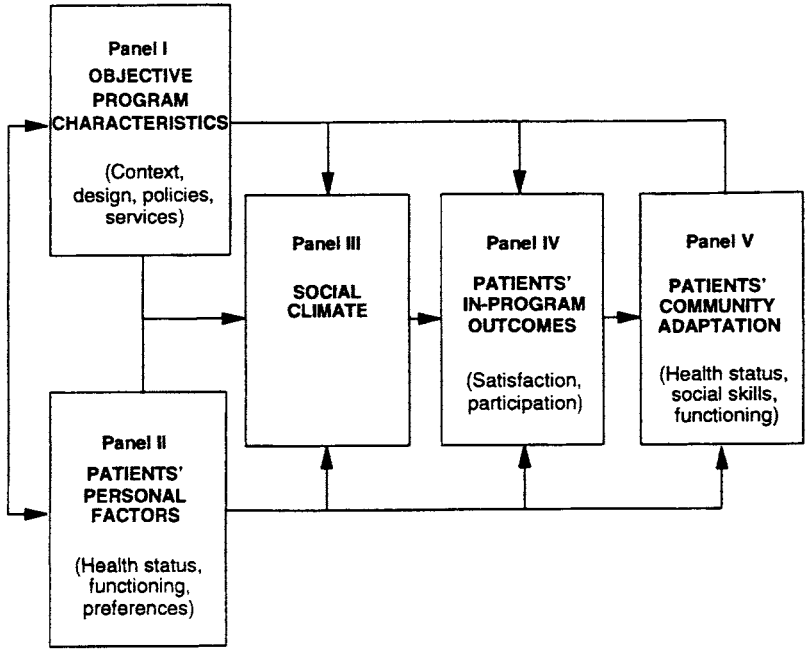
Conceptual Model

The conceptual model shown in figure 1.1 follows these guidelines and provides a framework for examining treatment programs and how they and their patients mutually influence each other. In this model, the connection between the objective characteristics of the program (panel I), patients' personal characteristics (panel II), and patients' adaptation in the community (panel V), is mediated by the program social climate (panel III) and by patients' in-program outcomes (panel IV). The model specifies the domains of variables that should be included in a comprehensive evaluation.

The objective characteristics of the program (panel I) include the program's institutional context, physical design, policies and services, and the aggregate characteristics of the patients and staff. These four sets of objective environmental factors combine to influence the quality of the program culture or social climate (panel III). The social climate is part of the environmental system, but we place it in a separate panel to highlight its special status. The social climate is in part an outgrowth of objective environmental factors and also mediates their impact on patients' functioning. In addition, social climate can be assessed at both the program and the individual level.

Personal factors (panel II) encompass an individual's sociodemographic characteristics and such personal resources as health and cognitive status, and chronicity and severity of functional impairment. They also include an individual's preferences and expectations for specific characteristics of treatment programs. The environmental and personal systems influence each other through selection and allocation processes. For example, most programs select new patients on the basis of personal and psychiatric impairment criteria. Similarly, most

FIGURE 1.1.
A Model of the Relationships between Program and Personal Factors and Patients' Outcomes



patients have some choice about the program they enter.

Both personal and environmental factors affect patients' in-program outcomes, such as their satisfaction, self-confidence, interpersonal behavior, and program participation (panel IV). In turn, in-program outcomes influence such indices of community adaptation as patients' health status, social and work skills, and psychosocial functioning (panel V). For example, on-site counseling and self-help groups and policies that enhance patients' decisionmaking (panel I) may contribute to a cohesive and self-directed social climate (panel III). In such a setting, a new patient may be more likely to develop supportive relationships with other patients and join a counseling group (panel IV) and, ultimately, to show better community adaptation (panel V).

The model shows that patients' adaptation is also affected directly

by stable personal factors. For example, patients who have less severe symptoms when they enter a program are likely to have less severe symptoms a year later. Treatment programs may have some direct effects as well, as when an individual experiences better outcome because of the quality of treatment provided in a setting.

Finally, the model depicts the ongoing interplay between individuals and their treatment environment. Patients who voice a preference for more self-direction in their daily activities may help initiate more flexible policies (a change in the environmental system). Patients who participate more actively in psychotherapy or self-help groups may experience improved self-confidence (a change in the personal system). More generally, individual outcomes contribute to defining the environmental system; for example, when the in-program behavioral outcomes for all patients in a program are considered together, they constitute one aspect of the suprapersonal environment.

The model incorporates the characteristics of staff (panel I) and how staff influence the social climate and patients' in-program and community adaptation. We focus almost entirely on patients' outcomes here, but the basic model can be extended to encompass the health care work environment and it's influence on the treatment environment and staff members' morale and performance (Moos and Schaefer, 1987).

From a broader perspective, environmental factors external to the program profoundly affect patients' community adaptation. Hospital and community programs typically constitute only one time-limited aspect of patients' lives; accordingly, their influence may be short-lived. To understand the determinants of patients' psychosocial functioning in the community, we need to consider their family and work settings and their broader life circumstances (Moos, Finney, and Cronkite, 1990).

In the next sections, we describe two main lines of work that led us to focus on the characteristics of treatment programs: historical analyses and descriptive studies of how treatment environments alter patients' in-program symptoms and behavior, and comparative evaluations that illustrate how different programs affect patients' longer-term adaptation. In essence, this body of research suggests that characteristics of treatment programs, such as those included in panels I and III of figure 1.1, influence patients' in-program (panel IV) and community (panel V) outcomes.

Historical Background and Descriptive Studies

In modern times, the idea that treatment environments can change the patients and staff who live and work in them can be traced to Philippe Pinel, who in 1792 removed the chains and shackles from the inmates of two insane asylums in Paris. Most of the patients stopped being violent once they were free to move around. Pinel pointed out that people normally react to being restrained or tied with fear, anger, and an attempt to escape. Pinel applied "moral treatment," and assumed that the social or treatment environment, especially tolerant and accepting attitudes, setting examples of appropriate behavior, humanitarianism, and loving care, affects recovery from mental illness.

> I saw a great number of maniacs assembled together and submitted to a regular system of discipline. Their disorders presented an endless variety of character; but their . . . disorders were marshalled into order and harmony. I then discovered that insanity was curable in many instances by mildness of treatment and attention to the mind exclusively. . . . I saw with wonder the resources of nature when left to herself or skillfully assisted in her efforts. . . . Attention to these principles of moral treatment alone will frequently not only lay the foundation of, but complete, a cure; while neglect of them may exasperate each succeeding paroxysm, till, at length, the disease becomes established, continued in its form and incurable. (Pinel, 1806)

The Rise of Moral Treatment

In 1806 the Quaker William Tuke established the York Retreat in England, emphasizing an atmosphere of kindness and consideration, meaningful employment of time, regular exercise, a family environment, and the treatment of patients as guests. The Quakers brought moral treatment to America, and Charles Dickens (1842) noted the results in a lively account of his visit to the Institution of South Boston, later known as the Boston State Hospital.

> The State Hospital for the insane is admirably conducted on . . . enlightened principles of conciliation and kindness. . . . Every patient in this asylum sits down to dinner every day with a knife and fork . . . at every meal moral influence alone restrains the more violent among them from cutting the throats of the rest; but the effect of that influence is reduced to an absolute certainty and is found, even as a means of restraint, to say nothing of it as a means of cure, a hundred times more efficacious than all the straight-waistcoats, fetters and handcuffs, that ignorance, prejudice, and cruelty have manufactured since the creation of the world. . . . Every patient is as freely trusted with the tools of his trade as if he were a sane man. . . . For amusement, they walk, run, fish, paint, read and ride out to take the air in carriages

> provided for the purpose. . . . The irritability which otherwise would be expended on their own flesh, clothes and furniture is dissipated in these pursuits. They are cheerful, tranquil and healthy. . . . Immense politeness and good breeding are observed throughout, they all take their tone from the doctor. . . . It is obvious that one great feature of this system is the inculcation and encouragement even among such unhappy persons, of a decent self-respect. (105–11)

Grob's (1966) history of the Worcester State Hospital in Massachusetts, which was established in 1830, documents the recognition of the importance of moral treatment and the patients' social environment (see also Kennard, 1983). He points out that Samuel Woodward, the first superintendent, thought that mental illness resulted from impaired sensory mechanisms: "If the physician could manipulate the environment he could thereby provide the patient with new and different stimuli. Thus older and undesirable patterns and associations would be broken or modified and new and more desirable ones substituted in their place" (53).

Woodward believed that mental illness was an outgrowth of detrimental social and cultural factors. The hospital implemented moral therapy, which consisted of a regular daily schedule and individualized care, including occupational therapy, physical exercise, religious services, and activities and games. Staff members were trained to treat patients with kindness and respect; physical violence and restraint were discouraged. The provision of moral treatment assumed that a healthy psychological environment could kindle renewed hope and cure individual patients. It implied that an appropriate social milieu could eliminate undesirable patient characteristics that had been acquired because of "improper living in an abnormal environment" (Grob, 1966, 66).

Although it is impossible to compare patients at Worcester in the 1830s and 1840s with patients today, the supportive structured climate of moral treatment may have been quite successful. Of more than 2,200 patients who were discharged from Worcester between 1833 and 1846, almost 1,200 or 54 percent were judged recovered. Moreover, in a long-term follow-up of almost 1,000 such recovered patients, in which information about the patient was obtained from family members, friends, employers, and clergy, nearly 58 percent were not readmitted to hospital and did not have a relapse (Grob, 1980).

Hospital Social Structure and Patients' Symptoms

The late nineteenth and early twentieth centuries witnessed a retreat from the principles of social treatment and increasing reliance on custodialism and physical restraint. During the 1950s and 1960s, however, theorists and clinicians again focused on the importance of the treatment environment. There was yet another reevaluation of the traditional disease model and its assumption that psychological disturbance resides in the individual alone. Hartmann's (1951) and Erikson's (1950) theoretical contributions reflected renewed interest in individual development and the link between external reality and perceptual and cognitive functions.

This focus was applied to try to understand the social structure and processes of psychiatric programs, which constitute the "reality" for hospitalized patients. Stanton and Schwartz (1954) and Caudill (1958) observed the importance of hospital social structure in facilitating or hindering treatment goals. Stanton and Schwartz's contribution revealed that patients' symptoms could be understood as a result of the informal organization of the hospital, that is, that the "environment may cause a symptom" (343). They found, for example, that hyperactive patients were typically the focus of disagreement between two staff members who themselves were seldom aware of this disagreement. The patient's hyperactivity often ceased abruptly when the staff members were able to discuss their disagreement.

Stanton and Schwartz also noted that a patient's dissociation may be quite reasonable in the face of certain social situations; for example, when two staff members strongly disagree about how to manage a patient, that patient may also be of a "divided mind." When staff disagreement or the "split in the social field" is resolved, the patient's dissociation usually subsides. Stanton and Schwartz (1954) conclude that "profound and dramatic changes such as observed in shock therapy . . . are no more profound and no more rapid than the changes produced . . . by bringing about a particular change in the patient's social field" (364). In addition, these authors showed how aspects of the hospital social environment, such as fiscal constraints stemming from financial pressure, may elicit staff conflict and confusion, which, in turn, generates low staff morale and collective disturbances among patients.

Caudill (1958) independently substantiated many of Stanton and

Schwartz's conclusions. In a clinical example, he revealed how the social structure of a psychiatric unit influenced a patient's behavior. Caudill showed how the patient's excited and disturbed behavior was due to his personal relationships with his therapist and with other patients. The therapist's interest in the patient was influenced by other staff members' attitudes, and the course of the patient's illness was closely associated with the hospital's therapeutic and administrative routines. Caudill (1958) concluded that "a patient's pattern of behavior cannot be sufficiently apprehended within the usual meaning of terms such as 'symptom' or 'defense,' but must also be conceptualized as an adaptation to the relatively circumscribed situation in which he is placed" (63). In another example, Stotland and Kobler (1965) show how a suicide epidemic in a hospital was directly related to changes in the hospital's financial and social structure and to resultant changes in staff morale, attitudes, and expectations of patient improvement.

Custodial Institutions

Although the development of moral treatment temporarily spawned a caring and humane social environment, as mental hospitals grew in size and complexity the emphasis on enlightened social treatment receded and institutions became more structured and custodial. The growing belief that immutable genetic and constitutional factors were the primary causes of mental illness contributed to this trend.

These changes led to the concept of "total institutions," which Goffman (1961) described as assuming absolute control over the life of people who reside in them. Total institutions break down barriers that ordinarily separate different domains of an individual's life, such as places of home, work, and recreation. In total institutions, all aspects of the residents' lives are conducted in the same place, that is, with a large group of other people who are all required to do the same things on a fixed schedule imposed by an apparently indifferent group of officials. Residents and staff interact with one another in restricted, formally prescribed ways. The rigidly structured, bureaucratic environment leads to apathy, passivity, and resignation among the residents.

Some hospital-based psychiatric programs in fact had many of the characteristics of a total institution. According to Wing and Brown (1970), who described Kerry ward, the ward door was always locked,

and the patients lived almost entirely within the ward. There was little contact with the rest of the hospital and virtually no contact with the outside world. No patient went home, less than half were visited by relatives, and only a few were allowed to leave the ward without supervision. Movement about the ward was subject to close control. There were few if any exceptions to the restrictive policies. The hospital provided the patients' clothing, and few patients had any personal possessions on the ward or even owned a toothbrush. The lack of privacy was almost total. The lavatory doors did not lock, and baths were taken under nurses' and patients' direct supervision.

Patients were caught up in a daily routine that was geared to staff requirements. Staff did not encourage patients to develop personal skills; for example, staff made the patients' beds. In describing the daily routine on Kerry ward, Wing and Brown (1970) emphasize the paucity of social interactions and activities. They note that "there were long periods when most patients were simply waiting for the next stage of the cycle to begin; this waiting was mostly spent in apathetic inactivity, in doing absolutely nothing. All but 1 of the 22 patients in the series spent three hours a day sitting at a meal table and half were totally unoccupied except when eating or at toilet" (137). Such pervasive deprivation must have severe detrimental effects on patients, contributing to their stagnation and loss of hope.

Several well-known authors have compiled vivid and insightful case studies describing these widely divergent treatment environments and their impacts. Mary Jane Ward (1946) wrote of a custodial mental hospital's shocking physical and social environment and its detrimental effects in *The Snake Pit.* In Ken Kesey's (1962) *One Flew Over the Cuckoo's Nest,* patients respond adaptively to a rigidly structured ward setting that required them to submit to the authority of "Big Nurse." In sharp contrast, a warm supportive therapist and a constructive, humanitarian hospital facilitated a young schizophrenic girl's recovery in *I Never Promised You a Rose Garden* (Greenberg, 1964). In *The Magic Mountain* Thomas Mann (1952) vividly describes how the social environment of a tuberculosis sanitarium slowly and insidiously forces a patient to submit to its procedures and effectively give up his outside life and identity. Solzhenitsyn's (1969) *Cancer Ward* presents a similar tale, with a different outcome.

The Emergence of Community Care

Beginning in the 1940s in the aftermath of World War II, mental health reform began to focus on creating a normal environment for mentally ill individuals in the community in order to counteract the insidious effects of custodialism in large mental hospitals. Historically, these reforms were foreshadowed almost 100 years earlier in the Belgian city of Gheel, which developed a cottage-based moral treatment system in which mentally ill individuals lived in local family homes, worked alongside local villagers, and enjoyed considerable personal freedom.

Ironically, Merrick Bemis, the third superintendent of the Worcester State Hospital, proposed a decentralized, cottage-type reorganization of the hospital in the late 1860s (Morrissey and Goldman, 1980). According to Bemis's plan, most patients would live in small homes accommodating twelve to fifteen individuals supervised by a married couple. These homes would provide a family atmosphere, physical exercise and social activities, and supportive rehabilitative care. Although this proposal was never implemented, it captured some of the key ideas underlying the development of community-based therapeutic environments.

Reaction against custodialism grew in the 1950s, fueled by popular exposes and academic studies of the unacceptable conditions in mental hospitals and their detrimental effects (Belknap, 1956; Goffman, 1961). The National Mental Health Act of 1946 and the Community Mental Health Centers Act of 1963 provided the impetus for the development of community-based mental health programs, but also for the eventual transfer of responsibility for many patients from mental health settings to other systems, such as general hospitals and nursing homes (Brown, 1985; Mechanic and Rochefort, 1990).

Largely as a result of these reforms, the prevalence of inpatient care episodes in specialty mental health facilities in the United States declined from 77 percent in 1955 to 26 percent in 1990. In contrast, the prevalence of outpatient episodes rose from 23 percent to 67 percent. (Partial care accounted for 7 percent of the episodes in 1990.) Moreover, state mental hospitals accounted for 63 percent of the inpatient and residential treatment episodes in 1955 compared with only 16 percent in 1990. In contrast, such episodes in private psychiatric hospitals and non-Federal general hospitals rose from 30 percent in 1955

to 66 percent in 1990 (Redick et al., 1994). These changes are impressive; nevertheless, in part due to population growth, the total number of inpatient and residential care episodes in mental health facilities increased from 1.3 million in 1955 to 2.3 million in 1990.

It is difficult to obtain precise estimates of the number of clients and episodes of care in community residential facilities. Segal and Kotler (1989) estimated that between 300,000 and 400,000 chronically mentally ill individuals live in halfway houses, board-and-care homes, and other supervised community facilities. Similarly, Mor, Sherwood, and Gutkin (1986) identified 118 government programs for older adults that regulate more than 29,000 residential facilities with about 370,000 residents. In addition, between 30 and 75 percent of the 1.5 million patients in nursing homes may have serious psychiatric disorders (Linn and Stein, 1989).

Although these community facilities have not been rigorously studied, they encompass a wide variety of programs, including supportive, family-oriented programs, psychosocial rehabilitation programs, structured therapeutic community programs, and custodial programs. Thus, the treatment environments of community programs reflect the same diversity as those of hospital programs. Because residents may remain in community programs for extended intervals, it is especially important to study their treatment environments and outcomes.

Comparative Program Evaluations

Naturalistic and descriptive studies of hospital programs increased mental health professionals' awareness of the importance of the treatment environment, but they did not identify the precise characteristics that affect patients' morale, symptoms, and behavior. In the 1960s and 1970s, a number of investigators tried to isolate such characteristics by formulating treatment programs to achieve specific goals and then evaluating patients' reactions and outcomes.

Social Rehabilitation in a Therapeutic Community

In order to treat patients with personality disorders in a therapeutic community, Maxwell Jones (1953) founded the Social Rehabilitation Unit at Belmont Hospital in London, England. The emphasis was on communal life and the sharing of feelings to produce a meaningful

experience in which individuals could grow and learn effective ways of functioning. The program was designed to involve patients in activities paralleling those of the community environments to which they would return. The unit incorporated group therapy, social activities, and work experience to provide patients with new social and job skills.

In an attempt to evaluate the rationale and effectiveness of this therapeutic community program, Rapaport (1960) considered the ideology, organization of patient and staff roles, and treatment and rehabilitation goals. The treatment ideology centered on the idea that "socio-environmental influences are themselves capable of effectively changing individual patterns of social behavior" (269). The program employed paraprofessional staff to interact with patients, allowed staff roles to remain much less structured than in typical programs, and avoided restrictive rules and regulations.

Rapaport's study showed that the program was not as effective as its sponsors hoped. A major program purpose was to teach patients effective patterns of work and social behavior that could be generalized to their lives in the outside community. Staff tried to help patients become aware of the reasons for their behavior and to take an instrumental role in changing it. In addition, patients were required to assume some responsibility for the operation of the unit. Patients had a voice in this participatory democracy and became accustomed to determining their living and working environment. But the staff failed to recognize that most of the patients were from lower socioeconomic groups and were qualified only for unskilled or semiskilled positions, in which they would be heavily supervised and have few decisions to make. Self-understanding was not particularly valued. The treatment program had taught patients patterns of behavior that were basically inappropriate outside the hospital and thus could not generalize from the hospital to the community environment.

Problem-Oriented Task Groups in a Supportive Community

Fairweather (1964) constructed a different type of milieu program. He considered chronic mental patients as individuals who were capable of establishing roles and statuses in the hospital, but who were unable to do so in the community. The dependent role patients assumed in the hospital made it difficult for them to readjust to the community, where such a role is seldom available. Thus, Fairweather