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The professional practice of social workers working with chronically mentally ill clients in the community.

Rasma Jankovskis

University of Windsor

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LA THÈSE A ÉTÉ
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NOUS L'AVONS REÇUE
THE PROFESSIONAL PRACTICE OF SOCIAL WORKERS
WORKING WITH CHRONICALLY MENTALLY ILL
CLIENTS IN THE COMMUNITY

by

Rasma Jankovskis
Donna Sutherland

A Thesis
submitted to the Faculty of Graduate Studies
through the School of Social Work
in Partial Fulfillment of the requirements
for the Degree of Master of Social Work at
The University of Windsor

October 1983
Windsor, Ontario, Canada
Research Committee

Dr. L. E. Buckley    Chairperson
Professor B. J. Kroeker Member
Dr. V. M. Signorile  Member
ABSTRACT

The purpose of this research project was to describe the professional practice of social workers working with the chronically mentally ill clients in the tri-counties of Essex, Lambton, and Kent. The research project is exploratory-descriptive in design. Its general purpose was to develop insights, ideas, and questions for future studies in the area of social work with the chronically mentally ill client. Research questions were used to focus on the elements specific to this area of social work practice and to solicit opinions of the workers about issues related to the client group.

The research population included all social workers in Ontario with at least 40% of their caseload consisting of chronically mentally ill clients. The actual research sample is geographically limited to include all eligible respondents in the tri-county area. This purposive sample numbered 10 social workers.

The researchers developed and pretested a semi-structured interview schedule including written and verbal questions. The data is discussed using descriptive univariate statistics.

The research findings indicated that the respondents working with the chronically mentally ill clients held
B.S.W. degrees, were in their late twenties and early thirties, and had five years work experience. Most respondents spent 75-100% of their total work time working with the chronically mentally ill clients. One-half of the respondents' working time was spent working directly with their clients and another one-quarter of their time was spent working on behalf of the client. The predominant social work functions were client advocacy and client follow-up. The major roles performed were teacher, enabler, and social broker.

Various issues and opinions about the chronically mentally ill client group were solicited from the respondents. The three major hurdles facing the person re-entering the community from a psychiatric setting were: stigma, lack of relational support; lack of vocational opportunity. Vocational workshops/employment and housing resources were stated as problematic by many respondents. Most of the respondents experienced verbal threats from their clients while very few respondents experienced physical assaults. Respondents did not view deinstitutionalization as successful. Many respondents identified the younger chronic clients as a special needs group. Stigma was unanimously identified as a problem for this client group.
ACKNOWLEDGEMENTS

The researchers wish to express their gratitude to a number of persons who provided them with their knowledge, time, and suggestions that helped them in the completion of this research project.

The researchers want to express their appreciation to the social workers who participated in the pretest. Their suggestions and feedback improved and added to the study. We are particularly grateful to all the social workers in the research sample who gave their time and shared their experience of working with chronically mentally ill clients.

A special and sincere thanks to our Chairperson, Dr. L. E. Buckley for her patience, guidance, and availability on a "moment's notice". We would also like to express our thanks to the other committee members, Professor B. J. Kroeker for his challenging questions, and Dr. V. M. Signorile for his support and encouragement.

To Joan Reid, a typist's typist, which says it all!

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CHAPTER 1

Introduction

Social work has existed as a profession assisting people with their social and emotional problems since the 19th century. "Social workers have always been involved in the treatment of the mentally ill" (Linn & Stein, 1981, p. 565).

Successful treatment and care of chronically mentally ill people in the community currently continues to be an issue of increasing importance. There has been progressive movement to deinstitutionalize the care of the chronically mentally ill person during the past 25 years in Ontario. Treatment and care in local communities has been emphasized over placement in traditional regional psychiatric institutions. In-patient beds (in Ontario) have been reduced 75% in the past 25 years—from 2,000 beds in institutions and community hospitals in 1958 to 650 beds currently available in Essex, Lambton, and Kent counties, for a population of 542,943 (Statistics Canada, 1982).

Although the deinstitutionalization movement has successfully reduced psychiatric bed occupancy, there are serious problems associated with this phenomenon. Community service agencies, patients and families have been inadequately prepared for this change of direction. A comprehensive
community support system has not been developed as an alternative. Community services have been placed in a "catch-up" situation. Chronically mentally ill persons find themselves in a confusing, and sometimes hostile environment. The Windsor Star reports: "There are tons of new street people in every community. They're people who, basically, have fallen through the cracks in the system" (McKeague, 1983, A.7). "Thus, as mental health care moves into the decade of the 1980's, it remains to be determined whether the Community Mental Health Care Movement ... is achieving its long-term objectives or whether it has evolved into a humanitarian myth" (Turner & Avison, 1983, p. 300).

Social workers play an important role in the care and treatment of the chronically mentally ill person. Through out-patient clinics, follow-up programs and community support programs, the professional social worker assists this client population to function appropriately and adjust to community living. The exact nature of the form of social work practice is minimally reported in the literature and is the focus of this research project. The purpose of the study is to describe the professional practice of social workers working with chronically mentally ill clients in the tri-counties—Essex, Lambton, and Kent. The goal is to develop insights, ideas, and questions for future studies in the area of social work with chronically mentally ill clients.
The study began with a review of the literature. This covered the following areas: Care of the Mentally Ill Person; Deinstitutionalization of the Mentally Ill Person; Deinstitutionalization in the United States; Deinstitutionalization of the Mentally Ill Person in Canada; The Chronically Mentally Ill Person; Stigma and the Chronically Mentally Ill Person; and The Involvement of Social Workers with the Chronically Mentally Ill Person.

The research project is exploratory-descriptive in design. The research questions were used to focus on the elements specific to this area of social work practice and to solicit opinions of the social workers about issues related to the chronically mentally ill client group.

The research population includes all social workers in Ontario with at least 40% of their caseload consisting of chronically mentally ill clients. The actual research sample is geographically limited to include all eligible respondents in the tri-county area (Essex, Lambton, Kent). This purposive sample numbered 10 social workers.

The researchers developed and pretested a semi-structured interview schedule including written and verbal questions. The data is discussed using descriptive univariate statistics.

The questionnaire and interview schedule covered three general areas: demographic information; social work elements involved in professional practice with the
chronically mentally ill clients, and social workers' opinions about issues concerning their chronically mentally ill clients.

The demographic information includes education, gender, age, employment setting, length of employment, prior contact with the client group and job titles. The second section covers the elements of social work practice: size of caseload; use of work time; social work functions; social work roles and professional gratification. The third section discusses the issues of stigma, availability of client services, and deinstitutionalization.
CHAPTER 2

Survey of the Literature

The literature was reviewed and is presented in the following sections: trends in caring for the mentally ill; deinstitutionalization in North America (both United States and Canada, with particular focus on Ontario); stigma towards the mentally ill person; definitions of the chronically mentally ill client; social workers' involvement and practice with and on behalf of the mentally ill person.

In reviewing the literature, the researchers utilized three computer searches, as well as extensive use of the general library resources including manual searches, government documents, and the interlibrary loan system. The review of literature is not meant to be exhaustive. We have examined five main areas to give a focus and understanding to the research topic. Time and resources have limited the breadth of this literature review.

Care of the Mentally Ill Person

Early Care of the Insane

A summary of literature on the historical trends in caring for the mentally ill person is described by Cutler (1981).
Throughout history, perhaps no other group of people have been so ambivalently regarded as the chronically mentally ill. These people were often confined to prisons, escorted to the edge of town to fend for themselves, or beaten until they quieted down or died. They were burned in the Inquisition as witches, chained to stocks by the Greeks, Romans, and early Americans, and placed involuntarily in large untherapeutic mental institutions in the nineteenth and twentieth centuries throughout the world. (p. 344)

As pointed out by Segal and Aviram (1978) "dumping" was a common practice from the fifteenth to the nineteenth century. Mentally ill individuals were taken by coach at night to another town and simply left there.

The treatment and care that the mentally ill have received has reflected the attitudes of people of that time towards the insane as well as their beliefs concerning the causes of mental illness.

The root causes of insanity have included an array of beliefs ranging from demonology, immorality, hereditary factors, childhood traumas, and social stresses.

Colonists equated insanity with disruptive, violent and deviant conduct and assumed it was caused by either demonological possession or moral turpitude. Cruel treatment, including whippings and beatings, was believed necessary to purge the afflicted of sin and terrorize him or her back to sanity. (Bell, 1980, pp. 1-2)

Segal and Aviram (1978) reviewed descriptions of eighteenth-century customs in England concerning the attitudes and responsibilities towards the insane.

If the mentally ill broke the law, they were judged by the penal law; if their mental condition led to poverty and dependence they were in the purview of the poor law; if wandering outside their legal place
of settlement without means or support, they were dealt with by the vagrancy laws. (p. 5)

In the 1820's, as American society developed, jails or poorhouses were the principal institutions that housed the insane. Those who were kept by their families were often hidden and excluded from family life (Committee on Psychiatry and the Community, 1978). The insane family member could be painfully isolated in "private homes, reinforced closets, stalls, pens and woodsheds" (Bell, 1980, p. 24).

In Canada before 1836, mentally ill persons were housed in local jails, poorhouses or in the basements of local general hospitals. They were ill kept, poorly clothed and fed, and often cold (Encyclopedia Canadiana, 1977).

The Development of Mental Institutional Care

In the 1820's in the United States, private asylums were founded by wealthy elites and influential physicians. Some believed that insanity was curable. In the private asylums there was the dedication to the use of "moral treatment" with the mentally ill patients (Williams, Bellis, & Wellington, 1978).

Bell (1980) explains moral treatment:

It entailed instilling in the patient a sense of right and wrong. It involved the removal of the patient from family and friends to an institution in a peaceful environment, individualized care by a sympathetic physician, occupational therapy, recreation, and the general avoidance of physical restraints or drastic treatment. (p. 13)
The private asylums claimed to be able to cure mental illness. Such cures could be attributed to the fact that overcrowding was avoided in these retreats and only a small number of chronic patients were accepted for treatment. The poor insane were not accepted for treatment (Williams et al., 1980).

Between 1830 and 1850 the reform movement to establish State mental institutions in the United States was underway. Dorothea Dix was one such social worker who crusaded about the plight of mentally ill persons in jails and almshouses. She was influential in founding over 30 mental institutions for this population (Committee on Psychiatry and the Community, 1978).

The success stories about curing mental illness in the private asylums through moral treatment were also influential factors in the reform movement. By the mid-1840's the public mental institution or asylum was generally accepted (Bell, 1980).

Williams et al. (1980) state:

Institutionalizing these dependent persons became a way to control welfare costs. . . . The [first] . . . goals . . . were to treat the insane from all classes with moral treatment. . . . Transferring these patients to the state hospitals served many purposes: it was humanitarian; it removed the burden of care from ill-equipped facilities; and it frequently shifted the financial burden of care from the towns to the state. (p. 65)

According to Segal and Aviram (1978), the development of institutional care of mentally ill persons provided
three major social policy functions:

(1) the basic humanitarian ideology of protecting the dependent; (2) the social control of a deviant group that poses a threat to the community, and (3) the demonstration of a curative potential that can be realized at minimum cost. (p. 3)

Thus, institutions were established to provide the insane with refuge and treatment, while protecting society.

Decline of Mental-Institutional Care

Bell (1980) described problems that were encountered after the state mental hospitals had been established. Hygienic problems developed in the overcrowded institutions. The outbreak of epidemic diseases (such as cholera, smallpox, and dysentery) contributed to high mortality rates. As the hospital patient population increased, the personal care once given to patients in the private and public asylums was no longer possible. Physicians lost contact with their patients.

In short, the congested mazes in asylums prevented a regular and easy contact between doctor and patient. Respect for the individual was lost; the patient became part of an unruly mob, without personal identity, a subject to be controlled rather than treated. (pp. 30-31)

Bell (1980) presents an explanation for the changing nature of the patient population.

In the early years of the asylum movement, patients shared a common middle-class cultural background. By mid-century the influx of paupers and immigrants, along with the admission of the criminally insane, the mentally retarded, the aged, and the alcoholic, altered the asylum's class makeup and psychological character. (p. 31)
The Committee on Psychiatry and the Community (1978) noted that state mental hospitals were often built in remote areas. These institutions were, from the beginning, plagued by financial difficulties.

The social isolation, the lack of professional resources, and stimulation, and low salary scales made it difficult to attract qualified psychiatrists.... The mentally ill became ignored and neglected and were warehoused out of the consciousness of most citizens.

The conditions in state hospitals cast a pall of pessimism over the profession of psychiatry.... The enthusiasm for moral treatment was lost and most psychiatrists accepted the fatalistic view that mental illness was inherited and untreatable. (pp. 298-299)

Mental state hospitals lost much of their therapeutic orientation and became custodial caretakers.

Donahue (1978) further describes conditions within the large mental institutions during the 1940's revealing the continuing decline of these institutions. Mental hospitals by this time were commonly called "snakepits." The themes of overcrowding, lack of facilities, and insufficient staffing persisted. As well, Donahue states:

The ethic of patient dignity was ignored. There were few treatment modalities available beyond electric shock therapy and some surgical practices, and they were of questionable value. Physical restraint was frequently used to subdue agitated or violent patients. Custodial incarceration was almost the universal mode of care for the mentally ill and amounted to little more than keeping patients physically alive. Neglect, poor patient care, rapidly increasing mental hospital populations and astronomical costs became such blatant problems that changes became imperative. (p. 103)

Mechanic (1979) reports on various negative consequences that were documented during the 1960's and have affected
long term institutionalized patients. He states:

Long tenure in institutions and dependence on institutional services were associated with a syndrome of apathy, hopelessness, and incapacity. The syndrome was called 'institutionalism' and was seen as having three interrelated components. First, long-term patients were not only ill, but often lacked strong ties with community, family, or work, and were vulnerable in addition because of age, poverty, and lack of social interests and ties. Second, there are those elements of disability that result more directly from the disease process itself and may become exacerbated with time unless rehabilitation efforts are made to reverse the process. Third are the erosive effects of the institution itself, such as the consequences that flow from lack of activity, participation, independence, and a sense of involvement. (p. 66)

The theme of institutional dependency, the loss of social and vocational competencies, and the loss of contact with relatives and significant others is discussed by Kiesler (1982):

Mental institutions have additional effects - the stigmatization by others as being mentally diseased, and the self-labeling as mentally ill - that could interfere with the new learning and sense of confidence necessary to produce positive therapeutic change. (p. 351)

The syndrome of institutionalism and its serious consequences helped to foster the belief that institutionalization, at least as long term care, was detrimental to the patients.

This overview on the historical development and decline of institutional care for the mentally ill person is essential to understanding the factors that influenced the move towards the community care of the psychiatric population.
Deinstitutionalization of the Mentally Ill Person

A review of the literature provides various definitions of deinstitutionalization. The term is understood to mean different things to different people. According to Mechanic (1979), the concept is often unclear and vague. A partial definition follows:

The movement of patient populations from large public institutions to other locations and the substitution of community treatment or short-term institutional care for long-term custody. . . . The term has also been used to refer to the transfer of patients from one institution to another, such as the movement of patients from mental hospitals to nursing homes, board and care facilities, and other sheltered living situations. (p. 66)

Another definition of deinstitutionalization is provided by Scherl and Macht (1979): "A process involving the avoidance of remote settings for the care of the mentally ill, including preventing both unnecessary admission to and retention in institutions; the concurrent expansion of community-based services for the treatment of the mentally ill" (p. 599).

Literature on deinstitutionalization reveals that this phenomenon has been applied not only to the mentally ill population, but also the mentally retarded, juvenile offenders, and other social deviants (Mechanic, 1979).

Bachrach (1978) points out that the philosophy underlying deinstitutionalization stems from three basic assumptions concerning mental health care.
1. Community care is a good thing - community-based care is preferable to institutional care for most if not all, mental patients. Community care is perceived as the more therapeutic alternative, and it represents the treatment of choice in most cases of mental illness.

2. Communities not only can, but are also willing to assume responsibility and leadership in the care of the mentally ill.

3. Deinstitutionalization is based upon an assumption that the functions performed by the mental hospital can be performed equally well - if not better by community-based facilities. Deinstitutionalization, in short, implies that the community is capable of providing, outside of institutional settings, the full range of patient services that are available inside the hospital. (p. 575)

Hatcher and Rasch (1980) describe the goal of deinstitutionalization as reintegrating the mentally disabled into the mainstream of society and the normalization of life for this population. Normalization means providing "patterns and conditions of everyday life which are as close as possible to the norms and patterns of mainstream society" (p. 66).

Deinstitutionalization in the United States

Factors Influencing Deinstitutionalization

Overcrowding in large state mental institutions had become a serious problem in the United States by the mid-twentieth century.

In view of the inhumane conditions and financial burden of the mental hospital system, the steady increase in the numbers of hospitalized mentally ill, and the growing disillusionment with the hospital as a mechanism of treatment and cure,
mental health problems could no longer be ignored and thus became a pressing public policy issue. (Segal & Aviram, 1978, p. 19)

The deinstitutionalization movement of the psychiatric population has been influenced and shaped by philosophical ideologies, and medical discoveries, as well as political, social, economical, and judicial forces that have been taking place in North America through the mid-1950's to the present time.

John A. Talbott (1981) reported in his book The Chronic Mentally Ill that:

Following World War II, the unprecedented interest in the mentally ill, coupled with the surge of work in social psychiatry and the initiation in 1955 of a Joint Commission on Mental Health and Illness set the stage for the era of community mental health. (p. 17)

As a result of the public's concern over the conditions in the United States mental health services, the Joint Commission on Mental Health and Illness was established by the U.S. Congress to make recommendations for a national health program (Segal & Aviram, 1978).

The thrust for deinstitutionalization in the United States was initiated by a speech by President John F. Kennedy to Congress in 1963. He recommended that a network of community mental health services be established throughout the country to replace institutional care (Talbott, 1981). Thus, in 1963, a new mental health delivery system, the community mental health centre, was created. "These centers, which were touted as the eventual replacement of the State
hospital system, paradoxically were not required to develop treatment programs for the chronically mentally ill" (Williams, Bellis, & Wellington, 1980, p. 62).

The deinstitutionalization movement coincided with the movement towards community mental health centres during the 1960's (Scherl & Macht, 1979). Sometimes the term 'deinstitutionalization' seems to be confused with the community mental health movement (Bachrach, 1976). The significant differences are aptly described by Kirk and Therrien (1975):

Although community mental health programs were established to supplant the traditional state mental hospital, both their ideology and their most common services are not directed at the needs of those who have traditionally resided in state psychiatric institutions. The ideology of community mental health has been primarily concerned with primary prevention, the importance of early diagnosis and treatment, consultation, social action, crisis intervention, short-term out-patient care, and time-limited brief inpatient care. Preferred target populations for such services are clearly normal populations who are at risk, persons with mild, acute, treatable disorders, who can be handled in office practice, or severely disordered persons suffering from their first psychiatric crisis. Community mental health programs do . . . have services . . . for patients with a long history of severe psychiatric disorder, but these programs are not meant to constitute the core of community mental health practice and are usually the least prestigious of services offered, have the fewest and least trained staff, and are often viewed as undesirable but necessary services. (p. 210)

Borus (1981) noted that in the 1960's professionals advocated reform in the large mental institutions and the development of community treatment for the mentally ill.
Deinstitutionalization was viewed as the solution to the problem.

Deinstitutionalization . . . occurred during an era when a more generalized political philosophy of social reform stressing society's responsibility to help the individual, has predominated. . . . Deinstitutionalization is ideologically committed to improving the lot of persons perceived as helpless in gaining access to life's entitlement. It is a movement dedicated to the dignity of individuals. (Bachrach, 1981, p. 56)

In the medical field the development of psychogenic drugs in the 1950's assisted in controlling mental illness and helped to change the "attitudes of professionals and families about the control of psychopathology" (Mechanic, 1979, p. 64).

Psychotropic drugs, also called "wonder drugs," the tranquillizers, neuroleptics, anti-psychotics and others were first introduced in 1952.

The drugs enabled mentally ill patients with disturbing symptoms to relax while remaining fully conscious. The major tranquillizers . . . provided chemical means of control, helping hospital personnel work with mental patients. Many distressing aspects of mental hospital life, related to the need to control disturbing behavior, disappeared. The hospital atmosphere changed, gave staff greater confidence, and encouraged . . . the unlocking of hospital wards, the trends towards early release. One of the most significant effects of psychoactive drugs was the new wave of optimism: feelings of hopelessness and apathy that had prevailed in mental institutions gave way to new hope that patients could be helped and that treatment could be effective. (Segal & Aviram, 1978, p. 27)

The establishment of child guidance clinics, psychopathic hospitals, outpatient and after care clinics, general
hospitals and the community mental health centres were becoming alternative placements to treatment in the large mental institutions (Talbott, 1981).

Advocates for the social reform movement favoured deinstitutionalizing the mentally ill patients. They believed institutions were "dehumanizing and anti-therapeutic, and that the community provides an opportunity for socialization and rehabilitation. The presence of chronically disabled persons in the community makes it impossible to deny their existence and needs" (Williams et al., 1980, p. 54).

Mechanic (1979) presents factors in the economic realm that influenced deinstitutionalization of the mentally ill. "The development of financial programs that subsidized and increased welfare assistance, medical care and payments to nursing homes was a crucial factor in allowing large numbers of dependent psychiatric patients to return to community living and other community institutions" (p. 65). Over the years, inflation contributed to the high cost of hospitalization and placed pressure on hospital administrators to reduce patient populations (Committee on Psychiatry and the Community, 1978).

It was believed that deinstitutionalization was economical and therefore acceptable to those who were concerned with fiscal reform. State legislators reduced their budgets by transferring the responsibility and financial expense of caring for the deinstitutionalized
mentally ill patient to other levels of government. "Income maintenance programs for released mental patients, based on federal policy change, played an important role in facilitating the mass emigration of mental patients from the hospitals to the community" (Segal & Aviram, 1978, p. 16).

Deinstitutionalization of the mentally ill person has been affected by the increasing importance of legal, judicial, and legislative actions that emphasized "the right of the individual to receive treatment in the least restrictive setting, the right to refuse hospitalization, and the right to be returned home as quickly as possible" (Spakes, 1983, p. 8). The Group for the Advancement of Psychiatry and Community (1978) reported: "New legislation has been designed to protect the civil rights of mental patients. Involuntary confinement is now limited to periods when mental patients are considered dangerous to themselves and others" (p. 290).

Obstacles to Successful Deinstitutionalization

 Various authors have indicated that there was poor or little planning before or during the deinstitutionalization movement. Messina and Davis (1981) describe some of the barriers to total deinstitutionalization:

The poor planning and inadequate preparation of the community for the placement of ex-patients,
... the fear of closing the hospitals and losing thousands of jobs and millions of dollars of revenue. ... Economic tides are presently against full implementation of massive deinstitutionalization of the mentally ill. (p. 36)

Scherl and Macht (1979) point out that communities were flooded with discharged psychiatric patients often before there was any community organization or program development for these individuals. As well, resistance towards deinstitutionalization was encountered from the patients, their families, and hospital staff.

The fear and stigma of the mentally ill has been a major obstacle to deinstitutionalization (Scherl & Macht, 1979; Talbott, 1979; Heaselton, 1982).

Messina and Davis (1981) identified another obstacle, the incompatibility of the social goal of deinstitutionalization and budget realities.

The impact of public opinion is reflected in the lack of a permanent commitment by most state legislatures to an organized and coordinated deinstitutionalization plan. The costs of such programs, fears of the people, stigma of mental illness and mental retardation, discrimination against the handicapped and lack of accurate information makes the voting populace hesitant to support the initiatives of social planners to return the handicapped to the community. ... The lack of effective advocacy and lobbying by the forces favoring deinstitutionalization is also an issue. (p. 37)

Stein and Test's (1976) article points out that there is reluctance among mental health professionals to work with the chronically mentally ill person. This creates obstacles for the discharged patient into the community.
The reason given for this reluctance is cited as the low status ascribed to those professionals who work with severely handicapped persons. 'High status' is given to those professionals who provide intensive psychotherapy to their less severely ill clients.

Messina and Davis (1981) claim that deinstitutionalization is a myth, only perpetuated by the beliefs and attitudes of mental health professionals. They state that there is insufficient research to prove that the mentally ill are able to live a better life outside of the mental hospital.

Bachrach (1978) has analyzed the various roles of mental institutions and suggests that these hospitals provided many functions that the community has not been able to duplicate. These hospitals provided not only asylum, long-term treatment, and custodial care, but additional functions such as: "relief to the patient's family . . . ; a sort of hiding place outside the community for some of its less attractive members; or an economical base for the hospital community" (p. 575).

Community readiness includes having the manpower, the available services and the attitudes towards the mentally ill person to accept disturbed persons into the community. Preparation takes time and all communities are not equally ready for discharged psychiatric patients.
Bachrach's (1978) opinion was that deinstitutionalization had not been successful.

Scherl and Macht (1979) reported that in the United States there was no national strategy to implement deinstitutionalization policy. It became a recognized planning goal of the Department of Health, Education and Welfare in 1976. The needs of the mentally ill person, such as after care, housing, vocational rehabilitation, and other support systems were not addressed until the late 1970's.

Consequences of Deinstitutionalization

The literature attests to unexpected consequences of deinstitutionalization. These were usually related to the preceding obstacles. Inadequate planning for effective community treatment programs for the mentally ill person left many of the psychiatric patients dumped into inadequate settings such as nursing homes, boarding homes, and single occupancy hotels (Scherl & Macht, 1979).

Those psychiatric patients who were transferred to nursing homes displaced the elderly who, as a result, frequently remained in the acute care facilities in hospitals while waiting for a space in the nursing homes. As psychiatric patients were discharged and remained in the community, "All acute care facilities, especially general hospital emergency rooms began to be used more to
handle the problems of the chronically mentally ill than dealing with acute mental conditions" (Talbott, 1979, p. 622). Suddenly cities were flooded with many disturbed mentally ill persons. These individuals found residency in low-cost housing, contributing to ghettos.

The Committee on Psychiatry and the Community (1978) reported that the deinstitutionalization movement had contributed to the growth of "a new and probably growing group of psychiatrically severely disabled persons who have spent most of their time in community settings and are treated in local hospitals during their acute episodes" (p. 309).

Two new phenomena appeared and have become known as falling between the cracks, and the revolving door syndrome. The former indicates a total lack of follow-up and after-care for discharged psychiatric patients. The latter syndrome refers to their continued readmission into hospital care (Talbott, 1979). The recidivism rate has been high since the deinstitutionalization movement was initiated. Marshall (1982) reported that only about 50% of discharged patients remain out of a hospital for one year. Lamb (1981) cites 65% to 75% of ex-psychiatric patients re-admitted into hospital care within five years.

Bassuk and Gerson (1978) draw attention to the needs of discharged psychiatric patients stating: "There is a shortage of housing, vocational rehabilitation, sheltered
employment or job referrals, transportation and recreation" (p. 50). Talbott (1979) claims deinstitutionalization did not occur but transinstitutionalization was achieved. Many ex-psychiatric patients have been transferred to nursing homes and penal institutions (also see Borus, 1981).

Talbott (1979) concluded that one beneficial consequence of the deinstitutionalization movement was that it revealed the shortcomings of the mental health delivery system in the United States. It exposed the flaws of a non-system.

Solutions to Problems Related to Deinstitutionalization

The literature revealed that there is no one easy solution to the problems encountered by the deinstitutionalization movement in the United States.

Bachrach (1978) proposes that the deinstitutionalization movement has encountered difficulties because of a conceptual oversight. She points out that deinstitutionalization is "frequently held to refer only to the release of patients from large mental hospitals" (pp. 573-574). She proposes that deinstitutionalization be viewed as a process, a fact, and a philosophy. Deinstitutionalization "as a process involves two elements: the eschewal (or shunning), or avoidance of traditional settings for the care of the mentally disabled, and the concurrent expansion of community-based facilities for the care of these individuals" (pp. 573-474).
Bachrach (1978) conceptualizes deinstitutionalization as:

A dynamic and continuing series of adjustments involving constant accommodation of all the components of the mental health service delivery system. The concept of continuity of care is a reflection of the dynamic nature of deinstitutionalization. Ideally . . . the patient is expected to move about freely from facility to facility or even in and out of the service delivery system. The ideas of a 'range of treatment alternatives' and 'freedom of choice' are critical elements. (p. 574)

This same author proposes other solutions to the difficulties encountered by the deinstitutionalization movement. She suggests that state mental hospitals should be "incorporated into a unified system of care and given a definite place in the range of treatment settings . . . until . . . the functions it fills can be placed in community facilities" (p. 577).

The target population for community-based care must be defined. Planning should involve those chronically mentally ill patients who can benefit from being deinstitutionalized. It is necessary to assess their needs and provide the appropriate services. Ex-psychiatric patients need medication, social services, financial assistance, rehabilitation, and housing (Talbott, 1979).

Talbott's (1979) solutions to the problems with deinstitutionalization included:

1. A reassessment of the attitudes of all segments of society towards the chronically mentally ill.
2. A broad coalition of health professionals, consumers, government officials, business leaders, and others . . . to combat widespread attitudinal biases and discriminatory practices that now exist.

3. Future attempts to deinstitutionalize patients and close state hospitals must have built-in funding for both institutional and community services during the phase-down process. (p. 623)

Scherl and Macht (1979) suggest that there has been a conceptual confusion generated by the development of the community mental health centre and the deinstitutionalization movement that occurred simultaneously. Messina and Davis (1981) point out that deinstitutionalization may succeed if mental health workers choose to act as advocates for the chronically mentally ill. These workers serving the chronically mentally ill need appropriate training and recognition in their work.

Deinstitutionalization of the Mentally Ill in Canada

In Canada, as in the United States, mental institutions were historically thought to be the appropriate place for the care and treatment of the mentally ill person (Richman & Harris, 1983). In Canada the mental hospitals had become overcrowded by the late 1950's. The situation called for remedy. "In 1960, 0.4% of Canadians were in mental institutions; of these 75,000 patients, one-half had been hospitalized over seven years. Death in hospitals was more likely than discharge alive for long-stay patients" (Heseltine, 1982, p. II.5).
In 1962, Saskatchewan had the largest number of psychiatric patients in mental institutions compared to the rest of Canada. The reason the patient population was so high was because Saskatchewan had a philosophy of providing psychiatric services. The motivation for quality care and the funding was already in place for deinstitutionalization to take place. The new policy involved planned discharge and the provision of alternative placements for the mentally ill person into the community. It contributed to a 40% reduction of the psychiatric population in mental hospitals between the years of 1963 and 1967 (Lawson, 1967).

Lawson (1967) reports that the philosophy behind the Saskatchewan Plan was that no individual should be institutionalized, not even for custodial care. Other methods of treating the mentally ill were preferable to incarceration.

Smith (1971) reports that reductions in the psychiatric hospitals were facilitated by policies that consisted of "A more selective admission policy with more emphasis on care outside hospitals; regionalization of services with care closer to home; active rehabilitation programs and higher treatment standards" (p. 67). These same authors stated that the Saskatchewan Plan "regionalized psychiatric care into small regional comprehensive mental health centres" (p. 68).
The decline of psychiatric patients in Saskatchewan's psychiatric hospitals was particularly noticeable. At Weyburn, between 1963 and 1966, the in-patient psychiatric census dropped from 1,505 to 522, a reduction of 65.3% (Smith, 1971). The Saskatchewan Plan was considered successful as it provided for a full range of services in each region for the mentally ill and made placement into a mental hospital more difficult. There was strong and consistent government support of the deinstitutionalization policy.

Deinstitutionalization in Ontario

Overcrowding in mental hospitals.

Deinstitutionalization in Ontario was a response to deal with the overcrowded provincial mental institutions.

In 1961, Ontario's psychiatric in-patient population was approximately 16,000 persons (Singh, 1976).

This unhealthy situation was due to . . . the commitment of many patients, usually in the older age groups, with varying degrees of senility who could have been managed in the community if other facilities had been available; the continued maintenance of many persons in hospital whose mental condition had long since become chronic; the increasing change from a rural to largely an urban way of life so that no longer were most families willing or able to assume responsibility in the home for a disabled member; the provision of adequate community facilities for the care of the chronically disabled and aged had not kept pace with the needs; and finally, the shortage of mental health professionals to provide adequate treatment. (Holling, 1969, p. 20)
As the psychiatric population increased, it was evident that many of the patients no longer required all of the services of the mental hospitals; however, these patients were not discharged to the community as they did not have the means to support themselves nor the housing outside of the hospital setting (Richman & Harris, 1983).

Ontario, as elsewhere, was influenced to reduce the mental hospital population as a result of the following: development of the psychogenic drugs; changes in the philosophy of caring for the mentally ill; knowledge of the negative effects of institutionalization; and various changes within the mental health care system (Sylph, Eastwood, & Kedward, 1976).

In Ontario itself, a number of important developments occurred in the 1950's and continued throughout the years to influence the movement to deinstitutionalize the mentally ill population.

Reports and legislation addressing deinstitutionalization.

The Dymond Report (1959) was an influential document that recommended changes in the mental health services in Ontario. It recommended a change from purely custodial care of the chronically mentally ill person.

The Dymond Report of 1959

Aimed at a program which would provide early treatment [for the mentally ill person] without legal formality, with minimal disruption of
community ties and an early return to a normal environment. It recommended the reduction of mental hospital patient population by 40-60 per cent. It also recommended that the hospital should function as a real 'therapeutic community' for patients with chronic mental disorders and not be considered as an institution for custodial care. Hostels and accommodation for discharged patients could be supervised by the hospital and follow-up and after-care services should be expanded. (Allodi & Kedward, 1973, pp. 280-281)

Both the Canadian Mental Health Association report of 1961 and the report of the Royal Commission on Health Services (1964) spelled out the principles of the deinstitutionalization movement in Ontario. The Canadian Mental Health Association report recommended:

Integration of psychiatric services with the physical and personal resources of the rest of medicine; close cooperation among treatment personnel and co-ordination of psychiatric services to ensure that the patient would receive appropriate help in his community through all phases of his illness, without interruption; co-ordination of local psychiatric services in hospitals, clinics, and other centers to promote maximum effectiveness; regionalization of psychiatric treatment services in population centers and establishment of a wide range of psychiatric services in larger communities; and decentralization of the management and administration of psychiatric services. (Richman & Harris, 1983, p. 66)

The key issue in the Royal Commission on Health Services Report pertaining to deinstitutionalization was the recommendation to remove all psychiatric patients from the mental institutions.

We believe that provinces should move with all due speed to remove all patients receiving or capable of
receiving active care from mental hospitals and transfer them to general hospitals. . . . We believe it can be accomplished by 1973 if we begin immediately to build additional psychiatric wings or units in most large general hospitals. . . . There will remain a large number of custodial patients, now in mental hospitals, who will not be transferred to active treatment, psychiatric hospitals or units. If possible these patients should be moved to other appropriate facilities, some of which are available and others we recommend to be established. (Royal Commission on Health Service, 1964, p. 25)

In order to facilitate the reduction of the psychiatric population in the institutions, alternative placements were developed for the care of psychiatric patients in the community. Changes in social welfare and mental health legislation occurred in the 1950's and continued through to the present.

Changes in the Mental Health Act of Ontario influenced the deinstitutionalization of the mentally ill person. Prior to 1967, a person certified by two physicians as mentally ill could be confined under psychiatric surveillance indefinitely. In 1967, the legislation changed so that any person who did not admit himself or herself as a voluntary patient in a psychiatric hospital when requiring such facilities could be admitted as an involuntary patient and held for one month on the certification of one physician if that person was a safety risk to himself and others.

Under the amended Mental Health Act, 1978, a person can be detained up to five days, and after that period may become a voluntary patient or be discharged. Changes
within this piece of legislation has increasingly lessened the time period a person designated as mentally ill can be held in a psychiatric facility unwillingly.

Alternative placements.

In Canada, each province is responsible for providing health services to its citizens. Each province has used different placements in depopulating its psychiatric institutions (Richman & Harris, 1983).

Ontario hospital administrators initiated an 'approved homes' program which in the 1960's was expanded.

In 1932 there were some approved homes functioning as half-way houses, and from the early 1950's their numbers increased, reaching a peak in 1967 and 1968. Patients in these homes, however, were 'on the books' and so responsibility for their psychiatric care remained with the hospital. (Allodi & Kedward, 1973, p. 281)

During the 1950's and 1960's, the placement of psychiatric patients into community foster homes was a widely used and popular way of reducing the mental hospital population (Murphy, 1972). Tcheng-Laroche, Murphy, and Engelmann (1976) reported that the use of foster homes was considered to be financially economical. There was the hope expressed that the long-term institutionalized mentally ill individuals might return to normality more quickly by being in a placement considered to be a more natural home-like setting. These researchers conducted a follow-up study of psychiatric patients who were placed
in 58 foster homes in three Canadian provinces (Quebec, New Brunswick, and Ontario). Three-quarters of the patients were diagnosed schizophrenic. It was found that psychiatric patients with a high degree of symptomatology placed in foster homes showed clinical improvement, i.e., less depression, anxiety, and suspiciousness. The chronic patient with a psychiatric history of more than 15 years improved the most. They, however, did not show improvement in social adjustment and did not resume any of their social roles. These psychiatric patients were socially isolated and did not acquire socialization skills in the foster homes. They recommended half-way houses for the psychiatric patient.

From 1962 until 1971, psychiatric beds in general hospitals were introduced in Ontario. Some chronically mentally ill patients may have received short-term treatment and placement in these facilities (Kedward, Eastwood, Allodi, & Duckworth, 1974). Another facility that was established to decrease the overcrowding was the creation of the residential units program.

Initially it meant only a change in the accounting system so that when patients were transferred to a different ward or to a villa, often in the grounds of the same mental hospital, they ceased to be 'on the books' and became 'persons' instead of 'patients'. (Allodi & Kedward, 1973, p. 281)

This residential units program, which was developed for those patients who no longer required hospital care, was phased out in 1971.
In 1964, the Act now known as Homes for Special Care Act encouraged the creation of a new kind of facility. This program was to be Ontario's answer to deinstitutionalization of the mentally ill population from mental institutions. In the Homes for Special Care Act, 1964, this new kind of facility for persons requiring special care was defined as "a home for the care of persons requiring nursing, residential or sheltered care" (Statutes of Ontario, 1964, c.39, R.S.O. 1980, c.202).

The features of the homes for special care were described by Sylph, Eastwood, and Kedward (1976).

Privately run but government-funded accommodation for severely disabled patients with relatively stable and socially acceptable behaviour, who require residential or nursing care but are thought unlikely to benefit from further hospital treatment. Salient features of the program include the formal discharge of patients from hospital and their legal reinstatement as 'persons,' the cessation of active psychiatric treatment, and the provision of on-going care and supervision by largely untrained personnel. Medical care is provided by general practitioners and the program looks to volunteer agencies to provide recreational and other activities for residents. (p. 233)

The homes for special care program was viewed as a way of gradually integrating the mentally ill person back into the community and providing them with a family care approach in their treatment (Allodi & Kedward, 1973).

The major flaw with this program was that discharged psychiatric patients were not provided with on-going psychiatric treatment (Richman & Harris, 1983).
By 1971 the Ministry of Health began its policy of decreasing facilities and beds in Ontario's psychiatric hospitals, through phasing out, closing down or merging various institutions throughout the province (Ontario Council of Health, Committee on Mental Health Services in Ontario, 1979).

Developments in social and welfare legislation provided some of the support systems required by the chronically mentally ill person to reside in the community. Examples are: Disabled Person's Allowances Act, S.O. 1955; Rehabilitation Services Act, S.O. 1955; General Welfare Assistance Act, S.O. 1960; Family Benefits Act, S.O. 1967 and their subsequent amendments. These various pieces of legislation provided for financial assistance, and vocational rehabilitation services which are necessary resources required by discharged psychiatric persons residing in the community.

The creation of the federal Canada Assistance Plan in 1966 provided the financial support for the Homes for Special Care program.

As the policy of reducing both patients and facilities occurred, rehospitalization or the revolving door syndrome appeared in Ontario as it had in the United States. "In Ontario the increase in hospital admissions between 1960 and 1971 was 107% but the increase in readmissions was 252%
constituting an increase in the proportion of readmissions of total admissions from 36% to 61% in 1971" (Kedward et al., 1974, p. 522). The pattern of discharge was similar. Singh (1976) reported that Ontario's psychiatric in-patient population dropped from about 16,000 in 1961 to 5,000 by 1975.

Criticisms of deinstitutionalization in Ontario.

Concerns about the deinstitutionalization movement involving the psychiatric population in Ontario have been voiced by the Ontario Public Services Employees Union in Marshall's (1982) book, *Madness: An Indictment of the Mental Health Care System in Ontario.*

Patients are being discharged without adequate or sometimes any consideration given to psychiatric and psychological aftercare or where they will live. . . . There is excessive use of medication. . . . Evidence indicates that in addition to a lack of community services and programs for patients after discharge, there is also a breakdown of the system within institutions. Because of budget cutbacks, hiring freezes and paper-before-people administration policies, residents of mental institutions and patients in psychiatric hospitals are not receiving the treatment they require. (pp. 28-29)

The Ontario's Council of Health publication *Agenda for Action* (1979) states that chronically mentally ill individuals require rehabilitative services to help maintain them in the community. "Little has been accomplished in terms of improving the availability and accessibility of these services" (p. 47). The Committee recommended a community support system model to assist in the rehabilitation
and maintenance of the chronically mentally ill persons in the community. This model includes: life skills programs to assist the chronically mentally ill to cope with everyday life; educational and vocational opportunities; a continuum of housing arrangements; social and leisure activities; assistance in financial management; self-help groups for the ex-mental patient and families of psychiatric patients; family support for those families caring for the mentally ill family member.

Heseltine (1982) reporting on the mental health care system in Ontario states:

Ontario's use of hospitalization in general is higher than the national norm... Ontario continues to put a disproportionate amount of its mental health care money into hospitals instead of the development of extramural and community care. Many of the current in-patients in psychiatric hospitals could have their treatment needs appropriately served through an extramural or community program... Ontario, like Canada as a whole, has reduced the number of patients, in public psychiatric hospitals and increased the number in psychiatric units in general hospitals. This has resulted in an overall decrease in the number of patients treated in hospital. However there does not appear to have been a comparable increase in community-based services. (p. II.28)

Richman and Harris (1983) remind us that community care of the mentally ill persons is a recent phenomenon. Deinstitutionalization in Canada is concerned with keeping the psychiatric population in the community and providing these individuals with continuity of care. This requires
that a variety of services are available in the community to meet the various needs of this population. More research must be undertaken to determine the kinds of services needed by the long-term chronically mentally ill person. Further criteria are needed to determine those mentally ill persons who may not have their needs met through community care. More research follow-up on discharged ex-mental patients, their adjustment, needs and uses of services in the community is necessary.

There needs to be better co-ordination among hospital treatment staff, aftercare workers, and social service program providers. Information about services available must be provided to ex-patients and families. Outreach must be more active and aggressive (Turner & Avison, 1983).

The Chronically Mentally Ill Person

In reviewing the literature, various authors have described and identified characteristics of a chronically mentally ill person. "Chronicity usually is used for an illness lasting a long time, interpreted by some as hospitalization for one or two years or the presence of a major psychosis (e.g., schizophrenia) for the same time period" (Talbott, 1980, p. 44).

Bachrach (1976) discussed deinstitutionalization describing the chronic mental patient as "those individuals who are, have been, or might have been, but for the
deinstitutionalization movement, on the rolls of long-term institutions" (p. 11). Cutler (1981) states simply that the chronically mentally ill population is composed of deinstitutionalized individuals: "the 'revolving door' persons who go in and out of hospitals and individuals with a chronic disability who are not hospitalized" (p. 376).

Cutler (1981) outlined and described characteristics of the chronically mentally ill person. They often exhibit bizarre or unusual symptoms and behaviours. They have difficulty organizing their thoughts, and thinking logically. This inhibits their ability to cope with the basics of daily living. Their work performance is greatly diminished. They lack self-confidence leading to possible dependency. A minimal amount of stress can precipitate symptomatic behaviour. Generally, they avoid and are uncomfortable with social and recreational activities. This behaviour is reinforced by the stigma associated with their condition. They are dependent upon, but often resistant to, chemotherapy.

For the purpose of this study, the definition of the chronically mentally ill person is that of Test (1981) who states:

Chronically mentally ill [persons are] those individuals who, by reason of severe and persistent mental disorder, experience serious limitations in their functioning relative to primary aspects of daily living such as personal relations, living arrangements, [and employment]. (p. 72)
Stigma and the Chronically Mentally Ill Person

Stigma and fear of the mentally ill has been identified as one of the major obstacles impeding community acceptance of this group. What is stigma? How does it affect the mentally ill person?

Cumming and Cumming (1965) state:

The word 'stigma' is often used to describe the way in which society stamps those who have been mentally ill. Its literal meaning is 'a stain on one's good name,' or a 'loss of reputation.' Originally, the word referred to a mark placed on a slave or prisoner as a sign of his status. Whether it is a visible mark or an invisible stain, stigma acquires its meaning through the emotion it generates within the person bearing it and the feeling and behavior toward him of those affirming it. . . . Stigma is generated and reinforced in interaction. (pp. 135-136)

Gallagher (1980), in his discussion about stigma towards the mentally ill person explains that: "The person who is or was mentally ill is stigmatized because he is deeply discredited for his failure to live up to societal expectations and frequently rebuffed whenever he attempts social intercourse" (p. 332).

Goffman (1963) in his book Stigma discusses the consequences of discrediting information upon the social identity of the ex-psychiatric person. He points out that knowing that an individual has a past psychiatric history tends to influence the way others view a person. There is a change from seeing the person as 'whole' and 'usual' to 'tainted' and 'discounted.' According to Goffman (1963):
"We believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances" (p. 5).

Research devoted to examining the public's attitude towards the mentally ill person reveals that up to 1960, mentally ill persons were feared, avoided, and stigmatized. Studies since 1960 show more varying results, although stigma is still present (Group for the Advancement of Psychiatry, 1978).

Lamy's study (1966) investigated the attitudes of two sample groups of undergraduate liberal arts students towards ex-psychiatric patients who had been treated in a mental hospital and discharged into the community. The research findings indicated that the ex-mental hospital patient was evaluated negatively and would have difficulty being accepted in the community. "It is predicted that the discharged mental patient will find the social community non-hostile, but unaccepting" (p. 455).

Freeman and Simmons (1961) interviewed the spouses and mothers of ex-mental hospital patients in an attempt to identify the feelings of stigma. These researchers defined stigma as "sensitivity to the reactions of community associates accompanied by withdrawal and concealment" (p. 316). They found that: "Stigma appears to be associated with the degree of bizarre behavior on the part of the
patient, the social class identification of family members, and their personality characteristics" (p. 321).

In their 1971 study, Benz and Edgerton interviewed a random sample of 1,405 respondents and reported "a greater acceptance of mental illness and the mentally ill" (p. 33). However, in contrast to the above findings, Rosenhan (1973) reported that the basic attitude held by all of us towards the mentally ill person is still characterized by mistrust and fear.

Miller and Dawson (1975) were interested in finding out how stigma related to the re-employment problems of discharged mental patients. They interviewed 156 patients who had returned to the hospital and asked them about their employment experiences while in the community. These researchers found

Very few had been fully and competitively employed, able to support themselves during the leave period. . . . Those who secured jobs generally worked only part-time or intermittently as domestics or field hands, or other menial jobs. Almost all were financially dependent, at least in part, upon their families or public welfare agencies. . . . Evidence indicates the need for vocational services of many kinds. (p. 287)

Fracchia, Canale, Cambria, Ruest, and Sheppard (1976) investigated the responses of 30 male and female suburbanites and found that this group of respondents associated dangerous and unpredictable behaviour with the ex-mental patient. These authors suggest: "The propensity to link the behavioral characteristics of dangerousness with mental
illness may constitute one of the major stumbling blocks to greater actual acceptance of mentally ill persons in the community" (p. 498).

Nuerhing (1979) studied both the social stigma felt by discharged psychiatric patients and the degree to which relatives and friends considered these individuals a burden. Using a sample of 332, he found that:

Available data suggests that the personal experience of stigma follows in part from one's community environment, ethnic background, social contacts (working, living with family members) and experiencing feelings of depression. The degree to which intimates view one as a burden is sex-role related, hinges upon interacting with family as influenced by one's level of depression and anxiety, and is affected by being in after care treatment. (p. 631)

Segal (1978) reviewed the literature to learn how the public currently views the mentally ill person and mental illness. From his research, he summarized and presented the following statements:

1. A broader range of behavior is viewed by the public today as mental illness.
2. The behavior itself or the pattern of behavior, is the major determinant of the positive or negative character of the public's attitude towards mental illness.
3. There is less reported social distance between the mentally ill and the public today, although situations requiring a greater degree of personal involvement still result in significant efforts of avoidance on the part of the public.
4. There is little evidence of a direct relationship between negative attitudes held by the public and their behavior toward the mentally ill; yet recent publications focused on keeping the mentally ill out of local communities imply such a relationship and require governmental intervention.
5. If the mentally ill assume roles in which they can be perceived as normal, they will be evaluated and treated as such. (pp. 211-215)

Heseltine, in his 1982 discussion document, Blueprint for Change: The Next Ten Years, proposed changes in the mental health delivery system in Ontario. He identified the negative attitude of the public towards the mentally ill person. He states:

1. Traditional administrative practice has located most psychiatric hospitals away from centres of population in buildings whose design is better suited to custody than to treatment. This encourages the idea that the public needs to be protected from all the mentally ill.

2. The current practice of accommodating some forensic cases, and also physically aggressive mentally retarded people in psychiatric hospitals has, by a process of association, led some members of the public to assume all psychiatric patients have similarly potentially dangerous behavior.

3. The media tends to support the view of the mentally ill as a disadvantaged group by implying negligence by hospitals and lack of resourcing from government.

4. Many discharged psychiatric hospital patients remain in the neighbourhood of the hospital because they are using the hospital's extramural programs, have lost contact with family and friends in their home community and identify with other ex-psychiatric patients in the area. The concentration of such people in a neighbourhood, the 'siting process,' results in local residents feeling 'dumped on' by outsiders. (p. III-12)

Atwood, in her 1982 article, reports "mental health clinicians, like the public, are ambivalent toward the mentally ill" (p. 172). The idea that practitioners may be prejudiced towards the mentally ill patient may shock those who assume that only the public rejects this client
group. Prejudice may stem from various sources, such as the social stigma towards the mentally ill, diagnostic labelling, cultural biases and a professional attitude that "ascribes status to the treatment of upper-income, nonpsychotic clients" (p. 176).

It can be concluded that many factors have contributed to the stigma and negative attitudes that the public has displayed towards the mentally ill person. Although some research indicates less negative attitudes towards the mentally ill person, public feelings are still stigmatic.

The Involvement of Social Workers with the Chronically Mentally Ill Person

Social workers have always been involved in the treatment of the mentally ill person. Historically, the work of the social worker often occurred within the community. Social workers were frequent witnesses to the consequences of environmental stresses upon the individual and his illness (Linn & Stein, 1981).

A notable social worker in the mid-19th century was Dorothea Dix who became an effective social reformer, lobbyist and advocate on behalf of the mentally ill population. She travelled throughout many U.S. states, visiting the jails and almshouses where the mentally ill were housed. She reported her findings to the public on
the abuse and indifferent treatment that the mentally ill persons received in their confinement. Dorothea Dix lobbied state legislatures and Congress for money, new facilities, and legislative changes in order to ameliorate the inhumane treatment and conditions of the insane (Bellsmith, 1959). Through her efforts, the first mental asylum was built in 1845. Many other new public and private institutions were constructed in the mid-19th century through the influence of this social worker (Encyclopedia of Social Work, 1977). Dorothea Dix also visited the mentally ill population in various parts of Canada. Through her influence, many mental institutions were constructed in the eastern provinces of Canada (Encyclopedia Canadiana, 1977). Dix advocated for proper care of the mentally ill person through use of institutions since she believed that this type of care could cure the illness.

The exact beginning of social work in psychiatric settings is not easily identified; however, in 1905 Dr. Richard Cabot and Ida Cannon developed a social work program at the Massachusetts General Hospital in Boston (Encyclopedia of Social Work, 1977). It was Dr. Cabot who defined the role of the social worker in the hospital setting as: "To complete my diagnosis through more careful study of the patient's malady and economic situation, and to carry out my treatment through organizing the resources of the community" (Osborne, 1964, p. 29). Thus, it appears
that the initial role of the psychiatric social worker was to be a subordinate and to follow the direction of the physician.

Bellsmith (1959) has documented that in 1906, E. W. Horton, a graduate of the New York School of Philanthropy (now the New York School of Social Work) was the first social worker to be employed in a mental institution—the Manhattan State Hospital. The explanation for social work in the mental hospital was stated by the State Charities Aid Association as follows: "This work is based on the perception that disease is frequently caused by adverse social, moral or industrial conditions and cannot be permanently cured unless these conditions are changed" (p. 1858).

The psychiatric social worker became a recognized specialty following World War I, and the role of the psychiatric social worker continued to develop through the 1940's and 1950's. Social workers, under the leadership of psychiatrists, became part of a team of professionals in the hospital setting. A shortage of psychiatric personnel in mental institutions resulted in psychiatric social workers engaging in more psychotherapeutic interventions under the guidance of a psychiatrist (Encyclopedia of Social Work, 1977).

In Canada, hospital social work began in 1910 through the establishment of the Montreal General Hospital Social Service Department (Osborne, 1964). Social workers, who
were employed in general hospital settings, were primarily responsible for discharge planning of the patient (Lurie, Pinsky, & Tuzman, 1981).

During the 1940's and 1950's, social work services became adjuncts of both institutional and hospital care of the chronically mentally ill. The role of the hospital social worker shifted from "discharge-planning to treatment-oriented services, and from in-patient to ambulatory care services" (Lurie et al., 1981, p. 13). The functions of the social worker working with this client group continued to expand in various directions. In a statement of standards for medical and psychiatric social workers, the Canadian Association of Social Workers (1952) stressed that the primary function of psychiatric and medical social workers was to provide casework services to patients (Osborne, 1964). In addition, they stated that it was appropriate for medical and psychiatric social workers to engage in the following activities:

- Practice of social casework and group work.
- Participation in program planning and policy formulation within the medical institution.
- Participation in the development of social and health programs in the community.
- Participation in the education program for professional personnel and social research. (Osborne, 1964, p. 31)

The functions of the social worker were sanctioned and approved, expanding in various directions—from that of caseworker to that of policy-maker, researcher and community organizer.
When the Dymond Report appeared in 1959 in Ontario recommending the deinstitutionalization of the psychiatric population from mental institutions, social workers again had a role to play. Greenland (1961), a social worker, responded to the Dymond Report (1959) stating that social workers could help with deinstitutionalization. He suggested that the social work profession research this psychiatric client population to find out what could be done to facilitate their return to the community. He addressed the importance of social workers to be aware of the resources both within the hospital and the community that would be of benefit in remotivating the chronic patients. He recommended that social group work techniques be devised for this client group. The involvement of patients' families and volunteer groups would increase the effectiveness of programs developed for the mentally ill person.

Linn and Stein (1981) described how social workers have been involved with psychiatric patients as they are discharged into the community. They state:

Social workers were the key persons responsible for establishing follow-up programs for psychiatric patients released into the community and foster care program for adults . . . was established through social work efforts. . . . Today in mental health settings, social workers frequently provide intake services, coordinate treatment, and provide individual, group, and family treatment. Some also function as supervisors and administrators. . . . Diagnostic and treatment skills are refined primarily on the job. . . . Social workers have provided innovative mental health services, such
as workshops for the families of schizophrenics and multifamily therapy for families of psychiatric inpatients. (pp. 56s-57s)

The importance of social workers to become and function as advocates on behalf of 'social victims' such as the chronically mentally ill person has been stressed. "The social worker can act as an advocate in accelerating a patient's discharge" (Hall & Bradley, 1975, p. 385). Nacman (1977) reports that the social worker in the role of an advocate has done a great deal to protect the rights of patients within the hospital and outside in the community by referring the patient to services to which he is entitled.

Koone (1973) described a prevention of institutionalization program in which social workers worked to maintain deinstitutionalized mentally ill patients in the community. In the hospital setting, the social workers prepared the client for discharge. In the community, the social workers prepared the community for the arrival of the chronically mentally ill person. The social workers performed as liaison, educator, and consultant to community agencies.

Although the social worker has played an important role in the general discharge planning of hospitals, there appears to be some difficulty in carrying out this role with psychiatric patients who are to be deinstitutionalized. There are not enough resources and support systems to maintain the chronically mentally ill person in the community at an acceptable level of care.
The Ontario Association of Professional Social Workers (1979) responded to the problem of deinstitutionalization. "Social workers in Ontario hospitals are ambivalent in facilitating the discharge process of patients from Ontario hospitals when they were aware of a paucity of community resources. . . . Structured residential, social and vocational rehabilitation programs are particularly lacking" (p. 52). The Association admits that the social work profession is not totally prepared to help the deinstitutionalized mentally ill population.

The facts are that we appear unprepared through policy and resources to deal with the most dramatic of our interventions in the mental health field, namely with deinstitutionalization. We advocate that given present resources, we give first priority to those in most need in the community. Those are our more chronically disabled population, the chronic psychiatric patient. (p. 57)
CHAPTER 3

Research Design and Methodology

The purpose of this research project was discussed briefly in the opening chapter. It is designed to describe the professional practice of social workers working with chronically mentally ill clients in the tri-counties—Essex, Lambton, and Kent. This chapter will discuss the design of the research project, the method of collecting data, the selection of the sample, and the approach to be taken in analyzing the data.

Classification of the Research

The purpose of exploratory studies is "to gain familiarity with a phenomenon or to achieve new insights into it, often in order to formulate a more precise research problem or to develop hypotheses" (Selltiz, Wrightsman, & Cook, 1976, p. 90). Tripodi, Fellin, and Meyer define exploratory studies as empirical research investigations which have as their purpose the formulation of a problem or questions, developing hypotheses, or increasing an investigator's familiarity of a phenomenon or setting for more precise future research. The intent to clarify or modify concepts may also be predominant. Relatively systematic procedures for obtaining empirical observations and/or for the analyses of data may be used. Both quantitative and qualitative descriptions of the phenomenon are often provided, and the investigator typically conceptualizes the interrelations among properties of the phenomenon being
observed. A variety of data collection procedures may be employed in the relatively intensive study of a small number of behavioral units. Methods which are employed include such procedures as interviewing, participant observation and content analysis. (Tripodi et al., 1969, pp. 48-49)

Using the same authors' categories, this study falls into the sub-type of an exploratory-descriptive study.

Exploratory-descriptive studies are defined as

those exploratory studies which seek to thoroughly describe a particular phenomenon. . . . The purpose of these studies is to develop ideas and theoretical generalizations. Descriptions are in both quantitative and qualitative form, and the accumulation of detailed information by such means as participant observation may be found. Sampling procedures are flexible, and little concern is usually given to systematic representativeness. (Tripodi et al., 1969, p. 49)

In 1981, Tripodi described this same level of knowledge as hypothetical-developmental knowledge. This level of knowledge "describes social phenomena in a qualitative manner for the purpose of developing general concepts into more specific measurable variables or generating more specific research questions or hypotheses" (Tripodi, 1981, p. 199).

The exploratory-descriptive research design is appropriate to use to examine a research problem which had received little previous research.

Research Design

"Research designs are logical strategies for planning research procedures and providing evidence for the development of knowledge" (Tripodi, 1981, p. 210). Using Tripodi's
categories of research design, this study is a cross-sectional case study design. The main intent of this research design is to "develop insights, ideas, questions, and hypotheses for further study" (Tripodi, 1981, p. 211). This research design employs a purposive sample rather than a random sample.

"Purposive sampling refers to a judgmental form of sampling in which the researcher purposely selects certain groups of individuals for their relevance to the issue being studied" (Williamson, Karp, & Dalphin, 1977, p. 111). In using purposive non-probability sampling, the results of the research cannot be generalized to the population.

Research Questions

Research questions are formulated to provide focus and structure to the collection and analysis of the data. The following are the research questions for this study:

What are the social work elements involved in working with the chronically mentally ill client group in the community?

What are the social workers' opinions about issues concerning chronically mentally ill clients in the community?

Nominal and Operational Definitions

The preceding research questions make it necessary to give specific definitions. These definitions will make the meanings explicit in terms of this particular research project.
The chronically mentally ill shall be defined as:

Those individuals who by reason of severe and persistent mental disorder, experience serious limitations in their functioning relative to primary aspects of daily living such as personal relations, living arrangements, . . . employment [and income]. (Test, 1981, p. 72)

The definition of social worker is taken from the Ontario Association of Professional Social Workers, 1979.

Social worker is a professional practitioner holding a Bachelor of Social Work (B.S.W.) degree or equivalent at the minimum, who offers expert service to clients by social work methods appropriate to the function of that agency, department, or organization.

For the purposes of this research, social workers are those people who have a Bachelor of Social Work or Master of Social Work degree(s) or both and at least 40% of their caseload consisting of chronically mentally ill clients.

Elements refers to the simplest parts of any art, science or subject of study (Webster's, 1981). For this research the elements shall be represented by such parts as: social work roles, functions, gratification, time disposition, and service resources.

Opinion is defined as "a belief or view based on interpretation of observed facts and experience" (Webster's 1981). Issues is defined as "something entailing alternatives between which to choose or decide; something involving judgements or decisions" (Webster's, 1981). For this study, this will include deinstitutionalization, stigma, social work education, accommodation, and referral services.
Population

The population for this research study was all social workers in Ontario with at least 40% of their caseload consisting of chronically mentally ill clients. The exact number is unknown.

Sample

There are two basic types of samples: probability and nonprobability. For this research study, nonprobability sampling was used. "Nonprobability sampling is particularly well suited for exploratory research where the focus is on the generation of theory and research ideas" (Williamson et al., 1977, p. 110). The sample findings cannot be generalized to the population.

Purposive sampling "refers to a judgmental form of sampling in which the researcher purposely selects certain groups or individuals for their relevance to the issue being studied" (Williamson et al., 1977, p. 111). For this study, social workers who had at least 40% of their caseload consisting of chronically mentally ill clients were chosen. This figure was chosen as it was believed this minimum number would require specialized knowledge and skills on the part of the respondent. This figure also allowed the researchers to include social workers in a hospital setting, increasing the sample size. This is consistent with Selltiz, Wrightsman, and Cook (1976) who state:
The basic assumption behind purposive sampling is that with good judgment and an appropriate strategy one can handpick the cases to be included in the sample and thus develop samples that are satisfactory in relation to one's needs. (p. 521)

The members of the sample were located through various approaches. Telephone calls were made to social workers or their supervisors at all general hospitals in the tri-county area. The researchers asked for the names of all social work staff who would qualify to be sample members. Each potential member was personally invited to participate in the research interview.

A social work supervisor at the provincial psychiatric hospital was contacted for the names of social workers employed by the hospital satellites in the tri-county area. Telephone calls were made to each local community information centre for names of agencies providing community mental health services. Appropriate staff at these community agencies were recruited for the sample. Finally, in contacting each individual respondent, the researcher asked if they knew other social workers who would qualify for the study sample. This acted as a check that ensured that the researchers had not overlooked any appropriate respondents.

The geographic parameters of the sample was the tri-county area: Essex, Lambton, and Kent. This includes the cities of Windsor, Sarnia, and Chatham. Although this did involve travelling time for the interviewer, it was feasible
and increased the sample size. These three counties are all part of the same catchment area for a provincial psychiatric hospital located in St. Thomas, Ontario.

The sample size was small consisting of 12 social workers contacted, of which 10 were able to participate in the research. This is acceptable for an in-depth study at an exploratory level to gain insight for future research (Tripodi & Epstein, 1980).

Method of Data Collection

Data were collected for this research study by a semi-structured interview schedule developed by the researchers after a review of the literature. The interview schedule acted as a guide for the interviewer and posed the questions to the respondent (Tripodi & Epstein, 1980). With the semi-structured interview schedule the same questions were asked by the interviewer but did allow for probing questions. The semi-structured interview schedule combined both written questions (fill-in-the-blank and forced choice) and verbal questions (open-ended). The schedule followed a funneling technique, beginning with simple questions and progressing to more complex questions.

The written portion of the interview schedule consisted of 14 questions in a questionnaire format. The respondents self administered this questionnaire at the beginning of the interview session. The questionnaire
examined demographic data and questions pertaining to the social work elements specific to the client group.

The verbal portion of the interview schedule originally was made up of 12 questions. After the pretest, four more questions were added for a total of 16. These open-ended questions covered a wide range of issues related to chronic mental illness, such as deinstitutionalization, stigma, service needs, client violence, and social work education.

The interview schedule (both written and verbal) was pretested. Five social workers in the London area were interviewed. They all worked with the chronically mentally ill client group and represented a variety of service settings. The pretest participants had worked with this client group for various lengths of time. The London area was chosen for the pretest to avoid contamination of the sample and depletion of eligible respondents locally.

The researchers chose the personal interview over the mailed questionnaire as the sample size was small and this approach would improve the response rate (Jenkins, 1975). The interview allows the interviewer to probe and explore the respondents' experiences (Jenkins, 1975). This is relevant since the purpose of the research project was to gain more insight into the topic area and develop a base for further research.
A decision was made by the researchers to use only one interviewer to gather data to facilitate consistency in interviewing techniques. This interviewer followed the guidelines from Gochros (1981). "An unobtrusive, neat and conservative appearance . . . compatible with the respondents' standards of proper dress" (p. 282) was used. The tape recorder was used discretely. Questions were asked in a slow and clear manner with appropriate emphasis on key words.

All interviews except one occurred in the respondents' offices. The exception occurred in a respondent's home. The sample was interviewed during a two-week period. This time limitation was imposed to reduce contamination.

The administration of the entire interview schedule ranged from 45 minutes to 2 hours. The respondents' answers to the open-ended questions were tape recorded to allow for accurate transcription and coding.

The pretest was valuable since it provided a trial run for both the interviewer and the research instrument. Based on feedback from the pretest participants, appropriate modifications were made prior to administering the instrument to the sample. The instrument has not been formally tested for external validity and reliability.

**Data Analysis**

The analysis of data will include three sections. The first section will be a discussion of demographic data
related to the sample. The second section will be a discussion related to the research question regarding social work elements involved in working with the chronically mentally ill client group. The third section will be a discussion related to the research question regarding social workers' opinions about issues concerning chronically mentally ill clients.

The data analysis will involve descriptive, univariate statistics due to the small sample size. Bivariate statistical analysis would be too distorted to use. The open-ended questions in the verbal section of the interview will be coded by theme frequency. Representative quotations from the interviews will be presented to illustrate findings.

Summary

This research project is exploratory-descriptive in design. Its general purpose is to develop insights, ideas, and questions for future studies in the area of social work with the chronically mentally ill client. Research questions were used to focus on the elements specific to this area of social work practice and to solicit opinions of the workers about issues related to the client group.

The research population included all social workers in Ontario with at least 40% of their caseload consisting of chronically mentally ill clients. The actual research
sample is geographically limited to include all eligible respondents in the tri-county area. This purposive sample numbered 10 social workers.

The researchers developed and pretested a semi-structured interview schedule including written and verbal questions. The data will be discussed using descriptive univariate statistics. Demographic information and findings related to the two research questions will be presented.
CHAPTER 4

Data Analysis and Findings

The data analysis in this chapter is presented in three sections. The first section will describe the demographic information about the sample. The variables are: education, gender, age, employment setting, length of employment, prior contact with client group, and job titles.

The second section discusses the social work elements involved in professional practice with the chronically mentally ill clients. The main elements are: size of caseload, use of work time, social work functions, social work roles, and professional gratification.

The third section describes the social workers' opinions about issues concerning their chronically mentally ill clients. The following are some of these issues: stigma, availability of client services, deinstitutionalization, and characteristics of clients. Finally, a summary of the research findings is provided.

The research sample was purposive, including all social workers in the tri-county area (Essex, Lambton, and Kent) with at least 40% of their caseload consisting of chronically mentally ill clients. The sample numbered 12 persons. Ten of these were respondents (two were unable to be interviewed.
during the sampling period. The research data was collected over a two week period in the late summer of 1983. The instrument was designed by the researchers and pre-tested on a similar respondent group. The instrument included both written and verbal queries with a number of open-ended questions. The technique of data analysis involves univariate analysis with coding of theme frequencies for the open-ended questions. Tables illustrate findings where suitable. Representative quotations are presented. Minor editing has been done to improve readability and maintain respondent confidentiality. Since the sample was selected purposively, the findings for the sample do not represent the population. Findings should not be generalized to represent opinions, or experiences of all social workers in Ontario working with this client group.

Demographic Findings Related to Respondents

Education

In the sample, all (100%) of the respondents reported holding a Bachelor of Social Work (B.S.W.) degree. Almost all (90%) respondents received their social work education from the School of Social Work at The University of Windsor. The remaining respondent was a graduate of King's College, University of Western Ontario.

The respondents received their B.S.W. during the past decade (1973-1983). Most of the respondents have practiced professionally for almost 5 years ($\bar{x} = 4.5$).
Gender and Age

The gender of the respondents in the sample was 6 (60%) female and 4 (40%) male. The age range of the female respondents was from 24 to 39 years with a mean of 29.4 years. One female failed to report age. The age range of the male respondents was 25 to 32 years of age with a mean age of 28.5 years.

Employment

Six (60%) of the respondents' caseloads were located primarily in the community, while 4 (40%) of the respondents worked with a caseload primarily located in a medical setting.

Respondents reported the length of time in their present employment ranging from 4 months to 11 years. The mean length of employment is 4 years and 2 months. The median is 2 years.

In response to the question, "Prior to your present employment, did you have any contact with the chronically mentally ill client group?" one-half (50%) of the respondents answered in the negative. Of the affirmative responses (50%), all had previous employment experience with this client group. As well, 3 of these 5 respondents indicated previous contact with the chronically mentally ill clients in one or more of the following: "social work
practicum"; "previous non-social work occupation"; and a "student residence."

Social work respondents were asked to state their official job title. Six (60%) of the sample reported their official title includes the term "social worker." The respondents were also asked "what job title do clients use to refer to you?". Most (90%) of the sample reported the job title used by clients was "social worker" with only one indicating a non-social work title.

Elements of Social Work Practice

Caseload Characteristics

The sample consisted of 8 full-time social workers and 2 part-time social workers. Of the full-time social workers, the caseload ranged from 25 to 210 clients with a mean of 69 clients. Because of the highly skewed distribution, the median of 45.5 gives the preferred measurement of central tendency. The respondents were asked to give the number of active clients on their caseload as shown in Table 1. Active was defined in the questionnaire as "some form of contact at least once a month." One-half (50%) of the social work respondents reported an active caseload from 30-39 clients.
Table 1

Size of the Active Caseload
of the Respondents

<table>
<thead>
<tr>
<th>Number of active cases</th>
<th>Frequency (n=10)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 - 19</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20 - 29</td>
<td>2*</td>
<td>20.0</td>
</tr>
<tr>
<td>30 - 39</td>
<td>5*</td>
<td>50.0</td>
</tr>
<tr>
<td>40 - 49</td>
<td>1</td>
<td>10.0</td>
</tr>
<tr>
<td>50 &amp; over</td>
<td>2</td>
<td>20.0</td>
</tr>
</tbody>
</table>

*Frequency includes 1 part-time worker

The sample was asked what percentage of their caseload was comprised of chronically mentally ill clients. The percentages ranged from 40% to 100% with a mean of 68.5%.

Use of Work Time

The social workers were asked to report the number of hours out of a 40-hour work week that they spent working with the chronically mentally ill clients on their caseload. Table 2 illustrates that more than three-quarters (80%) of the respondents spent from 75-100% of their total work time working with the chronically mentally ill clients on their caseload.
Table 2

Hours Spent Working with Chronically Mentally Ill Clients

<table>
<thead>
<tr>
<th>Social workers (f)</th>
<th>Number of hours worked per week (f)</th>
<th>Time worked (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n=10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>1</td>
<td>32</td>
<td>80</td>
</tr>
<tr>
<td>3</td>
<td>30</td>
<td>75</td>
</tr>
<tr>
<td>1</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>1</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>1*</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>1*</td>
<td>24</td>
<td>80</td>
</tr>
</tbody>
</table>

*Part-time social workers.

The respondents were asked to divide the preceding hours spent working with the client group into the following categories: "meeting directly with clients"; "working on behalf of your clients"; "performing other duties". Table 3 reveals that more than one-half (56.6%) of the respondents' working hours are spent in meeting directly with their clients. One-quarter (24.7%) of their working time is spent working on behalf of their clients and only one-fifth (18.7%) is spent in performing other duties.
Table 3

Division of Working Time

<table>
<thead>
<tr>
<th>Division of time</th>
<th>Range of time (%)</th>
<th>Mean time (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting directly with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>clients</td>
<td>42.9-70.0</td>
<td>56.6</td>
</tr>
<tr>
<td>Working on behalf of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>your clients</td>
<td>10.0-42.9</td>
<td>24.7</td>
</tr>
<tr>
<td>Performing other duties</td>
<td>13.3-25.0</td>
<td>18.7</td>
</tr>
</tbody>
</table>

The respondents were asked if they wanted to change any of their working time with and on behalf of their chronically mentally ill clients. Eight (80%) of the social work respondents stated that they did not want to change any of their allocations of time in the three time divisions.

Social Work Functions

Each of the respondents was asked to indicate their use of 11 social work functions. Table 4 presents the array of reported functions. The most frequently used functions were: client advocacy and client follow-up. It is important to note that one-half (50%) of the social workers engaged in monitoring medication, a function not usually associated with social work practice.
Table 4

Social Work Functions Used in Practice

<table>
<thead>
<tr>
<th>Functions</th>
<th>Very/ Frequently (f)</th>
<th>Very/ Infrequently (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client advocacy</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Client follow-up</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Client assessment</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Client referral</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Therapeutic counselling</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Program organization</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Agency consultation</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Crisis management</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Monitoring prescribed use of medications</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Family support groups*</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

(n=10)

*One respondent failed to report this function (n=9).

The respondents were given the opportunity to change any of their ratings. Client advocacy, program organization, and client follow-up were increased from "frequently" to "very frequently". Discharge planning and agency consultation were increased from "infrequently" to "frequently". When respondents were asked what prevented them from making changes in their functions practiced,
the most often reported responses were: "a lack of time"; and "funding". To quote a respondent: "Funds have not kept pace with deinstitutionalization. Therefore, programs don't meet the demands of our client group." Also reported was: "lack of [client's] family cooperation"; "lack of appropriate referral resources"; and "clients' tendency to improve only marginally".

Social Work Roles

The respondents were asked to specify (by percentage) the amount of time spent in performing the following five social work roles: social broker, enabler, teacher, mediator, advocate. The respondents were given printed definitions for their clarification during the question (see Appendix C). The pretest indicated that this was important for question clarity.

As shown in Table 5, the 3 roles enacted most frequently in almost equal proportions were: teacher, enabler, and social broker. Enacting the mediator and advocate roles was less frequent.

In answer to whether the respondents wished to change the percentages of their time spent in the five social work roles, 7 indicated "yes". They increased their time percentages slightly in the following roles: social broker, mediator, and enabler. They wanted a slight decrease in the percentage of time spent as teacher and advocate.
Table 5

Distribution of Social Work Roles

<table>
<thead>
<tr>
<th>Roles</th>
<th>Range of time (%)</th>
<th>Mean time (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td>10 – 50</td>
<td>27.5</td>
</tr>
<tr>
<td>Enabler</td>
<td>5 – 50</td>
<td>26.5</td>
</tr>
<tr>
<td>Social broker</td>
<td>5 – 60</td>
<td>25.5</td>
</tr>
<tr>
<td>Mediator</td>
<td>3 – 20</td>
<td>10.8</td>
</tr>
<tr>
<td>Advocate</td>
<td>5 – 20</td>
<td>9.7</td>
</tr>
</tbody>
</table>

A comparison cannot be made between the roles of the individual respondents in their change percentages as 3 respondents did not indicate a change in every category.

Referral Services

Each respondent was asked to indicate which community services they used for referral of their chronically mentally ill clients. The community services that were used for referrals by the respondents are given in Table 6. The services were ranked in order of frequency as reported. All (100%) respondents referred their chronically mentally ill clients to vocational assessment/training, housing, and financial assistance programs. As well, most (90%) referred their clients to psychiatric, medical/dental, and recreational/leisure services. The majority (60%) of the respondents referred their clients to sheltered workshop programs.
Table 6

Community Services Utilized by Social Workers

<table>
<thead>
<tr>
<th>Services</th>
<th>Frequency (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocational assessment/training</td>
<td>10</td>
</tr>
<tr>
<td>Housing</td>
<td>10</td>
</tr>
<tr>
<td>Financial assistance</td>
<td>10</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>9</td>
</tr>
<tr>
<td>Medical/dental</td>
<td>9</td>
</tr>
<tr>
<td>Recreation/leisure</td>
<td>9</td>
</tr>
<tr>
<td>Sheltered workshops</td>
<td>6</td>
</tr>
<tr>
<td>Employment/employees/union</td>
<td>3</td>
</tr>
<tr>
<td>Transportation</td>
<td>3</td>
</tr>
<tr>
<td>Other (occupational therapy)</td>
<td>1</td>
</tr>
</tbody>
</table>

The respondents were asked if they had difficulties with any specific services which they used on behalf of their clients. Many (70%) reported difficulties, while 10% reported no difficulties. Two (20%) did not answer the question. Those respondents reporting difficulties with referral services were asked to give examples. There were no similar themes in the responses, therefore they are not discussed here (see Appendix D).

Recognition of Competence

The respondents were asked about recognition of their social work competence. Over one-half (60%) replied that
they did receive recognition, while 2 indicated an ambivalent response to the question and 2 indicated a definite "no." Recognition (as reported by the respondents) was received most often from nurses than from patient/clients, and finally, physicians.

Work Gratification and Isolation

The social workers were asked what were sources of gratification in their work. Most indicated they receive gratification mainly from their clients. Seeing progress with their clients was meaningful. Examples ranged from clients "keeping their appointments" to "successful independent living". One worker stated, "Any time a client grows in their ability to move towards a give-and-take relationship . . . with peers or myself".

Social workers were asked if they felt isolated from the social work community. Over one-half (60%) indicated that they did not feel isolated, while one-third (30%) reported isolation, and one (10%) indicated feeling partial isolation. Two respondents identified contact with the O.A.P.S.W. as lessening the feeling of isolation from the social work community. No other theme emerged.

Social Work Education

The researchers were curious as to whether the respondents thought they had been prepared, by their social
work education, to work with their particular client population. Many (70%) respondents reported "no" while a few (30%) answered affirmatively. The negative responses were qualified: "I don't necessarily think it is the role of the B.S.W. program to give you this kind of specialized introduction"; "It helped me but it didn't necessarily prepare me."

The following are some of the suggestions that the respondents gave to improve the educational experience: "[Students] need more intense preparation to deal with each of the major mental disorders such as manic depression and schizophrenia"; "A course on psychotropic medication would help"; "Methods in dealing with your own discouragement when you realize you aren't getting far with clients"; "... more on group work"; "More training to equip us to work with non-verbal clients, who not only don't express themselves verbally but don't even experience life that way!"

In asking the respondents if they thought the social work profession was as involved with this client group as it should be, a variety of replies were received. No single theme emerged.

The researchers wanted to know if the social workers who worked with the stigmatized client group also experienced prejudice themselves from other social workers. There was an even (50%-50%) split between those who did experience prejudice and those that did not experience it.
Among those who reported prejudice, there was no identifiable theme. The following quotes indicate the variety of responses: "There's a lot of ignorant people in our profession"; "The person working with the chronically mentally ill would not be very high in a hierarchy of social work job status"; "I guess some of my colleagues see the chronic as a hopeless population"; "Colleagues think that I shouldn't waste my time with these people who have been hospitalized 15 times . . . they give up on people."

**Issues and Opinions About the Chronically Mentally Ill Clients**

**Re-entry Hurdles**

The respondents were asked in the interview for the three main hurdles facing the person re-entering the community from a psychiatric setting. Many (70%) mentioned that stigma was one of the main hurdles. This was discussed in terms of both self-stigma and community stigma. Lack of support from family and significant others was also a common theme. The third most frequently mentioned hurdle was the lack of employment or vocational opportunities available to this client group. (See Table 7.)

The following quotations about re-entry hurdles are taken from the interviews. The quotations have been selected to be representative of the respondents' comments.
Table 7

Hurdles Faced by Chronically Mentally Ill Clients Re-entering the Community

<table>
<thead>
<tr>
<th>Hurdles</th>
<th>Frequency of theme (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma</td>
<td>7</td>
</tr>
<tr>
<td>Isolation/lack of family and friends</td>
<td>7</td>
</tr>
<tr>
<td>Employment/vocational training</td>
<td>5</td>
</tr>
<tr>
<td>Housing</td>
<td>4</td>
</tr>
<tr>
<td>Institutionalization</td>
<td>2</td>
</tr>
<tr>
<td>Lack of programs</td>
<td>2</td>
</tr>
<tr>
<td>Lack of finances</td>
<td>1</td>
</tr>
</tbody>
</table>

"I think that the biggest hurdle that, not only the chronic patient face, but also the acute in-patient, is the stigma of having been in the hospital; having to deal with their friends and family because they really can't be accepting of themselves—-that it is O.K. to have a psychiatric illness"; "... the lack of significant others, the lack of family and friends; really the lack of opportunity for developing new significant others to replace the loss of those they may have initially had prior to their illness"; "Employment is very difficult for them to get. Basically they will have a gap in their resume. The employer asks 'Where have you been for the last year?' It usually
will come out that they have been in a psychiatric hospital. They won't get accepted."

Accessibility and Availability of Services

Respondents were asked if services were available or accessible to their clients. The two most problematic themes mentioned were: workshops/employment (60%); and housing (40%). The following are two sample quotations:

"We don't have any industrial workshops, education and training for specific jobs. The service may be there but there is a long waiting line. These people are out in the community and we let them wait and wait and there is nothing immediate for them when they first get out of the hospital. This causes a lot of problems.

"Right now we depend heavily on rest homes. It is unrealistic to expect rest homes to provide a different or better living arrangement under their present funding."

Aggressive Behaviour

Social workers were asked if they had ever been verbally threatened or physically assaulted by a chronically mentally ill client. Many (70%) indicated that they had been verbally threatened with examples ranging from indirect threats, to life-threatening threats. A few (30%) indicated that they had never experienced verbal threats. The term "threat" was not defined for this question; therefore it was left to the respondent to interpret what "verbal threat" meant.
Many (80%) of the respondents had never experienced any physical assault. Two (20%) stated that they had been physically assaulted. Those respondents were employed in a general hospital setting, where the client was being treated for an acute psychotic break. Neither was physically harmed—"I've never been hurt, never felt in mortal danger."

When the respondents were asked for an estimate, in a percentage form, of how many of their clients had been violent or aggressive towards others, most reported this type of aggression to be rare. The percentages ranged from 0% to 30% with a mean of 11.5%. As one respondent stated, "Chronically ill people are usually violent against themselves . . . very, very few of them are dangerous to other people."

Deinstitutionalization

Respondents were asked if they thought deinstitutionalization had been a success. Most (80%) stated emphatically that it had not been a success. Some of the immediate responses were: "not at all . . . it's a farce"; "I don't think it's really been tried"; "Oh Lord, no!". Two (20%) stated that they thought it had been a success. These responses were given with reservation and qualifiers. One respondent states: "It [deinstitutionalization] has demanded that the health care system take a look at itself
and see if we can really manage these people when they come into the community." Another social worker states: "It's been a success in the sense these people are living out in the community but with inadequate services." One respondent thought the term was a misnomer. The person thought the term should be "reinstitutionalization." Another respondent states: "We've simply made geographical switches, of going from large institutions to small ones."

The following were the themes for improvement of deinstitutionalization: more funding for community services; acute need for sheltered workshops for the higher functioning chronically mentally ill client; different and more housing alternatives; and a recreational facility.

Younger Chronically Mentally Ill Clients

Several social workers in the pretest interviews mentioned the problems of the younger chronically mentally ill person. Consequently, the following question was asked of the sample respondents: "Generally we think of the chronically mentally ill client as middle aged, medicated, and institutionalized. Tell me about the chronically mentally ill clients that do not fit this description." This question raised many issues and concerns.

All (100%) of the respondents raised the issue of the young chronically mentally ill client. The age group
referred to most often was 20-30 year olds. This younger group often has exhibited difficulties with drug and alcohol abuse, both past and current. They were referred to as: "restless, angry, unhappy, more likely to be aggressive. . . more actively frustrated"; "aimless"; and "non-compliant". This younger group of people openly express concern about medication: "The younger person is more resentful that he is having to take medication. He is more frightened of the side effects. The young person looks at the older person, and sees the results of years of medication."

The younger group are more energetic, consequently more restless. . . . They want something to do. . . . If we do not have sufficient programming to occupy a lot of their spare time or free time then we are faced with a number of behavior problems. . . . They are actually community problems.

**Stigma**

The respondents were asked to report any stigma suffered by the chronically mentally ill person. The respondents unanimously agreed that there is "definitely" stigma towards this client group. The respondents saw this stigma expressed in the following ways: unable to join or participate in regular community programs; lack of employment opportunities; and, the self-labelling stigma of being "sick". To quote the respondents: "The stigma that they impose on themselves is that they have accepted"
their labels and limited themselves as to how much they will do and how much they can do according to their labels"; "People, on the whole, are nervous . . . extremely uncomfortable with these people"; "People avoid the mentally ill because they look funny and act weird"; "People would rather avert their eyes than take a close look at them".

Accommodation

The researchers were interested in finding out where this client population lived in the community. The respondents were asked to give a break down of the types of accommodations in which their clients resided. In Table 8 it can be seen that on the average 50% of their clients lived in rest and lodging homes. The range varied from 10% to 100%.

<table>
<thead>
<tr>
<th>Type of Accommodation</th>
<th>Range (%)</th>
<th>Mean (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest and lodging homes</td>
<td>10 - 100</td>
<td>50.0</td>
</tr>
<tr>
<td>Other (apartment living)</td>
<td>0 - 30</td>
<td>30.0</td>
</tr>
<tr>
<td>Family home</td>
<td>5 - 40</td>
<td>22.2</td>
</tr>
<tr>
<td>Public housing</td>
<td>5 - 50</td>
<td>20.0</td>
</tr>
<tr>
<td>Hospital</td>
<td>5 - 50</td>
<td>20.0</td>
</tr>
<tr>
<td>Boarding home</td>
<td>3 - 20</td>
<td>7.6</td>
</tr>
<tr>
<td>Nursing home</td>
<td>2 - 10</td>
<td>6.0</td>
</tr>
</tbody>
</table>
The median and the mean were the same, 50%, with a mode of 70%. Apartment living was identified as second most utilized, while third was the family home. The hospital category may be distorted somewhat since 1 respondent refused to use "hospital" as the type of accommodation.

Community Services

Respondents were asked what services their clients were most likely to use. Table 9 indicates use of community services by the chronically mentally ill clients. The four most frequently used services were: psychiatric, financial assistance, housing, and transportation. The least frequently used services were: employment/employees/union, recreation/leisure, and sheltered workshops.

The final question of the interview schedule was a general question about who they thought should be responsible for co-ordination of community services. A broad interpretation of this question is indicated by the responses ranging from: "individual social workers acting as co-ordinators" to "Who should be God?".
Table 9

Services Used by the Chronically Mentally Ill Clients

<table>
<thead>
<tr>
<th>Services</th>
<th>Very/Frequently (f)</th>
<th>Very/Infrequently (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Financial assistance</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Housing</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Transportation</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Vocational assessment/training</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Medical/dental</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Sheltered workshops</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Recreation/leisure*</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Employment/employees/union</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Other - churches</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>hospital</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>occupational therapy</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

*1 respondent answered the same service type twice (n=11)
Summary of the Research Findings

This chapter has examined the data collected from questionnaires and taped interviews. The findings were presented in the following sections: Demographic Findings Related to Respondents; Elements of Social Work Practice; and Issues and Opinions About the Chronically Mentally Ill Clients.

The respondents working with the chronically mentally ill clients held B.S.W. degrees, were in their late twenties and early thirties, and had five years work experience.

The main findings related to elements of social work practice follow. Most respondents spent 75% to 100% of their total work time working with the chronically mentally ill. One-half of the respondents' working time is spent working directly with their client and another one-quarter of their time is spent working on behalf of the clients. The predominant social work functions were client advocacy and client follow-up. The major roles performed were teacher, enabler, and social broker. Most frequently used referral services were vocational assessment/training, housing and financial assistance followed closely by psychiatric, medical/dental and recreation/leisure referrals. The chief source of gratification for these social workers was client progress.
Various issues and opinions about the chronically mentally ill client group were solicited from the respondents. The major hurdles to community re-entry were: stigma, lack of relational support; lack of vocational opportunity. Vocational workshops/employment and housing resources were stated as problematic by many respondents. Most of the respondents experienced verbal threats from their clients while very few respondents experienced physical assaults. Respondents did not view deinstitutionalization as successful. Many respondents identified the younger chronic clients as a special needs group. Stigma was unanimously identified as a problem for this client group.
CHAPTER 5

Conclusions and Research Questions

In this chapter the major findings from the data analysis will be presented and discussed in the same order as the original data analysis chapter. Questions will be made based on the data findings and related readings.

Major Research Findings and Discussion

All social workers in the sample have a B.S.W. degree. The researchers had expected that the sample would include some social workers with a Master’s degree. Several respondents implied that it was not necessary to hold a Master’s degree to work with this client group. Almost all respondents obtained their B.S.W. degree from The University of Windsor, School of Social Work. The average age of the sample was approximately 29 years. The respondents present lengths of employment ranged from 4 months to 11 years. Five had worked previously with chronically mentally ill clients. "Social worker" is the title most often used by the clients in referring to the respondents.

The average caseload size of the social workers was 46 clients of which almost 70% were chronically mentally ill clients. More than three-quarters of the social workers' time was spent directly with or on behalf of the
chronically mentally ill clients. Less than one-quarter of their time was spent performing other duties such as recording, meetings, and public relations. This indicates that the respondents are actively engaged in their social work skills with their clients.

The research findings show that the most frequent social work functions performed by the respondents were client advocacy and client follow-up. These were followed closely by client assessment and client referral. The literature review illustrated the importance of advocacy, historically and currently. An unexpected finding was that one-half of the social workers monitored the clients' medication. This was relatively small in comparison to other functions even though it is usually seen as being outside the realm of social work practice. The function "family support group" had the lowest score. This may have been biased by the wording of this function in the questionnaire. The respondent interviews indicated that families were often a forgotten part of the client system. Most respondents indicated that they would like to be more involved with the social work functions of advocacy, program organization, and client follow-up. Some respondents stated that time and funding prevented this from happening.

In summarizing the findings regarding social work roles, the researchers found that the three roles practiced
most frequently were: teacher, enabler, and social broker. Mediator and advocate roles are less frequently used. Researchers found that if given the opportunity, the social workers would like to increase slightly their time spent in the roles of social broker, mediator, and enabler. The respondents wanted to decrease their time spent as teacher and advocate. There is a contradiction in the respondents' answers to advocate role and advocacy function as previously discussed.

The primary community services that were utilized for referral by the respondents were: vocational assessment/training; housing; and financial assistance. These three services were used by all respondents and were followed closely by: psychiatric; medical/dental; and recreation/leisure services. Over one-half used sheltered workshops as a referral. One reason may be that there is a lack of this service. Employment/employees/union was a category that only a few people used. This category may have been biased by the wording. The difficulties that respondents found with these services are described in Appendix D.

Over one-half of the respondents felt they received recognition for competence in their work. It is interesting to note that the respondents generally did not name professional peers as a source of recognition. However, the medical profession (nurses, doctors) was stated more frequently as a source of recognition of competence.
Clients were one of the major sources of recognition and gratification. Behavioural and relationship changes brought the most gratification to the social workers.

The respondents acknowledged that their undergraduate education did not specifically prepare them to work with this client group, but did give a general knowledge background.

There were two main themes identified as major hurdles for re-entry to the community: stigma and social isolation. Stigma was mentioned in the form of self-stigma and community stigma. The person takes on the "sick" label which limits them in what they do. This is reinforced by society's attitudes which stigmatize this group in numerous ways such as: derogatory comments, and lack of accessibility of services. The respondents identified long waiting lists, scapegoating, and lack of understanding of mental illness. The clients were isolated geographically, socially, and emotionally. One-half of the respondents indicated that lack of employment and vocational training were major hurdles. The respondents identified a need for a sheltered workshop with vocational training. The respondents mentioned that with the current lack of day programming, there often is a regression in their illness. This can precipitate behaviour problems resulting in rehospitalization. This unstructured time is particularly difficult for the young chronically mentally ill group.
The researchers asked questions relating to the issue of violence to seek the truth of society's belief that chronically mentally ill persons are dangerous to others. The respondents indicated that they personally had experienced very little physical violence despite a great deal of verbal threats. The examples of physical violence were limited to the hospital setting. It is the opinion of the researchers that the few incidences indicate that social workers are aware of client cues and signals and take measures to defuse physical outbursts. However, when asked to give incidences using aggression or violence by a client towards others, few, if any, were given.

Most respondents agreed that deinstitutionalization has not been a success. However, a few respondents suggested that there have been gains and improvements. It was suggested that there needed to be more funding for specific programs, e.g., sheltered workshops. In some cases, it is a matter of improving or expanding existing services with more choices given to the client group, e.g., vocational rehabilitation and housing. The respondents indicated that one-half of their chronically mentally ill clients presently live in rest and lodging homes. Some respondents indicated the need for more funding for programming within the rest and lodging homes.

All of the respondents indicated concern regarding the lack of programs for the young chronically mentally
ill clients. Some respondents indicated that in their particular community, there was no service available to the higher functioning chronically mentally ill client.

Research Questions

The purpose of an exploratory-descriptive research design is to "develop insights, ideas, questions, and hypotheses for further study" (Tripodi, 1981, p. 211). Based on the literature review and research findings, the following questions have been raised.

Social Work Functions and Roles

One-half of the respondents indicated that one of the functions they used in their social work practice was to monitor client's use of prescribed medication (see Table 4). Questions - Should social workers monitor the clients' use of prescribed medication as part of their job?

- Who should provide social workers working with chronically mentally ill clients, training on the side-effects and problems related to psychotropic medications? It is not presently provided in the social work curriculum.

Community Referral Services

Seventy per cent of the respondents indicated difficulties with auxiliary or supportive referral services.
Questions - Why are there so many difficulties with auxiliary or supportive referral services? The chronically mentally ill persons have been discharged in the community for at least 15 years.

- Can the processing of initial applications for services be expedited to accommodate the special needs of chronically mentally ill clients?

Social Work Education

Seventy per cent of the respondents did not think their social work education had prepared them to work with this particular client group.

Questions - Should curriculum specializations addressing the needs of particular client groups be offered at the B.S.W. level?
- Should the social work curriculum include basic knowledge regarding psychotropic medications?
- Has the social work curriculum kept pace with deinstitutionalization of mentally ill persons?
- Should the social work curriculum provide methods of communication suitable for working with non-verbal clients?
Issues and Opinions About Chronically Mentally Ill Clients

As indicated in Table 7, the three main hurdles facing the client re-entering the community from a psychiatric setting are stigma, social isolation, and lack of employment or vocational training.

Questions - Why is there still such a stigma toward the chronically mentally ill person in the community?
- What media mode would be most effective in reducing the stigma of the chronically mentally ill in the community?
- What types of social support networks are necessary for chronically mentally ill people to decrease their social isolation?
- What levels of employment training programs are needed by the chronically mentally ill people?
- What kind of day programs should be developed to meet the needs of a heterogeneous group such as the chronically mentally ill?

Young Chronically Mentally Ill Clients

All respondents identified the special needs and problems of the young chronically mentally ill client group.
Questions - Do the young chronically mentally ill clients need more physically demanding and stimulating programs?
- Has there been an increase in the number of young chronically mentally ill people in the community in the last ten years?

Future Research

There remain many issues concerning professional social work practice with chronically mentally ill clients in the community. This exploratory-descriptive research has highlighted some of the areas for possible future research.

Research Questions

- Is it a myth that chronically mentally ill people are more violent and dangerous than the average citizen?
- What are the accommodation needs of chronically mentally ill persons in the community?
- What are the gaps in social services for the chronically mentally ill persons in the community?
- Is there a need for systematic evaluation of programs designed for chronically mentally ill clients?
- What services could be developed to meet the unique needs of young chronically mentally ill clients?
- Do day programs or sheltered workshops have an effect on the recidivism rate of chronically mentally ill clients?
- Would a collection of inter-agency professionals, working with the chronically mentally ill client group, advocate for more funding to improve the quality of life for this client group?
APPENDIX A

SOCIAL WORKERS IN COMMUNITY MENTAL HEALTH

Questionnaire Section

The following questionnaire is part of the interview schedule. Your replies will be held in confidence. Your name and agency will not be identified with your responses.

For research purposes, the following definition of the chronically mentally ill client will be used:

Chronically mentally ill clients are those individuals who, by reason of severe and persistent mental disorder, experience serious limitations in their functioning relative to primary aspects of daily living such as personal relations, living arrangements, employment and income.

1. From what university did you receive your most recent social work degree and in what year?

   University   B.S.W.   M.S.W.   Year
   University of Windsor   _____   _____   _____
   Sir Wilfred Laurier   _____   _____   _____
   University of Toronto   _____   _____   _____
   King's College, U.W.O.   _____   _____   _____
   Other _____
   Specify________________

2. Gender:  
   Female_____; Male_____;

3. Age:  
   _____ years;

4. Employment Setting:  
   medical/psychiatric_____  
   community_____

5. How long have you been in your present employment?  
   _____ years' _____ months

6. (a) Prior to your present employment, did you have any contact with the chronically mentally ill client group?  
   Yes_____; No_____;
6. (b) If yes, in which of the following roles did you have contact with this population?

- previous employment
- social work field practicum
- previous non-social work occupation
- family member
- other specify

7. (a) What is your official job title?

________________________________________________________________________

7. (b) What job title do clients use?

________________________________________________________________________

8. (a) What is the size of your total caseload?

____ clients

8. (b) Of your total caseload, how many are active? 'Active' is defined as some form of contact at least once a month.

10 - 19 _____
20 - 29 _____
30 - 39 _____
40 - 49 _____
50 & over _____

9. Approximately what percentage of your caseload is comprised of the chronically mentally ill client?

____%

***** Since the focus of this research is the chronically mentally ill client group, please answer the following questions within this context. *****

10. (a) In an average 40 hour work week, approximately how many hours are spent working with the chronically mentally ill client group?

____ hours
10. (b) Please breakdown this total into hours spent:

   i) meeting directly with clients    ___ hrs.
   ii) working on behalf of your clients  ___ hrs.
   iii) performing other duties (i.e. recording,
        meetings, public relations)  ___ hrs.

10. (c) Would you like to change any of these time allocations?

     Yes ___; No ___;

10. (d) If yes, state what new time allocations you would like if you had a free hand to do so.

     i) meeting directly with clients  ___ hrs.
     ii) working on behalf of your clients  ___ hrs.
     iii) performing other duties  ___ hrs.

11. Approximately what percentage of your current caseload live in the following accommodations? (Note: percentages should total 100%)

     family home
     boarding home
     rest and lodging
     group home
     public housing
     nursing home
     hospital
     other specify
12. (a) Of your total work time per week, indicate on the scale below, how often you engage in each of the following functions on behalf of your chronically mentally ill clients?

<table>
<thead>
<tr>
<th>Functions</th>
<th>very frequently</th>
<th>infrequently</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>client advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>therapeutic counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>family support group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>client referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>client assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>program organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>discharge planning</td>
<td></td>
<td></td>
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<tr>
<td>agency consultation</td>
<td></td>
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<tr>
<td>monitoring prescribed use of medications</td>
<td></td>
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<tr>
<td>crisis management</td>
<td></td>
<td></td>
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<tr>
<td>client follow-up</td>
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</tbody>
</table>

12. (b) Would you like to increase or decrease the frequency of any of the functions?

Yes___; No___;

12. (c) If yes, indicate the specific functions and direction of these changes by placing an asterisk (*) in the new position.

12. (d) What prevents you from making these changes?

13. (a) Approximately what percentage of time do you spend enacting each of these five social work roles with the client group? (Note: percentages should total 100%.)

- social broker: ___%
- enabler: ___%
- teacher: ___%
- mediator: ___%
- advocate: ___%
13. (b) Would you like to make any changes in these percentages?

   Yes ___; No ___.

13. (c) If yes, what would the new percentages be?

   social broker ___
   enabler ___
   teacher ___
   mediator ___
   advocate ___

14. (a) The following is a list of general service areas. To the best of your knowledge, which services are your chronically mentally ill clients most likely to use?

<table>
<thead>
<tr>
<th>Services</th>
<th>very frequently 1</th>
<th>very frequently 2</th>
<th>very infrequently 3</th>
<th>very infrequently 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychiatric</td>
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<tr>
<td>medical/dental</td>
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<td>recreation/leisure</td>
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<tr>
<td>employment/employees/union</td>
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<tr>
<td>vocational assessment/training</td>
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<td>housing</td>
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<td>financial assistance</td>
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<tr>
<td>sheltered workshops</td>
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<td>transportation</td>
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<tr>
<td>other ___ specify ___</td>
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</tbody>
</table>

14. (b) Using the list of services above, indicate with an asterisk (*) to which particular services you make client referrals.

14. (c) Have you had difficulties with any specific services to which you have made referrals?

   Yes ___; No ___;

14. (c) If yes, please describe the difficulties.
Interview Schedule

1. What are the three main hurdles facing the person re-entering the community from a psychiatric setting?

2. Are your clients presently in need of services that are not available or accessible to them?

3. Do you think there is some stigma suffered by the chronically mentally ill persons? How do you see this most often expressed?

4. Since you are working with a stigmatized client group, have you ever yourself experienced prejudice from other social workers? In what ways?

5. Have you ever been verbally threatened by a chronically mentally ill client? Please give examples.

6. Have you ever been physically assaulted by a chronically mentally ill client? If yes, how many times? What were the circumstances? What was the form of your injury? How was it resolved?

7. Of your current caseload, how many have been involved in violent or aggressive acts towards others?

8. Do you think you receive recognition for your social work competence? From whom? In what ways?

9. In your opinion, is the social work profession as involved with this client group as it should be? If not, why not?

10. Did your formal social work education prepare you to work with this client group? How?

11. What specific suggestions do you have for social work educators that would help to prepare social workers to work with this population?

12. Do you feel isolated from the social work community?

13. What provides gratification for you in this job?

14. Generally we think of the chronically mentally ill client as middle aged, medicated and institutionalized. Tell me about the chronically mentally ill clients that do not fit this description.

15. Do you think deinstitutionalization of the mentally ill has been a success? How might it be improved?

16. If there should be more coordination of community services, who do you think should be responsible for the coordination?
APPENDIX C

Social Work Roles

Social Broker—to make connections between the client and the community; referral; assist a client to find and use a needed resource.

Enabler—assist clients to find the coping strengths and resources within themselves to produce changes necessary for accomplishing objectives; help client to alter environment.

Teacher—provide the client with new information necessary for coping with the problem situation; assist clients in practicing new behaviours or skills; and, may teach through modeling alternative behaviour patterns.

Mediator—efforts to resolve disputes that may exist between the client system and other persons or organizations.

Advocate—worker becomes the speaker for the client by presenting and arguing the client's cause when this is necessary to accomplish the objectives of the contract.
APPENDIX D

Affirmative responses to questionnaire item 14(c):

"Have you had difficulties with any specific services to which you have made a referral? If yes, please describe the difficulties."

- psychiatric referrals are difficult with the limited number of psychiatrists; vocational assessments are difficult as well.

- breaking through the "red tape" in the systems.

- disability pension takes too long, too much hassle for client.

- psychiatrists general unwillingness to provide details, information and suggestions as to possible points of intervention for client/patient. Doctors in general do not provide written consults despite social workers initial referral.

- lack of resources in area of housing, sheltered workshops and transportation to services.

- services inadequate and often inflexible; client group by nature of the illness are often non-compliant.

- vocational rehabilitation; Windsor housing.

- waiting lists; lack of understanding of mental illness; programs missing needs perhaps because they are out-dated and have not been reassessed.
REFERENCES


General Welfare Assistance Act, S.O. 1958, c.33, R.S.O. 1980, c.188.


Mental Health Act, S.O. 1954, c.50, R.S.O. 1980, c.262.

Rehabilitation Services for Handicapped Person's Act, S.O. 1955, c.71, R.S.O. 1980, c.525.


VITA AUCTORIS

Rasma Jankovskis was born in Riga, Latvia on April 14, 1943. In 1949, she and her parents immigrated to Canada.

Rasma received her primary education at Withrow Public School, and her secondary education at Riverdale Collegiate in Toronto. She attended The University of Toronto, majoring in Sociology. She received her Bachelor of Arts Degree in 1968.

In July 1981, Rasma enrolled in the Make Up Social Work program at The University of Windsor receiving her Honours Bachelor of Social Work degree in June 1982. Her undergraduate field placement was at Maryvale, a residential treatment centre for emotionally disturbed female adolescents, located in Windsor, Ontario. In the fall of 1982, she enrolled in the Master of Social Work program at The University of Windsor. Her field placement was with the Essex County Children's Aid Society, Rossini Adolescent program in Windsor, Ontario.

From 1966 to 1975 Rasma was employed with the Children's Aid Society of Simcoe County as general caseworker, adoption worker and foster family homefinder. As well, during the summers of 1977, 1978 and 1979 she worked at the same agency as a homefinder and intake worker. During the summer of 1982 she was employed with the Children's Aid Society of Metropolitan Toronto as an...
Intake Team worker, investigating various cases and relieving family service caseloads.

Rasma plans to graduate in the spring of 1982 with a Master of Social Work Degree. She is a member of the Ontario College of Certified Social Workers.
VITA AUCTORIS

Donna Mavis Sutherland was born December 30, 1943 in Welland, Ontario. She completed her elementary education at Homedale Elementary School, St. Thomas, Ontario. She completed her secondary education at Alma College, St. Thomas, Ontario in 1964. She received her diplomas in Social Service Worker (1970) and Child Care Worker (1977) from Fanshawe College, London, Ontario.

In 1970, Ms. Sutherland became the Director of Teen Girls' Home, Mission Services of London, Ontario. This agency provided residential services to adolescent girls referred from various sources. In 1973, Ms. Sutherland was asked to be the Supervisor of three group homes operated by the Canadian Mental Health Association under contract to the Ministry of Corrections. These homes provided residential services to girls and boys who were training school wards. Ms. Sutherland has held other positions such as retail clerk/bookkeeper, secretary, secretarial science teacher, and nurse's aide.

In the summer of 1979, Ms. Sutherland commenced her studies in Sociology, University of Windsor. On completion of her B.A. in 1981, she enrolled as a make-up student in the Bachelor of Social Work program at The University of Windsor. Her undergraduate field placement was the Teenage Parent Program, Wayne County Children's Services.
Detroit, Michigan. She received an Honours B.S.W. in 1982. That summer she worked as a community worker with the Adult Protective Service Workers program at Family Service Bureau of Windsor and Essex County.

Ms. Sutherland enrolled in the Master of Social Work candidate year at The University of Windsor in the fall of 1982. Her field placement was Family Service Bureau of Windsor and Essex County, Windsor, Ontario.

Ms. Sutherland will complete her M.S.W. requirements in October 1983 with the degree being conferred at spring convocation, 1984.