IN THE SHADOW OF ILLNESS: A SOCIAL GEOGRAPHY
OF THE CHRONICALLY MENTALLY DISABLED IN HAMILTON, ONTARIO

by

Robin A. Kearns, B.A., M.A. (Hons)

A Thesis
Submitted to the School of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree
Doctor of Philosophy

McMaster University
December, 1987
A SOCIAL GEOGRAPHY
OF THE CHRONICALLY MENTALLY DISABLED
DOCTOR OF PHILOSOPHY (1987) - MCMASTER UNIVERSITY
(Geography) - Hamilton, Ontario

TITLE: In the Shadow of Illness: A Social Geography of the Chronically Mentally Disabled in Hamilton, Ontario

AUTHOR: Robin A. Kearns, B.A. (University of Auckland)
M.A., Hons (University of Auckland)

SUPERVISOR: Dr S.M. Taylor

NUMBER OF PAGES: xv, 265
ABSTRACT

This thesis adopts a socio-ecological perspective on health and examines everyday life for the community-based chronically mentally disabled (CMD) in Hamilton, Ontario. As with most larger North American cities, this population is residentially concentrated in inner city census tracts. This shared central location implies a common experience of aspects of the urban environment.

An analytical framework is developed, based on socio-ecological principles. Coping and satisfaction are identified as two dimensions of community experience that may augment conventional measures of post-hospital outcome. On the framework, seven subsets of client and community variables are identified: personal characteristics, psychiatric profile, psychiatric services, housing, social support, lifestyle and beliefs and attitudes. Survey data collected in two rounds of interviews from an initial sample of 66 CMD clients drawn from three aftercare programs are used to undertake both quantitative and qualitative analysis. In the former, composite measures of coping and satisfaction are constructed and the relationships between these indices and client and community variables are examined using bivariate and multivariate techniques.
Qualitative analysis is based on narrative accounts offered by clients in the course of interviews. An interpretation of these texts and analysis of daily activity patterns is undertaken at both the level of particular individuals and the sample as a whole. This analysis of the experience of time, space and community life for the sample complements the evidence from quantitative inquiry.

Findings from the quantitative analysis indicate that clients coping well in the community were more involved in gregarious activities, had enough to do, had more significant others and were more involved in mental health services. Those more satisfied were older, had more significant others, did not live in a lodging home, were more residentially stable, had enough to do and were not recipients of an income supplement. Results of the qualitative analysis of narrative accounts and time budget data indicate that poverty and unemployment compound the effects of illness and lead to a monotonous experience of relatively unconstrained time within a highly constrained activity space.
ACKNOWLEDGEMENTS

This dissertation is the culmination of a four year period of inquiry during which innumerable people were of assistance and support. To name them all would exceed the bounds of a customary acknowledgement. However, certain individuals and institutions deserve particular mention. First and foremost, my gratitude is extended to Martin Taylor who supervised this thesis. His guidance and good cheer have been consistently central to my time at McMaster. I could not have envisaged a more supportive advisor during my doctoral years.

Two other people have challenged my thinking and offered valuable advice along the way. To Michael Dear and Norman White, I offer warmest appreciation. Further, Barrie Humphrey offered a meticulous commentary on the work and prompted me to think twice in various important places. Nick Kates also read an early draft and gladly offered critique.

Completion of the reported research was made possible through the co-operation and patience of the clients who generously shared details of their lives. Being exposed to their hope and courage in the face of various adversities has been inspiring. I was able to speak with
these people through the assistance of directors and staff of two mental health agencies in Hamilton. I am indebted to Phyllis Turner, Marilyn Jewell, Elaine Pitre, Janice Duda, John O'Neill and Terry Fisher of the Hamilton-Wentworth Branch of the Canadian Mental Health Association; and to Carl deLottinville, Gloria Muller, Mary Blenkarn, Neil McMahon and Colleen Claremont of Community Psychiatry Services. Financially, the work was supported by the Canadian Commonwealth Scholarship Committee and a grant from the Social Sciences and Humanities Research Council.

The Geography Department at McMaster has been a superlative setting for my years of graduate inquiry. Under the Chairmanship of Michael Webber then Brian McCann, I have felt supported and encouraged. A central dimension of this supportive ambience has been the enthusiastic and diverse company of fellow graduate students with whom I have shared all or part of my doctoral years.

Personally, this work is the culminating enterprise of a four year sojourn in Canada. Living in a new land lends a special flavour to graduate work and such a period during one's mid-twenties must ultimately be situated within a broader and ongoing journey. These years and, inevitably this project and document, have been nourished by the wit and wisdom of a host of fellow travellers and friends. To
you all, my life has been enriched. Pat, to thank you for companionship, both long-distance and in exquisite spots from Hermitage to Nain, is to only just begin. Together with my parents, Heather and Michael, you have been a source of encouragement in every weather.
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CHAPTER ONE
INTRODUCTION

This thesis addresses the need for a more comprehensive understanding of the social geography of the chronically mentally disabled (CMD) in Canada. The deinstitutionalisation policies implemented throughout North America in the 1960s and 1970s anticipated the planned relocation and rehabilitation of the CMD in community settings. However, ghettoisation of impoverished ex-patients and rising readmission rates to psychiatric hospitals have been identified as unintended consequences of deinstitutionalisation. These consequences are attributed to the speed with which deinstitutionalisation occurred rather than flaws in the integrity of the concept. This thesis explores the proposition that while deinstitutionalisation policies have amounted to a resettlement of the CMD, a reintegration of this group into community settings has been inadequately achieved.

1.1 The research questions

The phrase "coping in the community" has found
common usage in discussions concerning the welfare of the CMD in central city locations. While the literature has explored the notion of 'coping' at the level of theory, in practice there is a lack of understanding of what characteristics of the client and the environment affect the client's experience and ability to cope in the community. 'Community' itself cannot be a taken-for-granted dimension of urban life. The term most obviously implies geographic territory but also has strong connotations of relationship. Most fully, "being in community means being 'in association' with other people for active participation in all spheres of human activity" (Pape and Church, 1987, 2). Clearly, for any social group, positive community experience involves a sense of territorial as well as social belonging.

The literature is replete with studies of the community-based mentally disabled. All but a few of these are undertaken from the perspective of independent observers or mental health professionals. While a few anecdotal accounts by the mentally ill themselves have been published (e.g. Allen, 1974; Peterson 1982) studies have seldom attempted to systematically document the urban experience of the CMD.

The rationale of the thesis is therefore based on the practical and theoretical need for a more comprehensive
understanding of the structure of community life and the determinants of coping experience for the CMD. The thesis has four aims:

(i) to describe the everyday life of the CMD in Hamilton

(ii) to develop a concept of 'coping' that is appropriate for investigating community life for this group

(iii) to develop a methodology that will appropriately address the first two aims.

and

(iv) to examine the relationships between client and community characteristics and community experience and outcomes for a sample of this population

The population of interest requires initial definition. The chronically mentally ill have been defined as persons suffering from a mental disorder that is long term and produces serious psycho-social difficulties that sharply limit their ability to interact with their environment in such a way as to sustain themselves and/or relate competently to others.

(Toews and Barnes, 1986)

Embedded in this definition are the three dimensions of diagnosis, disability and duration discussed by Freeman and Moran (1984). Consideration of each of these dimensions can assist in situating this population in the contemporary urban context.

Predominant diagnoses are schizophrenia, affective disorders and organic brain syndrome. Until recently, these
Illnesses were accompanied by symptoms such as hallucinations, low energy and high anxiety that precluded psychiatric patients from community life. Advances in chemotherapy over the last three decades have allowed sufficient reduction of symptoms to permit discharge from hospitals.

The group is referred to as disabled because their deficits are more than physiological. Despite stabilization, mental disorder interferes with a person's capacity to function in such areas as maintenance of social networks and employment. 'Disabled' is a publically reinforced status with a significant number of the CMD in Canada being recipients of 'disability cheques' in exchange for an effective disqualification from regular employment.

The CMD are recognised as being afflicted by illnesses and disabilities that are long-term in duration. Chronicity implies that adaptation is a more realistic outlook than recovery for both older deinstitutionalised patients and younger people experiencing the onset of mental illness.

The CMD are a heterogeneous group. Each individual has a "unique configuration of strengths and needs" (Trainor and Church, 1984,3). Despite acceptance that the CMD are as diverse a group as the general population, certain common
experiences have made them an identifiable component in the social geography of the North American city. Two such experiences derive from the disabilities themselves. First, the needs of the CMD potentially change, with periods of ability and disability recurring throughout their lives. Second, the CMD can frequently be recognised by behaviour that is difficult for the general population to understand and cope with. These two experiences have led to patterns of service need and rejection.

Two other areas of common experience are ghettoisation and poverty. A significant proportion of the CMD are residentially clustered in proximity to downtown medical and social services, often in non-familial congregate living situations. An influential force in this clustering has been their status as a materially impoverished group largely reliant on public assistance.

There are three principal consequences of these shared experiences. First, the CMD tend to be isolated. Both physical and social isolation can arise from strained or severed links with family and friends. Second, difficulties re-establishing employment are experienced. Many inner city areas are lacking in job opportunities and the CMD lack confidence and continuity in the workplace. Being unemployed does more than enforce dependence on public support. It can
lead to a comprehensive erosion of self esteem that has the capacity, in itself, to impair mental health. Third, the CMD may have difficulties carrying out otherwise ordinary activities of daily life. Household living skills, for instance, may have atrophied through years in hospital, or in those with early onset of illness, simply never have been developed. In the absence of adequate preparation for community living, such deficits can further retard efforts at reintegration into the community.

These three consequences of disability (isolation, unemployment and poor living skills) all represent disqualifications from regular participation in urban life. The CMD can therefore be described as living in the shadow of illness, for they are incapacitated in ways that go far beyond direct consequences of ill-health. Their experience of disability is of a magnitude experienced by few other groups. Literally speaking, a shadow is that area shaped by the outline of one's characteristics. The spatial dimensions of this metaphor suggest a role for the social geographer in studying this group: to document the features, implications and determinants of disability as it is experienced in community life by the CMD.

The 'CMD' is a term chosen to identify a social group with particular illness histories who tend to share
similar experiences in the city. This label has been selected with recognition of the well-documented isolating power of labels themselves (e.g. Scheff, 1966; Scolari, 1978). This thesis examines the urban experiences of living with the social and medical designation of chronic mental disability. The choice to identify the group as primarily 'disabled' rather than 'ill' represents an attempt to recognise the broad range of difficulties experienced by the group in the course of everyday life.

1.2 The geographic context

This research seeks to build upon studies of the geography of mental health. This literature has emerged from social, behavioural and medical concerns in the discipline over the last decade. The consequences of decentralisation of mental health facilities into communities has provided a timely focus for geographers interested in planning, health care and social justice in the city (e.g. Wolpert, Dear and Crawford, 1975).

There have been two principal outcomes of deinstitutionalisation of the mentally ill in terms of the social geography of the city. On the one hand, conflict over the siting of group homes in suburban neighbourhoods has
been analysed (e.g. Dear, Taylor and Hall, 1980; Dear and Taylor, 1982). Externalities, such as perceived declines in property values, arising from the facilities rather than aversion to mental patients themselves have been identified as most influential in these conflicts. On the other hand, the clustering of former patients in the inner city has been described (e.g. Smith, 1975; Dear, 1977). This has been related to the 'public city' idea (e.g. Wolch, 1981; Beamish, 1981) which suggests that the clustering of welfare-dependent people and the siting of service facilities are mutually reinforcing factors.

Both sets of empirical work have viewed community mental health principally from the perspective of the community at large. Client viewpoints have received less attention in geography. A notable exception has been an attempt to survey Hamilton's 'psychiatric ghetto' from the viewpoint of the CMD themselves (Dear et al., 1980). The present work extends this preliminary contribution towards understanding the social geography of the CMD.

Two interrelated developments grant geography an additional role in analysing the implications of this change. These developments are: first, mounting evidence of the role of the environment in determining health status; and second, changing definitions of health in both theory
and policy. These will be examined in the context of the research question.

Historically, biomedical intervention has been presumed to be central in documented reductions in mortality and morbidity rates. However, the work of McKeown (1979) demonstrated that declines in the incidence of tuberculosis actually predated treatment breakthroughs. Factors located within a broadly circumscribed environment (e.g. diet, hygiene, lifestyle) were therefore demonstrated to be associated with enhanced health of the population. In recent decades, an 'epidemiologic transition' has been noted, involving a shift in the predominant causes of morbidity and mortality from largely infectious diseases to chronic "diseases of lifestyle" such as cardiovascular disease and cancer (Mayer, 1986). The long-term nature of chronic diseases has generated an interest in what conditions exacerbate latent illnesses. Geographers have responded to the 'epidemiologic transition' by analysing the associative effects of the urban environment on incidence of disease (e.g. Pyle, 1971) and psychological well-being (e.g. Daiches, 1981).

Recognition of the role of environmental factors as determinants of health has been contemporaneous with a rethinking of the health concept itself. Recent theoretical
reformulations have eschewed narrowly prescribed biomedical views (e.g. Brofenbrenner, 1979; White, 1981). In 1967 the World Health Organisation proclaimed health to be "more than the absence of disease . . . a state of complete physical, social and emotional wellbeing" (Breslow, 1972). This represented a clear mandate to scrutinize spatial variations in resources and opportunities for their influence on wellbeing.

In Canada, a similarly catholic approach to health has emerged. The environment, and the lifestyles it generates, were clearly implicated by the Lalonde Report (1974) as influential in preventable illness and death. More recently, the document Achieving health for all: A framework for health promotion clearly describes the essentially interactive relationship between environment and health. "Enhancing peoples' capacity to cope" is identified as a fundamental challenge in national health policy (Epp, 1986).

A geographic analysis of daily life experience of the ghettoised CMD and its determinants represents an engagement with the multi-factorial nature of health experience. As Mayer (1986) has commented, developing definitive concepts of the interaction between causal variables and ill-health is much more complex for chronic rather than infectious diseases. Taking up this challenge
with respect to behaviour among the CMD will require departures from established approaches in the geography of mental health. Previous studies in this field have successfully accounted for why the CMD are ghettoised in central city locations (e.g. Beamish, 1981; Moos, 1984; Dear and Wolch, 1987). The task at hand is to analyse experience among a Hamilton sample and identify the determinants of positive community experience.

1.3 Approach to the problem

The perspective adopted in this thesis is explicitly geographical. The work is behavioural in approach, using observational and survey methods to measure aspects of everyday life of the client group. A geographic inquiry into the experience of a social group examines the full range of the daily life environment. The thesis is therefore an attempt to understand how the total physical, social and economic surrounds impinge upon the experience of the CMD in a community setting.

As it has been described in both theory and policy statement, health outcomes arise from interactions between a social group and its environment. In the thesis, an interactive perspective is developed and, through both
qualitative and quantitative analysis, "a geography of human experience" (Ley, 1983, 4) is produced. The question of developing an appropriate methodology for this task amounts to a secondary theme that is explored in tandem with the substantive question at hand.

Concern for the welfare of the CMD over the last two decades has coincided with the development of social justice and humanistic perspectives in geography. These two perspectives began as separate critiques of an overly quantitative status quo in the discipline (see Harvey, 1973 and Buttimer, 1974 respectively). Concern in the former radical critique has been for the structural conditions that generate spatial and material inequalities. Humanistic studies have sought a return to the 'subjects themselves' and give voice to the experience of place and environment. Recent work has seen a melding of structural and humanist concerns through the analysis of localised territorial questions and a relaxing of philosophical exclusivity (e.g. Western, 1981; Ley, 1986; Jackson, 1987; Smith, 1987). The present work is consonant with these studies. These can be seen as constituting a "restructured humanism" - a geography of human experience strengthened by accounting for structural limits to action and constraints on experience.

At a methodological level, the thesis argues that
quantitative or qualitative approaches cannot alone provide a satisfactory basis for constructing a social geography of the CMD. Instead, methods of data collection and analysis must be drawn from both research traditions. The intention is that rigorous testing of relationships may, in the overall analysis, be afforded equal status and credence with interpretation of 'insiders' perspectives from the psychiatric ghetto.

1.4 Thesis organisation

Specific analysis of coping and community life among the CMD in Hamilton is prefaced in the thesis by consideration of applicable theoretical perspectives for studying health and behaviour in urban society. Chapter Two surveys four fields of literature that are relevant to the study population. An orientation to perspectives on health and medicine is followed by discussion of mental health in the urban setting. The phrase "coping in the community" is placed under scrutiny in a third section of Chapter Two. Theoretical and practical contributions to understanding coping behaviour are reviewed, followed by a survey of studies that, at least implicitly, have examined coping among the population of interest. These studies, largely epidemiological, have necessarily overlooked the
experiential dimensions of community experience. A view of client experience in the community is developed. The literatures of time geography and humanistic studies of place are then drawn on to develop a vocabulary for inquiry into the clients' world.

Chapter Three establishes the geographic context for the study. The deinstitutionalisation process is cursorily described with particular reference to the Ontario setting. This is followed by a more detailed description of the institutions, agencies and individuals that comprise local components of the mental health system. This chapter serves to complete the task, begun in Chapter Two, of situating the CMD in the urban context.

Chapter Four is devoted to questions of epistemology and appropriate research design. The thesis objectives indicate a need for both analytical rigour and depth of insight. A research design that seeks, as far as possible, to include the client group and researcher as participants is described. The rationale for this is both practical and compassionate. With respect to the latter, 'clienthood' has been bestowed upon the CMD by relationships of dominance. Regardless of how benevolent relations with the health system have been, there is a need to strive, at least within the interview setting, to transcend client-professional
relations and relate as partners in research. The chapter describes the way that this approach was translated into the Hamilton study design and associated ethical considerations.

The fifth chapter presents a model of coping that builds upon an interactive socio-ecological view of health. The chapter proceeds by unravelling the hypothesised "web" of relationships between client and community variables and a variety of outcome and experience measures. Through bivariate and multivariate techniques, the profiles of clients characterised by positive and negative objective outcomes and assessed experience are drawn.

The analysis in Chapter Six is deliberately individualistic and involves four stages. First, representative clients are presented largely through their own words. Second, 'insider' experience of specific components on the analytic framework are presented and these narratives are interpreted. Third, a description and analysis of daily activity patterns is generated from time-budget data. Fourth, a summary description of clients' views of what helps and hinders coping in the community is presented.

Chapter Seven draws elements of the analysis together by first assessing the extent to which Hamilton's inner city is a supportive setting for the CMD in the sense
suggested by previous studies (e.g. Dear and Wolch, 1987). Options for policy and research that emphasise the enablement of this population are posed. This leads to reflections on the role of a social justice ethic in geography and the extent to which this can inform the process of research design.
CHAPTER TWO
SOCIAL GEOGRAPHY AND MENTAL ILLNESS

The period since deinstitutionalisation has been one in which the chronically mentally disabled (CMD) have become an identifiable social group within core areas of many North American cities. Principal components of their disability are illness experience and poverty. The illness that keeps many dependent on aftercare services also plays a role in their certification as 'disabled' by the state. Mental disability tends to lock them into impoverished lifestyles, restricted housing opportunities and constrained social circles. The congregation of this group in the inner city has therefore been precipitated by forces that lie outside the disease process itself.

This chapter explores the recognition that the post-hospital well-being of the CMD is determined by a range of factors in the community environment. Consideration of the deinstitutionalised mentally disabled provides a case example of the way health is most appropriately viewed as shaped by forces diffused throughout society and space. The literatures reviewed in the course of this exploration are: the debate concerning health and medicine; the rel-
relationship between cities and ill-health; approaches to the concept of coping; post-hospital outcomes for the CMD; and geographical approaches to understanding the texture of daily life for the CMD.

The chapter will be organised as follows. First, the relationship between medical science and health is considered and a socio-ecological model (SEM) is described as a means for widening appreciation of the determinants of health. If, for the CMD, coping is to be seen as a 'fit' between person and environment, then a central question is what in the community facilitates or inhibits this fit. This discussion anticipates the development of an analytical framework for guiding analysis of coping outcomes later in the thesis.

A second section reviews studies that document the relationship between health and urban environments. Historically, inner city areas have been associated with social pathologies and incidence of mental illness. The literature reviewed here places contemporary questions concerning the welfare of community-based mentally ill in an historical context.

A third section begins by reviewing the ways coping behaviour has been conceptualised. Studies examining the determinants of successful community life for the mentally
are then reviewed with the goal of identifying variables that merit inclusion in later analysis. It is concluded that for present purposes coping is most appropriately considered as one dimension of client experience rather than as specific behaviours in response to events.

A final section of the chapter examines the way deinstitutionalised mentally ill are situated in urban society. Two literatures are consulted in this section. Humanistic and time geography can facilitate an understanding of the way temporal and spatial aspects of the lives of the CMD both reinforce and are a reflection of their current place in society.

2.1 Health, Illness and Society

An emerging body of opinion supports a reassessment of the relationship between health, medicine and society. The profession and science of medicine has been built upon the assumption that disease entities are associated with specific biological processes (Eyles and Woods, 1983). Critiques from behavioural, economic and structural-materialist perspectives have widened appreciation of the range of determinants of health (e.g. Culyer, 1976; Navarro, 1976). These critiques grant geography a renewed relevance.
In the discussion of health, health care and in particular, community mental health.

Recognition that a diffuse range of determinants contribute to health has immediate relevance in terms of the thesis objectives. Discovering the structure of everyday life and determinants of coping for the CMD are tasks that demand a stepping back from interest in biomedical details such as type and duration of diagnosis. Instead, the thesis objectives invite an investigation of the relationship between person and environment; social group and urban society. An important prelude to analysis is an exploration of the ways the concept of health has recently undergone a refashioning.

2.1.1 Medicine and health

Medical research and diagnosis have conventionally been founded upon what Dubos (1959) labels "the doctrine of specific etiology". This implies that for each physiological condition, there exists an identifiable cause. The doctrine underlies the biomedical disease model of health (White, 1981). The model posits a linear and unidirectional relationship between a cause, lesion and set of symptoms. Critics have recognised that determinants of disease
interact among themselves as well as simply contributing to a particular health outcome. According to Dubos, "most disease states are the indirect outcome of a constellation of circumstances" (emphasis added). These circumstances potentially arise not only in the physical environment, but also in the social, institutional and cultural contexts.

Recent medical advances have coincided with critical reassessment to reshape the health concept. Where the overarching preoccupation has conventionally been with physical health, concern now encompasses mental, social and economic as well as physical well-being. Health has become more broadly conceived of as an outcome of total lifestyle rather than simply a product of good nutrition and freedom from disease. As equitable quantity of life has become more attainable, so health has become more clearly articulated in terms of quality of life.

Despite these shifts in the conceptualisation of health, most of the activities of the medical profession and a plethora of health care programs continue to be based on a biomedical disease model of health. From this model arises the assumption that an equitable and efficient distribution of medical programs will lead to a reduction in both sickness and health costs. Neither of these assumptions has been demonstrated. Critics have questioned the role of
medicine in society from varying perspectives (e.g. Illich, 1975; Oakley, 1980; Navarro 1976).

Eyles and Woods define medicine as entailing "physical or chemical intervention to restore a disordered system to 'normality'" (1983, 49). This implies a fundamentally remedial and 'micro-level' orientation to health. In Western society, medicine has been organised around a set of established practices. Medicine generally involves ministrations to others, whereas health is a quality desired, attained or possessed by people. Health implies a state or condition and its relationship with medicine is therefore ambiguous. While the importance of medical advances in addressing conditions of human suffering is clear, there are definite limits to the ability of medicine to enhance health per se (Eyles and Woods, 1983).

Recent developments in medicine that more fully consider the person as situated within an environment (e.g. occupational health, family medicine, preventive medicine) herald a certain convergence of approaches to medicine and health. Nevertheless, as long as health is regarded as entailing more than the absence of disease, and medicine is oriented primarily towards curing disease, the relationship will remain ambiguous.

The ability of medicine to promote health is limited
by the fact that medical knowledge and expertise are generally administered by members of a profession to those who present themselves for treatment. Health is a state of well-being arising from interactions between persons and varied aspects of their physical, social and economic surroundings. If we accept this view, then we see that the range of activity a physician can undertake is considerably limited in terms of improving a patient's health. Constraints for the physician are threefold: the distinctiveness of each patient's understanding of health; limited knowledge of a patient's environment; and limited ability to manipulate and enhance aspects of the patient's environment. A physician therefore has limited access to the patient's 'world'. There are also limits to a physician's ability to alter those aspects of a patient's 'world' that are potential determinants of health and well-being (e.g. housing, income and social support).

In the mental health field, the emergence of social workers as a component of post-hospital psychiatric care has arisen from a recognition that the determinants of health may often be found in the experience of everyday life. For many CMD, social workers have become their principal caregivers - counselling, advocating and making referrals for the client. The medical profession has been generally slow
to acknowledge the mental health implications of the total environment. Although there are notable exceptions to this such as the McMaster and Calgary M.D. programs, other caregiving professions have tended to emerged and address selected health implications of peoples' total surrounds.

2.1.2 A Socio-ecological model of health

An alternative perspective on health has been proposed by White (1981). The socio-ecological model (SEM) builds on a biological view of the human organism interacting with a complex environment. White distinguishes between two aspects of ill-health outcomes. First, the lesion-based disease process is the conventional focus of the biomedical disease model of health. Second is the illness state, "the combination of experiences and performance deficits which tell us that sickness is present" (1981,12). Being rooted in experience and psychology rather than physiology, the illness state not only differs in origin from the disease process but also may develop without the presence of disease (Eisenberg, 1977; Reading, 1977).

Whereas disease invariably originates through interaction with a pathogenic environment, the way it progresses largely involves anatomical and physiological
change. By contrast, the illness state involves the behaviour and role change among the unhealthy in relation to others in society. The illness state is therefore a function of person-environment relations, involving interactions between symptoms, disability and specific illness behaviours on the one hand and social conventions, role attributions and expectations on the other.

The SEM proposed by White incorporates disease process and illness behaviours, the two outcomes of ill health. These are seen as arising "from an interactional process which has several multi-causal contributing factors". The ecological perspective is one that accommodates both the interdependence of organisms and the changeable nature of their physical and social surrounds. This perspective informs the SEM in which "the person is seen as one particularly versatile interacting element in a complicated social and physical ecosystem" (White, 1981, 139).

Ill-health includes the adoption of roles as well as a physical condition. This leads Eyles and Woods (1983) to suggest that illness can be conceptualised as a social relation. An early contribution to understanding these social relations of illness was Parsons' (1958) description of the 'sick role' that ordinarily accompanies the onset of
ill health. Adoption of the sick role involves profound transitions in status. Once translated into 'patiency', the sick role grants exemptions from regular duties. To speed recovery (or, in the case of contagious disease or violent behaviour, to protect others) a person is temporarily isolated from the arenas of regular activity. In cases of acute illness, stays at home or in hospital are brief and restrictions on mobility and interaction are temporary. However, mental illness is frequently lengthy and thus may involve prolonged isolation. The mentally ill have historically been regarded as 'outsiders' in urban societies (Sibley, 1981) and the history of the asylum (e.g. Rothman, 1971) amply documents the spatial isolation of this population.

The emptying of asylums over the last two decades grants the SEM a particular appropriateness in considering post-hospital outcomes of the mentally disabled. First, whereas formerly the social and interactional determinants of a patient's health were largely controlled in an institutional setting, a wider range of determinants in community settings now affect the health of the CMD. Second, in the process of re-establishing community life, the CMD have become involved in a process of renegotiating their social relations of illness. Despite stabilization of
their disorders by chemotherapy, the sick role has tended to be tenacious, and has been reinforced by both community attitudes (e.g. Dear and Taylor, 1982) and by residual disabilities. Proponents of the community mental health movement intended that those discharged should be distributed throughout a range of community settings. However, spatial concentrations of the CMD have commonly developed in downtown settings (e.g. Dear, 1977; Moos, 1984). This pattern suggests that for the ghettoised CMD, there is a commonly experienced environment, the health determinants of which may be identified and evaluated.

The ecological conceptual framework (Figure 2.1) suggests that in order to understand particular health outcomes (identified as w, x, y, z), both the persons being studied (P) and the significant elements of their environment (e1, e2, e3, etc.) must be understood. The bi-directional arrows of the diagram indicate not only that people and environments interact, but also that elements of the surroundings (e.g. housing, social support and income) are mutually interacting. Differing strengths of lines on the arrows signify differing magnitudes of relationship involved. This framework therefore suggests an "ecosystem" in which the effects of particular circumstances may reverberate in other areas of the system.
Figure 2.1 The ecological conceptual framework.

source: White(1981)
The ecological model implies that ill-health is not simply a matter of physical environment but is influenced by the complex social relations that permeate an individual's life history. This implication does not involve a return to environmental determinism, with its suggestion that environments 'cause' sickness. Rather, the view suggests that an understanding of the interaction between people and their social and physical surroundings is important in making sense of ill-health (Unit for the Study of Health Policy, 1979). This is especially important for considering the inner city CMD and the provision of community mental health care. Without an understanding of what coping might mean for this population, it remains unlikely that comprehensive service provision will be possible.

2.2 Geography, health and the city

This section examines the relationship between cities and ill-health, and in particular, mental illness. Urban areas of socio-economic disadvantage have been documented as featuring high rates of morbidity, including mental illness. The impact of deinstitutionalisation on the social geography of the city has been one of intensifying existing residential concentrations of the mentally disabled
In central locations. The contemporary location and lifestyles of the CMD are structured by pre-existing contours of socio-economic opportunity. This section examines first, the relationship between health and urban areas and, second, the specific associations between mental disability and urban ecological structure.

2.2.1 Health and the City

A strong association between urban areas and illness has been known for centuries. This section argues that cities and sickness have come to be historically linked and that there tend to be concentrations of morbidity—including mental illness—in particular parts of cities.

Increased morbidity and mortality rates were associated with the urbanisation accompanying the industrial revolution in Europe. Conditions such as residential crowding and poor sanitation precipitated epidemics of communicable diseases (Smith, 1979). Twentieth century advances in public health and preventive medicine have tended to equalise the health status of urban and rural populations. Other inequalities in health have remained, however. These tend to be associated with factors of location (e.g. environmental quality, access to health care)
or social group membership (e.g. differing use of services, proneness to morbidity).

In Great Britain, the 'Black Report' set out to describe and account for inequalities in the health of different social classes and make suggestions for remedial action (Townsend and Davidson, 1981). Variations in health status were shown to exist and these exhibit themselves spatially, given the concentration of lower income groups in the inner city. Differential access to and utilization of health services according to socio-economic status was also a major finding of the report. Such inequalities are therefore evident in specific local contexts of time and place and residential and occupational opportunities contribute to experience of certain qualities of urban environment. As a crude indicator of quality of life, mortality rates have been used in Hamilton to suggest the differentiating impact of socio-economic opportunity upon health status of residents (e.g. Liaw et al., 1986).

In the older core areas of British and North American cities, various socio-economic and environmental stressors have been documented as influencing the health status of residents. The clustering of impoverished, disabled and immigrant groups has added a particular character to these areas. In terms of health status, the
Inner city therefore represents a zone of disadvantage for certain groups. This disadvantage is rooted in both exposure to environmental stressors and less availability of medical services. These conditions are shaped by the interrelated forces of existing urban spatial structure and the momentum of dominant social processes.

Unlike other urban areas (e.g. the central business district), the inner city has tended to be an imprecisely defined zone. While conditions of the built environment and availability of services vary greatly between local contexts, inner cities are invariably associated with social pathology. Various factors have been suggested as shaping social problems of the inner city. First, core areas of larger cities tend to be zones of older industry and former prosperity. These conditions lead to rising unemployment and falling incomes among certain groups of residents. Second, housing stock tends to be older and in poorer condition. Third, lower rents are a centripetal force, drawing disadvantaged groups to central locations. At the same time declining conditions have tended to push away those with financial or educational freedom to move. These factors become "symptoms of nationwide processes that create and segregate poverty" (Harrison, 1983). Recent gentrification of core areas in North American cities, has,
however, represented something of a reversal of this trend (e.g. Ley, 1986; Smith and Williams, 1986).

2.2.2 Mental Illness in the City

This section examines the strong association that has been documented between mental illness and poverty in the inner city. Early analysis of schizophrenia in Chicago pointed to highest rates of incidence in the central city districts where ethnic groups and rooming houses predominated (Dunham, 1937; Faris and Dunham, 1939). Later studies lent support to this association between schizophrenia and ecological structure (e.g. Mintz and Schwartz, 1964).

Three explanations have been proposed to account for spatial variations in the residential location of the mentally disabled. First, a social isolation hypothesis suggests that residence in neighbourhoods where people tend to be isolated from a social support system of relatives and friends compromises mental health. Second, a social class hypothesis argues that the stressors associated with membership in lower socio-economic groups can precipitate or exacerbate mental illness. Third, a 'drift' hypothesis suggests that the mentally disabled tend to lose their
former economic security and social connectedness, and to consequently drift downwards in status, towards poorer central locations where lower rents and social services are available. Research has tended to test these hypotheses singly when a combination of all of the factors may well account for observed patterns (Daiches, 1981).

All three propositions suggest a link between mental illness and two potentially toxic elements in the urban environment: socio-economic deprivation and social isolation. Recent work has lent support to these hypotheses. Daiches (1981) confirmed that residents of Chicago’s innermost communities are most likely to be psychologically distressed. He found significant associations between respondents’ distress scores and attributes of their social relations and income. These findings confirm that both the social isolation and social class hypotheses have validity.

The link between schizophrenia and ecological characteristics has been explored using associative analyses (e.g. Giggs, 1973; Dean and James, 1981) and multivariate techniques (Giggs, 1983). In the latter study, Giggs found that social and material resources were most important in explaining variations in the prevalence of schizophrenia in Nottingham. A recent extension of this work has shown that strong relationships exist between incidence of a variety of
mental disorders and residence in rental accommodation and areas of new housing development in Nottingham (Giggs, 1985).

The foregoing ecological studies typify an approach that seeks to explain social processes and illness by inference from spatial patterns. In the wake of deinstitutionalisation, a new set of questions has emerged for the geography of mental health. First, emphasis has been on urban communities and their response to relocation of former patients into their midst. The work of Dear and Taylor (1982) characterises this attempt to better understand the patterns and processes of conflict around the siting of group homes in suburban neighbourhoods. In Ontario, dispersion of the CMD throughout urban areas has, to an extent, been inhibited by resistance to the establishment of group homes in suburban neighbourhoods. Inner city neighbourhoods have been shown to be more accepting of group homes for the mentally ill (Dear and Taylor, 1982) and lower rents predispose these locations to predominantly impoverished ex-patients.

A second emphasis in the geography of mental health has involved an attempt to shift perspective from the community-at-large to that of the psychiatric client. The observation of clearly defined residential concentrations of
the CMD in central city locations has prompted this shift in emphasis. Geographers have examined the character of the urban experience of the CMD and speculated on the effect of particular experiences on their wellbeing (e.g. Smith, 1975; Dear, 1977; Dear et al., 1980). In relation to this latter line of inquiry, current developments in the broader field of social geography are helpful in the development of further research. One recent emphasis in geography has been on locality studies. In these studies, relations between and within urban social groups have been the starting point for analysis. Investigations have examined the ways in which relations between groups are constrained by and reflected in spatial patterns in the city (Jackson, 1980b).

2.3 Coping and community life for the mentally disabled

Economic recession and reduction of social assistance in North America have had implications for the care of the CMD. Indicative of this are estimates that large numbers of the homeless in both Canada and the United States are persons suffering from long-term mental illness (Bassuk, 1984; Block, 1984; Lamb, 1984; Grey, 1986; Hope and Young, 1986). Apart from sporadic anecdotal accounts, there have been few attempts to describe and analyse how sufferers from
chronic mental disability cope with being outsiders in urban society.

Illness carries its own burden of coping difficulties. For a significant proportion of the mentally ill in Canadian cities, profound economic and social disadvantage only exacerbates the difficulties of coping with a pre-existing illness burden. A theoretical approach to community experience based on the SEM must attempt to extend its scope beyond questions of service access and utilization to address diverse aspects of well-being. This section reviews literature with the goal of formulating a perspective suitable for analyzing community life for the CMD. Two literatures form a basis for this task: first, studies that have dealt with adaptation to stressful events and environments; and second, studies which have identified the determinants of objective post-hospital outcomes measures for the CMD.

2.3.1. Coping, adaptation and health

Coping with community life for the CMD involves as much an adaptation to social and economic circumstances as it does dealing with a biological disease (Adler, Drake and Stern, 1983). Two established areas of study follow this
theme of adaptation to life circumstances and will contribute to the evolution of an appropriate perspective on coping. These are epidemiological field studies and stress research. A brief survey of these areas will lay the groundwork for developing an analytical framework for studying the dimensions of coping and satisfaction later in the thesis.

Epidemiological field studies examine the effects of environmental factors on the health status of particular population groups. Changes in the incidence of mental illnesses, for instance, have been associated with such changes in the environment as sudden unemployment caused by plant closures (e.g. Kasl, Gore and Cobb, 1975; Catalano, Dooley and Jackson, 1981). Paralleling these studies and comprising a second element in the framework is stress research. Studies of groups of psychiatric clients and community cohorts have demonstrated that those with schizophrenia are more likely to experience life crises in the months preceding the occurrence or recurrence of illness (e.g. Birley and Brown, 1970; Paykel et al., 1969). These findings, together with the observed high readmission rates of community-based psychiatric clients, suggest investigation of what events and experiences in the community might precipitate crises for this population.
Both epidemiologic and stress studies have focussed on life crisis events involving role transformations, changes in status or environment, or imposition of pain. This model of 'life events' as major determinants of mental well-being assumes that all changes, whether positive or negative, contribute to disequilibrium (Holmes and Rahe, 1967) and that this, in turn, promotes symptom formation (Dohrenwend and Dohrenwend, 1976).

The precarious equilibrium of many community-based psychiatric patients suggests that the character as well as the number of life events ought to be of research interest. A helpful perspective can be found in the work of Paykel and colleagues. In their research, events are attributed a differing potency according to how undesirable or uncontrollable they are, as perceived by the group involved (Paykel, et al., 1969). This finding has been confirmed by studies of psychiatric outpatients for whom desirable events have been negatively related to symptoms. This has led to the suggestion that "internal suffering and a bleaker life constantly interact to keep some persons trapped in a negatively coloured symptom-event matrix." (Grant, et al., 1981). Alternatively, life events have been distinguished as 'entrances' and 'exits' in the social field of the individual. Using this distinction, Jacobs and Myers (1976)
found a schizophrenic cohort to be burdened by significantly more 'exits'. The cumulative sense of these studies argues for the hypothesis that difficulties in coping with stressful environments may contribute to maintaining conditions such as schizophrenia.

Life events research has been extended from premorbidity studies to a focus on psychiatric patients in the community. Schwartz and Myers (1977) found that schizophrenic outpatients experience significantly more exit-related and undesirable events than a matched control group. Given this increased exposure to stressful events and patients' known vulnerability to stress, the researchers have questioned the fact that community placement decisions are so often made in terms of what is available rather than what would best meet client needs.

Stress and coping research has tended to emphasize dramatic events and this has been viewed by Lazarus (1981) as overlooking the cumulative influence of a finer texture of daily stresses. Lazarus (1981) has advocated a focus on ‘hassles and uplifts’ as an alternative avenue of research. This argument for significance of the relatively minor stresses of everyday life lends itself to studying the CMD, a group with potentially low resilience to stress (Goering et al., 1983).
The foregoing discussion has drawn attention back to the daily milieu and questioned its capacity for generating stressful situations. In this light, the term 'coping in the community' takes on a fuller meaning and becomes more relevant to the social geographer. The primary function of coping strategies is to better tolerate, or even change the situations out of which negative experiences arise (Pearlin and Schooler, 1978). Positive experience is likely to involve some degree of control over and competence within the environment. For a largely disenfranchised group such as the CMD, coping is therefore one dimension of experience in an urban environment. This proposed perspective on client experience will be discussed more fully in section 2.3.3.

2.3.2 Determinants of community tenure and readmission

Over the last decade numerous studies assessed the 'success' of deinstitutionalisation policies through attempting to identify the determinants of positive outcomes for the CMD. Two commonly used objective measures of outcome are community tenure and number of readmissions to hospital. As an extensive review of this literature has been undertaken by Laws and Dear (1987), the present survey aims to be selective rather than exhaustive in coverage. The aim
Is to identify the fundamental relationships that have been suggested as linking client and community variables with community tenure and readmission. These hypothesised or demonstrated relationships can serve as a basis for inquiry into dimensions of the experience of the CMD in the present study. The factors which have been studied in relation to outcome measures can be grouped as follows: personal characteristics; psychiatric history; social support; daily activity patterns; housing; and service provision.

Age, sex, marital status, and education have been considered as personal characteristics affecting community tenure. Readmission has been shown to be more frequent among younger ex-patients (Marks 1977; Woogh et al., 1977). However, there is a lack of consensus on the utility of age as a predictor of community tenure (e.g. Branff and Lefkowitz, 1979; Buell and Anthony, 1975). Recent concern for the "young adult chronic patient" (e.g. Bachrach, 1982; Segal and Baumohl, 1982) reflects a recognition of the particular needs of this group.

Researchers have rarely pointed to sex as a predictor of readmission. In some cases, it has been regarded as quite unrelated to community tenure (Woogh et al., 1977; Kirk, 1976). Marital status has been identified as more influential in determining community tenure, with those who are single or divorced considered to be most
prone to readmission (Rawls, 1971; Franklin, Kittridge and Thrasher, 1975; Vriesselman et al., 1975). Lower education has been similarly discussed, with readmission rates for those of less than high school education largely coinciding with inability to find work (Woolley and Kane, 1977). However, this association has not been universally accepted (e.g. Buell and Anthony, 1975; Kirk, 1976).

Surprisingly few studies have directly examined the relationship between income, employment and community tenure. In terms of employment effects, Franklin et al., (1975) showed that direct or indirect recipients of employment income were less likely to be rehospitalised. Estroff (1981) argues that for the CMD, the disabled identity is strongly reinforced by welfare dependency and effective disqualification from regular employment. From her ethnographic observations in Buffalo, Anderson (1979) argues that a return to hospital may itself be a coping strategy in the face of this enforced dependency and disqualification from employment.

Institutional experience, defined by the number of previous admissions, has been widely cited as a predictor of readmission (Rosenblatt and Mayer, 1974; Kirk 1976; and Braff and Lefkowitz 1979). McCarver and Craig (1974) point out that institutional experience encompasses a number of
factors (e.g. age at admission, duration of hospitalization and vocational training). The effects of these more specific factors on community tenure are unclear.

In terms of social support, a distinction can be drawn between formal and informal support networks. With reference to the former, Woolley and Kane (1977) found that high frequency of seeking counselling was positively related to their "adjustment profile". Informal social networks have been widely reported as impoverished in both extent and variety (Cheadle et al., 1978; Christenfeld and Havellwala, 1978; Sokolovsky et al., 1978; Cohen and Sokolovsky, 1979). These studies emphasize the influence of impoverished social support in potentially increasing the vulnerability to readmission of this population. Poor social support may be exacerbated when living situations such as rooming houses compound social with physical isolation. Hammer et al. (1978) report that schizophrenics tend to have small and fragile social networks making them more prone to rehospitalization than non-schizophrenics. With respect to family contact, Smith and Smith (1979) document fewer readmissions from those living with supportive families.

The daily activities of former mental patients have been described as characteristically passive (e.g. Dear et al., 1980). Boredom, a frequent complaint, is exacerbated by
chronic unemployment and poverty (e.g. Cheadle et al., 1978; Christenfeld and Havellwala, 1978; Dear et al., 1980). The positive effects of an active lifestyle have been demonstrated (Franklin et al., 1975). There is an extensive literature on the effects of various forms of community treatment which promotes activity on community tenure (e.g. Test and Stein, 1978).

With reference to the effects of living situation, Lamb and Goertzel (1971) showed that in the long term, residents in privately operated boarding homes were more prone to rehospitalization than those in half-way houses in which a more varied range of activities is offered. In the wider neighbourhood context, Smith (1978) documented a greater likelihood of readmission among mental patients living in the inner city "ghetto". The problems associated with life in the inner city for the CMD such as finding housing and employment have been widely documented (e.g. Allen, 1974; Aviram and Segal, 1973; Lamb, 1979; Mechanic, 1979). Others have noted some merits and potential benefits of inner city life for the mentally ill. Wolpert and Wolpert (1974) suggest that mutual support systems are more likely to emerge when former patients are concentrated in downtown locations.
2.3.3. Determinants of community experience

In the preceding section, psychological approaches to coping, adaptation and stress were reviewed. This literature adopts a level of analysis focussed on coping as behaviours responsive to particular events or stresses. This focus on coping strategies has, at least implicitly, informed case studies of street life among transients (Haunch, 1985) and stigma and identity management among the mentally ill (Herman, 1986). Both the theoretical literature and these case studies suggest a level of analysis at which events can affect objective outcomes (e.g. community tenure) and subjective experience in the community.

In section 2.3.2, studies indicating a range of factors associated with objective outcome measures were reviewed. These factors and measures usefully contribute to an understanding of community life for the CMD. The concept of principal interest in the present study is experience. The SEM proposed by White (1981) identifies a blend of symptoms, disability and illness behaviour comprising ill-health. Of these, disability and symptoms particularly contribute to experience in the environment. Consonant with the bidirectional flows of an ecological framework, this experience can be viewed in two ways: as a particular
determinant which contributes to outcomes of community tenure and readmission, or, alternatively, as a subjectively assessed 'outcome' shaped by a set of determinants. In this thesis, the latter view is adopted in analysis and will be further described in Chapter Five.

A research focus on the experience of the community-based CMD is a logical response to calls for heterogeneous groups of clients to be followed in post-hospital studies (e.g. Bachrach, 1976). In the Ontario context, the study by Fischer et al. (1981) reflected this concern by interviewing a range of dischargees and using a variety of instruments. A concern in the present study to document experience among a broad sample of clients reflects the socio-ecological view and a belief that symptoms and disability can be maintained by aspects of the environment as well as residual deficits arising from illness.

Although particular life circumstances vary between individuals, recognisable physical, social and economic environments exist in urban settings, shaping the lives of the CMD as a group. This is illustrated, for example, in the work of Dear et al. (1980) and Estroff (1981). These researchers point to widespread agreement but a lack of evidence on the negative effects of marginal income status and restricted activity patterns on satisfaction among the
CMD. Adoption of an experiential perspective is particularly appropriate for a social geography of the CMD in which interest centres on the role of the urban environment in structuring daily life and constraining coping ability.

While there is theoretical agreement in psychiatry that behaviour is a function of interaction between persons and environments, in practice, there remains a strong focus on the person (Bronfenbrenner, 1979). For a social geography of the CMD, the common expression 'coping in the community' can usefully be considered less in terms of particular strategies or behaviours and more as positive everyday experience. The SEM discussed earlier, with its emphasis on symptoms, disability and illness Behaviour, is well suited as a framework around which thinking on the urban experience of the CMD can be organised.

Two considerations distinguish the proposed perspective from those previously discussed in the literature. First, life events and stress research has tended to focus on particular events and crises and the way people have dealt with them. The present view of experience is concerned with the pattern of everyday life and not just the number and nature of events. Second, there has been a tendency, in at least earlier studies of post-hospital outcome, to focus exclusively on community tenure (i.e.
quantity of life in the community). In the operational framework developed later in the thesis, both experiential and objective measures are incorporated and tested for the effects of a common set of determinants. The thesis is therefore not arguing that the subjective measures should replace community tenure and readmission indicators but that the two sets in combination can provide a fuller understanding of community life for the CMD.

There are two implications of adopting this experiential perspective on the community-based CMD. First, this perspective shifts focus from behavioural strategies and asks less specific but ultimately broader questions of the way the CMD deal with urban experience. Consonant with the ecological framework (Figure 2.1), 'coping in the community' is seen as a more complex phenomenon than the various component life skills involved. The second implication is that the environment is seen as more than a series of interferences or events. Instead it is viewed as a seamless and interactive entity of which elements can be enabling or constraining of individual action, and contributing to a positive experience of life in the community.

Two forms of reflective appraisal on the part of individual actors are considered to be measurable dimensions
of experience. These are: first, a disposition towards a setting or situation; and second, self-judged performance within the same setting or situation. These concepts translate as 'satisfaction' and 'coping'. The feasibility of using subjective self-ratings to understand community life among the CMD has been demonstrated (e.g. Weissman and Bothwell, 1976; Lehman, 1983). Consonant with the Interactive SEM, coping is seen to be one dimension of the general experiente of people striving, consciously or otherwise, to attain a 'fit' with their environment (Kaminoff and Proshansky, 1981). Arising from this recognition is a need to consider both performance in and appraisal of the lived environment.

2.4 Place and time for the chronically mentally disabled

The foregoing discussions of models of health, coping and its determinants for the CMD point to the need for an understanding of community experience from the perspective of the disabled themselves. The ecological framework described earlier (Figure 2.1) permits consideration of the ways in which persons interact with elements of their surroundings. This framework is helpful in visualising the interconnectedness of aspects of daily life,
but an additional need is a more explicit language with which to deal with the temporal and spatial aspects of coping experience. This section reviews two literatures that aid further conceptualisation of the experience of being mentally disabled in the inner city. These are first, from time geography, the concept of 'paths' and second, from humanistic geography, 'insider' perspectives on sense of place and experience of health.

2.4.1 Daily paths and disability

Health outcomes have been described as determined by interactions between individuals, social groups and the community environment. Time geography is a perspective that combines aspects of this interactive epistemology with a firm recognition of the constraints upon individual agency (e.g. Hagerstrand, 1970; Pred, 1980; Tornquist, 1980). Conventionally, time geographic studies have been concerned with the scheduling of numerous activities and the constraints that shape this scheduling of spatial behaviour (e.g. Shapcott and Steadman, 1978). As Dear et al. (1980) have shown, there are few demands on the time of the CMD and boredom is consequently a frequent complaint. The time geographic notion of 'path' provides a useful tool for
describing the spatial opportunities and limitations for the
CMD.

The relation between life path and daily path is
described as essentially dialectical (Hagerstrand, 1975). A
person's life path is the journey through time and space
that is shaped by beliefs, attitudes and events arising from
interactions between the person and their environment. For
the urban dweller, the daily path consists of movement
through the city that is shaped by the schedules and
interactions of the day. Because history is cumulative, the
nature of the daily path is largely shaped by a person's
prior life path and a life path is likewise potentially
shaped by occurrences within each daily path. This has
relevance for considering the location of the CMD and their
use of time in the city. Because their life paths have been
marked by incidence of mental illness we can hypothesise
that daily paths will be distinctive compared to the general
population. The link between mental illness and poverty is
well established. On account of this, the daily paths of the
CMD will likely be similarly constrained in terms of time
and space as are those of other severely impoverished
groups.

Writers in the time geographic literature speak of
daily paths that are shaped primarily by three types of con-
straint. These are: first, capability constraints, the
disqualification from activities on account of disability
and disadvantage; second, coupling constraints, the
necessity of the individual to combine activities in
different places at overlapping times; and third, authority
constraints, the restriction or exclusion of a person from
particular places at particular times. Capability
constraints are particularly relevant for the CMD due to
psychiatric and social disadvantage. Further, from the
reviewed studies documenting post-hospital outcomes for the
CMD, it appears likely that unemployment and impoverished
lifestyles would minimise the number of coupling constraints
experienced by this group. Studies pertaining to community
attitudes towards the CMD (e.g. Dear and Taylor, 1982)
suggest that authority constraints exist less in the form of
compelling the CMD to be in certain places at certain times
and more in excluding them from particular places and
opportunities within the city (e.g. establishments where an
entrance fee or standards of dress are required). These
speculations can best be tested by consulting the patterns
of daily life experienced by the disabled themselves.

2.4.2 'Insider' perspectives and place

The second literature that can aid appreciation of
peoples' interactions with urban surroundings comes from humanistic geography. A principal focus for humanistic studies has been 'sense of place' (e.g. Relph, 1970). Attempts have been made to describe what constitutes the experience of a locality or region for its inhabitants and whether this is characterised by feelings of belonging or alienation (e.g. Tuan, 1974). With respect to the CMD, solely identifying the determinants of community tenure would comprise an incomplete account of their post-hospital experience. The research agenda must include attempts to discern the extent to which the CMD are 'at home' in the city and are granted a positive sense of place.

Two common elements have characterised studies of social groups and their experience of place. These are: first, the focus on translating and interpreting experience; and second, the absence of any prescribed method to access this knowledge. A recent infusion of structural critique into humanistic thinking has strengthened inquiry into geographic experience. This infusion has occurred in two ways: first, through a refined conceptualisation of place; and second, through the choice of substantive inquiries undertaken. These two developments will be examined in sequence.

'Sense of place' studies in geography have tended to
derive from literary sources or practitioners' personal impressions. Eyles (1985) has argued that communities are "focussed repositories of sense of place" as well as geographic places in themselves. The sociological tradition of community studies is therefore identified as an important source of accessing peoples' experience of place. Eyles argues that experiences within places as well as perceptions of places are structured by material and social opportunity. Pred (1984) has suggested a convergence between humanistic and time geography by noting that 'place' is not a fixed entity but an "historically contingent process". These assertions are part of a growing acknowledgment of the force of structural constraints in constituting sense of place. This recognition is of clear relevance in constructing a social geography of a disabled group. To use the words of Relph (1970), their experience of 'place' or 'placelessness' will be shaped by the material conditions of their existence.

A second acknowledgement of structural constraints in studies of place has come in the choice of subject communities and their places. Increasingly case studies of particular places are regaining acceptance as vehicles for the integration of historical context with documentation of
contemporary experience (Jackson, 1986). The work of Pahl (1985) on the Isle of Sheppey and Cornwell (1984) in East London serve as examples. The latter work is of especial relevance to the present discussion. Cornwell attempted to relate peoples' experience of place with their experience of health. This work represents part of a growing recognition that understanding of health and illness from medical sources is inevitably incomplete without reference to the client group (see also Estroff, 1981; Oakley, 1981; Eyles and Donovan, 1985).

Cornwell (1984) sought 'insider' perspectives among impoverished East Londoners and distinguishes 'public' from 'private' accounts of health. The former are those provided to health professionals. These tend to be constructed according to agreed vocabulary and categories while the latter are more personal and rooted in locale and social group affiliation. Cornwell had to spend time with East Londoners in their neighbourhoods and win their trust in order to hear their private accounts of health experience. In a similar fashion, a social geography of the CMD must be attentive to private accounts of coping and satisfaction with community life. As Eyles and Donovan (1985) point out, lay conceptions of health are influential in determining whether professional services are sought, and ultimately,
what patterns of service utilisation will emerge.

A commitment to seek 'insider' perspectives has implications for research design. As Strong (1979) has pointed out, what people say is very dependent on what questions are asked, who asks them and the general ambience of the occasion. These comments are all the more pertinent when dealing with the CMD, most of whom have been besieged by questions in medical contexts and who, upon return to community settings, may well have faced experiences of rejection. If we are to access what Cornwell (1984) describes as 'private accounts', it would appear imperative that opportunities for respondents to relate their accounts in relaxed settings be provided.

The contributions of humanistic and time geography to conceptualising the urban experience of the CMD can be summarised in a framework that 'situates' the individual in society (Figure 2.2). In common with the ecological framework (Figure 2.1), the individual is centrally placed on the diagram indicating a fundamental interest in the client perspective. This diagram indicates the advances made in discussion beyond the abstract ecological framework by showing social and spatial zones of interaction for the CMD. As a social group, their lives actively intersect and are impacted by both institutions - whose influence transcends
Figure 2.2 The Individual CMD client in society.

(after Laws and Dear 1987)
urban boundaries - and the nature of local territorial communities. The research task is to explain what, in the range of potential influences, determines positive coping experience for the CMD. These influences may arise from characteristics of the individuals themselves, the inner city environment, institutional policies or characteristics of society at large. From time geography, the notion of paths suggests that the examination of daily routines might indicate how, within particular settings, this spectrum of influences shapes patterns of daily activity. The further concept of sense of place, necessarily drawn from interaction between the CMD themselves, offers potential insight into how regard for their urban setting is coloured by experience of opportunities and constraints. The challenge is to examine the general interrelationships of Figure 2.2 so as to refine the abstract ecological model (Figure 2.1) and more appropriately represent the urban experience of the CMD.

2.5 Summary

This chapter has attempted to synthesise a group of disparate literatures that provide a context for the aims of the thesis. These literatures converge on the theme of
health behaviour in urban settings. As the research focus, the CMD are a group particularly well disposed to challenge conventional thinking about health. Reasons for this are two-fold. First, their disorders involve more than the presence of biomedical diseases, the conventional preoccupation of medicine. The conditions that both precipitate and are generated by mental illness are widely recognised as including a broad spectrum of a person's surroundings. Second, chronic mental illness is, by definition, long term. For many, chronicity is compounded by poverty, unemployment and social isolation. These factors converge in the creation of a disabled status which is frequently endorsed by receipt of social assistance in the form of 'disability cheques'. The etiology of both mental illness and disability therefore involves a range of personal and environmental factors. The SEM described earlier suggests consideration of illness and disability as conditions arising from personal, cultural and socio-economic environments.

As outlined in Chapter One, the first aim of the thesis is to describe the everyday life of the CMD in Hamilton. Preceding sections have established an historical context for this task, demonstrating that associations between socio-economic deprivation, environmental quality
and ill-health continue to be confirmed. These associations often geographically converge on the inner city as a zone of disadvantage.

A second aim is to evolve a concept of 'coping' that is appropriate for research with this population. In the stress research literature, 'coping' has principally been viewed in terms of specific behaviours or strategies enacted to deal with challenging situations. These situations have generally been 'life events' of a highly taxing nature. With respect to the CMD, a more plausible explanation for high readmission rates is the impact of a finer texture of community experience on a group whose resources and supports are poorly developed and commonly strained. The more commonplace 'hassles and uplifts' measured by Lazarus (1981) suggest a level of resolution appropriate for viewing coping as competence in the city.

Construction of an appropriate methodology to address the research tasks constitutes the third aim of the work. The disabled status of the study population adds an ethical imperative to this task. The literatures investigating the role of time and sense of place in urban life have suggested the importance of informal approaches to data collection. Disability involves a curtailed inclusion in the levels of participation ordinarily presumed in
society. Reduced opportunities to participate imply, in turn, an alteration in the way time and space are used. For the CMD, these reduced opportunities only partly arise from cognitive and emotional deficits. Although their disability has origins in mental illness, a constellation of other factors compound and reinforce this disability (see Estroff, 1981). There remains a pressing need to better understand the determinants of coping experience from the client perspective.

The fourth thesis aim is to measure the relationships between client and community characteristics and measures of coping. Since the enactment of deinstitutionalisation policies, researchers have both speculated and, to varying degrees of success, demonstrated that a range of factors are associated with community tenure. These factors (e.g. housing, social support, income) lend themselves to incorporation in an ecological framework of community experience and outcome. Community tenure has been a widely used surrogate for positive experience. The adoption of an approach focussing on client experience in the present work reinforces a need to seek out the perspective of the CMD themselves.
CHAPTER THREE
THE CHRONICALLY MENTALLY DISABLED IN HAMILTON

Since the late 1960s, psychiatric treatment in North America has shifted from an institutional to a community-based emphasis. In Canada, health services are primarily a provincial responsibility and this deinstitutionalisation process has therefore unfolded differentially among the provinces, both in the types of service provided and the rate of implementation. As the history and consequences of deinstitutionalisation in Canada have been comprehensively reviewed elsewhere (e.g. Richman and Harris, 1983; Dear and Wolch, 1987), this chapter will focus on changes in psychiatric treatment and services specifically in the context of the Hamilton health system.

The objectives of this chapter are two-fold: first, to describe the formation of the community-based CMD population in Hamilton's inner city; and second, to account for the development and present pattern of services available to this group. The chapter will demonstrate that the present distribution of clients and services is an observable reflection of deinstitutionalisation and community mental health philosophies. These broadly imple-
mented philosophies have been locally articulated through the agency of particular actors and historical circumstances.

An initial section of the chapter will briefly document the results of deinstitutionalisation policies in the provincial setting. Second, the role of individuals and institutions as catalysts to change in the provision of psychiatric care in Hamilton will be examined. A third section will describe the CMD in Hamilton and their affiliation with service agencies. Programs which served as sites for the present research are described in particular detail. A fourth section will present what has been described as a 'map of the mental health territory' and consider the ways in which support for the CMD in Hamilton conforms to such a map.

3.1 Deinstitutionalisation in Ontario

Prior to deinstitutionalisation, Canadian mental hospitals were described as generally "large, segregated and removed, remote from population centres" (Richman and Harris, 1983). In 1960, one half of the nation's 75,000 patients had been hospitalised for more than seven years. Community-based care began to be considered early in
the 1960s (e.g. Griffin, et al. 1963). Through the late
1960s and 1970s, various proposals for alternatively
organised modes of service delivery evolved.

Two factors which precipitated the reduction of in-
patient numbers were the development of the social welfare
system during the 1960s and a shift in federal funding to
general hospitals. Regionallised mental hospitals of 250-300
beds were developed and, in contrast to the Community Mental
Health Centres of the United States, these "worked toward
integrating psychiatric services with public health services
and social services" (Dear and Wolch, 1987, 33). In-patient
beds were consequently reduced in number from 370 per
100,000 in 1955 to 69 per 100,000 in 1977 (McKinsey, 1978).

Figures for Hamilton Psychiatric Hospital bear out
these trends (Table 3.1). During fifteen years (1970-85),
the number of patients "on the books" (in-patients and
patients on leave of absence) decreased by 55%. In the wake
of this reduction, entire wings at the hospital were closed
or converted to other uses. The figures for first admissions
show a more dramatic decrease, with the 1985 cohort being
only 37% of the number for 1970. This decrease largely
reflects the presence of alternative forms of care in the
community. As centres in Ontario developed both in-patient
psychiatric units at general hospitals and outpatient
<table>
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<th>Readmissions</th>
<th>Total</th>
<th>On Books</th>
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<td>858</td>
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<tr>
<td>1971</td>
<td>561</td>
<td>731 (53.5)</td>
<td>1367</td>
<td>810</td>
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<td>1972</td>
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<td>1974</td>
<td>398</td>
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<td>1052</td>
<td>635</td>
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<td>1052</td>
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<td>1985</td>
<td>279</td>
<td>643 (59.6)</td>
<td>1079</td>
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Notes: 1 Numbers in brackets show readmissions as a % of total admissions
2 Includes transfers

Source: Unpublished data provided by Hamilton Psychiatric Hospital, adapted from Laws. (1987).
clinics at psychiatric hospitals and community settings, a narrower range of diagnoses warranted admission. The readmission rates for Hamilton are shown in Table 3.1 and in 1985, the most recent year for which data are available, first admissions are at their lowest for the period.

As Dear and Wolch (1987) point out, deinstitutionalisation has been a service philosophy concerned less with reducing the numbers of consumers and more with transferring patients from traditional to non-traditional service settings. An initial mechanism for the reduction of inpatient populations was the Homes for Special Care Act of 1964. This created residential facilities funded for patients who neither required nor received treatment and supervision, but who nevertheless lacked the means to care for themselves independently. This represented a transfer of patients into semi-institutional settings, and by 1981, 15,000 patients had entered residential or nursing homes across Ontario (Heseltine, 1983).

Other developments in community-based care remained slow through the 1970s and focussed on the general hospitals where psychiatric bed capacity increased from 123 to 4,946 over the 20 years between 1956 and 1976 (Dear and Wolch, 1987). The result has been a uneven patchwork of community-based services in which the private sector has
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consequences of the broad processes of deinstitutionalisation and restructuring of the welfare state. The urban catchments of provincial psychiatric hospitals are the arenas within which these broad processes can be comprehensively understood. Hamilton has been well-studied as such an arena for the restructuring of the welfare state (see Beamish, 1981; Moos, 1984; Dear and Wolch, 1987; Laws, 1987). Attention will turn to the development of specific decentralised psychiatric services.

3.2 Development of Hamilton's psychiatric 'network'

The restructuring of mental health services in Hamilton received particular momentum with the initiation of the McMaster University School of Medicine. Its innovative approaches to medicine were carried into the Department of Psychiatry, formed in 1967. This section will examine the influence of this circumstance on the restructuring of the type and availability of psychiatric services in Hamilton.

The founding chairman, Dr N. Epstein, established the Department of Psychiatry with a goal of generating deinstitutionalisation philosophy in the Hamilton area through incorporating tenets of the community mental health movement in its operation (L. Levine, pers. comm.). The
Division of Health Sciences at McMaster, to which the Department of Psychiatry belongs, subscribes to this view as part of a broader philosophy. At the time of its instigation, patients were considered best treated as close to their natural environment as possible (Wheeler and Wharf, 1971).

From the outset, a community base was forced upon the Department as it initially had no campus location. The meeting of faculty and city clinical practitioners in different buildings propagated a liaison between hospital and community services (L. Levine, pers. comm.). In May, 1968, less than a year after the Department began operating on a full-time basis, a strategic plan was unveiled which called for the development, over time, of a network of psychiatric services . . . which would interact to achieve a degree of synergy; the effect of the network would be greater than the sum of effects of its component parts (Field Unit Project, 1973, 1-2).

A key linkage in this network was between the Hamilton Psychiatric Hospital (H.P.H) and the new Department. The then administrator of H.P.H encouraged the clinical director of the hospital to be a member of the Department of Psychiatry. Two other hospital settings were incorporated into the emerging network. The first of these, St Joseph’s Hospital, had Department faculty on staff who became
involved in 'milieu therapy'. The second, Child and Family Services, at Chedoke Hospital, was by nature a non-residential service. Early elements in the network were therefore oriented towards the community and interconnected by the membership of clinical directors and other staff on the Department faculty.

These affiliations were not seen, however, as sufficiently filling the expectations of a community psychiatry philosophy. Further efforts were made to bring mental health services closer to the community through public and professional education. An endeavour that served to develop community linkages was the development of a Clinical Behavioural Sciences Program that was oriented towards practicing mental health professionals already working for community agencies (L. Levine, pers. comm.).

A further key development was the Field Unit Project. This time-limited project brought together a group of consultants to assist in training members of community agencies and to forge linkages with existing services. The Unit, jointly financed by the Ontario Department of Health and a National Health Grant, was designed to develop new approaches in establishing relationships with community agencies and agents in providing more effective mental health services in all their aspects - prevention, treatment and rehabilitation (Field Unit Project, 1973).
The Field Unit initially comprised a staff of five social workers, a psychiatrist and a part-time sociologist. This later expanded to a membership of thirty "who did clinical work, but were stepping back from that to the goal of improving the ways community organisations dealt with psychiatric individuals" (G. Gilsa, pers. comm.).

Initially its policy was to retain a passive stance and respond to requests for assistance from community agencies and groups. By 1970, halfway through its lifespan, the Unit took a more aggressive stance, identifying key community agencies and developing consulting liaisons. In some instances, this involvement took the form of membership of the boards of voluntary agencies including the Canadian Mental Health Association. In their evaluation of the efficacy of the Field Unit, Wheeler and Wharf note the role of the Unit in providing guidance and expertise to local organisations in the adjustment to the "trend away from treatment of the individual as a deviant to a concern for the social environment of the client" (Wheeler and Wharf, 1971, 55). The Field Unit therefore effectively reinforced the trend towards community psychiatry in Hamilton.

The team approach employed by the Field Unit has been central to activities initiated by the Department of Psychiatry and has been implemented in affiliated clinical
settings (see Figure 3.1). Through the 1970s, the pattern of
distinctive post-hospital services for the CMD that emerged was
the general hospital system than tends to be the case elsewhere in North
hospital. For psychiatric clients resident in the inner city
clinicians affiliated with McMaster, this location has
helped integrate hospital and community. Second, highly
outpatient services have been built around clinical
teams, some of whom continue to be seconded from H.P.H. This
practice, established under the administration of Dr
M. Lemieux, means that staff salaried by the Province and
affiliated with H.R.H. actually contribute to community based outpatient programs. Rather than the development of
parallel sets of out-patient services, there has therefore been an integration of service between H.P.H. and the
university and selected general hospitals.

The influx of psychiatrists associated with the
nascent medical school, their emphasis on team work and the
use of innovative treatments (e.g. family therapy) created a
"depth of division" between these and certain private and
civic hospital psychiatrists, (Kidd, 1972). This division
partly accounts for the late inclusion of the General and Henderson hospitals in the evolving psychiatric network. The low involvement of Hamilton civic hospitals in psychiatric services was perpetuated when the members of the Department of Psychiatry took the initiative to establish a clinic in the underserved East End of Hamilton. The utilization rate of inpatient services was greater among East End residents than any group elsewhere in the city with the exception of the downtown core (Mitchell, 1970). The role of the planned service would be to provide direct care, consultation to general practitioners, and assistance in co-ordination of aftercare for East End residents discharged from psychiatric units in the city. This was to be "complementary with the psychiatric emergency services and outpatient services to be developed at the Hamilton General Hospital" (Anonymous, 1979). East Region Mental Health Services currently provides comprehensive outpatient services but psychiatric facilities at the civic hospitals remain underdeveloped and largely outside 'the network'.

In 1973, H.P.H. began scaling down its involvement in operating outpatient clinics and receiving psychiatric emergencies. Staff formerly involved in these activities at the hospital were seconded to other parts of the 'network', including the Emergency Psychiatric Team (E.P.T.) based at
St Joseph's Hospital. This unit was established in 1973 and comprises staff affiliated with Hamilton's General Hospital and the McMaster 'network' as well as H.P.H. The result of this restructuring is that a unit based in a general hospital is now the major point of access to the regional psychiatric hospital and serves as the only emergency service of that hospital.

3.2.1 Community Psychiatric Services

Community Psychiatric Services (C.P.S.), has its origins as one of the three in-hospital departments of St Joseph's Hospital in 1967. In 1970, the McMaster Department of Psychiatry was formed and St Joseph's was its sole location until the opening of the McMaster University Medical Centre. In the 1970s, C.P.S. was known as "43 Charlton" after its site near the hospital. A community emphasis was galvanised by its 'core city project', set up to extrapolate principles of milieu therapy into community settings. The project was dismantled in 1973 and in 1979, C.P.S. moved to the Fontebonne building of St Joseph's Hospital (N. White, pers. comm.). The staff comprise psychiatrists, psychiatric nurses and social workers, and work in clinical teams with caseloads structured according to
pathology and chronicity.

The clinical orientation of the service, together with its hospital location makes the name 'C.P.S.' something of a misnomer. While it originally incorporated elements of the community mental health philosophy such as community outreach and close liaison with other agencies, C.P.S. no longer embodies these principles. Rather, the service functions primarily as an outpatient psychiatry clinic (C. deLottinville, pers. comm.).

In January 1987, an in-program survey was undertaken and of the 420 clients seen by staff that month, 240 (57%) had been in H.P.H. within the last two years and 307 (73%) were living independently. Chronic cases, defined as those with the program over two years, numbered 149 (35%). Of these, 57% were single, 56% not working and only 29% had been in hospital for psychiatric reasons within the last two years. This low figure for readmissions is influenced by the proportion of depressive clients on the caseload of C.P.S.

3.3 The private sector and post-hospital services.

Both for-profit and non-profit elements of the private sector are relatively well-developed in Hamilton. For-profit services are principally represented by
"second-level lodging homes" which provide a reservoir of post-hospital accommodation for the CMD in Hamilton. Boarding homes were previously unregulated and catered to various low income groups. The by-law which established the "second level" designation was passed by the Hamilton City Council in 1981 in response to concern over living conditions (see Laws, 1987). Residents are frequently recipients of Family Benefits Assistance, known as the "disability pension" and part of the licensing arrangement involves direct payments of this allowance together with a subsidy to lodging home operators. Residents are, in turn, disbursed a monthly "comfort" allowance of $77. For reasons including available housing stock there has been a significant concentration of lodging homes within inner city census tracts (see Beamish, 1983; Demopolis, 1984).

The most active non-profit agency in community-based care for the CMD has been the Canadian Mental Health Association. The C.M.H.A. was active in advocating community services through the 1970s (M. Lemieux, pers. comm.) and this awareness and advocacy was promoted by the inclusion of representatives from a variety of community interests on its Board. The C.M.H.A. is continuing a commitment to "gap-filling" care through the evolution of the Residential Skills Development Program, a program that establishes
contact with residents of lodging homes who are otherwise unconnected with aftercare agencies. The two principal programs operated by C.M.H.A./Hamilton and serving the CMD in Hamilton are the Care Centre and Community Enrichment Services. The development and clientele of these programs will be briefly described.

3.3.1 The Care Centre

The origins of the Care Centre lie in the Friendship Club which was established in 1976 as a satellite program of the C.M.H.A. (C.M.H.A./Hamilton, 1976). This service took the form of loosely organised meetings held in various church basements. In 1976, the Friendship Club was annexed by the C.M.H.A. and in 1979 the Care Centre was established, first on King St. East and a year later at its present Victoria Avenue premises (E. Pitre, pers. comm.).

The Care Centre is described as "a drop-in centre primarily for persons suffering from mental illness" and the core group of approximately one hundred CMD "view other clients, staff and volunteers in an extended family role". Membership is described by the C.M.H.A. as drawn from those who "have travelled the psychiatric and community service system and for various reasons did not adjust to or utilize
programs or services offered" (C.M.H.A./Hamilton, undated). Those who visit participate in both scheduled and unscheduled activities provided, including games, living skills classes, and community tours.

Throughout 1986, the Centre was open two evenings each week, during which an average of 50 members attended coffee house activities. In addition to three permanent staff, the Centre regularly has community college students and shortterm workers placed through the Elizabeth Fry Society. While these additional staff have temporarily expanded its range of activities, their impermanence and the attendant fluctuation of levels of service provision has resulted in frustration on the part of clients (E. Pitre, pers. comm.)

The role of the Care Centre has changed over the last four years from a social and recreational drop-in centre to a more comprehensive support service for CMD people who are potentially unconnected with aftercare programs. Many of its members "have and do live with discrimination, stigma, apathy, deprivation (both physical and emotional), violence and abuse" (Pitre, 1986, 2). Although the Centre does not include counselling in its advertised function, staff have recently taken on a greater crisis intervention role. In 1986, it was estimated that 60%
of permanent staff time was devoted to crisis intervention and problem solving (Pitre, 1986).

Clients visiting the Care Centre regularly are known as 'members' although an open-door policy prevails. In the last quarter of 1985, membership was 325. Of these, 178 were noted to visit at least once a month, and 147 visited more sporadically. Reasons for irregular attendance include rehospitalisation, lack of transport, temporary change of location, commencement of employment, involvement in a training program, incarceration and medical problems. Weather is also noted as playing a role in shaping attendance, with increases in the warmer months (Care Centre, 1985). The Care Centre therefore provides a relatively unstructured and undemanding environment for ex-psychiatric patients, regardless of their level of need and level of service obtained elsewhere.

3.2.2 Community Enrichment Services

Community Enrichment Services (C.E.S.) was established in 1982 by C.M.H.A./Hamilton as a "case management" program with funding from the Ontario Ministry of Health. Case management is an approach to aftercare in which one person assumes primary responsibility for co-ordinating
post-hospital service needs and may act in an advocacy role on behalf of a client. The case manager therefore becomes a focal point in co-ordinating the client's encounters with an often fragmented array of service agencies.

The C.E.S. program has aimed "to maximize community tenure, improve the quality of life and promote community integration for chronically disabled ex-psychiatric adults residing in the community of Hamilton-Wentworth". These aims are achieved through needs assessment, counselling, skills development and encouraging clients to set their own goals. The program promotes the utilization of other available resources in the community (C.H.M.A./Hamilton, undated b).

By its second year of operation, the program had a caseload of 50 and a waiting list of 40, the 25-34 age group predominated and 74% of the caseload were recipients of Family Benefits Assistance (F.B.A.). In 1986, a third case-manager was added and the caseload rose to 75. Referrals have come from a variety of sources including general practitioners, outpatient clinics, the Care Centre and clients themselves. The program has no medical back-up and entry criteria include the stipulation that clients must be affiliated with a medical professional in the community. The non-medical character of C.E.S. distinguishes it from other
case-management programs in the city.

3.3 The chronically mentally disabled in Hamilton

Prior to the deinstitutionalisation process, numbers of the CMD could be ascertained by undertaking a census of inpatients of psychiatric hospitals. With the large-scale discharge of patients and incidence of mental illness among younger cohorts, many of whom have never been admitted to a provincial mental hospital, the enumeration of this population is no longer a simple task. It is widely recognised that only approximately 60% of the CMD are connected with case-management programs or outpatient clinics.

The role of H.P.H. as a repository for the CMD population has clearly diminished (see Table 3.1). In 1969, its maximum capacity was 1451. Since 1980, this capacity has been reduced to 502 with a current in-patient population of approximately 325 (Laws, 1987). The vast majority of Hamilton's CMD are therefore resident in community settings. This population has been estimated using national first admission cohort data (Bland, 1982) and population projections obtained from the Ontario Ministry of Treasury
and Economics (Table 3.2). In this data 'chronic' is defined as two years since diagnosis. Although derived from estimations, these data have importance in illuminating the general patterns of service provision in Hamilton.

Three observations can be made from Table 3.2. First, of the estimated total number of CMD, only approximately 30% of the population is served by 'case supervised' programs. The term 'case supervised' is coined to include those semi-structured aftercare services available in Hamilton ranging from group homes through outpatient clinics to case-management programs. These all provide some degree of co-ordinated care to clients. Data from the Care Centre are not included, for while it serves as a meeting place and service centre for the CMD, it does not fulfill case supervision functions. Significant numbers of the estimated 'not served' CMD population may well be regular or intermittent patrons of the Care Centre.

A second point deriving from Table 3.2 concerns the age groupings. There are estimated to be almost four times the number of older than younger CMD in Hamilton. The older cohort is most significantly served by outpatient clinics and the Fennell Program at H.P.H. These were established at the time deinstitutionalisation policies were enacted in Hamilton. A greater proportion of younger clients are
<table>
<thead>
<tr>
<th>Program</th>
<th>Age Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General outpatient*</td>
<td>(&lt;35</td>
<td>500</td>
</tr>
<tr>
<td>Hamilton program for schizophrenia</td>
<td>145</td>
<td></td>
</tr>
<tr>
<td>Community enrichment services</td>
<td>70</td>
<td>75</td>
</tr>
<tr>
<td>Fennell program</td>
<td>20</td>
<td>152</td>
</tr>
<tr>
<td>Group homes</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>NOT SERVED</td>
<td>382</td>
<td>1902</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>662</strong></td>
<td><strong>2734</strong></td>
</tr>
<tr>
<td>(% SERVED)</td>
<td>(42%)</td>
<td>(26%)</td>
</tr>
</tbody>
</table>

* C.P.S.
East Region Mental Health Services
McMaster Outpatient Psychiatry

Source: Adapted from data provided by B. Humphrey (1987) using calculations by Bland (1982)
identified as served by a case supervision program than their older peers.

A third point concerns the 'potentially unserved' category. While a proportion of this population may be either in need and desirous of involvement with an aftercare program, another proportion may well be receiving sufficient support from family, friends, community organisations or general practitioners to circumvent the need for formal aftercare services. Indeed, this presumption gives some necessary recognition to the success of deinstitutionalisation in general and local initiatives such as those undertaken by the Field Unit Project in Hamilton in the 1970s. The activities of that project, designed in part to better equip community agencies to deal with the CMD, may have led to a 'blending in' of some of this population. The 'potentially unserved' category on Table 3.2 refers, therefore, to service by formal programs and clinics. Some of the estimated population in this category may therefore be justifiably "out of reach" of the psychiatric service system, through being 'potentially served' by other professionals and agencies in Hamilton.

3.6 A map of the mental health territory

The particular pattern of support for the CMD in
Hamilton conforms to the 'typical map of the mental health territory' proposed by Pape and Church (1987). In this, the authors indicate both the levels of investment and patterns of relationship among stakeholder groups (Figure 3.2). In Hamilton, the formal psychiatric 'network' provides therapeutic treatment to the CMD and has become well developed under the impetus of university personnel and provincial funding.

Community groups and agencies provide activities and programs that fall outside the 'therapeutic treatment' designation and have less prominence on the 'mental health territory'. Reasons for this are twofold: first, because of their lack of funding relative to the 'formal system'; and second, because their mandate is to fill in service 'gaps' between components of the formal system. The activities of the C.M.H.A. in Hamilton specifically provide assistance to the CMD. Other agencies such as the Wesley Centre work with a range of people, including the CMD, who are facing difficult life circumstances.

A third subset of community agencies, including the YWCA and church groups, provide services and opportunities to any citizen in the community. Previous studies (e.g. Dear et al., 1980) have shown the CMD to be frequent patrons of this type of community group. The heavy lines on the diagram
Figure 3.2 A map of the mental health territory.

Source: Pape and Church 1987
Indicate the degree to which these sectors are likely to influence CMD individuals. Their unidirectional nature suggests that the person has "much less possibility or opportunities to have an impact in return" (Pape and Church, 1987, 8).

Two further components shown on Figure 3.2 are self-help and informal caring networks. Self-help is described as "a process of becoming increasingly self-reliant with the assistance of selected people for advice and support and with minimal dependence on professionals and formal services" (Pape and Church, 1987, 8). Although self-help groups exist in other Canadian centres (e.g. Hough, 1987), the only consumer-initiated organisations in Hamilton have been transitory (e.g. Johnson, undated). One successful example of the self-help concept has been the psycho-social clubhouse, originally developed at Fountain House in New York. In this setting, the CMD become 'members' rather than continuing to be known as 'clients'. The sense of membership is reinforced by a commitment on the part of the CMD to carry out tasks, participate in events and abide by certain rules. Opportunities for developing a variety of skills including employment are offered and, unlike many rehabilitation programs, membership is not time limited. Members figure strongly in decision-making at the clubhouse.
and an outcome of these features is a sense of 'ownership' difficult to achieve at a drop-in centre (Beard, Propst and Malamud, 1982). Clubhouses modelled after Fountain House are functioning in Toronto and Buffalo and during the research period, an ad hoc committee formed in Hamilton to explore the prospect of a local clubhouse facility.

Informal caring networks are, by definition, unorganised and can be hypothesised as being present and supportive in the lives of the CMD in Hamilton. As suggested by the findings of Smith and Smith (1979), the ongoing support of friends and family may substantially lessen the need for hospital care and improve quality of life for the CMD. Pape and Church point out that the very lack of organisation intrinsic to this form of support can lead to a lack of recognition of the importance of this component of the mental health environment.

On the diagram, the individual is overshadowed by the rest of the 'territory'. Two implications follow from this type of diagram. First, the research challenge is to focus on the needs of the CMD, and therefore attempt to map their experience of the mental health territory. Second, there is a need for broad-based samples in client-centred research. Survey samples entirely comprised of clients involved with the formal 'network' would clearly represent
only the better-served cohort in any urban context.

3.6 Summary

This chapter has surveyed the distinctive development and distribution of psychiatric services in Hamilton and the character of the local client population. The dual processes of deinstitutionalisation and restructuring of the welfare state have been described by Dear and Wolch (1987) as most "severely impacting "two incipient ghettos". These are first, the psychiatric hospital and its urban catchment and, second, the inner city and its health and welfare system.

In Hamilton, three factors have operated within these "incipient ghettos" to promote a relatively secure service network. First, H.P.H. is close to Hamilton's downtown area. While earlier this century, the escarpment separated the asylum from the city, H.P.H. is now within minutes of the downtown core. Second, the formation of the McMaster University Department of Psychiatry, with its early initiatives in promoting community treatment, led to an interconnected network of clinical sites. Dual appointments of staff at both H.P.H. and McMaster have narrowed the potential divide between hospital and community. Third, the highly active C.M.H.A. has developed programs which fill
Important gaps in the local service system.

The cumulative impact of these three factors is that in Hamilton, the two "incipient ghettos" have, to a large extent, spatially converged in the inner city. Estimates of the client population point to only about one third of chronic clients being served by 'case supervised' programs. More older clients are estimated to fall within the unserved categories. It is likely that a proportion of these utilise the opportunities provide by community groups and agencies such as the Care Centre. Given that Hamilton's "official" map of the mental health territory is identified as similar to that described by Pape and Church (1987), the research challenge is to uncover the experienced 'map of the territory' for the CMD.
CHAPTER FOUR
INTERACTIVE RESEARCH AND THE HAMILTON STUDY DESIGN

The socio-ecological approach to health described in Chapter Two focusses on the interactions between persons and their environments. To conduct research from this interactive perspective demands adjustments away from conventional behavioural research in terms of design, measurement and analysis. This chapter begins by considering interactive approaches to behavioural research in geography and the ways that conventional survey methods can be modified to accommodate this epistemology. A second section describes the ways these approaches have been incorporated into the present study design and the characteristics of the resultant sample.

4.1 Interactive research method

An analysis of the experience of an urban social group requires the gathering of data that pertains to interactions within the environment. The methodological question raised by the interactive epistemology underlying the SEM is "How does one gather data to measure inter-
action?" A central dilemma is that on the one hand only inadequate understanding may be gained by the 'detachment' prescribed by conventional behavioural methods. Yet, conversely, an engagement with the social group of interest inevitably brings the researcher into the very arena of interaction itself. This engagement may compromise the objectivity conventionally sought in social science. This section argues that informal field approaches pioneered by sociologists and anthropologists can be usefully combined with conventional behavioural methods in documenting the social geography of the CMD.

4.1.1 Familiarity and rapport

A rich heritage of participatory approaches to field observation in the social sciences has only relatively recently been applied in social geography (e.g. Ley, 1974; Rowles, 1978; Godkin, 1980; Jackson, 1980a; Boal, 1981). Participant observation is not an explicitly defined method but is rather seen as a "broad, flexible approach" (Jackson and Smith, 1984, 93). It is eminently suited to a developing interest in questions of place, territory and values among spatially-defined social groups. Participant approaches have been used to "study societies and institutions which are
radically different from those with which the observer is generally familiar" (Jackson and Smith, 1984). The purposes of these approaches can be summarised as the establishment of rapport with a social group and the gaining of familiarity with their geographic locale.

Researchers in geography who have adopted participant observation approaches have tended to do so primarily for the collection of data (e.g. Rowles, 1978; Godkin, 1980). A difficulty with such studies is that initial premises are all too easily confirmed by selective observation and reporting, however unintentionally such bias is introduced . . . the 'rules of the game' which apply to this type of field research cannot be adequately stated and the reader must judge the accuracy of the conclusions from the evidence of the written record and circumstantial details of how the field work was conducted (Jackson, 1980, 4).

The research question at hand suggests the use of participant observation for two reasons. First, the CMD are a ghettoised population, suggesting a group identity circumscribed by location and opportunity significantly different from that of the researcher. Second, the illness burden, treatment regimes, and stigma experienced by this group suggest that the structure of everyday life may well differ significantly from the general population. For these reasons, social scientists such as Anderson (1979) and Estroff (1981) have undertaken participant observation to gain access to the experience of being mentally ill.
Participant observation has been considered to be sufficiently flexible to be combined with questionnaire surveys. This introduces the possibility of bridging the epistemological gulf between 'insider' and 'outsider' in survey research (Jackson and Smith, 1984). A precedent for the combination of participant approaches with use of survey methods in geography has been set by Ley (1974) who studied impoverished Blacks in inner city Philadelphia. In the present research, a period as a participant amidst the CMD was considered important for the insights needed to formulate hypotheses and construct an appropriate survey instrument. Time with group members was also considered important for the establishment of rapport. This would not only be an informal entre into their 'world', but was anticipated as ultimately assisting in the formal interview process. Therefore, in the absence of complete participant observation such as that performed by Estroff (1981), reliance in this research has been upon a quasi-participatory approach including use of survey interviews.

Despite reciprocal benefits, participant approaches and conventional interview methods can never be completely compatible in a research schedule. Knowledge of the long term goal of undertaking a survey may well compromise the degree to which the researcher is accepted as a participant.
However to be covert about this goal would involve questionable ethics. Also, so long as a mix of familiar and non-familiar individuals are included in the survey, there exists the risk of variable quality in the responses. Yet these difficulties of 'fit' between approaches remain minor in the face of the anticipated combination of depth and rigour that use of both approaches can afford analysis. One avenue of enhancing this 'fit' was seen to be the interview encounter.

4.1.2 Interview as discourse

In addition to being a preliminary to formal data collection, adoption of participant approaches allows modification of the conventional interview process. In the typical interview method used by behavioural geographers and other social scientists, interviewers initiate topics, direct the flow of talk and decide when a response is adequate. Interviewees, on the other hand, are expected to adopt an active role only insofar as they disclose information. These observations lead Mishler (1986) to suggest that the standard interview is simply another manifestation of the stimulus-response paradigm central to the behavioural sciences.
Two elements are intrinsic to the formal interview encounter. First, for both the interviewer and the respondent, there is the unfamiliarity of the situation. Second, there is a likely awareness on the part of the respondent of the inequality inherent in the interview situation. This inequality may involve both knowledge and status (Oakley, 1981). While elements of inequality and artificiality are likely to remain as long as specific questions are asked, a number of modifications which will 'humanise' the interview can be found. One such modification is to follow the lead of Mishler (1986) and approach the interview as a discourse in which both the researcher and respondent are active participants. This type of approach potentially transforms the asymmetrical and hierarchical survey interview (Oakley, 1981) into a mutually affirming encounter.

4.2 The Hamilton study design

Interviews are widely recognised as an incomplete guide to actual behaviour (e.g. Phillips, 1971; Strong, 1979). In this study they have been regarded as a necessary but not sufficient dimension of the research design. The design involved three stages: first, the establishment of familiarity with the study population and locale; second,
the consolidation of rapport with one sub-population; and third, two rounds of semi-structured interviews. The first two stages were planned in order that an understanding of the 'world' of the CMD would have been achieved by the time formal data collection commenced and in order to inform the process of constructing the interview schedule. The research stages will be described in sequence.

4.2.1 Establishing familiarity

The need for familiarity with the research setting of Hamilton's Inner City prompted inclusion of a preliminary period of informal observation. This observation took three forms: first, volunteer presence at the Care Centre; second, volunteer involvement with the St Joseph's Day Program; and third, visits to a number of lodging homes.

During the early months of 1985, approximately four hours each week were spent at the Care Centre. This involved a presence at the storefront facility, getting to know clients as they offered conversation and acquaintanceship. This initial period allowed observation of the role of the drop-in centre and the difficulties experienced by members.

A second and concurrent involvement was with the Day Program, a fourteen week rehabilitation program affiliated
with C.P.S. Clients are referred from elsewhere in Hamilton's health system to this program and an intensive course of activities centres on development of personal and community living skills. Volunteer involvement in the leisure skills section was undertaken with the rationale of gaining appreciation of a more structured and supervised program and the clientele which it draws. The researcher's contribution comprised planning and participating in recreational activities.

Eight inner city lodging homes primarily housing the CMD were visited. These visits were made with the co-operation of the City of Hamilton Department of Public Health and provided information about the range of congregate living situations available to the CMD in Hamilton.

4.2.2 Consolidating rapport

During the summer months of 1985, a more active role was adopted at the Care Centre. A creative writing group was formed and weekly meetings were regularly attended by up to eight members who joined in discussions and shared their own writing. These gatherings provided a continuity of contact that would otherwise have been difficult to achieve in an unstructured drop-in centre. The self-revelation that
naturally arises in discussing one's writing promoted trust and rapport between clients and the researcher, allowing further insight into themes of concern to Care Centre clients.

4.2.3 Research Interviews

Collection of anecdotal data at the Care Centre informed the construction of the Life management in the city questionnaire (L.M.C.Q.). The instrument was designed to obtain two types of information: first, measures of client experience in the environment and post-hospital outcome; and second, characteristics of the clients and their community setting. Construction of the instrument was also informed by the studies reviewed in Chapter Two that point to variables that are determinants of post-hospital outcomes. Items were clustered into sections on living situation, social support, involvement in the psychiatric 'network' and income and employment status (see Appendix).

The L.M.C.Q. is designed to build rapport in the course of the interview. This is achieved through inclusion of open-ended as well as structured questions and scales. Items are arranged so as to foster a conversational rather than formal interview style. Further aspects of the
instrument as they pertain to data analysis will be addressed in Chapter Five.

The instrument was pilot tested with ten Care Centre clients during November, 1985. After minor adjustments, the remainder of the sample was interviewed between January and April 1986. The task of recruiting clients for the sample differed between the programs contacted. At the Care Centre, members were approached on the general activity floor and asked to participate in a study of "what it's like having had mental illness and living in downtown Hamilton". Those who showed reluctance were offered the opportunity to arrange to meet another day at their convenience. While a number of such arrangements were made, few were successful. The case-management orientation of Community Enrichment Services (C.E.S.) and Community Psychiatry Services (C.P.S.) precluded prior familiarity with respondents drawn from these programs. In an attempt to create a comfortable ambience in these interviews, clients' primary care-givers (i.e. social worker or psychiatric nurse) remained present throughout the interview. This proved an important aspect of protocol for all concerned. Respondents were noticeably at ease compared with some Care Centre clients and care-givers frequently remarked on the insight they gained through being present during the interview.
Care-givers in these programs selected clients from their case-loads on the basis of diagnostic suitability and anticipated willingness to participate in the interview.

Clients interviewed in all programs signed statements of consent, agreeing to provide information and to have the primary care-giver provide additional information. In the case of the two case management programmes, data from medical records were made available under the terms of consent. At all times, clients were offered the opportunity to decline a response to any question or questions. When audiotape was used, this was with the full consent of the client. Such was the willingness of some clients to offer 'private accounts' of their health experience that more than one enquired as to when a third interview would be arranged.

Interviews took place in a variety of settings, as chosen by the caregivers. These included sheltered workshops, lodging homes and clinical settings. Interview length varied between one half and two hours. Care-givers in the three programs provided anecdotal evidence about the clients and completed rating scales assessing their perceptions of the coping performance of each client.

The distribution of the sample according to the three contact programs is shown in Table 4.1. With a working
<table>
<thead>
<tr>
<th>Program</th>
<th>Total clients</th>
<th>approached (%)</th>
<th>Interviewed (%)</th>
<th>Reinterviewed (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Centre</td>
<td>200</td>
<td>31 (16%)</td>
<td>20 (10%)</td>
<td>14 (7%)</td>
</tr>
<tr>
<td>C.E.S.</td>
<td>75</td>
<td>27 (36%)</td>
<td>25 (33%)</td>
<td>25 (33%)</td>
</tr>
<tr>
<td>C.P.S.</td>
<td>240</td>
<td>22 (9%)</td>
<td>20 (8%)</td>
<td>19 (8%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>515</td>
<td>80 (16%)</td>
<td>66 (13%)</td>
<td>58 (11%)</td>
</tr>
</tbody>
</table>

Note: In all columns, % represents percentage of total clients in program.
assumption of only a moderate cross-affiliation, the combined clientele of the three programs is approximately 515. Two rounds of interviews were conducted six to eight months apart. The first round included 66 clients and was conducted during the late fall and winter months (1985-86); the second round in the summer and early fall of 1986. The 58 clients successfully reinterviewed in round 2 represents approximately 11% of the combined program population. C.E.S. is over-represented in the sample relative to the other programs, with 33% of its clients being included in the sample compared with 7% and 8% for the Care Centre and C.P.S. respectively. Of the 58 reinterviewed clients, 10 were involved in one or more of the contact programs, and one client was involved in both of the other programs. Cross-affiliation was most frequent between the Care Centre and C.E.S., presumably on account of the common C.M.H.A. connection.

The follow-up procedure was relatively straightforward with C.E.S. and C.P.S. at which care-givers made interview appointments with the clients. Tracing the Care Centre respondent's proved a greater challenge. For those who, after two months, had not been seen at the Care Centre, telephone and other enquiries were made. Reasons for clients being lost to follow-up were as follows: at the Care Centre,
one had died, one was in prison, two declined a second interview and two could not be traced; in C.E.S. one had been readmitted and in C.P.S., one could not be traced.

The sample was purposively selected according to the two criteria of age and sex, with the intention of including approximately one quarter of each age and sex combination. With respect to age, 35 was chosen as the cut-point. The rationale for this decision was that those under age 35 are likely to represent the 'young adult chronic' population described in the literature (e.g. Bachrach, 1982b; Segal and Baumeri, 1982) as having less institutional experience than their older counterparts diagnosed prior to deinstitutionalisation. The distribution of clients within the four age-sex combinations is indicated in Figure 4.1.

All but 19 of the 124 interviews were undertaken by the author. A female associate completed the remainder with female C.P.S. and C.E.S. clients in the second round, under the assumption that the common ground of gender might prompt certain clients to be more forthcoming in sharing details of daily life. In a few instances, this did prove to be the case.

The rationale for the design was two-fold: first, this allowed a test-retest comparison of responses to the survey instrument. A follow-up interview therefore allowed a
Figure 4.1 Structure of the client sample (round 1)
check and clarification of responses. Second, two rounds of interviews allowed a preliminary exploration of the effects of seasonality and related changes in the environmental circumstances on the clients' community experience.

4.3 Summary

In the medical context, Stimson and Webb (1975) have demonstrated a lack of congruence between patient behaviour in a consultation and what they say they do in another context. By extension, a danger in the present study was for clients to have envisaged the researcher as an agent of the medical or welfare systems to which they are dependent and to respond in a manner not congruent with daily practices. Three elements in the research design attempt to offset this possibility: the opportunities for the researcher to interact with clients outside the interview setting; the information from informed others; and the repetition of the interview six to eight months later.

The research sample was selected in a semi-structured manner according to criteria of age and sex. The group conformed to reported observations of the CHD population being largely single, schizophrenic, recipients of social assistance and living in boarding homes.
Mishler's (1986) call for research interviews to attend to context, discourse and meaning has been addressed in the present research design without compromising the process of data collection. First, sensitivity to the context of the population was achieved by establishing rapport with the CMD population. Local knowledge of the CMD and their inner city environs was then employed as the basis for constructing the instrument and conducting interviews. Second, interviews were conducted as discourses and clients were invited to "tell their story". Multiple encounters with some clients aided this process and narrative accounts were transcribed where possible. Third, the meaning of community life for the CMD was sought by eliciting narrative accounts as well as factual information. The responses amassed by the instrument therefore constitute more than what Cicourel (1982) describes as the fragments of information customarily removed from the life-setting of respondents in the course of social scientific endeavours.
CHAPTER FIVE
UNRAVELLING THE WEB:
THE DETERMINANTS OF COMMUNITY EXPERIENCE AND OUTCOMES

In this chapter, the SEM described in Chapter Two is adapted to the task of examining the determinants of community outcomes and experience among the client sample. The ecological conceptual framework (Figure 2.1), upon which the SEM is based represents complex interactions in the daily life environment. The multi-dimensionality of the SEM presents difficulties for empirical research. However, in the present case there is a need to 'unravel the web' of person-environment relationships in order to document the experience of the CMD and its determinants. Three tasks are therefore undertaken in this chapter: the development of a practical framework to identify determinants and to guide analysis; examination of the interrelations among measures of outcome and community experience; and an analysis of the association between hypothesised determinants and measures of outcome and experience.

The chapter begins by presenting an analytical framework for studying experience and outcomes based on the SEM. The second section describes the characteristics of the
sampled clients and their community setting. The third section describes the rating scales developed from the Life management in the city questionnaire and analysis of the determinants of these and objective outcome measures by means of non-parametric methods. The fourth section presents findings from the application of multivariate analysis to the data derived from rating scales.

5.1 A framework for analysis

The generic features of the SEM have been translated into a framework specifically designed for the analysis of community experience for the CMD (Figure 5.1). There is great difficulty in capturing the complexity of the SEM in an operational model. The framework is therefore presented as a guide for inquiry into relationships suggested by an ecological model. While inspired by the SEM, Figure 5.1 is, of necessity, limited both in terms of the elements and relationships shown. As discussed in Section 2.3.3, client experience in the environment can be plausibly viewed as either an 'outcome' shaped by a set of determinants or, alternatively, as a major determinant of objective outcomes. For the purposes of present analysis, the former view is adopted and coping and satisfaction, two dimensions of
Figure 5.1 A framework for analysis.
subjective experience of self, are treated as outcomes. These are hypothesised as being shaped by the same sets of interrelated determinants which are linked either directly or indirectly to community tenure and readmission.

The analytical framework identifies sub-sets of personal and community characteristics for which information was gathered from the client sample. Inclusion of particular sub-sets is based upon observations arising from personal experience, literature reviewed in Chapter Two, and earlier studies in the local context (Dear et al., 1980). Under the heading of personal characteristics, several variables have been suggested as of importance. These include age, gender, marital status, employment status, income and education (Franklin et al., 1975; Marks, 1977; Woogh et al., 1977; Wooley and Kane, 1977). Psychiatric history includes primary diagnosis, treatment regimes and record of hospitalisation. Utilization of psychiatric services covers participation in the various available aftercare programs. Social support has been suggested as including informal contacts such as family and friends (Smith and Smith, 1979) as well as more formal involvements (e.g. Woolley and Kane, 1977). Characteristics of the living situation are suggested to include aspects of both the dwelling and neighbourhood (e.g. Lamb and Goertz, 1971; Smith, 1978). Lifestyle includes the type, frequency,
duration and location of discretionary activities (e.g. Franklin et al., 1975). Given the largely unemployed nature of this population, this aspect is of major interest. A further area on the framework is salient beliefs and attitudes. Of interest here are those held either by members of the community (e.g. Dear and Taylor, 1982) or by the clients themselves (e.g. Estroff, 1981), which have an impact upon coping ability.

The framework attempts to represent the clusters of factors that are potentially linked to objective and subjective outcome measures. As such it is more a guide to 'unravelling the web' than a comprehensive model. Attention now turns to a closer examination of the characteristics of the sample.

5.2 Sample description

The total sample in round one comprised 66 clients. Of this number, 58 were re-interviewed. Schizophrenia was the predominant disorder of the group (2/3) with lesser representations of other disorders including manic-depressive, schizo-affective and personality disorder. Diagnoses for three Care Centre clients were unknown as they either could or would not provide this information nor
were they involved with someone who could provide the
information.

For admission to C.E.S., clients must have undergone
at least two psychiatric hospitalisations whereas at C.P.S.,
a client may be referred from a hospital or physician
regardless of number of admissions. In this study, however,
the sample was only drawn from those deemed 'chronic' and
having two or more admissions. At the Care Centre, there is
open membership. Although most of the clientele have had
multiple admissions, a minority have had no hospital
experience. Within the sample, two Care Centre members had
no hospital experience. During the two years prior to the
round one interview 3/5 had no hospitalisations and only
1/10 experienced two or more episodes in hospital. The
majority of respondents were receiving medication for
psychiatric illnesses.

The chronic psychiatric population in any inner city
location tends to be a largely single group. In the round
one sample, two thirds had never married and a further one
fifth were in consensual relationships which have since
dissolved. A greater number of females were married. In the
survey sample, only 1/5 were working in any regular fashion,
and of these, half were doing so in sheltered workshops. A
total of 3/5 had either been unemployed for over two
years or had never worked at all.

The sample members lived predominantly in census tracts located in what Elliott (1987) defined as the 'inner city' (Figure 5.2). Exactly one half of the sampled clients lived in 'second level lodging homes'. The high proportion of the sample living in this form of accommodation reflects the inner city location of the three surveyed programs. Significant clusterings of both lodging homes and treatment programs are found in the inner city.

Most of the sample (4/5) were recipients of either general welfare assistance or the 'family benefits allowance' (F.B.A.). A minority supported themselves through employment. Those at sheltered workshops received only a minimal supplement to the F.B.A. Residents of lodging homes were almost universally recipients of the F.B.A. The modal member of the sample was therefore schizophrenic, unemployed, likely to be living in an inner city lodging home on social assistance of less than $6,000 per year.

5.3 Client and community characteristics

This section provides a more detailed description of the characteristics of the client sample according to the data sub-sets identified on Figure 5.1. This description
will serve to introduce the variables used in analysis later in the chapter. Of the 66 clients initially contacted, 58 were successfully reinterviewed and it is with this latter group analysis was undertaken. The reported descriptive data is drawn from the second (summer) round of interviews.

An even number of clients reported having completed and not completed high school education and 2/3 of the group were not employed in any manner (Table 5.1). An even greater proportion (4/5) were recipients of social assistance and this characteristic is borne out in the levels of monthly income. Over 2/3 of the group falls within the $400-$599/month bracket. This is the current level of social assistance to the disabled.

Schizophrenia was the predominant diagnosis of the sample (Table 5.2). Respondents were asked what other mental health services they were utilising. Other surveyed programs were frequently cited as including family physicians and "other programs" such as St. Joseph's Day Program, Hamilton Program for Schizophrenia, Chedoke Child and Family Services and East Region Mental Health Services.

More than half of the round two sample was resident in lodging homes (Table 5.3). A majority of these clients did not have a room to themselves. For all types of household activities, those in lodging homes assumed a lower
<table>
<thead>
<tr>
<th>TABLE 5.1. PERSONAL CHARACTERISTICS OF CLIENT SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>&gt; 35</td>
</tr>
<tr>
<td>&lt; 35</td>
</tr>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>Less than h.school 29 (50%)</td>
</tr>
<tr>
<td>Completed h.school 29 (50%)</td>
</tr>
<tr>
<td><strong>Monthly Income</strong></td>
</tr>
<tr>
<td>&lt; $399</td>
</tr>
<tr>
<td>$400-$599</td>
</tr>
<tr>
<td>$600-$799</td>
</tr>
<tr>
<td><strong>Income Sufficiency</strong></td>
</tr>
<tr>
<td>Sufficient 30 (50%)</td>
</tr>
<tr>
<td>Insufficient 26 (45%)</td>
</tr>
<tr>
<td>Don't Know 2 (5%)</td>
</tr>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Manic-Depressive</td>
</tr>
<tr>
<td>Schizo-affective</td>
</tr>
<tr>
<td>Personality disorder</td>
</tr>
<tr>
<td>Affective disorder</td>
</tr>
<tr>
<td>Drug-alcohol prob</td>
</tr>
<tr>
<td>&quot;Other&quot;</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

* Includes multiple responses

(none reported = 26)
TABLE 5.3. LIVING SITUATION CHARACTERISTICS OF SAMPLE

<table>
<thead>
<tr>
<th>Type of Living Situation</th>
<th>Privacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lodging Home</td>
</tr>
<tr>
<td>Parental family</td>
<td>3</td>
</tr>
<tr>
<td>Lodging home</td>
<td>31</td>
</tr>
<tr>
<td>Independent alone</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent conjugal</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>W/friends &amp;/or rels.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>YMCA/YWCA</td>
<td>1</td>
</tr>
</tbody>
</table>

58

Number Participating in Household Activities by Living Situation (n=58)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Lodging homes</th>
<th>Other situations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooking</td>
<td>1</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Cleaning</td>
<td>4</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>Laundry</td>
<td>9</td>
<td>21</td>
<td>30</td>
</tr>
<tr>
<td>Grocery shopping</td>
<td>7</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>Buying clothes</td>
<td>22</td>
<td>25</td>
<td>47</td>
</tr>
<tr>
<td>Banking</td>
<td>21</td>
<td>23</td>
<td>44</td>
</tr>
<tr>
<td>Medical appointments</td>
<td>24</td>
<td>25</td>
<td>49</td>
</tr>
</tbody>
</table>
level of participation than clients in other forms of accommodation.

Details of the social support available to the sample are indicated on Table 5.4. The range of participation in organisations included elements of the formal mental health system and all three types of community agencies identified by Pape and Church (1987) in their "map of the mental health territory". These are: opportunities specifically for the CMD; agencies catering to various groups encountering difficult life circumstances and organisations patronised by a wide range of citizens. Clients were asked to identify up to four important people in their lives. Most of the sample recorded two or three 'significant others' but a quarter could identify only one or none at all. These 'significant others' tended to be family, friends and professional caregivers. Excepting family relationships, the mean duration of relationship tended to be short. Almost 3/4 of the group indicated that their important relationships were less than a year old. Beyond family, important contexts for relationship formation were other living situations and formal aftercare programs. Residents of lodging homes, for instance, often mentioned a roommate or the manager as a person important to them. While a large proportion of 'significant others' were contacted on
TABLE 5.4. SOCIAL SUPPORT CHARACTERISTICS OF SAMPLE

<table>
<thead>
<tr>
<th>'Significant Others'</th>
<th>Context of first meeting 'significant others'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>Lodging home</td>
</tr>
<tr>
<td>Parent(s)</td>
<td>C.P.S.</td>
</tr>
<tr>
<td>Sibling</td>
<td>H.P.H.</td>
</tr>
<tr>
<td>Therapist</td>
<td>Care Centre</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>Other aftercare</td>
</tr>
<tr>
<td>Spouse</td>
<td>Church</td>
</tr>
<tr>
<td>Other caregiver</td>
<td>Work</td>
</tr>
<tr>
<td>Boy/girlfriend</td>
<td>At home</td>
</tr>
<tr>
<td>'Family'</td>
<td>Coffee shop</td>
</tr>
<tr>
<td>Other relation</td>
<td>Other</td>
</tr>
</tbody>
</table>

120

* Family significant others not included.

Mean period of knowing 'sig. others' per client

<table>
<thead>
<tr>
<th>&lt; 1 yr</th>
<th>1-2 yrs</th>
<th>2-3 yrs</th>
<th>4-5 yrs</th>
<th>5+ yrs</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>43</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

Total # 'significant others' per client

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>9</td>
<td>15</td>
<td>19</td>
<td>9</td>
</tr>
</tbody>
</table>

58
at least a monthly basis, it is notable that for a number of clients, their 'significant others' were seen and contacted "almost never".

Descriptive statistics on the lifestyle of sampled clients shows a high frequency of passive and solitary activities (e.g. T.V. and radio, reading and "just sitting around") enjoyed by the group (Table 5.5). In general, however, the list is not dissimilar to that which might be hypothesised for any similarly impoverished group. The total number of activities reported per sample member ranged between zero and six. Clients report a greater number of activities at the time of the second interview, undertaken during summer and early fall. This apparent shift in activity level between seasons is also borne out in data on whether clients thought they had enough to do. Regardless of time of year, however, a majority (c. 2/3) reported that they were sufficiently occupied in their free time. Among the important places within Hamilton nominated by the group, the preponderance of public, free-of-charge places is noticeable. Again, this finding is likely to be more representative of the material poverty of the sample than be related to the experience of mental illness per se. The appearance of the Care Centre in both lists is indicative of its importance for the inner city CMD, although this
### TABLE 5.5: LIFESTYLE CHARACTERISTICS OF SAMPLE

<table>
<thead>
<tr>
<th>Activities currently enjoyed</th>
<th>Principal important places in Hamilton</th>
</tr>
</thead>
<tbody>
<tr>
<td>TV/radio</td>
<td>Jackson Square</td>
</tr>
<tr>
<td>Sports</td>
<td>Care Centre</td>
</tr>
<tr>
<td>Reading</td>
<td>Coffee shop(s)</td>
</tr>
<tr>
<td>Walking</td>
<td>Library</td>
</tr>
<tr>
<td>Listening to music</td>
<td>&quot;Home&quot;</td>
</tr>
<tr>
<td>Going to Care Centre</td>
<td>Church</td>
</tr>
<tr>
<td>Art gallery, movies, library</td>
<td>C.P.S.</td>
</tr>
<tr>
<td>&quot;Just sitting around&quot;</td>
<td>Recreation centre</td>
</tr>
<tr>
<td>Crafts</td>
<td>Citizen's Action</td>
</tr>
<tr>
<td>Going for coffees</td>
<td>Work</td>
</tr>
<tr>
<td>Housekeeping</td>
<td></td>
</tr>
<tr>
<td>Resting, eating</td>
<td></td>
</tr>
<tr>
<td>Games</td>
<td></td>
</tr>
<tr>
<td>Church groups</td>
<td></td>
</tr>
<tr>
<td>Singing, playing music</td>
<td></td>
</tr>
<tr>
<td>Writing</td>
<td></td>
</tr>
<tr>
<td>&quot;Don't know&quot;</td>
<td></td>
</tr>
</tbody>
</table>

**Total activities reported per client**

<table>
<thead>
<tr>
<th># activities</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>2</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enough to do?</td>
<td>Yes</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>26</td>
</tr>
</tbody>
</table>

|                | 58      | 58      |

* includes multiple responses
response does involve an element of self-selection with a proportion of respondents being at least sporadic visitors.

5.4 Measures of community outcome

Measures of both objective outcome and client experience were available from data derived from the LMCQ. With respect to the former, clients reported any admissions to hospital over the previous two years in the course of the round one interview. This information was confirmed where possible with the primary care-giver and updated in round two to cover the intervening months. For members of the sample drawn from C.E.S. and C.P.S., medical records indicating hospital admissions were available under the terms of consent. For these groups, the self-report data obtained for hospital admissions provided one index for checking the validity of self-report information generally. At the Care Centre, while no records of members' medical histories are kept, the principal care-giver was able to check the accuracy of about two thirds of those interviewed.

The majority of clients in all programs offered information that concurred with formal records and the knowledge of their caregivers. Where available, records rather than self-report data on hospital admissions were
used in the subsequent analyses. In total, therefore, for each client the data contain the number of psychiatric hospitalisations over a two and a half year period. The mean for the sample was 0.7, with a range from zero to 6. Length of community tenure ranged from one month to 32 years since last psychiatric hospitalisation, with a median of 3.5 years.

Data derived from information concerning hospital admissions gave rise to two outcome measures. Readmission is defined as the number of periods in which a client has been formally admitted to a general or provincial hospital for treatment of mental illness. A related measure, community tenure, is defined as the duration a client has been resident in a community setting since the most recent hospital admission for mental illness.

Self-report measures of experience in the community environment were obtained using two six-point rating scales. One was worded in terms of coping ('coping very well' - 'coping very poorly') and the other made reference to level of satisfaction ('very satisfied' - 'very dissatisfied'). Clients provided both self-assessments for each of five dimensions of community life: social situation, living situation, community experience, employment and income. Generally, these were easily completed, although in
some instances clients had to be encouraged to discriminate between mid-range points on the scale. A third measure was obtained by having the principal care-giver use the coping scale to rate the client on an overall basis, as well as on four of the five dimensions. Living situation was excluded because of the lack of opportunity on the part of most care-givers to observe clients in a home environment. All ratings were obtained in both rounds of interviews.

Data obtained from these rating scales are described in Tables 5.6 through 5.8. Three tendencies are apparent. First, clients consistently rate themselves as coping better than they are satisfied. This observation affirms the distinction made earlier between ‘coping’, involving performance within an environment and ‘satisfaction’, dealing with appraisal of that environment or situation. In the present case, it may well be self-esteem that prompted a number of clients to see themselves as doing “very well” despite conditions they are less than satisfied with.

Second, a comparison of client and care-giver ratings for coping shows the latter group to demonstrate less variation in their ratings across dimensions. Observation of Table 5.8 shows that the most common caregiver rating is uniformly one of clients coping “fairly well”. A third observation is the trend in all three scales for the highest rating (i.e. “very
<table>
<thead>
<tr>
<th>Dimension</th>
<th>Very well</th>
<th>Quite well</th>
<th>Fairly well</th>
<th>Fairly poorly</th>
<th>Quite poorly</th>
<th>Very poorly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social situation</td>
<td>Round 1</td>
<td>11</td>
<td>21</td>
<td>10</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>(n=50)</td>
<td>Round 2</td>
<td>16</td>
<td>19</td>
<td>15</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Living situation</td>
<td>Round 1</td>
<td>13</td>
<td>21</td>
<td>10</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>(n=50)</td>
<td>Round 2</td>
<td>10</td>
<td>17</td>
<td>13</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Community experience</td>
<td>Round 1</td>
<td>17</td>
<td>17</td>
<td>19</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>(n=50)</td>
<td>Round 2</td>
<td>18</td>
<td>15</td>
<td>28</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Employment</td>
<td>Round 1</td>
<td>12</td>
<td>14</td>
<td>22</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>(n=50)</td>
<td>Round 2</td>
<td>16</td>
<td>20</td>
<td>12</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Income</td>
<td>Round 1</td>
<td>13</td>
<td>13</td>
<td>21</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>(n=50)</td>
<td>Round 2</td>
<td>12</td>
<td>15</td>
<td>19</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>Round 1</td>
<td>66</td>
<td>86</td>
<td>90</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>(n=290)</td>
<td>Round 2</td>
<td>80</td>
<td>86</td>
<td>79</td>
<td>19</td>
<td>11</td>
</tr>
</tbody>
</table>

(n= # observations)
<table>
<thead>
<tr>
<th>Dimension</th>
<th>Very sat</th>
<th>Quite sat</th>
<th>Somewhat sat</th>
<th>Somewhat dissat</th>
<th>Quite dissat</th>
<th>Very dissat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social situation</td>
<td>Round 1</td>
<td>6</td>
<td>18</td>
<td>17</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Round 2</td>
<td>10</td>
<td>15</td>
<td>12</td>
<td>7</td>
<td>-</td>
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<td>(n=58)</td>
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<tr>
<td>Living situation</td>
<td>Round 1</td>
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<td>17</td>
<td>19</td>
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<td>4</td>
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<tr>
<td></td>
<td>Round 2</td>
<td>13</td>
<td>15</td>
<td>16</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>(n=58)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community experience</td>
<td>Round 1</td>
<td>9</td>
<td>21</td>
<td>18</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Round 2</td>
<td>12</td>
<td>28</td>
<td>11</td>
<td>3</td>
<td>3</td>
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<tr>
<td>(n=58)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td>Round 1</td>
<td>10</td>
<td>12</td>
<td>3</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Round 2</td>
<td>12</td>
<td>10</td>
<td>12</td>
<td>9</td>
<td>4</td>
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<tr>
<td>(n=58)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>Round 1</td>
<td>4</td>
<td>9</td>
<td>11</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Round 2</td>
<td>7</td>
<td>6</td>
<td>12</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>(n=58)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Round 1</td>
<td>35</td>
<td>77</td>
<td>68</td>
<td>49</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Round 2</td>
<td>62</td>
<td>74</td>
<td>63</td>
<td>35</td>
<td>28</td>
</tr>
<tr>
<td>(n=290)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 5.8

CAREGIVER RATINGS FOR CLIENT COPING

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Very well</th>
<th>Quite well</th>
<th>Fairly well</th>
<th>Fairly poorly</th>
<th>Quite poorly</th>
<th>Very poorly</th>
<th>Unable to rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social situation</td>
<td>Round 1</td>
<td>4</td>
<td>16</td>
<td>29</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>(n=50)</td>
<td>Round 2</td>
<td>5</td>
<td>15</td>
<td>24</td>
<td>7</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Community living</td>
<td>Round 1</td>
<td>2</td>
<td>19</td>
<td>29</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>(n=50)</td>
<td>Round 2</td>
<td>6</td>
<td>18</td>
<td>19</td>
<td>8</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Employment</td>
<td>Round 1</td>
<td>1</td>
<td>19</td>
<td>28</td>
<td>9</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>(n=50)</td>
<td>Round 2</td>
<td>6</td>
<td>18</td>
<td>28</td>
<td>14</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Income</td>
<td>Round 1</td>
<td>3</td>
<td>13</td>
<td>25</td>
<td>18</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>(n=50)</td>
<td>Round 2</td>
<td>7</td>
<td>6</td>
<td>29</td>
<td>11</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>Round 1</td>
<td>18</td>
<td>67</td>
<td>183</td>
<td>28</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>(n=232)</td>
<td>Round 2</td>
<td>24</td>
<td>49</td>
<td>92</td>
<td>39</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

(n= # observations)
well", "very satisfied") to be more frequently assigned in round two (summer). This trend is not, however, evident across the full extent of any of the scales. The observation therefore lends only weak support to the 'seasonality hypothesis' which argues that coping and satisfaction are positively influenced by the more clement weather and easier living conditions of the summer months.

Scores on the assessment scales were combined to generate three composite indices: self-assessed coping; self-assessed satisfaction; and care-giver assessed coping. In the first two cases, ratings were summed across the five dimensions (i.e. living situation, social situation, general community experience, employment and income). In the case of care-giver assessed coping, ratings were not made for living situation, so the composite index in this case comprised a summation of four dimensions only. The composite scales used in subsequent analysis were thus calculated from both rounds of the interview data.

The test-retest correlations between the two sets of self-assessed scores (Spearman's rho: self-assessed coping, 0.68; self-assessed satisfaction, 0.53) is evidence of the capacity of this group to provide reliable self-report data. However these correlations are not strong. They likely reflect the six to eight month time lag between interviews
and the shifting circumstances and life experiences encountered by the group.

Conventional psychometric methods were used to check the internal consistency of each of the three composite indices. The Cronbach alphas were acceptably high: self-assessed coping (.87), self-assessed satisfaction (.82) and care-giver assessed coping (.82).

A precedent for the use of self-report measures in the context of the mentally disabled was established by Weissman and Bothwell (1976). Whereas their instrument focussed on specific aspects of social adjustment, the present emphasis on experience in the environment required measures tapping a broader range of information. The fact that coping assessments were obtained from both clients and their care-givers allows a comparison of the two sets of measures in a similar fashion to Weissman and Bothwell's comparison of key informant and self-report ratings.

5.5 Relations between measures of outcomes and experience

The correlations between the indices of experience, readmission and community tenure were calculated using Spearman's rho. Readmission and community tenure show the strongest correlation. This reflects the fact that they are
different, but closely related, measures of quantity of life in the community (Table 5.9). The correlations among the assessment scales are all highly significant (p < 0.01) and positive. Self-assessed coping and satisfaction have the strongest correlation. This confirms that clients rating themselves as coping well were also generally the more satisfied with their life situation.

The moderate correlation between self and care-giver assessed coping indicates general consistency in the ratings of the two, although the result conceals the fact that the care-giver rating was significantly lower than the self-rating (the Wilcoxon test statistic, Z = -2.37, was significant beyond the 0.05 level).

The correlations between the assessment scales, readmission and community tenure are weaker than the correlations among the assessment scales themselves. Self-assessed coping is positively related to readmission and negatively related to community tenure. The same relationships for the satisfaction scale are in the opposite direction. Care-giver assessed coping is not significantly correlated with either measure. In short, those more frequently hospitalised and therefore more recently back in the community rate themselves as coping better but less satisfied than other clients. An interpretation of this
<table>
<thead>
<tr>
<th></th>
<th>Self-Assessed Coping</th>
<th>Self-Assessed Satisfaction</th>
<th>Care-Giver Assessed Coping</th>
<th>Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Assessed Satisfaction</td>
<td>.55***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care-Giver Assessed Coping</td>
<td>.41***</td>
<td>.31***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission</td>
<td>.23**</td>
<td>-.23**</td>
<td>.11</td>
<td></td>
</tr>
<tr>
<td>Community Tenure</td>
<td>.23**</td>
<td>.22**</td>
<td>-.10</td>
<td>-.80***</td>
</tr>
</tbody>
</table>

*** $p < .01$

** $p < .05$

All statistics are Spearman's rho.
finding might be that the higher levels of coping reported by more recently discharged clients may be related to the level of support they receive through formal aftercare programs. Recent discharges may also feel a somewhat stronger compulsion to report coping well out of a desire to convince themselves and others that they can succeed in the community. The lower level of satisfaction associated with recent discharge may be the result of the disparity between clients' expectations of and experience in the community. This disparity frequently emerged in the free responses offered by clients in the course of interviews.

5.6 Relationships between outcome, experience and independent variables

The relationships between the measures of outcome and experience and 21 client and community variables listed in Table 5.10 were examined using appropriate non-parametric methods (Spearman correlation, Mann-Whitney U test). The 21 variables represent six components in the analytical framework (Figure 5.1): personal characteristics; psychiatric history and service utilization; social support network; living situation; and lifestyle.

Ten of the 21 variables used in the analysis show significant \( p < 0.1 \) association with at least one of the
<table>
<thead>
<tr>
<th>Variables</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOCIO-DEMOGRAPHIC FACTORS</strong></td>
<td># years</td>
</tr>
<tr>
<td>Age</td>
<td>1=female, 2=male</td>
</tr>
<tr>
<td>Sex</td>
<td># grades, college yrs</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
</tr>
<tr>
<td><strong>SOCIAL ACTIVITIES</strong></td>
<td># activities</td>
</tr>
<tr>
<td>Participation, solitary activities</td>
<td></td>
</tr>
<tr>
<td>Participation, social orgs</td>
<td></td>
</tr>
<tr>
<td>Time since last out of Hamilton</td>
<td>0=no, 1=yes</td>
</tr>
<tr>
<td>Enough to do in spare time</td>
<td></td>
</tr>
<tr>
<td><strong>LIVING SITUATION</strong></td>
<td># residents</td>
</tr>
<tr>
<td>Housing type</td>
<td>1=lodging home, 2=other</td>
</tr>
<tr>
<td>Own room</td>
<td>0=no, 1=yes</td>
</tr>
<tr>
<td>Number of residents</td>
<td># moves</td>
</tr>
<tr>
<td>Res. mobility, last 2.5 years</td>
<td>0=other, 1=central core</td>
</tr>
<tr>
<td>Neighbourhood location</td>
<td></td>
</tr>
<tr>
<td><strong>INCOME</strong></td>
<td>$s per month</td>
</tr>
<tr>
<td>Amount</td>
<td>0=no, 1=yes</td>
</tr>
<tr>
<td>Income supplement?</td>
<td>0=no, 1=yes</td>
</tr>
<tr>
<td>Sufficiency</td>
<td></td>
</tr>
<tr>
<td><strong>EMPLOYMENT</strong></td>
<td># yrs since last job</td>
</tr>
<tr>
<td>Status</td>
<td>0=unempl., 1=employed</td>
</tr>
<tr>
<td>Duration of unemployment</td>
<td></td>
</tr>
<tr>
<td><strong>PSYCHIATRIC HISTORY AND AFTERCARE</strong></td>
<td># services</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>0=non-schiz., 1=schiz.</td>
</tr>
<tr>
<td>Contact program</td>
<td>0=C.Centre, 1=CES/CPS</td>
</tr>
<tr>
<td>Total programs</td>
<td></td>
</tr>
</tbody>
</table>
five outcome and experience measures (Table 5.11).

Associative relationships with only weak significance (i.e. 
p = <0.1) are reported in order to maximize the descriptive value of the analysis, given that the small sample size reduces the likelihood of highly significant results. The results can be considered from two perspectives: first, variations among outcome and experience measures; and second, variations among the independent variables. Results will be discussed in that order.

A similar pattern of association emerges for community tenure and number of hospitalisations. Clients who have had a larger number of admissions to hospital and a shorter length of time in the community generally have the following characteristics: they are younger and less involved in solitary activities, report not having enough to do and are more residentially mobile. In addition, recent dischargees tend to be more involved in mental health services. Clients who have had fewer hospital admissions generally report higher incomes.

With respect to the three indices derived from the client and care-giver assessment scales, six variables are significantly associated with satisfaction compared with four for self-assessed coping and five for care-giver assessed coping. Given the conceptual differences between
<table>
<thead>
<tr>
<th></th>
<th>COMMUNITY TENURE</th>
<th>READMISSION</th>
<th>SELF-ASSESSED SATISFACTION</th>
<th>SELF-ASSESSED COPING</th>
<th>CARE-GIVER ASSESSED COPING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.44***</td>
<td>-21.***</td>
<td></td>
<td>.27**</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>-.16*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program participation</td>
<td>-.32***</td>
<td>.20*</td>
<td></td>
<td>.24**</td>
<td></td>
</tr>
<tr>
<td>Solitary Activities</td>
<td>.17*</td>
<td>-21.*</td>
<td></td>
<td>-2.3**</td>
<td>-1.8*</td>
</tr>
<tr>
<td>Significant others</td>
<td></td>
<td>.21**</td>
<td></td>
<td>.40***</td>
<td>.32***</td>
</tr>
<tr>
<td>Residential mobility</td>
<td>-.36***</td>
<td>.20***</td>
<td></td>
<td>-.38***</td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td>-.33***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yrs. since Last Job</td>
<td>.21*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>392.0*</td>
<td>375.0***</td>
<td>256.0***</td>
<td>313.0*</td>
<td></td>
</tr>
</tbody>
</table>

Sig level $p < 0.01 ***$
$p < 0.05 **$
$p < 0.1 *$

1 Spearmen's Rho
2 Mann-Whitney U statistic
coping and satisfaction, one would not expect their respective correlates to correspond exactly. The former emphasises the client's performance in a community setting whereas the latter focusses on subjective judgements about prominent aspects of the community environment. The results suggest that the more satisfied client is generally older, able to identify several 'significant others', not living in a lodging home, residentially stable, not a recipient of social assistance and reports having enough to do in spare time.

Clients reporting coping well in the community are less engaged in solitary activities, have a greater number of significant others, and consider that they have enough to do in their spare time. Clients rated as coping well by the care-giver have similar characteristics. In addition, these clients are the ones more likely to be involved in mental health services, to report receiving sufficient income and be less likely to be on social assistance.

When the results are examined in terms of the independent variables, no one variable or group of variables stands out as a stronger correlate of the outcome and experience measures. Certain findings do, however, merit specific comment. The significantly negative association between income and hospital admissions supports diverse
findings on the link between poverty and ill-health but, in keeping with an ecological perspective, leaves open the question of which factor more strongly determines the other. Connected with poverty is the potentially detrimental effect of boredom on client wellbeing, suggested in previous studies (Dear et al., 1980). This association is supported by the present findings. Those reporting having enough to do in their spare time give more positive satisfaction and coping ratings and are less likely to have been hospitalised in the past. An interpretation of this finding is that one may need to have been out of hospital for some time before finding enough to do. The positive effects of an active lifestyle, demonstrated earlier by Franklin et al., (1975) are supported by these results.

The correlations for participation in solitary activities show that the clients with the lower coping scores are those spending more of their time alone. This echoes the findings of Hammer et al. (1978) and Sokolovsky et al. (1978) concerning the impoverished nature of social networks among the CMD. The results also reveal significant association between significant others identified by the clients and all three assessment scales. The correlations are particularly strong for the two coping measures. This follows Smith and Smith (1979) in suggesting the positive
effect that close personal relationships have upon client well-being in general, and on coping performance in particular.

5.7 Multivariate relationships between experience measures and independent variables

The combined effects of client and community variables were examined using discriminant analysis (Overall and Klett, 1972). The objects of undertaking discriminant procedures in the present analysis are three-fold: first, to determine which of the assessments of experience are best predicted by an array of independent variables; second, to determine the relative strength of these client and community variables as predictors; and third, to profile the characteristics of the client groups. Groups were defined by dichotomising the composite scales at the median value into coping 'better' and 'worse', and 'more' and 'less' satisfied. This had the advantage of equalising group sizes but the possible disadvantage of defining groups on the basis of cut-points which have no particular substantive significance.

All but one of the discriminating variables, listed in Table 5.12, are drawn from those used in the preceding analysis. These are: age, sex, education, living situation,
TABLE 5.12 PREDICTOR VARIABLES USED IN DISCRIMINANT ANALYSIS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td>1 &lt; 34</td>
</tr>
<tr>
<td></td>
<td>2 &gt; 35</td>
</tr>
<tr>
<td>SEX</td>
<td>1 Female</td>
</tr>
<tr>
<td></td>
<td>2 Male</td>
</tr>
<tr>
<td>EDUCATION</td>
<td>1 &lt; high school</td>
</tr>
<tr>
<td></td>
<td>2 &gt; high school</td>
</tr>
<tr>
<td>EMPLOYMENT</td>
<td>1 Unemployed</td>
</tr>
<tr>
<td></td>
<td>2 Employed</td>
</tr>
<tr>
<td>LIVING SITUATION</td>
<td>1 Lodging home</td>
</tr>
<tr>
<td></td>
<td>2 Other situation</td>
</tr>
<tr>
<td>PROGRAM PARTICIPATION</td>
<td>1 No other programs</td>
</tr>
<tr>
<td></td>
<td>2 Other programs</td>
</tr>
<tr>
<td>LIFESTYLE INDEX</td>
<td>1 - 8</td>
</tr>
</tbody>
</table>

Components:
- # Important places
- # Significant others
- # Non-psychiatric circumstances
- # of acquaintanceship with sig. others
- # Organisations (total)
- # Non-network organisations
- # Daily gregarious activities
- # Weekday trips out of house
- # Weekday out-of-house interactions
employment status and program participation. A seventh 'lifestyle index' variable was created as a summary measure of selected social components of a client's lifestyle. This score was weighted according to a client's degree of social activity and integration into community life. Component items in the lifestyle index are: total reported 'important places', total organisational affiliation, non-aftercare organisational affiliation, number of gregarious activities, number of significant others, number of non-illness related circumstances of meeting significant others, total weekday trips out of home environment; and total weekday out-of-house social interactions. Scores for each of these variables were dichotomised at the median and a single score was added to the index for each client showing greater than the median on any one variable. The internal consistency of the index was considered acceptably high (K-R$\alpha$.20 = .69) to include this 'lifestyle index' in further analysis.

The discriminant procedure produces a classification of groups on the basis of how closely individual scores are located to the group centroids. The accuracy of classification provides an index of the discriminating power of the particular variables used in the analysis. A totally accurate classification would result in no misclassified clients. Results for the three analyses are discussed below.
5.7.1 Discriminant analysis I: Self-assessed coping

The first analysis using discriminant procedures deals with the sample grouped according to self-assessed coping (Table 5.13). The underlined entries indicate the percentage of cases correctly classified as coping better or worse. The high number of mis-classified cases in this and the following analyses point to the difficulties in selecting the median as break-point in distinguishing the two groups and may also reflect the explanatory power of the independent variables used. Overall, however, 71% of cases are correctly classified into their respective groups.

The use of the discriminant functions and coefficients allows a profiling of characteristics of individuals predicted as falling into the two groups. The profile for an individual predicted as coping better is: female, older, better educated and more involved in aftercare. The person coping worse is predicted as being: younger, male, less educated, unemployed and less involved in aftercare programs. Coefficients for living situation and lifestyle index were small, indicating a minimal contribution of these factors in determining group membership. The profiles are generally consistent with the bivariate results already reported and suggestions in the
TABLE 5.13. RESULTS OF DISCRIMINANT ANALYSIS I: SELF-ASSESSED COPING

<table>
<thead>
<tr>
<th>Group Means</th>
<th>std. discrim. coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping worse</td>
<td>Coping better</td>
</tr>
<tr>
<td>Age</td>
<td>1.5</td>
</tr>
<tr>
<td>Sex</td>
<td>1.7</td>
</tr>
<tr>
<td>Education</td>
<td>1.3</td>
</tr>
<tr>
<td>Employment</td>
<td>1.4</td>
</tr>
<tr>
<td>Living situation</td>
<td>1.5</td>
</tr>
<tr>
<td>Program participation</td>
<td>0.4</td>
</tr>
<tr>
<td>Lifestyle Index</td>
<td>3.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Canonical corr.</th>
<th>Chl-sq</th>
<th>F ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.47</td>
<td>13.29*</td>
<td>.91*</td>
</tr>
</tbody>
</table>

**Percent Cases Classified into Each Group**

<table>
<thead>
<tr>
<th>Actual group</th>
<th>Predicted</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (Coping worse)</td>
<td>18 (62%)</td>
<td>1 (38%)</td>
</tr>
<tr>
<td>2. (Coping better)</td>
<td>6 (21%)</td>
<td>22 (79%)</td>
</tr>
</tbody>
</table>

**Grouped cases correctly classified** 71%

\[ \chi^2 = 22^{***}, 1 \text{ d.f.} \]

**sig. levels**
- \( p < 0.01^{***} \)
- \( p < 0.05^{**} \)
- \( p < 0.1^{*} \)
literature as to the characteristics of this group.

5.7.2 Discriminant analysis 2: Self-assessed satisfaction

The second discriminant analysis was conducted to predict and profile group membership according to composite self-ratings of satisfaction (Table 5.14). Compared to coping, the percentage of correctly classified cases is reversed; fewer members of group 1 (less satisfied) and more members of group 2 (more satisfied) are mis-classified. The overall figure for correctly classified cases (69%) is similar to that for coping.

According to this analysis, a more satisfied client is predicted as being: older, female, better educated, not resident of a lodging home and having a higher score on the lifestyle index. Conversely, a less satisfied member of the client sample is characterised as being: younger, male, less educated, resident of a lodging home and having a lower score on the lifestyle index. In this analysis, coefficients for employment and program participation are not significant in determining group membership. The inclusion of the living situation among the predictor variables in this analysis of satisfaction is of interest. This supports the earlier finding that satisfaction is a dimension of experience more
TABLE 5.14. RESULTS OF DISCRIMINANT ANALYSIS 2: S-A SATISFACTION

<table>
<thead>
<tr>
<th>Group Means</th>
<th>Less satiis</th>
<th>More satiis</th>
<th>Std. discrim. coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.4</td>
<td>1.7</td>
<td>.77**</td>
</tr>
<tr>
<td>Sex</td>
<td>1.7</td>
<td>1.5</td>
<td>-.45</td>
</tr>
<tr>
<td>Education</td>
<td>1.5</td>
<td>1.4</td>
<td>.26</td>
</tr>
<tr>
<td>Employment</td>
<td>1.3</td>
<td>1.3</td>
<td>-.13</td>
</tr>
<tr>
<td>Living situation</td>
<td>1.4</td>
<td>1.6</td>
<td>.46</td>
</tr>
<tr>
<td>Program participation</td>
<td>0.6</td>
<td>0.5</td>
<td>.03</td>
</tr>
<tr>
<td>Lifestyle Index</td>
<td>4.3</td>
<td>3.7</td>
<td>-.33</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Canonical corr.</th>
<th>Chi-sq.</th>
<th>F ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.38</td>
<td>8.48</td>
<td>1.01</td>
</tr>
</tbody>
</table>

Cases classified into each group

<table>
<thead>
<tr>
<th>Actual Group</th>
<th>Predicted Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td>1</td>
</tr>
</tbody>
</table>

| 1 (Less satisfied) | 22 (71%) | 9 (29%) |
| 2 (More satisfied) | 9 (33%)  | 18 (67%) |

Cases correctly classified 69%

sig. levels: p < 0.01 ***
              p < 0.05 **
              p < 0.1 *
strongly related to aspects of the environment, whereas coping tends to be more a self-referential measure of performance.

5.7.3 Discriminant analysis 3: Caregiver-assessed coping

The third analysis involves the composite measure of caregiver assessed coping as the criterion variable (Table 5.15). In this analysis, only 53 of the 58 cases could be grouped, as a complete set of caregiver assessments was not available. In two cases, clients were not on the caregiver's caseload at the time of the second interview and in a further three cases, ratings were made by caregivers on all dimensions of community life excepting employment.

A smaller percentage of cases is correctly classified in this analysis (64%). The discriminating characteristics of a client assessed by caregivers as coping worse are: male, older, less educated, employed, more involved in aftercare and a moderate score on the lifestyle index. Conversely, the characteristics of a client predicted to be assessed as coping better are: female, better educated, unemployed, less involved in mental health services, lower score on the lifestyle index.
### TABLE 5.15. RESULTS OF DISCRIMINANT ANALYSIS 1: C-G ASSESSED COPING

<table>
<thead>
<tr>
<th>Group Means</th>
<th>Coping worse</th>
<th>Coping better</th>
<th>Std. discrim. Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.6</td>
<td>1.5</td>
<td>-.03</td>
</tr>
<tr>
<td>Sex</td>
<td>1.7</td>
<td>1.6</td>
<td>-.16</td>
</tr>
<tr>
<td>Education</td>
<td>1.4</td>
<td>1.3</td>
<td>.20</td>
</tr>
<tr>
<td>Employment</td>
<td>1.2</td>
<td>1.3</td>
<td>.57*</td>
</tr>
<tr>
<td>Living situation</td>
<td>1.6</td>
<td>1.5</td>
<td>-.11*</td>
</tr>
<tr>
<td>Aftercare</td>
<td>0.5</td>
<td>0.7</td>
<td>.64*</td>
</tr>
<tr>
<td>Lifestyle Index</td>
<td>3.9</td>
<td>4.5</td>
<td>.16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Canonical corr.</th>
<th>Chi-sq.</th>
<th>F-ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.35</td>
<td>6.21</td>
<td>.57</td>
</tr>
</tbody>
</table>

**Cases classified into each group**

<table>
<thead>
<tr>
<th>Actual group</th>
<th>Predicted group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Coping worse)</td>
<td>18 (62%) 11 (38%)</td>
</tr>
<tr>
<td>2 (Coping better)</td>
<td>8 (33%) 57 (66%)</td>
</tr>
</tbody>
</table>

Ungrouped cases: 5

**Grouped cases correctly classified**: 64%

\[ X = 4.87^{**}, 1 \text{ d.f.} \]

**Sig. levels**: p < 0.01 ***  
p < 0.05 **  
p < 0.1 *
5.7.4 Multiple regression analysis

A limitation of the discriminant analyses is that creating criterion groups about the median is based more on technical concern for equal group size than on substantive differences in coping or satisfaction. One might therefore expect those cases located close to the median to be prone to misclassification. However, the overall sample is too small to allow the use of other cut-points.

As a means of addressing this concern, step-wise multiple regression was performed using the same three dependent variables, now operationalised as scores on the composite scales. The same array of independent variables was used. The results, shown in Table 5.16, indicate that for two of the three analyses, there is some consistency with previous findings in the variables that emerge as predictors. As in the discriminant analyses, age and aftercare emerge - albeit weakly - as predictors of self-assessed coping while age and living situation predict self-assessed satisfaction. This concurrence between findings obtained by the two multivariate techniques therefore reduces concern that the cut-point used in discriminant analysis produced artefactual results.

The equation for self-assessed coping was weak. The
### TABLE 5.16. RESULTS OF MULTIPLE REGRESSION ANALYSIS

<table>
<thead>
<tr>
<th>Dependent Var.</th>
<th>Regression Equation</th>
<th>P</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTCOP</td>
<td>37.6 + 0.15 (age) + 2.69 (aftercare)</td>
<td>.27</td>
<td>.07</td>
</tr>
<tr>
<td>TOTSAT</td>
<td>23.4 + 0.26** (age) + 3.87* (living sit.)</td>
<td>.36*</td>
<td>.13</td>
</tr>
<tr>
<td>TOTASS</td>
<td>29.6 + 0.68** (Lifestyle Index)</td>
<td>.29**</td>
<td>.08</td>
</tr>
</tbody>
</table>

**Significance level**

- *p < 0.01***
- *p < 0.05***
- *p < 0.1***
best equation contained two variables - age and aftercare - suggesting that those coping better were older and more involved in mental health services. Age and living situation appear as significant components of the equation for self-assessed satisfaction. This confirms that those more satisfied are generally older and living in other than lodging home situations. The only variable to enter the equation for caregiver-assessed coping is the lifestyle index. Components of this index (see Table 5.12) are all observable aspects of integration into the community. The result of this analysis implies the degree to which caregivers' assessments of coping may be based primarily on their observations of behavioural performance.

5.8 A coping satisfaction matrix

Previous bivariate analysis shows quite strong support for considering coping and satisfaction to be two distinct dimensions of community experience. As criterion variables, self-assessed coping and satisfaction were demonstrated to be reasonably well discriminated by a set of predictor variables. By combining these composite measures, individual cases were assigned places on a 2x2 coping-satisfaction matrix (Figure 5.3). The object of this
<table>
<thead>
<tr>
<th>HIGH</th>
<th>LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>Cell 4</td>
</tr>
<tr>
<td></td>
<td>N = 20</td>
</tr>
<tr>
<td>LOW</td>
<td>Cell 2</td>
</tr>
<tr>
<td></td>
<td>N = 7</td>
</tr>
<tr>
<td>LOW</td>
<td>Cell 3</td>
</tr>
<tr>
<td></td>
<td>N = 9</td>
</tr>
<tr>
<td></td>
<td>Cell 1</td>
</tr>
<tr>
<td></td>
<td>N = 22</td>
</tr>
</tbody>
</table>

Figure 5.3 A Coping-Satisfaction Matrix.
exercise was two-fold. First, from this assignment a new dependent variable (CSMAT) was created for use in further multi-variate analysis. Second, the assignment of cases to quadrants on the matrix provides a basis for identifying logical subgroups from which the characteristics of representative individuals can be examined in subsequent analysis. The consistency of group membership in quadrants of the matrix over time was tested ($\chi^2 = 18.4$, $p = 0.03$) and high coping-high satisfaction and low coping-low satisfaction quadrants were found to be most stable between rounds of interviews. Overall group membership was shown to be highly consistent.

Discriminant analysis was performed using the four groups defined by the quadrants of the matrix as the criterion variable. Potential predictor variables were the same set used in previous analyses. No client and community variables significantly predicted membership in the matrix subgroups and hence the results are not tabulated. Fifty percent of the cases across the four groups were correctly classified, indicating that although no single variable emerged as a significant predictor, in combination the variables discriminated among the groups beyond the level expected by chance alone (i.e. 25% correctly classified).
5.9 Summary

This chapter has described and applied a framework for studying measures of community outcome and experience for the CMD that is developed from the socio-ecological principles introduced in Chapter Two. The framework (Figure 5.1) brought together those factors suggested by the literature as influencing community life for the CMD. The framework emphasised the interconnectedness of these factors and served to guide analysis. The characteristics of the client sample were described and attention focussed on measures of both conventional subjective outcomes and objective outcome and client experience. The latter were analysed in composite form, using both bivariate and multivariate techniques.

The chapter has contributed to the study of community life for the CMD on both methodological and substantive levels. This analysis shows that self-assessment measures can provide reliable indices of coping and satisfaction, two dimensions of community experience. The results follow those of Weissman and Bothwell (1976) in demonstrating significant correlation between self-report and trained observer ratings.

The framework (Figure 5.1) and subsequent analysis
have allowed a formalising of the links that were proposed in an earlier study (Dear et al., 1980) as influencing community experience. The profiles obtained through bivariate analysis describe subgroups of clients for whom there may be a particular need to target aftercare services. Of particular relevance are the associations between coping and satisfaction and such aspects of the psycho-social environment as the presence of significant others and having enough to do. The importance of social/recreational aftercare programs in enhancing the post-hospital environment for the CMD demonstrated in earlier studies (e.g. Fisher et al., 1981) is supported by the present findings.

The pattern of these associations was further explored through use of multivariate techniques. The three discriminant analyses performed allowed a clear recognition of discriminating variables. Clients with positive outcomes tended to: be older, female, completed high school, not living in a lodging home, employed and more involved in aftercare. Those with lower coping and satisfaction assessments tended to be younger, resident in a lodging home, unemployed, have less than a high school education and be unconnected to forms of aftercare. This group also tended to register lower scores on the lifestyle index. These
results conform with earlier findings that suggested differential vulnerability of certain subgroups of the CMD (e.g., Cheadle et al., 1978; Christensen and Havellwala, 1978; Lamb and Goertz, 1971). The description of those with lower assessments also mirrors recent descriptions of the "young adult chronic" population (e.g., Segal and Baumhol, 1982; Bachrach, 1982b).

Discriminant analysis indicated the combination of characteristics that distinguish those with positive and negative community outcomes. The results confirm the interconnectedness of client and community variables as determinants of coping and satisfaction among the CMD. From the pattern of discriminant coefficients, it can be postulated that: first, personal characteristics (i.e., age, sex, education) broadly shape opportunities and perceptions; second, participation in activities — whether these be employment or aftercare — better predict self-assessed coping; and third, a client's lifestyle — including residential status — acts to predict self-assessed satisfaction. Multiple regression provided an extension of the analysis, indicating the strength of particular variables, including living situation and lifestyle in determining coping and satisfaction indices. As emphasised earlier, the small sample size necessarily limits the
confident we can place in the observed trends arising from multivariate analysis.

The quantitative analysis presented in this chapter is a necessary but not sufficient stage in the examination of the community life for the CMD in Hamilton. A return to the individuals who comprise the client sample represents an important extension and completion of analysis.

1. For the Mann-Whitney U test, the directions of the relationships are based upon a comparison of the mean ranks which are not reported.
CHAPTER SIX
GETTING BY: THE EXPERIENCE OF BEING MENTALLY DISABLED IN HAMILTON

This chapter presents the human face of the client sample by focussing on the perspectives of individual members as they describe their everyday life. Narrative accounts gathered in the course of interviews comprise the evidence that will be analysed to complement the quantitative approach taken in the preceding chapter. This shift in emphasis is important, for in the last chapter the treatment of subjective experience as an outcome involved clients rating but not naming the nature of that experience. The aim in this chapter is to present 'insider' perspectives on the experience of being mentally disabled in Hamilton. This task is undertaken by means of profiling representative clients, presenting accounts of the community experience of the sample, analysing their use of time and space and describing their experience of what helps and hinders their coping in the city.

In the first section, four clients will be introduced and their community experience will be conveyed using, as far as possible, their own accounts. The second section focusses more explicitly on the clusters of client and
community variables identified in the literature and used in the preceding analysis. Accounts will be presented as textual data which will be analysed as spoken evidence. The third section will undertake a closer examination of the structure of everyday life for the CMD by means of time-budget analysis. The type and duration of activities will be considered at both aggregate and individual levels of analysis. In the fourth section, the respondents' own views of coping experience will be considered. The fifth and final section will undertake a synthesis of the contribution to understanding made by this approach and findings.

6.1 Oral histories from the psychiatric ghetto

This section introduces four members of the client sample, as far as possible, in their own words. A frequent criticism in the use of particular respondents as spokespersons for a sample centres on the question of representativeness. To address this issue, individuals have been chosen according to their place on the coping-satisfaction matrix introduced in Chapter Five (see Figure 6.1).

Construction of separate matrices for data derived from each of the two rounds of interviews has facilitated identifying whether individuals made a positive, negative or...
Figure 6.1 Location of client sample on Coping-Satisfaction Matrix.
no shift in terms of quadrants. Among the profiled clients, Larry (low satisfaction/low coping) and Kate (low satisfaction and high coping) showed no change between interviews. Matt (high satisfaction/low coping) and Jane (high satisfaction/high coping) both demonstrated a positive shift in their self assessments between interviews.

These four clients have been chosen as spokespersons for the sample. In any group some individuals are more articulate and forthcoming than others and in this section, Larry, Kate, Jane and Matt have been chosen for their ability to speak from their personal perspective, but of a wider collective experience of being CMD in Hamilton. Although they were chosen from Figure 6.1 in order to bestow a representativeness and variability to their voices, they are not centrally located in their respective quadrants. This bespeaks the fact that their ability to provide narrative accounts was judged more important than absolute representativeness. The two clients Larry and Kate are clearly 'outliers' on Figure 6.1 but were consciously chosen for their ability and openness to articulate daily life experience. Indeed, it might be postulated that their expression of emphatic dissatisfaction and subsequent 'outlier' status on the matrix is related to their ability to formulate and forcefully express opinions about their
experience.

6.1.1 Larry

Seven years ago, Larry, who is 34, experienced the onset of schizophrenia and became separated from his wife and child. He has an honours science degree and prior to his illness had been offered scholarship support for graduate work. He now has little contact with his family.

As far as they're concerned, I'm a failure. No one's really important except my former wife and I can't see her. I can see my son once a month but often I don't because I'm too depressed.

I'm rapidly approaching a complete will to suicide. The mood elevators help, but they aren't entirely effective. A lot has to do with my life before 1978. After that I can't really handle anything else. Knowing the contrast makes you know the nature of reality. But I guess I'm lucky to have had the life I did until 1978.

Larry's institutional experience has been one of multiple hospital admissions over the last seven years. He is very much a loner, citing only his ex-wife and son as significant - though rarely seen - others. With respect to other friends, it depends what kind of friends you're talking about. There's the Wesley Centre. But for some reason half the guys there like beating people up. Part of my condition is being paranoid so I don't go there anymore. It's more for the outer fringe of society.

The paranoia associated with his illness combined with a
higher education lead him away from usual points of con
cgregation for the mentally ill and towards more solitary 
Sources of connectedness.

I work with Amnesty International by mail. I'd like to send money if I had some to spare. Sometimes I can really visualize the circumstances. Oppression is the worst crime. You have to know it before you can really relate.

Larry's disillusionment with regard to his lack of income, employment and suitable living conditions is a refrain in his narratives.

I spend a lot of my time on my favourite bench on King St reading. Sometimes I wish there was more to do.

I'm lucky in a way to be on disability. I remember living on $250 a month. It was worth the doctor saying I couldn't work any more. But it's still tough. Just some way of getting first and last month's rent. That would be a great step for ex-patients.

I like nothing about my life as it is. But spring is great. Thank God that doesn't depend on mankind. Every time it comes along it's great. I'm depressive so winter gives me severe problems. It's miserable I'd hitch out to Vancouver every year if I could, but I'd lose disability that way.

When initially interviewed, Larry was living in a single room in the central city. At that time, he said

I'm depressed because I'm not living where I'd like to be. My housing conditions are awful. Always have been in recent years. The rooms are always small. They're never well looked after. We're packed in like rats. There are mice and bugs where I'm living now. I never seem to be in a place I really want. I always get tired of places, so end up going to another one.
hoping it will be better. But it isn't, so I move on. It makes it worse because I'm used to better conditions. Right now I'm on Wellington. There's too much traffic and it's a slum. I just sit there and feel I'm just totally in the wrong place.

Seven months later, he had moved to an East End lodging home.

If I had a choice based on location, I'd stay here in Stoney Creek. But it's the social circumstances where I live that are driving me out. Public health rules in these places are OK but I don't need a den mother telling me what to do. I should be able to live in a one bedroom apartment so my housing needs aren't being met right now. I'd have enough for first and last month's rent—but that wouldn't leave any for food or clothing.

Larry reflected upon his transient lifestyle, and pointed to the powerlessness of his situation:

I've been on the move for the last 7 and a half years. Most mental patients don't have much control over their environment, no sense of domain. And the thing is, a mental patient needs more space than a healthy person.

For periods, Larry has spent time homeless, both in the Hamilton area and in British Columbia.

I like living outdoors sometimes. I lived mainly up on Stoney Creek mountain one summer. I lost a lot of weight but got on OK. Most people leave a lot in garbage cans.

There are hostels but people are rough. People will kick you up. If you want freedom, it's best to get out of the city. But the only way to eat is out of cans. You can't collect welfare if you don't have a place. So I've depended on my parents place for the address. But the problem is my parents will be dead in five years so I'd better keep an address myself.
I lived out for nine months in 1981. I had no money and was heavily schizophrenic. Ended up back in hospital. You know, I needed to go in but not just for the illness. Then in 1982 I lived four months in the Dundas area and in the city. It wasn't as good as Stoney Creek. Once in a while the police would check up and I was beaten up for bumbling.

Daily life is marked by a quest for places of refuge.

If I'm in Stoney Creek, I enjoy wandering on the country roads. I'm naturally paranoid, so that affects things. But here in the city it's not just feelings. It becomes rational to be paranoid. I spend much of my time just looking for safe places. I spend a lot of my time at the library. It's the only real drop-in in town unless you're really on the fringe. It's cool in the summer, warm in the winter and there's plenty to occupy the mind.

Larry's response to the question of how he copes in the community provides an impassioned indictment of the status quo:

There is no coping with the way it is. I have to work around knowing the wrongs of society and yet still live. You know it's pretty value laden to ask about coping. Best ask society how they're coping with people like me. We are what society's really like inside.

Are you asking me how I'm coping with the system? I can't cope with the system. People need work and I mean meaningful work. Not stuff that's a sham. In a better society I'd have a lot to do. I'm wasted in this one. I'm a violation of the basic standard all Canadians should be living by. People think it's the standards of those at the top of society that make the quality of society. Well it's not. It's how the people at the bottom are doing that counts. And there are a lot of us.
Kate is a 40 year old who spent seven months in HPH during 1985. She agreed to be interviewed at the Care Centre three months after discharge from hospital. For Kate, the hardships experienced in the community are more than compensated by the sense of freedom being out of hospital brings.

I don't want to depend on someone else to look after me. I don't like being treated like a child. I can't cope with that. I can't live like that. Even if I go without eating, somewehs I don't care. It's alright once you've got out of hospital. I can't cope with someone in control of me.

Upon discharge, Kate was placed at the Industrial Therapy (I.T.) workshop attached to H.P.H.

I'm an outpatient so they put me in the program for I.T. You make 51 cents an hour but I got tired of that. Haven't been doing it for a month now. I've been coming here (the Care Centre) and the days have been getting boring. I think I'm going to go back.

While she considers herself to be coping well with the freedoms offered by community life, she is far from satisfied:

I like nothing about the way things are. Absolutely nothing. Nothing interests me. I just watch T.V., that's all. There's piss-all to do in this town. The only solution is go back to I.T. for something to do. I just come here and watch T.V. at the house. I have spare time all the time and that's what I'm getting tired of.

Like Larry, Kate has little contact with family.
My mother lives in the West End but I don't see her. I don't know who my father is. I only see my brother John. Only see him if he's drinking and I don't drink that often. So I've only seen him once since I got out of hospital. I have a daughter, but she's no help. She thinks I'm going. I don't see her too often. That's probably best. I might get violent with her.

Her social contacts are largely with other people with severe mental disabilities.

I don't really have any friends in the city. But I go up to H.P.H. to get pills and see friends there. It doesn't bother me. I buy people coffee if I can. I know what it's like being there with no money. Then I met Mary at I.T. She told me about the Care Centre. She was in H.P.H. 20 years. I like the Care Centre. If I've got no money I can still come here looking like a mess.

Attitudes in the community bother Kate.

People have a strange reaction towards you if they find out you've been mentally ill. Today I saw a friend on the bus and he just got up and left. I feel people don't want to have me around because I've been mentally sick. Too many people don't understand. People who know I've been sick. It makes me so mad I feel like getting violent with them.

Kate moved eight times in the two years preceding the second interview.

Well at least I got out of hospital into a boarding house. I live on Herkimer. But I don't like the West End. I'd sooner be living here (Victoria Ave). Everything's far away. You're not close to anything. I'd like to get my own place and share it with someone else. I don't want to live by myself.

Her most recent move was from a lodging home into a single room with a companion. To this extent, she fulfilled a goal.
using a lodging home as a stepping stone.

I want to get disability but they say I'm still getting money from my ex-husband. Well I'm not and it's tough. I stayed with a friend called Bill but he kicked me out because I wouldn't go on his cheque. I don't want to depend on a man for food and clothes. Then I stayed on West Avenue for five weeks but that guy kept bugging me for sex. Then I stayed at a boarding house on Wellington. It's a real rat-hole and supposed to be only for men. The landlord was pretty understanding. But I couldn't stay there long. It's enough to make you kill yourself. Now I've got a friend called Rick and he's OK. We got a room with his income tax cheque. We're buddies.

6.1.3 Matt

Matt is a 52 year old father of two and former professional. Although his struggle with mental illness and alcoholism led to family disintegration, he is now reasonably satisfied with his life in Hamilton.

Everything's here I'll ever need. We're darn lucky, that's what I say. Look at how bad things are in New York City or Boston or somewhere. There are all kinds of facilities here - more than I realised. But I've observed that a lot of former mental patients I either met at H.P.H. or since I was there have a very low energy level. I'm baffled by this. They're just not motivated to get their lives together. To make the most of what they've got.

Matt has evolved a comprehensive network of social support through his consistent attendance at the Care Centre, coffee shops, Alcoholics Anonymous meetings, an inner city church and the canteen at H.P.H.
I have a lot of sources of socialising. I take delight in going to A.A. meetings. All the shaking of hands, it gives everyone a lift. It's better than sitting and looking at the boob tube. I'm not trying to impress people going to all these things. But you know it gives me a good state of wellbeing.

The girl at Tim Hortons, she's just great. She's just a kid but she's a great listener. You tell her something and she'll give you feedback. She'll never tell you you're an asshole like some do. She's very compassionate. There's a lot of people like that who'll tell me what I want to hear. But you've got to look for them. Coffee shops are good. I've been going to two other Tim Hortons and Uncle Tommys about daily for two years now.

Elaine at the Care Centre is pretty important too. She gives me comments and advice that's helpful. I don't need to feel any embarrassment about anything.

Then there's Reverend Black, the minister at church. I've been going there 2 years. We have Sunday night Bible discussions. Usually it's just a bunch of old ladies. I throw questions at him like "why is there so much hate in men today".

I go up to the canteen at H.P.H. and visit the staff and patients. Some I've known ten years. It's a good experience for me to go back up there and visit occasionally, though I did have bad times up there. They're not crazy you know. They haven't lost all feelings. They like to see an old face once in a while. I'd like to see some of those people join us in the community.

While Matt sees the Care Centre as an important part of his "world", he is also acutely aware of its limitations as a meeting place.

I first went to the Care Centre because I knew a lot of guys there - from H.P.H. and the boarding homes. But it was mostly guys. Now I go there more
often. There are young guys and girls I can unload on. I like going there to kid around with them. I have the welfare of all those people at heart. I say that if you’re happy you should show it and people will pick up on it. But too many people just sit there. There’s more going on at coffee shops I think sometimes. They just play cards instead of talking about interesting subjects. There’s too much gangling up on people going on. All the clients want to feel important, but they lack self esteem — so they want to have a fight. They feel no good and think the (staff) girls don’t like them. That’s not true but in the end they kick the shit out of each other.

Like Kate, Matt finds that public attitudes are at times bothersome. In his case, severe tardive dyskinesia makes Matt more visibly ‘different’ in public.

Sometimes young guys call me names like faggot. I wish they wouldn’t say things when they don’t know me. Sometimes I feel angry and feel like shouting back.

Matt has lived in his present inner city lodging home for 18 months now, and finds that this environment suits him.

It’s good to have a roommate who’s out at I.T. all day. It gives me the time on my own if I want. You need that to write letters and read. But no one needs too much solitude. It’s good to have a roommate too. He’s a swell guy. I met him on the wards. He laughs at my jokes and when he’s down, I play the harmonica and that puts a smile on his face. But he doesn’t get out enough. You can’t make someone. But I’m always hoping he’ll get out more like me.

The landlady’s a caring person. Just like my mother when I was growing up. If anyone’s off their appetite, she says “you shouldn’t be like that. You should go to the doctor.” Some ex-patients are in a half-way house but mine’s a 100% house.

With respect to his lack of employment and small
amount of money, Matt seems resigned to "getting by".

I tried for a job but there's little hope at Citizen's Action or Manpower. I used to be an electrical engineer but now I'm too content to have a job. There aren't too many jobs anyway.

I'm fortunate in having friends who'll loan me some cash when I'm out of cigarette or coffee money. I always write down the amount and pay them back. When I compare myself to people in Ethiopia, things are great and I'm satisfied. But compared to the rich in this city, I'm not satisfied at all. I wish I was working part time sometimes. So I'd have more money for cigarettes and coffees. I'm too dependent on others' generosity and I don't like it. It feels better when you're feeling self-reliant.

Matt is enthusiastic in the face of difficult circumstances, but still thinks he could be doing better.

It's a zest for life that keeps me going, a certain enthusiasm for being alive that I didn't have as a hospital patient. If you're going to find life boring, you're going to have difficulties coping.

6.14 Jane

Jane is 29 and one of the few sampled clients who is married. Jane has had 10 psychiatric hospitalisations over the last 10 years. For her, life has changed since participating in the St Joseph's Day Program and this was reflected in a positive shift on the coping-satisfaction matrix between interviews.

I don't like being "unable" to work. The Day Program helped. It gave me something to do. I used to just walk around and eat donuts. The Day Program has had a lot of good suggestions. Just staying in the apartment will drive anyone insane. I don't go to the Care
Centre - they're just a bunch of bums. They just go there to bum cigarettes and coffee. My husband went there once.

Whereas most clients have lost ties with former friends and family, Jane maintains connections with her hometown. This appears to compensate for the difficulties of establishing new friendships.

I go back to Brantford on the bus sometimes. I've never broken up with school friends. They accept me as I am. Here in Hamilton, I have friends from H.P.H. who come over for coffee once in a while. It's kind of hard making new friends. If you've been ill, you stay ill. You're identified. You're recognised on the street by other ex-patients from H.P.H.

Since being deemed eligible for the disability pension, her ability to access resources in the community has increased.

I can go to the Y for nothing. If you have welfare behind you, you can get away with anything. If I had more money, I'd go up to Brantford more to see my family. The bus isn't cheap. I'd buy clothes and make up. Maybe even have a vacation.

6.1.5 An Interpretation of the narrative accounts

The voices of these clients touch upon consistent themes of concern in the welfare of the CMD. Both Larry and Matt are people whose current lives sharply contrast their situations prior to the onset of mental illness. Then they had employment opportunities, spouses and families. The discontent is much sharper in Larry, consistent with
descriptions in the literature of the 'young adult chronic' population. The characteristics of Larry epitomise this group - single, unemployed, transient and discontent. With respect to social support, Kate and Matt both congregate with others with severe mental disabilities and live lives more anchored in the inner city than Jane and Larry. These latter two clients move beyond the ghetto in different ways - Larry by spending time alone on the outskirts of Hamilton and Jane by maintaining ties with her hometown.

Larry's homeless periods have not been for lack of somewhere to live, but rather because the conditions he could afford were unacceptable to him. His comment that most of the CMD have "no sense of domain" captures the rootlessness and powerlessness that marks their lives. Larry's paths through the city are an evasion of the public eye, "just looking for safe places". In the language of time geography, the changes in his life path with the onset of mental illness have markedly shaped his daily paths. In contrast, Matt has evolved purposeful paths, scheduled so that he is active through nearly all his waking hours - early morning at a coffee shop, during the day at the Care Centre, a weekday evening at an A.A. meeting and at church on the weekends. Matt is empowered by the positive interactions he finds in these circumstances and this
appears to overcome the feeling of being confined by poverty to the central city.

For Kate, social contact lies largely back at H.P.H. or at the Care Centre which for many is a hospital outpost where 'immigrants' to the community gather. Aside from socialising, Kate has little to do. The token earnings at I.T. are insufficient inducement to be enthusiastic about the structured lifestyle it offers. The harassment she encounters on her housing search is not atypical for the single female ex-patient. Her story is contrast to that of Jane whose spouse, links with home and fresh ideas from the Day Program underlie her positive self-assessment. Difficulties of poverty and stigma are moderated by these sources of self-esteem in her life.

6.2 Insider perspectives and community life

This section explicitly examines the influence of the sets of client and community variables identified and analysed in Chapter Five on the lives of sample members. The narrative data allow examination of the hypothesis that clients' experience of both space and time is shaped by forces located well beyond their own agency. For the majority who are not employed, life in the community grants them relatively unconstrained time in the context of highly
constrained activity space. This theme will be explored by considering narrative data sets grouped around the seven sets of variables identified on Figure 5.1.

6.2.1 Personal characteristics

Employment

The trouble is our entire society is geared to working people

I lost my job and I’ve tried everything. The Help Centre, the Manpower board, newspapers, the yellow pages, door-to-door. It’s hopeless.

Sometimes there’s the odd dollar to make clearing the snow in the neighborhood. On a good snowy week I can make $10-15. But this is a bad year for snow. Last summer I made some money strawberry picking. It wasn’t much but it was better than doing nothing.

I’m happy, I guess. I accept it. My greatest skill is talking to people. So I might as well enjoy it. If there’s nothing but I.T. then what’s the point in looking?

Well there’s I.T. But it’s not really industrial. More like a packing plant with no pay.

I just want to get some hard work and get adjusted. Not Mickey Mouse work. There’s no pride in that.

Four and a half years ago I was a Bell Canada operator and loved it. But then the system changed and they didn’t need me. Two years ago I was a short order cook for two days but couldn’t cope. March last year I was in the R.N.A. (Registered Nursing Assistant) program but dropped out. So last summer I was a volunteer here at St Joseph’s filling ice water glasses on the surgical ward. It was great. I enjoyed helping the elderly.

Those who accept disability assistance forego the
possibility of employment, but are able to participate in sheltered workshops. The tokenism of these options is keenly felt by some. For many CMD, those in society who are competitively employed remain the yardstick by which self-worth is measured. Some are cheerfully resigned to being not so much unemployed but unemployable. For others, the possibility of volunteering presents a meaningful alternative. While not bringing needed remuneration, this does enlarge a person's activity space through role redefinition and helps to meaningfully deal with their otherwise sparsely filled days.

Income

I'd buy more clothes if I had the money. Right now I have no chance of a job. If you go for an interview, you should look-good.

I need decent clothes. All I've got is what people have given me.

Basically we have enough money. But that's very basic. It's rough. There's no room for luxuries like Christmas presents.

It's not enough. It's just cigarette money.

They give us $2.50 each morning and I buy coke, chips and cigarettes. Then I bum cigarettes and coffee money. People are generous.

I usually run out. But it doesn't bother me much. It's tough but you learn to live with it. I don't like drinking and movies anyway. But I do like smoking and coffee. You learn to think of things that
don't cost much. Tim Hortons Is like a second home.

I get by. I tend to keep friends who can buy me coffee.

If I run out I can usually find money in the street. You know, phone booths, newspaper stands. I can even make tips by running errands for Care Centre people.

It's hard to do much around this town if you don't have any dollars. It's impossible. And they expect you to live on $77 a month. I mean it's not that anyone's looking for handouts or anything. If someone were to come and offer me a constructive way of living my life, then I would take it. I can't stand sitting around hoping when you should be out doing.

Poverty is a central influence operating to maintain the spatial constraints and temporal vacuum experienced by most of the CMD. Lack of money indirectly detracts from physical appearance, and as one client points out, this in turn restricts chances of employment. Poverty is a centripetal force drawing clients towards public and inexpensive points of congregation where privacy and self-esteem may well be compromised. The ironically termed "comfort allowance" of $77 issued to lodging home residents is clearly inadequate and promotes bumming and borrowing — further assaults on self-esteem. Material poverty therefore contributes to the emptying of clients' days of meaningful activity and restricts movements to well-worn paths and meeting places in the city.
6.2.2 Psychiatric history

We should have meetings to talk about curing ourselves.

There's one thing a psychiatrist can't say and that's what it's like to be on meds. They don't have a tendency to take patients as seriously as they should. I had to fight to get the drop in dosage that I wanted.

The most important thing that's happened to me lately is having found the step to by-pass the hospital. I mean getting oral meds from a G.P. I just don't want to encounter the psychiatric system any more. They treat you like children in there. They get you to sign an involuntary order. There's a real need for advocates in there.

I'm not going to H.P.H. anymore. That's where you go when they don't know what to do with you.

When they've let me out sometimes I've been totally incapable of finding a place. Sometimes I've come out really bad. Falling asleep on my feet.

The fact that their disabilities are chronic means that for the CMD, their psychiatric history is carried with them on a day-to-day basis. The cited texts point to the ways in which this history and the mentally disabled identity is reinforced by continued psychiatric treatment. The desire for personal involvement in treatment is borne out in the expressed desire for self-help settings and participation in medication decisions.

6.2.3 Psychiatric Services
There should be something like the Care Centre. It would be open long hours but you would need a referral to get in.

If it wasn't for the Care Centre, doing nothing would drive me nuts. The Centre sort of saves people from that.

I like meeting new people here. It's good just having a place to drop into, sit down and relax for a while. But it's open to everyone and people who aren't schizophrenic and have nothing to do come here. Some are out to cause trouble. That makes it harder.

This is really the only place in the community to go when you're low on energy. It takes people here a lot to get out and do things. It's like a big boarding house. It's alright. It serves its function. But the "after hours" for people leaves a lot to be desired.

I started here 7 years ago when it was on King and Emerald. People here are supportive of your feelings. They have the same situation as me. Some are even worse off. There's love here and that's better than treatment. You don't need any money to be here. You can get away from it all. I have the love of the people here. That's what makes it. They come up and say rewarding things. That's what I need.

There's no places for a person to go in the evenings. Now the Care Centre's only open one night a week. We need some sort of social centre.

I don't want to see people at the Care Centre. They're just bums.

It's good for me to have someone to talk to and so not end up back in the hospital. You try to keep out as long as you can. This time I'm not going off the needle, otherwise I'll be back up there. There should be something to do on the weekend. Nothing's open.

If it wasn't for John (social worker) keeping in touch, I don't know what I'd do. I need a push.
My mental health needs couldn’t be met anywhere else. I’ll never leave Hamilton because such good services are here. But I would like to see some sort of vocational training other than I.T.

Clients speaking of the Care Centre point to its role as a refuge and source of "asylum" from the stresses of the inner city. However, the inactivity of many at the Care Centre leads some respondents to have a condescending attitude towards them, and, in fact, pride themselves on not frequenting the place. Its open-door policy is of concern to members. Hassles from non-psychiatric visitors is a widely reported dissatisfaction, as are its hours of opening. When the Care Centre closes, so does the activity space of many psychiatric clients. Frequent recommendations by clients suggest the need for a social centre that is more exclusively tailored to the needs of the CMD.

Those who offered comments on the two case management programs valued the role of the therapists as confidantes and advocates. Whether directly or indirectly, these services extend the radius of clients’ social circles and potentially address issues of time management. The last text points to the need for transitional employment beyond that offered by a sheltered workshop setting. The texts point to the fact that while the Care Centre does provide a sense of belonging, many clients express a desire for
somewhere more exclusively "their own".

6.2.4 Social support

I only have friends at the boarding home and they're not very well people.

The problem with having other ex-patients as friends is that when they're down it rubs off on me.

Too much time on your hands can drive you crazy. But it's good to have the freedom to do what we want everyday. We have one couple of good friends. We meet for coffee three times a week. But it's not good having too many friends from the hospital.

I'm always running into someone from HPH to say "hello" to. It's quite a network of people I know. I call them friends I suppose.

We mostly go to Paul Bunyans and talk and smoke. There are usually a lot of people with psychiatric problems there.

I have plenty of things to do. It's just that I don't have the energy. I go and drink coffee at Paul Bunyans. There are friends there from hospital days. We talk and smoke and sometimes we just sit and don't talk at all. You know, I don't really think I have a social situation with the stigma thing about mental illness. I feel pretty much out on my own.

I go to the James Street Baptist church. It's a coffee house sort of thing and there's lots of drop-outs and ex-patients there. You might as well call it the "Jackson St psychiatric centre". The only other place I used to to see people is a bar on King St. but I've decided not to go there anymore. I don't want people like that as friends. I want friends who are not necessarily rich, but at least people who aren't psychiatric patients. I think I know what to say, but I just don't know where to meet them.

These texts suggest that the social circles within
which the CMD move tend to be constrained in their radius. Many lodging homes accommodate exclusively mentally disabled people and this cohabitation reinforces the natural formation of friendship networks among those of shared experience. Clients invariably know others from the hospital wards. But, as the second text points out, a preponderance of friends with disabilities can erode one's own sense of well being. As the third and fourth texts suggest, any friends are better than no friends, even if they do present a constant reminder of one's illness history.

Beyond the lodging homes, points of congregation are important as arenas of social interaction. For the CMD, two important criteria are that these be inexpensive and relatively anonymous. In Canadian cities, 24-hour coffee shops fulfill these requirements and provide a temporary niche for the impoverished and stigmatized. Citizens of all walks of life patronise these establishments and this is important for the way it generates a normalising atmosphere for the CMD. The particular coffee shop mentioned in the fifth and sixth texts was frequented by 14% of the original sample. Low demand in terms of expenditure and interaction and the presence of generally empathetic others grants coffee and donut shops a prominent place in the activity space of the CMD.
The last text mentions a weekly church-basement coffee house, another frequently cited place of social importance. This is similar in function and location to public coffee shops, but is distinctive for its non-normalising atmosphere. Patronage tends to exclusively comprise impoverished and stigmatised members of society. This prompts the speaker's tongue-in-cheek suggestion of its status as an unofficial psychiatric centre. The speaker poignantly alludes to his search for contexts in which he can break out of a circle of exclusively CMD friends. These texts point to the way that factors including constrained housing options, shared experience and material poverty converge in constraining the extent of natural social networks for the CMD. The preponderance of other psychiatric clients as friends can promote a social environment of mutual empathy buffering stresses of community life. But for many clients this creates a constrained-social space from which it is difficult to progress into wider circles.

6.2.5 Living situation

It's just no good. I love the people but I have a roommate who's sick and snores. What I'd really like is a place of my own. I used to cook for seven. Now I have nobody. It's like a big disaster.

They say you're free in the community, but living in
a boarding home you don't really have any freedom. Because everyone knows where you're going and what you're doing. I couldn't have a girlfriend there.

It would take $1000 a month to get out of here.

There's no curfew and this allows me to come and go as I please. The meals are good and the people there are settled. They're older but I get along with them. Boarding houses are a lot better here than they were in St John's.

The boarding house is old and draughty in the winter. Then in the summer, it's not well ventilated. The food's not the best. But I enjoy having my own room, good people to live with and a cable T.V. in the house. I have lots of friends in the area, that's a plus. But there's a lot of crime and people loitering.

I'd be much happier in an apartment of my own. But even if I could afford it, I lack the proper housing skills like budgeting, cooking and cleaning. When I moved in I expected to be taught skills to get an apartment on my own. But you find out they don't over-feed you and the meals are nothing special. They don't care if you're having living difficulties. They're just there to do their job.

It's structured and that helps. You get up in the morning and there's a reason to get up. The meals are served so you don't have to worry about starving. And it's clean. This is a good neighborhood. Close to the Care Centre, the Library, Paul Bunyans. But there are too many people bumming, especially ex-psychiatric patients. I know that I do it too, but not as much as they do.

I've found that if I don't have a good living situation, I'll end up back in hospital. I'm serious when I tell people I get suicidal if I don't have a good place to live.

It would be nice to be able to participate in the way the house is run.

I was in the North End for five and a half years. That place was really bad. People stealing,
bumming cigarettes, not enough food. The manager kept me there. He said I was perverted and that no one else would take me. He said I was the last straw of society, just an animal. But then I heard of C.E.S. from another client at the place.

The above texts are transcribed from the half of the client sample who speak from their experience of lodging homes. Few of those who had other living arrangements were particularly vocal on housing issues. Among the texts, the theme of spatial constraint is again borne out. While for some, the lodging home environment has appeal, the desire for independence is commonly expressed and for the first speaker, this is intensified by the contrast between present conditions and her pre-illness experience. The first two texts convey dissatisfaction with crowding. An adult living with up to 25 other non-familial others is recognised as not in an ordinary situation. Hospitals are settings where personal space is inevitably invaded, so the desire among some to find respite and re-establish their personal space is strong. Many clients are denied other housing opportunities by virtue of their poverty and the fact that their living skills have either atrophied or have never been acquired. The variability of responses to lodging homes is a reflection of differences in both client expectations and the physical, social and managerial conditions of particular
6.2.6 Lifestyle

The days are too long. There's too much spare time. Then nights are a problem. It's just T.V. and nothing else to do in the evenings.

I'm bored. I don't really do anything. If just work (at I.T.) come home, eat, smoke then go to bed. The weekends really get to me. I've got nowhere to go and nothing to do. I just sit in my third floor room and smoke. Where is there to go? I can go to a restaurant and buy a coffee but that's not much to do.

You go home to dinner, watch T.V. then go to bed. It's not much. Day to day it just seems like the same thing over and over. I have to get out of this.

Some days are better than others, but generally I'm pessimistic. When the Care Centre's closed I generally stay in and feel very bored. Sometimes I go to the Library or Art Gallery. I try to find as many free places as I can. But part of my social problem is that I only know people who've been part of the (St Joseph's) Day Program or from here (Care Centre) or the house. People tend to look down on mental illness as not contributing to society. But you can't control that.

I don't know what to do. I just sit around and walk the street. I go to Paul Bunyan's coffee shop three times a day. Us guys talk a lot. Sometimes it's nonsense. But it kills a little boredom.

It seems like there are 48 hours in a day sometimes. Some days are really long. Most days I'll take a walk up to H.P.H. and back. 'Course I wouldn't stay there, just there and back. Walking is nothing to us types, you know. We've got all day. It's good to get out and see nature. It keeps you smiling and fit.

I hate the idle time. It's the emptiness of the days. For four years I've been off and on in the
community but haven't been working. I paint sometimes but you don't get much inspiration from boredom. But I suppose it's a challenge.

These texts portraying predominant elements of clients' lifestyles are marked by boredom and repetition. The first three texts point to frequency of passive activities. Although the second speaker "goes to work", a sheltered workshop is neither interesting nor remunerative enough to compensate for the monotony of her "after hours". On weekends and evenings, the Care Centre is closed. The fourth speaker mentions other "free places" he patronises. The two older clients speaking in the sixth and seventh texts are more stoical. From these texts, we can see that components of boredom are: the frequency of interaction with other mentally disabled people; the limited places accessible to those of limited means; the repetition of activities; and the restricted activities available in the central city on weekends. These factors suggest that common language expressions such as "spare time" and "leisure" take on new meaning for a population whose lifestyle is shaped by unrestricted time but restricted use of space.

6.2.7 Beliefs and attitudes

It's a subtle sort of thing. People aren't as
understanding as they might be.

People give you funny looks. Neighbours on our street. Even here at the Centre. It gives you a funny feeling we're all isolated from the rest of society. They say, "look at those guys in there. They're sitting around drinking coffee all day." You have to be sick yourself until you know what it's really like.

On Wentworth Street there was discrimination against mental patients. Because there are so many boarding homes in the area. In one coffee shop, they'll keep you waiting to discourage you. In another they wouldn't even give me a glass of water. Three years ago I had a run-in with the manager at Grandma Lee's. I ended up with trespassing fines for refusing to leave.

I've got no respect for the police. They didn't believe me when I was raped. No one will believe you if you've spent your life in hospital.

I don't like all the put-downs from people. It gives me the impression I'm being stereotyped. For instance a Manpower counsellor said to me last month, "You've got no chance of a job, admit it." Not earning gets under my skin. I need the incentive to get my life together.

I like my apartment. I have lots of friends here. No one knows I've been mentally ill. Except other ex-patients and they don't mention anything.

I don't like being in the East End. The people here are sick. It's a nursing home. I don't need to be here.

I try to keep busy and feel meaningful. A man's meant to feel important through having a job. If a guy's disabled, they figure he loses his competitive spirit and urge to work. But I feel there should be more stress on people going back to a regular routine. Not just meds and the attitude that "you'll be OK till next week". That destroys your confidence for sure.
The era of community-based psychiatric care has improved public understanding of mental illness, but stigma has a particular tenacity. To those who have experienced psychiatric hospitalisation and rejection by friends, minor events have the capacity of reinstating the experience of isolation. The storefront location of the Care Centre makes its occupants clearly visible to passers-by and consequently open to occasional derision. Another text suggests that the clustering of lodging homes in particular neighborhoods has precipitated discrimination. Two further accounts graphically portray how in interaction with public officials, clients may encounter a lack of credibility on account of mental illness. Another speaker indicates the importance she places on "masking" her illness history and so evading any chance of disparaging attitudes. These texts therefore point to the ways that negative community attitudes may be exacerbated by social and residential clustering.

The final two texts suggest ways in which clients' self images are shaped by the circumstances into which they are thrust. CMD clients are not infrequently placed in congregate living situations along with the infirm elderly. The 'sick role' described by Parsons (1958) is therefore reinforced by this cohabitation. The final speaker makes
reference to the debilitating effects of unemployment, suggesting that self-esteem is undermined. Receipt of social assistance hinges on a disqualification from full-time employment and this reinforces an erosion of self-esteem.

6.2.8 Synthesis

Consideration of this series of texts has demonstrated the degree to which the client and community variables identified in Figure 5.1 contribute to particular experiences of place and time in Hamilton. While specific experiences remain highly idiosyncratic, interrelated themes emerge as refrains: boredom, routine, poverty, constrained choice and congregation in public places.

It should be recognised that the division of evidence into the themes represented by the variable clusters on Figure 5.1 has been undertaken for organisational purposes. The actual interconnectedness of issues is compromised in two ways. First, at the level of particular research encounters, pieces of text have been lifted from broader discourses. Textual evidence is originally embedded within a context of surrounding discourse (Mishler, 1986) and, for the sake of brevity, this is omitted from present consideration. Second, as suggested
In Figure 5.1, client and community variables are closely interrelated in their influence upon coping experience as well as outcome measures. Discussion of textual evidence within discrete categories therefore belies a profound interconnectedness of factors in the context of lived experience.

6.3 The rhythms of daily activity

A means to advance appreciation of the ways in which time and space are structured for the CMD is a closer examination of daily activity rhythms. This section seeks such an appreciation through building upon approaches used in the time geography literature (e.g. Shapcott and Steadman, 1978). Daily activity patterns will be examined at three scales. First, the sample will be examined at an aggregate level and differences in activities between seasons and days of the week will be considered. Second, activity patterns specific to age and gender will be considered by disaggregating to the four cells of the original design. A third perspective will be provided by returning to the individuals profiled earlier in the chapter and identified on the coping-satisfaction matrix. Data are derived from the LMCQ, in which clients
were asked to assist in the completion of a two-day diary. This took the form of recording the predominant activity by hour, on a sixteen-hour time sheet for the most recent week and weekend day. When numerous respondents indicated waking activity outside of this period, data were recorded for a full 24-hour cycle. For some clients, this approach was taxing on memory and patience and a detailing of the finer texture of daily life was not considered feasible. A result of the approach is that activities of less than a one-hour duration (e.g., journeys to and from places) are largely lost to the data set. In other instances, a short-duration activity (e.g., eating) is attributed sufficient importance to be rounded up to a full hour. A data set was assembled according to eleven categories, which were subsequently divided into active and passive groupings (Table 6.1). In this listing, the only ambiguous classification is the designation of attendance at a drop-in centre as "active." A client may well actively participate in scheduled activities and interact with fellow patrons, but this is by no means universal. Measures of the number of hours spent passively engaged may therefore be conservative.

6.3.1 Daily patterns of activity

The patterns of activity rhythms for the sample are revealing. The histogram presented in Figure 6.2 indicates
| **ACTIVE**  | Household chores  |
|            | Attendance at social centre  |
|            | Visiting  |
|            | Recreation  |
|            | Attendance at other public places  |
| **PASSIVE**  | Sleeping  |
|             | At home reading, talking or T.V.  |
|             | Eating  |
|             | Attendance at coffee shops, restaurants  |
|             | Seeing caregivers  |
Figure 6.2 Passive activities among client sample, weekday.
what percentage of the client sample are passively occupied throughout the 24 hour cycle for each of the two rounds of interviews. As a corollary, the area above the histogram represents the percentage of the sample engaged in active pursuits. For the weekdays detailed at both winter and summer interviews there are only two hours in which more than 50% of the sample were engaged in active pursuits. The congruence between rhythms of weekday activity in the different seasons is noticeable and this concurs with data from general populations (Shapcott and Steadman, 1978). Despite most of the CMD having fewer schedules than other populations, the routines of meal times at congregate living situations and hours of opening at drop-in centres do contribute to weekday activity rhythms that are relatively resistant to seasonal change.

In contrast, the pattern of activity for weekend days shows considerable seasonal difference (Figure 6.3). Whereas at the time of the winter interview, over 60% of the group were passively engaged throughout the entire 24 hour period, by the time of the follow-up interview in summer, the group demonstrates a markedly higher degree of activity. In winter, most are restricted to public transportation and on weekends, drop-in centres are closed, resulting in a low incidence of actively occupied time.
Figure 6.3 Passive activities among client sample, weekend
6.3.2 Activity patterns for the age-sex groups

Having established that the pattern of weekday activity for the sample tends to be consistent over time, attention now turns to differences between the age-sex subgroups. Data from round one interviews are collated in Figures 6.4 to 6.7. The histograms indicate the percentage of group members engaged, at any hour, in passive activities. These diagrams can provide an index of relative orientation to active pursuits among the age-sex subgroups. A measure of this is the number of hours in which less than 50% of the group are engaged in passive activities. According to this criterion, the two more youthful groups predictably demonstrate a less passive orientation. For the 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. This points to age being a variable that, perhaps understandably, demarcates the activity level of this population. Yet for all groups, the preponderance of passive activities is striking and strongly contrasts that likely for most in the general population for whom work or school prescribes at least eight active hours each day.
Figure 6.4  Passive activities among women clients under 35.

Figure 6.5  Passive activities among women clients over 35.
Figure 6.6 Passive activities among male clients under 35.

Figure 6.7 Passive activities among male clients over 35.
6.3.3. Activity patterns for four clients

Attention now turns to the four representative clients whose commentaries opened this chapter. The active/passive distinction overlooks the specific range of places and purposes encountered in the daily round of an individual's activity. In Figures 6.8 through 6.11, the eleven categories of activity have been loosely scaled on the vertical axes from more passive (i.e., sleeping, eating) to the more active (i.e., working, visiting friends). This is undertaken primarily for descriptive purposes. The ranking is arbitrary inasmuch as it assumes a common level of exertion and interaction experienced by different clients for any group of activities. This assumption is reasonable for the more passive activities (i.e., sleeping, eating) but less so for others. Attending a drop-in centre, for instance, may well be more or less demanding than spending time in a public place. The purpose is, however, primarily for the illustration of clients' time budgets and therefore an intuitive scaling of activities is justified. The portrayal allows recognition of peaks and troughs in the intensity of daily activity for specific individuals. Fuller data sets tended to be recovered in the second (summer) interview on account of the clients' familiarity with the
Interview protocol. Data from this round of interviews are therefore the basis for present discussion.

Larry's day is structured around the set mealtimes of the lodging home (Figure 6.8). In both the morning and afternoon he walks into the downtown area of Stoney Creek, looking in shop windows and then reading on a secluded park bench. In the evening, he watches television and occasionally talks with other lodging home residents. His weekend day is exceedingly similar.

For Kate, living independently means less daily structure than she formerly had in a lodging home (Figure 6.9). She arrives at the Care Centre shortly after it opens at 8-30 a.m. for a breakfast of free donuts and subsidized coffee. She remains, playing cards and talking until the Centre closes at four, at which time she goes to the apartment of another ex-patient and watches T.V. Back at her apartment, she smokes and watches more T.V. with her companion until midnight. On Sunday, time is largely spent sleeping. After two hours of walking around town, she returns and watches television with her companion. There was nothing else Kate could remember. As she remarked earlier, "All I have is spare time, and that's what I'm getting tired of."

In section 6.1.3, Matt spoke of his active social
Figure 6.8 Daily activity pattern for Larry (low coping/low satisfaction)
Figure 6.9 Daily activity patterns for Kate (high coping/low satisfaction)
life and this is borne out in his daily activity histogram (Figure 6.10). By 7.00 a.m., he is up and finished breakfast. When his roommate leaves for I.T., Matt walks downtown and stops for a coffee at Tim Hortons. For two hours he is at the Care Centre, talking and playing cards until mid-morning when he walks over to the Wesley Centre "to pick up a bag of free donuts". After entertaining other residents at the lodging home with some tunes on the harmonica, having lunch and then a rest, Matt returns to the Care Centre, stopping again at Tim Hortons on the way. After supper he visits a friend at another lodging home, and stops at Paul Bunyans coffee shop on return. Sundays are marked by church in the morning then afternoons—checking on friends and acquaintances at various coffee shops and restaurants. In the evening Matt returns to church for a Bible study.

Jane moves through a weekday centered on activities in the apartment that is home for her and her husband (Figure 6.11). She meets a friend for coffee at Tim Hortons mid-morning, then visits in the evening to play cribbage. Other hours are spent at home. On Sunday, she and her husband watch T.V. in the morning and in the afternoon take advantage of free movies at the Art Gallery and walk in the park.
Figure 6.10 Daily activity pattern for Matt (low coping/high satisfaction)
Figure 6.11 Daily activity pattern for Jane (high coping/high satisfaction)
6.4 Perceived aids and impediments to coping ability

The foregoing sections have inferred themes of coping difficulty from interpretation of clients' accounts of their experience. The question of what helps and hinders coping with everyday life was posed towards the end of each interview. Examination of these data indicates the associations clients make between community life and their perceived coping ability. There are striking resemblances between these 'insider' associations and the statistical associations demonstrated in Chapter Five.

The importance of psycho-social factors including maintenance of an active lifestyle and social life in aiding coping in the community are borne out in Table 6.2. Other frequently-cited aids to coping were: medication, acknowledging the way psychotropic drugs allow stabilization of disabling symptoms; and attitudinal factors such as "being optimistic" and "making the best of it". This last set of responses show a much greater frequency in round two interviews. This occurrence can be postulated as related to a seasonality factor. During summer months, it is easier for clients to move outside otherwise confining aspects of their lives (e.g. congregate living situations) and circulate through a greater variety of free public spaces. It is
### TABLE 6.2. SELF-REPORTED AIDS & IMPEDIMENTS TO COPING ABILITY

<table>
<thead>
<tr>
<th>AIDS</th>
<th>R1</th>
<th>R2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being Active</td>
<td>18</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>Attitude</td>
<td>6</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>Social life</td>
<td>12</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Medication</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td>Faith and hope</td>
<td>9</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Family and spouse</td>
<td>8</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Caregivers</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Nothing/don’t know</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Organisational affiliation</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>88</td>
<td>84</td>
<td>172</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMPEDIMENTS</th>
<th>R1</th>
<th>R2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td>15</td>
<td>12</td>
<td>27</td>
</tr>
<tr>
<td>Illness/depression</td>
<td>9</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>Poverty/unemployment</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Loneliness</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Living situation</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Relationship problems</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Rejection/stigma</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Insufficient help available</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>19</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>71</td>
<td>59</td>
<td>130</td>
</tr>
</tbody>
</table>

*Includes multiple responses*
easier for attitude to play a role in shaping coping ability under these seasonal circumstances, an observation unlikely to be at odds with respect to other groups in the general population.

Factors reported as hindering coping performance tended to be more idiosyncratic. This is reflected in the size of the "other" category. A similarly large number saw nothing in particular impeding their ability to cope. Of the 'other' responses, various manifestations of mental illness, poverty, unemployment and difficult living situations were widely reported. To a greater extent than the 'helps', the particularity of clients' circumstances at the time of interview added to the wide variety of 'other' perceived hindrances to their coping ability.

6.4 Summary

This chapter has examined aspects of community life for the CMD in Hamilton as it is experienced by members of the sample. The initial presentation of four vignettes served to focus on the individuals who comprise the sample. This is important, for frequent use of the "CMD" label can begin to mask the fact that although many clients endure similar conditions and experiences, the group is ultimately
heterogeneous in character. The narratives contained in these vignettes comprise what Cornwell (1984) has described as 'private accounts' of health experience.

The accounts offered by Larry, Kate, Matt and Jane touch on themes that were revisited under sharper focus in the following section. Here, common strands of experience contributed to a developing understanding of 'sense of place' for the CMD. The group are directed by circumstances and forces beyond their control into a geography of tightly structured space and loosely structured time. In this respect we can say that they are involuntary colonists in the central city. Their predominant settlement in the downtown zone has been precipitated by the circumstances of mental illness and the local ways in which deinstitutionalisation policy has unfolded. Clustered settlement is held in place by the forces of material poverty.

The emergence of this settlement pattern over the last twenty years affirms Pred's (1984) notion that 'place' is an historically contingent process. For the CMD, material and social opportunity have clearly circumscribed the contours of their experience within, and perceptions of, Hamilton. The texts examined in section 6.2 affirm Eyles' (1985) conception of communities as "focussed repositories of sense of place". The degree to which particular
individuals have a developed sense of place or belonging appears to depend upon the extent to which they have maintained links with family, or, in the case of Matt, penetrated the fabric of 'normal' social life through organisational affiliations.

The time budget data in the third section vividly conveyed the passivity of the lives of the CMD. For many, there are few schedules apart from the structure imposed by meal times. The surfeit of time and deficit of activity space tends to keep the majority engaged in passive activities. Apart from appointments with caregivers, the unemployed of the sample are not subject to the authority and coupling constraints described in the time geographic literature (e.g. Tornquist, 1980). This represents a detachment from the norms of North American society in which the necessity to be at particular places at certain times grants a sense of purpose and self-esteem.

Some of the observations made in the course of examining personal accounts and time budgets were borne out when clients were directly asked what helps and hinders coping ability. Psychosocial factors such as being engaged in activities and maintaining a social life were reported as influencing their coping performance. These same factors are recognised to be of paramount importance in rehabilitation
philosophy (e.g. Anthony, Cohen and Cohen, 1983) and proponents of the clubhouses for the CMD (e.g. Beard, Propst, and Malamud, 1982). Conversely it is unsurprising that the factors deemed to be greatest obstacles to coping are the illnesses themselves along with various "social side-effects" of disability - poverty, unemployment, poor living situations and social isolation.

Two conclusions can be drawn from this chapter. On a methodological level, this interpretive analysis represents an advance upon an exclusive reliance upon quantitative analysis such as that reported in Chapter Five. Textual analysis has produced complementary findings that indicate the particular interactions that exist on an experiential level between members of the sample and the community setting. While it is less easy to draw sample-wide generalisations from narrative material, a second point of conclusion is affirmation of the hypothesised tendency for the CMD to experience under-scheduled time and over-restricted activity space in their experience of community life.
CHAPTER SEVEN
CONCLUSION

The preceding chapters have described and analysed community life for a sample of the CMD in Hamilton. The principle contribution of this work has been an enhanced understanding of the nature and determinants of community outcomes and experience for this group. Secondary contributions include: first, application and extension of a socio-ecological model (SEM) of health; and second, an adaptation of conventional design to accommodate the procedural and ethical demands of such a model.

In this concluding chapter, these three areas of contribution will be summarised. First, the SEM introduced in Chapter Two will be revisited in light of the research findings. Second, reflections on a research design that has stressed involvement with the study group will be offered. Third, attention will turn to the geographic locale. The capacity of Hamilton's inner city to be a supportive setting for the CMD in lieu of rehabilitation in "culturally normative settings" (Wolfensberger, 1972) will be examined. In the fourth and final section, the social justice ethic that has been implicit throughout the thesis will be brought.
to the fore. It is argued that commitment to social justice in geography has predominantly been concerned with equity of supply of goods and services. The present research follows wider calls for a person-centred justice ethic that balances concern for equity of supply of goods with close attentiveness to personal expression of need.

7.1 A socio-ecological model of community experience

The ecological-conceptual framework (Figure 2.1) and SEM described by White served as the basis for constructing an analytical framework to guide inquiry into community experience for the CMD (Figure 5.1). This framework formalised the links between sets of factors that were proposed in an earlier Hamilton study (Dear et al., 1980) as influencing coping experience. At the aggregate level, these links were statistically tested in Chapter Five and described through use of narrative data in Chapter Six. In this section the abstract ecological framework is redrawn to include research findings integrated from both quantitative and qualitative analysis. The outcome is a descriptive model that incorporates our knowledge of the time, place and circumstances experienced by the CMD. The constraints associated with the way individuals are ‘situated’ in urban
society were suggested earlier in Figure 2.2. These constraints are implied in the present summary of the urban experience of the CMD (Figure 7.1).

Analysis in Chapter Five supported findings in the literature suggesting that more extensive social networks and engagement in gregarious activities are among the characteristics significantly associated with positive self-report measures. Other clusters of variables indicated on Figure 5.1 and associated with one or more outcome measures include residential type and stability, employment status, source of income and involvement with aftercare. These elements of the clients' environment, demonstrated to be associated with measures of outcome and experience, are indicated on the 'SEM of community experience'. The five variable clusters are located in an 'outer world of shared experience' for the client sample. A sixth variable cluster, 'attitudes and beliefs' is encircled with a broken line, indicating that the present analysis only allows speculation as to its importance for the group as a whole. Arrows between person and aspects of the environment indicate associative relationships of varying strength while lighter lines between variables indicate the recognised, but undemonstrated interconnectedness of variables.

Among individual members of the sample, poverty and
Figure 7.1 A Socio-Ecological Model of community experience.
unemployment were shown in Chapter Six to be exclusionary constraints which, for many clients, empty their days of meaningful and normalising experience. An 'inner world of personal experience' is indicated in Figure 7.1 as representing the ultimate distinctiveness of individual experience. In Chapter Six, textual data suggested that this individual experience is shaped by three interrelated dimensions: first, personal identity, which incorporates biographical experience and characteristics brought to bear on present experience; second, place which includes both dispositions towards locale and experience of one's 'place-in-the-world' (Eyles, 1985); and third, material existence which includes possession of and access to material opportunities. This experiential triad contributes to shaping the symptoms and disability discussed by White (1981) as inherent to ill-health and gives rise to either positive or negative experience in community settings. As 'outcomes' these sets of experience tend to be either enabling or disabling in their effects.

The 'SEM of community experience' provides a framework within which research findings can be fruitfully summarised. Disability, for example, has been noted as being reinforced by unemployment and dependence on social assistance (Estroff, 1981). Among the sample, limited social
support and congregate living arrangements further perpetuate disability as a devalued place-in-the-world. At the individual level, a disabled identity, limited sense of place and constrained material existence perpetuate negative community experiences. Positive or enabling community experiences are likely to be the result of positive self-identity, a sense of belonging and a material existence that begins to transcend marginality. Illustrative of this has been the indication in Chapter Five that high ratings of coping - one dimension of positive experience - are predicted by engagement in activities including employment and aftercare. These activities potentially contribute to self-esteem, a sense of place and material existence. Positive experience among clients is promoted by a configuration of opportunities shaping wellbeing among the population at large - including meaningful employment, earned income, social support, a range of housing options and community services.

While the model in Figure 7.1 fulfils an organising function for the thesis findings, in one respect it does violence to experienced and observed reality. The isolation of variables for analysis and identification on the diagram misrepresents the holism of experience. In making this caveat, it is not so much the limitations of the socio-
ecological approach that are identified, but rather the extreme difficulty of representing the complex dynamics of human-environment interaction.

7.2 Reflections on the research approach

This research has contributed to "the necessity of better understanding the relationships between medicine and health on the one hand and societies, individuals and environments on the other" (Eyles and Woods, 1983, 232). The focus has been maintained on a sample of individuals located within a local urban environment and the approach has been interactive in both epistemology and research design. This section reviews and assesses aspects of the approach.

The SEM that has been central to the thesis has sensitized the researcher to components of the environment that influence the health and well-being of the CMD. These interactions between person and environment were measured in two rounds of interviews that culminated an extended period of participatory research. There have been two beneficial outcomes of this approach: first, the instrument itself was informed by observation; and second, an ease of rapport meant that interviews could represent 'research encounters'. Participant involvement added both a fullness of data and an
appreciation of its significance in the 'world' of the CMD. Findings are therefore the fruits of more than simply a longitudinal study of the CMD.

Both statistical and interpretive modes of analysis have been employed. This has served to combine rigorous testing of relationships for the aggregate sample with a depth of appreciation for the lives and experience of individual respondents. In so doing, a balance between quantitative and qualitative approaches has been attempted. In terms of the literature, the study has attained a middle ground between epidemiological studies and anecdotal accounts of the ghettoised CMD.

Advantages of this approach can be identified in terms of the findings, the respondents and the researcher. First, as already suggested, the data gathered in the course of the study represent material less likely to be obtained by a researcher making a few discrete entrances and exits from the field. In this respect, the proximity of inner city Hamilton to the research base facilitated a broad spectrum of interaction not always achievable in health studies. Second, the respondents - especially those at the Care Centre - were advantaged by this approach, offering frequent comments and gestures of appreciation for the acquaintance-ship. A number of clients said that the opportunity to tell
their story in interviews was an enjoyable and uncommon experience. Third, for the researcher, the participatory approach and interview style facilitated an important personal 'conversion' to the reality of the 'world' of the impoverished mentally disabled.

Disadvantages of the approach centre on the instrument and sample members. The Life management in the city questionnaire is best suited to respondents who are both willing and able to provide accounts of their experience. In a minority of cases, an inability to answer questions without prompts was an embarrassing experience. These factors biased the narrative data set towards the experience of the more forthcoming and articulate clients.

The use of different methods has been deemed legitimate if they are theoretically integrated in the research (Eyles, 1985). In the present case, the SEM has guided analysis of a group of individuals who share particular illness histories, disabling experiences, and urban environments. The socio-ecological perspective can be extended to view the researcher as a part - albeit temporary - of the environment. This view has been implicit throughout the study. A consequence is that ethical and practical elements of research design have been integrated with the conceptual orientation of the project.
7.3 Towards Enablement

The thesis has argued that while Hamilton's inner city represents a zone of resettlement for the CMD, it falls short of being an ideal context of rehabilitation. As commentators on deinstitutionalisation have suggested (e.g. Shepherd, 1986), actors in the mental health system too easily hoped that discharge from hospital would facilitate "life after mental illness". Treatment philosophies such as milieu therapy, current at the time of deinstitutionalisation, postulated the curative effects of the psychosocial setting. These philosophies were inadequately translated from hospital to community environments. A socio-ecological perspective on the determinants of health and wellbeing has been offered as a prompt to reassess the importance of milieu. In this section, Hamilton's inner city is described for its value and potential as a supportive milieu for this group.

The ghettoisation of the CMD that is apparent in Hamilton through concentration of lodging homes has both positive and negative implications for the group. Common residence in particular neighbourhoods promotes frequent interaction among clients and an informal 'ex-patient
network’ has been evident in the narrative accounts of Chapter Six. For many, this friendship network is promoted by residence in lodging homes. Congregate living arrangements provide an intensity of contact not usually found among groups simply based on propinquity. ‘Lay referral’ of clients between lodging homes has been noted in the work Elliott (1987) performed on the data set. Other supportive activities such as visits to peers readmitted to hospital are positive consequences of ghettoisation. As Eyles (1985, 133) points out

Interacting with or simply living close to people perceived to possess similar attributes provides a sense of belonging; it symbolises a sense of identity with people and place.

For the majority, these interactions would be less likely to emerge without residential concentration. It is therefore unsurprising that other members of the CMD community commonly feature among their ‘significant others’. This element of social coherence among the CMD can be supportive in itself of positive experience.

A negative consequence of ghettoisation is the collective image of disability that the concentration of clients presents to the public and, more importantly, to themselves. Some clients, such as Larry (see section 6.2.1) choose to eschew the company of others with psychiatric experience because of this image. However, a rejection of
the company of other mentally disabled people still leaves one socially and economically 'disabled'. A second negative consequence of life in Hamilton's inner city is the mixed messages clients receive about being mentally disabled. Opportunities for constructive employment are few for this group and yet there remains stigma attached to being a recipient of social assistance. It is therefore unsurprising that care-givers fill a key role in the clients' support network, apparently legitimating the ambiguous experience of being CMD.

In summary, analysis suggests that as a geographic locale, aspects of Hamilton's inner city provide important support for those living 'in the shadow of illness'. Key elements of this are: first, a sense of community among the CMD through common experience, propinquity and, for many, cohabitation; second, easy access to a range of formal mental health services; third, the pool of licensed 'second level lodging homes'; and fourth, the presence of limited opportunities for sanctuary (e.g. the Care Centre, 24-hour coffee shops). Crude evidence of the effectiveness of existing conditions in contributing to a supportive locale can be inferred from the degree of community tenure indicated by the sample. The development of self-report measures and compilation of informal data has more directly
tapped experience of the supportiveness of the inner city. As long as a proportion of the CMD are, to quote one client, "just getting by", they are failing to meet the 'reintegration' goal of deinstitutionalisation policies.

The map of the 'mental health territory' in Chapter Three (Figure 3.2) helped organise a description of the configuration of support for the CMD in Hamilton. The activities of the Department of Psychiatry at McMaster University have strengthened the existing formal mental health system. A network of affiliated faculty has aided cross-referral of patients, consolidation of expertise at particular sites and an integration of the provincial psychiatric institution with local general hospitals. These are achievements that make Hamilton distinctive for its psychiatric service provision. However, community mental health philosophies, such as those embodied in the short-lived Field Unit Project, have been supplanted by a more pragmatic and clinical orientation over the last 15 years. Attempts at mental health promotion and reaching the 'unserved' in the downtown core have been largely assumed by the voluntary sector, notably the C.M.H.A. The shift in location by C.P.S. from a street address to a hospital wing is symbolic of a widespread 'clinicisation' of formal community mental health services in downtown Hamilton.
Users of the local mental health system are potentially better served by clinical services than their peers in other Canadian cities, and this has been recognised in the course of interviews by clients themselves. However, opportunities for clients to move beyond the 'maintenance' orientation of chemotherapy and counselling to more active rehabilitation remain limited. For many of Hamilton's CMD, including members of the sample, maintenance is sufficient therapy in itself (see Woodside, 1983). But others in the sample have expressed a clear need for actively supported yet non-clinical forms of rehabilitation (see section 6.2.3). While a number of outpatient clinics, including C.P.S., incorporate psycho-social programs in their service menus, these are offered either within or in close affiliation with clinical settings.

The patient image appears to be tenacious for all in the local mental health system. Staff deal with 'clients' and participants see themselves as 'ex-patients' or 'out-patients'. As Estroff (1981) points out, there are rituals surrounding entry to the mental health system, but there are seldom ritualised exits. For a person to shed 'clienthood' he or she must withdraw from mental health programs and this involves a threefold loss of social support from caregivers, contact with fellow participants and the social legitimacy
of being 'disabled'. An extension of the present study could usefully explore the degree to which being a 'patient' and 'client' helps or hinders positive experience in the city for the CMD.

For the CMD in Hamilton, the Care Centre offers a qualified refuge from clienthood. Its patrons include people who have never been in hospital, others who deny they have been in hospital and others still who claim they are 'volunteers'. Its open-door policy provides a vital 'port-of-entry' for the disenchanted mentally ill, but fails to fulfill the promise suggested in the term 'membership'. The Care Centre represents a blend of service and de facto self-help and while its undemanding atmosphere suits some CMD, others are clearly searching for something that more forcefully de-emphasises the 'client' role.

The most weakly developed element on the local mental health territory was indicated in Chapter Three as being the self-help sector. Elsewhere, clients helping each other in situations of free association have effected a transition from "consumer to citizen" (Church and Egan, 1986). Although informal helping networks have been indicated among the sample, two sets of findings suggest a need for a sharper focus for self-help in Hamilton. First, quantitative analysis in Chapter Five pointed to the
Importance of employment, social support and aftercare in promoting coping dimensions of positive community experience. The common factor in these findings was purposeful interaction, a quality to be found strongly in the free association central to the self-help concept. Second, narrative material indicated the strength of desire for a greater sense of belonging. This desire suggests a need for belonging to a place, as well as belonging to others. The clubhouse model discussed in Chapter Three provides an example of how a convergence of physical and social belonging in the city can be propagated in the form of a particular facility.

In Hamilton the degree of sophistication in the formal mental health system may possibly have acted to inhibit the emergence of organised self-help initiatives. This is on two counts of image and funding. First, well-developed psycho-social components of outpatient programs ossify 'clienthood' and reinforce the role of the clinic as the central resource-base from which clients venture out into the community. Second, to state funding agencies, the medical profession tends to be regarded as the primary caretaker of the mentally disabled and therefore, on account of the formal 'network', Hamilton has garnered a well-served image. While this may be the case for clinical
services. It is clearly not so with respect to the availability of other basic needs. A proportion of the present sample have been shown to lead socially, financially and occupationally impoverished lives.

The policy challenge is to strengthen the community resource base and bring the present research focus - the individual CMD person - into the centre of a revised 'map of the mental health territory' for Hamilton (c.f. Figure 3.1). Such a map would be one in which resources were developed for the CMD in such a fashion that they were no longer overshadowed by a 'map' top-heavy with formal mental health services. Experiential knowledge - held by clients, caregivers and others who deal with the CMD - is valuable in promoting natural rather than service relationships that can strengthen the resource base.

The recent proposal for a clubhouse for the CMD in Hamilton envisages a partial redrawing of the map of the mental health territory. Through the participation of clients, caregivers and other interested parties (e.g. parents), the act of 'redrawing the map' is underway within the planning process itself. New liaisons in small but efficacious ways strengthen ties between stakeholders. If established, this facility offers potential to grant the sense of belonging and autonomy many of the present client
sample only inadequately find in the city. A sense of mutual responsibility and natural, rather than contrived, associations potentially develop in a clubhouse setting both between members and with the wider community. These may alleviate some of the "top-heaviness" of the formal system on the 'map of the territory', with the clubhouse displacing some of the centrality of the clinic in the world of the CMD. In terms of the framework that guided the foregoing analysis (Figure 5.1), the social support network, housing options, lifestyle and beliefs may all, in varying ways, be influenced by the clubhouse experience. It can be therefore hypothesised that measures of assessed experience would be positively influenced by such a facility. Should a clubhouse be developed for the CMD in Hamilton, a useful extension of the present research would be an analysis of members’ experience with reference to the components of Figure 5.1.

7.4 Geography, social justice and health

Medical geography, much like the discipline as a whole, has developed a research commitment to discernment of patterns and analysis of the processes that determine these patterns. As a branch of medical geography, studies in the geography of mental health have charted a similar course.
However, the distinctive social history of mental illness has more readily thrust this work into the broader theoretical contexts of reproduction, territory and policy (e.g. Dear, 1981; Smith, 1980). Material deprivation has been central to this group occupying a distinctive place within what Badcock (1984) has called "unfairly structured cities". The present work has taken as a given the 'location' of some of the CMD in society and space and focussed specifically on the nature of their experience within the perimeters of ghettoisation.

The present analysis follows current trends in health, policy and philosophy as well as developments within geography itself. In Canada and elsewhere, public health has been asserted to be shaped by more than medical surveillance and the absence of disease (e.g. Lalonde, 1974; Townsend and Davidson, 1982; Epp, 1986). The importance of environmental determinants of health is central to the SEM described by White (1981) but this remains a recognition that is not strongly developed in the health sciences. The emergence of a socio-ecological approach is unveiling new roles for the social sciences and new alliances with the medical profession.

These developments are occurring at a time when concerns for welfare policy and personal wellbeing have
converged in the discipline of geography. An analytical focus on the wider 'health' of urban society (e.g. Laws, 1987; Dear and Wolch, 1987) has - at least implicitly - arisen from earlier calls for social justice and values in geography (e.g. Harvey, 1973; Buttner, 1974).

Aggregate analysis of human action has been the conventional pose adopted in geography and hence, questions of social structure have been, on balance, more adequately addressed than issues of individual agency. This is largely the case in the geography of mental health. By bracketing broader questions, the present work has contributed to the understanding of the agency of the ghettoised CMD. Following Eyles (1985), the work has indicated that experience of place and place-in-the-world are intimately related.

A justice ethic has been central to recent developments in geography. This has taken the form of a desire to discern social processes and promote appropriately just policy. While the nature of a social justice ethic has often remained only implicit in geographic work, calls for an equitable distribution of scarce resources has been a strong theme. As a consequence, geographers have advocated an amelioration of their material conditions experienced by disadvantaged groups. Such an ethic has animated the present work.
The conventional geographic interest in urban issues at aggregate levels of analysis has meant that a justice ethic has tended to focus on equity of supply of and access to goods and services. The present work has considered individual as well as aggregate characteristics of the CMD. Both a literal and analytic attentiveness to their experience has invoked another aspect of justice. This is the recognition that the disadvantaged have a right to voice their experiences and be heard by others in society. Research attentive to the needs of the CMD can be translated into a call for attention by policy-makers, following the broader concerns expressed elsewhere in Canadian society (e.g. Draches and Cameron, 1985; de Roo, 1986).

The ecological view adopted in this work also has a bearing upon these wider justice issues. The ultimate interdependence of all elements and components of an environment is fundamental to the ecological perspective. This tenet is carried into the SEM of health and when applied to the mental health field, challenges the widely encouraged belief that the CMD should achieve independence. This study has identified relationship, belonging and meaningful employment as among the pressing needs for this group. While financial independence is surely a desirable policy goal, evidence points to the enabling
consequences of a broader interdependence with others in society. The socio-ecological perspective is therefore iconoclastic in its implicit call to question the concept of independence that is embedded in Western society.

The CMD in Hamilton, like their peers in other cities, are located in but are not fully part of the community at large. In the spatial and social shadow of their illness, a qualified sense of community has evolved for many of this group. The research findings indicate a need for local policies to strengthen this incipient community among the CMD. The need for mechanisms to ensure that financial resources follow psychiatric patients out of hospital and into supportive services in the community is an implication of the research findings. As one explicit form of support, development of the clubhouse model in Hamilton warrants consideration. At the broader scale, this thesis supports the call for shifts in socio-economic policy to create a society more inclusive of disadvantaged groups. The social geography of the CMD in Hamilton points out the need for policy changes by revealing a discrepancy between the anticipated reintegration and actual resettlement of this group in the community environment.
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,
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 sat’d | quite sat’d | somewhat sat’d | somewhat dissat’d | quite dissat’d | very dissat’d |

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

| very sat’d | quite sat’d | somewhat sat’d | somewhat dissat’d | quite dissat’d | very 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 |

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 |

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 |

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 |

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

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 | 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 |

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 |

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 |

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

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?

<table>
<thead>
<tr>
<th>very sat'd</th>
<th>quite sat'd</th>
<th>somewhat sat'd</th>
<th>somewhat dissat'd</th>
<th>quite dissat'd</th>
<th>very dissat'd</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>very well</th>
<th>quite well</th>
<th>fairly well</th>
<th>fairly poorly</th>
<th>quite poorly</th>
<th>very poorly</th>
</tr>
</thead>
</table>

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?

<table>
<thead>
<tr>
<th>very sat'd</th>
<th>quite sat'd</th>
<th>somewhat sat'd</th>
<th>somewhat dissat'd</th>
<th>quite dissat'd</th>
<th>very dissat'd</th>
</tr>
</thead>
</table>
With respect to your money situation, how do you feel you are coping?

very well  quite well  fairly well  fairly well  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
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