

# **A STUDY OF THE DIMENSIONS OF COPING AMONG THE CHRONICALLY MENTALLY DISABLED**

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## ABSTRACT

Since the advent of deinstitutionalization in Canada in the late 1960's, there has been both a practical and theoretical need for a more comprehensive understanding of the structure of community life and the determinants of coping experience among the chronically mentally disabled (CMD).

In general, the provision of formal and informal after-care services designed to reintegrate ex-psychiatric patients into society have met with limited success. The problems of coping in the community (i.e. achieving a 'fit' between needs of the self and demands of the setting) are manifestly very complex and therefore related research requires a multidimensional framework that can include the social, physical and medical experiences of the CMD.

The rationale behind this project involves examining the effects on post-hospital outcomes of four categories of environmental variables (living situation and housing experience, material well-being, social networks and psychiatric profile and service utilization) using a behavioural model of coping developed by Dear et. al (1980). The relative strength of the behavioural dimensions of coping model will then be assessed by examining other factors potentially affecting coping ability that extend beyond the individual per se.

Given that there is an increasing emphasis on localized service delivery, social geographic studies into the problems surrounding coping are both timely and useful in terms of developing research methods that help explain the etiology of social problems; specifically those related to improving community care for the CMD. As a final note, results will be evaluated in terms of the implications for current mental health care policies in Hamilton.

## ACKNOWLEDGEMENTS

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## CHAPTER ONE INTRODUCTION

### 1.1 Scope and Objectives

The purpose of this project is to develop a better understanding of the problems facing ex-psychiatric patients in the community and how the structure of community life can affect coping experience. Since the advent of deinstitutionalization, psychiatric patients spend increasingly less time in hospitals and more time in the urban environment. The community is the primary site of formal and informal after-care services. Ideally, "deinstitutionalization" is designed to facilitate the reintegration process of the chronically mentally disabled (CMD) into society. However, implementation of the policy has not been without problems. In general the provision of community-based mental health services has been inadequate in terms of meeting the needs of clients. This situation may promote a "revolving door" pattern of repeated hospital admissions and discharge among clients who encounter inconsistent access to treatment and support systems that are often inadequate and/or inappropriate for individual needs (Taylor et. al, 1987).

The problems of coping in the community are manifestly very complex. The major objectives of this thesis include:

1. to use formalized operational measures of coping ability to better comprehend client and community variables that may affect the ex-psychiatric patient's urban experience



2. to examine the effects on coping of four categories of environmental factors using a behavioural model of coping developed by Dear et. al (1980). The four categories involve:
  - (a) living situation and housing experience
  - (b) material well-being
  - (c) social network
  - (d) psychiatric profile and support system
3. to assess the relative strength of the behavioural dimensions of coping model by examining broader factors rooted in society that may have an effect on coping ability but are not included in the objective testing.
4. to evaluate the findings in terms of the implications for current mental health care policies in Hamilton (Chapter 5).

A "geographic" examination of the community environment requires a multidimensional framework that can include physical, social and economic experiences of the CMD. Literature on community mental health has, in the past, concentrated on length of stay in the urban environment as an indicator of individual coping ability. However, community tenure cannot be treated in isolation from factors that contribute to living situation such as the type and quality of available housing, the effects of material well being on housing opportunities, the psychiatric history of the individual, and the social network of the client to highlight a few (Taylor et. al, 1987).

One of the strengths of the approach taken by this study in creating a greater theoretical and practical awareness of the determinants of coping experience for the CMD is that it considers both objective and subjective elements at various levels of analysis.

## 1.2 Report Organization

This report includes analytical techniques based on a study by Taylor et. al (1987). Material will be organized as follows. Chapter 2 is a literature review of relevant theories and past studies that provide an overall context of the project. The ideological framework focuses on the importance of the socio-ecological model of health (White, 1981) for the study design and measurement techniques.

Chapter 3 will outline the specific research criteria and methods that were used, giving a brief description of the Life Management in the City Questionnaire (LMCQ) and how data was obtained.

The characteristics of the client sample are reviewed in order to familiarize the reader with the Hamilton group and facilitate later discussion of the findings. The results of statistical analyses using Dear's model of coping are contained in Chapter 4. Further statistical commentary is also provided in the area of neighbourhood effects on mental health and coping ability as consistent with initial objectives.

Conclusions and suggestions for appropriate policy formation based on the needs of the Hamilton sample are discussed in Chapter 5. An evaluation of the behavioural model of coping will be based on findings in the report as well on material that is cited in the literature review.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 The Geography of Health Care

A geographical approach to health has particular relevance to the issues surrounding the assessment of post-hospital outcomes of the mentally disabled. In light of deinstitutionalized mental health care, appropriate intervention and after-care treatment programs depend upon a comprehensive understanding of the range of community and environmental factors that contribute to coping experiences. Although it is not the purposes of this review to list and evaluate the many perspectives that have been taken in analyzing health care, a brief exploration of social geography and health care is well-suited to the context of this research paper (Eyles and Woods, 1983).

In the late 1960's, the World Health Organization (WHO) extended the definition of health from the absence of disease to a "state of complete physical, emotional and social well-being" (cited in Elliott, 1987). Such an idealistic approach, although not without problems, draws attention to the fact that "medicine" and "health" are poorly understood given existing health care policies and programs. It is becoming increasingly obvious that medicine and biomedical technology, geared towards curing the physical manifestations of the disease process, cannot be used to solve the numerous, inherent problems of our health-care system (White, 1981).



These concerns centre around over-administration, cost-inefficiency, inadequate service provision and equitable allocation of resources. With this in mind, it may be valuable to re-examine the present conceptual framework of health and devise and implement a new one (White,1981; Eyles and Woods,1983). A different perspective such as the socio-ecological model of health (SEM) is constructive in generating more successful strategies in keeping with the WHO definition of health.

Sickness is commonly conceived as including both the etiological disease process and perceived illness states. Note however, that the origins of the two are found in very different types of interaction between the person and environment (Eyles and Woods, 1983). One method to facilitate a better understanding of individual interaction in complex sociological framework is to imagine the person as participating in a number of different, interrelated sub-environments (see figure 1). There are a series of potential outcomes (labelled w, x, y, and z) from this interaction that have profound medical, ideological and socio-cultural implications; mainly that medical methods used to fight disease should not by themselves be expected to have a large impact on society's increasing burden of illness (White,1981). Thus, appropriate preventative and creative strategies should attack the issue of "health" as being inseparable from the total environment. The socio-ecological model of health is particularly useful in evaluating the



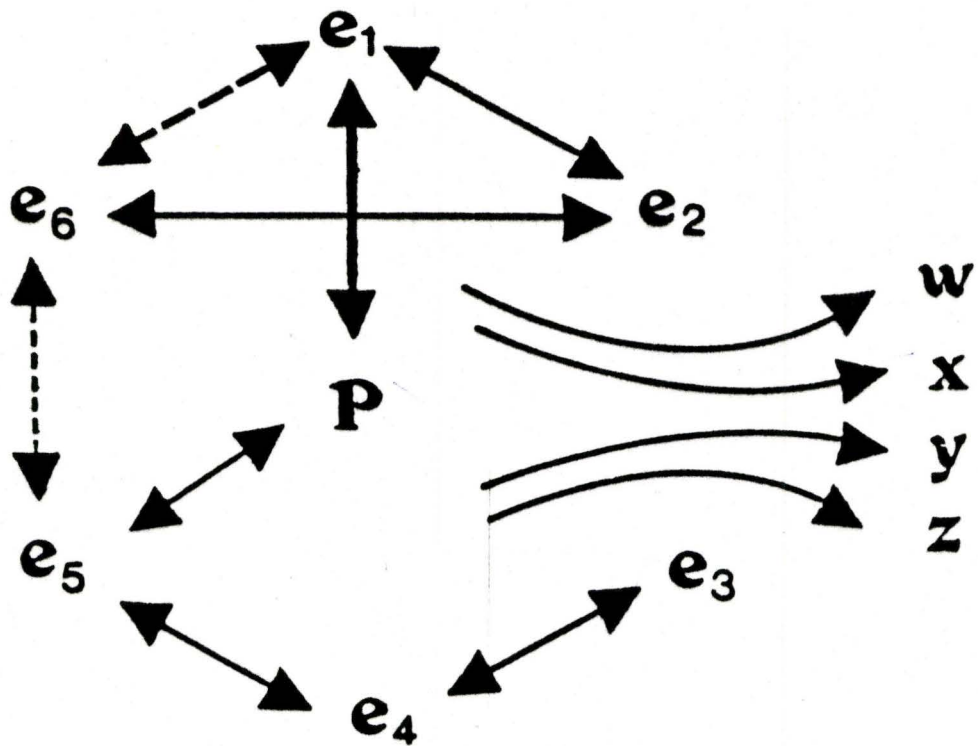


figure 1 The Socio-Ecological Model of Health

source: White (1981)

post-hospital experiences of the CMD which are linked to an individual's medical history and socio-physical environment. Coping therefore becomes a complicated process that can result in a number of potential outcomes depending upon the set of individual and community conditions present.

## 2.2 The Geography of Mental Health

Public policy on the form and location of mental health care has changed radically since the 1960's. The emphasis has shifted from large scale, state asylums to community oriented mental health care. This change was the product of many factors notably the Civil Rights Movement and questionable efficiency and effectiveness of institutionalized treatment. The past twenty years has witnessed a 75% decrease of patients on the books in state asylums, whereas the rates of admission doubled and those of discharge almost tripled. In fact, the proportions of readmissions doubled to form two-thirds of all admissions (Dear and Taylor, 1982). Moreover, in Canada, provincial laws were altered to enable cost-sharing arrangements with the federal government so as to facilitate the development of community-based mental health care programs.

Ideally, the community was to provide an environment where rehabilitation and hopefully recovery for the chronically mentally disabled (CMD) would be encouraged (Dear et. al, 1980). The principle behind deinstitutionalization is that of "normalization", attempting to minimize the stigma

and isolation associated with mental illness by undertaking treatment in a culturally normative environment (Elliott,1987). Policy objectives have received theoretical support from the public, patients and professionals. However, deinstitutionalization occurred prior to the development of adequate social service networks and community-based mental health facilities. Indeed, many have viewed the motive underlying deinstitutionalization with scepticism because of poor administrative support and inconsistent financing from government agencies that has resulted in fragmented and over-utilized support services.

The opinions of the Ontario Public Services Union typify these concerns:

All indications are that what has been called deinstitutionalization, a purported dedication to the generally valid concept of treatment in the community, is in fact a neo-conservative euphemism for divestment of public responsibility as a way of saving money.  
(cited in Elliott,1987).

Regardless of the fundamental intentions, deinstitutionalized mental health care policies have resulted in some long-term community problems, largely the result of a dramatic and sudden increase in localized mental health care demands.

Geographic literature on the impacts of decentralized treatment of the mentally ill has focussed on two major points. First is the "ghettoization" of the inner city CMD, making them an identifiable social group within core areas.



Kearns, (1987), argues that the present location of ex-psychiatric patients has been structured by pre-existing contours of socio-economic opportunity. Traditionally, urban areas especially city centres that may have relatively high concentrations of lower income groups, exhibit greater incidences of morbidity (Black Report, 1983). Increased unemployment rates, poor quality of existing housing stock and comparatively low rents have contributed to creating a zone of disadvantage for many inner city dwellers, mainly the CMD (Cohen et. al, 1980; Kearns, 1987; Aviram, 1978). The momentum of these dominant social forces draws disadvantaged groups to central areas and locks them into constrained social circles (Kearns, 1987; Taylor et. al, 1987).

The second area of emphasis concerns the community's attitude toward the mentally ill combined with the provision of mental health services. For example, Dear and Taylor (1982), undertook a systematic investigation of public reactions to the location of mental health facilities in Metropolitan Toronto to examine the socio-psychological processes that underlie community responses to the mentally disabled. They determined that the formation of beliefs and attitudes with respect to the CMD vary as a function of several broad factors, specifically patient characteristics and treatment situations, the characteristics of the individual within the general public and finally, the characteristics of the social context of the potential facility location. The planning problem relating to facility

location is twofold. First, client needs must be matched to a range of appropriate treatment settings from complete dependence to minimal support. Second, community opinions regarding treatment facilities must be accounted for as a fundamental characteristic of the immediate environment influencing the CMD with regards to self-perception and ultimately the ability to cope (Cohen et. al,1980; Elliott,1987; Taylor et. al.1987).

### 2.3 Coping in the Community

There is both a theoretical and practical need for a more comprehensive understanding of the structure of community life and the determinants of the coping experience of the CMD (Taylor et. al,1987). Implicit in this statement is a working definition of the terms "community" and "coping". Community includes both a geographical location and sense of social belonging, involvement as well as participation in various spheres of human activity. Coping is a concept less clearly understood. Generally, it involves a negotiation between needs of the self and demands of the setting (Dear et. al,1980; Taylor et. al,1987). A positive coping experience would involve an adequate "fit" between the person and environment in a community setting (Taylor et. al,1987).

In their study on Coping and Community Life Among the Chronically Mentally Disabled, Taylor et. al (1987) derived a socio-ecological model of coping from the generic features of



White's (1981) model of health. This model, shown in figure 2, involves operational measures that influence and account for both the quality and quantity of community life. The strength of this comprehensive approach lies in its ability to extend studies of coping behaviour beyond previous investigation of the length of community tenure. Implied in using this model is that a range of potential determinants of coping ability should be considered for their combined as well as individual influence on client outcomes. Existing literature supports some of the preliminary relationships in the model such as personal characteristics (education, marital status, gender) institutional experience, lifestyle and type of living situation as being predictors of coping experience. The socio-ecological model of coping is the main focus of the analysis described in subsequent chapters.

A wide ranging study using behavioural coping measures to test for the relative "fit" between person and the environment was conducted by Dear et. al in 1980. One of the objectives was to investigate the role of the client in the measurement of coping ability as a function of proficiency in five areas; housing, income, jobs, medical and psychiatric services and social needs (figure 3). Using Hamilton as a case study, the city itself was viewed as a "coping mechanism" that would either facilitate or hinder reintegration into the social environment. In other words, analysis of community life for the CMD consisted of identifying determinants of objective post-hospital outcome

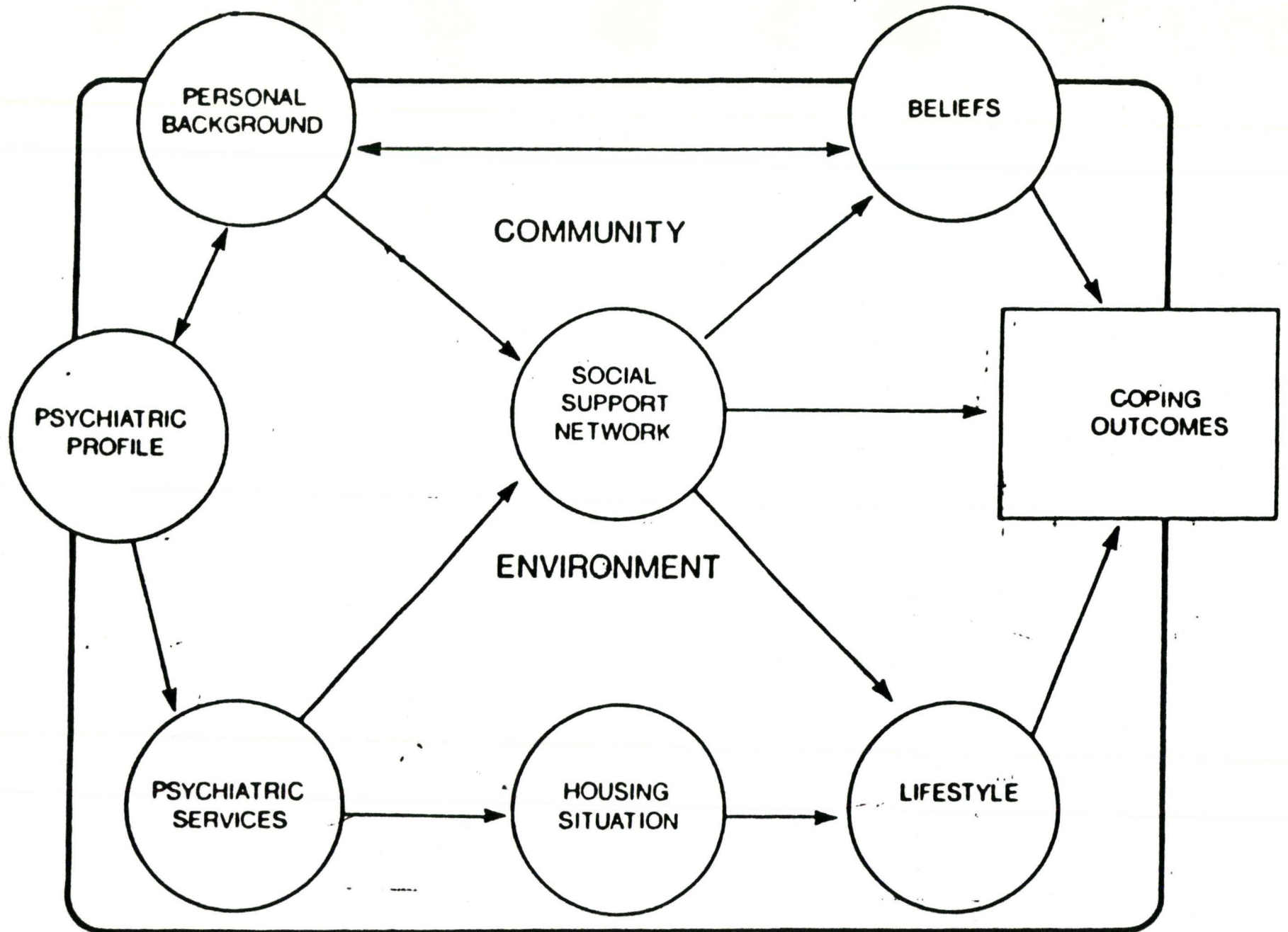


Figure 3 A socio-ecological model of coping

Source: Taylor et al (1987).



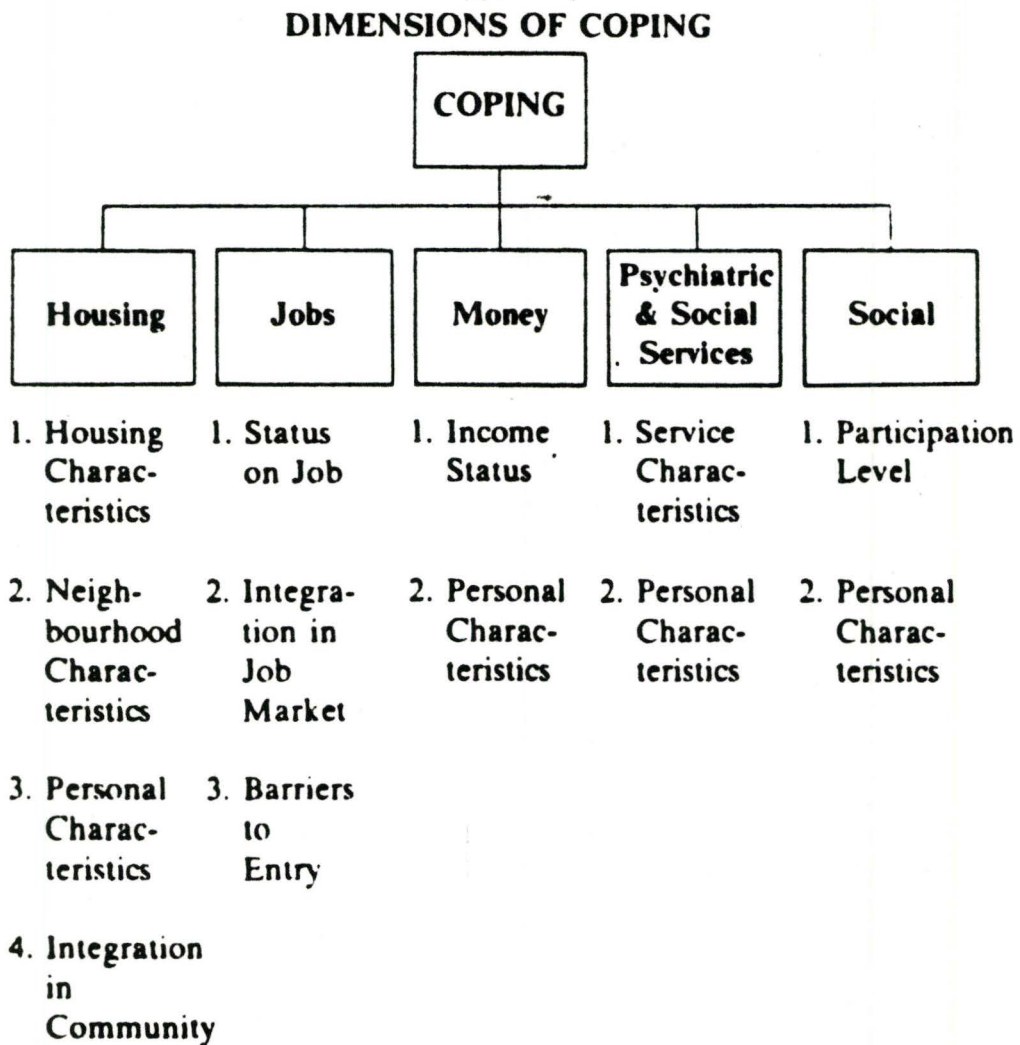


figure 3 Behavioural Dimensions of Coping Model

measures and representative of the ability to deal with and adapt to various events and circumstances (Kearns,1987; Taylor et. al,1987).

There are two major lines of inquiry for this research project. The first is an objective examination of the effects on coping ability of four sets of environmental factors from Dear's model of coping (1980). These include living situation and housing experience, material well-being (income and employment), social network (types and level of activity and community involvement) and psychiatric profile and service utilization. The data and analysis will be based on the case study of Hamilton conducted by Taylor et. al, in 1987.

The second topic of investigation involves interpreting the relevance of using the behavioural approach (Dear et. al,1980; Taylor et. al,1987) as a tool to measure the coping abilities of the mentally ill. The rationale behind this more subjective analysis stems from the idea that factors linked to coping are broader than those concerned with the individual per se , and extent to the socio-physical characteristics of the community in which the CMD find themselves. Mental health practioners now accept that the social and spatial context of an individual's community life can contribute to an overall understanding of mental health problems (Smith,1980). Given that there is an increasing emphasis on localized service delivery, applied social geographers may make meaningful contributions to mental

health studies in the area of developing research methods that help explain the etiology of social problems; specifically those related to improving the delivery of community-based mental health services.

Studies on the effects of neighbourhoods on mental health are usually either evaluative studies (those environmental influences that contribute to the evaluation of well-being) or responsive studies (investigating environmental effects on a range of behavioural outcome measures). Time geographic studies which are evaluative in nature, record the daily life experience of a client group. Daily experiences reflect the importance of neighbourhood characteristics and their contextual effects on individual evaluations of the urban setting and the corresponding set of responses. This information is particularly useful to achieve a clearer picture of the quality of life among the CMD and how that relates to overall coping ability (Kearns and Taylor, 1987).

The need to research neighbourhood effects on mental disability is critically important in terms of appropriate health care and community intervention. A more "sophisticated" mapping of the urban community that could serve to increase awareness and understanding of the relationship between health, medicine and society would be both useful and timely. Studies of neighbourhood effects on mental health are shaped by the relationships between many different variables such as the type of problem(s) to be



studied; the hypothesized relationship between neighbourhood characteristics and the dependent variables(s) selected as well as the way the researcher conceptualizes the structural effects of neighbourhoods (Smith,1980; Warren,1977).

Assuming that neighbourhoods are thought of as part of the solution to mental health problems (as opposed to part of the problems themselves) studies aimed at understanding their multidimensional properties in terms of direct and indirect socio-physical influences on post-hospital outcomes could provide a good starting point for future research on coping abilities.

It is on these issues that the second portion of this paper will concentrate, with the intent of contributing to a more comprehensive understanding of the structure of community life and the determinants of coping experience.

In light of some of the literature cited, it is clear that a wide array of theories and methodologies have been used to study coping in the community. Given the project objectives, that involve developing a better understanding of the difficulties encountered by ex-psychiatric patients in the community, some rigorous analytical testing of Dear's behavioural model of coping is required.

First, the relevance of the model as a tool to measure the coping experience of the CMD must be evaluated, and second, generalizations concerning broader community-based socio-physical factors that may influence coping ability will be based upon tests of the behavioural framework. Some

personal and more probable community-environmental variables may be implicated as significant coping influences that have not been incorporated fully into the model.

## CHAPTER 3

### RESEARCH DESIGN

The project objectives require establishing some familiarity with the study population in order that their coping experiences may be evaluated. This section provides a description of the client group , the sample design criteria, the logic behind the Life Management in the City Questionnaire and an overview of the analytical methods used to assess coping abilities among the test sample.

#### 3.1 Method

##### 3.1.1 The Sample Group and Design Criteria

Given that the exact number of the CMD in Hamilton are unknown, it is impossible to select a representative sample population with characteristics known to be indicative of the larger community. The client list therefore, was drawn from three different aftercare programs in the city to ensure sufficient variability in activities and lifestyle. The program groups involved were:

1. The Care Centre - run by the Hamilton Wentworth branch of the Canadian Mental Health Association as an inner-city drop in centre. The facility has up to 150 casual participants with a core group of about 80 people, who partake in loosely structured programs. Care centre participants tend to be unaffiliated with other aftercare programs in Hamilton.

2. Community Enrichment Services - is also sponsored by the CMHA/Hamilton. This case-management program involves close to 75 clients who are assigned to a social worker for counselling services.

3. Community Psychiatry Services - is one of the three main outpatient psychiatry units in Hamilton. Based at St. Joseph's Hospital, it involves nurses, social workers and psychiatrists meeting regularly with roughly 300 patients. The service objectives are comprehensive as the clients display a wide variety of disabilities and needs (Taylor et. al, 1987).

Age and gender were used as the primary determinants of sample design criteria. A two-by-two matrix was constructed to organize approximately equal numbers of male and female clients that were either 35 years old and younger or older than 35 years. This age-gender distribution was sought to control for both sexes, younger patients with presumably minimal institutional experience and older individuals with a greater likelihood of having had longer term hospitalization. Note that unless otherwise specified, statistical analyses and discussion of results is based on the 58 reinterviewed clients.

### 3.1.2 LMCQ

Data was provided through the administration of the Life Management in the City Questionnaire (LMCQ). The questionnaire was designed to obtain two types of information: first, measures of post-hospital outcome; and second, a descriptive account of clients and their community experience. The LMCQ was conducted with the intent of building a rapport with the client group by way of open-ended as well as structured questions and rating scales.

Items in the survey were grouped into sections that approximated the behavioural dimensions in Dear's original



coping model, including living situation, social support networks, involvement in psychiatric care programs, and material well that centred on both jobs and income (see Appendix).

Throughout the course of the interviews, clients' primary care-givers were present (with the exception of Care Centre clients) so as to create a comfortable environment for the respondents as well as provide insight into answers whenever appropriate. Care-givers were the primary source for selection of the sample population. They selected individuals from their case loads who were thought to be suitable on the basis of their health status and ability to participate in the interviews.

The survey, conducted by Taylor et. al (1987), was done in two rounds six to eight months apart. The first round was comprised of 66 patients and the second round had 58 patients, resulting in 88% of the sample being reinterviewed. The eight clients lost to the follow up round included; one who was in prison, one who had been readmitted to hospital, two who declined a second interview and three who could not be found (Taylor et. al, 1987).

## 2.2 Analysis

The LMCQ was designed to obtain information on both the quality (assessed coping and satisfaction) and quantity (length of time in the community) of post-hospital experience. In the course of testing, Independent variables

were grouped into one of the four categories (living situation and housing experience, material well-being, social network and psychiatric profile and service utilization) as consistent with Dear's behavioural model of coping.

Two sets of self-report scales were used to derive quality of life measures of coping (see Appendix). The set that dealt with coping used a six-point scale to represent some point between "coping very well" and "coping very poorly". The other set was worded in terms of satisfaction, again on a six-point scale, and included "very satisfied" to "very dissatisfied". Coping and satisfaction assessment were provided by the clients for five aspects of community life; living situation, social situation, community experience, employment and income. In addition to the self-rating scales, the primary care-giver also used the coping scale to assess the client in four of the five community categories, living situation being left out because of the inadequate opportunity to observe. Ratings in this manner were carried out for both rounds of interviews (Taylor et. al, 1987).

The measures of quantity of life were obtained by the clients providing personal records of hospitalization over the previous two years to the first interview. For the second interview, records were updated to cover the intervening six months. In both cases, the information was verified by the care-givers (Taylor et. al, 1987).

In later analysis, note that the quality of life assessment scales have been condensed into three indices;

self-assessed coping, self-assessed satisfaction and care-giver assessed coping. In each case, ratings were summed across the five community categories and composite scores were thus calculated from both rounds of survey data. Taylor et. al (1987) established that the test-retest correlations between the two sets of scores (Spearman's rho: self-assessed coping, 0.68; self-assessed satisfaction, 0.53) supported the claim that this group could provide reliable self-report data. The significance of obtaining self-report data as well care-giver assessments is that these measures facilitate data analysis of a broad range of factors which relate to their daily life and coping in the community.

Consistent with the research goals, quantitative analysis evaluated post-hospital experiences in terms of selecting specific client and community variables and testing them for significant relationships with the outcome measures. A total of thirty-three variables were chosen incorporating various aspects of the clients' living situation, social networks, material well-being and psychiatric profile and service use. Depending upon the nature of the independent variables one of three types of tests were used; the Mann-Whitney U test, Spearman's Rho correlations or the Kruskal-Wallis test. Significance levels were arbitrarily set at  $p < 0.05$  and  $p < 0.01$ . Eight variables were found to have statistically significant relationships with the outcome measures. A full account of test results is covered in the following chapter.



## CHAPTER 4

### RESULTS

#### 4.1 Sample Characteristics

A brief description of the client sample characteristics will be outlined with the intent of providing basic information on some of the client and community variables to be tested. The CMD in any location tend to be an identifiable subculture; their illness experience being exacerbated by profound economic and social disadvantage. The location of the CMD in core areas is a product of choice (choosing to be close to centrally clustered services and support facilities) and constraint (the inner city offering the least resistance to group homes, having the lowest rents owing to deteriorating housing stock and also being an area of informal support for many of the clients who happen to share similar disadvantages).

The age-gender breakdown indicates that the group with the smallest representation were females under the age of 35 (about 16%) and the greatest representation (approximately 31%) being males under the age of 35. Males and females over the age of 35 comprised 26% and 28% respectively of the entire surveyed group. The sample therefore, is biased towards the older age category and male clients.

Most of the respondents resided in central city lodging homes (see figure 4). The explanation for this may be found in the fact that the three participating program groups are

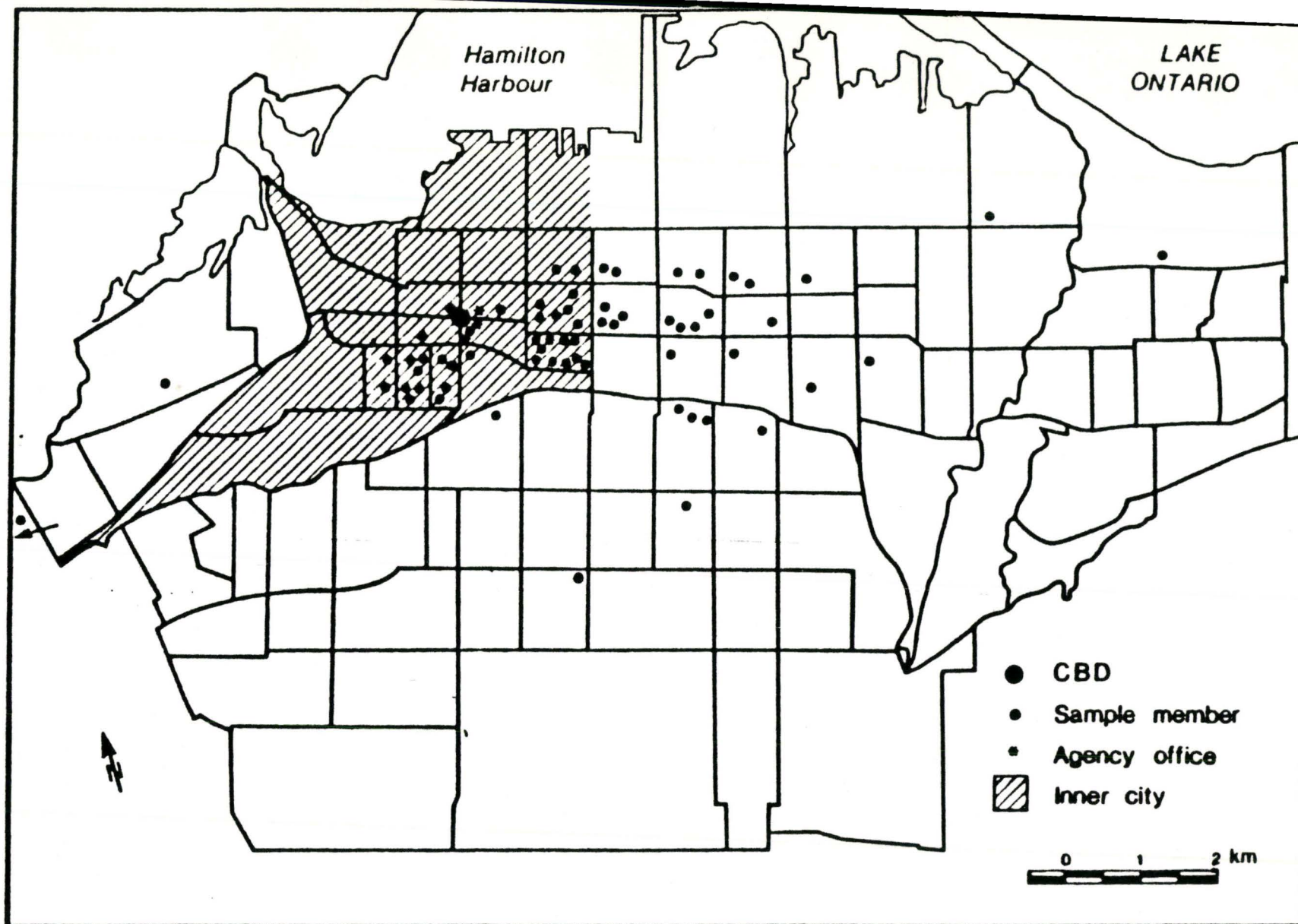


Figure 4 Residential Location of Client Sample at Time of Most Recent Interview.

Source: Taylor et al (1987).

located in the downtown core that has the greatest concentration of services and has traditionally been the area towards which disadvantaged populations gravitate.

Approximately 65% of the patients had never married, with females having a higher incidence of marriage. About one quarter of the sample could not identify a "significant other" in their lives, and of those who could, almost three quarters of the relationships were less than one year old. A large proportion of "significant others" were people involved in the living situation or aftercare services ( a combined total of roughly 47% of all nominated "significant others").

More than half the sample complained of not having enough to do with their spare time. Generally, people participated in passive social and household activities such as watching t.v., smoking, eating, "just sitting around" and talking. Only 35% of the sample indicated some affiliation to an organized group. Participation in activities was often tied to some component of aftercare programs.

Almost all of the clients (about 97%), received Family Benefit Allowance (FBA), while less than one quarter derived income from employment. Of those having a job, most worked in sheltered workshops or on a part-time or even casual basis. Note that the majority of interviewed clients felt that their income was inadequate, more than two-thirds of them being in the \$400-\$599 per month income bracket.

The greatest number of psychiatric diagnoses were schizophrenic (close to 64%), followed by manic depressives



Table 1

PERSONAL CHARACTERISTICS OF THE CLIENT SAMPLE

---

Age        < 35    27    (46.5%)  
              > 35    31    (53.5%)

Gender   female    24    (41.4%)  
              male     34    (58.6%)

Monthly Income

< \$199        1        (1.7%)  
 \$200-\$399    8        (13.8%)  
 \$400-\$599    38       (65.5%)  
 \$600-\$799    6        (10.3%)

Income Source

\*

Social Ass.	46	(79.3%)
Other	12	(20.6%)

\*Family Benefit  
 Allowance (97.1%)

Employment Status

employed        18    (31.0%)  
 unemployed    40    (69.0%)



Table 2

LIVING SITUATION AND HOUSING CHARACTERISTICS OF THE  
CLIENT SAMPLE

-----

Type of Living Situation

Parental Family	3	(5.2%)
Lodging Home	31	(53.4%)
Independent (Alone)	18	(31.0%)
Independent (Conjugal)	3	(5.2%)
With Others/Relatives	2	(3.3%)
YMCA/YWCA	1	(1.7%)

Own Room

Yes	24	(41.4%)
No	19	(32.8%)
n/a	15	(25.8%)

Type of Preferred Living Situation

Parental Family	2	(3.4%)
Assisted Housing	1	(1.8%)
"Better" Apt/House	7	(12.1%)
Other Lodging Home	4	(6.8%)
Independent	22	(37.9%)
Happy As Is	21	(36.2%)
n/a	1	(1.8%)

Table 3

SOCIAL NETWORK CHARACTERISTICS OF THE CLIENT SAMPLE

-----

Total Nominated Significant Others \*

Friend	28
Parents	19
Sibling(s)	19
Therapist	13
Child(ren)	10
Spouse	9
Other Care-Giver	7
Boy/Girlfriend	6
Family/Relatives	5
Other	4

\*  
includes multiple responses

Average Length of Relationship With Significant Others

< 1 year	42	(74.1%)
1-2 years	2	(3.4%)
2-3 years	3	(5.2%)
4-5 years	2	(3.4%)
5+ years	6	(10.3%)
n/a	2	(3.4%)

Participation in Organisations \*

Community Groups	19
Care Centre	16
Structured Mental Health	9
Church Membership	9
Recreation Centre	6
Seniors Clubs	4
General Drop-In Centres	2
Church Coffee House	1
Family Service Group	1

\*  
includes multiple responses

Table 4

LIFESTYLE CHARACTERISTICS OF THE CLIENT SAMPLE

-----

		*
<u>Activities Currently Enjoyed</u>		
TV/Radio	14	
Sports	12	
Reading	12	
Walking	11	
Music	10	
Going to Care Centre	10	
Movies, Library, Art Gallery	9	
"Sitting Around"	7	
Going for Coffee	6	
Crafts	6	
Housekeeping	5	
Resting, Eating	5	
Games	4	
Church Groups	3	
Writing	2	
"Dont' Know"	2	

\*  
includes multiple responses

Enough to Do?

yes	38	(65.5%)
no	20	(34.5%)



Table 5

PSYCHIATRIC PROFILE AND SERVICE UTILISATION CHARACTERISTICS  
OF THE CLIENT SAMPLE

Diagnosis

Schizophrenic	37	(63.8%)
Manic-Depressive	6	(10.4%)
Schizo-Affective	5	(8.9%)
Personality Disorder	3	(5.2%)
Affective Disorder	1	(1.7%)
Drug/Alcohol Addiction	1	(1.7%)
"Other"	1	(1.7%)
Unknown	2	(3.4%)
Missing	2	(3.5%)

Sample Group (Program)

Care Centre	14	(24.1)
Community Enrichment Services	25	(43.1)
Community Psychiatric Services	19	(32.7)

and schizo-affective and personality disorders. Considering the data gathered on client characteristics, the typical client in the sample would be male, schizophrenic, unemployed and living in the inner city. A more detailed breakdown of client characteristics are provided in tables 1 to 5.

#### 4.2 Relationships Between Coping and Satisfaction Measures

The correlations between the various coping indices were calculated in order to test the relationship between subjective and objective measures of coping and satisfaction. The results of the correlations between coping indices, recidivism (repeat hospitalization) and community tenure are displayed in table?. All correlations were computed using Spearman's Rho.

As might be expected, recidivism and community tenure (both measures of the quantity of community life) show the strongest correlation. In terms of quality of life measures, correlations among the assessment scales are all positive and indicate a significance level of  $p < 0.01$ . Total self-assessed coping and self-assessed satisfaction had the strongest relationship which confirms the idea that clients who were coping well were also generally more satisfied with their living situation. The relationships between care-giver and self-assessed coping was significant but weak, indicating that there is a general consistency between the two sets of measurements. The reason that the relationships is not a

strong one may be related to the fact that self-rating scores were higher than care-giver ratings.

A weaker correlation is shown between the assessment scales and quantity of life measures. In terms of self assessed coping, there is a negative relationship with community tenure and a positive one with recidivism. Self-assessed satisfaction shows the opposite trend, a positive relationship with community tenure and a negative relationship with recidivism. The inference here is that at discharge, clients find themselves coping better, but being less satisfied with their living situation. Conversely, the more time clients spend in the community, self-assessed satisfaction becomes greater than self-assessed coping ability. This pattern could result from clients having high expectations directly following discharge and being dissatisfied with less than ideal living conditions. Simultaneously, coping strategies seem more effective owing to immediate and higher levels of care and attention in the initial stages of community reintegration. Over time, it is likely that clients adapt to the reality of their living situation and becomes more satisfied but do not cope as well owing to less frequent contact with care-givers.

#### **4.3 Relationships Between Client and Community Variables**

The relationships between coping indicators and various client and community variables were tested using the appropriate non parametric methods. These variables were



Table 6

CORRELATIONS AMONG THE COPING INDICES

---

	Self- Assess. Coping	Self- Assess. Sat.	Care- Giv. Assess. Coping	Hosp. Admiss.
Self-Assess. Satisfaction	.547			
Care-Giv. Assess. Cop.	.407	.308		
Hospital Admissions	.044	-.291	.113	
Community Tenure	-.226	.201	-.115	-.848

---

(all correlations using Spearman's Rho)

strong one may be related to the fact that self-rating scores were higher than care-giver ratings.

A weaker correlation is shown between the assessment scales and quantity of life measures. In terms of self assessed coping, there is a negative relationship with community tenure and a positive one with recidivism. Self-assessed satisfaction shows the opposite trend, a positive relationship with community tenure and a negative relationship with recidivism. The inference here is that at discharge, clients find themselves coping better, but being less satisfied with their living situation. Conversely, the more time clients spend in the community, self-assessed satisfaction becomes greater than self-assessed coping ability. This pattern could result from clients having high expectations directly following discharge and being dissatisfied with less than ideal living conditions. Simultaneously, coping strategies seem more effective owing to immediate and higher levels of care and attention in the initial stages of community reintegration. Over time, it is likely that clients adapt to the reality of their living situation and becomes more satisfied but do not cope as well owing to less frequent contact with care-givers.

#### 4.3 Relationships Between Client and Community Variables

The relationships between coping indicators and various client and community variables were tested using the appropriate non parametric methods. These variables were

classified according to different components in the behavioural dimensions of coping model (Dear et. al, 1980), and the socio-ecological model of health (White, 1981) to include personal characteristics, living situation data, social and community support network, material well-being and lifestyle characteristics.

Of the thirty-three variables used in the analysis, eight showed significant association (either  $p < 0.05$  or  $p < 0.01$ ) with at least one of the five outcome measures. Living situation and housing experience variables were the most frequent correlates with the coping indicators. Some findings warrant commentary as they provide insight into factors that influence clients' coping abilities in the community (refer to table 7 for a list of significant variables).

#### 4.3.1 Living Situation and Housing Experience

Selected residential variables showed a significant relationship with at least one of the outcome measures. As might be expected, the number of moves (within the 2.5 year period previous to the interviews) and residential mobility (the number of moves combined with the average length of stay) are both significantly related to recidivism and community tenure (quantity of life measures). The number of hospitalizations are related to mobility because they were recorded as a move in the original survey. Upon further testing it was discovered that aside from hospital admissions



Table 7

**SIGNIFICANT RELATIONSHIPS BETWEEN COPING INDICES AND  
CLIENT AND COMMUNITY VARIABLES**

---

	SELF- ASSESS. COPING	SELF- ASSESS. SAT.	CARE-GIV. ASSESS. COPING	COMM'TY TENURE	HOSP. ADMISS.
<b>LIV.SIT:</b>					
tot.moves(2)		-.36*		-.48*	-.39*
res.mobility(2)		.18**	-.24*	-.56*	.52*
liv. sit.(1)		312.0**			
<b>SOCIAL NETWORK:</b>					
enough do(1)		256.0*			
education(1)				180.5*	303.5**
<b>MATERIAL WELL-BEING:</b>					
income source(2)					
1. welfare		-.19**			
2. work			.25*		
3. baby bonus		.23*			
enough income(1)		10.4*	4.2*		
<b>PSYCH.PROFILE SERVICE USE:</b>					
diagnosis(1)					243.5**

---

\* p < 0.05                      1 = Mann-Whitney U test  
                                   2 = Spearman's Rho  
 \*\* p < 0.01                    3 = Kruskal-Wallis test

and discharge, 56% of the moves were made for involuntary reasons such as financial problems or unacceptable living conditions (bad food, crowding, dirtiness). The results did not show a relationship between mobility and ratings of satisfaction of coping with the living situation. This is surprising because not only do the relationships make intuitive sense, but there has been general acceptance of the importance of an appropriate and stable living situation for the positive post-hospital coping experience in the community (Taylor et. al, 1987; Aviram, 1978). Indeed, both rounds of interviews showed a high proportion of the sample as being satisfied with their current living situation. Recall that assessment scales in the survey operated on a six point system in terms of self-rated coping and satisfaction and care giver assessed coping. Considering rounds one and two respectively, 73% and 75% of the respondents rated themselves as "satisfied" (either somewhat, quite, or very) (Elliott,1987). This result may be owing to the fact that the CMD may be resigned to their lot of typically sub-standard housing or possibly that clients have a tendency to over-rate their coping and satisfaction as part of an overall coping strategy that requires developing and maintaining a positive self-perception.

The relationship between living situation and satisfaction suggests that this might be an important variable in understanding coping in the community. Previously, it was stated that the majority of the sample

resided in second level lodging homes. Given that almost one quarter of the clients surveyed felt that their housing needs were not being met, it can be implied that discharge planners rely too heavily upon the lodging home system in Hamilton and are unable to provide a more integrated network of opportunities between extremes of total dependence and total independence. In terms of preferred living situations, the most frequent answer in both rounds was "independent" (39% and 33% respectively). The only other response mentioned with any regularity was "happy as is". When questioned about preferred location, most of the respondents indicated that central Hamilton would be their primary choice. Again, this trend may be the result of a combination of factors including affordable and available housing, proximity to health and other necessary services, as well as the central city being an area of "least resistance" to group housing projects.

#### 4.3.2 Material Well-Being

The most frequently mentioned factor that prevented clients from realizing their preferred locations was "financial constraints" (33% and 32% of the respondents in rounds one and two respectively). This result is expected because most of the sample received social assistance and fell into the \$400-\$599 per month income category. Material well-being, specifically income was cited as a significant factor that affected satisfaction and assessed coping ability. A logical connection can be made between this



result and the fact that most of the sample lives in inner city, sub-standard housing which although the most affordable is not the most desirable in terms of CMD coping and satisfaction.

It would not be unreasonable to suggest that control over one's individual finances might have a positive effect on individual satisfaction. The results however, did not support this idea, as a substantial proportion of the sample, close to 30%, allowed a trustee to control their financial affairs. Whatever the individual arrangement, there was no significant effect upon satisfaction with income.

Having a job can be very important to an individual in terms of increasing involvement in society, providing an adequate income and enhancing self-respect. A relationship between employment variables and coping indices might be expected, however the fact that the analysis did not reveal any significant results is not suprising because the test sample is small and very few clients were actually employed (only 16 out of a possible 58).

The reason for most of the sample being unemployed may be related to clients' status as ex-psychiatric patients and the stigma they bear in attempting to enter the job market and integrate into the workplace. Of those persons actually employed, clients felt that they "fit in" to their work environment which may have positive implications for coping and satisfaction.

#### 4.3.3 Social Network

Of the seven variables tested under the "social network" category only two had significant relationships with the five coping indices. Results showed that approximately 55% of the client sample reported not having enough to do in their spare time, and that these clients had lower overall levels of satisfaction. Other studies (for example, Dear et. al, 1980) have implied that the type of endeavour, particularly solitary activities, may have a detrimental effect on coping ability. Most of the clients that felt bored expressed a desire to have better access to social and recreational facilities and programs. The ability to participate in a more structured social network may be the result of geographically restricted travel patterns combined with low incomes.

The other significant variable concerned level of education. Rate of hospitalization was significantly related to the level of education, those having graduated from high school being more likely to be rehospitalized than those with less than a high school education. It follows therefore, that the high school graduates in the group had a shorter length of community tenure as results did indeed indicate. The effect of education on post-hospital outcomes is unclear. One possible explanation is that clients with a higher level of education may have greater expectations that they can realistically satisfy given the community environment and their restricted means and opportunities.

#### 4.3.4 Psychiatric Profile and Service Utilization

Schizophrenia is significantly correlated to community tenure and latest hospitalization. Frequent rehospitalization for schizophrenics may be the result of particular difficulties associated with this groups' illness experience making their situation in the community particularly fragile. The outcome therefore, is a revolving door syndrome, with clients being continually readmitted to and discharged from hospitals. As might be expected, the number of hospitalizations within the last year (prior to the survey) is significantly correlated with client assessed coping. In other words, clients with a lower frequency of hospitalizations were coping better within the community environment. Although a relatively high degree of satisfaction with living situation was reported, a majority of respondents identified the need for more counselling and medical services. Therefore, despite some satisfaction with current treatment programs, unmet needs are still being perceived by the service-dependent population. Clients' needs are often complicated by certain problems encountered in receiving care such as lack of communication between helper and those seeking help, and the alienating effect of certain professional attitudes (Dear et. al,1980).



#### 4.3.5 Summary

The results obtained in this section do not provide strong evidence for Dear's behavioural model of coping in terms of assessing client and community factors linked to coping ability. Findings do support the general relationships between inadequate income, low activity levels and boredom and the effects of living situation on coping and satisfaction as cited in previous literature (eg. Dear et. al,1980; Taylor et. al,1987; Kearns,1987). However, given the study objectives to develop an increased knowledge of the problems faced by ex-psychiatric patients in the community, further insight into the issue of coping must be sought in elements that extend beyond individual behaviour per se. Recall that the socio-ecological model of coping considers the person as situated within a multidimensional environment influencing post-hospital outcomes. A better understanding of coping, therefore, necessitates considering the interaction between people and their social and physical environments. Ideally, this may provide a better picture of the impacts of deinstitutionalization on the social geography of the city and the daily life experiences of the CMD.

#### 4.4 Neighbourhood Effects on Mental Health

The initial research task involved a comprehensive description of some community and client variables as they affect post-hospital experience among the CMD in Hamilton.



Statistical analyses confirmed some of the results found in earlier studies (eg. Dear et. al,1980; Taylor et. al,1987). It is important to consider the potentially significant effects on coping of some broader factors rooted in society that were not incorporated into the behavioural dimensions of coping model. The purpose of this section on neighbourhood factors is to expand upon the results already obtained in previous sections thereby allowing for a more comprehensive understanding of the structure of community life and the determinants of coping experience for the CMD.

#### 4.4.1 The Effects of Neighbourhood Factors On Mental Health and Coping

The focus of this section is a brief consideration of some of the ways neighbourhood characteristics can influence the mental health of their residents, specifically, the chronically mentally disabled. It is crucial to understand that mental health is not simply the absence of mental illness, and it would be wrong to assume that neighbourhoods where no mental illness is reported are necessarily healthy living environments (Smith,1980).

Neighbourhood variables can either amplify mental health problems or help provide a context for their solution which is the motivating principle behind deinstitutionalization. The functions of neighbourhoods vary as they provide a centre of personal meaning for an individual as well as a locus of a set of activities such as housing and recreation. Of particular importance to social geographers is evaluation the

neighbourhood as a set of structural characteristics that have a particular assembly of physical, ecological, geographical and demographic elements. The appeal of the structural definition of neighbourhood lies in the fact that physical attributes may be empirically researched using the socio-ecological health model as an overall framework.

For investigations of neighbourhood effects on mental health, Smith (1980) suggests that two types of studies, responsive and evaluative are appropriate. Responsive studies look at the environmental effects on a range of behavioural outcomes and measures of mental health. Research based on the behavioural dimensions of coping model (as outlined in this paper) is responsive in that multiple indicators were employed to investigate community and client variables associated with mental health and coping ability. An alternative responsive strategy would be to consider how neighbourhood circumstances influence the likelihood that different pathologies will be identified and reported. For example, in neighbourhoods where few people walk, it is probable that deviant behaviour will go unnoticed, unless behaviour is so atypical that it catches someone's attention (Smith 1980; Warren 1977). A detailed explanation of responsive studies is, however, beyond the scope of this section.

Evaluative studies concentrate on ways in which the environment (neighbourhood) influences evaluations of well

being. These studies are traditionally referred to as quality of life or social indicator studies (Smith , 1980). Essentially, researchers are trying to establish how satisfaction with neighbourhood contributes to satisfaction with life as a whole, and how neighbourhood satisfaction compares with satisfaction in other life domains (Smith, 1980).

The investigation of daily activity patterns of individuals serves as one means of discovering the experience of the CMD, and hence provide a better understanding of how neighbourhood and community factors influence satisfaction and coping. Time geography is a perspective that combines an emphasis on individual behaviour with a recognition of the constraints on individual activity. Time geographic research normally concerns the scheduling of various activities and the constraints that shape this scheduling of spatial behaviour (Kearns,1987). The next section will deal with describing the time geographic notion of "path" to outline some of the opportunities and constraints for the CMD in Hamilton. Discussion will combine findings from a study by Kearns (1987), in addition to drawing on data from the analyses of the effects of community and client variables on coping as presented in previous sections.

#### 4.4.2 Daily Activity Patterns of the Chronically Mentally Disabled in Hamilton

The term "life path" refers to an individual's journey through time and space that is shaped by beliefs, attitudes



and the events arising from interactions between the person and their environments (Kearns,1987). A person's "daily path" consists of movement through the city that is shaped by schedules and interactions of the day. The relevance of the time geographic perspective in examining the spatial behaviour of the CMD in the city lies in the fact that because their life paths have been marked by the incidence of mental illness they will necessarily be different compared to the general population. In the literature on time geography, capability constraints, the exclusion from activities on account of disability and disadvantage are particularly relevant for the CMD because of their psychiatric and social disadvantage (Kearns,1987). The other two types of constraints, coupling constraints defined as the necessity to the individual to combine different activities in different places at overlapping times and authority constraints, the restriction or exclusion of a person from certain places at certain times will not be considered in much detail.

This section will examine the daily activity patterns of the client sample that participated in the LMCQ in order to gain a better understanding of their community experience. Individual diary data was solicited as part of the LMCQ and subsequently assembled according to eleven categories of types and levels of activity. The eleven categories were divided into "active" and "passive" groupings.

Results from this study have already shown that most of the sample population did not feel they had enough to do and



likewise were primarily engaged in passive activities. In his paper, Kearns (1987) discovered that the pattern of weekday activities for the same Hamilton sample tends to be consistent over time during both the summer and winter months. In fact, there were only two hours in which more than 50% of the group were engaged in active pursuits. Implicit in these findings is the fact that the problems associated with coping in the community are complicated by tedium and an unstructured lifestyle. Weekend activity on the other hand showed considerable differentiation between seasons. During the winter interviews, over 60% of the sample were passively engaged throughout the entire 24 hour period. The follow-up interview in the summer the group demonstrated significantly higher levels of active pursuits (Kearns, 1987). This rhythm of activity over the course of seasonal change can in part be explained by mobility restrictions on the CMD during the winter because many are not able to afford public transportation.

Material poverty, in turn restricts the activity space and opportunities of the chronically mentally disabled. Given that low income was cited by most clients as a significant factor affecting satisfaction and coping it may be argued that an impoverished lifestyle has a deleterious effect on mental health in terms of limiting social and recreational activities and restricting general mobility. Chronic unemployment reinforces the cycle of unstructured time and constant poverty. Recall that the fundamental

principle behind deinstitutionalization was to facilitate a reintegration of the CMD into the community setting.

However, given the restricted social interaction of this group owing to a variety of interrelated disadvantages, it is clear that ex-psychiatric patients have experienced resettlement but not reintegration. Their illness experience and coping abilities are thus complicated by structural factors which reinforce disadvantages for the CMD.

Kearns used the age-gender breakdown of the total sample population to isolate different activity patterns among various sub-groups. Younger male and female clients ( <35 years old) are more active than their older counterparts. Specifically, for younger males, there are four hours in which less than half are passively engaged; for the younger females three; for older men one; for older women none (Kearns,1987). These general trends could be assumed to be typical of any population. It is the relative dominance of passive activities for all sub-groups that is significant. LMCQ data supports this finding as the majority of clients indicated that pursuits such as watching t.v., eating, talking, smoking and resting occupied most of their time. Compare this lifestyle to the general population for whom school or work constitutes at least eight hours of daily activity and it is not suprising that boredom is a problem among the CMD.

#### 4.4.3 Summary

The purpose of this brief introduction to the daily life experiences of the CMD in Hamilton was to show that the group is directed by circumstances in the community beyond their immediate control. Results show that in some respects coping abilities may be influenced by societal constraints that limit the number and types of social activities and economic opportunities available to ex-psychiatric patients. Spatial concentration of the CMD in the inner city may also be a reflection of predominant social attitudes that favour the principle of deinstitutionalization, but are unwilling to take responsibility for practical community-based mental health care programs in their own neighbourhood. Community attitudes therefore may exercise a subtle, but profound influence on the coping abilities and experiences of discharged mental patients. In a sense, the inner city area where most of the clients live becomes an "asylum without walls", a geography of tightly structured space and loosely structured time (Kearns, 1987).

Describing the daily activity patterns of the CMD did not reveal any specific social or structural factors connected with the community environment that could be considered as determinants of low activity levels, boredom and inability to reintegrate into society. In light of these results, it is necessary to reconsider the role of neighbourhood factors as influencing mental health. Because



neighbourhoods have multidimensional properties, it would be misleading and inaccurate to imply that either the socio-physical environment or individual behaviour were the causal determinants of mental illness. Rather, the passive and seemingly aimless lifestyle of the CMD revealed in the daily activity patterns represents the net effect of individual (psychiatric history, education, activity levels, income sufficiency and source) and neighbourhood related (living situation, housing experience) factors.

The ecological model of coping implies that mental illness is influenced by the complex social relations and physical environmental factors that permeate an individual's life history. Herein lies a starting point for more research on the post-hospital experience of the CMD; an integrated paradigm that accounts for individual behavioural outcomes in their broader socio-structural context.



## CHAPTER 5

### DISCUSSION AND CONCLUSION

#### 5.1 Discussion and Conclusions

Many patients view with fear the prospect of discharge from hospital because they frequently find themselves in a community, but not part of that community. This study has sought to evaluate how well an ex-psychiatric patient copes in the urban environment based on functional ability in four major areas; living situation and housing experience, social networks, material well-being and psychiatric profile and service utilization.

There are several advantages in using Dear's model of coping. To begin with, the model brought together a variety of interrelated community and client factors in a cohesive framework used to guide analysis. Secondly, the model is adaptable to a number of different testing scenarios. For example, using the socio-ecological model of coping as an initial reference point, different scenarios could be designed to test a broader or more specific range of client and community variables as they relate to coping ability. Moreover, it might be instructive to consider a greater number and variety of clients (in terms of psychiatric history, age-gender breakdown, socio-economic status etc.) in order to gain a greater insight into personal, subjective experiences of coping as opposed to more impersonal, aggregate trends that appear to be associated with larger

groups. A third contribution of the model to understanding post-hospital outcomes for the CMD centres around choice and measurement of community coping indices (Taylor et. al,1987). Past research has emphasized the role of community tenure as being indicative of the coping ability of discharged patients. The self-assessment measures designed by Taylor et. al (1987) provide reliable indices of coping and satisfaction which include quality as well as quantity of life factors involved in community experience. Results from this project indicate that the behavioural model of coping has only limited usefulness in increasing insight into the clients and community factors that contribute to coping experiences among the CMD. Only eight of the thirty-three independent variables tested revealed a significant relationship ( $p < .05$  ;  $p < .01$ ) with at least one of the outcome measures used. The results obtained confirmed findings from previous research on the CMD in Hamilton conducted by Taylor et. al in 1987. Significant associations were discovered in the areas of living situation and housing experience (total number of moves, residential mobility and type of living arrangement), social networks (activity levels and education), material well-being (source and sufficiency of income) and finally psychiatric profile and service use (the individual diagnose).

A major shortcoming of the behavioural model of coping lies in the fact that statistical analysis overlooks the specific range of places and purposes encountered in the

daily round of and individual's activity that could significantly affect coping strategies and abilities. Therein lies the strength of neighbourhood studies, and in the context of this paper, time geographic studies. An increased understanding of "sense of place" for the CMD may be derived by evaluating the ways in which time and space are structured for that group. A time-budget approach (recording a 24 hour diary of daily life paths) allows access to variations in the sample set at different levels of analysis, for instance, the aggregate sample, age-gender subgroups and individual clients.

An examination of the daily life experiences of the CMD did not provide any definite evidence that certain socio-structural characteristics of the community clearly contributed to mental-illness or specifically influenced coping abilities. One conclusion that may be drawn from these results is that greater insight into the issues surrounding coping may be gained by considering the contextual effects of neighbourhoods on individual evaluations and responses to the social and physical environments. Social pathologies have complicated etiologies, therefore it is necessary to study the factors that contribute to coping ability in terms of individual socio-behavioural conditions as they are influenced by and contribute to the physical environment.

Hamilton's inner city has inherent advantages and disadvantages that condition its role as a "coping



mechanism". Statistical analysis has shown that post-hospital outcomes of the CMD are influenced by the four areas discussed in this study and may also be affected by the role of individual perceptions of neighbourhood characteristics. Traditionally, physical and mental disability have combined with adverse public reaction to complicate the reintegration of the CMD into the community. The practical importance of research into coping ability stems from the immediacy and urgency of issues related to the delivery of care to the chronically mentally ill in the community. Given the results of this study, it is clear that future research must consider the complex socio-physical factors that influence and contribute to individual coping ability.

## 5.2 Policy Suggestions

The purpose of this paper was not to provide an extensive list of mental health care needs. However, on the basis of some of the results produced through analysis, it is clear that some pressing problems face the CMD in Hamilton. Foremost among these concerns are inadequate housing, both in terms of quantity and quality, poverty, chronic unemployment, unstructured time and boredom and lack of substantial social and recreational opportunities.

As it exists, there appear to be several gaps in Hamilton's mental health care network. More facilities in the areas of living situation and housing experience should be provided at points between the extremes of total



dependence and total independence to provide a better functioning, more integrated infrastructure to help clients adapt to community life as they move away from institutionalized treatment. To this end, policy formation and implementation is recommended in three major areas:

1. Creation of job opportunities - to reduce individual poverty, aid social reintegration and help create conditions for the development of a stronger self-image that is a necessary component of coping and overall well-being
2. Social Network Improvement - to improve coping ability and satisfaction through a variety of activities that are accessible and appropriate to individual needs
3. Housing Improvement - in both the quality and quantity of housing opportunities in a variety of neighbourhood settings and urban locations.

At the end of this study, it is obvious that the issue of understanding client and community variables and how they affect coping is highly complex. Some of the problems facing ex-psychiatric patients in the urban setting and the manner in which health care officials and the public should plan and administer appropriate intervention strategies have only just begun to be addressed.

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## APPENDIX

### LIFE MANAGEMENT IN THE CITY QUESTIONNAIRE (Round 1)

#### INTRODUCTION

##### Agency Director/Social Worker:

This is \_\_\_\_\_ who's from McMaster University. He's interested in what life's like in Hamilton for people who've had mental illness.

##### Researcher

I wonder if you'd be willing to spare some time and answer some questions? This sheet outlines what the study is about. If you're happy to participate perhaps you could sign this consent form. Thank-you.

---

I'm interested to know what your days are like. What do you like and dislike about everyday life right now?

#### I SOCIAL SUPPORT

1. Tell me about your family.
2. Where does your family live? (What city? or, if Hamilton, just the street name).
3. (Q 3-5, only if not living with family) How often do you see your family?
4. Are you happy with this frequency?
5. Would you like to be living with your family?

6. Are there any groups or organizations you belong to?

eg Church  
Recreation  
Political

7. Do you meet with groups of friends sometimes?

8. Who else do you spend time with?

1 2 3 etc

First Name

Relationship

Where/How met

How long have you  
known each other?

How often do you  
see each other?

Given all you've told me, how satisfied are you with your social situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd
---------------	----------------	-------------------	----------------------	-------------------	------------------

With respect to your social situation, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly
--------------	---------------	----------------	------------------	-----------------	----------------

## II LIVING SITUATION

9. Tell me about the place you live in right now. Is it  
with family  
independent  
hostel



lodging home  
other

10. Do you have your own room?
11. How many people do you live with?
12. What exactly do you like about your living situation?
13. Dislike?
14. Do you participate in household activities?

cooking  
cleaning  
laundry  
shopping  
buying your own clothes  
doing your own baking  
making doc's app'ts

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. If no, why not?
16. Would you like to be able to do more around the house?
17. What do you like about the house you live in now?
18. Dislike?
19. What about the neighbourhood you live in. What do you like about that?
20. Dislike?
21. Tell me about any difficulties you've had finding a suitable place to live.
22. Have you moved recently; say, in the last year or two? If so, tell me about the moves you've made.

date

type

moved to

because

- 1.
- 2.
- 3.

etc.

23. Where would you live if you could choose?

24. What sorts of things prevent this?

Given all you've told me, how satisfied are you with your present living situation?

_____	_____	_____	_____	_____	_____
very	quite	somewhat	somewhat	quite	very
sat'd	sat'd	sat'd	dissat'd	dissat'd	dissat'd

With respect to your living situation, how do you feel you are coping?

_____	_____	_____	_____	_____	_____
very	quite	somewhat	somewhat	quite	very
sat'd	sat'd	sat'd	dissat'd	dissat'd	dissat'd

### III THE COMMUNITY

25. What do you enjoy doing most in your spare time?

26. Is this on your own or with others?

27. Do you have enough to do in your spare time?

28. What sorts of things would you do, if you had the opportunity?

29. What prevents you from doing these things?

30. How do you travel around Hamilton?

31. How often in a week do you take the bus?

32. How often do you get out of Hamilton?

33. How did you travel to do this?

34. Do you find people in shops and offices friendly to you?

35. If not, how do you handle this situation?

Given all you've said, how satisfied are you with the kind of community you're living in right now?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd
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With respect to living in the community, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly
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#### IV PERSONAL HISTORY

36. What year were you born?

37. What year did you leave school?

38. What kind of psychiatric problems have you had?

39. When did you start having these problems?

40. Could you tell me about the times you've been in hospital over the past few years?

Year

Location

Duration

41. What sort of treatment (if any) are you currently receiving?

42. Are you satisfied your mental health needs are being met?

If no, why not?

43. Do you experience any difficulties in living in Hamilton that you think are related to mental illness?



eg to do with where you live?  
to do with money?  
to do with your safety?

44. What sort of help do you receive in these difficulties?
45. Have there been any particular happenings that have recently changed your life for better or for worse?
46. Do you have a police record?
47. Have you ever been harassed by the police? By other people?
48. How do you tend to feel about the day ahead when you wake each morning?

**V INCOME/EMPLOYMENT**

49. Tell me about the jobs you've had in the past few years.
50. Are you currently employed? (if no, go to Q 62)
51. Do you work:                      full time        \_\_\_\_\_  
   part time        \_\_\_\_\_  
   seasonally    \_\_\_\_\_  
   other            \_\_\_\_\_
52. Where do you work?
53. What do you do there?
54. How long have you worked there?
55. Did you have trouble finding a job?
56. (If 'yes' to above) What type of problems did you have?
57. Did anyone help you find a job?

If 'yes', who helped?

58. Do you feel you 'fit in' where you work?
59. What do you like about your job?
60. Dislike?

61. Are you thinking of changing jobs? If 'yes', why?

If Unemployed:

62. Are you looking for a job?

63. What sort of difficulties are you having, if you are looking?

64. Is anyone helping you find a job?

65. How long have you been unemployed?

Given all you've told me, how satisfied are you with your employment status?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd
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With respect to your employment status, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly
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All Respondents

66. How much money do you receive every month?

67. Where does this come from?

68. Do you manage your own money?

69. What do you spend your money on?

Type of Spending

Amount Each Month

70. Do you have enough money to meet your needs?

71. What would you do if you had more money?

72. How many more dollars each month would it take to meet your needs?

Given all you've told me, how satisfied are you with your income situation?

very	quite	somewhat	somewhat	quite	very
sat'd	sat'd	sat'd	dissat'd	dissat'd	dissat'd

With respect to your money situation, how do you feel you are coping?

very	quite	fairly	fairly	quite	very
well	well	well	well	well	well

Taking into account all we've talked about, what helps you to cope with everyday life?

What makes it difficult to cope?

THANK YOU



**LIFE MANAGEMENT IN THE CITY QUESTIONNAIRE**  
(Round Two)

**I.D. #** \_\_\_\_\_

**Date** \_\_\_\_\_

**Interview Site** \_\_\_\_\_

**Primary Caregiver** \_\_\_\_\_

1. Tell me what you like about everyday life right now?
2. Dislike?

**SOCIAL SITUATION**

3. Whom in your family have you seen lately?

How often?

4. Are you happy with this frequency?

5. What groups and organizations are you now involved in?

6. How often have you been meeting with groups of friends recently?

7. Who are the most important people for you right now?

RELATIONSHIP

1

2

3

DURATION OF  
RELATIONSHIP

CIRCUMSTANCES  
OF MEETING

REGULARITY OF  
CONTACT

WHERE DO YOU  
USUALLY MEET?

8. Who bothers you most?

How do they do that?

How often do you see them?

9. Who notices when you're having a hard time?

Who do you worry about?

Given all you've told me, how satisfied are you with your social situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd
---------------	----------------	-------------------	----------------------	-------------------	------------------

With respect to your social situation, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly
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#### LIVING SITUATION

12. Are you still living at \_\_\_\_\_?

If not, what moves have you made since the last interview?

Have there been any difficulties finding a suitable place to live?

13. Do you have your own room?

14. Do you feel your housing needs are being met?

If no, why not?

15. What exactly do you like about your living situation?

16. Dislike?

17. What about the neighbourhood you live in; What do you like about it?

18. Dislike?

19. Where would you live right now if you could choose?

20. Would this be on your own or with others?

21. What prevents this?

Given all you've told me, how satisfied are you with your present living situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd
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With respect to your living situation, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly
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#### THE COMMUNITY

24. Tell me about how you've been spending your spare time lately.

25. Do you have enough to do in your spare time?

26. Tell me about where you spend most of your spare time.

27. How often in the last month have you:

Been to a shopping mall?  
Taken the bus?  
Gone out for coffee?  
Gone out for a meal?  
Seen a movie?  
Been to a bar?  
Visited a friend?  
Been to the bank?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Been to a post office?	_____
Talked to neighbours?	_____
Been to a doctor?	_____
Seen your social worker?	_____
Been out of Hamilton?	_____

28. What are the most important places in Hamilton for you right now?

	1	2	3
PLACE			
WHY DO YOU GO THERE?			
HOW LONG HAVE YOU BEEN GOING THERE?			
HOW DID YOU FIRST GET TO KNOW ABOUT THIS PLACE?			
DO YOU GO ON YOUR OWN OR WITH OTHERS?			
HOW OFTEN DO YOU GO THERE?			
HOW DO YOU FEEL WHEN YOU ARE THERE?			

Given all you've said, how satisfied are you with the kind of community you're living in right now?

_____	_____	_____	_____	_____	_____
very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd

With respect to living in the community, how do you feel you are coping?

_____	_____	_____	_____	_____	_____
very well	quite well	fairly well	fairly poorly	quite poorly	very poorly



## PERSONAL HISTORY

31. Have you been in hospital since we last talked?
32. How did you come to be involved in CPS/CES/Care Centre?  
How long have you been involved?
33. Tell me about this programme/place; what do you like about it?
34. Is there anything you dislike about it?
35. What other mental health services are you receiving?
36. Are you satisfied your mental health needs are being met in Hamilton?  
Why?
37. What other services do you think should be available?
38. Have there been any important events that have changed your life since the last interview?

## EMPLOYMENT

39. Are you still (un)employed?  
(If newly employed), Details of employment:  
What do you do?  
How did you find the job?  
Do you feel you 'fit in'?  
What do you like/dislike about the job?
40. If still unemployed:  
Are you looking for a job?  
What sorts of difficulties are you having?

Is anyone helping you find a job?

When was your last job? Why did you leave?

Given all you've told me, how satisfied are you with your employment situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd
---------------	----------------	-------------------	----------------------	-------------------	------------------

With respect to your employment situation, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly
--------------	---------------	----------------	------------------	-----------------	----------------

#### INCOME

44. How much income do you receive every month?

45. Where does this come from?

46. Do you have enough money to meet your needs?

47. Do you tend to run out of money before the end of the month?

If so, how do you cope with this situation?

48. What would you do if you had more money?

49. How many more \$ per month would it take to meet your needs?

Given all you've told me, how satisfied are you with your income situation?

very sat'd	quite sat'd	somewhat sat'd	somewhat dissat'd	quite dissat'd	very dissat'd
---------------	----------------	-------------------	----------------------	-------------------	------------------

With respect to your money situation, how do you feel you are coping?

very well	quite well	fairly well	fairly poorly	quite poorly	very poorly
--------------	---------------	----------------	------------------	-----------------	----------------

53. Taking into account all we've talked about, what helps you to cope with everyday life right now?

54. What makes it difficult to cope?

THANK-YOU