CHRONICITY IN SCHIZOPHRENIA:
FACT, PARTIAL FACT, OR ARTIFACT?

Derived simply from the Greek word "chronos", meaning time, the label "chronic" denotes an illness of long duration or one of frequent recurrence. However, when chronic is paired with schizophrenia, as in "This person is a chronic schizophrenic," the connotation becomes an expectation of deterioration, defect, or deficit states (1). These perceptions about schizophrenia have pervaded and guided clinical judgments (2,3), treatment programming (4,5,6), policy formulation (7,8), and priority funding decisions (9). These perceptions have also stripped hopes of recovery from patients and their families (10,11). Further, the use of phrases such as "deinstitutionalization of chronic mental patients" glosses over the large heterogeneity of patient types, courses of illness and recovery, and the actual shifts in composition and migrations of groups of patients within society (12,13,14).

In this report, we will summarize a century of research and clinical evidence (or lack thereof) about the concept of chronicity in schizophrenia. In addition, we will present alternative ideas which provide different views of the disorder and the recovering person. Such changes in the perceptions of the complex processes involved in schizophrenia carry strong implications for the patient, the
Switzerland. Two decades later, during and after the First World War, he went back to Rheinau to visit about once a year, usually when the weather was fine during the summer. His former schizophrenic patients always greeted him warmly and enthusiastically. Much as these greetings pleased him, he usually made the painful observation, "Most of them did seem to have deteriorated." Then, depressed, he would ask, "Is there really nothing that can stop this disease?" If he spent all his life wrestling with the question whether there was an "organic process" at the basis of schizophrenia, it was mainly because of experiences like the above. But E. Bleuler did not know how many improved patients were out for their Sunday walks during his visits, and certainly not how many had been released and were living at home, recovered. Had he known, and if he had not continued to meet only the most severe cases among his old problem children, his assessment of the schizophrenias would have been strongly influenced. A number of generations of clinical psychiatrists had experiences similar to his.

(pg. 413) (19)

It is clear that the evidence points to the fact that Kraepelin's sample was culled selectively from those patients who remained continuously institutionalized and members of Bleuler's sample were often lost to follow-up leaving only the ones who remained to be studied. Both investigators also had samples which included those patients who would meet criteria for other diagnostic categories. Thus, the classical descriptions of course and outcome for schizophrenia upon which the bulwark of psychiatric thinking was built were probably not representative of the complete
range possible for this disorder.

2. **Current Short-Term Caseloads**

   Today, many clinicians also have a biased sampling because of their predominantly short-term caseloads. Perhaps only a certain segment of the entire population of people who once were diagnosed as schizophrenic continue to need and receive care and this is rarely noted. The group which the clinician continues to see and treat appears to represent the entire picture of schizophrenia. Further, if a particular patient enters a caseload and functions only marginally for five to ten years with repeated episodes, the tendency on the part of the clinician is to think that this level will continue or worsen. With short-term caseloads, not enough additional time elapses to check that assumption. Such patients are often regarded as fairly unresponsive to early program efforts, and when they continue to be marginal, they are viewed as treatment failures in which the disorder has gotten the upper hand. If such a person drops out of the caseload, a busy clinician often assumes that the patient has simply transferred to another clinician's caseload across town or is living a marginal existence in a single room occupancy hotel. Rarely does the clinician assume a forward movement toward better functioning and reintegration into the community. There is no built-in systematic feedback to clinicians about successes. They
receive only negative messages signaled by the reappearance of those patients with a new episode.

However, there are clinicians, such as M. Bleuler (19, 28-34) at Burghölzli Hospital in Switzerland and G. Brooks (35-44) at Vermont State Hospital who have stayed in one setting over decades. They have followed along prospectively those patients in an intact cohort who were also discharged to the community. These clinicians and others like them report that numbers of once-chronic patients significantly improve and recover across their life course.

B. The Effect of Contradictory Research Evidence

To compound these problems of biased sampling, both short- and long-term follow-up studies presented over the years have been both contradictory and confusing (45-51). Some of these studies reported poor outcome, while others did not. Many reviews of the literature (16, 52-54) have outlined numerous reasons why such contradictions have existed (see Table 1).
Table 1

Some methodological problems in early long-term follow-up studies which make comparison difficult.

1. Different samples selected because of different criteria for the diagnosis of schizophrenia.
2. "Schizophrenia" often not defined.
3. Different length of follow-up periods.
4. Outcome often defined only as "recovered" or "unrecovered".
5. Varying sources of data in follow-up (e.g., case records vs. actual interview).
6. Lack of "blindness" in data collection procedure (e.g., that the investigators knew previous history of the subjects).
7. Use of clinical non-structured interviews.
9. Too many missing or deceased subjects.

It appears that the confusing empirical data and the clinical descriptions from potentially biased samples, available since the time schizophrenia was described less than 100 years ago, have not provided much clarification or accurate information about the long-term course and outcome of schizophrenia.

II. CURRENT INVESTIGATIONS AND CONCEPTS

A. The Five Recent Long-Term Studies of Schizophrenia

Within the last decade, a number of systematic studies investigating the short- and long-term outcome in schizophrenia have addressed the range of methodologic issues mentioned above. All have found heterogeneity in outcome functioning, rather than simply marginal or
deteriorated states.

The five very long-term follow-up studies reported since 1972 have produced astonishingly similar results which appear to override their differences in design (20). Each of these studies found that one half or more of each cohort had significantly improved or recovered when assessed at twenty-, thirty-, and forty-year follow-up periods. Two of these studies were those mentioned earlier as the research cohorts of two long-stay directors of hospitals, M. Bleuler and G. Brooks. Table 2 summarizes these five studies.

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Table 2
Five Long-Term Studies
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<table>
<thead>
<tr>
<th>Investigators</th>
<th>Sample Size</th>
<th>Average Length in Years</th>
<th>% Subjects Recovered and/or Improved Significantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. Bleuler (1972) Burghölzli - Zurich</td>
<td>208</td>
<td>23</td>
<td>(53-68)</td>
</tr>
<tr>
<td>Huber, et al. (1979) Bonn Studies</td>
<td>502</td>
<td>22</td>
<td>57</td>
</tr>
<tr>
<td>Ciompi &amp; Müller (1976) Lausanne Investigations</td>
<td>289</td>
<td>37</td>
<td>53</td>
</tr>
<tr>
<td>Tsuang, et al. (1979) Iowa 500</td>
<td>186</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>Harding, et al. (1984) Vermont</td>
<td>269</td>
<td>27</td>
<td>(52-68)</td>
</tr>
</tbody>
</table>
Manfred Bleuler (19, 28-34) followed over 23 years 208 patients who were either first admissions or readmissions as a representative cohort admitted to Burghölzli Hospital in Switzerland during 1942-3. He found that 53% of the entire group were significantly improved or recovered. In separating out the first admissions, he found 68% recovered or improved (19).

In the United States, the most recent long-term study has been the prospective study across an average of 27 years by Brooks of his sample containing 269 very chronic subjects (35-44). This study also includes an in-depth current assessment which has just been completed by Harding, Brooks, Ashikaga, and Strauss (20, 55-58). Brooks' subjects at the time of selection in the mid-1950's averaged 16 years duration of illness, 10 years of total disablement, and six continuous years of hospitalization (44). At follow-up, they demonstrated good outcome with one-half to two-thirds of all cohort subsamples (alive or deceased and diagnosed for schizophrenia by either DSM III or DSM I) having achieved significant improvement or recovery (12, 20, 57-58).

The results of these two prospective studies are supported by the three other very long-term studies which have been cross-sectional assessments of cohorts selected retrospectively from old case records. A Swiss study, conducted by Ciompi and Müller (59) in 1976, assessed 289
subjects at an average of 36.9 years after first admission. This research team found that 53% of the study subjects were improved or recovered. The Bonn Study conducted in 1975 by the team of Huber, Gross, and Schütter (60) studied 502 subjects at an average of 22.4 years after admission and found 57% recovered or significantly improved (61). After completion of the study, Huber and his team (61) wrote: "schizophrenia does not seem to be a disease of slow progressive deterioration. Even in the second and third decades of illness, there is still potential for full or partial recovery" (p. 595).

Finally, a second study in the United States, "The Iowa 500" (62), also produced similar results. This investigation followed up 186 subjects who had been admitted consecutively between 1934 and 1944 to the University Psychiatric Hospital in Iowa City. At an average of 35 years later, 46% recovery and improvement was found in their schizophrenic sample (63). Members of this sample had met the more narrow Feighner criteria for schizophrenia (3).

Thus, recent more methodologically sound research has found that one-half to two-thirds of over 1400 subjects studied for longer than twenty years achieved recovery or significant improvement. These results represent a major challenge to the current prevailing concept of outcome in schizophrenia as resulting in marginal levels of function or a downward deteriorating course.
B. Persistent Findings of Heterogeneity Across Outcome Functioning

Among shorter-term studies, the work of Strauss and Carpenter (64-66) also revealed that outcome was not a unitary process but consisted of a set of "open-linked" systems such as occupational functioning and social competence. These "open linked" systems operate semi-independently of each other and of symptoms and hospitalization. Further work by the same team also found wide heterogeneity of outcome functioning even at the 5-year follow-up point (67). This variation across outcome domains has been found by many others (e.g., Bland and Orn [68] in their 14-year Alberta Hospital follow-up study; Gardos, Cole, and Labrie [69] in their Boston State Hospital study of 12 years follow-up; and cross-culturally in the WHO [70] International Pilot Study of Schizophrenia, two- and five-years follow-up).

In addition to these studies of hospital admissions, there is a recent epidemiologically-based population study of all people diagnosed as having schizophrenia drawn from the county of Buckinghamshire, located 50 miles north of London. This catchment area of approximately 500,000 people utilizes a single mental hospital (71). With 99% of the entire sample (N=121) followed-up at the five-year point, 48% of the cohort, consisting of first admission and readmission schizophrenics, achieved a good outcome. Of the
first admissions only group, 58% had a good outcome.

C. The Failure of Diagnostic Criteria to Predict Long-Term Functioning

Major efforts to reduce the observed heterogeneity of outcome have revolved around the definition of who is really schizophrenic and who is not. Two types of strategies have been undertaken to clarify these issues. The first has been focused on narrowing the criteria to achieve a homogeneous group with "core", "nuclear", "process", or "true" schizophrenia, such as Feighner, et al. (3), Langfeldt (72), Schneider (73), the RDC by Spitzer, et al. (74), and the DSM III (2). The second strategy has been to change the diagnosis of schizophrenia to another category if subjects recovered or improved, as in Langfeldt's schizophreniform psychosis (75), Jaspers' reactive psychosis (76), or Leonhard's cycloid psychosis (77).

Both strategies have been tested by targeting samples with these systems of criteria and conducting outcome studies. In every case, where careful methodology was used, outcome was found to be heterogeneous, with half or more of the subjects displaying significant improvement (20,63,67,69,78-79). Diagnosis of schizophrenia has not been confirmed by association with outcome beyond a limited degree. In fact, empirical data tend to validate Vaillant's contention that traditional "prognosis and diagnosis are two
different dimensions of psychosis" (see footnote, and also 80).

Evidence points to the fact that beyond "outcome" even the evolution in the course of schizophrenia is not a foregone conclusion. There appears to be a wide spectrum of possible courses that patients follow. Huber, for example, identified 73 courses and later reduced them to 12 composite forms (60); Ciompi (81) and Bleuler (19) have established a minimum of 8. Work is just beginning to provide an understanding of the determinants of the evolution of the disorder and improvement over time, since previously not even the heterogeneity of outcome had been widely recognized.

It is clear that even if there is a natural history for schizophrenia tending toward an expected outcome, the roles of patient personality and of the environment both in and out of the hospital in aiding or interfering with the expected outcome are too powerful to permit uniformity. No matter what diagnostic system is employed, many patients persist in getting better. Misconceptions from the past which have hindered the ability to judge more accurately the full picture of the disorder have been dispelled. Such misconceptions or "...errors," said E. Bleuler, "are the greatest obstacles to the progress of science" (18).

D. The Difficulties of Separating the Effects of the Environment from the Effects of Schizophrenia

As early as 1960, Brown (82) noted that the number of patients residing in hospitals over two years (the criteria for chronicity proposed by Kramer, et al. [83], in the classical Warren State Hospital study) had decreased from two-thirds in the 1920's to one-third in the 1930's. By the 1950's, in the United Kingdom, only 12-13% of schizophrenic patients were in the hospital over two years. Wing (84) concluded that institutionalization in and of itself had contributed to the picture of disability for those who stayed. Patients were rarely reviewed for discharge after two years because their loss of social skills was perceived as persistent psychopathology when in fact it may have been an independent feature caused by long-term hospitalization itself.

In 1971, Ludwig (85) studied a hospitalized sample and itemized a "code of chronicity" which vividly described how institutionalized people become socialized into a "good patient" role. His list included: "to be dull, harmless, and inconspicuous; to evade responsibility, minimize stress, ignore others, to retain the right to behave unpredictably and have a certain 'diplomatic immunity'." These acquired skills may have made life easier for both patients and staff as a compromise in an untenable situation, but were inimical to social integration into the community. Table 3 is a list
collected from the current literature to describe "the pool of chronic patients" in caseloads today. It is remarkable how much of this description overlaps with Ludwig's code.

Table 3
Stereotypic Description

The Chronic Mental Patient Is:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unproductive</td>
<td>Slightly disheveled</td>
</tr>
<tr>
<td>Surviving in low standard housing</td>
<td>A victim or victimizer</td>
</tr>
<tr>
<td>Emotionally isolated</td>
<td>Frustrating</td>
</tr>
<tr>
<td>Maintained on medication</td>
<td>Dependent</td>
</tr>
<tr>
<td>Generally dull and colorless or erratically flamboyant</td>
<td>Apathetic</td>
</tr>
<tr>
<td>Unable to generalize learning</td>
<td>Unemployed or unable to work in competitive market</td>
</tr>
<tr>
<td>Chronically ill</td>
<td>A tax drain</td>
</tr>
<tr>
<td></td>
<td>Has poor quality of companionship</td>
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</tbody>
</table>

To understand these characteristics, Strauss and Glazer (6) have described some of the processes in the chronic patient which can be helpfully differentiated. Rather than seeing chronicity as a single attribute, they noted four separate aspects: 1) chronicity of symptoms; 2) chronicity of dysfunction in occupational and relationship spheres; 3)
chronicity of receiving treatment; and 4) the 'chronic attitude', a sense of hopelessness, of having given up, of having settled into being bizarre or disabled' (pg. 208).

In understanding this picture of chronicity it has been difficult to separate the residual effects of the disorder (such as negative symptoms) (86,87), the effects due to institutionalization (26,88), the socialization into the patient role (25,85,89), the lack of rehabilitation (90,91), reduced economic opportunities (92) or social status (93,94), the side effects of medication (95,96), and the role of lack of staff expectations (44,97), self-fulfilling prophecies (98,99), and loss of hope (10).

Given the many factors contributing to chronicity in "chronic mental patients" and the fact that the group under treatment at any time represents only a fraction of persons who have had episodes of schizophrenia, a doubt rises as to whether chronicity is a necessary and inherent outcome of the disorder.

III. SOME SUGGESTED CONCEPTS ABOUT IMPROVEMENT AND RECOVERY IN SCHIZOPHRENIA

In the search for new perspectives, several concepts about the recovery and the course of schizophrenia have been developed by investigators who have spent most of their professional lives living and working with, treating and learning from, people who have coped with this illness.
These concepts include the possible ameliorative effects of aging and the deleterious effects of psychosocial events; the probability that schizophrenia is primarily a prolonged illness rather than a chronic one; a focus on the person who has the disorder and ways of reaching that person; as well as appreciating the person-illness-environmental interaction in disorder and recovery.

A. Aging and Psychosocial Factors Affecting the Person

Drawing upon his experience in conducting the longest follow-up to date (catamnestic years ranging up to 64 years after first admission), Ciompi (81) cites the natural aging process as an ameliorative factor in the dissipation of the illness in later years. He speculates that biological factors dampen the illness effects which allow the once-afflicted person to resume a more normal life course. In addition, he perceives chronicity to be primarily due to psychosocial artifacts introduced by such forces as institutionalization and understimulation; overstimulation by family members, labelling, life events, expectations of significant others, and the "general psychosocial inertia" exhibited by patients to reduce "insecurity, fear, and tension" (88). Ciompi further cites the variability of long-term courses, the lack of specificity of negative symptoms for just schizophrenia, the sparsity of genetic evidence, and the reversibility of residual states to
strengthens his case for psychosocial causes of chronicity. He concludes that "the development of a person who was once psychotic must be viewed more as an open life process than as a disease process" (88).

B. More A Prolonged Illness Than A Chronic One

In assessing the impact of schizophrenia across a person's lifetime, Harding and Strauss have concluded that the disorder is primarily more a prolonged illness than a chronic one. Harding cites many other so-called chronic disorders (shown in Table 4) which have heterogeneous outcomes that include significant improvement or recoveries. The list is by no means all-inclusive.

<table>
<thead>
<tr>
<th>Table 4</th>
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<tbody>
<tr>
<td>Some So-Called Chronic Disorders Which Can Improve Over Time</td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Rheumatoid Arthritis               Peptic Ulcers</td>
</tr>
<tr>
<td>Ankylosing Spondylitis             Urinary Tract Infections</td>
</tr>
<tr>
<td>Epilepsy                           Alcoholism</td>
</tr>
<tr>
<td>Asthma                             Heroin Addiction</td>
</tr>
</tbody>
</table>

A person can be quite disabled with certain forms of arthritis and play tennis again (100-102). Many young people with serious seizure disorders for 10 years or more
requiring heavy dosages of phenobarbitol and Dilantin recover and go on to normal lives without medication or seizures (103-104). Many early onset asthmatics go about their lives free of the disorder later (105-106), as do some "chronic" forms of alimentary tract ulcers (107) and urinary tract disorders (108). In the field of psychiatry, Vaillant has tracked the recovery of alcoholics (109) and heroin addicts (110) who had long histories of severe disorder.

Speculations could be made about the roles of the body's seeming ability to right itself (111-112); the persistence of the human psyche, the developmental evolution of coping strategies, and a changing environment which is more or less helpful to promote the return to health. Alterations in any of these factors could account for the heterogeneity of outcome for people with the same disorder.

C. A Person With A Persistent Underlying Vulnerability

Zubin believes that schizophrenia has become increasingly benign during the last century with a significant reduction in catastrophic downhill courses (113, see also 30). He views schizophrenia as primarily an episodic disorder. Zubin and Spring (114) consider the patient to be a person with a persistent underlying vulnerability -- an essentially well person with intermittent episodes of illness rather than a sick person with intermittent episodes of wellness. Chronicity, as well
as the negative symptoms which mark it, is seen to be an artifact caused by: 1) the iatrogenic and nosocomical effects of treatment as well as 2) the cold reception which the former schizophrenic patient receives when he returns to his often noxious ecological niche resulting in a rapid return to chronicity, or 3) a return to an inadequate premorbid personality. Separation of the behaviors due to premorbid status from the focal disorder of schizophrenia needs recognition and has become a task for on-going research (113).

D. The Person Behind the Disorder

Focusing upon the person as Zubin does, M. Bleuler (19) states, "In the schizophrenic psychoses... the old intellectual competence, warmth and emotional depth are discernible behind every serious state of morbidity, time and time again" (pg. 453). Based on his view of the person and the disorder, Bleuler has suggested that generic components of any form of treatment should be "stimulating and appealing to the patient's healthy element, in particular to his need to make contact with others... [Favorable influences]... are in essence the same forces that develop a healthy personality from childhood on and keep it healthy. They include active participation in the community of his fellow men and the natural unfolding of the abilities with which the patient was endowed" (pg. 298).

In a recent example illustrating the idea of trying to
reach the person behind the disorder, the Extended Treatment Service Division of New York Hospital has developed a program which looks beyond treatment of an illness to trying to find evidence that "the person is still there". Signs of "aliveness" are seen as glimmers of light shining out through openings or cracks in the exterior psychosis. Treatment consists of encouraging more of the light to filter through. This viewpoint is directly opposed to a prevalent one which pictures the person disappearing into a central core of illness. Under this conception, treatment consists of seeking openings in the core to push light into the darkness (K. Terkelsen's personal communication to C. Harding, 1983).

As another clinician who followed his patients over decades, Brooks in Vermont also came to see the person behind the disorder. In reflecting upon the turn-around of most of his once very chronic patients, Brooks has identified four primary ingredients of the Vermont rehabilitation program which appeared to reduce chronicity. "Drugs relieved the anguish and fevered mental activity. People were trusted and hence expected to be capable. Goals (jobs, homes, companions) were a new experience of hope for many. People were allowed, even encouraged, to show compassion (aide to patient, patient to patient, patient to aide)" (personal communication to C. Harding, 1984).

The present state of the art does not permit clinicians
to predict who will not turn around towards health. Therefore, since most patients eventually do move in the direction of recovery, early closure of assessment needs to be avoided. Brooks (39) has eloquently pleaded for the "right to rehabilitation" for each patient as an integral part of every treatment plan in order to encourage the turn-around.

F. The Person-Illness-Environment Interaction

In studying a person's struggle back from a psychotic episode, Strauss and colleagues in the Yale Longitudinal Study have conducted intensive and repeated observations of the first year after an episode with a follow-up after the second year (58,112,115-119). Their findings suggest that multiple interactions occur between persons and their environments to shape the recovery process. Severe psychiatric disorder has been found not to be a unitary, linear, unfolding process, but one that ebbs and flows at different rates across different areas of functioning. Furthermore, patients appeared to be active participants in shaping their own recovery process. As an example, Breier and Strauss (118) have recorded ways in which people have learned to control their own incipient psychotic symptoms such as delusions and hallucinations. Those authors suggested a way to teach these skills to other patients.

These findings have lead Strauss to speculate that the
form of traditional diagnosis needs to be revised in order to reflect this dynamic process in the individual-environment interaction. Multiaxial "patterns" of premorbid functioning could be incorporated into the diagnostic formulations to help predict better both morbid processes and on-going future patterns in the pursuit of recovery. Thus diagnostic classification would move from a static snapshot to longitudinal working hypotheses.

IV. SUMMARY

Current expectations, including those stated in the DSM III, have depicted the person with repeated episodes of schizophrenia as having a chronic deteriorating course with residual symptoms and deficits in functioning such as work, social relations, and basic self-care. We have challenged these expectations by providing evidence about the field's misconceptions, both historical and recent, upon which these assumptions were made.

In addition, we have presented research data and many newer concepts which have evolved about the causes and course of chronicity in schizophrenia and about the person with the disorder. These new data and concepts demonstrate the existence of a more flexible dynamic process in which the person is not a mere passive actor but a more active participant than has been appreciated. Recent more systematic research has found significant improvement over
time with widely heterogeneous levels of functioning, even within the same person. This improvement over time means that the illness is more a prolonged one than a chronic one. Traditional diagnostic criteria continue to be relatively non-specific in predicting long-term outcome. However a suggestion is made to revamp the diagnostic system into one of multiaxial patterns across time. Multiple contributions to the formation of and the recovery from chronic states and behaviors are seen as stemming primarily from psychosocial sources as well as the effects of underlying vulnerability, aging, and developmental growth. The focus has been shifted back from the disorder to the person who is seen as a vulnerable human being living a life with intermittent episodes of schizophrenia. As these episodes taper off across time, the person gathers his or her energies to redevelop and improve levels of basic functioning such as self-care, work, and social relations.

V. IMPLICATIONS

The revival of rational hope for improvement and recovery patients and their families, as well as changing the way clinicians perceive their tasks (20). The data mandate the return of control over their own lives to patients by permitting a collaboration in treatment decisions. The provision of opportunities to learn or re-learn social and occupational skills, self-management of psychotic symptoms, and medications, as well as ways to
fine-tune their environments in order to meet the needs of particular vulnerabilities, all would encourage the turn-around to health and competence.

Further, with the return of patients to the community, many families have become the primary case managers. Any kind of supports which can be provided to augment their understanding of the nature of schizophrenia, to increase skills of dealing with returned relatives, and to procure respite services would enhance family member education, coping abilities, and feelings of competence and must be considered a priority in programming as well (120).

And finally, the restructuring of service delivery systems to accommodate slow uphill returns to health may be more cost-effective in the final analysis. The person who represents a tax drain in day treatment facilities can become over time a a taxpayer and an active citizen instead. A system which offers opportunities for multiple levels of functioning in housing, occupational, and social skills with allowance for people utilizing these offerings on an as needed basis (going in and out, and up and down through these multiple levels) may work better in the long run than a lock-step rigid process which expects recovery in a short time or lifetime custodial care with not much in between. Reports have shown that eventually most people can cycle out of the mental health system and utilize natural supports in the community (12). Flexible longitudinal


