A COMMUNITY PROGRAM FOR CHRONIC SCHIZOPHRENICS: A LOOK AT OUTCOME EFFECTIVENESS

A Thesis

by

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ABSTRACT

A COMMUNITY PROGRAM FOR CHRONIC SCHIZOPHRENICS:
A LOOK AT OUTCOME EFFECTIVENESS (May 1982)

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The purpose of this study was to investigate the effectiveness of a program designed to enhance self-help skills and personal adjustment of deinstitutionalized chronic psychiatric patients. The research was directed towards measuring these differences between a group of aftercare clients in a community mental health center receiving a traditional, medical approach to treatment and an experimental group which participated in a "club-house" model of treatment while also receiving traditional services. The Personal Adjustment and Role Skills Scale was completed for each subject in both groups pre-treatment and then two months after the initiation of the new treatment program.

The data were analyzed by means of a Wilcoxon matched pair signed rank test to determine if there were any differences in performance between the two

treatment groups (medical aftercare versus "clubhouse" plus medical aftercare). There were no significant differences elucidated, however recommendations are made for further research in this area of study.

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INTRODUCTION

Advances in drug therapy and changes in treatment concepts since the 1950's have contributed to a growing trend toward shorter and less frequent hospitalizations of the chronic psychiatric patient. Indeed, in 1955 there were 559,000 patients in state psychiatric hospitals in the United States; in 1976 there were only 171,000, a decrease of 60 percent (Lamb, 1981). However, as more and more former psychiatric patients became consumers of community mental health services it was clear that mental health professions and systems were unprepared to meet the challenge of providing services from which these persons could benefit. The situation was so glaringly deficient that the public media published articles which questioned the advisability of continuing to discharge these patients (Daniloff, 1978 and Koenig, 1978).

However, while there certainly are deficiencies in the provision of community mental health services to the chronic psychiatric patient, there are now a series of new programs being developed to close the gap. Programs patterned after the model established at Fountain

House in Manhattan and Fairweather Lodge in Wisconsin are springing up around the nation.

The population of chronically hospitalized psychiatric patients has recently come under close scrutiny. Studies report many descriptive characteristics of these individuals which are relevant to understanding the population (Chaudry, 1979; Strayer and Keith, 1979; Summers, 1979).

In order to examine the reasons for the repeated hospitalizations of chronic psychiatric patients, Strayer and Keith interviewed 53 patients four days after hospital discharge (Strayer, et al., 1979). The authors designed a retrospective behavior mapping instrument which reconstructed in detail the subjects' activities, locations and interactions. The results indicated that many subjects lived alone or in someone else's residence and that they had limited social contacts outside the home. A majority (76%) had a territorial range of less than one block; most didn't know the location of common community facilities nor had they used them. Many of the basic self-help skills including cooking, washing clothes, and straightening up after oneself were not performed by a significant number (63%) of these people.

Summers (1979) reports a study in which consecutive new admissions to a large urban psychiatric

aftercare clinic over a nine month period were surveyed on a variety of demographic variables as well as psychiatric history, symptomatology and social and domestic role performance. The findings reveal a group of chronically unemployed, socially isolated patients who had been hospitalized more than three times and whose problems related more to empty lives and borderline social functioning than to psychopathological symptoms. One of Summer's conclusions is that in addition to assuring psychiatric stabilization prior to discharge, criteria should also be included to measure capacity for social adjustment and independent living in the community.

A study conducted in Manhattan investigated the personal networks of former mental patients (Sokolovsky, et al., 1978). Subjects were randomly selected from records maintained at neighborhood mental health centers. All subjects had been hospitalized more than twice and were diagnosed as schizophrenic. All subjects resided in a New York single room occupancy hotel. An attempt was made to relate social networks to degrees of personality disturbance and the chances of remaining out of an institution. Forty-four hotel residents were interviewed and observed. The findings indicate: 1) Schizophrenics have significantly fewer interpersonal contacts than do nonpsychotics

but are not totally isolated; 2) variations in number and degree of interpersonal relationships occur within the schizophrenic spectrum, and 3) small networks and a low degree of connectedness correlate with more frequent rehospitalization. The authors suggest that social networks can have a preventive role in psychiatric illness within a community setting. These results are compatible with both Strayers' and Summers' research and seem to point in the direction of a new approach to aftercare community mental health programming.

New Programming in Aftercare Services

With the exception of a few programs, the movement away from the traditional, medical model of aftercare services towards a psychosocial type of program has just begun to gain momentum. Fountain House in Manhattan and Fairweather Lodge in Wisconsin have gained national recognition among mental health professionals. These programs operate on the premise that residential care, vocational counseling, skill training and ongoing therapy must be integrated for optimal rehabilitation.

Fountain House was, in the beginning, a halfway house for the mentally ill and has evolved into a center for the psychosocial rehabilitation of persons suffering from mental illness (Chaudry, et al., 1979). Activities supported by the program include psychiatric consultation, family counseling, job placement,

psychosocial rehabilitation and transitional employment. Fountain House is based on a clubhouse model which is non-medical and based on a wellness model.

The community lodge concept, another psychosocial model, has recently been launched and described in the literature (Armstrong, 1979). The program begins in the hospital through small group wards which are designed to foster group cohesiveness and provide training in daily life skills. Patients, when ready, move to the lodge where they are visited daily by a lodge coordinator who assists them with any daily living problems which may arise. The goal is to eventually withdraw all outside support and allow the lodge to become truly self-sustaining.

A program located in Washington, D. C., similar to Fountain House is supported and funded by the community mental health program, and is designed to provide support for deinstitutionalized mental patients (Daniloff, 1979). The program was begun in 1977 and operates from the basement of an old church. At the end of 1978, the program had treated a population of 90. Specific programs for the members include operation of a clubhouse for members, operation of a thrift store, and an aggressive attempt to place members in temporary part-time, entry level jobs.

Each of the aftercare programs discussed above are having significant impact on the aftercare/rehabilitation programming not only at the community mental health level but also at the state and federal levels. More and more emphasis is being placed on the development of similar programs as part of comprehensive mental health programming.

A review of the literature reveals a clear shortage of studies designed to investigate the outcome effectiveness of aftercare programs. The studies that are available seem to fall into two major categories; those dealing with the traditional, medical model and those dealing with programs designed to influence psychosocial functioning. Test and Stein (1978) in their overview of aftercare studies, report that most of these researchers chose as their measure of treatment effectiveness the rate of recidivism of the population being studied. These authors urge more studies to deal with the issue of poor community functioning and quality of life. Judging effectiveness by recidivism rates seems to discount a major feature of community living which is the quality of that life. Until researchers and program managers are able to determine whether or not treatment programs are assisting their participants in becoming more self-sufficient and economically

independent, these programs risk losing financial support from all levels.

Overall studies of outcome effectiveness demonstrate that at least in the area of reducing recidivism any type of aftercare is better than no aftercare. Beard (1963) studied aftercare provided at Fountain House, a psychosocial rehabilitation center mentioned previously in this paper. His findings report that of those persons who became involved in the Fountain House program versus those persons receiving no treatment, the group receiving treatment had a consistently lower return rate to institutional care. Several other studies (Claghorn, et al., 1971; Katkin, et al., 1971; Sheldon, 1964) report similar findings. The drawback to each of these studies is that the degree of effectiveness of program intervention is based entirely upon recidivism rates. The issue of improved psychosocial functioning is not even addressed.

The research that has been performed in studying the milieu approaches to aftercare effectiveness is most relevant. Meltzoff and Blumenthal (1966) randomly assigned discharged patients accepted for day-treatment or a conventional outpatient clinic approach. After 18 months of treatment, their results showed that day-treatment patients had fewer readmissions and spent less time in the hospital, were less symptomatic and

were employed more often than were the outpatient controls. These researchers also observed that daycare was more effective for the lower functioning patients whereas there was little difference between the modalities for the higher functioning patients. A hypothesis to be derived from this might be that those patients with lowered levels of psychosocial functioning are in need of the most intensive services.

Fairweather (1969) reports similar findings with regards to intensive treatment. He compiled data on two groups of discharged VA patients randomly assigned to a community lodge program (previously described in this paper) or to a traditional community aftercare control group. In the lodge condition, after 16 months, the patients were determined to have spent significantly fewer days in the hospital than did the controls. These patients also demonstrated a higher level of employment, though these jobs were usually related to the lodge. Fairweather reports no differences between the groups on symptomatology, other measures of psychosocial adjustments or satisfaction with life. The drawback for these last conclusions is that the data were derived from self-report/clinician report and therefore more subject to bias.

Lamb and Goertzel (1972) studied the variable of environmental expectations on outcome among chronically

disabled patients. Patients ready for discharge were randomly assigned to one of two conditions: 1) High expectancy consisting of day treatment, halfway house, and sheltered workshop; or 2) low expectancy which consisted of placement in boarding or family care homes. Thus, low expectancy patients were placed in more sheltered environments where it is assumed they were less stressed. Follow-up data revealed the following: 1) High expectancy patients were released from the hospital more quickly than low, even though both groups were labeled "ready" for discharge at the time the study was begun; 2) high expectancy patients were readmitted more often in the first six months; 3) high expectancy were more integrated socially. It may be hypothesized from this study that high expectations create more stressful situations for psychiatric patients and thus, community programs should address the issue of lowering initial stress in the individual's environment as an aid to early adjustment.

All of these studies on the effectiveness of aftercare and others not reported here involving drug therapy suggest that aftercare programs have been effective at reducing the number of readmissions to psychiatric facilities. However, few if any of these studies address, or demonstrate any effectiveness on levels of psychosocial functioning among consumers of

these programs. Both Mosher and Keith (1978), and Test and Stein (1978) suggest in their reviews that it is time that outcome effectiveness studies direct some attention to determining whether there are any changes to be noted in the areas of psychosocial functioning and improved quality of life.

Statement of the Problem

The need for more empirical information pertinent to the effect and success of the new "clubhouse" model for the psychosocial rehabilitation of the chronic psychiatric patient recently has been recognized. Nevertheless, the total body of quantitative research in this area remains limited. The present investigation is an attempt to increase the amount of quantitative research that is available by implementing and analyzing an outcome effectiveness review of the "clubhouse" program sponsored by Highlands Mental Health Services in Abingdon, Virginia.

The null hypothesis for this study is that the control and experimental groups will not differ on items reflecting the following categories of personal adjustment and role skills:

For Females:

1) Interpersonal Involvement (Items 1-5)
2) Anxiety-depression (Items 6-10)
3) Confusion (Items 11-15)

4) Alcohol/Drug Abuse (Items 16-19)

5) Household Management (Items 20-24)

6) Outside Social (Items 30-32)

For Males:

1) Interpersonal Involvement (Items 1-5)

2) Agitation/Depression (Items 6-10)

3) Anxiety (Items 11-14)

4) Confusion (Items 15-19)

5) Alcohol/Drug Abuse (Items 20-24)

6) Household Management (Items 25-28)

7) Outside Social (Items 34-37).

METHOD

Subjects

All subjects in this study had extensive histories of psychiatric hospitalizations and at the time of this study were residents of Washington County, Virginia, living in rest homes. All were being served by the aftercare program at Highlands Mental Health Services and receiving traditional aftercare services consisting of regular medication monitoring and regular appointments with the staff psychiatrist to assure proper medication procedures were being used. During this study both experimental and control groups continued to receive this service, thus both groups received some type of treatment. Subjects for the clubhouse program (experimental treatment group) were screened and selected for participation based on the staff's subjective evaluation that these patients would do well in the program. Subjects for the control treatment group (receiving only traditional services) were drawn from the remaining pool of aftercare clients and matched with the experimental treatment group on the basis of age, sex, diagnosis and length and number of psychiatric hospitalizations. The total number of male subjects was 24;

12 in each experimental and control treatment group, and the total number of female subjects was 20; ten each in the experimental and control treatment groups. The experimental treatment group participated in the clubhouse program which involves two to three days per week (six hours per day) in a structured rehabilitation program which had as its goal to improve members personal adjustment (see Appendix F). All subjects gave their written agreement to participate in the research program.

The Instrument

The instrument used for evaluating change was the Personal Adjustment and Role Skill Scale (PARS) developed by Ellsworth (1975). The PARS scale was developed for use by significant others and was first used to evaluate the community adjustment of hospitalized veterans with a diagnosis of schizophrenia. Ellsworth defined significant others as those persons with whom the subject lived. The scale validity and reliability had been established through extensive testing in eight psychiatric hospitals and 22 mental health clinics. Ellsworth (1975) reports almost all reliability estimates as being in the 80's and 90's. Additionally, concurrent validity (agreement between ratings by significant others and self) was demonstrated to be between .50 and .62. The scale is designed to be used

pre- and post-treatment and is recommended for use in evaluating program effectiveness (Ellsworth, 1975).

The PARS scale consists of 40 items for females and 44 items for males. Of these items, #38 to 44 for men and #34 to 40 for females were demographic data which was unnecessary for this study and therefore these items were eliminated from the data collection. Each item is descriptive of some personal adjustment or role skill behavior. Examples of items are as follows:

For females:

1) Interpersonal Involvement "Been able to talk it through when angry"

2) Anxiety Depression "Acted restless and tense"

3) Confusion "Forgotten to do important things"

4) Alcohol/Drug Abuse "Been drinking alcohol to excess"

5) Household Management "Helped with chores around the house"

6) Outside Social "Attended meetings of civic, church or other organizations"

For males:

1) Interpersonal Involvement "Discussed important matters with you"

2) Agitation/Depression "Said people didn't care about him"

3) Anxiety "Had difficulty sleeping"

4) Confusion "Been in a daze or confused"

5) Alcohol/Drug Abuse "Been drinking alcohol to excess"

6) Household Management "Done household cleaning"

7) Outside Social "Participated in recreational activities outside the home (sports, movies, dances, etc.)"

Procedure

This researcher met individually with all rest home operators who had patients participating in the study. They were given detailed instructions on filling out the scales. Data were collected on the pre-test and two months later on the post-test. Rest home operators were instructed to have the same person fill out the forms during each procedure.

Analysis of the Data

Scores for each subject were computed individually for each variable on the PARS form. For males, items #20-24 (Alcohol/Drug Abuse) and 30-33 (Relationship to Children) were not analyzed as none of the subjects had access to alcohol/drugs or children. For females, items #16-19 (Alcohol/Drug Abuse) and 26-29 (Relationship to Children) were not analyzed as none of the subjects had access to alcohol or drugs and children were not living in the rest homes. The Wilcoxon matched pair signed ranks test was used to analyze the results and determine if there were differences in performance between experimental treatment and control treatment groups.

RESULTS

There were no significant differences in performance pre- and post-treatment between experimental and control groups at the .01 level of significance on any of the variables (see Tables 1 and 2). Therefore, the null hypothesis must be accepted. There were several trends noted which were of particular interest, however.

Scores for female subjects showed some response difference on two items of the scale with the experimental group moving in a positive direction, i.e., making changes toward a more productive level of functioning. On item 3 for females, "been able to talk it through when angry," the data suggests women in the experimental group more likely to be able to do this. Additionally, on item 7, "said things looked discouraging or hopeless," subjects in the experimental treatment group less frequently made these types of statements in the post-treatment phase. Both of these items suggests that positive changes may be occurring in the broader categories of interpersonal involvement and agitation/depression.

TABLE 1

RESULTS OF THE WILCOXON SIGNED RANK TEST

MALES BY ITEM

Item		P Value
1.	Shown consideration for you	.028
2.	Felt close to members of household	.180
3.	Discussed important matters with you	.022
4.	Been able to talk it through when angry	.043
5.	Cooperated with things asked of him	.317
6.	Said people don't care about him	.180
7.	Said people treat him unfairly	.593
8.	Complained or worried about problems	.139
9.	Said people try to push him around	.180
10.	Said life wasn't worth living	.109
11.	Had difficulty eating	1.000
12.	Been nervous	.059
13.	Acted restless and tense	.018
14.	Had difficulty sleeping	.180
15.	Jumped from one subject to another when talking	.180
16.	Just sat and stared	.059
17.	Forgotten to do important things	.593
18.	Been in a daze or confused	.018
19.	Needed supervision or guidance	.317
20-24	Omitted	
25.	Helped with chores around house	.109
26.	Done household cleaning	.043
27.	Prepared meals for the family	.108
28.	Done laundry, ironing, or mending	.317
29-33	Omitted	
34.	Been involved in activities outside the home	.180
35.	Attended meetings of civic, church, or other organization	.624
36.	Participated in recreational activities outside the home	.273

TABLE 2

RESULTS OF THE WILCOXON SIGNED RANK

BY ITEM - FEMALE

Item		P Value
1.	Shown marked consideration for you	.317
2.	Shown interest in what you say	.180
3.	Been able to talk it through when angry	.018
4.	Shown affection toward you	.593
5.	Gotten along with family members	.593
6.	Acted restless and tense	.593
7.	Said things looked hopeless	.018
8.	Had difficulty falling or remaining asleep	.361
9.	Been nervous	.317
10.	Talked about being afraid	.593
11.	Forgotten to do important things	.109
12.	Lost track of time	.180
13.	Needed supervision or guidance	.237
14.	Been in a daze or confused	.109
15.	Seemed off in a world by herself	.180
16-19	Omitted	
20.	Done the household cleaning	.068
21.	Prepared the evening meal	.068
22.	Done the laundry, ironing, or mending	.109
23.	Done the grocery shopping	1.000
24.	Helped with chores around house	.317
25-29	Omitted	
30.	Been involved in activities outside the home	.028
31.	Attended meetings of civic, church, or other organizations	.028
32.	Participated in recreational activities outside the home	.686

Scores for male subjects also reflected some trends in a positive direction, i.e., higher level of functioning. On item 13, "acted restless and tense," the data suggests males in the experimental group were less frequently rated as behaving in this manner on the post-test. Ratings on item 18, "been in a daze or confused," suggests that males in the experimental group post-test were less often in a confused state. Thus, for males, there were suggestions of improvement in functioning observed in the broad categories of anxiety and confusion. A hypothesis that deserves further investigation is that the clubhouse program is effecting change in reducing levels of anxiety and confusion for subjects in the program.

DISCUSSION

Discussion of this research project falls most meaningfully into three categories: (1) problems encountered with the PARS scale, (2) problems related to the population being studied, and (3) problems related to the program itself.

Use of the PARS scale posed two questions for this study. First, the PARS scale is designed to be answered by significant others, i.e., those persons with whom the patient is living. In this case, significant others may not have been unbiased enough to answer objectively. To state this another way, rest home operators are dependent upon having patients to fill up their beds and thus may have a vested interest in not recognizing or encouraging positive changes. Another equally relevant point is whether any subject residing in a rest home setting improves in personal adjustment skills. Stated another way, do residential settings facilitate positive changes or maintain the status quo? It would be valuable for further research to compare the adjustment of community aftercare clients (living in private homes) in the Clubhouse program and rest home subjects. A second problem with the PARS scale is

that it seems to be designed for the "acute" patient who may be more likely to resume a premorbid level of adjustment rather than the chronic patient who is unlikely to achieve significant readjustment. The PARS does not seem to be sensitive enough to pick up the small increments of change which can be expected in a chronic population. It is likely that as programs for the newly discharged chronic patients grow, the programs will have to develop their own instruments for measuring change based solely on clearly specified, observable behavior. The fact that a few of the items showed changes pre- versus post- suggests that the subjects' behavior may be changing. The challenge is to determine exactly what behavior is changing and how this behavior is changing. This can perhaps be accomplished by basing rating scales on individualized treatment goals of each subject. Standardized measuring instruments may not be useful for measuring outcome effectiveness.

There are also problems related to the population being studied. With a population whose length of stay in psychiatric hospitals has been several years, one is unlikely to demonstrate short term changes in behavior after initiating treatment programs. In fact, long term goals of 9-19 months would be a more realistic time interval before expecting significant changes

to occur for such a population. Data could be tabulated at regular and frequent intervals, but results will not likely appear until after several months of participation. Also, to reiterate a point previously mentioned, chronic problems are likely to change in minute increments and any research instrument will have to be sensitive to small changes.

Finally, although the Clubhouse program had a basic philosophy (See Appendix F) it did not, at the time of this investigation, have clear goals for the program or its participants. Thus, the program did not have specific individualized goals for each participant around which to begin to remediate behavior. Since obtaining the results of this study, the program has begun to develop specific goals for itself and each participant. A lesson learned from this study is that it is difficult to evaluate changes which have not been specifically and concretely outlined and described before implementing treatment programs. Ideally, then, all programs should begin with a needs assessment and clarification of goals.

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APPENDIX A

PARS Consent Form

HIGHLANDS MENTAL HEALTH SERVICES
158 W. Valley Street
Abingdon, VA 24210

PARS CONSENT FORM

I, _____ do hereby give my
(patient's name)
consent to and authorize the Highlands Mental Health Services to send the PARS (The Measurement of Community Adjustment and Role Skills) questionnaire to _____
(name of
_____ upon my admission to the center,
rest home)
and again in 90 days after treatment begins.

I understand that this information is requested by authority of the center's Quality Assurance Committee for the purpose of helping the center to evaluate and thereby improve the effectiveness of its treatment; and that the information collected will become a part of my permanent record and will be treated in a confidential manner.

I understand that had I refused to give this consent, there would have been no penalty, and it would not have affected my care and treatment at the center in any way.

I understand that this consent is subject to revocation by me at any time, and unless an earlier date is

specified, that it automatically expires 120 days after the date affixed below.

Date	Signed (Patient)
	Signed (Witness)

APPENDIX B

PARS V Community Adjustment Scale

Pretreatment FEMALE Items

PARS V COMMUNITY ADJUSTMENT SCALE

PRETREATMENT FEMALE ITEMS

DURING LAST MONTH, HAS SHE...

1. Shown consideration for you?
2. Shown interest in what you say?
3. Been able to talk it through when angry?
4. Shown affection toward you?
5. Gotten along with family members?
6. Acted restless and tense?
7. Said things looked discouraging or hopeless?
8. Had difficulty falling or remaining asleep?
9. Been nervous?
10. Talked about being afraid?
11. Forgotten to do important things?
12. Lost track of time?
13. Needed supervision or guidance?
14. Been in a daze or confused?
15. Seemed off in a world by herself?
16. Been drinking alcohol to excess?
17. Been using drugs excessively?
18. Become drunk on alcohol or high on drugs?
19. Had a drinking or drug problem that upset family?
20. Done the household cleaning?
21. Prepared the evening meal?
22. Done the laundry, ironing, and mending?
23. Done the grocery shopping?
24. Helped with chores around the house?
25. Are there usually children in the home?
    (1) _____ No (If you marked "No", skip to question 30)
    (2) _____ Yes (If you marked "Yes", answer questions 26-29)
26. Kept her promises to the children?
27. Shown affection toward the children?
28. Known the right thing to do when disciplining the children?
29. Found the children showing respect for her?
30. Been involved in activities outside the home?
31. Attended meetings of civic, church, or other organizations?
32. Participated in recreational activities outside the home?
33. Looked for or obtained employment?
34. Did she earn an adequate amount of money from work-last month?
35. Did she look forward to going to work each day?

APPENDIX C

PARS V Community Adjustment Scale

Posttreatment FEMALE Items

PARS V COMMUNITY ADJUSTMENT SCALE

POSTTREATMENT FEMALE ITEMS

DURING LAST MONTH, HAS SHE...

1. Shown consideration for you?
2. Shown interest in what you say?
3. Been able to talk it through when angry?
4. Shown affection toward you?
5. Gotten along with family members?
6. Acted restless and tense?
7. Said things looked discouraging or hopeless?
8. Had difficulty falling or remaining asleep?
9. Been nervous?
10. Talked about being afraid?
11. Forgotten to do important things?
12. Lost track of time?
13. Needed supervision or guidance?
14. Been in a daze or confused?
15. Seemed off in a world by herself?
16. Been drinking alcohol to excess?
17. Been using drugs excessively?
18. Become drunk on alcohol or high on drugs?
19. Had a drinking or drug problem that upset family?
20. Done the household cleaning?
21. Prepared the evening meal?
22. Done the laundry, ironing, and mending?
23. Done the grocery shopping?
24. Helped with chores around the house?
25. Are there usually children in the home?
    (1) _____ No (If you marked "No", skip to question 30)
    (2) _____ Yes (If you marked "Yes", answer questions 26-29)
26. Kept her promises to the children?
27. Shown affection toward the children?
28. Known the right thing to do when disciplining the children?
29. Found the children showing respect for her?
30. Been involved in activities outside the home?
31. Attended meetings of civic, church, or other organizations?
32. Participated in recreational activities outside the home?
33. Looked for or obtained employment?
34. Did she earn an adequate amount of money from working last month?
35. Did she look forward to going to work each day?

APPENDIX D

PARS V Community Adjustment Scale

Pretreatment MALE Items

PARS V COMMUNITY ADJUSTMENT SCALE

PRETREATMENT MALE ITEMS

DURING LAST MONTH, HAS HE...

1. Shown consideration for you?
2. Felt close to members of household?
3. Discussed important matters with you?
4. Been able to talk it through when angry?
5. Cooperated (gone along) with things asked of him?
6. Said people don't care about him?
7. Said people treat him unfairly?
8. Complained or worried about problems?
9. Said people try to push him around?
10. Said life wasn't worth living?
11. Had difficulty eating (poor appetite, indigestion, etc.)?
12. Been nervous?
13. Acted restless and tense?
14. Had difficulty sleeping?
15. Jumped from one subject to another when talking?
16. Just sat and stared?
17. Forgotten to do important things?
18. Been in a daze, or confused?
19. Needed supervision or guidance?
20. Been drinking alcohol to excess?
21. Been using drugs excessively?
22. Become drunk on alcohol or high on drugs?
23. Had a drinking or drug problem that upset his relationship with family?
24. Had a drinking or drug problem that kept him from working?
25. Helped with chores around house?
26. Done household cleaning?
27. Prepared meals for the family?
28. Done laundry, ironing, or mending?
29. Are there usually children in the home?
30. Spent time with the children?
31. Shown affection toward the children?
32. Kept his promises to the children?
33. Been consistent in how he reacts to the children?
34. Been involved in activities outside the home?
35. Attended meetings of civic, church, or other organization?
36. Participated in recreational activities outside the home (sports, movies, dances, etc.)?
37. During the last month, has he looked for or obtained employment?

APPENDIX E

PARS V Community Adjustment Scale

Posttreatment MALE Items

PARS V COMMUNITY ADJUSTMENT SCALE

POSTTREATMENT MALE ITEMS

DURING LAST MONTH, HAS HE...

1. Shown consideration for you?
2. Felt close to members of household?
3. Discussed important matters with you?
4. Been able to talk it through when angry?
5. Cooperated (gone along) with things asked of him?
6. Said people don't care about him?
7. Said people treat him unfairly?
8. Complained or worried about problems?
9. Said people try to push him around?
10. Said life wasn't worth living?
11. Had difficulty eating (poor appetite, indigestion, etc.)?
12. Been nervous?
13. Acted restless and tense?
14. Had difficulty sleeping?
15. Jumped from one subject to another when talking?
16. Just sat and stared?
17. Forgotten to do important things?
18. Been in a daze, or confused?
19. Needed supervision or guidance?
20. Been drinking alcohol to excess?
21. Been using drugs excessively?
22. Become drunk on alcohol or high on drugs?
23. Had a drinking or drug problem that upset his relationship with family?
24. Had a drinking or drug problem that kept him from working?
25. Helped with chores around house?
26. Done household cleaning?
27. Prepared meals for the family?
28. Done laundry, ironing, or mending?
29. Are there usually children in the home?
30. Spent time with the children?
31. Shown affection toward the children?
32. Kept his promises to the children?
33. Been consistent in how he reacts to the children?
34. Been involved in activities outside the home?
35. Attended meetings of civic, church, or other organization?
36. Participated in recreational activities outside the home (sports, movies, dances, etc.)?
37. During the last month, has he looked for or obtained employment?

APPENDIX F

Highlands Clubhouse

HIGHLANDS CLUBHOUSE

Statement of Purpose

To help clients obtain their optimum level of functioning within their respective environment.

Program Goals:

(1) To facilitate and support successful integration of the individual into their community.

(2) To improve the quality of life by providing a diverse set of meaningful activities.

(3) To improve the individual's ability to perform independent living skills.

(4) To enhance the sense of self-worth and provide social interaction and community involvement through recreational activities.

(5) To provide opportunities for members to develop better work habits.

(6) To facilitate socialization of members through peer support, role modeling, and social training.

VITA

Jean Murray Gay was born in Norwalk, Connecticut on November 11, 1947. She was raised in South Carolina and North Carolina. College matriculation occurred from September, 1965 until August, 1969 at North Carolina State University when she received a Bachelor of Arts degree with a major in sociology. After graduation, Ms. Gay worked for seven years as a rehabilitation counselor for the State of North Carolina. In September, 1977, she began study towards a Master's degree in clinical psychology at Appalachian State University. Final requirements were completed in the Fall of 1981 and graduation occurred in the Spring of 1982.

Ms. Gay is employed by Highlands Mental Health Services as clinical coordinator. She is executive director of Family Therapy Training and leads training workshops.

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