

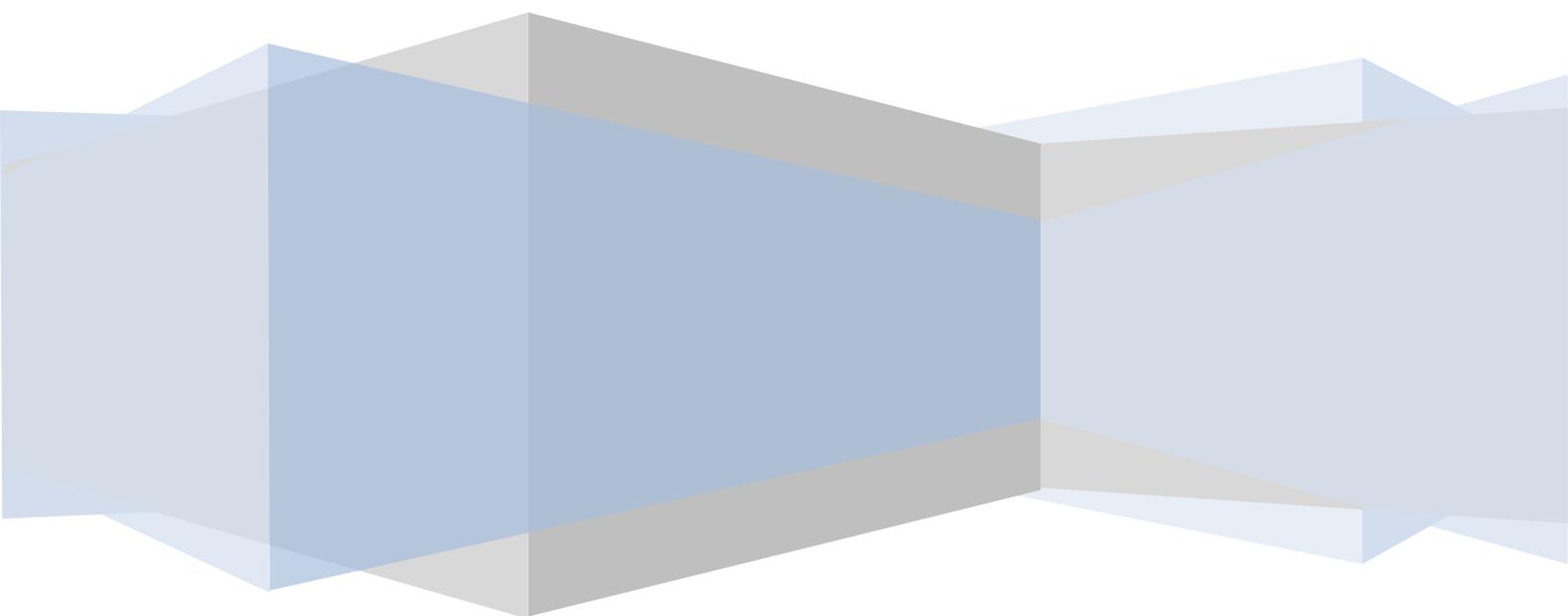
Mayview Discharge Study

Two-year outcome report

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University of Pittsburgh Mayview Discharge Study

Report on two-year outcomes

EXECUTIVE SUMMARY

Purpose: It is important to follow outcomes for people discharged from long-stay psychiatric inpatient facilities into community residential and treatment settings in order to continue to learn about the process of recovery, and in order to track quality of care in community settings.

Method: This study followed 65 people discharged from Mayview State Hospital when it closed in December, 2008. They represented 75% of a random sample of people in the hospital who participated in the community support planning process linked to the closing. We saw participants every three months for two years. Research-validated standardized assessments were completed every six months. The intervening visits focused on qualitative data collection in the form of conversations with participants and providers, and interviews structured around well-being, satisfaction, and current adjustment. Descriptive field notes were taken at every visit.

Results: Participants overwhelmingly reported that they preferred community living to the hospital, captured in the statement “it’s the freedom factor”. Most participants felt safe and comfortable in their new residences. However, community integration is still a challenge for most participants, and many would like a greater variety of interesting activities to engage in. Qualitative observations also suggest that housing and therapeutic living situations will present on-going concerns.

Psychiatric symptoms decreased over time, with 60% of participants meeting a recently-published criterion for remission of psychotic symptoms, and 50% meeting this criterion also in the context of low or mild symptoms of other major mental disturbance. Indicators of social adjustment also showed improvement over the two-year observation period. Other indicators, including quality of life, progress towards recovery and perceptions of care did not change over the two-year time period. Compared to other similar samples, levels of quality of life and recovery were medium or high. In contrast, standardized ratings of satisfaction with care were rather lower than those seen in other populations, and suggest possible areas of quality improvement.

Conclusions: People discharged from Mayview State Hospital clearly felt emancipated, not evicted. Some important indicators of health and well-being improve over two years. No indicator measured in the study deteriorated over the two year observation period. Many participants find very real sources of satisfaction in their lives in the community. As summarized by one participant when asked about leaving Mayview, “The best experience has been knowing I can make it in the real world”.

Mayview Discharge Study
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INTRODUCTION

For the past half century, the goals of mental health treatment have been to provide people with serious psychiatric disabilities effective treatments in the least restrictive settings. As capacity and expertise for community psychosocial and psychiatric services have evolved, most people with even the most serious psychiatric disorders receive nearly all their treatment outside of hospitals. During the first decades of the shift to community services, a majority of people with psychiatric disorders were accommodated, with varying degrees of success, and length of hospital stays decreased substantially (Desai & Rosenheck, 2003). However, those with complicated clinical needs and few social and family resources, and those with sex-related and other criminal problems, experienced long stays in hospitals as their primary mode of treatment (Fisher et al 2009).

In the past two decades, these long stay patients have been relocated or re-settled as many public psychiatric hospitals have closed. Their short- and long-term adjustments are reported consistently as mostly positive in clinical, social, and service delivery domains in the US as well as other countries (McIerney et al., 2010, Ireland; Furlan et al., 2009, Italy; McCrone et al., 2006, UK; Nierman & Lyons, 2001, US; Okin et al., 1995, US; Rothbard, & Kuno, 2000, US)¹. Rothbard and Kuno (2000) examined the outcomes of hospital closures in Philadelphia, Massachusetts, London, and Italy and concluded, “the long-stay discharge population shows an improved life satisfaction following discharge, with little or no deterioration in level of functioning. In addition, costs have generally been the same or less for discharged patients living in the community. In Philadelphia, the cost of care was substantially reduced; in Massachusetts, as well as London, costs were, on average, no higher in the community versus the state hospital, particularly after the first year following discharge.” McIerney et al. (2010) report that five years after discharge the gains of the first year were not sustained, however, Okin et al. (1995) found that at 7.5 years, overall well being and functioning were stable if not improved. It will be important to continue longer term follow up studies to explore which improvements endure and progress, and which deserve ongoing or increased attention.

Topor and colleagues (2009) and Flanagan and Davidson (2009) point out that recovery and resettlement from hospital to community are long term processes, and that developing social relationships and dealing with stigma are enduring challenges. In a consumer-led research project, McCourt (2000) found that four years after returning to community living, the respondents preferred the freedom and comfort of their living situations, and that attaining autonomy in decision making and exercising individual advocacy were important unmet goals.

Along with the generally encouraging results of relocation, it also clear that it is much more complicated to provide excellent care for the former long term hospital residents in a wide range of community settings than it is to confine people with serious disabilities in self-contained institutions. For all of the

¹ Throughout the report, we use research terminology that may differ from policy and advocacy language.

recognized shortcomings of hospital care, long term placement provided food, shelter, on site psychiatric and medical care, and protection for many patients. A community system must also address many of the same clinical and daily living needs, many of which cross the boundaries of social and psychiatric service systems. The current mental health care system must evolve to be versatile enough to serve the former hospital residents along with others with need – that is, complex, flexible care must be available on a routine basis.

In 2007, Mayview State Hospital was one of eight psychiatric inpatient facilities managed by the Commonwealth's Department of Public Welfare. Mayview (then called Marshalsea) opened in 1893, and operated as an asylum and poor house until 1941, when it came under state management. In the 1930's, the time of the highest census, Mayview was home to over 4,000 residents. Census has been declining since the discovery of more effective psychotropic medications in the 1950's, and the advent of community-based mental health services and deinstitutionalization in the 1960's. Mayview served as the state-operated long-stay psychiatric facility, and forensic unit, for five counties in western Pennsylvania, including Allegheny, an urban county that includes the city of Pittsburgh, and four rural or semi-rural counties, including Beaver, Greene, Lawrence and Washington counties. Plans to close the hospital were announced in August, 2007.

In anticipation of the closure of Mayview State Hospital, the five surrounding counties collaborated on reviewing and strengthening the portfolios of community-based services and housing options. The planning group included representation from state and local mental health officials, providers, consumers, families, managed care, advocates, each county, and the hospital. A process was established to develop a Community Support Plan (CSP) for each individual discharged. CSPs were developed over multiple planning sessions, and included family members, providers, and advocates of the individual's choosing. Mayview State Hospital was closed in December, 2008. This paper reports on a two-year, prospective, multi-method, longitudinal study of outcomes for people discharged. The design and content of the study incorporate the perspectives and findings of the comparable cumulative research, some of which is cited above.

METHODS

Overview

The study followed 65 people from a random sample of people living in the hospital at the time the closure was announced and who were slated for discharge. Study interviewers met with participants every three months for two years. All study interviewers were graduate students at the University of Pittsburgh School of Social Work or Public Health. Study personnel also included two senior faculty from the University of Pittsburgh and the University of North Carolina, Chapel Hill, and an experienced project director (the authors of this report). Study interviewers received 10-20 hours of training on the study procedures from the project director. Training particularly focused on two instruments that required interviewer ratings, the Brief Psychiatric Rating Scale, and the Social Adjustment Scale-II. All staff were

supervised by the project director and the senior faculty at weekly staff meetings. At these meetings, study procedures were reviewed, and each interviewer's contacts with each participant were discussed.

All procedures were approved by the University of Pittsburgh Institutional Review Board, and participants were reminded at each assessment that they were free to decline any part, or all, of the study participation, and their decision about whether or not to participate in no way affected their services.

Sample

We randomly selected a sample of 87 hospital residents. Each person living in the hospital 12 months prior to the closing who participated in the discharge process had an equal chance of being selected for the sample. 65 members of the sample (75%) consented to participate.

Recruiting

We worked with county staff and providers to approach the individuals included in the random sample regarding their willingness to participate in the study. We explained the procedures, and assured potential participants that that they could skip any part of the procedures they did not like and that their participation in no way affected their services. When people were uncertain about their interest in participation we made multiple visits until they could decide. Formal consent forms were signed at the beginning of the study, and at each subsequent visit participants agreed again to our presence.

Recruiting began about six months into year-long CSP-driven discharge and closing process. Additionally, a number of people considered participation over fairly lengthy periods of time. Thus, participants were recruited into the sample anytime from before discharge up through 18 months after discharge. Table 2 shows the recruiting timeline.

Table 2: Recruiting timeline

<i>Timepoint recruited</i>	<i>N</i>
Hospital	21
By 6 months post-discharge	28
By 12 months post-discharge	10
By 18 months post-discharge	6
Total	65

Sample characteristics

Participant characteristics are shown below.

	Range or category	Average or Percent
Age	19 to 90	44.5 years
Gender	Men	42 (72%)
	Women	23 (28%)
Race	White	36 (55%)
	African American	29 (45%)
Length of stay	5 months – 22 years	4.5 years
Length of stay (frequency)	< 1 year	6 (9%)
	1-2 years	24 (37%)
	2-5 years	19 (29%)
	5-10 years	8 (12%)
	> 10 years	8 (12%)
Primary diagnosis	Schizoaffective Disorder	21 (32%)
	Schizophrenia or Psychosis NOS	34 (52%)
	Major Depressive or Mood Disorder	5 (8%)
	Other (Bipolar, Impulse Control, Personality)	5 (8%)

Living arrangements

Following discharge, most participants lived in supported/supervised settings throughout the study period. Two people lived independently (in single or shared settings without required or in residence services) at all post-discharge time points in which they participated. Five people who lived in supported settings early in the study moved into independent living situations later in the study, and four people who lived in independent settings at earlier time points moved to supported settings at later time points. Two participants lived with family. One participant lived with his wife throughout the study period, and one participant lived with his parent in the second year of the study.

Most study participants who lived independently were in low-income public housing, in contexts of varying degrees of services and safety. One such setting had behavioral health staff on site for part of the study period.

Over the course of the study, two participants died, both of natural causes, and two were incarcerated. Each of these four events occurred close to the two-year follow up.

Measurement

We used qualitative and quantitative techniques to learn how participants were faring in the community settings to which they were discharged.

225 standardized assessments and 138 check-ins were completed for the 65 participants over the course of the two year observation period.

Analyses

Qualitative analyses

The authors read all of the qualitative material in order to develop a summary for each participant, and to develop overall themes. These data consisted of the transcripts of the semi-structured and conversational interviews, transcripts of the relocation interviews, and interviewer field notes. We regularly discussed all qualitative materials and their summary over the course of the study, in an iterative process of conceptual mapping and themes development.

Quantitative analyses

Change over time was analyzed with latent growth curve analyses, an analysis specifically designed to estimate change over time in studies in which observations are missing, and participants join at different points in the study trajectory, as was the case here. The analysis estimates a rate of change for each individual based on the data available for that person, and uses those estimates to calculate a rate of change for the group. That rate of change is then tested for statistical significance. An individual's rate of change can be estimated from any two observations; thus, the analysis is well suited to data sets with missing observations. Analyses were conducted using SAS 9.2, PROC MIXED and PROC GLIMMIX.

Where they are available, we also provide means from other published samples in order to provide perspective on how people discharged from Mayview fared compared to other similar groups that have been studied.

RESULTS

Qualitative Results

Interviews and observations showed that participants decidedly prefer their new residences to Mayview, that they are mostly safe and comfortable, and that there is still work to be done on community integration. Themes were developed using direct quotes from conversations and interviews, as well as our direct observations.

Participants prefer their new residences to the hospital

Interviews with participants show that they overwhelmingly prefer their new residences to the hospital. Almost to a person they stated that they preferred their new residence because they had more freedom. They also stated that they preferred living in smaller settings, in which they had more say over the day-to-day aspects of their lives, including when and where to go out, room décor, and choice of music and television programming, and other choices of activities.

Interviewer: Compare where you are to Mayview. *Participant:* No comparison. It's better. It's the freedom factor.

I have more freedom. I like the staff here. I like the fact that I can do my own laundry.

I like where I am a lot better. I obey all the rules here. Where I am helps with my main issues, and I get to talk to my mom a lot here.

I'm free. I go more places. I do what I want to do.

Participants report being safe and comfortable

Interviews and observations also showed that most participants reported that they felt safe in their residences, and found them comfortable places to live.

It is much better here. Here, I am much more relaxed. I get to go out a lot more with CTT as well.

It's better here. It's pretty good. I am much more comfortable.

I like it better here. There are less people. If residents don't get along, it gets taken care of by staff.

Community integration is lacking, and life can be monotonous

A substantial minority of participants reported that their lives were rather static. Some people did not appear to be offered many choices of activities, other people found the rounds of occasional outings to similar settings monotonous after some period of time. Continuing to offer an array of activities in residential settings, and to find ways for people to become more independently involved with on-going community activities, will be an on-going concern.

Interviewer: What is a typical day like here now? *Participant:* Sleeping. [Laughs.] *Interviewer:* You just sleep all day? *Participant:* No. I get up and watch TV or come out here and smoke. *Interviewer:* What else do you do during the day? *Participant:* Nothing.

Sleeping. Groups. That's about all. Listen to the radio.

I don't go anywhere. I don't have any money. I only get \$75 a week.

Although reports of a substantial minority of participants suggest that more variety in activities, and more stimulating activities would be welcome, some people are well integrated into community activities.

Right now, I'm in the process of getting prepared to get a job...I'll see what kind of things I want and am able to do. I want a part-time job that won't interfere with my checks.

Participants depend on staff

In keeping with the difficulties of community integration, a substantial number of participants rely primarily on staff for social contacts, and often see few people other than residential staff or service provider. As stated by one participant: “no one has visited me besides my peer mentor and CTT”. Some people reported these contacts to be very positive, though not everyone did.

Positive assessments

[The staff nurse] helps with cigarettes. If I have a hard time, I talk to her.

[CTT is] not bad. I like them guys. They're nice. They do things for you—take you out shopping, get something to eat. They're always busy when they come here. They have to go somewhere, be somewhere. They got a bunch of clients. Their caseload is too high.

I have 24-hour access to my case manager. I can call her whenever I need help or need to talk. She is my best friend, guardian, and big sister.

I always talk to [my CTT worker] a minimum of three times a day, sometimes more...I can talk to her any other times—if there's something going on, or I need her to advocate for me... She truly cares about all her people.

They talk to me, relate to what I'm going through. They sympathize.

Critical assessments

I have no idea how long I'm staying here or where I'm going or nothing.

They were promising a complete wrap-around thing, and what I ended up with was not a wrap-around thing.

Yeah, the staff makes me nervous. I don't know why.

A CTT worker took me to the bank. I don't know who it was.

Many people have complex medical needs

Medical fragility is quite common among people discharged from the hospital, and it should be borne in mind that community integration, social adaptation, and quality of life must be improved or maintained in the context of what can be quite complex medical needs.

For my diabetes, they increased my meds because at night I am unstable. My blood sugar fluctuates. Now, I get a shot and a pill sometimes three times a day.

I'm still suffering from diabetes, hypertension, asthma, bronchitis, GERD, and a seizure disorder.

Asthmas, diabetes, seizure disorder, COPD, HBP, serious allergies, problems involving my muscles and nerves.

I was hospitalized medically for high sugar because of my diabetes and choking.

So many meds...all day!

Housing is a continuing concern

The hospital closing process was attentive to housing needs for people with psychiatric disabilities. Substantial efforts were made to ensure a sufficient range and number of therapeutic residences. Many of these service levels are costly, and are designed to be of relatively short duration; that is, some of these service settings are designed to support people for a period of time during which they gain skills to thrive in less restrictive living settings. For people with severe disorders this can be problematic. Over the two year course of the study we observed a number of people who adjusted well to settings that were generously staffed, only to learn that they would soon need to find alternative housing. For people who may benefit from stability in housing and staffing the many levels of residential services and the need to change among them due to regulated acceptable time periods can be confusing and disrupting.

People with psychiatric disabilities whose care is financed through the public sector are generally poor, and public housing is one of the major residential alternatives for people who are doing well, and can live well, with less support, in community settings. Public housing is not always available, and is not always safe or attractive. This will be an on-going problem for policy-makers who work in this area.

The promise and peril of choice

Some participants experienced excellent adjustment and outcomes. Over the two years of the study we met people who developed relationships, found work, and participated in volunteer activities. This subgroup of people was able to take advantage of opportunities developed in the system, and also create their own opportunities.

In contrast, a small number of participants exercised their greater freedom to continue or renew risky behaviors. These people particularly valued the freedom and choice that community settings offered. One noticeable pattern in this small group was to use illegal substances with old (and sometimes new) friends, and some of these people experienced significant consequences in the criminal justice system.

We were unable to follow up with a small number of people because they were in jail. When people went to jail, they appeared to us to stay there for lengthy periods of time, sometimes without apparent sentencing. We did not always have access to information about specific situations. When we had access to information about the details, illegal substance use, and criminal activities related to substance using were involved.

Quantitative Results

Analysis of the standardized instruments shows clearly that psychiatric symptomatology decreased over the two-year study period. At the two-year post-discharge time-point, 60% of participants met a recently published recommended criterion for remission of symptoms of schizophrenia, and 50% met criteria for remission of symptoms of schizophrenia and other major mental disorders. Participants also appeared to grow more comfortable with their social lives as measured by the Social Adjustment Scale.

No other quantitative indicator changed over the two year time period. Attitudes towards medications, quality of life, standardized indicators of recovery and satisfaction with services did not change over time. Mostly, the scores on these indicators appear to show that people discharged from Mayview are doing well compared to other similar populations. The one exception to this is in perceptions of care, where Mayview participants are rather lower than a large published sample.

The following sections provide detailed description of measurement and results for indicators measured with standardized instruments.

Psychiatric symptoms

Psychiatric symptoms were assessed with the BPRS (Overall & Gorham, 1962). The BPRS is an interviewer-rated checklist of 18 symptoms of major mental illness, and is perhaps the most widely used research measure of psychiatric symptomatology (Burns, 2007; Mortimer, 2007). It is highly sensitive to change, and can be accurately rated by a variety of clinical and research staff (McGorry et al., 1988; Mortimer, 2007; Overall & Rhoades, 1982).

Interviewers were trained to reach a criterion of agreement with accepted standards, receiving 10-20 hours of training and practice to reach the criterion. Agreement was checked periodically throughout the study period. The BPRS was rated at every standardized time point.

Ratings for BPRS items range from 1 (not present) to 7 (extremely severe). BPRS totals range from 18 (if each of the 18 symptoms is rated 'not present') to 126 (if each of the 18 symptoms is rated 'extremely severe'). Leucht and colleagues (2005) developed cut-points for the BPRS to correspond with mild, moderate, and severe levels of illness by linking BPRS scores with Clinical Global Impressions for 1,979 participants with schizophrenia in seven drug trials. They report that "mildly ill" equates to a BPRS score of 31, "moderately ill" to 41, and "severely ill" to 53.

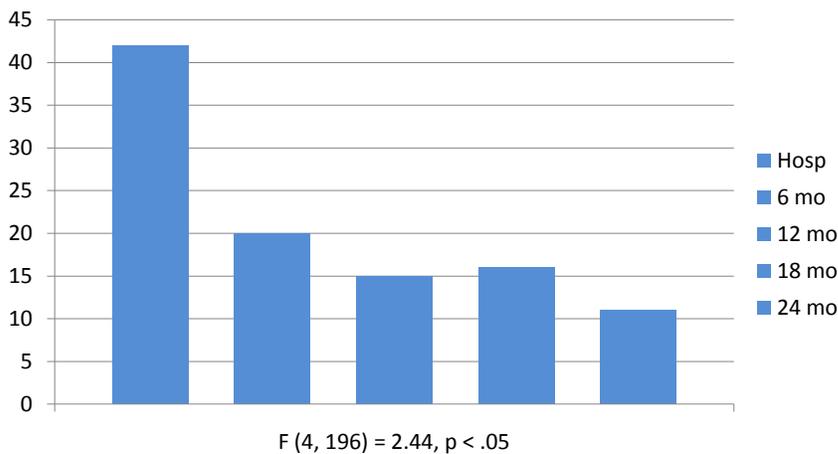
The analysis is based on 221 observations of 64 participants in the study. Changes in psychiatric symptomatology were modeled with latent growth analyses using SAS Proc Mixed. This analysis showed that psychiatric symptomatology decreased significantly over time, estimating that on average, BPRS scores decrease about five and a half points per year (estimate for slope is $-.45$ points per month). This effect was significant, $t(155) = 5.79$, $p < .0001$.

The table below shows the mean BPRS score for people participating in each time point, and the percent of people who meet criteria for at least moderate illness at each time point. Both decrease substantially.

	Hospital	6 months	12months	18 months	24 months	Results of change analysis
N	19	40	48	49	45	64
Average BPRS score (SD)	39.5 (14.6)	34.9 (13.8)	31.2 (10.7)	30.5 (10.8)	28.5 (9.4)	t(155) = 5.79, p <.0001
% with at least "moderate" illness (BPRS \geq 41)	8 (42%)	8 (20%)	7 (15%)	8 (16%)	5 (11%)	F(4, 196) = 2.44, p < .05

The number of people who experience moderate levels of symptoms or greater drops substantially over the course of the study.

Percent with at least moderate illness (BPRS >41)



Symptom remission

Andreasen and colleagues (2007) have recently proposed criteria for remission of symptoms of psychotic illness. They define remission as a state in which symptoms are reduced to low levels unlikely to affect behavior or well-being, and are maintained at these low levels for a substantial period of time. They note that symptom remission is a more limited construct than recovery, which focuses on establishing meaning and satisfaction, and successful functioning in community, social and vocational roles. Andreasen and colleagues suggest that symptom remission will be a helpful precursor to recovery for many individuals with severe mental illnesses; we add to this observation that many people may find

meaning and activities even in the presence of on-going significant symptoms. Nonetheless, it is clear that at least for some people, the reliable reduction of symptoms to less bothersome levels is likely to improve quality of life, and may serve as a precursor to other important areas of recovery, such as social or vocational functioning.

Andreasen and colleagues(2007) propose that symptoms of schizophrenia can be considered to be in remission when BPRS scores on seven items related to psychosis have been observed to be no more than mild for at least six months. The symptoms included in the rating of remission are grandiosity, suspiciousness, unusual thought content, hallucinations, conceptual disorganization, posturing, and blunted affect.

The remission of psychotic symptoms alone is significant, yet has to be considered in relation to the presence of additional clinical factors such as depression and anxiety. We have estimated symptom remission for psychotic symptoms alone, and also in the context of an overall BPRS of less than 31, the cut-point associated with mild illness in the Leucht et al. analysis. (Curtis and colleagues used a similar definition, in which blunted affect had to be less than 3, and overall BPRS had to be less than 30).

50 people participated in at least two standardized assessments in the second year of the study (between 12 and 24 months post-discharge). We considered them to be in remission from symptoms of schizophrenia if they scored 3 or less on each of the seven psychotic symptoms identified by Andreasen for the last two observations in this time period. **30 of the 50 participants (60%) met this criterion for remission. 24 of the 50 people (48%) met this criterion and also had BPRS scores of 31 or less, indicating that other major symptoms were also mild.**

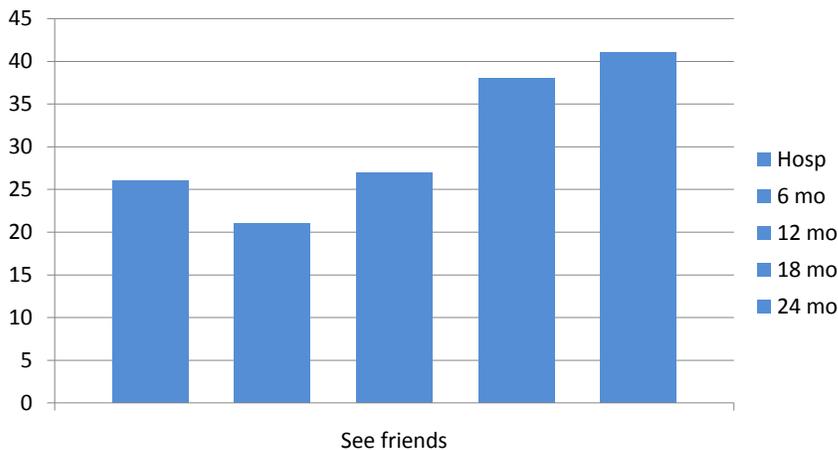
Social life and social adjustment

Developing and maintaining supportive social relationships is a key component of well-being in general, and particularly for recovery for the participants discharged from Mayview. Having lived in a relatively closed community for varying lengths of time, they were met with the opportunity and challenge of many changes in this domain. In the hospital, patients have little control over with whom they interact, and are geographically distant from family and friends. One of the goals of leaving Mayview was to improve the social and relational landscape.

We used two instruments to measure social life and social adjustment. The Social Networks/Social Support interview (Estroff & Zimmer, 1994, Estroff et al., 1995) asks people to report how many people they see in various social roles, and we use it to report objective indicators of where people lived, and whether they receive visits from family and friends. We also used the Social/Leisure subscale from the Social Adjustment Scale (Schooler, Hogarty & Weissman, 1979). Nine probes are used to elicit information about whether people are engaged in social life and leisure activities, and whether they are experiencing difficulties in these areas. Interviewer ratings of the nine areas result in an overall numeric score for social adjustment that is frequently used in psychiatric research.

Regular contact with friends. The number of participants who reported seeing friends regularly increased over the course of the study. Participants often nominated residents in their households as friends – this appeared to increase over the course of the study.

See friends regularly (percent)



	Hosp	6 months	12months	18 months	24 months
N	19	43	49	50	48
Saw friends regularly	26%	21%	27%	38%	41%

Regular contact with relatives. We also asked whether people who were not living with relatives whether they saw relatives regularly (at least once a month). One person lived with his parents in the second year of the study, and one person lived with his wife throughout the study; they were omitted from these analyses. At each time point, about 35% of people reported they were seeing family members regularly. Most visits were with parents or siblings. Parent visits were slightly less likely at the two-year follow up, and some participants reported that they lost their parents over the course of the study.

Very few people in the study who had children reported regularly seeing them. However, there were small indications that the people who saw their children re-connected with them post-discharge, and that the number of people seeing their children regularly increased at the two-year post-discharge follow up.

Percent of people who saw family members regularly

	Hosp	6 months	12months	18 months	24 months
N	19	43	49	50	48
Saw family regularly	6 (35%)	15 (40%)	17 (35%)	17 (34%)	17 (26%)
<i>Who visited?</i>					
Spouse	0 (0%)	1 (3%)	1 (2%)	1 (2%)	1 (2%)
Child	0 (0%)	2 (5%)	2 (4%)	2 (4%)	4 (8%)
Parent	3 (18%)	6 (16%)	7 (14%)	8 (16%)	4 (8%)
Sibs	2 (12%)	5 (13%)	6 (12%)	2 (4%)	6 (12%)
Other	1 (5%)	1 (3%)	1 (3%)	4 (8%)	2 (4%)

Most people who are not getting visitors would like to. About 80% of people who were not socially active would like to get visitors. Most people who saw family or friends reported that they were happy to get visitors.

People who are not seeing family or friends regularly, who would like visitors

	Hosp	6 months	12months	18 months	24 months
N	5	20	21	23	16
Want visitors	4 (80%)	13 (65%)	19 (90)%	19 (83%)	13 (82%)

Social life and leisure: standardized interview rating

An addition indicator of social adjustment derived from the Social and Leisure Activities subscale of the Social Adjustment Scale-II (SAS-II; Schooler, Hogarty & Weissman, 1979). The SAS-II is a well-validated, widely used measure of social adjustment in people with severe mental disorders (Priebe, 2007). It consists of nine probes that address contact with friends, opportunities for leisure activities, and social comfort and friction. Interviewers ask the probes conversationally (for example “What kinds of things do you do in your free time”, with follow-up probes as necessary), and then rate each item from 0 (no social impairment) to 4 (substantial social impairment). All answered probes are averaged, and thus the overall score ranges from 0 to 4, with lower scores indicating better social adjustment. There are not published cut-points, however, the anchors associated with each problem provide guidance about interpretation of the scores.

Our results showed both that social functioning in this group of people is strong, and also that it improved over the two year course of the study. As can be seen the table below, the growth curve analysis indicates clearly that scores improve over time.

Average scores at each of the five study time points ranged from 1.6 to 2.1. An examination of item responses in this range indicate that the level of social activity and adjustment is quite high. Item anchors in this range suggest that participants see friends and families twice a month or more, usually

talk easily with someone they consider a friend, experience only mild friction with others, and recover quickly if they feel hurt or offended in social interactions.

	Hospital	6 months	12 months	18 months	24 months	Test of change over time
N	18	37	46	47	45	65
SAS-II	1.9 (.90)	2.1 (.92)	1.8 (1.6)	1.6 (.72)	1.6 (.91)	t(144) = 2.92, p < .005

These means compare favorably with other published similar samples. 91 people with schizophrenia were recruited during an inpatient admission to a university hospital in Germany and followed for one year reported an average SAS score of 3.6 (SD = 1.2) (Wittorf et al, 2008). 81 men with schizophrenia who completed a treatment trial including social skills training or a support group reported means of 2.5 – 3.2 at the completion of treatment (Marder et al., 1996). Both of these research samples show substantially poorer functioning than the Mayview group followed here.

Attitudes towards medication

Medication is a part of daily life for most people discharged from the hospital. Medication regimes are demanding, and side effects can be significant. How people perceive the usefulness and side effects of their medication is thought to be related to whether or not people will take them.

The Drug Attitude Inventory 10-item version (DAI-10) measures subjective response to medication. The items measure negative experiences (“I feel weird – like a zombie – on medication”) and positive experiences (“My thoughts are clearer on medication”). Participants rate each item as true or false, and items are then coded as +1 (for positive perceptions of medication) or -1 (for negative experiences with medication). Scores on the inventory range from -10, completely negative, to +10, completely positive. Scores of less than 0 have been considered as indicative of negative perceptions with medications that could lead to medication discontinuation.

Attitudes towards psychotropic drugs did not change over the course of the study. Average scores are in the low positive range. Between 26 and 37% of people at each time point report scores less than 0, representing negative perceptions of medications. This percentage did not increase outside of the hospital.

	Hospital	6 months	12 months	18 months	24 months	Test of change over time
N	19	38	44	48	43	64
DAI	3.16 (6.26)	2.26 (5.50)	3.50 (5.50)	3.02 (5.29)	2.74 (5.83)	t(144) = .43, NS
% < 0	26%	28%	28%	22%	31%	

Average scores and percent of people reporting scores of less than 0 are similar to studies that report other community-dwelling samples of people with serious mental disorders (Dassa et al., 2010; De las Cuevas & Sanz, 2007). Dassa and colleagues provide the estimate of negative attitudes towards medication that is most comparable to the work reported here. They conducted a one-week survey in the fifteen hospitals serving the south eastern region of France, and asked all people with a diagnosis of schizophrenia not in immediate need of hospitalization to complete the DAI. They report that 30% of these people were more negative than positive about medications according to this instrument. De las Cuevas and Sanz surveyed more broadly across diagnostic groups. Their survey included all people attending community mental health outpatient services on La Gomera Island in the Canary Islands. 26% of these outpatients were diagnosed with schizophrenia; the remainder of the sample included mood, anxiety, somatoform and “stress-related” disorders. The mean for DAI score was 3.6 (SD = 4.1) in this outpatient sample, and 23% reported scores of 0 or less on this instrument.

Quality of Life

Quality of life has been a very active area of research in the study of the long-term adjustment of people with psychiatric disabilities. The ability to enjoy life and find meaningful activities, and whether the environment supports meaningful and enjoyable activities is core to recovery goals, and to human life.

The World Health Organization developed a quality of life instrument so that this key indicator of societal health could be tracked across nations over time. It was collaboratively developed to accurately capture aspects of life known to be associated with overall well being and quality of life. It has been used in a number of large studies tracking outcomes of people with mental disorders. The domains, and many of the items, are compatible with and indicative of components of recovery. For example, the items inquire about whether life is meaningful, satisfaction with capacity for work, and satisfaction with personal relationships. The environment subscale directly addresses a number of areas of interest, including perception of safety, the healthfulness of the physical environment, and whether finances support daily needs.

We administered the World Health Organization Quality of Life Scale (Brief Version). This is a well standardized scale that has been used with many populations, including people with severe and persistent mental disorders. It was developed to accurately capture aspects of life that are known to be associated with overall well being and quality of life. It is composed of 25 items, each rated from 1 to 5, with lower scores representing lower quality of life. All subscales are rescaled and presented on scales from 0-100, for ease of comparison. Higher scores are associated with higher quality of life.

The six scores provided by the WHOQOL-Bref are:

Overall quality of life. The overall quality of life is rated with one item: “How would you rate the quality of your life” from 1 (very poor) to 5 (very good).

Overall satisfaction with health. Satisfaction with health is also measured with one item: “How satisfied are you with your health” from 1 (very dissatisfied) to 5 (very satisfied).

Physical health. Seven items address ability to carry out activities of daily living, dependence on medicine, fatigue, mobility, pain, sleep quality, and satisfaction with capacity for work.

Psychological well being. Six items address how much the person enjoys life, whether life is found to be meaningful, self esteem, spirituality, ability to concentrate, and satisfaction with body image.

Social relationships. Two items assess satisfaction with personal relationships and social support.

Environment. The environmental subscale includes eight items that assess satisfaction with financial resources (“have you enough money to meet your needs”), availability of information (“how available to you is the information that you need in your day-to-day life”), opportunities for leisure, transportation, and availability of health services.

The six sub-scales described above were analyzed for change over time. In addition, because a number of the items were of particular interest, we tested each item separately (results not tabulated). Only satisfaction with social relations showed any indication of change. As can be seen in the table, the effect of time for that indicator was marginally statistically significant – the test results estimate that there is a 10% chance that the apparent improvement was observed in error. No other area of quality of life, and no single item, showed significant change over time.

	Hospital	6 months	12 months	18 months	24 months	Test of change over time
N	17	37	45	45	43	65
Quality of life	67.6 (30.3)	64.9 (33.0)	73.3 (26.9)	74.4 (24.7)	70.8 (24.6)	t(135) = .46, NS
Satisfaction with health	61.8 (38.6)	63.5 (32.1)	71.1 (30.1)	69.4 (29.1)	67.3 (32.7)	t(136) = 0, NS
Social Relations	54.4 (26.8)	60.7 (23.4)	66.8 (20.6)	61.0 (22.8)	68.6 (22.9)	t(132) = 1.73, p < .09
Physical Health	63.6 (17.4)	60.8 (19.1)	68.1 (16.0)	66.9 (15.3)	66.5 (19.3)	t(135) = .06, NS
Psychological well-being	59.8 (19.0)	58.3 (16.7)	62.4 (17.6)	63.6 (17.6)	63.9 (17.3)	t(135) = 1.27, NS
Environment	61.4 (21.0)	59.3 (20.4)	64.8 (17.4)	66.3 (18.4)	63.4 (20.6)	t(135) = .58, NS

The WHOQOL Bref has been quite widely used to chart quality of life for people with mental illness since it has become available. Participants in this study compared favorably to other people with severe mental disorders for whom quality of life has been examined. This table summarizes a number of studies that have employed this instrument. We have arranged the studies in the order of the average score on the WHOQOL score for Psychological Well-Being. Each study reported averages using a common scoring technique, or provided sufficient information that scores could be transformed onto the standard scale for this level of comparison.

	Psychological well-being	Social Relations	Physical Health	Environment
People hospitalized with schizophrenia in Taiwan Kao et al., 2011	48.5	49.6	53.8	47.8
People with schizophrenia recruited from university-based outpatient services in Taiwan. Yen et al., 2008	49.1	50.4	55.3	46.0
Community-dwelling people with schizophrenia treated in Barcelona Mas-Esposito et al., 2011	51.1	40.9	57.8	57.8
Healthy control volunteers recruited through advertisements in Taiwan Yen et al., 2008	54.5	62.2	70.8	51.9
US WHOQOL instrument validation sample (includes sick and well people) Skevington et al., 2004	61.2	57.5	71.9	48.1
Mayview sample, 2-years post-discharge	63.9 (17.7)	68.6 (22.9)	66.5 (19.3)	63.4 (20.6)
People with schizophrenia receiving outpatient treatment in Austria Hofer et al., 2006	64.5 (17.4)	62.1 (21.7)	69.3 (14.2)	73.8 (11.9)
Representative sample of residents of Denmark Noerholm et al., 2004	69 (16)	69 (18)	77 (17)	74 (16)
Representative sample of residents of Victoria, Australia Hawthorne, Herrman & Murphy, 2006	71 (14)	72 (18)	73.5 (18)	75 (13)

Progress towards recovery

Recovery is perhaps the most important construct to emerge in mental health treatment in the last thirty years. It has its origins in the lived experiences of community and grassroots advocates and people experiencing mental illness. While recovery can mean different things to different people, its core ideas are that autonomy, meaning, self worth and interesting activities are goals for all people, and that successful service systems will support development in these areas. Definitions and measurement are still actively evolving.

We measured progress towards recovery with the Recovery Assessment Scale (Corrigan et al., 1999, Giffort et al., 1995, McCabe, Saidi & Priebe, 2007). The 41 items of the original version of the RAS were developed from the illness and recovery narratives of four consumers, which were abstracted by researchers, and then verified and expanded upon by 12 consumers (Giffort et al., 1995). Subsequent exploratory and confirmatory factor analyses showed that 24 items reliably constituted five factors (Corrigan et al., 2004; McNaught et al., 2007); the list was later revised to 22 items. Each item is rated

from 1 (strongly disagree) to 5 (strongly agree), and higher scores are associated with more positive attitudes towards recovery.

The five subscales include:

Personal Confidence and Hope: 9 items (recently revised to 7), for example, “I have an idea of who I want to become”, “I’m hopeful about my future”, and “I can handle stress”.

Willingness to Ask for Help: 3 items, including: “I know when to ask for help”, “I am willing to ask for help” and “I ask for help when I need it”.

Goals and Success Orientation: 5 items, for example, “I have a desire to succeed”, “I have my own plan for how to stay or become well”, and “I have goals in life that I want to reach”

Reliance on Others: 4 items, for example, “Even when I don’t care about myself, other people do”, and “I have people I can count on”

Not Dominated by Symptoms: 3 items, including: “Coping with my illness is no longer the main focus of my life”, “My symptoms interfere with my life less and less” and “My symptoms seem to be a problem for shorter periods of time each time they occur”.

Scores are calculated by adding items. Some authors re-scale each item to range from 0-4 (from the original 1-5). When this is done, the lowest possible score for all subscales is 0. Whether or not this is done, subscales with more items have a wider range of possible values than subscales with fewer items. The Not Dominated by Symptoms subscale includes 3 items, and thus ranges from 0 to 12, with 12 representing the highest possible value, or the equivalent of the best recovery outcome in that area. The Goals and Success Orientation subscale includes 5 items, and thus ranges from 0 – 20. A score of 20 on the Goals and Success Orientation subscale is roughly equivalent to a score of 12 on the Willingness to Accept Help subscale.

Scores for the Recovery Assessment Scale showed little change during the study period. We examined change using the 41-, 24- and 22-item total scores, and the five subscales (we tested both versions for the subscale that has recently been revised). The table shows the total scores for the 41-item version. The items were scaled to range from 0-4 for this report, following the convention established by Andresen.

These findings underscore the extended time frame and episodic, incremental processes of recovering that is well documented by researchers (Schrank & Slade 2007). As Topor and colleagues (2009) explain, recovery occurs both within and around the individual, and involves shifts in relationships with friends, family, and mental health professionals. None of these changes happen rapidly. Providing the foundations and environment for consumers’ varied pathways, along with those of the mental health system, is a reasonable first phase after discharge.

	Hospital	6 months	12 months	18 months	24 months	Results of change analysis
N	19	38	44	47	44	64
41-item total	123.3 (23.2)	121.4 (24.5)	128.5 (24.4)	125.0 (24.1)	122.2 (24.7)	t(142) = .80, NS
Personal Confidence and Hope (9 items)	26.5 (6.5)	26.0 (7.6)	28.7 (6.1)	28.0 (7.0)	27.5 (5.6)	t(140) = .42, NS
Willingness to ask for help	9.2 (2.5)	9.2 (2.2)	9.9 (1.9)	9.5 (2.4)	9.3 (2.3)	t(139) = .48, NS
Goal and Success Orientation	15.7 (4.0)	15.6 (3.6)	16.4 (3.7)	15.9 (3.7)	16.0 (3.3)	t(142) = .38, NS
Reliance on others	12.2 (2.6)	12.0 (3.0)	12.0 (3.5)	12.6 (2.7)	12.0 (3.2)	t(142) = .17, NS
Not dominated by symptoms	8.0 (2.7)	7.7 (2.9)	8.4 (2.6)	7.4 (2.8)	7.3 (2.9)	t(137) = .89, NS

The average scores for participants in this study are comparable, or slightly better, than other published reports of RAS scores. Andresen, Caputi, and Oades (2010) report on baseline data from the Australian Integrated Mental Health Initiative, a large, multi-site initiative investigating the Collaborative Recovery Model (Oades et al, 2005). 281 people with a diagnosis of a psychotic disorder and high needs as rated by a standardized assessment (the CANSAS, Phelan et al., 1995), were recruited by their case managers, and completed the RAS along with some other questionnaires. Their average score for the 41-item version of the RAS and the 5 subscales detailed by Corrigan et al. 2004 are shown in comparison to the Mayview participants at the two-year post-discharge time point. Corrigan and Phelan (2004) report on the baseline scores of 176 people with serious mental illness in Illinois at the time they were recruited to participate in a study of the effects of consumer operated services on a variety of consumer outcomes. (Their scores are rescaled to include 0 for comparison to the other samples.)

	RAS total (41 item version) (0-164)	Personal confidence and hope (9-item version) 0-36	Willingness to ask for help (0-12)	Goal orientation (0-20)	Reliance on others (0-16)	Not dominated by symptoms (0-12)
Mayview sample, 2-years post-discharge	122.2 (24.7)	27.5 (5.6)	9.3 (2.3)	16.0 (3.3)	12.0 (3.2)	7.3 (2.9)
People with serious mental illness participating in the Illinois site of the Consumer Operated Service Project Corrigan & Phelan, 2004		24.2 (6.1)	8.8 (2.4)	14.6 (2.7)	11.8 (2.7)	6.9 (2.8)
Australian sample of people with psychotic disorders Andresen, Caputi and Oades, 2010	112.4 (22.1)	23.4 (6.05)	8.5 (2.4)	14.2 (3.6)	11.9 (2.6)	6.8 (2.9)

Other studies with published RAS data tend to focus on associations across study variables, without reporting means, or do not report aspects of the scoring needed to understand how reported means compare to this study.

Perceptions of Care

Satisfaction with care is a key indicator of the quality of services. People discharged from Mayview moved into many other supported residential and treatment facilities, and it is valuable to assess how they perceive their new settings in comparison to the hospital.

We measured satisfaction with care using the Perceptions of Care survey (Eisen et al, 2002). This instrument was developed in response to recent interest in developing standardized instrumentation that can be used for benchmarking, quality assurance efforts, and accreditation across mental health and substance abuse service settings. This instrument was designed to measure satisfaction with mental health and substance abuse inpatient and residential services. It consists of 21 items, 18 of which are usually reported as one-item tests of satisfaction with various aspects of services. A subset of items can also be combined to form subscales. Because some of the items appear in more than one subscale, they are reproduced below in their entirety. Individual items have varying response options; all items are rescaled so that they are equally weighted to be combined, and all subscales are scaled from 0 to 100.

Information received: Did the staff tell you about the benefits and risks of medications you are taking? Did the staff give you information about your rights as a patient? Did the staff give you information about rules and policies of the program?

Interpersonal aspects of care: Did the staff give you reassurance and support? Were you involved as much as you wanted in decisions about your treatment? Did the staff listen carefully to you? Did the staff who treated you work well together as a team? Did the staff spend enough time with you? Did the staff treat you with respect and dignity? Did the staff explain things to you in a way you could understand?

Continuity/coordination of care: Did the staff tell you about the benefits and risks of medications you are taking? Did the staff review plans for your continued treatment? Were you told who to contact if you have a problem or crisis? Did the staff tell you about self-help or support groups? Did the staff give you information about how to reduce the chances of relapse?

Global evaluation of care: Did the staff give you reassurance and support? How much were you helped by the care you received? Using any number from 1 to 10, what is your overall rating of the care you received? Would you recommend this facility to someone else who needed mental health care?

Satisfaction with care as rated by the POC appeared to rise after discharge, but did not change reliably over time over the full course of the study.

	Hospital	6 months	12 months	18 months	24 months	Results of change analysis
N	20	38	45	47	45	64
Information received	66.7 (35.9)	79.8 (30.5)	76.3 (28.8)	76.6 (28.4)	73.3 (33.8)	t(143) = .35, NS
Interpersonal aspects of care	56.7 (25.7)	62.5 (25.2)	63.8 (30.7)	64.3 (26.8)	64.0 (24.9)	t(143) = 1.20, NS
Continuity/coordination of care	58.5 (36.7)	67.6 (29.4)	69.8 (30.7)	68.5 (33.8)	68.8 (29.6)	t(143) = .98, NS
Global evaluation of care	59.9 (27.1)	65.5 (25.5)	71.7 (25.6)	68.6 (28.7)	64.5 (28.4)	t(143) = .21, NS
Total score	61.8 (25.2)	66.9 (21.7)	68.9 (22.9)	68.8 (22.8)	68.2 (22.1)	t(144) = 1.14, NS

Eisen and colleagues (2002) provide results for the POC across 14 mental health and substance abuse inpatient facilities, and included 6,972 participants. Average ratings on POC subscales are shown in contrast to the ratings made by participants in this study at the two-year time points.

	RAS total (41 item version) (0-164)	Personal confidence and hope (9-item version) 0-36	Willingness to ask for help (0-12)	Goal orientation (0-20)	Reliance on others (0-16)	Not dominated by symptoms (0-12)
Mayview sample, 2-years post-discharge	122.2 (24.7)	27.5 (5.6)	9.3 (2.3)	16.0 (3.3)	12.0 (3.2)	7.3 (2.9)
People with serious mental illness participating in the Illinois site of the Consumer Operated Service Project Corrigan & Phelan, 2004		24.2 (6.1)	8.8 (2.4)	14.6 (2.7)	11.8 (2.7)	6.9 (2.8)
Australian sample of people with psychotic disorders Andresen, Caputi and Oades, 2010	112.4 (22.1)	23.4 (6.05)	8.5 (2.4)	14.2 (3.6)	11.9 (2.6)	6.8 (2.9)

Ratings may be rather higher in the Eisen et al. data for at least two reasons. They were unable to track the number of people who declined to complete the survey, and it is frequently the case that people who are dissatisfied with services choose not to complete surveys. Additionally, the 14 inpatient units surveyed were shorter-stay programs, and satisfaction with such units may be fundamentally different from satisfaction with long-stay residential-type programs. Nonetheless, it is worthwhile to note the a number of the item responses in the Mayview discharge study meet the criterion for initiating quality assurance interventions recommended by Eisen. She suggests that quality improvement activities be initiated for any item that receives less than 80% positive endorsement. If this standard were used, a number of targets for quality improvement could be identified, including staff listening carefully to consumers, working well as a team, explaining things in understandable ways, and involving consumers in treatment.

Perception of Care Items: Mayview sample and Eisen et al. National Sample.

	Mayview sample, 2 years post-discharge				Eisen et al., 2002											
	Yes N	%	No N	%	Yes N	%	No N	%								
1. Did the staff give you information about the rules and policies of the program?	37	82%	8	18%			6359	92%	553	8%						
2. Did the staff give you information about your rights as a patient?	36	80%	9	20%			6238	90%	678	10%						
14. Did the staff tell you about self-help or support groups?	31	70%	13	30%			5203	78%	1465	22%						
15. Did the staff give you information about how to reduce the chances of a relapse?	26	60%	17	40%			5047	77%	1532	23%						
3. Did the staff tell you about the benefits and risks of the medications you are taking?	26	58%	19	42%	No meds 2		5450	84%	1062	16%	Not taking medication 151 2%					
12. Did the staff review with you plans for your continued treatment after you leave the program?	33	75%	11	25%	Unsure 3		5563	84%	434	6%	Unsure 658 10%					
13. Were you told who to contact in case you have a problem or crisis after you leave the program?	36	80%	9	20%	Unsure 2		4434	67%	1280	19%	Unsure 889 14%					
18. Would you recommend this facility to someone else who needed mental health or substance abuse treatment?	27	59%	13	28%	Unsure 6 13%		5441	83%	392	6%	Unsure 736 11%					
	Never		Sometimes		Usually		Always		Never		Sometimes		Usually		Always	
4. Did staff explain things in a way you could understand?	2	4%	9	20%	20	44%	14	31%	384	6%	774	11%	2179	32%	3553	52%
5. Were you as involved as you wanted in decisions about your treatment?	12	28%	9	21%	13	30%	9	21%	433	6%	1108	17%	2138	31%	3594	52%
7. Did the staff listen carefully to you?	4	9%	12	27%	14	32%	14	31%	150	2%	937	14%	2228	32%	3594	52%
8. Did the staff work well as a team?	3	7%	12	28%	12	28%	16	37%	161	2%	711	10%	2086	31%	3889	57%
9. Did staff spend enough time with you?	6	13%	10	22%	13	29%	16	36%	236	3%	1042	15%	2371	34%	3260	47%
10. Did the staff treat you with respect and dignity?	2	5%	7	16%	11	25%	24	54%	126	3%	1042	15%	2371	34%	3260	47%
11. Did the staff give you reassurance and support?	5	11%	8	18%	12	27%	20	44%	157	2%	851	13%	1889	28%	3747	56%
6. How much does the staff involve your family in treatment	More than I wanted 5	11%	Less than I wanted 4	9%	About the right amount 11	25%	None, which is what I wanted 24	55%	More than I wanted 383	6%	Less than I wanted 604	9%	About the right amount 3690	54%	None, which is what I wanted 2101	31%
16. How much were you helped by the care you received?	Not at all 9	20%	Somewhat 8	18%	Quite a bit 16	36%	A great deal 12	27%	Not at all 248	4%	Somewhat 1150	17%	Quite a bit 2448	37%	A great deal 2835	42%

From 1-10, what is your overall rating of care in the program?	1	2	3	4	5	6	7	8	9	10										
Mayview sample	3	7%	1	2%	1	2%	11	4%	2	4%	4	9%	7	15%	5	11%	5	11%	12	26%
Eisen et al., 2002	88	1%	82	1%	134	2%	177	3%	374	6%	338	5%	817	2%	1533	23%	1223	18%	1941	29%

SUMMARY AND CONCLUSIONS

The two year point is a crucial time point in this longitudinal study. We have observed how participants have coped with the initial transition period of moving from Mayview into the community and are poised to begin to observe how the later stages of the transition unfold, as participants become more settled into the community. At this point, however, we do have multiple indicators about the study participants that can be summarized as follows:

1. Their quality of life, living circumstances, health and mental health status, and access to needed services are all at least stable, and in many instances improving.

Participants, for the most part, report doing well in their new homes and are getting the basic services that they need, including regular doctor and dentist appointments and visits with treatment team members. Living in comfortable, homey settings is a crucial factor in keeping quality of life stable.

2. Re-establishing social relationships and developing vocational and other meaningful activities and interests are challenging areas that merit further attention.

Once participants have stable and comfortable homes, the real work comes with getting them connected to other people and to develop interesting and meaningful activities. Although caregivers are an important resource and serve as the primary social contacts for many individuals, it is crucial that participants develop natural supports in the community.

3. A small percentage have remained in hospitals, spent time in jail, experienced failing health, changed residences because of lack of fit, or have had acute psychiatric care episodes and setbacks. These individuals continue to receive mental health services.

Enhancements in mental health and residential resources prior to the closure of the hospital no doubt contributed a great deal to the measurable success of the participants in the study. Through the comprehensive planning of the overall transition and informed attention to planning for each individual, the former Mayview residents experience freedoms, choices, and perceptions of themselves that were incompatible with hospital life. These individuals are becoming more aware of the options and possibilities that are open to them and are gaining confidence in their abilities to achieve their goals. As one participant put it,

“The best experience has been knowing that I can make it in the real world.”

Perhaps the most significant challenges lie in continuing the personalized focus of services and continuity of providers, as well as continued safe, comfortable residences, over a long period of time. In view of the tendency of some of the gains of community living in the first years after transition to erode over time, the goal of making former Mayview residents an exception is worth pursuing.

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