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An examination of aftercare services for the chronically mentally ill in two communities

Lorraine Ferris
Wilfrid Laurier University

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AN EXAMINATION OF AFTERCARE SERVICES FOR THE CHRONICALLY MENTALLY ILL IN TWO COMMUNITIES

by

LORRAINE FERRIS

B A (HONS) York University, 1982

Submitted in partial fulfillment of the requirements

for the Master of Arts degree

Wilfrid Laurier University

1985

For My Family

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I would like to thank my advisor, Dr. Steve Chris for all his help, encouragement, and support through (what turned out to be) a long process. Also, I would like to thank my committee members, Dr. Mark Pancer, and Dr. Fred Binding. Dr. Mark Pancer as a second reader, read many versions of this thesis and contributed valuable assistance.

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ABSTRACT

Within the last few decades there has been a shift from traditional institutional approaches in mental health to community-based service delivery systems. Researchers examining the community-based model have focused on improving the quality of community care. Specifically, use of aftercare services has been found to improve the quality of community care (Byers, Cohen, & Harshbarger, 1978; Gittelman 1974; Krauss & Slavinsky 1982, Weinman et al., 1978). Co-ordination of services has also been shown to improve the quality of community care by increasing the effectiveness of aftercare (Broskowsky, Marks, & Burmen 1982, Clark 1976, Krauss & Slavinsky, 1982). At the level of the chronically mentally ill, quality of community life is affected by the quality of care. Researchers have shown that psychiatric patients or clients experience poor quality of life in the community (General Accounting Office, 1978, Krauss & Slavinsky, 1982, Lamb, 1982).

The present research was designed to examine: [1] service providers' perceptions of aftercare service co-ordination in their community, [2] service receivers' (i.e., the chronically mentally ill's) perceptions of their quality of life in the community; and, [3] factors hypothesized to affect co-ordination of services for the chronically mentally ill in the community. Organizational research has demonstrated that co-ordination is affected by relationships: [1] within the agency; and, [2] between community agencies (Evan, 1967, Etzioni, 1961, Marks & Broskowski, 1982). These factors hypothesized to affect co-ordination are referred to as intraorganizational perceptions and interorganizational perceptions respectively.

Two communities were studied One community operated from a community care model where chronic mental patients/clients were treated entirely in the community or on a hospital out-patient basis. The second community operated from an institutional care model using in-hospital, out-patient and community treatment. A comparison was made between the two communities using data provided by service providers.

Two scales were constructed for this research. The scale for service providers examined perceptions of co-ordination of services for the chronically mentally ill, interorganizational perceptions, and intraorganizational perceptions The self-administered instrument was constructed in the form of a multiple-choice and 5-point Likert format scale The scale for service receivers examined Quality of Life in the community by measuring [1] life adjustment, based on factors outlined by Krauss & Slavinsky (1982) which were - a need to be taken care of; a need for social interaction, a need for relief from psychiatric symptoms, a need for basic life necessities, and a need for hope, and, [2] life satisfaction using an adapted version of the Bradburn Satisfaction Scale (Bradburn, 1969). The self-administered service receiver instrument was constructed in the form of a multiple choice and 5-point Likert format scale

It was found that co-ordination of services was moderate in the institutional care model and low in the community care model. There was a significant difference between the two communities in the perceived level of co-ordination of services

Interorganizational perceptions affected co-ordination of services at the local level. Chronically mentally ill persons experience a poor quality of life in the community. Life adjustment was affected by the level of care, relief from psychiatric symptoms, and hope of recovery provided by service providers.

This paper concludes with a discussion of the limitations in the research. It is shown that there is no reason to believe that the results were spurious. Recommendations based on the research are provided, and directions for further research are suggested

INTRODUCTION

Historically, the two dominant modes for dealing with the chronically mentally ill in our society have been, (1) institutionalization, which advocates inpatient mental health treatment; and, (2) de-institutionalization, which emphasizes community care (Krauss & Slavinsky, 1982). Within the last few decades there has been a shift from traditional institutional approaches in mental health to community-based service delivery systems. Professionals in the community-based approach are not viewed as guardians but rather as "community agents", whose purpose is to develop and conserve human resources and restore effective functioning to people whose performance has been impaired (Smith & Hobbs, 1970).

As the patterns of service delivery to the chronically mentally ill changed from an institutional to a community-based model, a number of investigators have focused their research on strategies designed to improve the quality of community care (Byers, Cohen & Harshbarger, 1978, Gittelman, 1974, Krauss & Slavinsky, 1982, Weinman et al., 1978). For example, a number of researchers have reported that one of the most effective systems for dealing with the chronically mentally ill in the community is the provision and utilization of aftercare services (Byers, Cohen & Harshbarger, 1978, Gittelman, 1974, Krauss & Slavinsky, 1982; Weinman et al., 1974). Aftercare for the chronically mentally ill involves linking patients with community-based programs or services upon discharge, monitoring their progress and providing advocacy and support to achieve satisfactory community adjustment (Wasylenki, Goering, Lancee, & Ballantyne, 1982). Aftercare services are specifically designed to enhance mental health clients' physical, psychological, and social adjustment to their community. A number of divergent activities are subsumed under the rubric of aftercare services: Day hospitals, halfway houses; vocational rehabilitation; socializing clubs; and administration of psychotropic drugs.

While the use of aftercare services has been shown to improve quality of community care for the chronically mentally ill, its effectiveness is dependent on a secondary factor - the level of co-ordination of these services by service providers (Broskowsky, Marks & Burmen, 1982; Clark, 1976; Gittelman, 1974; Halpert, 1970; Kase, 1979; Krauss & Slavinsky, 1982; Rosengren & Lefton, 1970). Collectively, these studies indicate that communities with aftercare services tend to have unco-ordinated service delivery systems, have gaps and overlaps in services, and little or no established communication or referral system, which may affect quality of community care.

The present study was designed to examine (1) service providers' perceptions regarding the co-ordination of aftercare services, (2) service receivers (i.e. the chronically mentally ill's) perceptions of their quality of life, and (3) factors hypothesized to affect the co-ordination of services for the chronically mentally ill. Quality of life will be measured using a number of psychosocial and physical dimensions hypothesized to affect life adjustment and life satisfaction in the community (Krauss & Slavinsky, 1982).

The literature review will examine: (1) the community care model emphasizing the advantages and disadvantages of de-institutionalization for the chronically mentally ill, (2) co-ordination of community services with particular emphasis on identifying which factors affect co-ordination both within agencies and between agencies; and (3) needs of the chronically mentally ill in order to identify which services should be provided in the community in a co-ordinated manner. It is assumed that these needs will be linked to the concept of "quality of life" for ex-psychiatric patients.

This research is of particular interest to the field of community psychology, a discipline which searches for new paradigms, new ways of understanding health and mental health care issues, and new action oriented strategies (Rappaport, 1977). Community psychology is committed to offering data and theories related to human ecology (the fit between people and environments) and system analysis, with the particular emphasis each has on individual behavior or experience (Scribner, 1970). This study makes two primary contributions to community psychology: (1) the focus on the person-environment fit of the chronically mentally ill and the community, and, (2) action research as a model for investigating human service delivery systems.

LITERATURE REVIEW

DE-INSTITUTIONALIZATION OF THE MENTALLY ILL

History of De-institutionalization for the Mentally Ill

The shift from traditional institutional care to community-based care resulted primarily from the community mental health movement of the 1960s. Advocates of the new method were concerned with the increase in patient population in already overtaxed public mental hospitals. It was widely believed that the treatment facilities had poor quality of care and low expenditures for patients. Gottesfeid (1977) reported that supporters of community mental health viewed institutionalization as dehumanizing, regressive, and more expensive than community care.

Community mental health advocates criticized supporters of institutional care for their use of the medical model. In the medical approach to mental illness, problems in living are conceptualized as being related to physical illness instead of being analogous to learned and environmental conditioned responses (Cowen, 1967; Rappaport, 1977). The main focus in the medical model was on the central nervous system, the brain, and organic causes of mental illness. With the conceptualization of mental illness as being the result of physical illness, medical advocates had employed a range of physical interventions to cure the problem as well as various approaches to psychotherapy. Physical treatments included such medical procedures as psychosurgery, electro-shock therapy, and large dosages of psychotropic drugs.

Additionally, the patient-doctor relationship employed in the medical model approach to mental illness was criticized. In this relationship, the active and participatory role of the patient was terminated once professional assistance was acquired. The doctor assumed a passive role until the patient acquired his or her services. The authoritative active role of the professional commenced once patient-doctor contact had been established.

In contrast, the community mental health movement supported a new paradigm which considered the antecedent role of external forces in mental illness (Zax, 1980). An interactionist orientation was employed in which the individual and his or her family, work, and community were regarded as elements which operated interdependently. The community mental health model viewed the total mental health care delivery system as being comprised of a wide range of services and settings (i.e., medical care, recreational activities, vocational training). Community resources and services were seen as essential therapeutic tools. This new model assumed that mentally ill individuals were clients who could play an active role in their own health care. Moreover, professionals were seen as needing to develop a more preventative role where high-risk populations could be identified early before problems developed.

The community mental health movement emerged with the advent of (1) Effective and available psychotropic agents for psychotic conditions, making it possible for clients to live in the community, (2) legislation requiring less restrictive settings for care, and (3) the establishment of new federal funding mechanisms that made it possible for discharged mental patients to continue receiving benefits (Talbott, 1981). These additional factors aided a shift in the locus of the problem from the mental hospital to the community (Talbott, 1981). While the concept of community mental health originated and had its greatest strength in the United States, Canada also felt the effects of the movement. Turner and Avison (1983) note that similar developments in new patterns of care for the chronically mentally ill were clearly observable in Ontario. In 1959, Matthew Dymond, then Minister of Health, provided the Ontario Legislature with a report which stated that the organization of mental health services should be inaugurated at the community level and mental hospitals should have a closer proximity to the community (cited from Greenland, 1961; Turner & Avison, 1982) The Dymond Report directly affected the number of patients being discharged into the community care system in a positive direction from 1960-1971 (cited from Turner & Avison, 1983).

Consequences of De-Institutionalization for the Mentally Ill

It has been acknowledged by both critics and supporters of the community mental health movement that de-institutionalization for the chronically mentally ill has failed (Anthony, Buell, Sharratt, & Althoff, 1972; May, Tuma & Dixon, 1976; Rappaport, 1977, 1985a, 1985b). While the consequences of de-institutionalization have not been uniformly negative, there is a reported gap between the promise of more economical and humane treatment and the eventual outcome of the change of care for the chronically mentally ill. Scull (1981) argues that for the majority of chronically mentally ill "what appears to have changed is the packaging rather than the reality of their misery" (p 17). The four main consequences of de-institutionalization for the mentally ill are

(1) an increase in patient population in alternative custodial care (i e., residential settings and nursing homes)

(2) an increase in the frequency of re-admissions to institutions

(3) more strain on the community

(4) poor quality of life for the mentally ill in the community

1. INCREASE IN PATIENT POPULATION IN ALTERNATIVE SETTINGS

Research has shown that chronic patients have been shifted from state and county mental hospitals in the United States to alternative hospital settings (Felton & Shinn, 1981, Kiesler, 1982; Paul & Lentz, 1977, Redlich & Kellert, 1978). According to American statistics, since 1960 the number of admissions in traditional care of state and county hospitals has drastically decreased, primarily because these institutions were the target for the de-institutionalization movement (Kiesler 1982, Vischi et al., 1980). However, Vischi et al. (1980) have noted that inpatient admissions have dramatically increased in general hospital psychiatric units, community mental health centers, VA psychiatric units and private mental hospitals

This revolving door phenomenon has also been docume~~nted~~ in Canada. An analysis of hospital settings in Canada indicates that 81% of admissions for the mentally ill were to public general hospitals; 19% were admitted to public mental hospitals (Statistics Canada, 1979). An essential point is that 20% of the patients with mental illness in public general hospitals were released. Individuals leaving public general hospitals are being re-admitted to public mental hospitals.

2. INCREASE IN FREQUENCY OF RE-ADMISSIONS IN INSTITUTIONS

It has been demonstrated that there are high rates of relapse for the mentally ill (Anthony, Buell, Sharratt, & Athoff, 1972, Anthony, Cohen, & Vitalo, 1978, Bassuk & Gerson, 1978, May, Tuma & Dixon, 1976, May, Tuma, Yale, Potepan & Dixon, 1976). The relapse rates for the chronically mentally ill increase over time after their initial discharge, 25-30% relapse at six months, 35-50% relapse at one year, and 70-75% relapse by three to five years (Anthony et al., 1978).

3. STRAIN ON THE COMMUNITY

A number of authors have documented the strain de-institutionalization has placed on the mentally ill, their relatives, and their community (Arnoff, 1975, Davis, Dinitz & Pasamanick, 1974, Wing & Brown, 1970). Although the well-being of ex-patients with intact families is relatively good, the accumulated financial and psychological cost to families over the course of the illness is so immense that there often is a refusal by families to shoulder the intolerable burden in the future.

It has often been demonstrated that the chronically mentally ill in the community are involved in numerous criminal acts (Ozarin & Sharfstein (1980), following an analysis of 162 chronically mentally ill patients having been in the community for one year, provide data indicating that 8% had police involvement. Hoffman (1981), in a recent thesis on "Mental Health Services for Ontario Correctional Clients: A Target Population and Service Description with an Evaluative Component", found that 63% of inmates in Ontario Correctional institutions had previous contact with the mental health system, while 49% had prior psychiatric treatment. Consistent with the previous findings (Hoffman, 1982) found that 7% of this population have severe reoccurring psychiatric illnesses.

4. POOR QUALITY OF LIFE FOR THE MENTALLY ILL IN THE COMMUNITY

Ex-psychiatric patients discharged into the community often experience poverty and unemployment (Slavinsky, et al., 1976). Long-term psychiatric patients discharged into the community cluster in low-income and poor-housing areas within close proximity to the hospital, and the chronically mentally ill usually do not return to their original communities (Greenblatt & Glazier, 1975). The psychiatrically disabled suffer impoverished lives after being discharged into the community because they are usually unemployed and require government financial assistance (Krauss & Slavinsky, 1982). Estroff (1981) reported that within one year after being released from the hospital, 30-50% of the chronically mentally ill work, while after one year only 20-25% are employed.

There are several other indicators of the poor quality of life for the chronically mentally ill in the community. Krauss and Slavinsky (1982) report they often become the victims of criminal acts. It has also been documented that people dislike and avoid the mentally ill even to the point of blocking their entry into the community (Rabkin, 1979). Felton and Shinn (1981) note that for every community program that survives, one community program fails as a result of community backlash.

Impediments to De-institutionalization for the Mentally Ill

The literature on de-institutionalization as a viable alternative for dealing with the chronically mentally ill in our society was hindered by the following factors

(1) lack of political and economic support for implementation of de-institutionalization (The Ad Hoc Committee on the Chronic Mental Patient, 1979; Kiesler, 1982, Price & Smith, 1982)

(2) lack of expanded community-based services for the chronically mentally ill (Armstrong, 1979, Bachrach, 1978, Evans, 1979; Lamb, 1979; Rappaport 1985a, 1985b, Test, 1981, Test & Stein, 1978)

(3) lack of co-ordination between various health and social agencies (Bassuk & Gerson, 1977; Evans, 1973, General Accounting Office, 1978, Gilbert & Specht, 1977, Halpert, 1970; Lamb, 1976; Lamb, 1982)

1. LACK OF POLITICAL AND ECONOMIC SUPPORT FOR IMPLEMENTATION OF DE-INSTITUTIONALIZATION

Although the Canadian and American federal governments amended legislation governing alternative hospital settings, the responsibility for fees was still the individual's. It has been shown that the majority of mental health clients who use community services are unable to pay for it and must rely on third party payment (Wolford et al., 1972). Private insurance plans and policies favor in-patient hospitalization - there are economic incentives for the chronically mentally ill to be institutionalized. The Ad Hoc Committee on the Chronic Mental Patient 1979; Kiesler, 1982, and Price and Smith, 1982, emphasize that there is a lack of economic incentive in the United States for states to develop community care programs, and chronically mentally ill individuals to seek community care instead of hospitalization. The result of this is a political shift away from support of local community mental health services. The President's Commission on Mental Health (1978) summarized the situation by commenting that "... the level and type of care given to the chronically mentally disabled is frequently based on what services are fundable and not on what services are needed or appropriate" (Platman, 1978, p. 369).

In Canada, the same lack of economic and political support for the de-institutionalization of the chronically mentally ill is evident. A case in point is the situation in the Province of Ontario. There are ten provincially owned and operated psychiatric hospitals across Ontario - Brockville Psychiatric Hospital; Hamilton

Psychiatric Hospital; Kingston Psychiatric Hospital; London Psychiatric Hospital; North Bay Psychiatric Hospital; Penetanguishene Mental Health Centre; St. Thomas Psychiatric Hospital; Lakehead Psychiatric Hospital (Thunder Bay); Queen Street Mental Health Centre (Toronto); and the Whitby Psychiatric Hospital. There are several other psychiatric hospitals which are not government-owned: Homewood Sanitarium - Short Term (Guelph); Homewood Sanitarium - Long Term (Guelph); Victoria Hospital - Long Term (London); Royal Ottawa Hospital; Sudbury Algoma Hospital; Clarke Institute of Psychiatry (Toronto); and Metfors (Toronto). According to the Ontario Ministry of Health, there are sixty-three hospitals in the province with psychiatric units (Ministry of Health, Annual Report, 1982/1983). As of 1983, there were ten community health centres in Ontario (Ministry of Health, Annual Report, 1982/1983).

It is only within the last two years that community health centers and health service organizations received full status as components of the Ontario Health care system. Previously, community health centres and health service organizations were considered experimental alternatives to the traditional method of delivering local health care. This new policy changes the funding format from short-term contracts to long-term overall budget based on the specific programs provided.

The funding mechanisms for psychiatric hospitals (provincial), hospitals with psychiatric units (public); and community mental health centers differ. Although the funding mechanisms for various mental health centres differ, overall provincial government funding to health institutions has not kept pace with inflation (Liberal Committee on Health Care in Ontario, 1982). In fact, grants to hospitals with psychiatric units (public) were inadequate to meet subsistence needs (Liberal Committee on Health Care in Ontario, 1982). For example, community-based mental health services in Ontario were grossly underfunded. According to the Ontario Ministry of Health, 121 programs were funded in 1980/1981 with a budget of $14,022,300 (Ministry of Health An[illegible]al Report 1980/1981). In 1982/1983, 19 new and 6 expanded community mental health programs were provided with funding. The actual statements of expenditure for these programs are not available. However, it has been stated that funding was inadequate to meet the demand for community care services. Another instance where the balance between institutional and community-based services in the province is not evident is in the example of the Lakeshore Psychiatric Hospital closure. Ten million dollars was given to institutional programs and only 3 million to community programs.

The Liberal Committee on Health Care in Ontario, 1979, concluded that the chronically mentally ill in the community are the most neglected group in Ontario - a finding which is supported by the lack of financial committment by the Ministry of Health. The Social Planning and Research Council- Hamilton, charged that "the Minister of Health effectively had washed his [sic] hands of providing appropriate community-based alternatives to institutional care. To date, no other Ministry has stepped forward to take on this responsibility" (cited from Liberal Committee on Health Care in Ontario, 1979). The Liberal Committee on Health Care in Ontario, 1979, charges that the unpredictability of funding for community-based services has made it extremely difficult for ex-psychiatric patients to make the transition to independent living.

2. LACK OF EXPANDED COMMUNITY-BASED SERVICES FOR THE CHRONICALLY MENTALLY ILL

Bachrach (1978) argues that there has been too much preoccupation on changing policies for community treatment and not enough effort directed toward expanding community programs to assist the mentally ill in making the transition from the hospital to community life. The general view in the literature is that partisans of de-institutionalization helped to create policies which removed the mentally ill from hospital confinement to communities, which were unprepared for the shift in treatment (Rappaport, 1985a, 1985b). Armstrong (1979) has shown that the lack of specific rehabilitative programs in the community has prevented most hospitalized mentally ill patients from being released. Similarly, Evans (1979) has pointed out that community-based services for the mentally ill were inadequate for almost 30% of in-hospital patients.

One explanation for the lack of expanded community-based services for the mentally ill, beyond political and economic considerations, was that service providers lacked an understanding of the chronic impairment which caused socially dysfunctional behavior (Krauss & Slavinsky, 1982). Mental illness was not seen as being a possible life-long problem requiring extensive and long-term supportive structures (Lamb, 1979, Test, 1981; Test & Stein, 1978); therefore, the community was not prepared to offer long-term support and services (Rappaport 1985a; 1985b).

3. LACK OF CO-ORDINATION AMONG VARIOUS HEALTH AND SOCIAL AGENCIES

The last impediment to successful de-institutionalization of the mentally ill has been the lack of co-ordination of the service delivery system in the community. According to Halpert (1970), mental health service programs have often developed without adequate and identifiable goals and in the absence of sufficient consideration of the needs of the target population. It has been well documented that instead of having a well-integrated system of services most communities have a disorganized array of agencies with overlapping or conflicting goals (General Accounting Office, 1978, Gilbert & Specht, 1977, Halpert, 1970 Lamb, 1976; Lamb 1982). The General Accounting Office (1978) reports that the service delivery system has been disorganized and chaotic. Hospital release policies have not been co-ordinated with the availability of aftercare facilities in the community (Bassuk & Gerson, 1977, Evans, 1983, General Accounting Office 1977). Evans (1973) has shown that community-based services were inadequate for almost 30% of the chronically mentally ill population because there was a lack of community linkages in service and referral

Implications of De-institutionalization for the Mentally Ill

A number of community-oriented researchers have argued that the problem with de-institutionalization was not the concept but rather the implementation (Fairweather, 1972; Fairweather et al., 1969; Fairweather et al., 1974, Marx, Test, Stein, 1973; Moscowitz, 1980; Stein, Test & Marx, 1975; Test, 1981; Test & Stein, 1978).

It has been demonstrated that when community programs are successfully implemented, the therapeutic outcomes surpass those of hospital treatments (Braun et al., 1981; Fairweather, 1972; Fearweather et al., 1969; Fairweather et al., 1974; Kiesler, 1982; Marx, Test, Stein, 1973; Moscowitz, 1980; Rappaport, 1985b; Stein, Test, Marx, 1975; Test, 1981; Test & Stein, 1978). Rappaport (1985a, 1985b), in a review of existing community-based mental health programs, has concluded that programs which are successfully implemented are characterized as ongoing, assertive, and flexible enough to identify the deficiences in the individuals and build on their strengths.

THE LONG-TERM CHRONIC MENTAL PATIENT IN CONTEMPORARY COMMUNITIES

The examination of the consequences of impediments towards implementing de-institutionalization procedures demonstrated that at the community level two aspects seem important to successful de-institutionalization: (1) co-ordination of services, and (2) improved quality of life for the chronic mentally ill person making the transition from the mental hospital to community care. These two aspects will be discussed in this section.

Problems Affecting Individuals Afflicted with a Chronic Mental Illness

It is imperative that the service delivery system give sufficient consideration to the needs of the chronically mentally ill, especially factors that affect the quality of life of the psychiatrically disabled in the community. Without this focus on quality of life, community care may not be care at all. For an overwhelming number of mentally ill patients, community care is of a lesser quality and quantity than hospital care where "at least food, clothing, shelter and the presence of people routinely are available" (Morse 1978, p. 639-640).

Simon (1965) in his discussion on the long-term mentally ill patient describes this special population as being marginal, vocationally inadequate, socially isolated, and possessing exaggerated dependency needs. As a result of emotional disabilities, the chronically mentally ill have a lack of self confidence, inability to communicate, poor problem-solving techniques, and an inability to tolerate the pressure from the usual crises of life (Lamb, 1976). The emotional disabilities of the mentally ill may be so severe and persistent that, without assistance they will not be capable of creating nor maintaining the support systems they need to remain in the community (Stein, 1979). These support systems are seen as essential in "giving the patient a sense of mastery - the feeling that he (sic) can cope with his (sic) internal drives, his (sic) symptoms, and the demands of his (sic) environment" (Lamb, 1979, p 9)

Ludwig (1971) and Sandall (1975) provide a basis for understanding the chronically mentally ill patient separating from the hospital setting According to Sandall (1975), upon discharge from the mental institution, the chronic mental patient has an abrupt and traumatic confrontation with reality Lamb (1976) refers to this painful experience as "cultural shock" where previous fears and inadequacies come to the fore Chronic mentally ill patients with prolonged hospitalization have more complicated problems (Ludwig, 1971) Ludwig (1971) describes these long-term patients as experiencing

> " a deterioration in work habits, a diminution in self-discipline, an atrophy in social skills, the avoidance of competitive situations, a passive rather than active orientation toward the satisfaction of their needs, and long exposure to an environment that places minimal demands and stresses on them There is also a tendency for their value system to change Ambitions, success, and the dreams of youth begin to vanish and are supplanted by a resignation to the status quo and a nagging insecurity about their ability to cope outside the familar hospital setting. To accentuate this feeling of social alienation even further, friendships evaporate over the years, family members die, family ties weaken, and numerous other roots to the original community begin to wither In effect, the patients' emotional and intellectual lifelines to the outside world become progressively closed off"

Ludwig, 1971 pp 192

QUALITY OF LIFE

From the perspective of Zautra and Maio (1981) the quality of life experienced by community members needs to be analyzed within the context of two major categories: (1) life adjustment and (2) life satisfaction. Although these researchers do not deal with the chronically mentally ill specifically, their framework is useful in examining the quality of life of ex-patients in the community.

Life Adjustment

A number of researchers have indicated that the chronically mentally ill have very special needs in the community setting (Lamb, 1976, Ludwig, 1971, Sandall, 1975, Simon, 1965, Stein, 1979). Krauss and Slavinsky (1982) analyzed the literature on the needs of chronic psychiatric patients in the community and reported that the following psychosocial and physical dimensions affect the chronic patients quality of life in the community:

- a need to be taken care of [dependency]
- a need for social interaction [social disability]
- a need for relief from psychiatric symptoms
- a need for basic life necessities
- a need for hope

The management of services for the chronically mentally ill must begin with the recognition of the *need to be taken care of* (Bowers, 1974, Lamb, 1979, Robbins, 1978). Even programs that emphasize the importance of including clients in the planning of services recognize that the mentally ill want service providers to take over the responsibility of looking after them (Robbins, 1978, Walters & Bowers, 1974). Although there are many difficulties for professionals in dealing appropriately with the dependency element, the chronically mentally ill attempt various actions to get service providers to take care of them.

The chronically mentally ill have a *need for social interaction*. Edelson (1976) states that the chronic patient must be included socially in the community before true integration is possible. Unfortunately, the difficulty in establishing social interaction appears to be the direct result of difficulties with patients' unconventional thought or perceptions and social isolation (Krauss & Slavinsky, 1982). Individuals suffering from a chronic mental illness do not attempt to interact with others unless they are assisted in seeking or provoking stimulation with the environment. Social interaction is an essential factor affecting the quality of life of those afflicted with a chronic mental illness. Research has indicated that the social networks and natural support systems of the chronically mentally ill tend to be small, transient, closed, asymmetrical and non-reciprocal (Beels, 1975; Pattison & Pattison, 1981; Sokolovsky, Cohen, Berger & Geiger, 1978). Moreover, Pattison and Pattison (1981) report that social networks and natural support systems are affected by the severity of symptoms.

The chronically mentally ill have a *need for relief from psychiatric symptoms* (i.e., depression, anger, motor retardation, thought disorders, hyperactivity, elations, or social withdrawal). Psychiatric symptoms of patients may be stabilized at a low level with the aid of medication. According to Reider (1974), it is important that therapeutic dosages of phenothiazines be monitored in the community through supervision. Klerman (1977) has indicated that if the long-term psychotropic drugs are not set at appropriate maintenance levels, there may be an increase in neurologic complications

All individuals living in a community have a *need for basic life necessities*. However, as a result of their mental illness, many long-term patients find it especially difficult to obtain food, clothing, shelter, and medical attention. Often the need for physical medical services is overlooked for this chronic population because they are usually seen by medical professionals who focus on their mental illness (Krauss & Slavainsky, 1982; Talbott & Linn, 1978, Wing, 1978) However, it has been stated that the psychiatrically disabled do require medical assistance for multiple concurrent physical illnesses (Krauss & Slavinsky, 1982, Talbott & Linn, 1978; Wing, 1978). In order for the chronically mentally ill to experience an increased quality of life in the community they must be given the basic life necessities of food, shelter, clothing, and medical services

All chronic mentally ill patients in the community have a *need for hope*. It is difficult for professionals to extend services to meet this need One reason proposed in the literature is that mental health professionals attempt to ignore treatment failures As the illness persists, it is difficult for service providers to remain optimistic and sympathetic. This situation may lead to rejection and hostility on the part of the professional towards the chronic patient in the community It has been stated that this type of behavior is coincident with a time in the patient's life when continued and renewed support is most important (Krauss & Slavinsky, 1982).

It is essential that mental health professionals recognize that chronically mentally ill patients make slow changes or improvements (Allen, 1974). Instead of setting unrealistically high expectations, it is important that clinicians and patients set expectations that match the client's rate of progress. When acceptance of a realistic rate of progress is established, service providers will be capable of instilling hope that the positive effects of rehabilitation will emerge.

Life Satisfaction

A full assessment of quality of life includes the satisfaction level of the chronically mentally ill living in the community. Researchers have argued that life satisfaction should be a major component in our concept of well-being (Palmore & Luikart, 1972). The concept of psychological well-being and level of happiness is often used to measure life satisfaction (Bradburn, 1969). Campbell et al. (1976) have demonstrated that the life satisfaction dimensions of happiness, general well-being, and satisfaction are interrelated.

While concern with issues of happiness and life satisfaction has a strong tradition in the mental health field (Roberts, Pascoe, & Attkisson, 1983), these dimensions often examine a general life adjustment factor. There does not seem to be a body of literature that assesses people's feelings about their lives regarding multiple dimensions, which may be conceptualized as different from life adjustment factors.

CO-ORDINATION OF AFTERCARE SERVICES

The growing complexity of and accelerated change in communities has helped to create disruptive effects on social services (The Social Planning Council of Metropolitan Toronto, 1970). According to Clark (1976), an ad hoc approach has been used in the development of mental health programs. Highly specialized institutions (i.e., schools, hospitals) whose programs and functions are generally known do not seem to experience the mental health system as incoherent. Mental health programs which are offered to people in relation to where they live, experience the system as incoherent (Clark, 1976; The Social Planning Council of Metropolitan Toronto, 1970).

According to the literature, despite the obvious advantages of co-ordinated mental health services in communities, there remain serious barriers to their development (Marks & Broskowski, 1981). Two areas which affect co-ordination of services at the local level are (1) intraorganizational factors, and, (2) interorganizational factors (Marks & Broskowski, 1981). According to Sarason (1977), the interorganizational structure is examined by investigating the functioning of organizations using an analysis of their internal structures. Warren (1967), Turk (1970), Baker and Schulberg (1970), examined the interorganizational structure by focusing on the interaction between two or more organizations with particular reference to the organizational pattern. They found that how agencies communicate is contingent upon internal factors. Although intraorganizational and interorganizational factors are discussed separately, the variables are interdependent and interact with one another in complex and poorly understood ways (Marks & Browskowsky, 1981). Those factors will be discussed in this section

Intraorganization Factors

The findings from organizational research on co-ordination at the service provider level has primarily focused on intraorganizational factors (Evan, 1967, Etzioni, 1961) The study of intraorganizational factors involves examining individuals within organizations, emphasizing characteristics that affect ability and willingness to develop and maintain program linkages.

Marks and Broskowsky (1981) reviewed the literature on intraorganizational relationships and offered a summary of variables affecting co-ordination at the local service provision level. It was found that organizations which are internally well-controlled, organized, co-ordinated, and can be described as possessing flexible innovative leadership styles, are excellent candidates for developing external linkages (Marks and Broskowski, 1981) The concepts of *controlled, organized,* and *co-ordinated* are different Internally well controlled agencies have a distinct governing body which is aware of all aspects of the organization To be well organized, an agency must have a clear and precise framework which delineates the various departments and job descriptions An agency that is well co-ordinated exhibits a lack of gaps and overlaps in departmental functions and staff responsibilities Additionally, there is a pulling together and collaboration among staff and departments for better service delivery and productivity

Interorganizational Factors

Researchers interested in mental health organizational research have not extensively examined interorganizational variables (Evan, 1967). This is surprising since it has been shown that formal organizations are embedded in an environment (with varying complexities of norms and values) with other institutions (Evans, 1967). However, since interorganizational factors are part of a general class of boundary-relations, this neglect is understandable. Boundary-relation issues are enormously complex because it is difficult to analyze the division between one organization and another.

Marks and Broskowsky (1981) have identified three interorganizational factors which affect co-ordination at the local, service provision level (1) the interdependency among agencies in the service delivery network, (2) the extent of complementary service goals among organizations; and, (3) the extent of similar philosophies of service delivery. In addition, support from top levels in the organization, to form linkages is an important variable in providing co-ordinated services (Marks and Broskowsky, 1981). Sarason et al. (1977) notes that the emergence of networks between agencies is contingent on the extent to which needs and purposes of agencies are matched.

A main issue in co-ordination of services is the relationship between public and voluntary agencies. Gilbert and Specht (1974,1977) state that agency funding structures are an important aspect of co-ordination. It was found that public agencies were more likely to be involved in a co-ordinated network than either voluntary or private organizations

CO-ORDINATING MENTAL HEALTH PROGRAMS IN THE PROVINCE OF ONTARIO

In 1973, the Ontario Ministry of Health responded to the concern that co-ordination of health planning should be provided at the local level by establishing health planning bodies throughout the province. It funded twenty-one permanent District Health Councils. Each of these councils was funded by and accountable to the Ministry of Health. The responsibilities of a District Health Council include the development of policies and plans for the delivery of health care within its district utilizing the provincial policies, guidelines, and standards as its framework. A specific responsibility of the District Health Councils was to "provide leadership for and ensure the development of co-ordinated health care groups and programs in the primary and secondary care sectors in the district" (Health Planning Task Force, 1974).

Co-ordination of Mental Health Programs in the Region being Studied

During the time that the Ontario Ministry of Health was implementing new District Health Council co-ordinating bodies, a Steering Committee in the region was exploring alternative service delivery programs which would permit a combination of health and social service planning. An independent research team was appointed by the Steering Committee, with the support of the Regional Government and the ministries involved. This research team investigated community attitudes toward health and social planning in the area, with the specific mandate to recommend a model or models for Regional Social and Health Planning. As a result of the recommendations, a model was accepted and the District Health Council and the Social Resources Council were established in 1977.

The Social Resources Council was established as a demonstration project funded, by the Province (75%) and Region (25%). After a three year trial period, the Council was found to be successful and warranting financial support from the Ministry of Community and Social Services and the Regional Municipality.

At the present time, objectives of the council include being an advisory planning body, and focusing on planning for voluntary and government social services in the Region. The Council is not directly responsible for the administration or delivery of social services, nor does it replace the function of boards of social service agencies, the Regional Health and Social Services Committee, or the local staff of the Ministry of Community and Social Services (Social Resources Council, September, 1982). One of the responsibilities of the Resources Council is to encourage the development of co-ordinated social service programs and plans within the Region and to make recommendations on ways of achieving optimum use of existing resources (Social Resources Council, September, 1982).

The District Health Council is an advisory body to the Minister of Health for Ontario. The District Health Council is responsible for: (1) analyzing community health needs and making recommendations on short-term priorities for immediate expenditure or action; (2) setting up a planning mechanism to determine the long-term health needs of the region, and (3) meeting those needs in an effective and economical fashion consistent with the resources available.

In 1982/1983, several changes in this organizational model were made. The Community Health Committee functioning as a Short-Range Planning Committee was eliminated and replaced by an Emergency Health Systems Planning Committee. Additionally, after discussion by the board of the District Health Council and the Social Resources Council, the existing Joint Mental Health Committee was restructured through the formation of a new Mental Health Committee under the direction of the District Health Council. The terms of reference for this new, reconstituted committee included determining gaps and identifying needs in mental health services with particular attention to institutional and community-based mental health services within the region.

The Social Resources Council has the mandate to encourage the development of co-ordinated social service programs and plans, while the District Health Council is responsible for identifying gaps and specific needs in mental health services. However, neither council is responsible for co-ordination of mental health services in the region. Since 1973, there has been no published investigation on co-ordination of mental health services in the region.

The region is not offering service delivery of mental health programs in accordance with any co-ordinated model, although co-ordination may be present in an informal manner.

PRESENT RESEARCH

This research was designed to investigate the co-ordination of aftercare services for the chronically mentally ill in two communities in Southwestern Ontario and to evaluate the quality of life of former mental health patients in each community.

Community 1, according to key informants in the area, has a well co-ordinated service delivery system which is well managed for the chronically mentally ill in their area. This community is served by a general hospital which does not provide in-hospital beds for individuals with mental illness. Patients who have a severe condition and require hospitalization are sent to a psychiatric facility in another city. The mentally ill in this community usually receive community services through the Community Mental Health Centre which operates from within the general hospital on an out-patient basis. For the purposes of this research, Community 1 shall be labelled *Community Care Model*.

Community 2, according to key informants, has an unco-ordinated service delivery system operating for the chronically mentally ill. This community has a major general hospital which has full-patient in-hospital facilities for the mentally ill. There are no community services being directly offered from the hospital, however, patients usually become eligible for out-patient day treatment when the attending physician releases them from ward care. For the purposes of this research, Community 2 shall be labelled *Institutional Care Model*.

The first purpose of this study is to examine co-ordination of services in the two communities as reported by the service providers. This study will elicit reponses regarding the degree of co-ordination of services in each community, as well as on the intraorganizational and interorganizational factors affecting co-ordination of mental health services. The self-report data from the service providers will explore the following questions:

[1] Is there a difference between the two communities in the reported level of co-ordination, interorganizational factors, intraorganizational factors?

[2] Who do the service providers indicate have the mandate to co-ordinate services and who do they report should have this responsibility?

[3] Which of the following variables is related to whether or not service providers report that their agency is involved in a co-ordinated network: funding structures; ratio of paid staff to volunteer staff; opinion of who should co-ordinate services intraorganizational or interorganizational factors?

The second purpose of this study is to examine the service receivers' perception of their quality of life. The point of view of the chronic mental patient is often neglected because most research has focused on consumer satisfaction ratings instead of quality of life. Several problems have emerged with the use of consumer satisfaction ratings.

According to the literature, the general satisfaction level of mental health clients with service received is between 80-90% (Gove and Fain 1977; Spensley et al., 1980). It appears that consumer satisfaction data may not provide functional information for this study, because of the restricted variability of responses. Lebow (1983), based on a review of the consumer satisfaction literature, reports that no study has shown dissatisfaction levels above 10%. It is suggested that part of the reason for these inflated satisfaction levels may be due to a number of methodological problems such as sample selecting and social-psychological artifact (Gutek, 1978, Larson et al., 1979; Scheirer, 1978).

Several researchers have questioned the adequacy of having consumers judge treatment since there may be a distortion of satisfaction levels because of intensity of treatment and lack of experience in assessing treatment appropriately (Langs 1976, Scheirer 1978). Langs (1976) and Scheirer (1978) have indicated that consumer satisfaction data is not based on informed decision processes but rather on transference projections, cognitive dissonance, client characteristics, and unconscious processes. Based on the work by Simon (1965), Lamb (1979), Ludwig (1971) and Krauss and Slavinsky (1982) on the mental impairment of the chronically mentally ill discussed in an earlier section, it seems reasonable to question whether their impaired mental status will interfere with the decision process required to evaluate satisfaction with services in the community. Moreover, service receivers may not want to judge services for fear of reprisal.

Hence, in order to include service receivers in this research, quality of life is investigated rather than consumer satisfaction. Quality of life is examined using measures of: (1) life adjustment based on factors outlined by Krauss and Slavinsky (1982), which were - a need to be taken care of, a need for social interaction, a need for relief from psychiatric symptoms, a need for basic life necessities, and a need for hope, and (2) life satisfaction using an adapted version of the Bradburn Satisfaction Scale

More specifically, self-report data from the service receivers will explore the following questions

(1) What are the levels of life adjustment and life satisfaction for the chronically mentally ill?

(2) Are the psychosocial and physical dimensions of life adjustment separate measures of quality of life or are they related to life satisfaction levels?

For purposes of this research, individuals who are *chronically mentally ill* and requiring aftercare services are defined as persons in the community who have been diagnosed as being: schizophrenic or manic-depressive In addition, these individuals must have four or more of the following characteristics indicative of chronicity

- two or more psychiatric admissions in the past five years
- failed to follow through on post-discharge plans (including out-patient treatment)
- evidence of an unstable job/vocational history or ina[illegible] to obtain employment
- involvement with three or more community agencies or services

- frequent crises which have required professional attention/intervention
- a history of non-compliance with medication regimes
- a lack of a supportive social network (other than immediate family).

The term *co-ordination* is defined as the following factors present among service providers:

- lack of overlaps or gaps in services
- information sharing
- established communication and referral network
- awareness of services offered in the region
- success in interfacing with the service system

METHOD

This research was comprised of three phases. In the first phase, key individuals in two communities were interviewed. The second phase involved a mail survey to service providers in the two communities. In the last phase, service receivers (chronically mentally ill individuals) in both communities were surveyed using a mail questionnaire. Figure one shows a general overview of these three phases

FIGURE ONE - THE THREE PHASES

PHASE	PARTICIPANTS	METHOD OF DATA COLLECTION	PURPOSE
1	key persons in the community familar with the service delivery	in-person interview	to examine the quality and quantity of co-ordination; informal networks; and, opportunity to be in a co-ordinated network.
2	service providers	mail survey	to examine the perception of co-ordination; intraorganizational and interorganizational factors hypothesized to affect co-ordination
3	service receivers	mail survey	to examine the quality of life.

PHASE ONE - KEY INFORMANTS

Participants

The ten participants interviewed in this phase were key individuals familar with the service delivery system for the chronically mentally ill in the two communities. These participants were involved in the aftercare service system and were affiliated with a number of agencies in the community

Materials

Multiple choice and open-ended questionnaire (Key Informant Instrument-Appendix A)

Measures

The face-to-face interview was structured along the lines of a five-response-category, 7-item Likert scale with three additional open-ended items (Appendix A) The purpose of the interview was [1] to examine the perceived differences or similarities between the two communities in quality and quantity of co-ordination, [2] to explore perceptions of informal co-ordination networks, and [3] to attain perceptions of the opportunities to be in a co-ordinated network in both communities

Key individuals were also asked to examine and comment on the surveys for phases Two and Three of the research

Procedure

Key individuals were contacted by phone to arrange a 45-minute, in-person interview Respondents were met and interviewed at their respective work settings

PHASE TWO-SERVICE PROVIDERS

Participants

The Directors of 38 community organizations who served the chronically mentally ill in each of the two localities were asked to participate in the study

Materials

- Directory of Community Services for the Region 1983-1984 prepared by the Social Planning Council
- Letter of introduction to Service Providers (Appendix B)
- Multiple choice mail survey (Service Providers' Survey -Appendix C)

Measures

The purpose of the survey was to investigate the service providers' perception of (1) co-ordination; (2) intraorganizational factors, and (3) interorganizational factors The instrument utilized was a multiple choice and Likert format scale specifically designed for this research (Appendix C). This instrument was divided into two sections. Section A and Section B.

Section A

Five questions appeared in this section These items were concerned with service providers (1) location, (2) funding mechanism, (3) ratio of paid staff to volunteers; (4) knowledge of the existence of a co-ordination model; and (5) type of co-ordination model preferred.

This information was required to analyze variables that may affect the reported levels of co-ordination and interorganizational and intraorganizational factors.

Section B

A 22-item Likert scale with a five response category appeared in this section. Item responses ranged from "strongly disagree" to "strongly agree" with "neither agree nor disagree" as a mid-point. This scale examined: (1) service providers' perceptions of co-ordination, and (2) interorganizational and intraorganizational factors hypothesized to affect co-ordination.

(1) Service Providers' Perceptions of Co-ordination- These nine questions (items 2 - 11 inclusive) were concerned with service providers' perceptions of overlaps or gaps in services, information sharing, established communication and referral networks between agencies, awareness of services offered in the community, and the amount of success agencies experienced when dealing with the service delivery system.

(2) Interorganizational Factors- These six questions were concerned with the service providers' perceptions of factors between agencies in the community

hypothesized to affect co-ordination. These factors were:

[A] the interdependency among agencies in the service-delivery network - item #19

[B] the extent of complementary service goals among organizations - item #20

[C] the extent of similar philosophies of service delivery - items #14 and #22

[D] support from top levels in the organization to forming linkages - item #21

[E] security of funding - item #1

[3] Intraorganizational Factors- These six questions were concerned with service providers' perceptions of factors within their agency hypothesized to affect co-ordination. These factors were:

[A] internal control- items #12 and #13

[B] internal organization - items #15 and #16

[C] internal co-ordination - item #17

[D] flexible innovative leadership styles - item #18

Procedure

Each of the service providers who served the chronically mentally ill were mailed a letter of introduction and a survey (Appendix B and Appendix C). The major objectives of this survey were to research their perception of the co-ordination of services and to examine the structure of each organization.

In the letter to agency directors, the researcher informed each: How his or her organization was selected, the general goal of the study, how and when the data would be collected; and who was conducting the survey. Participants were assured they would receive a copy of the completed study if requested.

If the organization was committed to participate in the study, the contact person was asked to mail the survey back to the researcher within two weeks. A self-addressed stamped envelope was enclosed.

Organizations which did not return the survey within the two weeks were telephoned by the researcher to see if the agency did receive the information, had any questions, required more time to complete the survey, or did not wish to participate

Data analysis procedures will be discussed in the Results section.

PHASE THREE - SERVICE RECEIVERS

Participants

A sample of individuals classified as chronically mentally ill in each of the two communities participated in the study

Materials

- Letter of introduction for service organizations (Appendix D)
- Letter of introduction for service receivers (Appendix E)
- Service receivers' survey of Life Scale - Appendix F)

Measures

The instrument utilized was a multiple choice and Likert ~~format~~ scale specifically designed for the research (Appendix F)

The purpose of the survey was to examine quality of life using two measures. [1] life adjustment and [2] life satisfaction. In addition, the following personal data was obtained (items 1 - 7 inclusive) [1] geographic location [2] marital status [3] number of children [4] occurrence of in-hospital treatment and [5] satisfaction with the services in the community. For the purposes of controlling the number of surveys completed by each individual, the participants were asked their date of birth. One of two returned surveys with the same date of birth would be discarded

Life Adjustment Scale

The Life Adjustment Scale examined five psychosocial and physical dimensions using four multiple choice questions and seven Likert format questions.

More specifically, the Life Adjustment Scale examined the following factors:

[A] a need to be taken care of - items #10 and #11

[B] a need for social interaction - items #8 and #9

[C] a need for relief from psychiatric symptoms - item #12

[D] a need for basic life necessities - items #13, #14, #15, and #16

[E] a need for hope - items #17 and #18

Life Satisfaction Scale

The Life Satisfaction Scale was based on the Bradburn (1969) *Psychological Well-Being Scale*. Bradburn's scale was modified to have five response categories instead of two, with item responses ranging from "definitely yes" to "definitely no" and with "neither yes nor no" as a mid-point. The Bradburn Scale (1965) consists of two dimensions of affect. Positive and negative. The positive affect scale (PAS) was derived by weighing the response options to the five positive-oriented items (items 19, 20, 21, 24, 26) ranging from neutral-low, to moderately positive, to highly positive. The negative affect scale (NAS) was derived by weighing the response options to the five negative-oriented items (items 22, 23, 25, 27, 28) ranging from neutral-low, to moderately negative, to highly negative. The Affect Balance Scale combined the PAS and NAS into a single measure reflecting Life Satisfaction by balancing the [1] strongly positive [2] moderately positive [3] positive-negative [4] moderately negative and [5] strongly negative.

Procedure

Service agencies serving the chronically mentally ill were mailed a letter from the researcher informing them of the nature of the study and asking them to provide their clients with the survey (Appendix D). Service receivers (chronically mentally ill individuals) were given a letter of introduction (Appendix E) and a survey (Appendix F) through an agency that was serving them.

In the letter, the researcher outlined: the general goal of the study; how and when the data would be collected; and who was conducting the survey. Participants would be given a copy of the completed study if they wished by: [1] picking up a copy at the office of the service providers who originally gave them the survey, or [2] contacting the researcher.

The survey examined the ex-patients' Quality of Life using measures of Life adjustment and Life satisfaction.

The letter of introduction and the survey were given to the service receivers by the service providers. The service receivers were asked to answer only one survey, and return this survey to the researcher.

If the individual agreed to be a participant, she or she was asked to mail the survey back to the researcher within two weeks. A self-addressed stamped envelope was enclosed.

Data analysis procedures will be discussed in the Results section.

RESULTS

The results are presented in three separate sections. [1] the first section presents individual responses from the key informant interview, [2] the second section examines service providers' responses on co-ordination of services and intraorganizational and interorganizational variables; and, [3] the third section examines service receivers' responses to the Quality of Life Scale. All statistics were calculated using the Statistical Package for the Social Sciences Programme (SPSSX, Norusis, 1983)

RESULTS - SECTION 1

KEY INFORMANTS

Ten people participated in the face-to-face interview. These key informants were familar with the service delivery system in both the institutional care model and community care model. All ten individuals were asked questions pertaining to both communities.

Quantity/Quality of Co-ordination of Services

Respondents in key informant interviews (see Appendix A for interview formats) were asked to rate the two communities on both quantity and quality of perceived co-ordination (see Table 2).

Quantity of Co-ordination of Services

In the institutional care model, quantity of co-ordination of services was rated moderate by 20% and low by 80%. In the community care model, quantity of co-ordination of services was rated as moderate by 50%, low by 25% and high by 25%.

Quality of Co-ordination of Services

In the institutional care model, quality of co-ordination of services was rated as low by 40% and very low by 60% of respondents. In the community care model, quality of co-ordination of services was rated moderate by 37.5%, low by 25%, and very low by 37.5%

Overall Co-ordination of Services

Analysis of data from interview respondents on quality and quantity of co-ordination yielded the following results:

[1] Key informants indicated that the community care model had more co-ordination than the institutional care model.

[2] Key informants indicated that the community care model had a higher quality of co-ordination than the institutional care model.

[3] In each community the amount of co-ordination of services was reported as being higher than the quality of co-ordination.

Content analysis was used to examine open-ended questions. Respondents attributed differences between the two communities in co-ordination of services to, [1] differences between the two areas in treatment philosophies, [2] homogeneity of treatment philosophies within each community, and [3] size of the community

TABLE 2

FREQUENCY DATA ON QUALITY AND QUANTITY OF CO-ORDINATION OF SERVICES

	VERY HIGH	NEITHER HIGH/LOW	LOW	VERY LOW
QUANTITY OF CO-ORDINATION				
<u>Community 1*</u> (TOTAL=8)	2	4	2	
<u>Community 2*</u> (TOTAL=10)		2	3	
QUALITY OF CO-ORDINATION				
<u>Community 1*</u> (TOTAL=8)		3	2	3
<u>COMMUNITY 2*</u> (TOTAL=10)			4	6

*COMMUNITY 1 = COMMUNITY CARE MODEL
*COMMUNITY 2 = INSTITUTIONAL CARE MODEL

Differences Between the Two Communities on Treatment Philosophies

Key informants indicated that the two communities did have different care models: [1] the community care model used an ambulatory care model for dealing with the chronically mentally ill client, and, [2] the institutional care model used a hospitalization model. Some key informants reported that co-ordination of services was considered more important in the community care model because all services had to be offered without the use of in-patient hospital settings. Failure to provide necessary community services required by the chronically mentally ill clients would result in the removal of the individual from her or his community and admittance to an out-of-town hospital. The hospitalization of a client was seen as a last resort and considered a failure of the ambulatory model. Several respondents reported that although the community with the community care model had been offered funding for in-patient care, the offer was not accepted. In the institutional care model, key informants reported that recidivism of the client was not viewed as a treatment failure. Moreover, institutions were reported as showing little concern for the co-ordination of services between their setting and the community.

Homogeneity of Treatment Philosophies Among Service Providers in each Community

The homogeneity of treatment philosophies was identified as a factor affecting differences in co-ordination between the two communities. Service agencies in the community care model were all viewed as operating from the community-based, ambulatory care philosophy, while service agencies in the institutional care model were not seen as having similar treatment philosophies. Key informants reported that many service agencies in the institutional care model operated from a community-based philosophy One respondent said that there was a feeling of "we" and "they" between the different agencies operating from different treatment philosophies in the health care system. Respondents indicated that they had witnessed these two different patterns of care in the institutional care model creating conflict affecting co-ordination of services.

Key informants reported that the agencies they were affiliated with in the institutional care model were involved in small, co-ordinated networks with other service providers operating out of a similar philosophy of care One respondent stated that many service providers' operating from similar treatment philosophies had worked together at some time. when people changed jobs they kept their contacts A lack of overall co-ordination of services resulted from the existence of these small networks

Size of the Communities

The size of the two communities was viewed as an important factor affecting co-ordination of services While the community with the institutional care model was very large and geographically spread out, the community with the community care model was small with agencies within close proximity (i e , many community-based agencies shared facilities with the Community Mental Health Centre)

Informal Networking in the Communities

Table 3 presents the frequency distribution from key informants on questions dealing with informal networking in the two communities.

Overall, respondents stated that it was "common" or "very common" for service providers in the institutional care model to meet informally (70%). For the community care model (62.5%) stated it was "common" or "very common" for service providers to meet informally. For the institutional care model, no respondent indicated that it was "uncommon" for service providers to meet informally whereas in the community care model twenty-five percent (25%) believed it was "uncommon".

Responses to open-ended questions indicated that in the institutional care model individuals from service agencies who met informally and exchanged information on co-ordination of services all had similar positions in the delivery system (i.e., Directors, Board Members, Administrators). Specifically, front-line workers who directly dealt with chronically mentally ill clients were not included in these informal sessions because the communication occurred during breaks at board meetings. Administrative personnel were more likely to be members of various boards and therefore to be involved in informal exchanges of information. Respondents commented that front-line workers would benefit the most from informal discussions on co-ordination of services.

TABLE 3

FREQUENCY DATA ON INFORMAL CO-ORDINATION NETWORKS

	VERY COMMON	COMMON	NEITHER COMMON/ UNCOMMON	UNCOMMON	VERY UNCOMMON
HOW COMMON FOR SERVICE PROVIDERS TO MEET INFORMALLY?					
Community 1* (TOTAL=8)	2	3	1	2	
Community 2* (TOTAL=10)	4	3	3		

*COMMUNITY 1 = COMMUNITY CARE MODEL
*COMMUNITY 2 = INSTITUTIONAL CARE MODEL

RESULTS - SECTION TWO

SERVICE PROVIDERS

Results from the mailed out service providers' survey (See Appendix C) are presented in two separate sections. [1] the first, referred to as preliminary analysis, presents a factor analysis of the survey instrument for service providers; and [2] the second, referred to as major analyses, examines three of five factors extracted from the factor analysis (labelled co-ordination, intraorganizational perceptions, and interorganizational perceptions) in relation to the experimental questions.

PARTICIPANTS

Of the 80 agencies sampled, 10 stated that their agency was not involved with the chronically mentally ill. Fifty-three of the remaining seventy agencies responded to the survey: 18 agencies in the community with the community care model, a 90% response rate, and 35 agencies in the community with the institutional care model, a 72% response rate. All respondents were either directors of the agency or held equivalent positions.

Funding Structures - Funding structures were similar for most participants. 59% of the service providers in the community care model received government funding, 12% community donations and, 29% received a combination of government funding, community donations, and fees from clients. In the community with the institutional care model, 58% of service providers received government funding, 18%

received community donations, 1% received fees from clients, and 23% received a combination of government funding, community donations, and fees from clients

Ratio of Volunteers to Paid Staff - Participants were similar on the number of volunteers to paid staff. Seventy percent of service providers in the community care model had 0-20% volunteers on staff; twelve percent had 21-40% volunteers on staff, six percent had 61-80% volunteers on staff, and, twelve percent had 81-100% volunteers on staff In the institutional care model, sixty-eight percent had 0-20% volunteers on staff, twelve percent had 21-40%, eight percent had 61-80%, and twelve percent had 81-100%.

PRELIMINARY ANALYSIS

Factor Analysis

Factor analysis was conducted to determine the degree of association of scale items and to extract empirically derived groupings among the items This preliminary analysis is a data reduction technique that provides (a) a battery of intercorrelated variables having common factors, which can be more precisely represented in terms of these reference factors, and (b) common factor loadings indicating the nature and extent of correlations between variables (Kim & Mueller, 1978a, 1978b).

The responses on the service providers' survey were analyzed using the FACTOR sub-program in SPSSX Each survey scale item categorized by the researcher as measuring co-ordination, interorganization perceptions, and intraorganization perceptions, was scored on a 5-point Likert-type scale from (1) for "strongly disagree" to (5) for "strongly agree".

All missing values were replaced with the variable mean; hence all cases were used in the factor analysis and substitutions were treated as valid responses (i.e. MEANSUB.SPSSX). Initial factors were extracted from the correlation matrix using the Principal-components technique (Harman & Jones, 1966). Factors extracted were rotated to orthogonal simple structure using the Varimax solution. After rotation, 5 factors with eigenvalues greater than 1.0 emerged. These factors together accounted for 53.5% of the variance with factors contributing 22.3%, 11.6%, 7.9%, 6.0%, and 4.7%.

Factor loadings on the Rotated Factor Matrix which were smaller in magnitude than .50 were eliminated from further analysis. Tables 4, 5, 6, 7, and 8 present variables belonging to each of the five factors.

Scales in Service Providers' Survey Instrument

Factor analysis indicated that items used to measure co-ordination, interorganizational perceptions and intraorganizational perceptions were grouped together in distinct ways as hypothesized. Variables in factor 1 can be labelled *co-ordination*, variables in factor 2 can be labelled *intraorganizational perceptions*, and variables in factor 4 labelled *interorganizational perceptions*. As indicated in Table 4, co-ordination is measured using five variables. Intraorganizational perceptions, as indicated in Table 5, are measured using four variables, which all pertain to how respondents perceive the internal workings of the agency. As indicated in Table 7, interorganizational perceptions are measured using two variables concerning how the agencies view themselves in relationship to other service providers.

There are several important issues relating to factors 1, 2, and 4 represented in Table 4, 5, and 7 respectively. Factor 1, the co-ordination factor, has five items with factor loadings varying in magnitude from .55 to .80. The total amount of variance accounted for by this factor is high-22.3 %. Factor 2, the intraorganizational perceptions factor, has four items with factor loadings varying in magnitude from .53 to .89. The total amount of variance explained by this factor is relatively high, 11.6%. Factor 4, interorganizational perceptions factor, has only two items with factor loadings between .59 to .65. The total amount of variance explained by interorganizational perceptions is 6%. Comparatively, this factor is weak because (1) only two items loaded on the factor; (2) the magnitude of the factor loadings is only at the criterion level (.5) or just above, (3) total variance accounted for is only 6%, and (4) the items loaded on the factor appear on the service providers' survey as sequential questions, raising the question of survey bias. However, the interorganizational perceptions factor will be included in further analysis because it was based on strong theoretical considerations. Moreover as Table 9 indicates, the interorganizational perception factor did not correlate with other factors above the .5 level. Table 10 indicates that the two items in factor 4 did not correlate with other items in the other factors. Therefore while there is a weak component in this factor, eliminating it from further analysis is not warranted.

Variables in factors 3 and 5 indicated new entities. Factor 3 can be labelled *attitudes* and factor 5 *referrals* for this study. Variables in each of the two factors are presented in Tables 6 and 8 respectively.

Analysis of the five factors raises some interesting issues. Factor 1, *co-ordination*, consists of four items originally conceptualized as measuring co-ordination, and an additional item pertaining to strong directive leadership in any agency. This indicates that the internal variable of leadership is related to how much agencies in the community co-ordinate their efforts. Factor 2, *intraorganizational perceptions*, consists only of items which were originally conceptualized as measuring the internal workings of an agency. Factor 4, *interorganizational perceptions*, consists of two items which were originally conceptualized as measuring an agency's percept[illegible] of other service providers in their community.

Items in factor 3, *attitudes* and factor 5 *referral* are particularly interesting. In factor 3, each one of the three items originally was conceptualized as measuring co-ordination, intraorganizational perceptions, and interorganizational perceptions, yet the items loaded heavily in the same factor. Specifically, an agency's belief that co-ordination is important, encouragement of staff to form co-operative relationships with other agencies, and the agency reports of financial security, all seem to be related in some way. Factor 5 indicates that receiving referrals from other service providers is linked to being knowledgeable about other agencies in the community. This finding is not very surprising since being knowledgeable about other agencies may in fact make the agency higher in profile and therefore more likely to receive referrals. There are many other possible explanations. For example, perhaps being knowledgeable about other agencies makes an agency seem more open and co-operative and therefore it is more likely to have clients sent from other service providers. It is interesting to note, however, that these factor items are not related to co-ordination as hypothesized. It was expected that receiving referrals and being knowledgeable about other agencies would be items which contributed to increased co-ordination.

The scales measuring co-ordination, interorganizational perceptions, and intraorganizational perceptions have very promising elements. In reference to factors 3 and 5, it is possible that there are more items which are related to these factors that were not drawn out in the survey. Further test refinement will help to establish the validity of these factors. However, test refinement is beyond the scope of this present research.

Pearson-Product Correlation Coefficients were computed between the five factors using the factor mean. Table 9 presents the correlation matrix. Correlation coefficients range from .08 to .5 indicating a low to moderate relationship between factors. This finding indicates that a high relationship between factors does not exist.

Items within the five factors were analyzed using the RELIABILITY sub-program in SPSSX. Procedure RELIABILITY performs an item analysis on the components in factors by computing commonly used coefficients of reliability. Reliability definitions and estimates were made using Alpha Model; the overall alpha was .8237. The alpha associated with: factor 1 (co-ordination) was .8144; factor 2 (intraorganizational perceptions) was .8423; factor 3 (attitude) was .6500; factor 4 (interorganizational perceptions) was .7098; and factor 5 (referral) was .6981.

Since the main focus in this thesis is on co-ordination, interorganizational perceptions, and intraorganizational perceptions, these factors will be used in further analyses. Co-ordination, interorganizational perceptions and intraorganizational perceptions will be examined under the section labelled *Major Analyses*. Readers interested in the two additional factors (attitudes and referrals) should refer to Appendix G for statistical analyses.

It should be noted that in all the subsequent analyses, an average score on each of the five factors will be used. This average score was derived by adding up the numerical response on each item in the factor and dividing by the number of items. Hence, each respondent has one overall score for each of the five factors.

TABLE 4

VARIMAX ROTATED PRINCIPAL COMPONENTS LOADINGS FOR FACTOR 1

ITEM	CO-ORDINATION FACTOR
11. Agencies in the community work well together	.80050
9. Agencies in the community communicate	.74544
5. Co-operative information sharing between agencies	.72987
12. Agency has a strong directive leadership	.61817
10. Patients/clients are linked efficiently with services in the community	.55118
Eigenvalues	4.90495
% Total Variance	22.3

TABLE 5

VARIMAX ROTATED PRINCIPAL COMPONENTS LOADINGS FOR FACTOR 2

ITEM	INTRAORGANIZATIONAL PERCEPTIONS FACTOR
15. Agency has a clear framework	.89704
16. Agency has a sense of collaboration	.78583
13. Agency notices if staff disobey rules	.77824
17. Agency is well co-ordinated	.53153
Eigenvalue	2.55719
% Total Variance	11.6

TABLE 6
VARIMAX ROTATED PRINCIPAL COMPONENTS LOADINGS FOR FACTOR 3

ITEM	ATTITUDE FACTOR
2. Agency believes co-ordination is important	.73991
21. Agency encourages staff to form co-operative relationships with other agencies	.58888
1. Agency is financially secure	.51962
Eigenvalue	1.74338
% Total Variance	7.9

TABLE 7
VARIMAX ROTATED PRINCIPAL COMPONENTS LOADINGS FOR FACTOR 4

ITEM	INTERORGANIZATIONAL PERCEPTIONS FACTOR
19. Belief that agencies in the community are interdependent	.65201
20. Belief that other agencies in the community have complementary service goals	.59987
Eigenvalue	1.32080
% Total Variance	6.0

TABLE 8
VARIMAX ROTATED PRINCIPAL COMPONENTS LOADINGS FOR FACTOR 5

ITEM	REFERRAL FACTOR
7. Agency receives referrals from other service providers	.92035
6. Agency is knowledgeable about other agencies in the community	.55923
Eigenvalue	1.03377
% Total Variance	4.7

TABLE 9
PEARSON CORRELATION COEFFICIENTS BETWEEN FIVE FACTORS

	FACTOR 1 (CO)	FACTOR 2 (INTRA)	FACTOR 3 (ATT)	FACTOR 4 (INTER)	FACTOR 5 (REF)
CO	1.000	.3899 p=.002	.2682 p=.029	.5154 p=.000	.1563 p=.137
INTRA		1.0000	.3425 p=007	.4222 p=.001	.0985 p=.246
ATT			1.0000	.2063 p=073	.3724 p=004
INTER				1.0000	.0869 p=.272
REF					1.0000

MAJOR ANALYSES

This section examines factors that measure co-ordination, interorganizational perceptions, and intraorganizational perceptions in relation to the experimental questions

After each experimental question two sections are presented. [1] analysis, and [2] summary and comments The analysis section presents the statistical procedures and findings. The summary and and comments section expands on the findings.

Two statistical procedures were utilized to analyze data from the service providers' survey [a] t-test, and, [b] multiple regression analysis T-tests compare means by calculating Student's t and testing the significant difference between the means. Multiple regression analysis was used to study the relationship between a dependent variable and a set of independent variables. The method specified to build the multiple regression equation was forward stepwise selection. This process entered variables eligible for entry by calculating F values, and removed variables that were no longer useful from the equation (Pedhazur, 1982).

EXPERIMENTAL QUESTION #1

Is there a difference between the two communities in the reported level of co-ordination, interorganizational perceptions, or intraorganizational perceptions?

Analysis

T-tests were performed on data from the community care model and the institutional care model to determine if there was any statistical significance between communities on service providers' self-reported data about co-ordination, interorganizational perceptions, and intraorganizational perceptions. Missing values were replaced with the variable mean hence, all cases were used in the T-test and substitutions were treated as valid responses.

On a five-point scale, the mean response on co-ordination, interorganizational perceptions, (i.e., belief that agencies in the community are interdependent and have complementary service goals) and intraorganizational perceptions (i.e., agency has a clear framework, and a sense of collaboration) in the community care model was 2.8, 4.1, and 3.0 respectively. Responses ranged from 1.0-4.2 for co-ordination, 2.0-5.0 for intraorganizational perceptions, and 1.0-5.0 for interorganizational perceptions. The mean response from the institutional care model on co-ordination, interorganizational perceptions, and intraorganizational perceptions was 3.2, 4.1, and 3.3 respectively. Responses ranged from 1.8-4.4 for co-ordination, 2.0-5.0 for intraorganizational perceptions, and 2.0-5.0 for interorganizational perceptions.

Results of the t-tests indicated that service providers' perceptions of co-ordination in the institutional care model were significantly higher than in the community care model, [$F(49) = 2.45$, $p < .05$]. Interorganizational perceptions [$F(49) = 1.37$, $p > .05$] and intraorganizational perceptions [$F(49) = 1.64$, $p > .05$] were not found to be significantly different in the two communities.

Summary and Comments

The institutional care model reported a significantly higher level of co-ordination than the community care model. This finding was contrary to perceptions of key informants. Several possible explanations for this finding may be proposed. There may be more effort in the community with the institutional care model to co-ordinate services in an effort to compensate for the size of the community. As noted earlier the institutional care model is utilized in a community which is very large and geographically spread out. Key informants reported that meeting informally and discussing co-ordination of services does not occur more in one community than in the other. Therefore, meeting informally to discuss co-ordination may not be a factor in understanding the statistically higher perceived levels of co-ordination in the community with the institutional care mod[illegible]

As predicted, both communities reported low to moderate levels of co-ordination. This finding supports the work (by the General Accounting Office, 1978, Gilbert and Specht, 1977, Halpert, 1970, and Lamb, 1976) which specifies that services in the community are unco-ordinated. Since there is little incentive to co-ordinate this finding is not surprising. Many other factors also may be affecting co-ordination at the local level.

It is interesting to note that interorganizational perceptions (i.e., belief that agencies in the community are interdependent and have complementary service goals) in both communities were fairly high (4.1), with intraorganizational perceptions (i.e., agency has a clear framework, sense of collaboration, is well co-ordinated) at the mid-range (3 0, 3.3). Key informants had reported that there were differences among agencies in the institutional care model on treatment philosophies. Therefore, it might have been suspected that interorganizational perceptions would have been much lower in the community with the institutional care model because these perceptions deal specifically with inter-agency relations Key informants may not have been informed on co-ordination of services in the two communities

This analysis indicates that service providers do feel strongly that agencies are interdependent and have complementary service goals, yet they disagree that agencies in the community work well together, communicate, share information, and link patients efficiently with services in the community

EXPERIMENTAL QUESTION #2

Who do the service providers indicate has the mandate to co-ordinate services and who do they indicate should have this responsibility?

Analysis

Who has the Mandate to Co-ordinate Services

COMMUNITY CARE MODEL - Overall, 41% of respondents indicated that the Ministry of Health has the mandate to co-ordinate services; 12% District Health Council; 29% Canadian Mental Health Association; and 18% other agencies. Respondents who believed agencies other than those listed on the survey had the mandate to co-ordinate services reported these agencies to be: [1] the Ministry of Health with the Community and Social Services; or [2] Ministry of Health, District Health Council, and Canadian Mental Health Association.

INSTITUTIONAL CARE MODEL - Overall, 30% of respondents indicated that the Ministry of Health has the mandate to co-ordinate services; 1% Ministry of Community and Social Services, 1% Social Resources Council, 26% District Health Council, 15% Canadian Mental Health Association; 26% indicated that nobody had this responsibility; and 1% indicated that other agencies had the mandate to co-ordinate services. Respondents who believed agencies other than those listed on the survey had the mandate to co-ordinate services reported these agencies to be, [1] the Ministry of Health with the Community and Social Services, or [2] the District Health Council with the Canadian Mental Health Association.

Who Should Have the Mandate to Co-ordinate Services

COMMUNITY CARE MODEL - Overall, 41% of respondents indicated that the Ministry of Health should have the mandate to co-ordinate services; 18% District Health Council; 29% Canadian Mental Health Association; and 12% other agencies should have the mandate to co-ordinate services. Respondents who believed agencies other than those listed on the survey should have the mandate to co-ordinate reported several alternatives: an independent co-ordination office, Ministry of Health with Community and Social Services; Community Mental Health Clinic; coalition of groups who plan together; and Ministry of Health Services.

INSTITUTIONAL CARE MODEL - Overall, 26% of respondents indicated that the Ministry of Health should have the mandate to co-ordinate services, 29% District Health Council, 20% Canadian Mental Health Association, 1% Ministry of Community and Social Services; 1% Social Resources Council, 1% nobody should have the responsibility; and 22% indicated that other agencies should have the mandate to co-ordinate services. Respondents who believed agencies other than those listed on the survey should have the mandate to co-ordinate reported several alternatives: an independent co-ordination office, Ministry of Health with Community and Social Services; coalition of groups who plan together; and Ministry of Health Services.

Summary and Discussion

It is interesting to note that only service providers from the institutional care model knew that nobody had the responsibility to co-ordinate services, however, the percentage was still low (26%).

Service providers assume that co-ordination was the responsibility of some government body both in the community care model and institutional care model (53% and 56% respectively). There may be an attitude in the two communities that agencies are not expected to make co-ordinated efforts because the Ministry of Health or District Health Council provides direction in networking.

Furthermore, with co-ordination being perceived as being low (community care model) or in the middle range (institutional care model), it is very interesting that 59% in the community care model and 56% in the institutional care model believed that the government should have the mandate to co-ordinate services. This indicates that even though the government was assumed to be the co-ordinating body by over half of the respondents, and co-ordination was perceived as being only low to moderate, service providers still wanted the government to have the responsibility

The Canadian Mental Health Association was indicated by 15% of service providers in the community care model and 20% in the institutional care model as an agency which should have the mandate to co-ordinate services. This agency was the only non-governmental service provider which was thought to be a good organization for co-ordinating services

EXPERIMENTAL QUESTION #3

Which of the following variables is related to whether or not service providers report that their agency is involved in a co-ordinated network: funding structures, ratio of paid staff to volunteer staff, belief of who should co-ordinate services, intraorganizational perceptions, and interorganizational perceptions?

Analyses

Two separate regression analyses were computed in which (1) funding structures, ratio of paid staff to volunteer, belief of who should co-ordinate services, intraorganizational perceptions, and interorganizational perceptions were regressed on co-ordination and, (2) additional predictors of attitude and providing referrals were regressed on co-ordination. The forward stepwise procedure was utilized for both analyses.

Results are summarized in Table 10.

When funding structures, ratio of paid staff to volunteer, belief of who should co-ordinate services, intraorganizational perceptions (factor 2), and interorganizational perceptions (factor 4) were regressed on co-ordination, the interorganizational perceptions factor was found to significantly account for 26% of the variance [$F(1,51) = 18.25$, $p < .0001$]. No other independent variable was significant.

When the two additional factors (attitudes and referrals) were regressed on co-ordination, both predictors failed to significantly explain any further variance in the dependent variable of co-ordination.

Summary and Discussion

It was indicated by service providers that the reported level of co-ordination in a community was related to an agency's interorganizational perceptions (i.e., belief that agencies in the community are interdependent and have complementary service goals). Therefore, it was demonstrated that interorganizational perceptions played a role in determining the perceived level of co-ordination reported by a service provider. This finding may support the work by Marks and Broskowsky (1981) where interorganizational factors were said to affect co-ordination at the local service provision level. It is important to consider, however, that the interorganizational perceptions factor (factor 4) was relatively weak.

It is interesting to note that no other independent variable played a significant role in determining the level of co-ordination. Marks and Broskowsky (1981) concluded that intraorganizational relationships affected co-ordination. This finding was not supported by the present research. This research also did not support the finding by Gilbert & Specht (1974,1977), that a main issue in co-ordination of services was the relationship between public and voluntary agencies. Gilbert and Specht (1974;1977) stated that public agencies were more likely to be involved in a co-ordinated network than either voluntary or private organizations. Funding structures were utilized in the present research to categorize an agency as being either voluntary or public. However, the present research does indicate that all types of agencies are experiencing co-ordination in the same way. Based on previous analysis it may be said that this level of co-ordination is low. This finding supports the work by Clark (1976), and The Social Planning Council of Metropolitan Toronto (1970), where it was shown that agencies experience the system as unco-ordinated.

TABLE 10 - SUMMARY TABLE
REGRESSION OF INDEPENDENT VARIABLES ON CO-ORDINATION

PREDICTORS	MULTIPLE R	R SQUARE	df	F	p
Interorganizational perceptions (TOTAL=52)	.513	.263	(1,51)	18.25	.0001
Intraorganizational perceptions (TOTAL=52)	.251	.063	(1,51)	3.96	ns
Attitudes (TOTAL=52)	.233	.054	(1,51)	2.24	ns
Referrals (TOTAL=52)	.127	.016	(1,51)	1.10	ns
Should have the mandate to co-ordinate (TOTAL=52)	.108	.012	(1,51)	.80	ns
Ratio of paid staff to volunteer (TOTAL=52)	-.070	-.005	(1,51)	.33	ns
Has the mandate to co-ordinate (TOTAL=52)	.060	.004	(1,51)	.23	ns
Funding structure (TOTAL=52)	.038	.001	(1,51)	.09	ns

SUMMARY - SECTION 2 - SERVICE PROVIDERS

Factor Analysis extracted five factors which were labelled co-ordination, intraorganizational perceptions, attitudes, interorganizational perceptions, and referrals. It was indicated that the measures utilized for co-ordination, interorganizational perceptions, and intraorganizational perceptions were very promising. The factor labelled interorganizational perceptions was found to be fairly weak. However, due to theoretical considerations used to form questions pertaining to relations between agencies, this factor was found to be useful in further analyses. All three factors of co-ordination, intraorganizational perceptions, and interorganizational perceptions were used in the analyses. It was suggested that in future research, the two additional factors of attitudes and referrals be analyzed further for validity by test refinement

Service providers in a community with a community care model reported co-ordination as being low; and a community with an institutional care model, an area said by key informants to be unco-ordinated, reported a statistically higher level of co-ordination Co-ordination in both communities was rated "low" to "neither low nor high" Therefore, respondents indicated that their perception of co-ordination of services in their own community is significantly different. Interorganizational perceptions in both communities were high, indicating that organizations strongly believed that agencies in the community were interdependent and had complementary service goals. Intraorganizational perceptions in both communities, measured by conditions within the organization (i.e., a clear framework, sense of collaboration, co-ordination, and awareness of staff disobedience), were in the middle range.

The belief that the Ministry of Health/District Health Council currently has mandate to co-ordinate services was held by 59% of service providers in the community care model and by 55% in the institutional care model (although in reality nobody has this mandate). Only 26% of the service providers were aware that no agency had the mandate to co-ordinate services. All 26% of the respondents answering correctly were in the institutional care model. An overwhelming number of service providers responded that the Ministry of Health/District Health Council should have this responsibility: 59% in the community care model, and, 55% in the institutional care model.

There were no significant differences between the community with the community care model or institutional care model in which agency they believed presently had the mandate to co-ordinate services or should have this responsibility.

Marks & Broskowski (1981) indicate that interorganizational and intraorganizational perceptions can either hinder or enhance co-ordination. This study has demonstrated that interorganizational perceptions (i.e., belief that agencies in the community are interdependent and have complementary service goals) made a significant difference in determining the reported level of co-ordination. Intraorganizational perceptions (i.e., agency has a clear framework, sense of collaboration, is well co-ordinated) were not shown to make a significant difference in determining the reported level of co-ordination.

RESULTS - SECTION 3

SERVICE RECEIVERS

Results from the service receiver survey (See Appendix F) are presented in two sections: [1] the first section, referred to as preliminary analyses, presents the scoring on the Quality of Life Scale, and also examines items in the service receivers' quality of life scale; and [2] the second section, referred to as major analyses, examines specific experimental questions.

There was one statistical procedure utilized in this section: Pearson Correlation Coefficients. Pearson correlation produced a matrice of correlation coefficients indicating the relationship between various items. In a correlation matrix, coefficients may range in value from -1.00 to 1.00 with 0 indicating no relationship.

PARTICIPANTS

Location - All 42 respondents resided in the community with the institutional care model.

Marital Status - Sixty-seven percent (67%) of respondents were single, twelve percent (12%) widowed, nine percent (9%) separated, five percent (5%) married, five percent (5%) divorced, and two percent (2%) living common-law.

Number of Children - Forty-seven (47%) of respondents did not have any children, thirty-three percent (33%) had one, and twenty percent (20%) had two or more.

In Hospital Treatment - Sixty-seven percent (67%) of respondents had been hospitalized for emotional problems and thirty-three percent (33%) were unsure if they had been in the hospital for treatment. No respondent reported that they had never been in hospital for emotional problems.

Length of Time in the Community - Thirty-one percent (31%) of respondents who had been hospitalized for emotional problems had been in the community for under one year; nineteen percent (19%) for one to two years; seven percent (7%) had been in the community for three-four years; and, fourteen percent (14%) for five years or more. Although only sixty-seven percent (67%) of the respondents had been in the hospital for emotional problems, seventy-one (71%) answered this section. Therefore it can be assumed that four percent (4%) of respondents unsure if they had been hospitalized for emotional problems answered this section.

Satisfaction with Services in the Community Seventy-five percent (75%) of the respondents reported that they were either satisfied (52%) or very satisfied (23%) with services in the community. Fourteen percent (14%) were neither satisfied or dissatisfied while only eleven percent (11%) reported they were not satisfied (9%) or very dissatisfied (2%) with services in the community. This finding is consistent with consumer satisfaction literature (Gove and Fain 1977, Spensley et al., 1980) which indicates that the general satisfaction level of mental health clients with service received is very high.

7

PRELIMINARY ANALYSES

Scoring of Service Receivers' Survey

Life Adjustment Scale - Responses were scored on a 5-point Likert type scale from (1) "definitely no" to (5) "definitely yes". The following subscales were derived from this measure: [1] need for social interaction; [2] need for hope; [3] need for life necessities; [4] need for relief from psychiatric symptoms; [5] need to be taken care of. Subscales which had more than one item pertaining to them, were averaged across items.

Life Satisfaction Scale - Positive affect items were scored on a 5- point Likert type scale from (1) "definitely no" to (5) "definitely yes". Items which measured negative affect were scored on a 5-point Likert type scale from (1) "definitely yes" to (5) "definitely no".

Analysis

Prior to the examination of specific questions, preliminary data analysis was conducted to assess the relationships between variables.

All items were correlated and a Pearson product moment correlation matrix was obtained. Table 11 presents these results. The Pearson product moment

TABLE 11 - PEARSON PRODUCT CORRELATION MATRIX

	SOCINT	CARE	RELIEF	LIFEHEC	HOPE	SPLEASED	SWAY	SPROUD	SREST	SBORED	SEXCITED	SLONELY	STOP	SANGR
SOCINT	1.0000 (42) P= .	.1806 (41) P= .129	.1052 (42) P= .254	.0335 (42) P= .417	.3344 (41) P= .016	.0652 (41) P= .343	-0.1953 (41) P= .111	-0.0819 (41) P= .305	-0.2553 (41) P= .054	.1661 (40) P= .153	-0.0322 (40) P= .422	.2690 (41) P= .045	-0.2061 (41) P= .098	-0.240 (41) P= .06
CAPL	.1806	1.0000	.3552	.4850	.1468	.2729	-0.3973	-0.3488	-0.0994	-0.0309	-0.2141	.0930	-0.0319	-0.079
	(41) P= .129	(41) P= .	(41) P= .011	(41) P= .001	(40) P= .183	(40) P= .044	(40) P= .006	(40) P= .014	(40) P= .271	(39) P= .426	(39) P= .095	(40) P= .284	(40) P= .423	(40 P= .31
RELIEF	.1052 (42) P= .254	.3552 (41) P= .011	1.0000 (42) P= .	-0.0246 (42) P= .439	.1022 (41) P= .262	.0947 (41) P= .278	.0081 (41) P= .480	-0.2498 (41) P= .058	.0029 (41) P= .493	.0921 (40) P= .286	.0326 (40) P= .421	.1653 (41) P= .151	.0841 (41) P= .301	.043 (41 P= .39
LIFEHEC	.0335 (42) P= .417	.4850 (41) P= .001	-0.0246 (42) P= .439	1.0000 (42) P= .	-0.1062 (41) P= .254	.0929 (41) P= .282	-0.5040 (41) P= .000	.0059 (41) P= .485	-0.1840 (41) P= .125	.0121 (40) P= .471	-0.3253 (40) P= .020	.2241 (41) P= .080	.1023 (41) P= .262	-0.063 (41 P= .34
HOPE	.3344 (41) P= .016	.1468 (40) P= .183	.1022 (41) P= .262	-0.1062 (41) P= .254	1.0000 (42) P= .	.1012 (42) P= .262	.2449 (42) P= .059	-0.1343 (42) P= .198	.2325 (42) P= .069	.1246 (41) P= .219	-0.1088 (41) P= .249	.1355 (42) P= .196	-0.1661 (42) P= .147	.058 (42 P= .35
SPLEASED	.0652 (41) P= .343	.2729 (40) P= .044	.0947 (41) P= .278	.0929 (41) P= .282	.1012 (42) P= .262	1.0000 (42) P= .	-0.1759 (42) P= .133	.0593 (42) P= .355	-0.1172 (42) P= .230	.0660 (41) P= .341	-0.1393 (41) P= .193	.1978 (42) P= .105	-0.0443 (42) P= .390	.158 (42 P= .15
SWAY	-0.1953 (41) P= .111	-0.3973 (40) P= .006	.0081 (41) P= .480	-0.5040 (41) P= .000	.2449 (42) P= .059	-0.1759 (42) P= .133	1.0000 (42) P= .	.2022 (42) P= .099	.4315 (42) P= .002	-0.0475 (41) P= .384	.2726 (41) P= .042	.0851 (42) P= .296	-0.0329 (42) P= .418	.184 (42 P= .12
SPROUD	-0.0819 (41) P= .305	-0.3488 (40) P= .014	-0.2498 (41) P= .058	.0059 (41) P= .485	-0.1343 (42) P= .198	.0593 (42) P= .355	.2022 (42) P= .099	1.0000 (42) P= .	.0472 (42) P= .383	.0474 (41) P= .384	.1773 (41) P= .134	.2111 (42) P= .090	.1131 (42) P= .238	-0.128 (42 P= .20
SREST	-0.2553 (41) P= .054	-0.0994 (40) P= .271	.0029 (41) P= .493	-0.1840 (41) P= .125	.2325 (42) P= .069	-0.1172 (42) P= .230	.4315 (42) P= .002	.0472 (42) P= .383	1.0000 (42) P= .	.0594 (41) P= .356	-0.0531 (41) P= .371	.0182 (42) P= .454	.1645 (42) P= .149	.437 (42 P= .00
SBORED	.1661 (40) P= .153	-0.0309 (39) P= .426	.0921 (40) P= .286	.0121 (40) P= .471	.1246 (41) P= .219	.0660 (41) P= .341	-0.0475 (41) P= .384	.0474 (41) P= .384	.0594 (41) P= .356	1.0000 (41) P= .	.1500 (41) P= .175	-0.0132 (41) P= .467	.0940 (41) P= .279	-0.052 (41 P= .37
SEXCITED	-0.0322 (40) P= .422	-0.2141 (39) P= .095	.0326 (40) P= .421	-0.3253 (40) P= .020	-0.1088 (41) P= .249	-0.1393 (41) P= .193	.2726 (41) P= .042	.1773 (41) P= .134	-0.0531 (41) P= .371	.1500 (41) P= .175	1.0000 (41) P= .	-0.3365 (41) P= .016	-0.1237 (41) P= .220	-0.242 (41 P= .06
SLONELY	.2690 (41) P= .045	.0930 (40) P= .284	.1653 (41) P= .151	.2241 (41) P= .080	.1355 (42) P= .196	.1978 (42) P= .105	.0851 (42) P= .296	.2111 (42) P= .090	.0182 (42) P= .454	-0.0132 (41) P= .467	-0.3365 (41) P= .016	1.0000 (42) P= .	.1074 (42) P= .249	.095 (42 P= .27
STOP	-0.2061 (41) P= .098	-0.0319 (40) P= .423	.0841 (41) P= .301	.1023 (41) P= .262	-0.1661 (42) P= .147	-0.0443 (42) P= .390	-0.0329 (42) P= .418	.1131 (42) P= .238	.1645 (42) P= .149	.0940 (41) P= .279	-0.1237 (41) P= .220	.1074 (42) P= .249	1.0000 (42) P= .	.438 (42 P= .00
SANGR	-0.2408 (41) P= .065	-0.0773 (40) P= .313	.0436 (41) P= .393	-0.0633 (41) P= .347	.0585 (42) P= .356	.1583 (42) P= .158	.1841 (42) P= .122	-0.1284 (42) P= .209	.4377 (42) P= .002	-0.0529 (41) P= .371	-0.2420 (41) P= .064	.0950 (42) P= .275	.4386 (42) P= .002	1.00 (4 P= .
SDEPRESS	. (0) P= .	. (0) P= .	. (0) P= .	. (0) P= .	. (0) P= .	. (0) P= .	. (0) P= .	. (0) P= .	. (0) P= .	. (0) P= .	. (0) P= .	. (0) P= .	. (0) P= .	. (P= .

correlation matrix indicates that items in the two scales of life adjustment and life satisfaction are not highly correlated. This demonstrates a low probability of multicollinearity, a problem said to be present when independent variables are correlated.

Summary and Comments

The subscales of life adjustment and life satisfaction seem to have promising elements. There is not a high degree of correlation between sub-scales There is no indication that any of the items should be eliminated from further analysis.

Factor analysis would be a better indicator of the validity of the scales. However, a larger sample size would be required before factor analysis would be appropriate.

MAJOR ANALYSES

EXPERIMENTAL QUESTION #1

What are the levels of life adjustment and life satisfaction for the chronically mentally ill in the community?

Analysis

Table 12 presents service receivers' responses on Life Adjustment. The means for items measuring life satisfaction are presented in Table 13.

Summary and Comments

Overall, of the five psychosocial and physical dimensions measured, social interaction was the lowest. Service receivers reported that they had contact with four people or less (of either parent, child, social worker, nurse, psychologist, psychiatrist, counsellor, family doctor, or friend) per month. Parents and family doctors were reported as main contact persons. Quality of the contact averaged at 1 "no help at all". Family doctors were reported as offering the most help, averaging 2 "some help".

Overall, reported levels of life satisfaction were neither high nor low (3.0). The only item which had a high mean response rate was *feeling pleased about accomplishing something*. However, all other items were in the middle category.

It is very interesting to note that the chronically mentally ill report a low quality of life in the community. These findings are consistent with the results from a number of authors who have documented the poor quality of life for the mentally ill in the community (Estroff, 1981, Greenblatt & Glazier, 1975, Krauss & Slavinsky, 1982;

Slavinsky, et. al., 1976). In most research on quality of life, life satisfaction measures are included with life adjustment. It is not possible to investigate what each measure has to uniquely contribute to overall quality of life. This study was designed to examine both dimensions separately. This research clearly demonstrated the reported levels of elements of life satisfaction and life adjustment.

Intuitively, the reported level of social interaction seems very low. Since this population have on-going emotional problems, one may suggest that they should have a minimum of one contact per month with nurses, psychologists, psychiatrists, counsellors, or social workers. However, this was not found to be the situation. No information was gathered from a different population on social interaction for comparison, making it impossible to infer if levels of social interaction were common. It is important to note however, since social interaction was the least met life adjustment need, that this finding is consistent with other research. Krauss and Slavinsky (1982), Lamb (1979), Ludwig (1981), Sandall (1975), and Simon (1965), all report that this special population is socially isolated. Ludwig (1971) in particular specifies that chronic psychiatric patients or clients in the community become progressively closed off and alienated from other people, including friends and family. Individuals suffering from a chronic mental illness do not attempt to interact with others unless they are assisted in seeking or provoking stimulation with the environment.

TABLE 12

SERVICE RECEIVERS' RESPONSES ON LIFE ADJUSTMENT DIMENSIONS

DIMENSION	MEAN (X) RESPONSE
Social Interaction (TOTAL=41)	.9512
Taken Care Of (TOTAL=41)	2.2293
Relief from Psychiatric Symptoms (TOTAL=41)	3.6667
Life Necessities (TOTAL=41)	3.7476
Hope (TOTAL=42)	3.5595

2 OF/DE 2

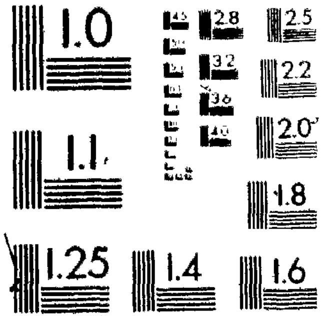

TABLE 13

SERVICE RECEIVERS' RESPONSES ON LIFE SATISFACTION

DIMENSION	MEAN (X) RESPONSE ON LIFE SATISFACTION
Pleased about accomplishing something	4.1190
Felt like things were going their way	3.2857
Proud because someone complimented them	3.6429
Felt so restless that they couldn't sit long in a chair	2.6429
Bored	2.3095
Excited or interested in something	3.2381
Lonely or remote from others	2.6078
Felt on top of the world	2.4762
Upset over being criticized	2.8095
Depressed or very unhappy	2.4762
TOTAL MEAN (X) RESPONSE ON LIFE SATISFACTION	2.9609

QUESTION #2

Are the psychosocial and physical dimensions of life adjustment separate measures of quality of life or are they related to life satisfaction levels?

Analysis

Pearson-Product Correlation Coefficients were computed to determine the relationship between the life adjustment and life satisfaction (see Table 11)

The Life adjustment factor of social interaction did not correlate with any items measuring life satisfaction

A significant negative correlation was found between the reported level of care and feeling [1] pleased about having accomplished something (-.2790, $p< .05$) [2] that things were going their way (-.3396, $p< .01$), [3] lonely and remote from others (-.5557, $p<.0001$); and [4] upset over someone criticizing them (-.5389, $p< .0001$) Therefore, as the level of care increased, feeling pleased about having accomplished something and having things go their way decreased. This finding also indicates that an increase in the amount of care reported is associated with decreases in feelings of being lonely and remote from others. Increases in the amount of care reported was also associated with being upset over someone criticizing them.

Relief from psychiatric symptoms correlated significantly with feeling: [1] pleased about accomplishing something (.2976, $p< .05$), [2] that things were going their way (.3863, $p< .01$), and, [3] proud about a compliment (.3827, $p< .01$) As the individual felt better he or she was more likely to feel pleased about having accomplished something; that things were going his or her way, and proud about having received a compliment

Life necessities did not correlate significantly with life satisfaction factors.

The amount of hope displayed by service providers that the respondent will recover from emotional problems was found to correlate positively with their feeling pleased about having accomplished something (.3991, $p < .01$). Therefore when service providers indicated that they had hope that the client or patient would recover the service receiver was more likely to feel pleased about having accomplished something

Summary and Comments

Overall life adjustment dimensions of level of care, relief from psychiatric symptoms, and hope of recovery correlated with items measuring life satisfaction. It is important to note that the life adjustment dimension of social interaction was not related to life satisfaction measures It may have been suspected that social interaction was related to feelings of loneliness and remoteness (life satisfaction elements) because of a lack of contact with people. However, statistically there is a distinction between just being with other people and actually communicating with them Therefore, the level of social interaction reported are not generalized to overall life satisfaction but rather seem to indicate a separate need.

It was demonstrated that as the perceived amount of care received in the community increased, feeling pleased about having accomplished something and having things go their way decreased. As the amount of care increased, feelings of loneliness and remoteness from others decreased as did feelings of being upset over being criticized These findings are extremely important. The chronically mentally ill may be judging how well they are doing by whether or not they are receiving care.

This finding is helpful in understanding why receiving care makes service receivers feel less pleased about having accomplished something. Service receivers may be defining accomplishments as not receiving care. This point seems valid when it is noted that as the amount of hope of recovery displayed by service providers increased, the likelihood that service receivers felt they had accomplished something increased.

The finding that feelings of loneliness and remoteness decrease with increased in care raises a very important issue. Receiving care does create a situation where the client or patient can be with others. However, while receiving care the chronically mentally ill do not feel that they are interacting with others Since only service receivers from a community with an institutional model responded, it is possible that the client/patient is not in an active-participatory role

As individuals experienced relief from psychiatric symptoms they had a greater likelihood of feeling pleased about accomplishing something and feeling that things were going their way, as well as feeling proud because someone complimented them on something they had done It is clear that feeling better contributes to greater levels of life satisfaction.

SUMMARY OF RESULTS FOR SECTION 3 - SERVICE RECEIVERS

The Quality of Life Scale indicated some promising elements. Items pertaining to either Life Adjustment or Life Satisfaction were not highly related between subscales. It is suggested that future research should be aimed at refining this scale.

The only service receivers responding to the survey were from the institutional care model. Therefore, comparisons of responses between service receivers in the community care model and the institutional care model were not possible.

The reported levels of life adjustment dimensions and life satisfaction dimensions were reported separately.

The life adjustment factors level of care, relief of psychiatric symptoms, and hope of recovery were related to items measuring life satisfaction. These relationships were dealt with and discussed.

DISCUSSION

Patterns of Service Delivery

There have been two patterns of care for the chronically mentally ill: [1] institutionalization; and [2] de-institutionalization. The institutionalization model utilizes in-patient mental health treatment while the de-institutionalization model advocates community care for the chronically mentally ill. Each of the two patterns has specific underlying assumptions. In the institutional care model a medical approach is emphasized, which views mental illness as a physical illness. Medical advocates employ a range of physical interventions (i.e., psychopharaceutical drugs, electro-shock, psychosurgery) to cure the problem as well as various approaches to psychotherapy. In contrast, the community care model emphasizes a community mental health approach, which considers external forces (i.e., family, work, and community) as they may relate to mental illness. This model assumes that a total health care system is needed whereby a wide range of community resources and services (i.e., medical care, vocational training, recreational activities) is offered.

Within the last two decades there has been enormous support for a shift from institutional care to community care for the chronically mentally ill. The literature suggests that the establishment of de-institutionalization (community care model) as a viable alternative in our society was hindered by several factors. One of these was a lack of co-ordination among various health and social agencies (Bassuk & Gerson, 1977, Evans, 1973, General Accounting Office, 1978, Gilbert & Specht, 1977, Halpert, 1970; Lamb, 1976; Lamb, 1982). It has been well documented that most communities have a dissorganized array of agencies with overlapping or conflicting goals (General Accounting Office, 1978; Gilbert & Specht, 1977; Halpert, 1970; Lamb, 1976, Lamb, 1982).

In the present research, reported levels of perceived co-ordination in both the community care and institutional care model were only low to moderate. This finding supports previous research on lack of co-ordination of services (Clark, 1976; Evans, 1983, General Accounting Office, 1977, Krauss & Slavinsky, 1982).

In the present analysis two communities, one with an institutional care model and another with a community care model, were compared on a measure of service delivery co-ordination. Specifically, services providers in both communities were asked questions concerning their perception of co-ordination of services for the chronically mentally ill in their community. The service providers in the institutional care model reported a significantly higher amount of co-ordination than service providers in the community care model. Several factors may be operating in the institutional care model, which contribute to significantly higher levels of perceived co-ordination. First, release policies in the institutional care model here, may link the client or patient to community aftercare services when discharged. Such policies would initiate service co-ordination at a crucial time for the individual. Previous researchers (Bassuk & Gerson, 1977, Evans, 1983, General Accounting Office, 1977) who have reported poor service co-ordination have not indicated the existence of such facilitating release policies. Second, community aftercare workers while managing individual clients' or patients' community treatment may be aiding in the co-ordination of services between the hospital (where clients/patients are identified for the aftercare program) and in the community (where clients/patients live after in-patient treatment)

Factors Affecting Co-ordination of Services

Organizational research has indicated that co-ordination of services is affected by relationships within an agency, referred to as intraorganizational perceptions, and between agencies, referred to as interorganizational perceptions (Marks & Broskowsky, 1981).

This present study failed to find intraorganizational perceptions as a factor affecting co-ordination of services. However, the present findings support previous research, which demonstrates that interorganizational perceptions relate to co-ordination of services In other words, the present research indicates that beliefs that other agencies in the community are interdependent and have complementary service goals are important factors affecting co-ordination of services. One might conclude that it is possible that agencies have a higher likelihood of co-ordinating services when there is a sense of commonality and absense of competition. However, it is important to note that factor 4, *interorganizational perceptions*, was found to be a somewhat weak entity, statistically Therefore confidence in the finding of a relationship between interorganizational perceptions and perceived co-ordination may be somewhat diminished

While intraorganizational perceptions failed to show they significantly affected co-ordination, analysis indicated that intraorganizational perceptions were related to the third factor described here as *level of attitudes* (i.e., service providers are financially secure, believe that co-ordination is important, and encourage staff to form co-operative relationships with other agencies). Since some of the items loading on the attitude factor were orginally conceptualized as measuring co-ordination, it is possible that previous researchers measured co-ordination using items from this research's factor 3 *attitude factor*. This would offer a possible explanation for the finding that intraorganizational perceptions did not affect co-ordination.

Co-ordination and Quality of Life for the Chronically Mentally Ill

Effectiveness of aftercare services in the community is said to be dependent on the level of co-ordination of services by service providers (Broskowsky, Marks, & Burmen, 1982, Clark, 1976, Krauss & Slavinsky, 1982). Effectiveness of services may be measured by the level of quality of life for the chronically mentally ill.

In the community with institutional care, elements measuring quality of life for the chronic psychiatric patient were relatively low. Quality of life was measured by life adjustment and life satisfaction measures. Information from the community care model on quality of life of the chronically mentally ill was not obtained.

Further data gathered from chronic psychiatric patients in the community with the institutional care provides interesting information regarding the enhancement of life quality for these individuals. The chronically mentally ill persons reported that their quality of life was enhanced by increases in care; relief from psychiatric symptoms; and service providers giving hope of recovery from the psychiatric illness.

Summary

This research has demonstrated that co-ordination of aftercare services is relatively low. It was indicated that interorganizational perceptions affected co-ordination at the local level. It was also demonstrated that those who are chronically mentally ill experience a RELATIVELY poor quality of life in the community. These findings are consistent with those cited by previous researchers (General Accounting Office, 1978; Gilbert & Specht, 1977; Halpert, 1970; Krauss & Slavinsky, 1982; Lamb, 1982, Marks & Broskowsky, 1981)

LIMITATIONS

Service Providers

The level of co-ordination was measured by perceptions from service providers. Unfortunately, there was no objective data base to examine the difference between perceived and actual. One of the problems in measuring actual co-ordination is using accurate instruments.

Service Receivers The main limitation of this study concerns sampling procedures for obtaining data from service receivers, the chronically mentally ill clients themselves. The respondents were contacted indirectly through service providers which raises the question, was the data collected representative of the chronically mentally ill persons in the community? Unfortunately since a research proposal was not provided to agencies for their Board Review, most service providers were unable to distribute the service receivers' survey to their clients or patients Therefore, only a few service providers participated in this phase of the research, those who did were affiliated with non-profit, community- oriented agencies based in the institutional care model. This may have affected the responses of service receivers.

Distribution of the service receivers' survey through service providers also created other research limitations. It was difficult for the researcher to exert control over: [a] random selection of participants; and [b] individual completion of the instrument. Service receivers responding to the research may not have provided a representative sample of the chronically mentally ill. Service providers may have selected clients or patients with a level of functioning which enabled them to participate in the research According to key informants, these better functioning individuals have been involved in many studies. Additionally, it is impossible to ascertain if service receivers completed the survey alone and made independent judgements.

The total number of service receivers responding to the research was insufficient to [a] test further the validity and reliability of Life Adjustment and Life Satisfaction measures, and [b] regress items in the Life Adjustment Scale and Life Satisfaction scale separately. First, the Quality of Life scale could not be subjected to statistical procedures for refinement. With insufficient sample size, it was not possible to determine the consistency of scores obtained by the same person with different equivalent items. This reliability test would indicate the range of fluctuations likely to occur Investigating what the scale measures and how well it measures it were validity questions that this study could not address. Second, it is imperative that sample size be considered in relationship to the number of independent variables being considered. Due to the small sample size the number of independent variables had to be minimal.

Despite some of the admitted limitations of this study, there is no reason to believe that results are merely spurious expecially since results did concur with previous research.

The instruments constructed for surveying service providers and service receivers were based on theoretical considerations The scales indicated very promising elements. The service providers' survey had intercorrelated variables with common factor loadings which represented reference factors of co-ordination, intraorganizational perceptions, and interorganizational perceptions The service receivers' survey had items measuring either life satisfaction or life adjustment which did not have a high interrelationship across scales

RECOMMENDATIONS

Service Providers

Service providers have indicated in other studies, that they experience the system as fairly incoherent (Bassuk & Gerson, 1977; Evans, 1973, General Accounting Office, 1977; Krauss & Slavinsky, 1982). Moreover, other research has indicated that an ad hoc approach has been used in the development of mental health programs (Clark, 1976). Therefore, the relatively low levels of perceived co-ordination of services by service providers is not surprising

This study has indicated that interorganizational perceptions (i.e., belief that agencies in the community are interdependent and have complementary service goals) can affect co-ordination. If service providers believe that agencies in the community are not interdependent and do not have complementary service goals then co-ordination will be negatively affected. This suggests that an educational campaign aimed at demonstrating interdependence and non-competitive goals among agencies may be useful. This educational campaign could be accomplished through workshops involving representatives of community service providers. The focus of these workshops would be on illuminating individual and common service delivery goals and objectives. Team development strategies as outlined by Pfeiffer and Jones (1980) could be employed as an appropriate workshop format

The study has shown that many service providers believe that the Ministry of

Health/District Health Council should co-ordinate services in the community for the chronically mentally ill. This attitude among the respondents may have been fostered by perceptions that the Ministry of Health/District Health Council were: [a] established and on-going; [b] unaffiliated with the service delivery system; and [c] most knowledgeable about the agencies in the community due to their role in the funding process. A lack of time among service providers to be in an active co-ordinating role may also have affected their decisions. Service providers have clearly indicated in their responses on who should co-ordinate services, that there must be a co-ordinating body. Due to the willingness of service providers to accept direction from the Ministry of Health/District Health Council, their role as potential co-ordinators of service delivery systems should be examined. A possible alternative, which reflects service providers' beliefs on who should co-ordinate services in the community for the mentally ill, may be the formation of a co-ordinating committee under the direction of the District Health Council. Members of this group might include: [1] service providers directly involved in case management (front-line workers); and [2] service providers who are appointed by an agency's board or director to represent their views. Representation from both the government and volunteer groups would be important. Rotation of agencies on the committee could be considered. Last, consumer participation should seriously be considered.

Incentives for service providers to join in a co-ordinated network are strongly urged. At the present time, service providers receive no encouragement to co-ordinate services. The Ministry of Health/District Health Council should investigate an incentives program. A possible strategy may be to make program funding contingent on rational program planning. Program plans, which could be submitted yearly to the funding source through the District Health Council, would empirically demonstrate program need and report statistically on linkage and co-ordination. Linkage and co-ordination could be demonstrated by referrals to other agencies, co-ordination meetings with other agencies, cancelling programs already being offered in the community, or beginning a program because it is needed. A strong co-ordinating body should be in place before incentive programs are initiated.

Service Receivers

It has been well documented that the chronically mentally ill have a poor quality of life in the community (Greenblatt & Glazier, 1975, Krauss & Slavinsky, 1982; Slavinsky et al., 1976) The present research supports these previous findings.

This study suggests that planned interventions from the service delivery system are warranted to ensure the clients' or patients' adjustment in the community The present study demonstrates that social interaction arguably, was the least met need. It may be proposed that programs be developed to increase the possibility of social interaction by social skills training and providing an environment where interaction is possible Individuals could receive social skills training and then be encouraged to join recreational and social activities. Social skills training should be on-going Since it was demonstrated that social interaction was not just relief from isolation, it is important that social skills training, recreational, and social programming be combined

According to this study, patient or client life satisfaction is positively related to receiving care, hope of recovery, and relief from psychiatric symptoms from service providers. Several recommendations are offered. First, service receivers who provided additional data by writing accompanying letters indicated that aftercare workers were extremely helpful. Similarly, key informants and service providers acknowledged the important role of the aftercare team. Comments regarding the aftercare team indicated the success of the program in: [1] co-ordinating individual cases; [2] providing advocacy for life necessities (i.e., housing, food); [3] maintaining contact with clients or patients who would normally not be seeing anyone, and [4] helping clients/patients adjust to residing in the community. Therefore, extension of the aftercare program by increasing the number of team workers should be seriously considered. Second, service providers should be made aware that extending hope of recovery to a client or patient increases life satisfaction. Hopeful attitudes are encouraged by agencies in the service delivery system to have realistic expectations and establish realistic rates of progress. Since it has been shown that extending hope and encouragement is very difficult (Allan, 1974) service provider support groups be helpful. Such support groups for caregivers may provide encouragement to instill hope of recovery, a forum to discuss the difficulty in providing hope of recovery, and assist caregivers in dealing with the day-to-day problems of this special population.

Finally, the present research provided some evidence that an institutional care service delivery model could foster perceptions of service co-ordination at levels higher than a community care service delivery model. The community care system in this study, functions without in-patient hospital facilities and under policies theoretially designed to encourage the use of community services. The institutionally centered service delivery system may be useful for effective co-ordination because it is the one service that all chronic psychiatric patients have contact with. A possible strategy for co-ordinating services may be the use of a local in-patient facility available when necessary for particular stressful times in the chronic patient's life. Use of this facility may encourage bonding and responsibility by in-patient staff thus facilitating co-ordination of services emanating from a central source. Facility policy must be to connect patients or clients to aftercare services in the community. The facility board should have community representation of service providers.

FUTURE RESEARCH

Changes in the patterns of service delivery to the chronically mentally ill have made community-based care possible. Developments in identifying effective systems for dealing with the psychiatric client or patient, coupled with investigation of the quality of community life would help to improve de-institutionalization. Specific recommendations for future research arising out of this study are the following:

- A refinement component for the Quality of Life scale which involves testing its reliability and validity
- Education and team building to nurture positive interorganizational perceptions. An attempt could be made to measure co-ordination before and after such interventions.
- The two additional factors (labelled level of attitudes and referrals) emerging in the service providers scale were not handled in depth in this study. Thus, a study which focused on survey construction using these factors would be useful
- Replication of this study using a more direct method for surveying service receivers. This direct method may increase sample size and provide a more representative sample of the chronically mentally ill in the community
- Planned interventions to increase hope of recovery extended by service providers to clients or patients. An attempt could be made to compare different approaches to increasing the extension of hope of recovery (i.e., mutual aid group for service providers, workshops, lectures)
- The development of a way to measure co-ordination directly. It may attempt to measure co-ordination of services by examining case studies of clients or patients, to measure gaps and overlaps by forming a directory, quantification fo co-ordination events, and referrals

CONCLUSION

The growing and accelerated changes in communities have helped to create disruptive effects on the mental health system and recipients of services. The effects on the mental health system have resulted in unco-ordinated delivery of services. It may be argued that the most severe consequences of the changes are experienced by service receivers (i.e., the chronically mentally ill) who experience a poor quality of life in the community.

Tessler and Goldman (1982) report that measuring quality of life for persons with chronic mental disabilities is a challenge for further research. Lamb (1981) has noted that quality of life scales are unrealistic for the chronically mentally ill persons because of the focus on "helping them become part of the mainstream of our society" and "normalization" This research has attempted to examine the chronically mentally ill person's quality of life in way that is meaningful Analysis of literature in the area was reviewed and a subsequent scale developed While the Quality of Life scale does need to be subjected to rigiourous refinement, it is a beginning in making appropriate goals for the mentally ill which involves living lives of dignity with a reasonable amount of comfort in the community.

This research does not provide definitive conclusions regarding the effects of level of co-ordination of services on quality of life for the chronically mentally ill Still intuitively, effective service co-ordination should enhance the life experience of these clients and this thesis urges measures to development rationally co-ordinated service delivery systems However, several other levels of intervention may be necessary to improve the quality of life of the chronically mentally ill: (1) increase in amount of care; [2] changes in the setting of rehabilitation goals to make expectations more realistic; [3] improved methods for dealing with psychiatric symptoms; and [4] increases in community resources allocated to this special population (i.e., housing, food, medical attention)

This research is of special interest to community psychology The values of community psychology focus on maximizing the fit between individuals and their environments. From this perspective human well-being is determined not only by intrapsychic factors but also by factors in the social environment. Emphasis in community psychology rests on the development of human resources. One general conclusion of this action research is that the de-institutionalized chronically mentally ill client/patient have specific and special needs which are not being met in the community Community psychology must focus on maximizing the fit between the mentally ill and their community

APPENDIX A

KEY INFORMANT INSTRUMENT

APPENDIX A

INTERVIEW OF KEY INDIVIDUALS

For the purposes of this research, individuals who are chronically mentally ill requiring aftercare services, shall be defined as a person in the community who has been diagnosed as being: schizophrenic, or manic-depressive. In addition, the individual must indicate four or more of the following characteristics:

- has two or more psychiatric admissions in the past five years
- has failed to follow through on post-discharge plans (including out-patient treatment)
- has evidence of an unstable job/vocational history or inability to obtain employment
- has involvement with three or more community agencies/services
- has frequent crises which have required professional attention/intervention
- has a history of non-compliance with medication regimes
- has a lack of a supportive social network (other than immediate family)

NAME

____

AGENCY

____

DATE ____________________________________

(1) a What is the quantity of the co-ordination of aftercare services for the chronically mentally ill in the community two?

- very high
- high
- neither high nor low
- low
- very low

(1) b What is the quantity of the co-ordination of aftercare services for the chronically mentally ill in community one?

- very high
- high
- neither high nor low
- low
- very low

(1) c Why do you perceive the quantity of co-ordination in this way?

____

____

____

(2) a. What is the quality of the co-ordination of aftercare services for the chronically mentally ill in community two?

- very high
- high

- neither high nor low
- low
- very low

(2) b. What is the quality of the co-ordination of aftercare services for the chronically mentally ill in community one?

- very high
- high
- neither high nor low
- low
- very low

(2) c. Why do you perceive the quality of co-ordination in this way?

(3) If service providers in each of the two communities indicate that co-ordination in the two communities are different, what kinds of explanations would you possibly have?

---

(4) a. How common do you think it is for service providers to meet informally (i.e., at social gatherings, during coffee breaks in meetings) and exchange information contributing to the co-ordination of services for the chronically mentally ill in the community two?

- very common
- common
- neither common nor uncommon
- uncommon
- very uncommon

(4) b How common do you think it is for service providers to meet informally (i.e., at social gatherings, during coffee breaks in meetings) and exchange information contributing to the co-ordination of services for the chronically mentally ill in community one?

- very common
- common
- neither common nor uncommon
- uncommon
- very uncommon

(5) Do you think there is any difference in the amount of opportunity for service providers in either of the two communities to be involved in a co-ordinated network?

- definitely yes
- yes
- neither yes nor no
- no
- definitely no

(6) If service receivers in each of the two communities indicate a difference in co-ordination of services in the two communities, what kinds of explanations would you possibly have?

____

____

____

(7) In light of the goals of the research what do you think of the

mail survey for service providers ______________________________

____

survey for service receivers ______________________________

____

APPENDIX B

LETTER OF INTRODUCTION TO SERVICE PROVIDERS

Date

Agency name ______________________________

Agency address _________________________

Attention: ________________________________

Dear ________________________________

Your organization was drawn from the Directory of Community Services for (NAME OF REGION) Region, 1983-1984 because your agency is involved with the chronically mentally ill

I am currently researching the effectiveness of services for the chronically mentally ill in the (NAME OF REGION) Region who are in need of aftercare I am enclosing a mail survey with a self-addressed envelope This research is for my M.A. in Social Community Psychology at Wilfrid Laurier University My thesis advisor is Dr Steve Chris

As you may be aware of at this time, the District Health Council are also conducting a study in the area of mental health The District Health Council study is a comprehensive mental health investigation of the entire region Through discussions, the District Health Council and myself have co-ordinated our efforts so that we do not duplicate work. It is important then that both studies receive community participation. Since my study will be completed first, I will be providing the District Health Council with a copy of my results

I would *greatly appreciate* your *participation* in this study If you would like to be involved, please complete the attached survey and return it in the self- addressed envelope provided within two weeks. The survey was specifically designed so that it will take you *only 10-15 minutes to complete*. The information will be *treated with the upmost confidentiality*. The information will be seen only by myself and my thesis advisor.

Thank-you very much for your assistance. If you should be interested in the results of the study, please indicate this on the survey. If you should have any questions please do not hesitate to contact me at Wilfrid Laurier University, 884-1970. Please leave the message with the Graduate Psychology Secretary

Sincerely

L. Ferris

Graduate Student/Wilfrid Laurier University

APPENDIX C

SERVICE PROVIDERS' SURVEY

SURVEY FOR SERVICE PROVIDERS
INSTRUCTIONS

For the purposes of this research, individuals who are chronically mentally ill requiring aftercare services, shall be defined as a person in the community who has been diagnosed as being: schizophrenic, or manic-depressive. In addition, the individual must indicate four or more of the following characteristics:

- has two or more psychiatric admissions in the past five years;
- has failed to follow through on post-dischange plans (including out-patient treatment).
- has evidence of an unstable job/vocational history or inability to obtain employment;
- ~~has~~ frequent crises which have required professional attention/intervention;
- has a history of non-compliance with medication regimes,
- has a lack of a supportive social network (other than immediate family).

The term *co-ordination* for the purposes of this research, shall mean the following factors present among service providers

- lack of overlaps/gaps in services,
- information sharing,
- established communication and referral network,
- awareness of services offered in the community;

- success in interfacing with the service system.

Before beginning, please make sure that you have read our definitions.

The following survey will only take you about 10-15 minutes to complete.

Please answer *all the questions*.

When you have completed the survey, please return it in the envelope provided.

Thank you very much for your participation. If you wish to have a copy of the results, please indicate this below. The researcher will mail you the results when the study has been completed.

IF YOU WISH A COPY OF THE RESULTS OF THIS STUDY, PLEASE INDICATE BELOW

[ ] YES

[ ] NO

SURVEY FOR SERVICE PROVIDERS

NAME OF AGENCY

____

POSITION OF THE INDIVIDUAL COMPLETING THE SURVEY

____

SECTION A

1. Where is your agency located?

☐ Kitchener-Waterloo

☐ Cambridge

☐ other, please specify ______________________

2. How is your organization funded? (more than one may be checked)

☐ with governmental funding, please specify ______________

☐ with community donations

☐ with fees from clients

☐ other, please specify ______________

3. What percentage of people within your organization, who provide services to your clients, are volunteers (not being paid for their services)?

☐ 0-20%

☐ 21-40%

☐ 41-60%

☐ 61-80%

☐ 81-100%

4. Who do you believe presently has the mandate to co-ordinate services for the chronically mentally ill in your community? (Check only *one answer*)

☐ Ministry of Health

☐ Ministry of Community & Social Services

☐ Social Resources Council

☐ District Health Council

☐ Canadian Mental Health Association

☐ Mayor/Alderpeople/Counsellor

☐ No one

☐ Other, please specify ______________________________

5. Who do you believe should have the mandate to co-ordinate services for the chronically mentally ill in your community? (Check only *one answer*)

- [ ] Ministry of Health
- [ ] Ministry of Community & Social Services
- [ ] Social Resources Council
- [ ] District Health Council
- [ ] Canadian Mental Health Association
- [ ] Mayor/Alderpeople/Counsellor
- [ ] No one
- [ ] Other, please specify ______________________

PLEASE CONTINUE ON THE NEXT PAGE.....

SECTION B

FOR EACH OF THE FOLLOWING STATEMENTS, PLEASE INDICATE THE EXTENT TO WHICH YOU AGREE OR DISAGREE. PLEASE CIRCLE ONE ANSWER PER QUESTION. FOR THE PURPOSES OF THIS SECTION, PLEASE USE THE FOLLOWING RATING SCALE.

1 = STRONGLY DISAGREE

2 = DISAGREE

3 = NEITHER AGREE NOR DISAGREE

4 = AGREE

5 = STRONGLY AGREE

1 Our organization is financially secure on a year to year basis 1 2 3 4 5

2 Co-ordination of services for the chronically mentally ill in the community is important 1 2 3 4 5

3. There are gaps in services being offered in this community for the chronically mentally ill requiring aftercare.	1	2	3	4	5
4. There are overlaps in services being offered in this community for the chronically mentally ill requiring aftercare	1	2	3	4	5
5 There is co-operate information sharing between agencies in this community serving the chronically mentally ill on services, programs, lectures, special events, being offered	1	2	3	4	5
6 Our organization is sure that they are knowledgeable about other service providers programs, mandates, and services in this community for the chronically mentally ill requiring aftercare.	1	2	3	4	5
7 Our organization frequently makes referrals to other agencies for clients-patients in this community who are chronically mentally ill requiring aftercare services.	1	2	3	4	5
8. Our organization frequently receives referrals from other agencies for clients-patients in this community who are chronically mentally ill requiring aftercare services	1	2	3	4	5
9 Organizations involved with the chronically mentally ill in this community communicate on matters affecting their service provision.	1	2	3	4	5

10. Chronically mentally ill clients-patients released in this community, are linked with the necessary agencies with assistance from service providers (i.e., out-patient clinics) in an efficient way.	1	2	3	4	5
11. Agencies in our community serving the chronically mentally ill, work well together.	1	2	3	4	5
12. Our organization has a strong directive leadership (governing body) to regulate itself.	1	2	3	4	5
13. It is likely for staff in our organization to be noticed if they disobey rules/regulations/policy, etcetera in connection with dealing with our clients.	1	2	3	4	5
14 Other agencies in our community serving the chronically mentally ill operate programs which are organized in a similar way to ours.	1	2	3	4	5
15. Our organization has a clear organizational framework which stipulates the various departments and/or job descriptions.	1	2	3	4	5
16 Our organization has a strong sense of collaboration and pulling together among staff	1	2	3	4	5
17 Our agency is co-ordinated in such a way that there are little or no gaps/overlaps in departments/job descriptions.	1	2	3	4	5
18 Staff in our agency exhibit flexibility and innovativeness which allows them to develop their own leadership styles	1	2	3	4	5
19. Agencies in our community serving the chronically mentally ill are interdependent.	1	2	3	4	5

20. Agencies in our community serving the chronically mentally ill have service goals which complement each other (i.e., one agency handles housing needs, another governmental assistance, etcetera). 1 2 3 4 5

21. Our organization encourages their staff to form collaborative and co-operative relationships with other service providers in the community. 1 2 3 4 5

22. Most agencies in our community serving the chronically mentally ill operate from treatment-philosophies which are similar to our organizations. 1 2 3 4 5

THANK-YOU AGAIN FOR YOUR PARTICIPATION!

APPENDIX D

LETTER OF INTRODUCTION FOR SERVICE ORGANIZATIONS

NAME OF AGENCY________________

ADDRESS______________________________

____

Dear Sir/Madam:

I am a graduate student at Wilfrid Laurier University in the M.A. Community Psychology program. My thesis advisor is Dr. Steve Chris. I am conducting research on the effectiveness of services for the chronically mentally ill in your community. Your agency has already been contacted regarding your participation in the study. I thank you for your consideration in this matter.

As you may be aware of at this time, the District Health Council are also conducting a study in the area of mental health. The District Health Council study is a comprehensive mental health investigation of the entire region. Through discussions, the District Health Council and myself have co-ordinated our efforts so that we do not duplicate work. It is important then that both studies receive community participation. Since my study will be completed first, I will be providing the District Health Council with my full results.

I am interested in surveying the service receiver's - your clients. In order to ensure that the service receiver's cannot be identified in any way by the researcher and that they fully understand that they are under no obligation to complete the survey, I am asking for your assistance.

I have provided with this letter, several surveys and letters of introduction for your clients. I would greatly appreciate it if you would give them to the clients who are considered chronically mentally ill. If you have more than fifteen clients who fit this definition, please randomly select fifteen For the purposes of this research, individuals who are chronically mentally ill requiring aftercare services shall be defined as a person in the community who has been diagnosed as being schizophrenic or manic- depressive. In addition, the individual must indicate four or more of the following characteristics

- has 2 or more psychiatric admissions in the past 5 years
- has failed to follow through on post-discharge plans (including out-patient treatment)
- has evidence of an unstable job/vocational history or inability to obtain employment
- has frequent crises which have required professional attention/intervention
- has a history of non-compliance with medication regimes
- has a lack of a supportive network (other than immediate family)

If you are willing to participate in this stage of the research please distribute the enclosed letters and surveys to your clients It is important that the individuals understand that they do not have to participate and that their names etc will be kept confidential.

Thank you again for your assistance.

Sincerely

Lori Ferris Graduate Student Wilfrid Laurier University

APPENDIX E

LETTER OF INTRODUCTION

FOR SERVICE RECEIVERS

Dear Sir/Madam:

I am doing research on how well organizations in your community are doing in meeting your needs. I have asked the agencies to fill out a survey on how well they think they are doing in serving you.

However, I would like to find out how well you think the agencies are doing in meetings your needs. In order to discover this, I need you to fill out the survey attached and return it to me in the envelope provided

I would *greatly appreciate your help* this research. Therefore, if you would like to be involved, please fill out the survey and return it to me in the envelope provided If you should have any questions you may contact me at Wilfrid Laurier University by phoning 884-1970 Please leave message with the Graduate Psychology Secretary

If you are interested in receiving the results, you may ask at the agency which gave you this survey The results should be available by September 30 1985. If you wish you may contact me directly for the results

Sincerely

L.FERRIS Graduate Student Wilfrid Laurier University

APPENDIX F

SERVICE RECEIVERS' SURVEY

SURVEY FOR SERVICE RECEIVERS

Instructions

In each of the following questions, please circle the answer which most describes your situation, feelings, beliefs, etcetera. Please try to answer each question.

1. Where do you live?

[ ] Kitchener-Waterloo

[ ] Cambridge

[ ] other, please specify ________________________________

2. What is your marital status?

[ ] married

[ ] separated

[ ] divorced

[ ] single

[ ] common-law

[ ] widowed

3. Do you have any children?

☐ no

☐ 1

☐ 2

☐ 3 or more

4. What is your date of birth? ______________________

5. Have you ever been in-hospital for emotional problems?

☐ yes

☐ no

☐ unsure

6. If you have been in-hospital for emotional problems, how long ago was your stay in the hospital?

☐ 0 - 6 months ago

☐ 7 - 12 months ago

☐ 1 - 2 years ago

☐ 3 - 4 years ago

☐ 5 or more years ago

7 Overall, do you think you are satisfied with the services you have received in your community?

[ ] definitely yes

[ ] yes

[ ] neither yes nor no

[ ] no

[ ] definitely no

8. In the last month, which of the following people or groups have you had contact with?

Parent:	once	twice	three times or more
Children:	once	twice	three times or more
Social Worker:	once	twice	three times or more
Nurse	once	twice	three times or more
Psychologist	once	twice	three times or more
Psychiatrist	once	twice	three times or more
Counsellor	once	twice	three times or more
Family Doctor:	once	twice	three times or more
Friend(s):	once	twice	three times or more

9. Which of the following people who you have had contact within the last month, has helped you the most?

Parent:	no help	some help	alot of help
Children:	no help	some help	alot of help
Social Worker:	no help	some help	alot of help
Nurse:	no help	some help	alot of help
Psychologist:	no help	some help	alot of help
Psychiatrist:	no help	some help	alot of help
Counsellor:	no help	some help	alot of help
Family Doctor:	no help	some help	alot of help
Friend(s):	no help	some help	alot of help

10. Which of the following people or groups have helped you contact people who could help you?

- ☐ parent
- ☐ children
- ☐ social worker
- ☐ nurse
- ☐ psychologist
- ☐ psychiatrist
- ☐ counsellor
- ☐ family doctor
- ☐ friend

11 How often have you felt frustrated with an agency because you have been unable to get help from them or assistance in finding someone who could help you?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 times or more

12. Do you have relief from the emotional problem you once had?

[ ] definitely yes

[ ] yes

[ ] neither yes nor no

[ ] no

[ ] definitely no

13. Do you have proper housing?

[ ] definitely yes

[ ] yes

[ ] neither yes nor no

[ ] no

[ ] definitely no

14. Do you have enough food?

[ ] definitely no

[ ] no

[ ] neither yes nor no

[ ] yes

[ ] definitely yes

15. Do you have enough clothing?

[ ] definitely no

[ ] no

[ ] neither yes nor no

[ ] yes

[ ] definitely yes

16. Do you have any medical problem(s) which have not been looked into by a doctor?

[ ] definitely yes

[ ] yes

[ ] neither yes nor no

[ ] no

[ ] definitely no

17. Do you feel like people working with you are hopeful that you will recover from the emotional problems you have been having?

[ ] definitely yes

[ ] yes

[ ] neither yes nor no

[ ] no

[ ] definitely no

18 Do you feel like people are looking after you in your community?

[ ] definitely no

[ ] no

[ ] neither yes nor no

[ ] yes

[ ] definitely yes

19. During the past few weeks did you ever feel pleased about having accomplished something?

☐ definitely yes

☐ yes

☐ neither yes nor no

☐ no

☐ definitely no

20. During the past few weeks did you ever feel that things were going your way?

☐ definitely yes

☐ yes

☐ neither yes nor no

☐ no

☐ definitely no

21. During the past few weeks did you ever feel proud because someone complimented you on something you had done?

- [ ] definitely yes
- [ ] yes
- [ ] neither yes nor no
- [ ] no
- [ ] definitely no

22 During the past few weeks did you ever feel so restless that you couldn't sit long in a chair?

- [ ] definitely no
- [ ] no
- [ ] neither yes nor no
- [ ] yes
- [ ] definitely yes

23 During the past few weeks did you ever feel bored?

[ ] definitely yes

[ ] yes

[ ] neither yes nor no

[ ] no

[ ] definitely no

24. During the past few weeks did you ever feel particularly excited or interested in something?

[ ] definitely yes

[ ] yes

[ ] neither yes nor no

[ ] no

[ ] definitely no

25. During the past few weeks did you ever feel very lonely or remote from other people?

[ ] definitely no

[ ] no

[ ] neither yes nor no

[ ] yes

[ ] definitely yes

26. During the past few weeks did you ever feel on top of the world?

[ ] definitely no

[ ] no

[ ] neither yes nor no

[ ] yes

[ ] definitely yes

27. During the past few weeks did you every feel upset because someone criticized you?

☐ definitely yes

☐ yes

☐ neither yes nor no

☐ no

☐ definitely no

28. During the past few weeks did you ever feel depressed or very unhappy?

☐ definitely yes

☐ yes

☐ neither yes nor no

☐ no

☐ definitely no

DO YOU WANT A COPY OF THE RESULTS OF THIS STUDY?

[ ] YES

[ ] NO

WHERE SHOULD THE RESULTS OF THE STUDY BE SENT?

[ ] to the service agency which gave this survey. The agency name and address is:

____

____

____

[ ] to another address:

____

____

THANK YOU FOR YOUR PARTICIPATION. PLEASE PUT THE SURVEY IN THE ENVELOPE AND MAIL IT AS SOON AS POSSIBLE. THE POSTAGE IS PAID FOR.

APPENDIX G

ANALYSIS OF FACTORS 3 AND 5

RESULTS - SECTION TWO - SERVICE PROVIDERS

MAJOR ANALYSES

The co-ordination, intraorganizational perceptions, and interorganizational perceptions factors have been utilized in the main results section. This appendix examines the other two factors extracted from the factor analysis (labelled attitudes and referrals).

Factor 3, *attitudes*, accounted for 7.9% of overall variance, while factor 5, *referrals*, contributed 4.7% in explaining the variance. It should be noted that factor 5 is a weak factor and therefore confidence in it is diminished.

After each experimental question referring to how one of the factors relates to all the other factors, two sections are presented as in the major analyses: [1] analysis, and [2] summary and discussion. The analysis section presents the statistical procedures and findings while the summary and comments section expands on the findings.

Multiple regression analysis was used to study the relationship between a dependent variable and a set of independent variables. The method used to build the multiple regression equation was forward stepwise selection. This process enters variables based on significant F values into the equation and examines variables already in the analysis for their continued usefulness. Variables in the equation which are not found to be useful are removed from the analysis (Pedhazur, 1982).

Question #1

How do service providers' responses on provision of referrals relate to all other factors?

Analysis

Regression analysis using the forward stepwise procedure was carried out where the dependent variable was referrals and the independent variables were: attitudes, co-ordination, interorganizational perceptions, and intraorganizational perceptions.

Table 14 summarizes the results.

Multiple R was found to be significant, [$\underline{F}(1,51) = 3.82$, $p < .01$]. Factor 3 (see Table 3) consisting of financial security, importance of co-ordination, and encouragement of staff to form co-operative relationships with other agencies, was found significantly to account for 15% of the variance in provision of referrals, [$\underline{F}(1,51) = 8.69$, $p < .01$].

Summary and Discussion

Service providers' reported level of referrals was related to attitudes (referrals means that the agency receives referrals from other service providers and knows about other agencies in the community) This indicates that attitudes consisting of financial security, importance of co-ordination, and encouragement of staff to form co-operative relationships with other agencies, play a significant role in determining an agency's provision of referrals. No other independent variable demonstrated a significant relationship to provision of referrals.

It is interesting to note that referrals (i.e., being knowledgeable about other agencies in the community and receiving referrals) are not related to co-ordination, interorganizational perceptions, nor intraorganizational perceptions. This indicates that co-ordination is definitely not related although the two were originally conceptualized as measuring the same condition. Receiving referrals is not dependent on how much an agency believes that service providers are interdependent and have complementary service goals. An agency's internal structure does not affect other service providers' willingness to send clients to the agency for services

TABLE 14 - SUMMARY TABLE
REGRESSION OF INDEPENDENT VARIABLES ON PROVISION OF REFERRALS

PREDICTOR	MULTIPLE R	R SQUARE	df	F	p
Attitudes (TOTAL=52)	.382	.146	(1,49)	8.69	.01
Funding Structure (TOTAL=52)	-.211	-.044	(1,49)	2.63	ns
Has the mandate to co-ordinate services (TOTAL=52)	.114	.013	(1,49)	.68	ns
Co-ordination (TOTAL=52)	.061	.004	(1,49)	.19	ns
Intraorganizational Perceptions (TOTAL=52)	-.033	-.001	(1,49)	.05	ns
Should co-ordinate services (TOTAL=52)	.031	.001	(1,49)	.05	ns
Interorganizational Perceptions (TOTAL=52)	.010	.000	(1,49)	.00	ns

Question #2

How do service providers' responses on attitudes relate to all other factors?

Summary and Discussion

Regression analysis using forward stepwise procedure was computed where the dependent variable was attitudes (consisting of financial stability/importance of co-ordination/encourgement of staff to form co-operative relationships with other agencies) and the independent variables were: co-ordination, interorganizational perceptions; and, intraorganizational perceptions.

Table 15 summarizes the results.

Multiple R was found to be significant.[$F(2,50) = 7.81$, $p < .001$]. Provision of referrals was found to be the best predictor of attitudes, accounting for 15% of the variance. [$F(1,51) = 8.69$, $p < .01$]. The F associated with the increment in R square change by the addition of intraorganizational perceptions was also found to be significant. [$F(1,51) = 6.06$, $p < .05$]. Intraorganizational perceptions accounted for 11% of the variance in attitudes.

Summary and Discussion

It was demonstrated that the reported level of attitudes (i.e., service providers are financially secure, believe that co-ordination is important, and encourage staff to form co-operative relationships with other agencies) was related to provision of referrals and intraorganizational perceptions (i.e., agency has a clear framework, has a sense of collaboration, and is well co-ordinated). This indicates that level of attitudes depends significantly upon provision of referrals and intraorganizational perceptions.

Agencies with strong intraorganizational conditions (i.e., have a clear framework, sense of collaboration, and co-ordination) are confident that they are knowledgeable about other agencies and they receive referrals. These findings provide interesting information. Agencies with strong intraorganizational conditions may be more willing to share resources because they do not feel threatened by other agencies. It is possible that these agencies have a strong sense of self and do not need to remain closed to input from other service providers.

TABLE 15 - SUMMARY TABLE
REGRESSION OF INDEPENDENT VARIABLES ON ATTITUDES

PREDICTOR	MULTIPLE R	R SQUARE	df	F	p
Provision of referrals (TOTAL=52)	.382	.146	(1,51)	8.69	.01
Intraorganizational perceptions (TOTAL=52)	.106	.092	(1,51)	6.07	.05
ALL SIGNIFICANT PREDICTORS	.488	.238	(2,50)	7.81	.01
Has the Mandate to co-ordinate (TOTAL=52)	.210	.044	(1,51)	2.80	ns
Funding Structure (TOTAL=52)	.096	.009	(1,51)	.58	ns
Should have the mandate to co-ordinate (TOTAL=52)	.084	.007	(1,51)	.44	ns
Interorganizational Perceptions (TOTAL=52)	.077	.006	(1,51)	.33	ns
Ratio of Paid Staff to Volunteer Staff (TOTAL=52)	.045	.002	(1,51)	.13	ns

SUMMARY - APPENDIX G - RESULTS FROM SERVICE PROVIDERS

Literature on referrals and attitudes as defined in this study are scarce. This section has provided information on the relationship of referrals and attitudes to other factors of co-ordination, interorganizational perceptions (i.e., belief that agencies in the community are interdependent and have complementary service goals), and intraorganizational perceptions (i.e., agency has a clear framework, and sense of collaboration, and is well co-ordinated).

This section has shown that intraorganizational perceptions and referrals (i.e., agency receives referrals from other service providers and is knowledgeable about other agencies in the community) were significant predictors of attitudes (i.e., agency is financially secure, believes co-ordination is important, and encourages staff to form co-operative relationships with other agencies).

It is suggested that future research investigate referral and attitude factors in more depth

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