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RATINGS OF PROFESSIONAL CAREGIVERS ON SERVICES FOR

THE CHRONICALLY MENTALLY ILL IN NOVA SCOTIA:

IMPLICATIONS FOR PROGRAM PLANNING

by

© Margaret Jean Bayer

Submitted in partial fulfillment

of the requirements for the degree of

Doctor of Philosophy

at

Dalhousie University

November, 1984

Dedication

This dissertation is dedicated to the memory of my friend Joyce Chew. She was a friend among friends and the many shared moments through our years of graduate studies will be treasured forever.

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ABSTRACT

The main purpose of this descriptive survey was to facilitate program planning by obtaining data on priorities, importance and feasibility relating to services for the treatment of the chronically mentally ill by the nurses, psychiatrists, psychologists and social workers who provide inpatient, community and rehabilitation services for the chronically mentally ill in Nova Scotia. The study also determined whether there were significant differences among the professional and work setting groups in the way in which they rated priorities and the importance and feasibility of services:

A five point scale questionnaire was designed and given to all members of the four professional groups who worked in the mental health facilities in Nova Scotia. Of the 540 questionnaires distributed, 351 were used in the data analysis. Frequencies, ANCOVA at the .05 level of significance and the Spearman Rank Correlation were used to determine the following results.

The three most important services were (1) psychosocial rehabilitation, (2) medical and mental health care and (3) support to family and community. There were differences among the professional groups in the importance ratings on two services and work setting influenced the ratings on one service. The services ranked most feasible included (1) assistance with benefits, (2) medical and mental health care and (3) psychosocial rehabilitation. There were differences among the professional groups in the feasibility scores on three services and work setting affected scores with one service.

Professionals expressed no preference to change the amount of time they spent working with the chronically mentally ill. They did indicate that the overall priority for the chronically mentally ill should be increased, especially the emphasis on treatment in the community and community support services. There was a preference for priority for institutional support services to remain the same. Professionals in the inpatient and community setting rated four of the five priority questions higher than those in the rehabilitative setting. Professional groups differed in their preference for changes in priority to institutional services. Knowledge of differences among the professional groups can help the program planner identify areas for further discussion in order to build professional commitment to the implementation of program changes for the chronically mentally ill.

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Chapter 1

Introduction

Since the 1800's, care of the chronically mentally ill on both sides of the Atlantic Ocean has fluctuated among times of immense cruelty and neglect, brief periods of specialized treatment, and basic custodial care. The latest period of change, over the last twenty to thirty years, was different because of improvements in diagnosis, psychotropic medication and other treatments. All of these have led to increased control of symptoms thus reducing the need for institutionalization.

Of even more significance was the philosophical change in attitudes toward the care of the chronically mentally ill. Long term hospitalization came to be viewed negatively by most professionals and community members. Not only was it costly, but loss of contact with family, community and the effect of hospitalization itself were believed to contribute to chronicity. The alternative was to treat the patient in the community and a wave of discharges from psychiatric hospitals began in the 1950's (Bachrach, 1979; Talbott, 1979, 1980, 1981; Williams and others, 1980).

This new trend, called deinstitutionalization was based on four assumptions (Bachrach, 1979; Talbott, 1979):

1. Community care was the treatment of choice.
2. Community care could provide treatment functions as well as or better than institutions.

3. Communities were willing and able to assume leadership in the care of the mentally ill.

4. Community care was less expensive.

The results of this radical change in the treatment of the chronically mentally ill have been a subject of analysis by both the layman and the professional in the last five years. There is general consensus that the goals of deinstitutionalization have not been met (Lamb, 1981; Bachrach, 1978; Talbott, 1979). That is not to say that there are not fewer patients in institutions as the number decreased by more than 50 per cent from 1950-1976 (Lamb, 1981; Talbott, 1979; Toews and Barnes, 1982). The chronically mentally ill in the community, however, did not make the gains that were anticipated. Many chronically mentally ill lived in deplorable conditions, only 10 to 30 per cent were employed, often at a less skilled job than they held prior to the illness, up to 50 percent were readmitted to hospital within a year and 60 to 70 per cent were readmitted within five years (Anthony, Cohen and Vitals, 1978).

The community mental health centers, which were established to provide services to the chronically mentally ill, used the resources for work with other populations (Lamb, 1981; Zusman and Lamb, 1977). The fact that the chronically mentally ill continued to be underserved was confirmed in a recent cross-Canada study (Toews and Barnes, 1982). They stated that "the service system for the care of the chronically mentally ill in Canada is severely overloaded and mental health practitioners are having difficulty managing the number of

patients looking to them for help" (p. iv). In other words, the program changes that have been proposed for the chronically mentally ill in the past have not been fully implemented.

STATEMENT OF THE PROBLEM

The purpose of this study is to facilitate program planning by investigating consensus, commitment and priorities related to the services for the chronically mentally ill by the nurses, psychiatrists, psychologists and social workers who provide the care in inpatient, rehabilitation and community settings in Nova Scotia. Specifically, the following questions will be addressed in the study:

1. How much of the clinical time of professional caregivers is presently directed to the care of the chronically mentally ill?
2. Would professional caregivers prefer to change this percentage of time?
3. Within the resources presently available, do professional caregivers believe there should be changes in the overall priority given to financial and human resources for the chronically mentally ill?
4. Do professional caregivers believe there should be changes in the emphasis on treatment of the chronically mentally ill in the community?
5. Do professional caregivers believe there should be changes in the priority given to the development of community support services for the chronically mentally ill?

- 4
6. Do professional caregivers believe there should be changes in the priority given to the development of institutional support services for the chronically mentally ill?
 7. How do professional caregivers rate the importance of services associated with a comprehensive treatment program for the chronically mentally ill?
 8. How do professional caregivers rate the feasibility of services associated with a comprehensive treatment program for the chronically mentally ill?
 9. Are the services of a comprehensive treatment program for the chronically mentally ill that are identified as the most important ~~also the ones that are identified as the most feasible?~~

Where appropriate it will be determined whether significant differences exist among the four professional groups and among those who work in the various settings with regard to the research questions posed.

NEED FOR THE STUDY

There is a need for change in the provision of services for the chronically mentally ill in Nova Scotia (Bayer, 1982; Crook, 1983). Need assessment includes the identification of the nature of a problem and the establishment of priorities so that programs can be developed to deal with it (Fishman and Neighler, 1978; Warheit and others, 1974).

The first step, assessment of the problem and the current services available to treat it have been described in the literature (Bayer, 1982). The second step, in needs assessment, that is, the description of peoples' ideas about the problem and services to treat it is less readily available in Nova Scotia. This step provides important information when choosing priorities, the third stage in needs assessment (Stuart, 1979). The need for a study that will provide information on the beliefs of professionals on priorities and the importance and feasibility of services for the chronically mentally ill will be further explained by briefly describing the necessity for change and current knowledge about professionals' belief in these areas.

In Nova Scotia, responsibility for a full range of services for the chronically mentally ill is divided between the Department of Health (Division of Mental Health Services) and the Department of Social Services (Townsend, 1982). In spite of the mandate of these two government departments, the available resources for the chronically mentally ill in Nova Scotia are limited (Crook, 1982).

The limitation of present resources was made more explicit in a recent study at one community mental health center in the province. Treatment for the chronically mentally ill consisted primarily of medication which was monitored by the psychiatrist. Ninety per cent of the chronic population in the study were seen an average of once a month or less and seventy per cent of those contacts were approximately fifteen minutes in length. Only 25 per cent of the sample were employed, most of them in unskilled jobs (Bayer, 1982).

Considering the limited resources that are presently available, it is not surprising that health care professionals have been asked to make a greater commitment to provide services for the chronically mentally ill (Freeman, 1983). This cry for greater commitment is not only reflected in the professional literature but also by non-professional organizations in the community. The 1982 annual meeting of the Nova Scotia Division of the Canadian Mental Health Association focused on the chronically mentally ill and stressed the need for a broader base of support services for the chronically mentally ill (Crook 1982). In recognition of the present need for economic restraint, it was suggested that members should focus on areas of the system which could be improved (McCormick, 1983). Statements such as this emphasize the need for research on priority setting in Nova Scotia.

The need for clear identification of goals was stressed in the literature (Bachrach, 1974, 1978, 1979; Leighton, 1982; Leithwood, 1982; Stern and Minkoff, 1979; Winslow, 1982). Often there is no agreement on specific goals or else commitment is been made to contradictory goals that may only result in dissipation of the limited resources (Leighton, 1982). In other words, programmatic chaos can result when there has been failure to formulate policy or goals and to build a consensus relating to the goals as a preliminary step toward a major commitment (Scherl and Macht, 1979).

In spite of the expressed importance of consensus in the literature by writers such as Jones (1982), Leighton (1982), and Scherl and Macht (1979), the results of studies on consensus point to the need for clarification on consensus among professionals in Nova Scotia. The

question of whether aftercare services should be delivered primarily by practitioners who have lower levels of professionalization, little or no experience in psychotherapy or who specialize in aftercare was addressed in a 1975 study in Pennsylvania, U.S.A. (Rubin, 1978). In the sample of 192 practitioners, those with more experience as a psychotherapist tended to assign less importance to the aftercare recommendations. Those who did more aftercare work or worked in units specializing in aftercare tended to assign more importance to outreach and express more optimism regarding aftercare. Nurses, psychiatrists, psychologists and social workers did not differ from each other on any of the variables.

The questionnaire used in the Rubin study (1978) was revised and used in 1979 in Leon County, Florida, to estimate levels of agreement on the importance of aftercare by staff in a state hospital and staff in an associated community mental health center (Rubin and Johnson, 1982). Hospital staff rated the aftercare services as more important than did community staff.

A recent Canadian study also provided results on consensus among those responsible for the care of the chronically mentally ill (Toews and Barnes, 1982). Thirty questionnaires were sent to key professionals in each province. The 222 questionnaires that were returned answered questions on satisfaction with the availability and quality of service, barriers to service, program needs, knowledge, professional values, role of Canadian Mental Health Association, and professionals as case managers or consultants. There were no differences in any of these areas by work area or professional category.

The results of these three studies suggest that work setting may influence the assessment of services for the chronically mentally ill, whereas there may be considerable consensus among the four professional groups. These results should be viewed in light of the limitations of the studies discussed below.

Each study by Rubin (1978) and Rubin and Johnson (1982) addressed only one of the important areas, i.e., agreement among professionals or agreement between hospital and community staff. Sample size was very small in some cells, e.g. psychiatrists, $N=11$; nurses $N=13$; inpatient, $N=18$. Neither the Rubin (1978) nor the Rubin and Johnson (1982) study addressed the need for explicitness in goals or objectives when interpreting the data. The general scale in the earlier study included 22 out of 32 items, yet this was treated as a single unit. It is not enough to know whether a broad range of services is important, especially in times when resources are severely limited. Which parts are considered more important than others and which are perceived as more feasible to attain are important in planning services that will increase the professional's commitment as well as provide greater service to the chronically mentally ill.

Many of these limitations were addressed in the design of the study by Toews and Barnes (1982). In their study, however, participants were not asked to rate the importance or the feasibility of services. The participants were key informants rather than part of a random sample which may have increased the amount of agreement among both the professional groups and workers from different settings. Only four from each of the four professional groups in Nova Scotia participated

in the Canadian study so it is not possible to generalize these results to the professional population in Nova Scotia. This points to a need for further research on consensus among the four professional groups in Nova Scotia, especially in the area of importance and feasibility.

Another reason for not making the assumption that consensus exists among the professional population in Nova Scotia relates to the education of professionals. The educational institutions for the four professional groups in Nova Scotia were contacted to determine the amount of theoretical and clinical focus on the chronically mentally ill that is provided for each student. The medical program provided the most theoretical and clinical exposure to the chronically mentally ill, but minimal exposure in the community setting (Munroe, 1984). Although most nursing schools focus on chronic illness, the special needs of the chronically mentally ill are seldom highlighted and clinical exposure varies from student to student with little taking place in the community (Blaikie, 1984; Brennon, 1984; Burchell, 1984; Hughes, 1984). The master's programs in psychology and social work do not provide a theoretical focus on the chronic mentally ill and clinical experience depends on the type of field placement (Carlson, 1984; Hill, 1984; Leighter, 1984). The amount of theory and experience provided in the basic educational programs may influence consensus among the professions and also the commitment they have to the provision of services for this population. Thus, it remains to be seen, whether a truly representative sample of professional caregivers in Nova Scotia would place priorities on the same services and be as cohesive as the samples in the studies by Rubin (1978) and Toews and Barnes (1982); or would reflect the differences suggested in the Rubin

and Johnson study (1982).

The need for commitment to the provision of services was identified in the literature (Achilles and others, 1983; Gotowala, 1982; McCormick, 1983; Rubin and Johnson (1982); Stern and Mintoff (1979).

Only Rubin and Johnson (1982), however, addressed this question in their research. They interpreted the level of importance attributed to aftercare as an indication of commitment. A moderate level of importance was attributed to aftercare by community workers i.e. 5.95 on a nine point scale. Hospital workers had a higher rating (6.94).

Rubin and Johnson expressed concern that this may really reflect a low level of commitment in practice as response biases would have been in the direction of inflated scores (1982). The expressed need for commitment by professionals and limited research points to the need to include the concept of commitment in future research.

In addition to the need for answers to the research questions asked in this study, there is a need for research that can be useful in identifying related educational issues. Although many reasons have been given for the lack of change in the care of the chronically mentally ill, only rarely is education identified as a related factor (Krauss and Slavinsky, 1982; Lamb, 1979). This lack of acknowledgement of educational issues not only ignores an important variable in relation to consensus and commitment but makes it difficult for program planners to take advantage of research on the implementation of change by educators such as Hall and Loucks (1977) and Leithwood (1982).

Failure to produce anticipated outcomes is a problem shared by both the education and health system. The recent focus of attention on

programs for the chronically mentally ill that have not been fully implemented provide an opportunity to reexamine this problem combining both a health and an education perspective.

In conclusion, agreement by professional caregivers in all settings on the importance, feasibility of care and on the establishment of priorities are required if meaningful changes are to take place in the care of the chronically mentally ill. The views of a representative sample of professional caregivers in Nova Scotia on the care of the chronically mentally ill have not yet been obtained. Knowledge of these views may facilitate program planning in the following ways:

1. by establishing whether there is support for increasing the priority given in mental health services to the chronically mentally ill in Nova Scotia.
2. by establishing service priorities for the chronically mentally ill in Nova Scotia.
3. by establishing the need for increased team building among the four professional groups.
4. by establishing the need for increased team building among professionals working in different settings.
5. as a method of promoting discussion, developing consensus and establishing service priorities among all groups concerned with services to the chronically mentally ill.
6. by identifying educational issues relating to the planning and provision of services for the chronically mentally ill in Nova

Scotia.

7. by adding to the knowledge about views on the care of the chronically mentally ill by professionals in a variety of settings.

DEFINITION OF TERMS

Chronically Mentally Ill. Throughout this study chronically mentally ill will refer to persons who have one of a variety of psychiatric disorders (organic brain syndrome, schizophrenia, recurrent depressive and manic depressive disorders, paranoid and other psychoses and other disorders that may become chronic) that interferes with their ability to function in three or more of the following aspects of daily life: personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning, recreation and economic self-sufficiency.

Most individuals have a history of extensive institutional care but also included are those who have required only short periods of hospitalization, treatment in the community on an outpatient basis only, or who have remained in the community without any professional services (Goldman, Gattozzi and Taube, 1981).

Comprehensive Mental Health Service For Chronically Mentally Ill. In this study this term will refer to a mental health service for the chronically mentally ill that includes the twelve components listed in sections of the questionnaire relating to importance and, feasibility. (See Appendix A)

Professional caregivers. All Registered Nurses, Psychologists, Psychiatrists and Social Workers who are employed in mental health facilities under the Department of Health in Nova Scotia and those employed in Regional Rehabilitation Centers under the Department of Social Services in Nova Scotia will be called professional caregivers in this study.

Importance of Treatment Components. Importance will refer to item means and to the rank order of the twelve treatment services as indicated by the responses to the section on importance in the questionnaire. (See Appendix A)

Feasibility of Treatment Components. Feasibility will refer to the item means and to the rank order of the twelve treatment services as indicated by the responses to the section on feasibility in the questionnaire. (See Appendix A)

Program Planners. Although few, if any, professionals are specifically designated as program planners, many of those involved in the provision of services to the chronically mentally ill have a potential role to play in this regard. The term program planner refers then to anyone who may be in a position to influence or change the provision of services to the chronically mentally ill in Nova Scotia.

LIMITATIONS OF THE STUDY

1. Results of the study will be limited to persons with a chronic mental illness and may not apply to other recipients of mental health services.

2. Generalizations will be limited to the four professional categories and may not apply to other professional and non-professional caregivers in Nova Scotia.

3. Generalizations will be limited to four categories of professional caregivers and will not extend to other categories vital to the delivery of health services such as patients, family, community, government.

AN OUTLINE OF THE REMAINDER OF THE PAPER

The remainder of the study will contain four chapters. Chapter 2 will consist of a review of related literature. A description of methodology and procedures will be presented in Chapter 3. Results of the study will be described in Chapter 4; followed by discussion, summary and recommendations in Chapter 5.

Chapter 2

REVIEW OF RELATED LITERATURE

Introduction

An appreciation of the treatment of the chronically mentally ill in the past is necessary in order to understand the importance of the priority given to those with this type of illness now and in the future. Knowledge from the literature of the relative importance and feasibility of each type of service in present day treatment is required to make the data from the present study more meaningful. This review of the literature will include a section on the treatment of the chronically mentally ill in the past and one on the treatment approaches that are considered applicable to the present population of chronically mentally ill.

Treatment of the Chronically Mentally Ill: Past

A historical overview will be presented, drawn from Canadian authors as well as those from other countries that have influenced the development of psychiatric services in Canada. This overview will be divided into sections on moral treatment, custodial care, individual care, and deinstitutionalization.

Explicit descriptions of the treatment of chronic mental illness in the earlier history were difficult to find as a clear distinction between acute and chronic forms of illness was not made, even though

references were made to chronic forms of illness. It is assumed that references to chronic illness in the literature referred to those persons who did not return to their former level of functioning after a reasonable period of treatment.

Prior to the nineteenth century the treatment of the mentally ill was described as inhumane. Often the mentally ill were without resources at all, the object of ridicule and abuse as they wandered about the countryside. Medical attention did not generally improve the treatment of the mentally ill because living conditions in institutions included filth, darkness, isolation, poor nutrition and brutality at the hands of the keepers. Medical treatment itself could also be cruel because of the use of emetics, purgatives, and bloodletting in an effort to cure insanity. This incredible inhumanity was attributed to ignorance, fear and the belief that mental disease was incurable (Alexander and Selesnick, 1966; Deutsch, 1949).

Moral Treatment: Early Nineteenth Century

Treatment of the mentally ill changed in the nineteenth century when moral treatment of the insane gained momentum. Although one Frenchman, Phillipe Pinel (1745-1826) has received most credit for this change in approach, the change was much more universal, as reflected in the work of Vincenzo Chiarugi (1759-1820) in Italy; William Tuke (1732-1822) in England; Benjamin Rush (1745-1813) in America and Andrew Duncan (1744-1828) in Scotland (Caplan, 1969; Henderson, 1964).

Moral treatment was based on several ideals:

1. Insanity was believed to be curable by placing the person in

hospital with an individual program of work and recreation, a heavy emphasis on religious and education services, as well as the supports of group living. Attention was given to the quality of the caregivers and the presence of a sympathetic superintendent.

2. The belief that human problems were capable of being solved and that the burdens of the unfortunate should be relieved.
3. A scientific and medical climate that encouraged examination of mental illness as a disease to be studied by observation and rational deduction rather than being considered divine retribution or demonic possession.

The proponents of moral treatment believed that chronicity was possibly caused by the use of restraints, idleness and brutality. They "sought therefore to manipulate the milieu ... in order to produce therapeutic rather than pathogenic pressure" (Caplan, 1969: 5). The emphasis was on the prevention of chronicity rather than on special treatment approaches for the chronic group. The chronic population did benefit however from those idealistic superintendents who took the stand that the curable and incurable should not be separated in spite of arguments by others that segregated programs would be less expensive to run.

The emphasis on education was another part of moral treatment which affected the treatment of the chronic population. Formal schooling as well as training in religion, healthy habits of life, work and instilling social skills "was intended not only for mental

reconstitution but also to stave off further deterioration from intellectual idleness, particularly in chronic cases" (Caplan, 1966: 36).

In addition to trying to improve the institutional environment for the mentally ill, some advocates of moral treatment tried to close the distance between institution and community by public education, thereby easing the way for the mentally ill to return to the community. In Scotland in particular and less frequently in England and America the quiet and less troublesome cases were boarded with families in the community (Caplan, 1966; Henderson, 1964). It is assumed that many of the chronic cases fit the criteria of less troublesome and benefitted from this approach.

The positive response to moral treatment resulted in an emphasis on attaining high cure rates which negatively affected the chronically mentally ill. That is, cure rates were often published and some institutions claimed cure rates as high as 95 per cent. One way to maintain these high cure rates was to limit the number of chronic patients in institutions (Caplan, 1966).

This trend was noted in Nova Scotia as well. In 1868 the board of the only mental institution in the province decided that serious consideration be "given to the type of patient which should be admitted to the institution" (Purdy, 1976: 9). This led to the establishment of separate municipal hospitals in Nova Scotia for the care of the chronic, incurable, and indigent patient and established a pattern of separate services for the chronically mentally ill in Nova Scotia that has never been completely reversed.

In spite of this positive period in the treatment of the mentally ill and the similarity to present day goals for the treatment of the chronically mentally ill, most of the benefits seem to have been directed toward the treatment of the acutely ill. It appears that the chronically ill gained from this era primarily because they were in the same environment as the acutely ill, rather than being a prime focus of attention. These indirect benefits of moral treatment were most likely unavailable to many chronically mentally ill since the application of moral treatment depended a great deal on the quality of the superintendent of each institution.

In conclusion, this positive treatment era did not have a great impact on the lives of the majority of the chronically mentally ill. Moral treatment in its pure form was really short lived, lasting half a century at the most. In addition, there was an emphasis on preventing chronicity rather than treating it so that the special needs of this population were still usually unacknowledged or denied.

Custodial care: Mid-nineteenth Century

Caplan discussed five areas of change from the moral treatment era that helped to develop the subsequent period of custodial care (1969):

1. Treatment of the insane became synonymous with treatment in an asylum. More institutions were built as "the mounting backlog of chronic cases in their hospitals disrupted the social organization on which their therapeutic system depended" (Caplan, 1969: 60).

2. The institutions were managed by a combination of lay and professional people. In addition to the acutely ill, the professional had to deal with frugal administration, political patronage and an influx of troublesome chronic patients resulting in reliance on force and regimentation rather than on trust and persuasion. Within a few years the public asylums in the British Isles and the United States became identified with the care of the chronically mentally ill and middle class people sought treatment elsewhere. The easy solution was to build more asylums which failed to address the inability of lay and professional caregivers to identify the goals for those occupying the institutions. (Caplan, 1969; Henderson, 1964).
3. Moral treatment stimulated a body of legislation dealing with items such as commitment, discharge, and administration that affected the treatment of the chronically mentally ill. New York State for example, required chronic cases to be discharged to families or poorhouses thirteen months after admission (Caplan, 1969). The British Lunacy Act of 1890, resulted in a loss of public interest in improving conditions for the mentally ill (McKerracher, 1966). These laws once in place were difficult to modify even when it was recognized that they had drawbacks.
4. The myth that mental illness was curable which was generated during the moral treatment era could not be maintained as more and more chronic cases filled hospitals. In the United States this population often included people from foreign countries with different languages and customs. The lack of consideration of

the ethnic factors resulted in many "curable" patients joining the ranks of the chronically mentally ill (Caplan, 1966; Williams and others, 1980). The increase of chronic cases as well as concern about relapses of discharged patients resulted in disillusionment and led to a greater belief in the incurability of mental illness. This led to greater fear of the mentally ill, more isolation and longer confinement. In contrast to the earlier period "there was little speculation at this time about possible environmental causes for relapse in discharged patients and almost none about aftercare" (Caplan, 1966: 94). All of this led to a greater backlog of chronicity, more expectations of the institutions, poorer results, greater disillusionment and less public support.

5. The moral treatment era was built on a medical model that emphasized the importance of the qualified physician. This helped to raise the standards that had existed earlier but denigrated the role of nonmedical people at a time when manpower was scarce.

The end result was a low ebb in the care of the chronically mentally ill during the second half of the nineteenth century. At the most, the chronic but affluent mentally ill received custodial care in private institutions that was humane. The public asylums were seen as custodial facilities for the poor and/or racially inferior insane (McKerracher, 1964). The public regarded the chronic insane as part of a despised and dependent group requiring public dole and public care, not as a group with a disease amenable to treatment (Williams and

others, 1980). Even their right to public dole was questioned as economic pressures increased. Work for the chronically mentally ill became more a means of earning their keep rather than a part of rehabilitation.

Economics became increasingly important to the type of care available because the chronically mentally ill were often caught in the financial struggles among different levels of government. If communities were responsible for their chronic cases, they were often kept in local jails or poorhouses with even lower standards of care since that was less expensive than paying the cost of asylum care (Caplan, 1969; Williams and others, 1980). In Nova Scotia the care in some municipal hospitals was described as kind and decent but generally the standards did not make them suitable for even custodial purposes. "Their budgets were too small and the heterogeneous mixture of human miseries and disabilities they contained were too great" (Leighton, 1982: 53).

Individualized Care: Early Twentieth Century

This low ebb in the care of the mentally ill changed once more with the turn of the twentieth century and a change in thinking by the public. The disadvantaged were seen as objects of care whose needs were to be attended by a benign paternalistic state. Public concern in America was stimulated by the book "A Mind That Found Itself" published by Clifford Beers in 1907 about his experiences in an asylum. This led to the formation of the National Committee for Mental Hygiene in 1909 which stressed education, research on mental illness, prevention and the development of mental hygiene clinics (Deutsch, 1949; Williams and others, 1980). As a result of this pressure, individual programs for

each patient were promoted. These programs centered on work, recreation and education. The use of physical and drug restraint was discouraged (Caplan, 1966):

Care of the chronically mentally ill was sometimes influenced by the latest scientific thinking of that time (Leighton, 1982). The classification of a deteriorated group of schizophrenia reinforced the idea of incurability and the need for nothing more than custodial care. Even the excitement of Freud's theories did little for the treatment of the chronically mentally ill as they were not seen as amenable to psychoanalysis (Leighton, 1982).

The chronically mentally ill were placed more in the foreground by the belief that there were very few patients who couldn't be helped in some ways. Recovery was achieved by developing assets in both patient and environment and using the patient as a partner in this process (Leighton, 1982). Their status was also improved by the belief that improvement in chronic states was theoretically possible and the goal of treatment was to help the person deal with reality and to be able to adapt to changes in the environment. This included maximum freedom for the patients so they did not get so removed from normal life and relatives did not get too accustomed to the idea of institution for the patients. These positive changes resulted in more attention being given to the quality and training of nonmedical personnel, the start of occupational therapy and social work services, all of which improved institutional services for the chronically mentally ill.

Although there were now glimpses of new goals for the chronically mentally ill the treatment for the majority of those with a chronic

mental illness did not change. The economic impact of two world wars and a major depression helped to keep the care at the custodial level. Attitudes did not change drastically in most areas and any changes in treatment were directed toward the acutely ill more often than the chronically ill. This was noted particularly in Nova Scotia because of the separate treatment institutions for those with acute and chronic illness (Leighton, 1982).

Deinstitutionalization: Mid Twentieth Century

The treatment of the chronically mentally ill changed once again in the 1950's. The beginnings of a new movement which was later called deinstitutionalization really started in a silent and innocuous manner. The mental hospitals were filled to overflowing and there was an attempt to decrease the population in institutions. Several factors reinforced this silent beginning until the trickle of change became a torrential downpour resulting in dramatic decreases of 50 to 60 per cent of the populations of mentally ill in state and provincial institutions by the late 1970's (Bachrach, 1979; Talbott, 1979, 1980, 1981; Toews and Barnes, 1982; William and others, 1980; Zusman and Lamb, 1977).

One factor was the advances made in psychotropic medication which resulted in control of the more florid and bizarre symptoms of many mentally ill. The removal of these symptoms reduced the need for the protective environment of an institution and complemented the developing philosophy of the community mental health movement.

The community mental health advocates believed that long-term

hospitalization itself helped to produce the chronic effects of mental illness. They also claimed that the community was more conducive to minimizing chronic mental illness because the patient was close to family, friends and the mainstream of life.

These popular beliefs of the time could not have brought about the drastic reduction in institutional population without legislative support. In the United States, for example, the Community Mental Health Center Act, 1963, made provisions for the establishment of many mental health centers which were to provide services to the mentally ill and were eventually to replace state hospitals. Legislative and judicial forces in the U.S. also emphasized patients rights, treatment in the least restrictive environment and more stringent legal conditions for commitment to a hospital.

Economics was also a factor in promoting the reduction of chronically mentally ill in institutions. Treatment in the community was expected by some to be less expensive and would lead to the use of other sources of federal funding.

If one looks at numbers, deinstitutionalization was a great success. In the United States in 1955, State hospitals had a census of 550,000. In 1980 that number had been reduced to 170,000, a decline of 60 per cent (Talbott, 1980). In Toronto, Canada "the number of inpatient psychiatric beds decreased from 370 per 100,000 population in 1955 to 69 per 100,000 in 1977" (Wasylenki and others, 1981: 493).

If one looks beyond numbers, however, deinstitutionalization has been considered a failure in North America (Ashbaugh and Bradley, 1979;

Braun and others, 1981; Scherl and Macht, 1979; Shore and Shapiro, 1979; Talbott, 1979; Toews and Barnes, 1982; Wasylenki and others, 1981; Zusman and Lamb, 1977). "The net result of the movement was that what had been achieved was not deinstitutionalization but transinstitutionalization. The chronic mentally ill patient had his locus of living and care transferred from a single lousy institution to multiple wretched ones" (Talbott, 1979: 622). Deinstitutionalization was frequently criticized when it was recognized that there were often obviously mentally ill people in the streets, ghettos of chronically mentally ill were developing, there was an increase of younger residents in nursing homes and the mental health centers were servicing populations other than the chronically mentally ill. The majority of chronically mentally ill either were lost between the cracks, i.e. following discharge they stopped receiving mental health services at all or else they joined the revolving door syndrome whereby 35 to 50 per cent were readmitted within one year of discharge and 65 to 75 per cent within five years (Lamb, 1981; Talbott, 1979).

Although the change from institutional to community care had been taking place for the previous thirty years, attempts to conceptualize the change and analyze why it did not work have occurred only recently (Lamb, 1981). The reasons cited for failure were complex, often interrelated and ranged from the philosophical to the practical (Bachrach, 1978; Talbott, 1979; Scherl and Macht, 1979; Zusman and Lamb, 1977).

First, deinstitutionalization was a sweeping change that affected much more than the provision of health services. Not only were

patients, caregivers and government involved, but care of the patient in the community had a direct impact on families, communities, and business as well. Yet deinstitutionalization took place without general consensus of all those involved (Scherl and Macht, 1979). It was not surprising that professionals, families, institutions, business and government agencies reacted when the realities of deinstitutionalization started to occur. It became "a process in search of a policy" (Scherl and Macht, 1979: 600) instead of a policy with a well planned process.

Not only was there a lack of societal consensus but also lack of planning (Bachrach, 1978, 1979; Talbott, 1979). At best, this planning "has often been naive; at worst, neglectful" (Bachrach, 1979: 387). There was no testing of the basic ideals; (1) that community care was better and (2) cost less than institutional care. It had also been assumed that communities would develop the alternate resources that were needed once the patients were in the community. The reality has been that many patients were and still are discharged to communities that have not developed the resources necessary for continued care (Toews and Barnes, 1982).

Part of the lack of planning was attributed to the overwhelming naiveté by the proponents of deinstitutionalization and oversimplification of the needs of the chronically mentally ill (Bachrach, 1979). Even though most chronic patients within the institution had been receiving, at the most, humane and custodial care there seemed to be a lack of awareness of the many supportive services that were an automatic part of any closed system such as a medical

, institution. Lodging, food, and clothing were automatically there without conscious planning on the part of the patient or the majority of caregivers. Social, recreational, medical and sometimes vocational services were within arm's reach. The restricted environment of the institution was identified as harmful and was accompanied by the assumption that a less restricted environment such as the community would automatically be more beneficial. Even if there had been no naiveté about the needs of the chronically mentally ill on the part of the caregivers, the development of community resources did not keep pace with the rate of increase of chronically mentally ill in the community. Not only were there not enough mental health centers but there were major deficits in the availability of other community support services such as housing, employment and social rehabilitation. The money used in the institutionalization of the chronically mentally ill did not follow the patients into the community. Even the money that had been initially allocated for the community developments in the earlier years of deinstitutionalization was reduced in more recent years (Bachrach, 1979; Toews and Barnes, 1982).

In addition to lack of funds there was also naiveté by the proponents of deinstitutionalization about the number and diversity of agencies that provide these community services. These agencies often had different mandates, priorities and motivation for the provision of services to the chronically mentally ill, for example, most boarding homes were established by the private sector for financial gain. The fragmentation of services that resulted has contributed greatly to the failure of deinstitutionalization. In other words, care of the

chronically mentally ill has been provided by several small and independent subsystems instead of one large, integrated system and the onus of bringing these fragmented services together into a comprehensive system has been left to patients with major ego defects.

Last, but maybe of most importance, the attitudes toward the chronically mentally ill have been cited as a reason for the failure of deinstitutionalization. Less stigma toward mental illness did develop but it was not completely eradicated (Lamb; 1979). Bizarre behavior no matter how harmless still aroused fear in citizens and it was not uncommon for communities to resist the development of specialized housing for the chronically mentally ill (Miller, 1982). This meant that many mentally ill in the community did not have the acceptance by others that was needed in order to be integrated into the community.

Stigma was not limited to the general citizenry. The professionals who provided the services were also accused of having negative attitudes toward the chronically mentally ill. In fact, the chronically mentally ill seemed to receive lowest priority in many centers (Brown, 1982; Lamb, 1981; Toews and Barnes, 1982; Zusman and Lamb, 1977). "There is a fair degree of consensus now that community health planning is de facto geared toward the care of persons who can, for the most part, and most of the time, look after themselves" (Bachrach, 1978: 573). While it could be argued that the social climate of the 60's oversold the beneficial effects of such preventive efforts in the clinics and that the neglect of the chronic population was not related to staff attitudes, others suggested that the neglect reflected professional lack of interest in the chronically mentally ill (Donlan

and Rada, 1976).

Lamb (1979), postulated that most mental health professionals thrive on and encourage some dependency in client relationships. This need for dependency, however, is balanced by the professional's need to confirm professional competency by seeing that clients become more autonomous and seek higher levels of adaptation to their environment. When the chronic patient seems locked in a dependency relationship and appears to make little or no progress, the professional develops feelings of incompetency and frustration because their own needs are not met. Lamb (1979) also stated that the professional's "dissatisfaction with a primary role of gratifying chronic dependency needs and a more or less covert moral rejection of our patient's surrender to passivity are probably two of the roots of neglect of the mentally ill" (p. 204).

From this review of deinstitutionalization, proponents of the movement had many goals for the chronically mentally ill. If these goals had been met the chronically mentally ill would have moved from the restricted environment of the institution to a community environment where they could once again be part of the mainstream of life. These goals have not been met for the majority of the chronically mentally ill. The reasons cited for these poor results were all related in some way to lack of planning, lack of resources, lack of knowledge of needs and continuing negative attitudes toward the chronically mentally ill.

Summary

Treatment of the chronically mentally ill has fluctuated over time from the inhumane to the humane. At times this treatment has been a reflection of societal attitudes toward any form of mental illness. At other times it has been a reflection of attitudes toward chronic mental illness. Most often positive changes in treatment approaches were beneficial to the acutely ill rather than the chronically ill. Only those chronically ill who were part of the same environment as the acutely ill were part of a new approach. That is not to say there were not isolated exceptions to this general pattern such as those idealistic superintendents during the moral treatment era and proponents of community mental health. It does mean that these highlights in treatment of the chronically mentally ill have never generalized to the majority of treatment environments even during periods of good intentions such as occurred during deinstitutionalization. It remains to be seen whether it is possible to change centuries of neglect so that the majority of chronically mentally ill rather than a minority receive appropriate treatment.

Treatment of the Chronically Mentally Ill: Current Services

This section of the review of the literature will draw on writers, primarily from the last five years, who describe services that are presently considered important in the care of the chronically mentally ill. Some of the ideas are not new and may apply equally to other forms of mental illness but are being written with the special needs of the chronic population in mind.

The variety of programs directed toward care of the chronically mentally ill, especially in the community has increased since the 1950's. Test and Stein (1978) reviewed the research on community programs for the chronic patient in the United States and noted that most program development lacked a theoretical framework or evidence of demonstrated effectiveness. In addition, specialized programs were not universally available. It was found that community services most often consisted of brief individual counselling and supervision of medication (Turkat, 1981).

The difficulties encountered in providing services to the chronic patient resulted in a series of working conferences convened in 1974 by the National Institute of Mental Health in the United States (Turner and Shifren, 1979). These conferences led to the development of the Community Support System concept, which provided a framework for treatment of the chronically mentally ill and new ways of funding these services. It was found that the changes in government policy and funding

patterns have resulted in increased services for the chronically mentally ill in many areas, especially partial hospitalization programs, case management, residential programs and services for youth (Runck, 1984). The services described in this concept have been recommended for Canadian settings as well (Report of the Mental Health Planning Survey, 1979; Toews and Barnes, 1982). This section will describe the Community Support System concept, as well as each of the services included in such a system. The current knowledge about the importance and feasibility of each service as reported in the literature since 1978 will be incorporated into the description.

A community support system was defined "as a network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (Turner and Shifren, 1979:1). The guidelines were client-oriented as determined by the functional characteristics of the chronic population. The conference members agreed that communities should have services to help the chronically mentally ill fulfill basic needs, provide opportunities for them to overcome the effects of their mental disorder and to assist the community in coping with chronic mental illness. Specifically these services would:

1. identify clients, whether in hospitals or in the community and reach out to offer appropriate services to those willing to participate,
2. assist clients in applying for income, medical, and other benefits,
3. provide twenty-four hour, quick-response crisis assistance in the

least restrictive setting possible,

4. provide psychosocial rehabilitation services,
5. provide supportive services of indefinite duration,
6. provide adequate medical and mental health care,
7. provide back-up support to family, friends and community members,
8. involve concerned community members,
9. protect client rights, both in hospitals and in the community and,
10. provide case management services. (Turner and Shifren, 1979:2)

Knowledge of the overall efficacy and feasibility of the Community Support System was limited. Bachrach (1982) built on previous outcome reviews of Test and Stein, (1978) and Braun, and others (1981) in assessing the current knowledge of the outcomes of community support systems. It should be noted that these earlier outcome reviews focused only on the impact of aftercare, early discharge and programs providing alternatives to hospitalization for the patient and did not address the impact of community support systems on families, communities or professional caregivers. It could only be concluded that community-based programs provided satisfactory alternatives to hospitalization. Patients in the community did no worse and in some ways had more positive outcomes than their counterparts in hospital control groups. Community programs that were successful had adequate funding and high staff ratios. Community support programs reduced hospitalization rates and increased time spent in the community. Control of symptoms was generally equal for

(both hospital and community groups. Psychosocial rehabilitation approaches showed mixed results, either no differences between treatment and control groups or a slight difference in favor of the psychosocial treatment group. There was a clear indication that the clients preferred treatment in the community.

Evidence of treatment gains as a result of community programs is very limited and tenuous and should be interpreted with caution (Bachrach, 1982). These limited results were attributed in part to the difficulties in assessing outcomes. These difficulties were identified as:

1. absence of explicitly stated research and/or program goals,
2. absence of adequate indices of outcomes other than rehospitalization rates,
3. lack of validity of other outcome indices,
4. lack of standardization of groups,
5. lack of standardization of time frames used in the measurement of outcome and
6. absence of methodologies that will measure the interactive effect of treatment components.

Information about the feasibility of community support services was less frequently reported than information about the importance of these services in spite of the fact that chronic mental illness accounted for approximately 87 per cent of the total cost of mental illness in the

United States (Scharfstein and Clark, 1978). The original notion that community care would be less expensive has not yet been clarified. It was found that community care was ten percent more expensive although the benefits were also greater than traditional hospital care (Weisbrod and others, 1980). A more recent economic analysis of three community care projects focusing mainly on psychosocial rehabilitation found that there were definite economic benefits to the community programs but noted that there are many gaps in the knowledge of the economic benefits from vocational rehabilitation (Bond, 1984).

Fenton and others (1984) conducted a Canadian, two year, study of health costs and concluded that the manpower and operating costs of hospital treatment is higher than home treatment and that the cost of treatment failure in home care accounted for at least 39.1 percent of the home care cost, suggesting that community care is feasible.

In other words, empirical results of studies on community support systems are extremely limited and few interactive effects are known. Description of programs and results published in the literature and included in the following review of the ten services in a community support system may have been more a statement of belief, reflection of hope and involvement of ego than a clear indication of success based on a sound theoretical framework (Bachrach, 1982).

Identify clients and provide outreach services

What is meant by identification of clients was not clarified in the literature. The broadest interpretation would mean the identification of anyone in a community who had a chronic mental illness. A more limited

interpretation would be the use of one of three methods of identification in an American study (Szymanski and others, 1982):

1. persons who have been hospitalized previously and who currently require outpatient care,
2. persons previously hospitalized who are rehospitalized over a period of time,
3. diagnosed schizophrenics who were currently receiving outpatient treatment.

Method 1, produced a rate 2.9 times that of method 2, and 3.5 times that of method 3. With this method, patients who have already "slipped through the cracks" and are not receiving treatment would not be identified. Estimates of the chronically mentally ill in nursing homes, boarding homes and private homes would be needed as well as methods used in the study by Szymanski and others (1982).

The size of the chronic population in Canada has never been definitely determined. Bland (1984) combined national data with outcome results from limited studies to provide "an epidemiological perspective on schizophrenia and affective disorders" (p.242). It was suggested that there are 60,000 schizophrenic and 18,800 affective psychosis patients who are disabled in Canada. Four patients require community support for every patient receiving institutional support. In addition, approximately eight percent of the population, many with a chronic mental illness receive no treatment at all (Leighton and others, 1984).

Part of the responsibility of this service is to locate those in need

and help then remain in care in spite of the fact that the characteristics of chronic mental illness such as low esteem, low motivation make it difficult for patients to seek out services that would help them cope with their illness.

Outreach was discussed but a precise definition of what was meant by outreach was not clearly identified in the literature. Outreach may mean nothing more than contacting patients who did not show up for treatment (Turner and Shefren, 1979). Beard, Malamud and Rossman (1978) studied the effect of outreach techniques over a nine-year period in New York. One group received home visits, telephone and/or letter contact for two years following intake into a program that included day programs, evening and week-end social activities, transitional living and work opportunities. The control group received no reaching out contacts. The reaching out groups spent twice as long in the community before rehospitalization and 40 percent fewer days in the hospital. The experimental group also attended the program twice as often as the control group. In another study the discharge planning of 119 chronic schizophrenics in four inpatient centers was assessed over one year in order to identify the areas of discharge planning that were most important in preventing rehospitalization (Caton and others, 1984). The adequacy of discharge planning, especially linkage with other agencies affected both treatment compliance and early rehospitalization rates. One other study was designed to assess utilization of community support services throughout the United States. Only transportation to programs was reported under outreach and it was found that 30 percent of 1,471 chronically mentally ill were provided transportation during the month under study (Tessler and others, 1982).

The review of empirical results on identification and outreach services indicated that services were utilized by patients, clearly affected their attendance rates in programs and increased time spent in the community before rehospitalization. Although writers in the current literature generally acknowledged that identification and outreach were important they rarely identified specific roles and failed to recognize the feasibility implications of this service. Epidemiological studies of the prevalence of mental illness ranged from 20-26 percent yet the treatment rates are seldom over one percent (Leighton, 1982, 1984). Obviously, if prevalence rates are to be considered in planning for outreach, the cost of such a program would increase drastically.

Assist clients in applying for entitlements

Assisting clients in applying for entitlements was considered important because the nature of chronic mental disability often left the person with an inability to pursue employment, to provide for nutritional, housing and medical needs and without the skills necessary to gain access to programs where these benefits could be received. (Turner and Shifren, 1979).

In the one month utilization study it was found that of 1,471 chronically mentally ill, 40 percent received medical care, 8.7 percent received dental care, 20 percent were helped in applying for income benefits and 20 percent were referred to community resources for other entitlements (Tessler and others, 1982). Anderson (1982) stressed the need for mental health professionals to place high priority on this function as many mentally disabled drop requests if they are denied after

taking the initial step. He urged professionals to be persistent when dealing with agencies that provide entitlements and to be specific in providing documentation.

Mueller, Posternak and Handler (1980) stressed the need for changes in the attitude of professionals so that their protective, caretaking attitudes do not encourage dependency and an expectation of non-achievement. Because of changes in benefits that precipitated a financial crisis for a group of patients in a residential home, a course was designed to help 15 clients make their own financial decisions. Topics relating to finances in six areas, e.g. residential home, sheltered workshop, and government entitlements, were covered in a two year course that was originally planned for weekly meetings over three months. Leaders were astounded at the interest, attendance, changes in attitude, changes in ability to make financial decisions as well as improvement in test results on knowledge relating to finances. According to the authors, the changes in the attitude of group leaders was even more surprising, as the staff realized how much they contributed to patients' low expectation.

Provide 24 Hour, Crisis Services

A clear description of crisis services was not included in the discussions in the literature. It appeared to include the availability of knowledgeable staff, either in person or by phone, on a 24 hour basis. Also mentioned were trained staff to provide services such as crisis foster homes, halfway houses, and easy access to hospitalization (Turner and Shifren, 1979).

Little was found in the recent literature that would clarify the importance of crisis services, either theoretically or empirically. Turner and Shifren (1979) and Talbott (1980) indicated that the chronically mentally ill were more vulnerable to stress and often needed care on an emergency or crisis basis, but provided no explanation for this. Bachrach (1981b) and Sheets and others (1982) referred to the increased demand made on emergency room services in general hospitals as a result of deinstitutionalization. No statistics were included with this statement. Chronic repeaters in the emergency room often have profound psychological, social and economic problems and the need was stressed for more cooperation among agencies to provide support for those with a chronic mental illness (Munves and others, 1983). It was also found that approximately 16 percent of 1,471 clients received crisis assistance in one month and approximately 7 percent had an emergency hospitalization (Tessler and others, 1982).

Krauss and Slavinsky (1983) stressed the importance of professionals recognizing the need for a crisis intervention model as part of a framework for working with the chronically mentally ill. Many normal developmental milestones become crisis situations for the chronically mentally ill and considering a crisis intervention model can help to identify appropriate strategies for intervention. Cesnik and Stevenson (1979) also contributed to the understanding of the importance of 24-hour crisis assistance. They claimed that most chronic patients who came to emergency room did not require hospitalization. In spite of this, hospitalization often occurred because staff could not go into the patient's environment to develop the support network that could prevent hospitalization (Turner and Shifren, 1979).

Cesnik and Stevenson (1979) stressed the importance of crisis services for community relations. If these services were unavailable, those left to deal with the crisis, such as general hospital staff and law enforcement staff, developed negative attitudes toward mental health agencies and ultimately toward the chronically mentally ill. The stressful and potentially dangerous working conditions for staff in such a program was also highlighted and implied that finding sufficient staff to implement this type of program might be one factor affecting feasibility. Blume and Sovronsky (1981) reported on a plan that established a community support system in a New York county. This program used 8 on-call social workers for crisis intervention in 1978 to 1980. Cost for all programs were included in the report. Crisis intervention cost \$32.00 per contact in 1979 and was one of two programs, dropped by 1980. No explanation was given for the program cut but the report could serve as an indication of the low priority given to this function.

Provide psychosocial Rehabilitation

Psychosocial rehabilitation comprised a number of services that were called the heart of a community support program. They most frequently centered around (1) daily living skills, (2) social skills, (3) leisure activities and (4) vocational skills (Turner and Shifren, 1979). The importance of psychosocial rehabilitation services may be related to the fact that successful treatment within a hospital has not necessarily been seen as an indication of successful adjustment to the community as measured by recidivism rate or post hospital employment (Anthony and others, 1978; Test and Stein, 1978). In fact, employment rates in

follow-up studies ranged from 10 - 30 percent (Anthony and others, 1978; Spivack and others, 1982; Long and Runck, 1983). The lifestyle of 99 long term patients in a Philadelphia Mental Health Center lacked work-task orientation and showed more orientation toward health and social relationships. Most frequently their time was spent listening to the radio, watching television or sleeping. They were involved in few activities that took place in the community or involved friends (Spivack and others, 1982). There was, in fact, general agreement that many chronic patients had difficulty performing basic activities of daily living and in forming or maintaining adequate interpersonal relationships (Cohen and Sokolovsky, 1978; Solomon and others, 1980; Talbott, 1980; Turner and TenHoor, 1978; Woodside and Mercer, 1983).

The psychosocial rehabilitation club was one method of providing these services that received favourable reports in the literature (Anchor Mental Health Association, 1980; Beard and others, 1978; Long and Runck, 1983; Turkat and Buzzell, 1982, 1983; Turner and Shifren, 1979). In spite of the importance given these services, social and recreational outlets were one of three services least readily available in Canada (Toews and Barnes, 1982).

These clubs, often modelled after the Fountain House Program in New York City were organized so that the chronically mentally ill were involved as needed contributing members of the organization rather than as patients to be treated. Variety and comprehensiveness in programs were stressed so that the members had a real choice in finding a social, vocational and/or living environment that met their needs.

Almost all psychosocial rehabilitation programs offered some type of

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social skills training, yet a review and critique of the empirical results of programs in social skills did not reveal clear indications of their efficacy (Wallace and others, 1980). Social skills training was effective in changing some verbal and non-verbal elements in interpersonal communication. These changed behaviors did not necessarily translate into increases in the person's ability to have needs met by the environment nor did the increased gains in training frequently generalize to new situations. There were many methodological shortcomings in the studies and wide variation in training methods that made it difficult to compare results (Wallace and others, 1980). It was suggested that present training methods may have too narrow a focus and may ignore elements that are essential to social skills. In addition, programs should include strategies to help the participants use the new behavior in their natural environment. Liberman, (1982) stressed the inclusion of cognitive problem-solving strategies in a four-level hierarchy of social skills development model in areas such as peer and family relations; community living; vocations and symptom management.

In most psychosocial rehabilitation programs there was also a focus on vocational needs centered on programs such as:

1. prevocational training where the members participate in functions necessary for maintenance of the club,
2. transitional employment, and
3. independent employment in the competitive markets or sheltered workshops environment (Turkat and Buzzell, 1982; Weintraub and Harnois, 1981).

In Canada, sheltered occupational opportunities were the least available service. Those that were available were considered to be low in quality (Toews and Barnes, 1982).

The movement of members from one vocational program to another was researched in a program that had been operating since 1977 in Atlanta, Georgia (Turkat and Buzzell, 1982). As a result of the study it was concluded that placement into independent employment was short lived unless time had been spent in prevocational and/or transitional employment first.

The one month utilization study of services by 1,471 chronically mentally ill revealed that 52 percent had been assessed for psychosocial needs, 23.5 percent participated in activities for community living skills; 17.9 percent in programs to enhance employability and 17.9 percent in sheltered workshops (Tesslers and others, 1982).

In other words the literature indicated that psychosocial rehabilitation programs were believed to be important and were utilized. It provided little information about the effectiveness of these efforts or about the feasibility of programs that all require specialized skills on the part of staff.

Provide Supportive Services of Indefinite

Duration

The description of supportive residential and vocational services, as described by Turner and Shifren (1979) and Turner and Ten Hoor (1978) addressed the heterogeneous nature of chronic mental illness, for example, some chronic patients required services for a limited period of

time, others required specialized living, social and vocational services for the remainder of their life. Not only did the span vary widely, but there has been a wide variation in the amount of living and vocational independence that can be handled by each person with a chronic mental illness.

Not only does this heterogeneity affect vocational programs but also the range of living accommodation that is required if clients' needs are to be met. In spite of alternate living arrangements being identified as an area of great need, discharge planning in this area was the least well done by professionals (Caton and others, 1984). Alternate living arrangements have been identified as one of the least available and most needed services in the recent Canadian study (Toews and Barnes, 1982).

In the 1980 survey by Tessler and others (1982) it was found that more than 50 percent of 1,471 clients lived in settings that provided little or no supervision i.e., private homes, rooming houses, boarding homes and unsupervised apartments. Approximately 32 percent lived with family members. Unfortunately, the report did not indicate the number of chronically mentally ill who were in a variety of supervised facilities.

Residential facilities which provided some type of supervision included foster homes, halfway houses, supervised apartments and lodges. Foster care placement was described as offering the advantage of family rather than psychotherapeutic care, and facilitating a more intense relationship between patient and caretaker. Carpenter (1978) noted that foster care services need more research, considering the service it provided.

Halfway houses were developed to provide temporary help to the client

in community adjustment. Carpenter's review of the residential literature indicated a wide variation in the selection of residents, staffing, programs and financing of halfway houses. Lodge accommodations as developed by Fairweather (1964) differed from other living accommodations as residents lived together and also ran a business e.g. janitorial services. Both the residence and business were run with a minimum of supervision by professionals. Another alternate living arrangement was supervised apartments, often rented by an agency or directly by a small group of patients (Benn, 1983). The sponsoring agency then provided the programs and supervision needed for residents to function appropriately in these apartments. Carpenter (1978) concluded that

1. the need for all of these residential facilities will continue to rise, especially the need for supervised apartments,
2. care must be taken to ensure that alternate living arrangements are more than low quality custodial care,
3. alternate living accommodations were cheaper than hospitalization although the report did not indicate whether program costs were included in this assessment and
4. patients generally preferred alternate living arrangements in the community.

From the review of the literature on supportive residential and vocational services, it was noted that stress was placed on the need for these supportive services, whereas the feasibility question was rarely addressed. There were few indications of qualifications of staff,

specialized training required, amount of supervision given or any other factors which gave indications of the feasibility of including such a wide range of options in a comprehensive service for the chronically mentally ill.

Provide Adequate Medical and Mental Health Care

The chronically mentally ill have physical health needs that are greater than those of the general population (Turner and Shifren, 1979). This means that assessment of need for medical and dental treatment should be part of the total provision of services to the chronically mentally ill. This aspect of care was not well developed in the recent literature. It is difficult to know whether this implies low importance given to the provision of physical health care or lack of interest in researching such an obvious area. No matter which explanation is appropriate the lack of emphasis is contradictory to the philosophy behind the outreach function which indicated that the chronically mentally ill did not seek out services to meet their needs.

Information on mental health care received greater priority in the literature. A review of the literature on the provision of drug, milieu, individual, group and or/ family treatment however, is beyond the scope of this review, even though many articles were available. It may be safe to conclude that these services are considered important as many agencies provided only medication and individual therapy services for the chronically mentally ill (Bayer, 1982; Enzinas, 1982; Turkat, 1981).

PROVIDE BACK-UP SUPPORT TO FAMILIES, FRIENDS AND
COMMUNITY MEMBERS

Support for others who are involved with the chronically mentally ill may include (1) education, (2) family support (3) group support and/or (4) respite care. Some studies in the literature reviewed, focused only on the impact of mental illness on people in the patient's environment. Other studies dealt with the type of support that can be given to those involved with the mentally ill. Most often families of the chronically mentally ill with a diagnosis of schizophrenia were used in the studies. In a 1969 study, one family member of each of 92 patients showing disability, high likelihood of relapse and residency in the city of Saskatoon was asked to complete a 26 item scale of home problems. The percentage of family respondents who experienced problems with anxiety, worry about odd behavior, need for excessive companionship, interference with social or leisure activities, adverse affect on children and an overall sense of severe burden, ranged from 47 to 80 (Smith, 1969). A more recent Canadian study found that the most frequent problem behaviors for families of schizophrenics had to do with deficits in functioning whereas the problems most difficult to manage were concerned with insight, compliance, abnormal experience and beliefs (Runions and Prudo, 1984). Doll (1976) studied 125 families of the chronically mentally ill in Cleveland, Ohio and found that families will care for their disturbed relative and express little shame about this, but heavy emotional and social costs accompany this acceptance.

Kreisman and Joy (1974) reviewed the literature on 'the families' response to mental illness in 15 areas such as, the families' definition

of the problem, effects of distance or closeness of relationship to the patient, attitude toward its sick member, tolerance of deviance. It was concluded that contradictory evidence was found in all areas. These results could have reflected true differences but more likely reflected the inadequacies of the research to date.

Even though the impact of mental illness on families and others has not been adequately researched, it is known that 32 to 50 percent of chronically mentally ill live with their family (Goldman, 1982). Frequently health professionals involved in patient care have failed to recognize the family as a possible support in the treatment of patients or to see the family as a group in need of specialized attention (Boyd and others, 1981; Lamb and Oliphant, 1978; Platman, 1983; Willis, 1982).

The past pattern of ignoring the significance of family involvement may be changing as more family treatment models are developed and tested (Anderson and others, 1980; Atwood and Williams, 1978; Boyd and others, 1981; McGill and others, 1983). In these newer approaches the emphasis has changed from involvement with the family in order to change the pathology that may have caused the illness to one of involvement with that family in order to provide education about the nature of the illness, train the family in specific tasks that can influence the course of the illness and provide support for the families during a time that is known to be long and difficult (Boyd and others, 1981).

Beels and McFarlane (1982) have classified these recent models into relatives groups, psychoeducational family therapy and behavioral family therapy. Most approaches for the chronically mentally ill included some form of initial education, followed up by problem solving and support

that continued for periods ranging from 9 months to 2 years. Relapse rates were reduced in those models that were tested empirically (Anderson, and others, 1980; Boyd, and others, 1981; Leff, 1976). Keyle (1983) described a support group for friends and families of schizophrenics which consisted of seven sessions, lasting two hours each. The estimated cost of the program without any volunteer contributions was approximately \$5,000.00.

Beels and Mac Farlane (1982) proposed that programs involving multiple family groups could turn into autonomous self help groups. Not all self help groups have developed in this fashion. In fact, families of the chronically mentally ill have not waited for the professional to recognize their needs but started banding together in order to provide support for each other, advocate for the rights of the ill family member and inform professionals of their needs (Lamb and Oliphant, 1978; Willis, 1982).

The literature on services to families of the chronically mentally ill was one of the few areas under review which identified that intervention clearly showed positive outcomes and were economically feasible. Feasibility extended to the staff as well, since skills required in some family intervention models were within the repertoire of most mental health professionals (Atwood and Williams, 1978; Beels and McFarlane, 1982; Boyd and others, 1981).

Involve Concerned Community Members

The basic purpose behind the involvement of community members was to improve the links between the formal mental health system and informal

community support systems and give acknowledgement to the capacity of the community to provide services to the chronically mentally ill (Turner and Shifren, 1979; Turner and Ten Hoor, 1978).

Community resistance to involvement can play an important role in the implementation of this function. Community attitudes were studied in Metropolitan Toronto by Taylor and Dear (1981). They concluded that the attitudes toward the mentally ill varied significantly by life-cycle stage and that "personal experience of mental health care--has a significant effect on subsequent attitudes toward the mentally ill and the provision of mental health services" (p. 234). Therefore, the use of volunteers such as members from churches, synagogues, schools and civic clubs to provide social, recreational, residential and employment opportunities not only provided needed services but also increased acceptance of the chronically mentally ill in the community.

Just how mental health services get community members involved was seldom reported in recent literature. The impact of such volunteer services on client functioning received little attention as well although Culter and Beigel (1978) described a program which used volunteers from churches to help chronic patients learn survival skills, arts and crafts and socialize over lunch prepared by the group. The recidivism rate was significantly reduced for those who participated regularly in the program. Cutler (1979) emphasized the need to build trust and respect in the community, find community leaders, involve the community in the planning stage, perform careful recruitment and screening of volunteers and provide consultation and support to the volunteer program if a useful and feasible service was to be developed.

The review of the current literature on involvement of community members provided insufficient studies to conclusively determine either the importance or feasibility of this function. The literature does, however, convey a sense that this function has not been given the recognition it deserves as one of the community support services for the chronically mentally ill.

Protect Client Rights

Turner and Shifren (1979) included the following in their description of protection of client rights (1) informing clients of their rights verbally and in writing, (2) posting information on rights and grievance procedures and (3) making redress of grievances available. Talbott (1982) and Glasscote (1978) referred to service advocacy i.e., the patient was provided with adequate services and obtained access to them. Intagliata (1982) categorized advocacy into:

1. Individual client advocacy which was provided by education of the client, direct intervention by the case manager, requesting administrative support within the agency, seeking legal services and/or the services of outside groups that traditionally act as advocates for the chronic mentally ill.
2. Systems level advocacy which was provided through recognition of gaps in services, documenting of such needs and/or joining with others to act as a catalyst for the new provision of services.

In a one month study of 1, 471 clients, "19.1 percent of clients had been informed of rights and grievance procedures, 10 percent had received training in legal rights and 8.3 percent some kind of advocacy services

related to grievance or legal procedures" (Tessler and others: 210). Finally, it noted that Canadian professionals identified, "1) inadequate funding, 2) lack of integrated community support and care programs, 3) poor coordination of available resources, 4) negative public attitudes towards people with chronic mental disorders" as the most important service barriers (Toews and Barnes, 1982:32). All of these barriers could be included within the advocacy function and could be interpreted as an indication of the importance of advocacy and protection of clients' rights.

Provide Case Management

The underlying principles of case management have been identified for more than 20 years (Ozarin, 1978). Labeling these principles as case management and specifying what this meant in relation to care of the chronically mentally ill has provoked considerable discussion in recent years. There appeared to be complete agreement that case management was a key element in the provision of services to the chronically mentally ill. (Intagliata, 1982; Lamb, 1980; Lourie, 1978; Ozarin, 1978; Schwartz and others, 1982; Test, 1979; Turner and Shifren, 1979).

Intagliata (1982) integrated the key concepts found in the case management literature and suggested that "case management is a process or method for ensuring that consumers are provided with whatever services they need in a co-ordinated, effective and efficient manner" (p. 657). The most common objectives of case management included continuity of care, enhancement of accessibility, enhancement of accountability, and an increase in efficiency of services. It was stressed that increased efficiency resulted in more cost effectiveness and not necessarily in a

reduction of cost as case management most often led to an identification of more client needs. The basic functions included in all models of case management were: (1) assessment, (2) planning, (3) linking, (4) monitoring and (5) evaluation. Other models have included: (1) outreach, (2) direct services and (3) advocacy as case management functions.

The use of a case manager was most frequently identified as the way to implement these functions. The name for this role varied, e.g. broker, enablers, program co-ordinator or resource manager. No matter which name was used, their role was identified as critical as it provided the human link between the client and the services (Intagliata, 1982). The quality of the personal commitment between client and manager was described as the most influential aspect of case management.

The importance of this personal relationship may have been why Lamb (1980) advocated so strongly for the therapist-case manager role. He maintained that a therapeutic involvement was necessary to properly assess a client and that the primary therapist was the appropriate person for that role. Schwartz and others (1982) questioned Lamb's position, stating that most mental health professionals did not have the proper attitude or skills to perform case management functions. This view was not believed in Canada as nurses, psychiatrists, psychologists, social workers and occupational therapists were rated by a professional sample as being well suited to case manager tasks. Social workers and nurses were rated as most suited to act as case managers (Toews and Barnes, 1982). Intagliata (1982) reported that the therapist system was found to result in extensive counselling and assessment but neglect the linking, referral, follow-up and evaluation functions. A second case management

model used case managers who provided little or no direct service for 20-30 clients. A third model utilized a core service team, usually multidisciplinary which was described as broader in scope than the individual model and had the advantage of constant availability of a team member, more energy and ideas for a difficult task and less staff burn out (Test, 1978).

Paraprofessionals were often used in the case manager role. Most systems required not more than a B.A. level degree. Other systems employed professionals with masters or doctoral degrees (Intagliata, 1982). Research is not yet available as an aid in clarifying the education and/or experience most desirable for case management. The literature clearly reported the importance of case management yet a project in Nova Scotia reflected the difficulties in providing case management function when a mandate for this function has not been established by the funding sources (Carlson, 1982). A pilot project, using a case manager for discharge planning, continuity of care and co-ordination of resources for fourteen hospitalized patients was continued from January 1981 until December 1982. As a result of this project it was concluded that:

1. some form of case monitoring seemed useful,
2. further study of case management was necessary,
3. that need for case monitoring was more extensive than current services could provide and
4. cost restrictions prohibited service expansion except through a volunteer basis.

Summary and Conclusion

Based on a review of recent literature, it could be stated that treatment of the chronically mentally ill presently requires a broad interpretation of the deinstitutionalization process and recognition of the heterogeneous nature of this population. Successful treatment of the chronically mentally ill would be enhanced by consensus among those involved in their care as well as a commitment to the provision of a comprehensive service that incorporates continuity of care. The priority given to writing and publishing material relating to the chronically mentally ill increased in the last five years. The writings reflected a concern and commitment to care of the chronically mentally ill. It was less clear whether the ideas conveyed in the recent literature reflected the views and/or behaviors of the many who provide direct care for this population. In addition it was not clear whether the ideas for treatment produced the intended results. Empirical results on the development of staff consensus, staff commitment, program outcome and methods of program development were very limited.

Researchers concluded that treatment in the community was preferred and was as effective as treatment in the hospital. All services were described as important but knowledge of independent and interactive effects of services were scarce. Psychotropic drugs, outreach services and supportive programs for families had the clearest empirical indication of positive results. Case management and psychosocial services were described as key ones but empirical results were not available to support this idea. Vocational and residential services were described as most needed but, again empirical results were not available

to determine the specific role they play in outcome. The type of financial and/or human resources required to provide these services was rarely addressed in the literature, although the myth that community services were cheaper was dispelled.

In conclusion, the current literature generally confirmed that services for the chronically mentally ill were important and expensive but no clear indication of the relative importance and feasibility of each service was provided. It appears that professionals must still rely on their belief system, hope and ego involvement when making decisions regarding services for the chronically mentally ill. Consequently knowledge of the professional's views is important in order to identify goals and develop programs in a way that increases the professionals' commitment to them. Further research regarding the views of professionals on the importance and feasibility of services should be undertaken in order that this information can be included in future decision making.

Chapter 3

METHODS AND PROCEDURES

The proposed study was predominately a descriptive survey, the main purpose of which was to facilitate program planning by obtaining data on priorities, importance and feasibility relating to services for the treatment of the chronically mentally ill by four professional groups in Nova Scotia.. A questionnaire was developed for this purpose and was given to all nurses, psychiatrists, psychologists and social workers who worked in inpatient, community or rehabilitative settings in the province of Nova Scotia. The study was also designed to determine whether there were differences in the ratings among the four professional groups and among the professionals who worked in the three settings.

Sources of Data

Population

The nursing, psychiatry, psychology and social work population worked in the 18 institutions or agencies that carry the primary responsibility for mental health services for the chronically mentally ill in the province of Nova Scotia. These institutions were subdivided into inpatient, rehabilitative and community settings.

Population by Setting

Inpatient Services (Department of Health). The eight inpatient services provided in three regions throughout the province included two psychiatric hospitals and six psychiatric units associated with general hospitals. Services in the Eastern Region of the province were provided by one psychiatric hospital and one psychiatric unit in a general hospital. Psychiatric beds are used for short term and long term care.

The mainland region of the province utilized psychiatric units that were associated with two general hospitals. Both units were situated in towns and draw on small urban and rural communities. These two units were designated as short-term care units but one had a medium to long term care unit as well.

The Metro Halifax region included the largest psychiatric hospital. In addition to providing short and long term care to that region, this hospital also provided specialized forensic, long-term children's and geriatric services for the whole province. The remaining inpatient services in Metro Halifax were provided by four psychiatric units within general hospitals. One of these four psychiatric units specialized in children's services (Townsend, 1982).

Regional Rehabilitation Centers. There were three rehabilitation centers operated by the Department of Social Services to provide residential rehabilitation for mentally retarded and post-mentally ill residents, i.e., patients who have been hospitalized and no longer require the active treatment provided in hospital but still require

rehabilitation in order to function in the community. Two of these centers are in urban settings and the third is in a rural setting. More than 50 per cent of the 500 rehabilitation beds were used by the post mentally ill (Thorpe, 1983).

Community Services. There were 10 separate units under the jurisdiction of the Department of Health providing community mental health services in Nova Scotia. Two were associated with psychiatric hospitals, one with a children's hospital and the remainder as departments of psychiatric mental health services in general hospital settings. Day programs were provided in five of these settings. Mental health services were provided to populations ranging from the unhappy but mentally healthy to the chronically mentally disabled.

Population by Profession

Psychologists. Questionnaires were sent to approximately 60 psychologists who worked in 18 institutions or agencies providing treatment for the chronically mentally ill in Nova Scotia. The majority of psychologists worked in the community setting. A small percentage worked in the rehabilitative setting and the remainder worked in the inpatient setting. Included in this sample were those who were employed as a psychologist in Nova Scotia or were on the Candidate's list for registration as a psychologist. Educational preparation included either a master's or a non-medical doctoral degree.

Nurses. Approximately 350 nurses who worked in the 18 units providing care for the chronically mentally ill in Nova Scotia were sent questionnaires. Of these, the majority were employed in the inpatient

setting, the smallest percentage in the community setting and the remainder worked in the rehabilitative setting. Each nurse in the study was registered as a nurse in Nova Scotia and had completed a nursing diploma, Bachelor's or Master's degree.

Psychiatrists. Approximately 60 psychiatrists in Nova Scotia working in the 18 facilities providing care for the chronically mentally ill were sent questionnaires. Around fifty percent of the psychiatrists worked primarily in an inpatient setting, a small percent worked in the rehabilitation setting and the remainder worked primarily in the community setting. Included in the study were all medical doctors who were employed in a psychiatrist's position.

Social Workers. Questionnaires were sent to approximately 70 social workers who worked in the 18 institutions and agencies providing care to the chronically mentally ill in Nova Scotia. Approximately fifty percent of social workers worked in the community setting. Of the remainder, most worked in the inpatient setting and a minority worked in the rehabilitative setting. All social workers employed in a social work position and educated at the Bachelor's, Master's or non-medical Doctoral level were included in the study.

Conceptual Framework

First, a conceptual framework for the study, drawn from a review of related mental health and education literature was used to identify broad areas to be included in the questionnaire. In this conceptual framework chronic mental illness includes persons who suffer from one of a variety of psychiatric disorders that prevent the development of

their ability to function in three or more primary aspects of daily life: (1) personal hygiene, (2) self-direction, (3) interpersonal relationships, (4) social transactions, (5) learning, (6) recreation and (7) economic self-sufficiency. They may reside only in institutions, only in the community or may move between institution and community (Goldman and others, 1981). Successful programming for this population will be facilitated by consensus concerning proposed program changes and commitment by the professional caregivers in order to provide continuity of care for the chronically mentally ill through a comprehensive treatment service. Key concepts to be considered by the program planners involved in the care of the chronically mentally ill include: (1) consensus, (2) commitment, (3) continuity of care and (4) comprehensiveness. Consensus and commitment are necessary in order to implement a successful treatment program for the chronically mentally ill. Continuity of care and comprehensiveness are necessary in order to address the unique, heterogeneous medical and rehabilitative problems associated with chronic mental illness.

Consensus

Consensus refers to the development of a general agreement within society (Scherl and Macht, 1979). Developing consensus in relation to the chronically mentally ill is difficult because so many parties are involved. Patients, families, friends, community members, government as well as service providers are all necessary in the provision of quality care. Yet general agreement on concepts relating to the treatment of the chronically mentally ill is required before goals can be realized (Jones, 1982; Leighton, 1982; Scherl and Macht, 1979). The

difficulties inherent in developing consensus among such a diverse group may be visualized when one considers that professional caregivers alone may have difficulty achieving consensus among themselves because of differences in professional preparation or work setting. If goals for the chronically mentally ill are to be operationalized as intended and not fail due to resistance by professional caregivers, consensus among professionals must be developed.

Commitment

Agreement on the importance of goals is necessary but not sufficient for their implementation. Commitment to the appropriate plan of action by those involved is also necessary (Achilles and others, 1983; Gotawala, 1982; Jones, 1982; Stern and Minkoff, 1979; Sybouts, 1981). All may agree that improved services are needed for treatment of the chronically mentally ill but unless there is a willingness for professional caregivers to become involved and a willingness to provide the necessary resources when there is a limit to fiscal and human resources available to all health services, then goals will not be achieved. New programs usually require changes in the present practices of professional caregivers. Imposing preconceived ideas on a group will only antagonize the people involved. A system of two-way communication and decision making is necessary in order to bring about change in attitudes and feelings that results in commitment (Jones, 1982). Unless strategies are developed to help the practitioner reduce the differences between old and new practices, commitment will remain low and serve as a major obstacle to the implementation of any proposed changes (Leithwood, 1982).

Comprehensive Services

There must be agreement on what is to be included in treatment of the chronically mentally ill. Because of the unique and heterogeneous medical and rehabilitative problems associated with chronic mental illness, a comprehensive or broad approach is needed. The literature reflected general agreement with the ten components of a community support system as developed by the United States National Institute of Mental Health in 1976. This comprehensive service included.

1. identification and tracking of the target population
2. assistance in applying for entitlements
3. crisis stabilization services in the least restrictive setting
4. psychosocial rehabilitation services
5. supportive living and working services
6. medical and mental health care
7. support to family, friends and community members
8. involvement of community in planning
9. protection of client, and
10. case management (Turner and Ten Hoor, 1978).

Continuity of Care

Failure could still occur even when all of the above services have been provided if the chronically mentally ill person, often with major ego

deficits is left with the responsibility to provide continuity among these services. Continuity of care, i.e. "the orderly, uninterrupted movement of patients among the diverse elements of the service delivery system" (Bachrach, 1981a:1449) includes individualized planning, the availability of a variety of services and the development of a interpersonal relationship with the patient. Continuity of care can be facilitated if there is agreement among professional caregivers in inpatient, rehabilitative and community services.

Instrument

A questionnaire (Appendix A) consisting of three parts was developed for the purpose of this study. The content of the questionnaire was based on two sources (1) the conceptual framework for the study and (2) the questionnaire used by Rubin and Johnson (1982). Section A and B of the questionnaire were designed to elicit perception on the importance and feasibility of services for the chronically mentally ill in Nova Scotia. The ten components of a community support service as identified in the literature were used as the guide for services in the questionnaire. Two of the ten components were subdivided, specifically (1) identification and tracking of the target population and (2) supportive living and working service, to facilitate assessment of feasibility and importance. This resulted in the inclusion of twelve services in the questionnaire.

Items from the questionnaire used in the Rubin and Johnson study (1982) were used where possible to provide specific examples of tasks that are descriptive of each service. The Rubin and Johnson (1982) questionnaire was developed to rate the commitment of mental health

practitioners to tasks relating to care of the chronically mentally ill. Criterion validity was assessed in 1974 and reliability in 1978 and 1979 on the 22-question Aftercare Orientation Scale. All except one of the corrected item-total correlations from studies in 1975 and 1979 were significant ($p < .001$). High internal consistency reliability was indicated by the coefficient alpha of .906 in 1975 and .918 in 1979.

Twelve of the examples included in Section A or B of the questionnaire were drawn from the "Aftercare Orientation Scale" (Rubin and Johnson, 1982). New examples were generated for those services that were not included in the Aftercare Orientation Scale, resulting in the inclusion of twelve services and two examples descriptive of each service in section A and B of the questionnaire.

The five questions in section C of the questionnaire were designed to reflect the commitment of professional caregivers to improved services for the chronically mentally ill in Nova Scotia. The subjects were asked to give their opinion on priority using a five-point scale.

The first draft of the questionnaire was subjected to analysis by members of the supervisory committee. A draft questionnaire was sent to four mental health consultants, each representing one profession. These consultants, all members of the Division of Mental Health Services, Department of Health, were asked to provide feedback on the appropriateness of the examples, the general format and the clarity of the questionnaire. The feedback provided by the consultants was incorporated in another revision and the questionnaire was again reviewed by the supervisory committee.

PROCEDURE

The department head in each institution or agency was contacted in order to (1) provide an accurate list of names of professional caregivers (2) enlist help in encouraging participation of staff in the study and (3) suggest a non-clinical staff member who would be willing to assist in the delivery and collection of questionnaires.

A covering letter (see Appendix B), questionnaire and coded return envelope, was sent to each subject. Each subject was asked to rate section A on importance, section B on feasibility and section C on priorities. The subjects were asked to return the questionnaires in a sealed envelope to the designated staff member within a week. At the end of the week, the department head was again contacted by the researcher to obtain the completed questionnaires.

Using the code on the return envelope, a list of subjects who had not returned the questionnaire was compiled. A second letter (see Appendix c), questionnaire and stamped envelope was sent to all professionals who did not complete the questionnaire, requesting that they do so and send the results by mail directly to the researcher. The results were then coded, key punched and a computer file created and stored at the Computer Center at Acadia University.

Data Analysis

Using percentages, the demographic data of (1) the total group, (2) each professional group and (3) each work setting group were

described. The priority questions were answered by rating each of five priority questions on a five point scale. With each priority question the mean and standard deviation of each professional group and worksetting group was determined. An ANCOVA at a .05 level of confidence was completed (Nie and others, 1975).

Each question on the twelve services included in the questionnaire was rated on a five point scale for importance and feasibility. The percentage of respondents that chose each option as well as the percentage that chose values 1 or 2 and values 4 or 5 were identified. The services were then rank ordered. Differences among the professional and work setting groups were determined by ANCOVA and the Student Newman Keul Procedure at the .05 level of confidence (Nie and others, 1975). Based on results from other studies (Rubin, 1978; Toews and Barnes, 1982) and frequency data from the present study, (1) sex, (2) qualifications, (3) years of experience, (4) type of employment and (5) time with this population were identified as covariates for questions on priorities, importance and feasibility.

In the Rubin study, respondents with higher educational degrees and those with more psychotherapy experience tended to assign less importance to aspects of aftercare. It was also found that those who do more aftercare work assigned more importance to these tasks. In the Toews and Barnes study (1982) females rated the services for the chronically mentally ill less satisfactory than did males. In the present study, 35 percent of the professionals in the rehabilitation setting worked part time. The ANCOVA results on the covariates can be found in Appendices D, E and F. The Spearman Rank Correlation

Coefficient was used to determine the relationship between the ranks for importance and feasibility.

Chapter 4 .

ANALYSIS OF DATA

This chapter describes the data resulting from the statistical procedures outlined in Chapter 3. In order to answer research question one regarding the amount of clinical time directed to the chronically mentally ill, the chapter begins with an analysis of the demographic data pertaining to each group of professional caregivers. The remaining data are organized into four sections dealing with the research questions on priorities, importance of services, feasibility of services and relationship between importance and feasibility.

Analysis of Demographic Data

Of the 540 questionnaires that were distributed, a total of 351 were returned. This represents a return rate of 65 percent. The proportion of each professional group on the mailing list was compared to those included in the study. Each profession in the study was represented by at least 50 percent of its population with lowest representation from psychiatry and the highest from psychology. The proportion of respondents in each professional group was approximately equal to the proportion of each professional group in the population. The demographic data of the total group and each professional and work setting group are presented in Tables 1, 2, and 3.

Table I

Demographic Data of Total Group

| Categories | | N | Percent |
|--------------------------------|-----------------|-----|---------|
| Profession | Nurses | 231 | 65.8 |
| | Psychiatrists | 37 | 10.5 |
| | Psychologists | 41 | 11.7 |
| | Social Workers | 42 | 11.9 |
| Highest Qualifications | Nursing Diploma | 186 | 52.4 |
| | Bachelor's Deg. | 46 | 13.3 |
| | Master's Deg. | 62 | 17.5 |
| | Doctoral Deg. | 20 | 5.6 |
| | Medical Deg. | 37 | 10.4 |
| | Other | 4 | 1.1 |
| Sex | Female | 268 | 75.7 |
| | Male | 86 | 24.3 |
| Setting | Inpatient | 192 | 55.2 |
| | Community | 96 | 27.6 |
| | Rehabilitation | 60 | 17.2 |
| Extent of Employment | Full time | 301 | 84.8 |
| | Part time | 54 | 15.2 |
| Years of Work | 1-5 | 31 | 34.9 |
| | 6-10 | 85 | 24.2 |
| | 11-15 | 71 | 20.2 |
| | 16-35 | 66 | 20.7 |
| % of Time With This Population | 1-25 | 99 | 30.7 |
| | 26-50 | 96 | 29.9 |
| | 51-75 | 59 | 18.3 |
| | 76-100 | 68 | 21.1 |

Total Sample

The demographic data of the total group are found in Table 1. In the total group, the majority were nurses. The percentages of psychiatrists, psychologists and social workers were approximately equal. The ratio of females to males was 3:1. The institutional setting employed approximately one half of the professionals. Another 27.6 percent worked in the community setting and the remainder in the rehabilitative setting. Approximately 35 percent of the sample had less than 5 years of experience while approximately 21 percent had more than 16 years of experience. Full time employees were in the majority. Thirty percent of the sample spent less than one quarter of their time providing care to this population where as only 21.1 percent spent more than three quarters of their time with the chronically mentally ill.

Analysis of Demographic Data - Professional Groups

Nurses. The demographic data for nurses are presented in Table 2. The nursing group was almost completely female and almost all educated at the diploma level. Approximately five percent had a master's degree. Nurses worked most often in an institutional setting with nursing representing the smallest number of any profession in the community setting. The majority of nurses worked full time and had an average of nine years experience. They spent the highest percentage of time (56.6%) of any profession in work directed toward the care of the chronically mentally ill.

Table 2

Demographic Data by Professional Group

| Category | Nursing | | Psychiatry | | Psychology | | Social Work | |
|------------------------|---------|------|------------|------|------------|------|-------------|------|
| | N | % | N | % | N | % | N | % |
| Total N | 231 | | 37 | | 41 | | 42 | |
| Female | 219 | 94.8 | 06 | 16.7 | 14 | 34.1 | 27 | 64.3 |
| Male | 12 | 5.2 | 30 | 83.3 | 27 | 65.9 | 15 | 35.7 |
| Nursing Dip. | 184 | 79.4 | - | - | 1 | 2.4 | - | - |
| Bachelor Deg. | 36 | 15.6 | - | - | 2 | 4.9 | 6 | 14.3 |
| Master Deg. | 10 | 4.3 | - | - | 17 | 41.5 | 33 | 78.6 |
| Ph. D. | - | - | - | - | 20 | 48.8 | - | - |
| Medical | - | - | 34 | 94.4 | 1 | 2.4 | 2 | 4.8 |
| Other | 1 | 0.4 | 2 | 5.6 | - | - | 1 | 2.4 |
| Inpatient | 155 | 68.0 | 13 | 37.1 | 12 | 29.3 | 11 | 28.2 |
| Community | 25 | 11.0 | 20 | 57.1 | 25 | 61.0 | 24 | 61.5 |
| Rehab. | 48 | 21.1 | 2 | 5.7 | 4 | 9.8 | 4 | 10.3 |
| Years of Exp. | | | | | | | | |
| 1-5 | 89 | 39.0 | 3 | 8.1 | 12 | 30.0 | 17 | 40.5 |
| 6-15 | 98 | 43.0 | 11 | 29.7 | 24 | 60.0 | 20 | 47.6 |
| >16 | 41 | 18.0 | 23 | 62.2 | 4 | 10.0 | 5 | 11.9 |
| Full Time | 190 | 82.3 | 33 | 89.2 | 36 | 87.8 | 37 | 90.2 |
| Part Time | 41 | 17.7 | 4 | 10.8 | 5 | 12.2 | 4 | 9.8 |
| <25% Time With Chronic | 41 | 20.0 | 16 | 44.4 | 24 | 63.2 | 17 | 44.0 |
| >25% Time With | 72 | 35.1 | 5 | 13.9 | 3 | 7.9 | 10 | 26.3 |

Psychiatrists. The data for psychiatrists are presented in Table 2. The majority of psychiatrists were male and worked most often in the community and inpatient setting. Very few worked primarily in the rehabilitation setting. They were the most experienced of all the professions, having an average of 18.4 years of experience. Approximately 40 percent of their time was directed toward care of the chronically mentally ill.

Psychologists. The demographic data for psychologists are presented in Table 2. Of the 41 psychologists in the sample, the male/female ratio was 2:1. Overall they had higher educational qualifications than nurses and social workers with almost one half of the sample educated at the Ph. D. level. They worked mostly in the community with about one third in the inpatient setting as well. They had an average of 9.8 years experience and approximately one third of their time was spent in work directed to the care of the chronically mentally ill.

Social Workers. The demographic data for social workers are presented in Table 2. There were approximately twice as many female social workers as there were male social workers. Most had their Master's degree. The majority worked in the community setting with the smallest percentage in the rehabilitative setting. As with the other professions, the majority worked full time. Social workers had an average of 8.3 years experience and spent 44.7 percent of their time in work with the chronically mentally ill.

Analysis of Demographic Data -Work Setting Group

Inpatient Setting Group. The demographic data for the group working in the inpatient setting are found in Table 3. The inpatient sample consisted of 80.7 percent nurses and less than 7 percent in each of the other three professional groups. The sample was predominately female. The majority cited a nursing diploma as the level of educational qualification. Only 1.0 percent reported having a Ph. D. Most worked full time with an average of approximately 10 years experience. On the average, inpatient professionals spent 50 percent of their time providing care to this population.

Table 3

Demographic Data by Work Setting Group

| Category | Inpat. | | Commun. | | Rehab. | |
|----------------------------|--------|------|---------|------|--------|------|
| | N | % | N | % | N | % |
| Total N | 197 | | 96 | | 60 | |
| Nurses | 155 | 80.7 | 25 | 26.0 | 48 | 80.0 |
| Psychiatrists | 13 | 06.8 | 20 | 20.8 | 02 | 03.3 |
| Psychologists | 12 | 06.3 | 25 | 26.0 | 04 | 06.7 |
| Social Workers | 11 | 05.7 | 24 | 25.0 | 04 | 06.7 |
| Others | 01 | 0.5 | 02 | 02.1 | 02 | 03.3 |
| Female | 161 | 83.9 | 52 | 54.2 | 50 | 84.7 |
| Male | 31 | 16.1 | 44 | 45.8 | 09 | 15.0 |
| Nursing Dip. | 128 | 66.7 | 11 | 11.5 | 45 | 75.0 |
| Bachelor Deg. | 27 | 14.1 | 11 | 11.5 | 08 | 13.3 |
| Master Deg. | 19 | 09.9 | 38 | 39.6 | 02 | 03.3 |
| Ph.D. | 02 | 01.0 | 15 | 15.6 | 03 | 05.0 |
| Medical Deg. | 14 | 07.3 | 20 | 20.8 | 01 | 01.7 |
| Years of Exper. | | | | | | |
| 1-5 | 74 | 38.9 | 30 | 31.6 | 18 | 30.5 |
| 6-15 | 78 | 41.1 | 43 | 45.2 | 39 | 54.2 |
| >16 | 40 | 20.0 | 22 | 23.2 | 09 | 15.3 |
| Full Time | 167 | 87.0 | 88 | 91.7 | 39 | 65.0 |
| Part Time | 25 | 13.0 | 08 | 08.3 | 21 | 35.0 |
| <25% Time With Chronics | 35 | 20.8 | 54 | 59.3 | 06 | 11.0 |
| >25% Time With Chronics | 35 | 20.8 | 06 | 06.6 | 26 | 48.1 |

Community Setting. The data for professionals working in the community setting are found in Table 3. The community sample had a more even representation of each profession and of each sex. Educational qualifications were higher than in the other work settings, for example, 15.6 percent had a Ph.D. Most worked full time and had an average of 11 years of experience. Professionals in the community spent approximately 32 percent of their time with this population.

Rehabilitation Setting Group. The data for professionals working in the rehabilitative setting are found in Table 3. The professional staff in the rehabilitation centers also consisted primarily of nurses. Few psychiatrists worked full time in this setting. Because of the high percentage of nurses, the majority of staff were female and educated at the diploma level. Many more staff worked part time in this setting. The professionals had an average of nine years experience and spent 69 percent of their time involved in care of this population.

Results Relating to Questions on Priorities

Priorities

Five questions were asked relating to priority. These questions related to (1) changes in time spent with the chronically mentally ill, (2) overall priority, (3) treatment in the community, (4) community services and (5) institutional services. The means and standard deviations of each professional and work setting group are found in Tables 4, 5, 8, 9, 10 and 11. Based on results from other studies (Rubin, 1978; Toews and Barnes, 1982) and on the frequency data from the present study, (1) sex, (2) qualifications, (3) years of

experience, (4) type of employment and (5) time with this population were identified as covariates. An ANCOVA at a .05 level of significance was completed (see Appendix D, Tables 19 to 23). The results of each of the five questions on priority are described below. The ANCOVA data has been summarized in Tables 6 and 7.

Research Question One: Percentage of Clinical Time

Presently Directed to the Care of the Chronically Mentally Ill

Table 4 presents the means and standard deviations relating to the amount of clinical time that was directed by each professional and work setting group to the care of the chronically mentally ill. The total group spent 49.8 percent of their clinical time in care relating to this population. Among the four professions, nurses spent the highest percentage of time involved in this type of care, followed by social workers, psychiatrists and psychologists. Those who worked in the rehabilitation setting spent the highest percentage of time with this population. Community professionals spent the least amount of time.

Research Question Two: Preference for Change in Amount of Clinical Time

Professionals were asked their preferences for changes in the amount of clinical time they direct toward care of this population. The results of this question are presented in Table 5. No group indicated a preference to decrease the amount of time that was directed toward care of the chronically mentally ill. On the other hand, no group expressed a preference for increasing the amount of time spent working with this

population. The answers to this question could range from 1 to 5 yet the mean for each group ranged from 3.005 to 3.455, indicating a preference for no change in the amount of time spent working with the chronically mentally ill (see Table 5). Professional affiliation did not influence the scores, however work setting made a significant difference (see Table 6). The professionals in the community and rehabilitation work setting had a greater tendency to increase the time spent with this population than did the professionals in the inpatient work setting (see Table 7).

TABLE 4

Percentage of Present Clinical Time Related to
the Care of the Chronically Mentally Ill
by Profession and Work Setting

| Group | Mean | SD | N |
|--------------------|-------|-------|-----|
| Total Group | 49.79 | 29.69 | 351 |
| Nurses | 56.57 | 28.71 | 231 |
| Psychiatrists | 39.22 | 25.91 | 37 |
| Psychologists | 30.05 | 24.92 | 41 |
| Social Workers | 43.76 | 31.00 | 42 |
| Inpatient Sett. | 53.55 | 27.32 | 192 |
| Community Sett. | 32.60 | 24.69 | 96 |
| Rehabilitat. Sett. | 69.02 | 29.45 | 60 |

Table 5

Preferences for a Change In the Percentage of Clinical
Time Spent Working With This Population by
Profession and Work Setting

| Group | Mean | SD | N |
|-----------------|------|------|-----|
| Total | 3.15 | 1.04 | 351 |
| Nurses | 3.12 | 1.12 | 231 |
| Psychiatrists | 3.05 | 0.82 | 37 |
| Psychologists | 3.19 | 0.75 | 41 |
| Social Workers | 3.32 | 0.97 | 42 |
| Inpatient Sett. | 3.00 | 1.17 | 192 |
| Commun. Sett. | 3.26 | 0.83 | 96 |
| Rehabil. Sett. | 3.45 | 0.71 | 60 |

Table 6

F Ratio of Effects of Priority Variable on Professional Affiliation and Work Setting When Controlled for Sex, Qualifications, Years of Experience, Type of Employment and Time With This Population

| Priority | Ind. Var. | F Value | Sign. of F |
|--------------------------|------------------|-----------------|----------------|
| Change time With Pat. | Prof. Setting | .340 5.235 | .796 .006 a |
| Priority to This Pop. | Prof. Setting | 1.064 4.727 | .365 .010 a |
| Treat in Community | Prof. Setting | 0.821 11.031 | .483 .001 a |
| Community Services | Prof. Setting | 0.605 14.021 | .612 .001 a |
| Institut. Services | Prof. Setting | 4.871 0.313 | .003 a .732 |

a = Significant beyond .05 level

Table 7

Groups Identified as Significantly Different on
Priorities, Using Student Newman Keul
Procedure (.05) a

| Priority | Group | | | |
|------------------|-----------|------------|----------------|-------------|
| | Inpatient | Community | Rehabilitation | |
| Change Time | 3.01 - | 3.26 + | 3.45 + | |
| Overall Priority | 4.52 + | 4.31 - | 4.08 - | |
| Treat in Commun. | 4.59 + | 4.43 + | 4.02 - | |
| Commun. Services | 4.78 + | 4.81 + | 4.28 - | |
| | Nursing | Psychiatry | Psychology | Social Work |
| Institut. Serv. | 3.29 + | 3.68 + | 3.10 | 2.73 - |

a = + = significantly higher than other groups

- = significantly lower than other groups

Research Question Three: Changes in OverallPriority For the Chronically Mentally Ill

Within the resources presently available for all mental health subjects were asked whether the priority given to the chronically mentally ill should be changed. The results of this question are presented in Table 8. On a Scale of 1 to 5, the overall mean was 4.39, indicating that the professionals believed there should be an increase in the priority given to the chronically mentally ill from present resources. Individual group means ranged from a low of 4.08 to a high of 4.52 (see Table 8). Professional affiliation did not significantly influence the assessments of priority (see Table 6). Work setting, however, was significant in that the professionals in the inpatient setting indicated that higher priority should be given to the chronically mentally ill than did the professionals in the community and rehabilitation setting (see Table 7).

Table 8

Preferences for Changes in Overall Priority Given to the
Chronically Mentally Ill by Profession and Work Setting

| Group | Means | SD | N |
|-----------------|-------------------|------|-----|
| Total | 4.39 | 0.78 | 351 |
| Nurses | 4.45 | 0.73 | 231 |
| Psychiatrists | 4.29 | 0.91 | 37 |
| Psychologists | 4.15 | 0.85 | 41 |
| Social Workers | 4.39 | 0.80 | 42 |
| Inpatient Sett. | 4.52 | 0.73 | 192 |
| Community Sett. | 4.31 ^a | 0.71 | 96 |
| Rehabit. Sett. | 4.08 | 0.91 | 60 |

Research Question Four: Changes in Emphasis on
Treatment in the Community

The professionals were asked whether the emphasis on treating the patient in the community should be changed. The results of this question are presented in Table 9. The total group mean of 4.45 indicated that the emphasis should be increased. Choosing from a scale of 1, meaning decrease significantly to 5, representing a significant increase, the professional and work setting group means ranged from a low of 4.00 to a high of 4.59 (see Table 9). Professional affiliation did not significantly affect these ratings whereas the scores for work setting groups were significantly different (see Table 6). Those professionals working in inpatient or community settings had a significantly higher rating on the need for greater priority for treatment in the community than did those in the rehabilitation work setting (see Table 7).

Table 9

Preferences for Changes in the Emphasis on
Treating the Patient in the Community
by Profession and Work Setting

| Group | Means | SD | N |
|-----------------|-------|------|-----|
| Total | 4.45 | 0.89 | 351 |
| Nurses | 4.47 | 0.89 | 231 |
| Psychiatrists | 4.00 | 1.22 | 37 |
| Psychologists | 4.56 | 0.63 | 41 |
| Social Workers | 4.56 | 0.67 | 42 |
| Inpatient Sett: | 4.59 | 0.82 | 192 |
| Community Sett. | 4.43 | 0.79 | 96 |
| Rehabilit. Sett | 4.02 | 1.07 | 60 |

Research Question Five: Changes in Community

Support Services

The professionals were asked whether there should be changes in the priority for the development of community support services for the chronically mentally ill. The results of this question are presented in Table 10. Professionals indicated that priority for community support services should be increased (overall mean 4.69). All professional groups had means higher than 4.59 and there was little variation among or within the groups (see Table 10). While professional affiliation did not affect the ratings on this question, there were significant differences among the scores of those professionals working in different settings. The scores for both the inpatient and community work setting were high (4.87 and 4.81 respectively) whereas the rehabilitation work setting (4.28) was significantly lower (see Table 6 and 7). Although the rehabilitation work setting scores were significantly lower, an increase in emphasis on community support systems was still indicated by the professionals in the rehabilitation work setting.

Table 10

Preferences for Changes in the Priority Given
to Community Support Services by
Profession and Work Setting

| Group | Mean | SD | N |
|------------------|------|------|-----|
| Total | 4.69 | 0.62 | 351 |
| Nurses | 4.67 | 0.65 | 231 |
| Psychiatrists | 4.59 | 0.86 | 37 |
| Psychologists | 4.83 | 0.38 | 41 |
| Social Workers | 4.80 | 0.40 | 42 |
| Inpatient Sett. | 4.78 | 0.56 | 192 |
| Community Sett. | 4.81 | 0.39 | 96 |
| Rehabilit. Sett. | 4.28 | 0.85 | 6 |

Research Question Six: Changes in Institutional Support Services

The professionals were also asked whether there should be changes in the development of institutional support services for the chronically mentally ill. The results of this question are presented in Table 11. Overall, the professional and work setting groups indicated that the priority for institutional support services should remain the same (mean 3.25) although there was more variation in this response than in other questions on priorities (S.D. 1.33). Professional affiliation did significantly affect the scores on this question, (see Table 6). Among the professional groups, nurses and psychiatrists expressed the greatest need for increase in priority for institutional support services (mean 3.29 and 3.67) and social workers rated that question the lowest of any group (mean 2.72) (see Table 11). Values for the work setting group ranged from 3.01 to 3.33 (see Table 11), reflecting no significant difference among the work setting groups (see Table 6).

Table 11
 Preferences for Changes In the Priority Given
 To Institutional Support Services by
 Profession and Work Setting

| Group | Means | SD | N |
|------------------|-------|------|-----|
| Total | 3.25 | 1.33 | 351 |
| Nurses | 3.29 | 1.33 | 231 |
| Psychiatrists | 3.68 | 1.23 | 37 |
| Psychologists | 3.10 | 1.28 | 41 |
| Social Workers | 2.72 | 1.34 | 42 |
| Inpatient Sett. | 3.31 | 1.43 | 192 |
| Community Sett. | 3.01 | 1.19 | 96 |
| Rehabilit. Sett. | 3.33 | 1.12 | 60 |

Summary

Overall there was agreement that greater priority should be given to the treatment of the chronically mentally ill. There was also agreement that there should be increased emphasis on treatment in the community. Respondents felt there should be greater priority given to community services but priority given to institutional services should remain the same. In spite of the expressed need for greater priority of services, the group as a whole did not want to increase the time spent working with this population. Professionals in the inpatient work setting expressed less preference for an increase in the time with the chronic group than did those in other work settings.

The professionals in the inpatient and community work setting most often expressed a greater need for increased priority for services than did those in the rehabilitation setting. In only one instance did the professional affiliation affect the rating on priorities. Nurses and psychiatrists had more of a tendency to increase priority for development of institutional services whereas social workers indicated the least desire to increase priority for institutional services.

Research Question Seven: Importance of Services

The importance of services was determined by rating each service on a five point scale with one indicating a service that was definitely not important and five reflecting a service that was definitely important. Covariates used included (1) sex, (2) qualifications, (3) years of experience, (4) type of employment and (5) time with this population. Differences among the professional and work setting groups were determined by ACNOVA and the Student Newman Keul Procedure at the .05 level of significance. Details relating to the F ratio of the main effects, interaction, and covariates are available in Appendix E, Tables 24 to 35. The services are listed by rank order in the summary of the results found in Tables 12 to 14. The percentage of respondents that chose each option as well as the percentage that identified the item as not important (values 1 and 2) and important (values 4 and 5) are recorded in Appendix F, Tables 36 to 47. Each of the twelve services is described below.

Importance Of Psychosocial Rehabilitation Services

Psychosocial rehabilitation was considered the most important service by the total sample from mental health facilities in Nova Scotia (see Table 12). Ninety percent of the professionals rated it as important whereas only 0.8 percent considered it unimportant (see Table 12). The percentage of the sample in each professional and worksetting group that rated the service as important ranged from 78.4 percent to 93.3 percent (see Appendix F, Table 36) but the variation in the group scores was not significant at the .05 level (see Table 13).

Table 12

Importance of Services by Rank and Percentage of
Total Group to Choose Imp. (Option 4+5) or
Not Imp. (Option 1+2)

| Rank | Service | % Not Imp | % Imp. | Mean | S.D. |
|------|----------------------|-----------|--------|------|------|
| 1 | Psychosocial Rehab. | 0.8 | 90.1 | 4.49 | .695 |
| 2 | Health Care | 2.8 | 88.1 | 4.44 | .785 |
| 3 | Support to Others | 1.1 | 88.1 | 4.41 | .725 |
| 4 | Residential Serv. | 1.4 | 86.8 | 4.40 | .761 |
| 5 | Reaching Out | 3.9 | 86.0 | 4.35 | .838 |
| 6 | Assist With Benefits | 2.8 | 86.0 | 4.27 | .771 |
| 7 | Protect Rights | 3.9 | 78.0 | 4.23 | .911 |
| 8 | Vocational Services | 3.7 | 81.7 | 4.19 | .818 |
| 9 | Case Management | 2.8 | 76.4 | 4.16 | .849 |
| 10 | Crisis Services | 5.6 | 75.8 | 4.14 | .931 |
| 11 | Involve Community | 3.4 | 76.1 | 4.05 | .838 |
| 12 | Identify Pat. | 7.4 | 74.7 | 3.99 | .941 |

TABLE 13
F ratio of Main Effect of Importance Variable on Professional
Affiliation and Work Setting when Controlled for Sex,
Qualifications, Years of Experience, Type of
Employment, and Time With This Population

| Service | Ind. Var. | F Value | Sign. of F |
|------------------|-----------|---------|------------|
| Psycho. Rehab. | Prof. | 0.971 | .407 |
| | Setting | 1.666 | .191 |
| Health Care | Prof. | 1.104 | .348 |
| | Setting | 1.380 | .253 |
| Support Others | Prof. | 1.126 | .339 |
| | Setting | 0.197 | .821 |
| Resident. Serv. | Prof. | 0.245 | .865 |
| | Setting | 2.807 | .062 |
| Reaching Out | Prof. | 5.166 | .002a |
| | Setting | 2.189 | .114 |
| Assist Benefits | Prof. | 0.207 | .891 |
| | Setting | 0.345 | .708 |
| Protect Rights | Prof. | 2.016 | .112 |
| | Setting | 0.115 | .871 |
| Vocational Serv. | Prof. | 0.215 | .886 |
| | Setting | 2.444 | .089 |
| Case Management | Prof. | 1.440 | .231 |
| | Setting | 1.484 | .228 |
| Crisis Services | Prof. | 0.263 | .852 |
| | Setting | 3.236 | .041a |
| Involve Commun. | Prof. | 1.843 | .139 |
| | Setting | 1.554 | .213 |
| Ident. Pat. | Prof. | 2.903 | .033a |
| | Setting | 2.297 | .102 |

a= significant beyond .05 level

Table 14

Groups Identified as Significantly Different on
Importance of Services, Using the Student
Newman Keul Procedure(.05)a

| Service | Nursing | Psychiatry | Psychology | Social Work |
|--------------|-----------|------------|----------------|-------------|
| Ident. Pts. | 4.00 | 4.30 + | 3.68 - | 4.05 |
| Reach Out | 4.48 + | 4.38 + | 3.68 - | 4.26 + |
| | Inpatient | Community | Rehabilitation | |
| Crisis.Serv. | 4.27 + | 3.85 - | 4.22 + | |

a + = Significantly Higher than other Groups

- = Significantly Lower than other Groups

Importance of Medical and Mental Health Care Services

Medical and Mental Health services were ranked second in importance (see Table 12). It was rated important by 88.1 percent of the sample, and viewed as unimportant by 2.8 percent of the sample (see Table 12). From 81.0 to 91.7 percent of the individuals in each professional and work setting group rated this services as important (see Appendix F, Table 37). No group was significantly different from the other (see Table 13).

Importance of Services to Support Family and Community

This service was ranked third from among the twelve services (see Table 12). It was rated as important by 88.1 percent of the professionals and unimportant by 1.1 percent (see Table 12). The percentage in each professional and work setting group that rated it as important ranged from 81.1 percent to 92.9 percent (see Appendix F, Table 38) with no significant differences among the professional or work setting groups (see Table 13).

Importance Of Supportive Residential Services

Residential services were also considered quite important, having the fourth place rank (see Table 12). It was considered important by 86.8 percent of the sample whereas 1.4 percent considered it unimportant (see Table 12). The percentage of individuals in each group that ranked it as important ranged from 82.9 percent to 90.1 percent (see Appendix F, Table 39) but there were no significant differences among the scores of the professional and work setting groups (see Table 13).

Importance of Reaching Out Services

This service was ranked fifth in importance (see Table 12). It was considered important by 86 percent of the total sample whereas only 3.9 percent did not consider it important (see Table 12). From 68.3 to 89.6 percent of the respondents in each professional and work setting group rated this service as important (see Appendix F, Table 40). Nurses, psychiatrists and social workers rated this service significantly higher than did psychologists (see Table 14). The variation among the

work setting group was not significant (see Table 13).

Importance of Services to Assist Patients Obtain

Benefits

Assisting patients to obtain benefits was considered the sixth most important service (see Table 12). Eighty-six percent of the sample rated it as important. It was considered unimportant by only 2.8 percent of all professionals (see Table 12). The percentage of the sample in each professional and work setting group that rated the service as important ranged from 68.3 percent to 91.7 percent (see Appendix F, Table 41). There was no significant variation among the professional or work setting groups (see Table 13).

Importance of Services to Protect Clients Rights

Protection of rights was ranked in the seventh position (see Table 12). It was considered important by 78.0 percent of the sample, and 3.9 percent of the sample considered it unimportant (see Table 12). The percentage of individuals in each professional and work setting group that rated it as important ranged from 64.9 percent to 95.2 percent (see Appendix F, Table 42). The differences between the professional and work setting group scores did not differ significantly (see Table 13).

Importance of Vocational Services

Vocational Services were ranked in the eighth position (see Table 12). It was rated as important by 81.7 percent of the sample whereas 3.7 percent considered it unimportant (see Table 12). From 79.2 percent to

91.7 percent of the individuals in each group rated it as important (see Appendix F, Table 43) but the differences among the scores of the professional and work setting groups were not statistically significant (see Table 13).

Importance of Case Management Services

Case Management was considered the ninth most important service by all of the sample (see Table 12). It was considered important by 76.4 percent of the sample with percentages among the professional and work setting groups ranging from 70.0 to 85.7 percent (see Appendix F, Table 44). It was considered unimportant by 2.8 percent of the sample (see Table 12). These differences among the scores of the professional and work setting group did not achieve a .05 level of significance (see Table 13).

Importance of Twenty-four Hour Crisis Services

Crisis services ranked tenth in the overall list (see Table 12). It was considered important by 75.8 percent of the sample and unimportant by 5.6 percent (see Table 12). The percentage of the sample in each professional and work setting group that rated the service as important ranged from 63.5 percent to 80.8 percent (see Appendix F, Table 45). Professional affiliation did not influence the ratings on the importance of this service but the scores of the work setting groups differed significantly from each other (see Table 13). Professionals working in the community rated crisis services significantly lower than did the professionals working in inpatient or rehabilitation settings (see Table 14).

Importance of Services to Involve the Community

This service was considered one of the least important, i.e., it was ranked number 11 (see Table 12). Yet 76.1 percent of the total sample rated it as important and only 3.4 percent rated it as unimportant (see Table 12). The percentage of individuals within the groups that rated community involvement as important ranged from 64.9 percent to 85.7 percent (see Appendix F, Table 46). The scores for each professional and work setting group did not differ significantly (see Table 13).

Importance of Services to Identify Clients

This service was ranked the least important of all services (see Table 12). In spite of this, 74.7 percent of the total sample rated it as important (see Table 12). The percent of the sample in each professional and work setting group that rated the service as important ranged from 61 percent to 83.3 percent (see Appendix F, Tables 47). There was significant variation among the professions in their views on importance (see Table 13). Psychiatrists rated this service significantly higher than the other three professions (see Table 14). Psychologists rated the service significantly lower than the other professions, i.e., 61 percent considered it important compared with 83.3 percent of the psychiatrists. (see Table 25, Appendix E). Work setting did not significantly influence the rating on the importance of this service (see Table 13).

Summary.

The three most important services were (1) psychosocial rehabilitation, (2) medical and mental health care, and (3) support to family and community. The services that were ranked least important included (1) 24-hour crisis services, (2) community involvement, and, lastly (3) identification of patients. It should be noted, however, that all services were considered important. The percentage of individuals that rated the services as important ranged from a low of 74.7 percent to a high of 90.1 percent. No service was considered unimportant by more than 7.4 percent of the sample.

For the majority of services, professional affiliation or work setting did not significantly affect the ratings on importance. There were exceptions, psychologists considered it less important to identify patients than did the other professions. On the other hand, psychiatrists rated this service as more important than all the rest. Psychologists also rated reaching out services as less important than did the other three professions. Work setting influenced the rating on crisis services with the professionals in the community setting rating this service as less important than did those in the inpatient or rehabilitation setting.

Research Question Eight: Feasibility of Services

The feasibility of services was determined by rating each service on a 5 point scale with 1 indicating a service that was definitely not feasible and 5 reflecting a service that was definitely feasible. Based on results from other studies (Rubin, 1978; Toews and Barnes, 1982) and the frequency data from the present study (1) sex, (2) qualifications, (3) years of experience, (4) type of employment and (5) time with this population were used as covariates. Differences among the professional and work setting groups were determined by ANCOVA and the Student Newman Keul Procedure at the .05 level of significance. Details relating to the F ratio of the main effects, interaction, and covariates are available in Appendix G, Tables 48 to 59. The percentage of respondents that chose each option as well as the percentage that identified the item as not feasible (values 1 and 2) and feasible (values 4 and 5) are recorded in Appendix H, Tables 60 to 71. The services are listed by rank order in the summary of the results found in Tables 15 to 17. Each of the twelve services is described below.

Feasibility of services to Assist Patients Obtain Benefits

Assisting patients with benefits was considered the most feasible of all services (see Table 15). Only 5.1 percent of the population rated

Table 15

Feasibility of Services by Rank and Percentage of
Total Group to Choose Feas. (Option 4+5) or
Not Feas. (Option 1+2)

| Rank | Services | % Not Feas. | % Feas. | Mean | S.D. |
|------|----------------------|-------------|---------|------|------|
| 1 | Assist With Benefits | 5.1 | 86.8 | 4.22 | .31 |
| 2 | Health Care | 7.3 | 82.0 | 4.17 | .93 |
| 3 | Psychosocial Rehab. | 6.5 | 79.5 | 4.05 | .88 |
| 4 | Protect Rights | 9.8 | 68.8 | 3.90 | 1.01 |
| 5 | Support to Others | 10.7 | 68.9 | 3.81 | .93 |
| 6 | Involve Community | 9.6 | 58.9 | 3.70 | .91 |
| 7 | Identify Pat. | 20.8 | 66.7 | 3.64 | 1.12 |
| 8 | Case Management | 16.6 | 60.5 | 3.63 | 1.02 |
| 9 | Reaching Out | 27.5 | 58.4 | 3.46 | 1.12 |
| 10 | Residential Serv. | 22.9 | 52.8 | 3.41 | 1.06 |
| 11 | Vocational Services | 26.1 | 49.1 | 3.34 | 1.06 |
| 12 | Crisis Services | 32.0 | 48.0 | 3.31 | 1.17 |

TABLE 16

F ratio of Main Effect of Feasibility Variables on Professional Affiliation and Work Placement When Controlled for Sex, Qualifications, Years of Experience, Type of Employment, and Time With This Population ;

| Service | Ind. Var. | F Value | Sign. of F |
|------------------|------------------|----------------|---------------|
| Assist Benefits | Prof Setting | .568 .767 | .637 .465 |
| Health Care | Prof. Setting | .096 5.971 | .962 .003a |
| Psycho. Rehab. | Prof. Setting | 2.525 4.149 | .058 .017a |
| Protect Rights | Prof. Setting | .966 .369 | .409 .692 |
| Support Others | Prof. Setting | 1.402 .581 | .242 .560 |
| Involve Commun. | Prof. Setting | 4.218 .525 | .006a .592 |
| Ident. Pat. | Prof. Setting | .169 .887 | .917 .479 |
| Case Management | Prof. Setting | 1.226 .143 | .300 .867 |
| Reaching Out | Prof. Setting | .776 .151 | .508 .860 |
| Resident. Serv. | Prof. Setting | .719 .337 | .542 .714 |
| Vocational Serv. | Prof. Setting | 1.060 3.646 | .366 .027a |
| Crisis Services | Prof Setting | .353 .416 | .787 .660 |

a = significant beyond .05 level

Table 17

Groups Identified as Significantly Different on
Feasibility of Services, Using Student
Newman Keul Procedure (.05)^a

| Service | Inpatient | Community | Rehabilitation |
|--------------|-----------|------------|----------------|
| Psych Rehab. | 3.96 - | 4.10 - | 4.32 + |
| Health Care | 4.03 - | 4.47 + | 4.22 - |
| Vocat. Serv. | 3.27 - | 3.35 | 3.65 + |
| | Nursing | Psychiatry | Psychology |
| Involve Com. | 3.69 | 3.38 - | 4.02 + |
| | | | Social Work |
| | | | 3.78 |

a + = Significantly Higher than Other Groups

- = Significantly Lower than Other Groups

it as not feasible and by far the majority (86.8 percent) rated it as feasible (see Table 15). From 81.1 to 91.7 percent of respondents within the groups indicated that assisting clients with benefits was feasible (see Appendix H, Table 60). No significant differences among the professional or work-setting groups were found (see Table 16).

Feasibility of Services to Provide Medical and Mental Health Care

Medical and Mental health care was considered the second most feasible service (see Table 15). It was considered feasible by 82.0 percent and not feasible by 7.3 percent of the sample (see Table 15). From 77.1 to 90.6 percent of the individuals within the professional and work setting groups rated this service as feasible (see Appendix H, Table 61). Significant differences were not found among professional groups but were found among the work setting groups (see Table 16). The community professionals rated it more feasible than those in the other two settings. Those in the inpatient setting rated this service as

less feasible than did those in the community and rehabilitation setting (see Table 17).

Feasibility Of Psychosocial Rehabilitation Services.

This was considered the third most feasible service (see Table 15). It was rated as feasible by 79.5 percent and not feasible by 6.5 percent of the sample (see Table 15). From 62.2 to 88.3 percent of respondents within the professional and work setting groups rated this service as feasible (see Appendix H, Table 62). No significant differences were found among the professional groups (see Table 16). Significant differences were found however, among the work setting groups (see Table 16). Those in the inpatient setting rated this service as less feasible than did those in the community or rehabilitation setting. On the other hand, those in the rehabilitation setting rated this service as more feasible than did those in other settings (see Table 17).

Feasibility of Services to Protect Patients Rights

This was ranked as the fourth most feasible service (see Table 15). It was considered feasible by 68.8 percent and not feasible by 9.8 percent of the sample (see Table 15). The number of individuals within the professional and work setting groups who rated this service as feasible ranged from 63.3 to 73.8 percent (see Appendix H, Table 63). Significant differences were not found among the professional or work setting groups (see Table 16).

Feasibility of Services to Family and Community

This service was ranked fifth (see Table 15). It was considered feasible by 68.9 percent of the sample. Another 10.7 percent rated it as not feasible (see Table 15). From 54.1 to 71.9 percent of the respondents within professional and work setting groups rated this service as feasible (see Appendix H, Table 64). Significant differences among the professional and work setting groups were not found (see Table 16).

Feasibility of Services to Involve Community Members

Involving community members was ranked sixth (see Table 15). It was seen as feasible by 58.9 percent of the sample. Only 9.6 percent of the sample rated it as not feasible (see Table 15). The percentage of respondents rating the service as feasible within professional and work setting groups ranged from 40.5 to 78.0 (see Appendix H, Table 65). Professional affiliation influenced the feasibility rates (see Table 16). In other words, psychologists saw it as more feasible to involve the community than other professional groups. Psychiatrists rated this service as less feasible than the professionals in other groups (see Table 17). No significant differences were found among work setting groups (see Table 16).

Feasibility of Services to Identify Patients

Identification of patients was ranked seventh (see Table 15). It was considered feasible by 66.7 percent of the sample. Another 20.8 percent rated this service as not feasible (see Table 15). The

percentage of respondents in each professional or work setting group that considered this service to be feasible ranged from 61.0 percent to 81.0 percent (see Table 61, Appendix H). This variation was not great enough to indicate significant differences among the professional or work setting groups (see Table 16). The interaction of profession by setting was significant (see Appendix H, Table 66) suggesting that social workers and psychiatrists in the rehabilitation setting view identification of services as less important than did other professionals.

Feasibility of Case Management Services

Case management was ranked eighth (see Table 15). It was considered feasible by 60.5 percent of the sample. Another 16.6 percent considered it unfeasible (see Table 15). From 53.3 to 73.8 percent of the respondents within professional and work setting groups rated case management as feasible (see Appendix H, Table 67). The variation among the scores of those in the professional and work setting groups was not significant (see Table 16).

Feasibility of Reaching Out Services

Reaching out with services was ranked ninth (see Table 15). It was rated as feasible by 58.4 percent of the sample and considered not feasible by 27.5 percent of the professionals (see Table 15). Percentages within the professional and work setting groups that considered this service important ranged from 43.9 percent to 61.9 percent (see Appendix H, Table 68). No significant differences were found among the scores of those in the professional and work setting

groups (see Table 17).

Feasibility Of Supportive Residential services

Residential service was one of the least feasible services. It was ranked in the tenth position (see Table 15). It was considered not feasible by 22.9 percent of the sample whereas 52.8 percent rated it as feasible (see Table 15). The percentages within the professional and work setting groups that rated the service as feasible ranged from 35.1 to 58.5 (see Appendix H, Table 69). Significant differences were not found among professional or work setting groups (see Table 16).

Feasibility of Vocational Services

This service was ranked eleventh (see Table 15). More than a quarter of the sample considered it not feasible (26.1 percent) and only 49.1 percent rated it as feasible (see Table 15). The number of individuals within the professional and work setting groups who rated this service as feasible ranged from 32.4 to 65.0 percent (see Appendix H, Table 71). Professional affiliation did not influence the rating for feasibility but significant differences were found among work setting groups (see Table 16). The professionals in the rehabilitation setting rated vocational services as more feasible than did the professionals in other settings. The professionals in the inpatient setting rated these services as less feasible than did those in other settings (see Table 17).

Feasibility of Twenty-four Hour Crisis Services

Crisis service was ranked the least feasible (see Table 15). Less than one half of the professionals (48.0 percent) considered crisis services to be feasible. A considerable number (32.0 percent) rated it as not feasible (see Table 15). The percentage of individuals in each professional and work setting group who rated crisis services as feasible ranged from 37.8 to 53.3 percent (see Appendix H, Table 71). No significant differences among the professional and work setting groups were found (see Table 16).

Summary.

The services that were ranked as most feasible included (1) assistance with benefits, (2) medical and mental health care, and (3) psychosocial rehabilitation. The services considered least feasible were (1) residential services, (2) vocational services, and last (3) crisis services. Overall scores on the feasibility scale were lower than the scores on the importance scale. The percentages of respondents that rated the services as feasible ranged from 48 to 86.8 percent. The percentage of respondents that rated the same services as not feasible ranged from 5.1 to 32.0 percent.

The professional and work setting groups responded to the feasibility question with more variation than they did to the importance question but still the feasibility rating for the majority of services did not change significantly with changes in professional affiliation or work setting. The interaction of profession with work setting was significant for services to identify patients. The professional

affiliation was a factor with services to involve the community.

Psychiatrists rated this service as more feasible than did other professions. This same service was rated less feasible by the psychologists than by the other professional groups.

Professionals in the inpatient setting considered (1) psychosocial rehabilitation, (2) health care, and (3) vocational services as less feasible than the professionals in other settings. The professionals in the rehabilitation setting rated (1) psychosocial rehabilitation and (2) vocational services as more feasible than professionals in other settings. The community professionals viewed medical and mental health care as more feasible than did those professionals in other settings.

Research Question Nine: Relationship Between Importance and Feasibility

The relationship between the overall ranks for importance and feasibility was determined by use of the Spearman Rank Correlation Coefficient. The Spearman Rank Coefficient of .3917 on the overall ranks for importance and feasibility was not statistically significant. Although the rank order of the importance and feasibility of service was not significantly correlated, it is noteworthy that there are similarities among the highest and lowest rankings in both importance and feasibility (see Table 18). Services for health care and psychosocial rehabilitation were ranked in the top three in both importance and feasibility. In addition, crisis assistance was also ranked among the lowest three in importance and feasibility.

Table 18

Rank of Feasibility and Importance of Services
(1=Most Imp. or Feas.)

| Feasibility | Service | Importance |
|-------------|--------------------------------|------------|
| 1 | Assist With Benefits | 6 |
| 2 | Medical and Mental Health Care | 2 |
| 3 | Psychosocial Rehabilitation | 1 |
| 4 | Protection of Rights | 7 |
| 5 | Support to Family and Friends | 3 |
| 6 | Involve Community | 11 |
| 7 | Identify Clients | 12 |
| 8 | Case Management | 9 |
| 9 | Reach out With Services | 5 |
| 10 | Residential Services | 4 |
| 11 | Vocational rehabilitation | 8 |
| 12 | Crisis Assistance | 10 |

Summary

There was a 65 percent return rate in the study with all groups representing at least 50 percent of the population. The answers to questions on priorities, importance and feasibility are summarized below.

With the priority questions, the sample as a whole indicated that the priority for the chronically mentally ill should be increased, especially the emphasis on treatment in the community and community support services. In spite of this fact, the total group did not indicate a preference for increasing their work time with the chronically mentally ill. The results also indicated that the sample believed priority given to institutional support services should remain the same.

There were some differences among the groups in the ratings on priorities. Work setting significantly affected the results on the first four of the five priority questions. The professionals in the inpatient and community work setting most often expressed a greater need for increased priority for services than did those in the rehabilitative setting. The results of the last priority question on institutional support services were influenced by professional affiliation. Nurses and psychiatrists had a greater tendency to increase priority for development of institutional support services whereas social workers indicated the least desire to increase priority to these services.

The results on the importance question showed that all twelve services were considered important by at least 75 percent of the total sample. The three most important services were (1) psychosocial rehabilitation, (2) medical and mental health care, and (3) support to family and community. The services that were ranked least important included (1) crisis services, (2) community involvement and (3) identification of patients.

In only three services did professional affiliation or work setting influence the ratings on importance. Professional affiliation affected the ratings on services to identify and reach out to patients. Psychologists rated the importance of these two services lower than did those in other professions. Work setting influenced the ratings on the importance of crisis services with community professionals rating this services significantly lower than did those in other work settings.

The results on the feasibility question showed that all services were considered feasible by at least 48 percent of the total sample. On the other hand, some of the twelve services were seen as not feasible by up to 32 percent of the sample. The services that were ranked the most feasible included (1) assistance with benefits, (2) medical and mental health care and (3) psychosocial rehabilitation. The services considered least feasible were (1) residential services, (2) vocational services and (3) crisis services.

In only four services did professional affiliation and work setting affect the ratings on feasibility. Professionals in the inpatient work setting rated three services significantly lower than did professionals in other settings. Professional affiliation significantly affected the

rating on one service where psychologists rated services to involve the community as more feasible than did the other professional groups. The social workers in the inpatient and rehabilitative settings rated the identification of patients as more feasible than other groups.

When the ratings on importance were compared to the ratings on feasibility, it was unclear whether the services seen as most important were also the ones considered the most feasible. However, two of the three services that were identified as most important were also two of the three services identified as most feasible. In addition, crisis services were ranked low in both importance and feasibility.

Chapter 5

Discussion

The discussion of results will be divided into four sections, (1) importance, (2) feasibility, (3) relationship between importance and feasibility and (4) priorities. Each section will list the relevant research question. This will be followed by a discussion of the implications of the results. The chapter will end with a section on the impact of the study design on results, followed by a summary and recommendations.

The study was a descriptive survey, the main purpose of which was to facilitate program planning by obtaining data on the importance, feasibility and priorities relating to services for the treatment of the chronically mentally ill. A questionnaire was developed for this purpose and was given to all nurses, psychiatrists, psychologists and social workers who worked in inpatient, community and rehabilitative settings in the province of Nova Scotia. Participants rated the importance and feasibility of services for the chronically mentally ill and the need for changes in priorities. The study also determined whether there were significant differences among the professional groups and among the professionals who worked in inpatient, rehabilitative and community settings in the way in which they rated services and priorities.

Importance of Services

Research Question Seven

How do professional caregivers rate the importance of services associated with a comprehensive treatment program for the chronically mentally ill?

Discussion

The twelve services for the chronically mentally ill were all considered important. Such services have been rated as important in two previous studies (Rubin, 1978; Rubin and Johnson, 1982). The symposia that were part a Canadian study also conveyed the impression that services were considered important by key informants in Canada (Toews and Barnes, 1982). Since the majority of professionals in the present study rated all services as important, there seems to be clear empirical evidence that nurses, psychiatrists, psychologists and social workers in a variety of worksettings and having varying amounts of responsibility for the chronically mentally ill consistently rate comprehensive services for this population as important.

It could be argued that the positive response to the questions on importance occurred because of the nature of the question asked. The possibility of respondents replying to questions in a set way, almost regardless of the content of the question is common in self-report questionnaires (Tuckman, 1972; Warwick and Lininger, 1975). Respondents may have rated the importance questions high because to do otherwise would be perceived as professionally unacceptable.

The high ratings on importance could also be attributed to position bias. In this study there may have been a bias toward the right hand side of the scale. This alternative appears less plausible as an explanation of high rates on importance as the response ratings on the feasibility question were lower and more varied even though the questions were similar in content and design.

Whether the services are rated very high because of the response set or because of strong beliefs of the respondents may be impossible to determine. It may be more important to recognize that even if professionals say that a service is important, they will not necessarily act as if it is important (Wicker, 1969). Many other factors may hamper the implementation of program changes such as conflicting interests, conflicting goals, inadequate rewards, inadequate resources and a host of other reasons external to the practitioner (Stern and Minkoff, 1979; Leithwood, 1982). If a mental health agency has been directing most of its resources toward the unhappy but healthy population and is asked to act on their expressed belief in the importance of services to the chronically mentally ill, goal conflict will likely result. In a similar fashion, if a professional who is interested primarily in individual psychotherapy is asked to act on the same beliefs, the conflict of interest will likely influence how the request is implemented.

Even though knowledge of the exact level of importance can not be determined and belief in importance may not be the only determinant of behavior it is still important to know that the professional perceives these services to be important when planning programs for the

chronically mentally ill. If program changes are planned and they are considered important by the people who actually implement the programs then there is a greater chance that the changes will be implemented as planned. Believing in the importance of the services provides a foundation for removing other barriers to implementation such as conflict of interest and goals. It is not likely that practitioners will be committed to a program they do not believe is important (Rubin and Johnson, 1982).

The results of the study not only reflect the services that are considered important but also which services are considered more important than others. In this time of fiscal restraint, priorities do have to be set and awareness of the relative importance of each service as viewed by the professionals may help in the difficult task of establishing priorities (McCormick, 1983; Leighton, 1982). Therefore, (1) psychosocial rehabilitation, (2) medical and mental health care and (3) support for families and communities, the three services that are considered most important by the professionals in Nova Scotia will be discussed in relation to the relative importance placed on that service in the literature. In a similar manner, (1) crisis services, (2) involvement of community and (3) identification of clients, the three services that are considered least important by the professionals in Nova Scotia will be discussed.

Most Important Services

Psychosocial Rehabilitation. This was considered the most important service by the professionals in Nova Scotia. These services incorporate a variety of programs involving activities of daily living, social

skills, vocational skills and leisure time activities. Because this service is so broad it is difficult to make specific interpretations about it from the response in the study except to note that the high level of importance attributed by the professionals in Nova Scotia was also reflected in the literature (Turner and Shifren, 1979). More adequate provision of these services especially in the community would greatly improve the variety of options available to treat specific problem areas with patients and could influence the amount of time necessary for hospitalized treatment (Bachrach, 1982; Test and Stein, 1978; Braun and others, 1981). Provision of these services may not only affect treatment options, but also the quality of life since many chronic patients are unemployed and have few social supports (Spivack and others, 1982).

There would be advantages to the program planner if this service was considered a starting point in implementing change. Promoting new programs that involve the least amount of change for the participant is one way to reduce the resistance to change (Leithwood, 1982). The variety of alternatives that are possible under this broad category may mean that the skills needed to start a program could already be available within present resources and therefore may present less hurdles to initial implementation.

Implementing change in this area would not be without difficulty. It has been noted that social and recreational outlets were judged to be one of the least readily available services in Canada (Toews and Barnes, 1982). In Nova Scotia in particular, a high priority placed on these services would present many hurdles to the program planner

because it would have to be decided whether these services were to be developed by the Department of Health or of Social services or a combined effort on the part of both.

Medical and Mental Health Care. The provision of medical and mental health care was rated second in importance by the professionals in Nova Scotia. Various forms of psychotropic, individual, family and group therapy were also the subject of considerable discussion and empirical study in the literature, giving the impression that they were considered very important, especially treatment with psychotropic medications (Turkat, 1981). It is not certain whether the high rating given this service by the professionals in Nova Scotia is based on theoretical and empirical knowledge about its importance or because it is the service that is provided almost universally throughout the province. Placing a high priority on this services does imply the necessity of a variety of psychotropic, individual, family and group treatment options available for the chronically mentally ill. It also implies the necessity of a close link between the general practitioner, dentist and mental health services. Placing priority on these services would improve the quality of care to the patient and would also provide the opportunity to teach patients about the interrelatedness of physical and mental health.

If increased priority were placed on health care it would mean considerable changes from present practice for according to the literature the usual mode of treatment for the chronically mentally ill in the community has been brief psychiatric assessment followed by medication (Bayer, 1982; Enzinas, 1982; Turkat, 1981). The

implementation of these changes however, would likely be more readily accepted because of the professionals' perception of the importance of this service. If the priority were lowered, professionals might have difficulty giving less priority to a service they rate so important and which now occupies a considerable proportion of their time.

Support for Others. The professionals in Nova Scotia considered support for family and community members to be the third most important service. Services in this area include education, support (either for each family or in groups) and/ or respite care. This high rating on support to families may be an indication of an increase in focus by the professionals in Nova Scotia that was also noticed in the literature (Boyd and others, 1981; McGill and others, 1983). Programs that provide education and support for families was one of the areas that was being actively researched.

There appears to be an inconsistency however, as the impression was conveyed in the literature, mostly by family members, that professionals have not been very effective in this area and the focus has been on treating the patient independently of the family, or on seeing the family as pathological rather than normal and needing support with a difficult situation (Platman, 1983; Willis, 1982). There may be periodic contact with the family or friends of the chronically mentally ill but very little is available on a program level. In other words, support to family and friends still comprises a small part of present treatment efforts (Enzinas, 1982). This discrepancy could also reflect the educational ideals about families that are part of most professional's preparation, ideals that are not necessarily translated

into action.

If high priority is placed on this service, the definition of support would need to be clarified by both the professional groups and the families. If one defines support as a 10 minute conference at the end of an appointment and the other sees it as frequent respite care, then dissatisfaction is bound to arise. A high priority given to the development of these services would likely require development of new programs for families which will involve professional time. If programs for respite care were also developed more fiscal resources would likely be needed as well as co-ordination between health and social services. Development of these services would likely result in less stress on families, more appropriate non-professional support for the patients, earlier recognition of developing crisis and earlier intervention.

Least Important Services

Crisis Services. The availability of professional help on a 24-hour basis was rated tenth out of the twelve services. This service was also infrequently discussed in the literature, perhaps implying that it was not considered high in importance by current writers. Professionals may have rated this area as less important because there is not a clear conceptual framework for crisis intervention with the chronically mentally ill in the literature and most mental health services in Nova Scotia do not have special crisis services. This means that professionals do not have theory or experience to guide them in the assessment of crisis services. In addition the word crisis may be more readily associated with acute illnesses rather than chronic or

long term illness, possibly influencing the perception of importance with this population.

If greater priority is placed on this service by decision makers, professionals may have difficulty implementing changes because it is considered less important. On the other hand, if the priority for crisis services is lowered, professionals are not likely to advocate changes in the priority given this service. Based on the few writers who discuss crisis services for this population, there are, however, ramifications if low priority is placed on this service. The chronically mentally ill are more vulnerable to stress and normal developmental milestones can become major crises (Krauss and Slavinsky, 1982; Turner and Shifren, 1979). If a full range of crisis services are not available with mental health input, families and emergency services in general hospitals are left to deal with the crisis, often resulting in premature hospitalization and negative attitudes toward the chronically mentally ill and the mental health agencies (Cesnik and Stevenson, 1979).

Involvement of the Community. This service was ranked eleventh by the professionals in Nova Scotia. The literature as well did not convey a clear picture of the importance of close involvement between mental health services and members of the community. The lower rank may imply a lack of certainty about the significance of this service rather than a clear judgement about its importance.

If this lower rating on importance is translated into lower priority being given to improving the links between the mental health system and the informal community support system there may be more long-range implications than just the loss of the support services and manpower

that are provided by volunteers. Personal contact with mental health services does affect attitudes toward the provision of these services (Taylor and Dear, 1981). If there is not an effort to increase the links between mental health and the community, the support may not be there when requests are made for fiscal resources or closer contact with the community. Negative public attitudes toward people with a chronic mental illness was one of the major barriers to the development of services in Canada (Toews and Barnes, 1982) and professionals in Nova Scotia underestimate this stigma (Barkow, 1983). This condition may remain unchanged if the priority given to this service remains low.

If the decision makers place a high priority on this service, when the professionals rate it lower in importance, program planners will need to attend to this discrepancy, possibly by discussion and education, before seeking a commitment to program change.

Identification of Clients. Identifying those with a chronic mental illness was ranked the least important of the twelve services rated by the professionals in Nova Scotia. As in the pattern with the two previous lower ranking services, the importance of identification of patients was not clearly identified and less frequently discussed in the literature than were other services. If the beliefs of professionals influence their behavior and this service is given low priority by them as well as the decision makers, it has implications for the resources required to treat the chronically mentally ill. It has been identified that the characteristics of chronic mental illness make it difficult for patients to seek the services that can be most

helpful to them (Turner and Shefren, 1979). If only the patients who actively request help are given it, many patients will remain untreated in the community, possibly at a lower rate of functioning or will require hospitalization because they do not receive the necessary treatment (Leighton and others, 1984). This would reduce the number of patients requiring services and, of course, reduce the cost of providing these services.

If professionals are told to give this high priority when they believe it is lowest in importance, follow through may be poor without additional planning given to this service by the programmer. Unfortunately, there is little empirical data to assist the program planner in determining the most appropriate methods of identifying patients.

Significant Differences

Are there significant differences among the four professional groups and among those who work in the inpatient, rehabilitative and community settings in their ratings on the importance of services associated with a comprehensive treatment program for the chronically mentally ill?

Discussion

Differences among professional groups occurred in two of the twelve services: (1) identification of patients, (2) reaching out to offer services. Differences among the work setting groups occurred with crisis services. There were no differences among the professional or work setting groups in the remaining nine services.

In the ratings on importance for both (1) identification of patients and (2) reaching out to offer services, (see Table 14), psychologists rated these services as less important than did the other professionals although it must be remembered that these services were still rated as important by psychologists. A factor which may have influenced the ratings in these two areas is that community psychologists spend less time with the chronically mentally ill than do other professionals and they may be less involved in providing this service than other professionals.

If these services are given high priority and psychologists consider it less important than other professions, goal conflict may occur. This may be of even more importance if the psychologist is in a position of leadership or decision making within the mental health service. It should alert the program planner to a need for discussion of this service among the professional groups before decisions on priorities are made so that consensus on goals can be developed.

Psychiatrists also differed in this area. They rated the identification of patients and reaching out to offer services as more important than other professions. This may possibly reflect the pronounced role they play in the assessment of the more severe types of mental illness. It may also result in psychiatrists advocating that more emphasis be placed on these services even though identification of patients was rated lowest in importance by the total sample.

The differences between psychiatrists and psychologists in the assessment of identification of patients and reaching out to offer services may be an example of the tendency of these two professions to

differ generally: Psychologists and psychiatrists have been described as having serious rivalry problems in Nova Scotia that includes vying for power and ideological differences, (Barkow, 1983),

Work setting accounted for differences in the third area, crisis services. The community professionals rated 24-hour crisis services lower than did those in other work settings. Since most crises occur in the community and it is often a crisis that precipitates a return to hospital, it appears contradictory that community professionals would rate this service lower. Perhaps it is the familiarity with returns to hospital that makes the inpatient and rehabilitation professionals rate this service higher. Since very few community mental health agencies in the province presently have organized crisis services for chronic patients, the lack of familiarity with such a service and a vision of evening and weekend work may have influenced the community professionals' ratings. It does point to a need for clarification of the role of crisis services by the community professionals.

The fact that there were no differences among nurses, psychiatrists, psychologists and social workers in ten of twelve services would indicate that these are areas of consensus. This result supports the findings in other studies where there were no significant differences among the ratings of the four professional groups (Rubin, 1978; Toews and Barnes, 1982). The fact that there are no differences among the professionals in different work settings in eleven of twelve services supports the results in the Toews and Barnes study (1982) but contradicts the findings in the Rubin study (1982) in which community mental health workers rated the importance of tasks in the treatment of

chronically mentally ill as less important than inpatient workers in a unit for chronic patients. The contradiction could possibly be explained by the differences in the design of the two studies. In the Rubin study (1982) the services were grouped together in one large category called aftercare. Cell sizes were smaller as well. The relatively small size of Nova Scotia perhaps results in more interface between the professionals in various settings thus facilitating consensus. There could be a positive interpretation of the differences in the findings as well. The first study was conducted in 1979 and the present study in 1983. Perhaps the differences in findings represent progress that has been made in the intervening years in the belief in the importance of services for the chronically mentally ill by the professionals in the community.

The fact that the four professional groups in Nova Scotia share similar perceptions of the importance of services for the chronically mentally ill in Nova Scotia and the fact that the type of work setting in which these professionals work does not alter their perceptions on most services is very important to those planning programs for the chronically mentally ill. It is encouraging to think that there can be consensus among four professional groups that have been known to disagree about major issues (Barkow, 1983; Langsley and Barter, 1983). It means that there is one less barrier to the implementation of programs.

In spite of apparent consensus among these groups in many areas, it must be remembered, however, that professional and/or work setting differences do exist. The questions answered in this study were

general and may tend to minimize differences that could exist regarding specific objectives and/or methods of implementation of programs. In other words, the closer the change gets to affecting the function of a profession or work setting, the more likely it is that professional and/or work setting differences will appear.

Feasibility of Services

Research Question Eight

How do professional caregivers rate the feasibility of services associated with a comprehensive treatment program for the chronically mentally ill ?

Discussion

It was concluded that the twelve services were considered feasible by at least 48 percent of the population but there was greater variation in the level of feasibility of each service than was apparent in the ratings on the importance of services. The variation in responses to feasibility may have occurred because there is less of a response set to the feasibility question than was the case with the importance question. It may also reflect less knowledge by the respondents about feasibility on which to base their perception. If lack of information is partially responsible for the responses, it may indicate a need to include open discussion with the professional caregivers on the feasibility of services when an agency or institution is setting priorities.

The fact that services for the chronically mentally ill have been

rated as feasible by many of the professionals will enhance the implementation of program changes if they occur in those areas that are seen as feasible. There are, however, many professionals who consider many services low in feasibility and if program changes are planned in these areas, the perception of low feasibility will have to be addressed as part of steps taken to implement new programs. Since there is wider variation on the feasibility question, the program planner should reassess the feasibility question with the professionals in any setting where changes are to take place.

Other areas of discussion centered on the feasibility question may be needed. If professionals, for instance, perceive that a service is feasible when in fact it is not feasible, discussions will be necessary between program planners and program implementors to achieve consensus on goals. If a program is rated as very important but also as low in feasibility, e.g., residential services, then steps will need to be taken to clearly identify how the service can become feasible. It is also important for the program planner to determine how an increase in feasibility of a service will affect other goals the professionals may have as this will likely affect the degree of commitment the professional is willing to make to the new service, e. g., if greater resources are made available for residential services, resulting in less resources available for services in an area to which the professional is already committed, the resulting goal conflict may affect implementation.

It is important for the program planner to recognize that professionals are not likely to risk themselves and fight for the

acquisition of a service that is seen as unfeasible, even though it is considered important. If the provision of these services is to have greater priority, the perception of the feasibility of the services by the professionals in Nova scotia will need to be addressed before the professionals will likely lend their weight to advocating for these services.

The results of this study not only reflect the feasibility of the services but also which services are perceived as more feasible than others. The three services that were seen as most feasible were (1) assisting with benefits, (2) provision of medical and mental health care and (3) psychosocial rehabilitation. Seventy- nine percent or more of the professionals saw these services as feasible. One explanation of why these services were seen as feasible could relate to the fact that they are services in which professionals are frequently involved at present. The services that are seen as least feasible were (1) residential services, (2) vocational services and (3) 24-hour crisis assistance.. Only 48 to 52 percent of the professionals saw these services as feasible. The frequent unavailability of these services in the community may have contributed to the low rating on feasibility.

Most Feasible Services

Assisting with Benefits. Helping clients get access to programs that can meet their nutritional, housing, health and employment needs was rated as the most feasible service. One reason for this rating may be due to the relatively simple, practical nature of these services. In addition, the client in an institutional setting frequently has many of

these needs met by that environment.

If priority was increased to this service, an important benefit to the chronically mentally ill could be provided without a major drain on the available resources for other mental health services because it is primarily a co-ordination service based on an accurate awareness of the needs of the chronically mentally ill. Even if some professionals did not think they had the skills necessary to implement this type of service, supplying them with knowledge of the necessary resources would be relatively easy for the program planner. If priority to this service was decreased, the fact that it was perceived as feasible by the professionals may make it more resistant to change.

Medical and Mental Health Care. These services were rated as the second most feasible service. The assessment of feasibility in this case may relate to the present availability of a variety of medical, dental, individual, family and group therapies within the health and rehabilitation system. If higher priority is given to this service, what may be required is the co-ordination of these services so that the variety of services are available to fit the needs of the chronically mentally ill rather than all patients having to adapt to a single form of service. If priority for medical and mental health care was lowered, there may be strong opposition by professionals as this service is viewed as both feasible and important.

Psychosocial Rehabilitation. The provision of the many social, vocational and recreational services that can be included under this broad category was rated as the third most feasible service. These services are often an integral part of the inpatient and rehabilitative

setting which may have influenced the rating. They are available however, only in a limited manner in the community setting where often the physical structures to provide the programs are not available (Bayer, 1982). Possibly the feasibility of these services within the institutional versus the community setting needs to be determined apart from this study's overall feasibility rating.

If a higher priority was given to this service, the high feasibility rating would help the program planner increase the professionals' commitment to changes in this program area as most professionals are somewhat familiar with these services and may be more open to planned changes in this area. Lowering the priority would be difficult because the services are seen as both important and feasible.

Least Feasible Service

Residential Services. The provision of a variety of living arrangements was rated as the tenth most feasible service. In addition, it was one of the three services in the national study that was identified as needing the most improvement (Toews and Barnes, 1982). One reason why it was seen as less feasible could be the capital expenditure as well as expenditure for program and human resources that is usually required for residential services such as half-way houses and apartment buildings. Other programs such as the provision of foster homes would require human resources only. Another reason for the low feasibility may be the difficulty inherent in combining the efforts of those in government departments, professionals in the field and citizens in the community.

If lower priority is placed on this service, the chronically mentally ill, especially in the community will continue to be without resources that are considered important. If higher priority were placed on this service it would most likely change the amount of fiscal resources available in other areas. Perhaps the program planner has to place an emphasis on helping groups improve their advocacy function as a first step in changing the feasibility of residential services and become more creative in the development of new ways to provide these services.

Vocational Services. Provision of a variety of vocational options was rated as the eleventh most feasible service out of twelve. There is a difference in the provision of vocational options in the community and institutional settings. The institutions have built in opportunities for vocational development and what is often required is the co-ordination and supervision of these services. In the community, however such opportunities within normal work environments are difficult to develop. Many chronically mentally ill require specialized work environments and sheltered work placements. As with residential services, an increase in priority in this area may affect the availability of resources for other areas and would require co-ordination among several groups. The chronically mentally ill will continue to be underserved in this area if the priority is lowered. Professionals will advocate less for a service that they perceive as low in feasibility. As with the provision of residential services, the program planner may need to help groups become more creative in the provision of these services and to act as advocates if they are also considered important.

Crisis services. The availability of professional help on a 24-hour basis was seen as the least feasible service. One explanation for the low rating on feasibility may be an image of endless manpower needs possibly in a way that would affect the present functioning of the professionals because of more night and weekend work. To implement this service may decrease the present availability of resources for other programs. Since professionals perceive this service to be low in feasibility and importance they are not likely to advocate for changes in this service.

Significant Differences

Are there significant differences among the four professional groups and among those who work in the inpatient, rehabilitative and community settings in their ratings on the feasibility of services associated with a comprehensive treatment program for the chronically mentally ill?

Discussion

It was concluded that only one difference was accounted for by professional groups, that is in the ratings on services to involve the community. Work setting accounted for differences in feasibility ratings for three services: (1) psychosocial rehabilitation, (2) health care, and (3) vocational services. There was an interaction effect with ratings on feasibility of services to identify patients. There were no differences among professional or work setting groups in eight of the twelve services.

With services to involve the community, psychiatrists rated it as

less feasible than other professionals. One explanation of these results may be that psychiatrists have traditionally been the professionals giving primarily direct services and often have relied on other professionals to provide indirect services. Psychologists rated the same service as more feasible than other professionals perhaps because the psychologists had the highest percentage of their profession working in the community, resulting in a higher level of community involvement. If psychologists perceive the involvement of community as more feasible, they may be more apt to initiate community based programs and to advocate for these services. If there is a question of whether there should be priority given to this service, psychiatrists and psychologists are more apt to disagree with each other because of their differing views on the feasibility of this question and their tendency to disagree with each other on issues (Barkow, 1983).

Professionals in different work settings had differing views on the feasibility of (1) psychosocial rehabilitation, (2) health care and (3) vocational services. One explanation for the differences in feasibility may be that services performed most frequently in a particular work setting are seen as more feasible by those in that setting e.g., psychosocial services in the rehabilitation work setting. Professionals in work settings where services are seen as more feasible may be able to help professionals in other areas determine ways to make these services more feasible.

The provision of medical and mental health care was seen as more feasible by the professionals in the community than those in other

settings. The same service was seen as less feasible by the professionals in the inpatient setting. Since this service is also identified as high in importance by all professionals, differences in perception of feasibility may result in differences in expectations of this services. Community professionals may expect more to be accomplished with available resources than inpatient professionals. If expectations are not met, it may lead to dissatisfactions with professionals in the other work setting.

Psychosocial rehabilitation and vocational services were identified as more feasible by the professionals in the rehabilitation setting than by professionals in other work settings. Professionals in the inpatient setting perceived these services to be less feasible than did professionals in other settings. If professionals in the rehabilitation setting perceive these services as feasible and important, they are more likely to advocate for these services within their system and there would be a greater willingness to put a higher priority on these services in the rehabilitation setting than in the inpatient or community setting.

Social workers and psychiatrists in the rehabilitation setting rated services to identify patients as less feasible than did other professionals. It is likely inappropriate to speculate on this interaction effect as the results were based on the ratings of only two psychiatrists and four social workers.

Importance and Feasibility

Research Question Nine

Are the services of a comprehensive treatment program that are identified as most important also the ones where the greatest feasibility has been indicated?

Discussion

The services that were identified as most important were not necessarily the ones that were identified as most feasible. One explanation for the lack of significant correlation may be the close scores that were obtained on the importance and feasibility questions.

In spite of the lack of correlation, some observations are worthy of mention. Two of the three services that were considered most feasible were also two of the three services that were considered most important, i.e. the provision of (1) medical and mental health care and (2) psychosocial rehabilitation. It should also be noted outpatient services were identified as the most readily available service in Canada whereas social and recreational outlets were services that were considered least available (Toews and Barnes, 1982). In other words, psychosocial rehabilitation services are considered among the most important, least available and most feasible of services for the chronically mentally ill. Perhaps this is an indication that programs to improve social and vocational skills, activities of daily living and leisure time skills need to be given high priority at this time.

Crisis assistance on the other hand was considered both less

important and the least feasible of all services in this study and was not mentioned at all in the national study (Toews and Barnes, 1982). Perhaps this is an indication that professionals believe that this service should be given low priority at this time.

The fact that there was not a statistically significant correlation between the importance and feasibility of services makes it more difficult to set priorities and to identify the most appropriate places to initiate change. If priority is given to a service that is high in importance but low in feasibility, the feasibility of the service will have to be resolved before change is initiated. If a higher priority is given to a service that is feasible but considered low in importance, the program planner will have to plan ways to ensure the commitment of the professionals to this service.

Priorities

Research Question One

How much clinical time of professional caregivers is presently directed to the care of the chronically mentally ill?

Discussion

Approximately one half of the professional time of nurses, psychiatrists, psychologists and social workers is presently directed toward the care of the chronically mentally ill in Nova Scotia. The present proportion of time spent with the chronically mentally ill constitutes a major part of the professional resources for all mental health services in the province. Yet, local authorities suggest that

present services are nowhere near adequate (Crook, 1982; Mac Cormick, 1982; Leighton, 1982). However it is important not to be misled by the overall figure of 50 percent. The picture changes somewhat when the data are analysed according to profession, work setting and the placement of patient population. The majority of the chronically mentally ill live in the community (Bland, 1984; Leighton and others, 1984). Yet in this study it is the community professionals who direct the least percentage of time to this population. The amount of time that community professionals spend with the chronic mentally ill may be one reason why they continue to be underserved. The amount of time may also be an indication that other populations have been given greater priority in the community setting as was suggested in the literature (Bachrach, 1978). It could also be that the amount of professional time is not deficient but that other resources such as vocational and psychosocial services, not involving primarily the time of nurses, psychiatrists, psychologists and social workers are required. Although the results of this study cannot provide this information, the results do indicate the need for more exploration into the use of the time of professionals with the chronically mentally ill in the three work settings.

The percentage of clinical time spent with the chronically mentally ill is influenced by professional affiliation as well as work setting. The majority of psychologists direct less than 25 percent of their time to the chronically mentally ill. Nurses and social workers are the two professional groups that directed the greatest percentage of time toward the chronically mentally ill in the study.

It is possible only to speculate on whether variation in the percentages of time spent with the chronically mentally ill is reflective of differences in interests, commitment, conflicting goals or differentiation of function. Maybe the low time of psychologists relates to the traditional roles of the four professionals. Traditionally, those with an illness were cared for by nurses and medical doctors and co-ordination with the community has traditionally been a role of social work. Psychology is the youngest profession and may have less of a defined role with the chronically mentally ill. Although the four professions were considered suitable for case management, nurses and social workers were seen as the most suitable in the national study (Toews and Barnes, 1982).

Possibly the education of the professionals plays a part in their involvement with this population. Nurses and medical doctors all have some exposure to the chronically mentally ill. This does not necessarily happen with all social workers and psychologists who are trained in Nova Scotia. The psychiatry and psychology sample had the highest qualifications in length of education. Possibly this leads to greater interest in patient populations in which the professional can use more psychotherapy skills. If Lamb (1980) is correct and there are negative attitudes toward the chronically mentally ill possibly these roles are relegated to the nurses and social workers because their roles are perceived as having less status. This idea was supported by Rubin (1978) in a study which suggested that community aftercare should be delivered primarily by practitioners who have lower levels of professionalization. Lamb (1980) disagreed with this concept, believing that high levels of professionalization are needed to assess

and treat the chronically mentally ill. It may be in this area that the chronically mentally ill are not benefitting fully as most psychologists have expertise in assessment and behavioral programming, among other things. In a time when new approaches are needed to treat the chronically mentally ill, greater input from psychology may be helpful.

Recognition that there is variation in the amount of time spent with the chronic mentally ill by the four professions highlights the need expressed by Krauss and Slavinsky (1982) for more knowledge about the specific functions of each profession in the care of this population. Discussion by professionals about role specifics may be necessary before program planners would be able to determine the most appropriate proportion of time given by each profession. This caution is particularly relevant in view of the discussion of the following research question.

Research Question Two

Would professionals prefer to change the percentage of clinical time spent with this population?

Discussion

Professionals did not want to change the percentage of time they direct to the care of the chronically mentally ill. The lack of preference for change in time spent with the chronically mentally ill appears contradictory to the responses to other questions on priority. The professionals indicated that greater overall priority should be given to the chronically mentally ill and in particular greater priority to

the development of treatment in the community and community services. It would seem logical to assume that if priorities were to be increased in these areas it would have implications for the use of professionals time, yet no profession or work setting has expressed a preference for an increase in the amount of time they work with the chronic mentally ill. Perhaps it is a way of saying "I want to see things changed for the chronically mentally ill as long as I don't have to change in the process." This may be a hint of the gap that may exist between what the professionals think and their actual behavior (Rubin and Johnson, 1982).

The low scores on the question on changes in time spent with this population are of even more concern if the response set to provide socially acceptable answers was yet again operating and resulted in an inflated score (Tuckman, 1972). It is important not to gloss over the potential significance of these results as changes are not likely to be implemented after they leave the policy makers if no efforts are made to increase the commitment of those professionals who have to implement the change.

Suggestions for increasing the commitment of professionals include the provision of organizational supports for compliance with the programs for the chronically mentally ill (Rubin and Johnson, 1982). Examples of such supports would be time to develop programs as well as some autonomy in the use of resources to do this. Rubin suggested the use of lower levels of professionalization in staffing as well as specialized units for the chronically mentally ill so that support for professionals is more accessible (1978). Methods of increasing

commitment through discussion, role modeling, identification of barriers the implementation of change have also been discussed by others (Jones, 1982; Leighton, 1982; Leithwood, 1982).

The educational literature provided a conceptual framework for the implementation of change that emphasized knowledge, skills, resources, and motivation that would be equally useful to the mental health program planner (Leithwood, 1982). This framework may be particularly useful since the role of education as a method to increase commitment to the chronically mentally ill has been underemphasized in the mental health literature even though it may be one reason for the preference for no change in the time spent with the chronically mentally ill. For example, there is a possibility that the average length of experience of professionals in Nova Scotia has educational implications that may affect the level of commitment of the professionals. As a group the professionals have an average of ten years experience yet only in the last few years has there been an increase in emphasis on the chronically mentally ill and only five or six years since the literature reflected this increased focus, mostly in the form of journal articles. Only in the past two or three years have a variety of texts been written that deal specifically with the chronically mentally ill especially in the community and very few of these focus on the specific contribution of the different professions. If it is correct to assume that the majority of professionals presently in the field have not had educational experiences that provide them with a conceptual framework in planning and implementing care for the chronically mentally ill, it is not surprising that commitment may be

Commitment may also be low because of the educational preparation of the professionals as it is doubtful whether even present day professional graduates are getting the educational experiences necessary for informed decision making in relation to the chronically mentally ill (Blaikie, 1984; Carlson, 1984; Hill, 1984; Munroe, 1984). This implies that professionals in the field now and those undergoing professional preparation have a need for continuing education on chronic mental illness.

Education regarding services for the chronically mentally ill need to be approached in three ways:

1. an educational component relating to the chronically mentally ill within the professional schools for nursing, psychiatry, psychology and social work within Nova Scotia.
2. educational programs for the professionals who are already in the field.
3. educational programs for non-professional policy and program makers.

Significant Differences

Are there significant differences among the professional and work setting groups in their preference for changes in the amount of time they direct to the care of the chronically mentally ill.

Discussion

Professionals in the community and rehabilitation setting had a greater

tendency to increase the time spent working with this population. The professionals in the settings that spent the greatest and the least percentage of time with this population are the ones who had more of a tendency to increase time spent with this population. Perhaps this is an expression of satisfaction with their role by the professionals in the rehabilitation setting who work primarily with the chronically mentally ill or an indication that few other options are available to them. The response by the professionals in the community who spent the least amount of time with the chronically mentally ill, may be an indication of willingness to expand their role.

Research Question Three

Within the resources presently available, do professional caregivers believe there should be changes in the overall priority given to financial and human resources for the chronically mentally ill?

Discussion

The professionals indicated that the overall priority given to the chronically mentally ill within the resources presently available for all mental health services should be increased slightly. There is no doubt that we are in an era of limited fiscal resources and that goal setting has to take place if we are to prevent the syndrome described by Leighton where goals are "mutually interfering with one another while dissipating the resources" (Leighton, 1982:15). If the priority for the chronically mentally ill is increased it is logical to assume that given no increase in resources, some other service or services will have to decrease. Such a move would certainly affect those with investment in the areas that are decreased. Therefore, in spite of the support of professionals for an increase in priority for the chronically mentally ill, such a step cannot be made in isolation. Extremely careful planning to reduce the impact of such a change and to ensure the support of professionals as they cope with the implications of any change would be necessary (Achilles and others, 1983; Gates, 1981; Gotowala, 1982; Leithwood, 1982).

Significant Differences Regarding Research

Question Three

Are there significant differences among the four professional groups and among those who work in the inpatient, rehabilitative and community setting in their ratings on changes in overall priority for the chronically mentally ill?

Discussion

Professionals in the inpatient setting expressed more of a preference for higher priority be given to the chronically mentally ill than did professionals in other settings. The frequent readmission of the chronically mentally ill to hospital may be one explanation for the higher response of professionals in the inpatient setting. The professionals in the inpatient setting may also be less negatively affected by an increase in priority to the chronically mentally ill than the community professionals who work with many different populations in the community. These results may also imply that inpatient professionals may more readily advocate for greater priority for this population than would those professionals in other settings.

Research Question Four

Do professional caregivers believe there should be changes in the emphasis on treatment of the chronically mentally ill in the community?

Discussion

Professionals believe the emphasis on treating the chronically mentally

ill in the community should be increased. If the increased emphasis on treatment in the community were to take place it would have major implications for the community work setting. The impression conveyed in the literature is that the community, both professional and non-professional has not embraced the chronically mentally ill (Bachrach, 1978; Lamb, 1981). During the course of this study nothing has come to light to indicate that Nova Scotia is any different than the rest of Canada and the United States in relation to this issue. In other words, implementing an increased emphasis on treatment in the community may not be easy.

Three major factors could be obstacles to increasing the emphasis on treating the chronically mentally ill in the community. The first is the professionals themselves. The community professional presently directs the least amount of work time to the services of the chronic mentally ill. In addition to that they expressed a preference for this time to remain the same. Not only is the overall proportion of professional time low in the community but the proportioning of the four professional groups works against an increased emphasis in the community. The four professional groups in the community are approximately equal in number (see Table 3) yet nursing and social work were the professions that spent the greatest amount of time with the chronically mentally ill and were the professions rated as most suited to act as case managers for the chronically mentally ill (Toews and Barnes, 1982). If the assumption is correct, i.e., that nurses and social workers are best suited for case management, one wonders whether the proportion of nurses and social workers in the community should be increased along with careful planning

to increase the willingness of all of the professions to be more involved and committed to services for the chronically mentally ill.

Resources such as vocational, residential and leisure facilities are the second obstacle to increased emphasis on treatment in the community. Community professionals cannot provide the services without the necessary resources. Not only has the lack of resources been mentioned throughout the literature on the chronically mentally ill; but is cited as one of three major obstacles in program implementation in educational literature (Leithwood, 1982; Toews and Barnes, 1982).

The community itself may act as the third obstacle to the increased emphasis on treatment in the community. "Negative public attitudes toward people with chronic mental disorders" was cited as one of the four most important service barriers (Toews and Barnes, 1982:32). This national study recommended that the Canadian Mental Health Association provide public education "to sensitize the community to the needs of the chronically mentally ill and to aid in decreasing the stigma associated with the disability" (Toews and Barnes, 1982:45). Although identified as important by the respondents in this study, involving the community was ranked as one of the least important of the twelve services. Clearly there is a major educational need here as well as a need for research into the most effective means of educating and involving the community.

Significant Differences Regarding Research

Question Four

Are there significant differences among the four professional groups and among those who work in the inpatient, rehabilitative and community

setting in their ratings on priority for treatment of the chronically mentally ill in the community?

Discussion

Professionals in the inpatient and community setting preferred more emphasis on treatment of the chronically mentally ill in the community than did professionals in the rehabilitation setting. The higher priority rating by the professionals in the community and inpatient setting may be due to the emphasis on short term treatment in these settings whereas in the rehabilitation setting long term treatment is emphasized. This result could be interpreted positively as an indication of shared goals between those in the inpatient and community setting. The results could also reflect a readiness for professionals working in institutions to be more involved in the community. This does not imply leaving the institution but rather changing the definition of institutional work so that it includes greater interface with the community (Craig and Laska, 1983:620).

Research Question Five

Do professional caregivers believe there should be changes in the priority given to the development of community support services for the chronically mentally ill?

Discussion

Professional caregivers believe there should be an increase in the priority given to the development of community support services for the chronically mentally ill. Resources are an important part of community

services, all of which were identified as important by the professionals in this study. Yet sheltered occupational opportunities, housing resources and social and recreational outlets were the least readily available of the services in Canada (Toews and Barnes, 1982). Two of the above services were viewed as the least feasible of services to provide for the chronically mentally ill in the present study. The high priority score on this response does provide some indication that the professionals perceive that the resources needed to implement an increased emphasis on treatment in the community are not presently available to do the job (Toews and Barnes, 1982).

In addition to the lack of resources, those that are presently available are poorly coordinated (Toews and Barnes, 1982). In Nova Scotia, this may be due to a lack of clarity of areas of responsibility. Inpatient services are directed by the Department of Health, rehabilitation services are directed by the Department of Social Services and community services are provided by both the Department of Health and the Department of Social Services. A system that unites such separate services may be necessary before a major change in the community can take place (Barkow, 1983).

The question on priority for community services does not provide any indication of how an increase in community support services could be achieved. Obviously if such a feat were to be achieved within the present resources, major reordering of priorities on the part of the system as a whole would have to be accomplished.

Significant Differences Regarding Research

Question Five

Are there significant differences among the four professional groups and among those who work in the inpatient, rehabilitative and community setting in their ratings on priority for community services for the chronically mentally ill.

Discussion

Professionals in the inpatient and community setting preferred more emphasis on community services for the chronically mentally ill than did professionals in the rehabilitation setting. The professionals in the inpatient and community setting may have a tendency to rate the priority responses higher than those in the rehabilitation setting since patients transfer between inpatient and community setting much more frequently than between community and rehabilitation settings. The frustrating experience of seeing patients return to hospital often shortly after discharge may make inpatient and community professionals more aware of the limitations of community services, resulting in the expressed need for greater priority in these areas.

Research Question Six

Do professionals/caregivers believe there should be changes in the priority given to the development of institutional support services for the chronically mentally ill?

Discussion

Professional caregivers believe that the priority given to institutional support services for the chronically mentally ill should remain the same. The fact that the professionals preferred an increase in the development of community services while at the same time indicating that priority for institutional support services should remain the same could indicate a commitment by all to the ideology associated with the deinstitutionalization movement. It is important to note that the professionals in institutional settings, i.e., inpatient and rehabilitation settings, expressed this view as strongly as those working in the community.

Significant Differences Regarding Research

Question Six

Are there significant differences among the four professional groups and among those who work in the inpatient, rehabilitative and community setting in their ratings on priority for institutional support services for the chronically mentally ill?

Discussion

Nurses and psychiatrists expressed greater preference for an increase in institutional services for the chronically mentally ill than did other professionals. Social workers expressed less preference for an increase in institutional services than did other professionals. Professional affiliation influenced only the rating on priorities in institutions. Although still indicating that the priority remain the same, nurses and

psychiatrists had more of a tendency to increase institutional support than did psychologists and social workers. This difference could relate to the strong historical investment that psychiatrists and nurses have in the hospital setting and investment that social workers traditionally have in the community.

Impact of Study Design on Results

On reviewing the methodology, the procedure for implementing the study generally worked well. Since the study included all members of the four professional groups involved in the implementation of programs for the chronically mentally ill, the objective was to achieve a high response rate. In an effort to enhance this, the questionnaire was coded when first sent out and to those who did not respond in the first round, a non coded questionnaire was sent in a stamped, self-return envelope on the assumption that anonymity would increase the response rate. Since this resulted only in an additional ten percent response rate, perhaps the anonymity was not as important as the researcher having access to the respondents for further follow-up if the return rate was low enough to jeopardize the results of the study.

The goal of a high response rate also influenced the design of the questionnaire. It was kept short to increase the probability of a high return rate. Perhaps a section on the perception of the availability of the twelve services in Nova Scotia would have added helpful information without necessarily diminishing the return rate.

The questionnaire was designed so that respondents would choose from a five point scale. The responses tended to fall within a range of two or

three points, especially for the question on importance. The use of a seven point scale may have helped to elicit greater differences among the respondents.

Summary

The study was a descriptive survey, the main purpose of which was to facilitate program planning by obtaining data on priorities, importance and feasibility relating to services for the treatment of the chronically mentally ill by the nurses, psychiatrists, psychologists and social workers who provide inpatient, community and rehabilitation services for the chronically mentally ill in Nova Scotia. The study also determined whether there were significant differences among the professional and worksetting groups in the way in which they rated priorities and the importance and feasibility of services.

Based on a conceptual framework which emphasized the necessity of consensus and commitment in order to plan programs for the chronically mentally ill that provide continuity of care through comprehensive services, a five point scale questionnaire was designed and given to all members of the four professional groups who worked in the mental health facilities in Nova Scotia. Of the 540 questionnaires distributed, 351 were used in the data analysis. There were 231 questionnaires from nurses, 37 from psychiatrists, 41 from psychologists and 42 from social workers. Frequencies, ANCOVA at the .05 level of significance and the Spearman Rank Correlation were used to determine the following results.

The twelve services included in the questionnaire were all considered important by at least 75 percent of the total sample. The three most

important services were (1) psychosocial rehabilitation, (2) medical and mental health care and (3) support to family and community. There were differences among the professional groups in the importance ratings on two services and work setting influenced the ratings on one service.

Since all services were considered important in this study, the ranking of services may not be an indicator of major differences between them. If the professionals, however, tended to answer the questions positively because of a response set, the rank may well reflect far greater differences in the behavior of the professionals.

When the professional's ratings of the importance of services are compared to the importance described in the literature, it appears that the lower ranked services in the study are similar to the areas in the literature in which program planning and empirical studies are least available. Thus, the greatest need for creative program planning and evaluation may be found in the areas of crisis services, involvement of community and identification of clients. All services were rated feasible by at least 48 percent of the total sample. There was considerable variation in the feasibility of the different services, with some services considered not feasible by up to 32 percent of the sample. The services ranked most feasible included (1) assistance with benefits, (2) medical and mental health care and (3) psychosocial rehabilitation. The services ranked least feasible were (1) residential services, (2) vocational services and (3) crisis services. There were differences among the professional group in the feasibility scores on three services and work setting affected scores with one service.

Professionals spend an average of 50 percent of their time in work related to the chronically mentally ill and expressed no preference to change this amount of time. The professionals did indicate that the overall priority for the chronically mentally ill should be increased, especially emphasis on treatment in the community and community support services. The results indicated that priority for institutional support services should remain the same. Professionals in the inpatient and community work setting rated four of the five priority questions higher than professionals in the rehabilitative setting. Professional affiliation affected the responses to the priority question on institutional services for the chronically mentally ill.

When looking at differences among the groups, professional groups differed more frequently on the importance and feasibility of services than work setting groups. With the priority question, the work setting groups differed more often than professional groups. The results on differences can help the program planner identify areas in which further discussions are needed before any changes in programs take place. The views that are shared by the groups can also be used to build commitment to programs for the chronically mentally ill.

It was noted that psychosocial rehabilitation services which are considered low in availability were ranked high in both importance and feasibility. This may indicate that psychosocial rehabilitation should be given high priority. In addition crisis services were ranked low in both importance and feasibility, indicating perhaps that professionals believe this should be given low priority.

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Recommendations

Based on the results of this study, the following recommendations for further study are made:

1. Since four professional groups only were included in this study, it is recommended that the study be repeated with other groups that are important in the provision of services to the chronically mentally ill. Such groups would include other professionals, patients, family, community members, board members and appropriate government officials.
2. Since there may be a need for professionals to spend more time with the chronically mentally ill and to be more aware of the needs of these patients it is recommended that pilot projects be developed, implemented and evaluated to increase professional commitment. In particular, there should be (1) educational programs directed toward upcoming graduates in the professional schools for nurses, psychologists, psychiatrists and social workers and (2) inservice educational programs for professionals presently working in the field.
3. Since the availability of resources influences the commitment of professionals to program implementation, it is recommended that innovative means of developing resources be given high priority.
4. Since professional affiliation and worksetting are only two variables that may affect the consensus and commitment of professionals it is recommended that in other investigations

demographic variables such as sex, years of experience and qualifications of professionals be the object of focus rather than treated as covariates.

5. Since psychosocial rehabilitation was perceived as most important and also feasible, the development of these services should be given serious consideration in the establishment of priorities for the development of services for the chronically mentally ill in Nova Scotia.
6. Since crisis services were considered both less important than other services as well as low in feasibility, it is recommended that further research be carried out to determine both the importance and the feasibility of this type of service.

The discussion of the conceptual framework emphasized consensus and commitment as two concepts that are important to the program planner. The following suggestions relating to the development of consensus and commitment are directed primarily towards professionals who do not necessarily consider themselves expert program planners, but have the motivation and interest to improve the care given to the chronically mentally ill in Nova Scotia.

1. Development of consensus among professional groups on more than a superficial cognitive level, although difficult to achieve is a goal that should be vigorously pursued. Discussion must be encouraged among all professionals who will be involved in the implementation of services for the chronically mentally ill as well as the administrators who provide the mandate and structure for

these services. Discussion within a service unit should include more than the four professional groups identified in this study. It is equally important to include other categories of nursing personnel, occupational therapists, recreational therapists and clergy as well as other categories of non-professionals caregivers.

2. A committee or interest group within each major catchment or service area may facilitate the implementation of changes and also provide the necessary peer support in the accomplishment of any proposed changes. Such a committee or interest group should incorporate care-givers in the three work settings and the different categories of health care workers. Attention to the special character of different professionals and work setting groups will help to identify the problems which may occur, thus facilitating the development of consensus.
3. Discussion, a key to the development of consensus and commitment may take many forms. One method would be to use the questionnaire developed for this study as a vehicle for discussion. The twelve service areas could be used to identify services that are presently available, importance and feasibility of the services as seen by that group and areas most urgently in need of improvement. This could lead to the establishment of priorities and goal setting. Since the results of this study indicate that all services are considered important, it may be helpful to focus discussion on short-term goals as well as long-term goals in order to determine where initial change will take place.

4. Inservice education would be a necessary part of any process to increase consensus and commitment. It is important that underlying concepts are understood by all caregivers and consensus is achieved on how each concept would be applied within each service unit.

Important concepts would include

- A. chronic mental illness
- B. community, hospital and rehabilitative care
- C. continuity of care
- D. least restrictive environment
- E. the twelve services that are identified in this study

5. Once priorities have been set and initial goals clearly outlined, identifying the obstacles to achieving these goals is required (Leithwood, 1982). Hopefully, the discussions that have already taken place have set the stage for an honest acknowledgement of obstacles relating to values, motivation and professional roles as well as providing the environment to develop strategies to overcome these obstacles. The key point being that to bring about change that also increases practitioners' commitment to the change, requires advance planning to remove obstacles before the change is initiated.

6. Leithwood (1982) emphasized that "inadequate" organizational structures and support can be a major obstacle to initiating change. Finding ways to recognize, support and reward those who

provide the care for the chronically mentally ill can enhance their commitment. This may be as personalized as direct verbal feedback, support to decrease priorities in other areas so that time is available for services for the chronically mentally ill, advocating for funding for needed resources, encouraging practitioner autonomy (Rubin and Johnson, 1982) and/or providing for program evaluation so that changes are well documented (Stern and Minkoff, 1979). More specific suggestions for the administrative structure at either the local level or provincial government would include:

- A. Encourage the designation of a person or persons in each major service unit to be overtly recognized as having a role in coordinating the planning for the development of services for the chronically mentally ill. Program planning takes time and this role would have to be incorporated as part of the professional workload and not just added on to the normal workload of the professional.
- B. Provide opportunity for persons who are interested in program development for the chronically mentally ill to increase their knowledge base of both this type of illness and of program development for this population. A workshop on this topic would be a starting point. This level of management could also advocate for the development of a course through continuing education at the university level.
- C. Encourage and facilitate discussion between the hospital, community and rehabilitative services and Mental Health

Association in each region so that program development can proceed in a united manner and resources are not dissipated by the pursuit of conflicting goals.

The foregoing represent some suggestions, albeit limited, whereby the data presented in the study might be utilized in concert with the conceptual framework to promote the effective development of services for the chronically mentally ill. The theme running throughout is the necessity of contact and communication among the professional groups. Hopefully this study will serve the purpose of initiating such activity.

APPENDIX A
QUESTIONNAIRE

SERVICES FOR THE CHRONICALLY MENTALLY ILL IN NOVA SCOTIA

The following questionnaire is related to services for the chronically mentally ill in Nova Scotia. For this questionnaire the term chronically mentally ill refers to persons who suffer from one or more or a variety of psychiatric disorders that prevent the development of their ability to function adequately in several aspects of daily living. Most patients with a chronic illness have required extensive institutional care, but some have required only short periods of hospitalization or have been treated in the community without any hospitalization.

Directions for Section A - Importance and Section B - Feasibility

In Section A and B you will be asked to express your opinion concerning the Importance and the Feasibility of services for the chronically mentally ill. The same items will be used in both Sections, but you will be asked to consider the question in a different way in each section. The following example may help to differentiate between Importance and Feasibility.

Assume that an effective treatment (X, Y, Z) has been found for lung cancer. Most people would consider it extremely important that this new treatment be available to all lung cancer victims. However, such widespread availability is probably not feasible because the treatment is very expensive, requires specialized equipment to implement and/or requires highly specialized skills by any practitioner providing the treatment. Therefore, this question could be answered as follows:

SECTION A - IMPORTANCE.

The X, Y, Z treatment for lung cancer is

Not Important
Moderately Important
Moderately Important
Quite Important
Extremely Important

1 2 3 4 ⑤

SECTION B - FEASIBILITY

The X, Y, Z treatment for lung cancer is

Definitely Not Feasible
Probably Not Feasible
Unknown Feasibility
Somewhat Feasible
Definitely Feasible

1 ② 3 4 5

SECTION A - IMPORTANCE

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The following twelve statements describe services that could be provided for the chronically mentally ill by relevant institutions and agencies. Two examples of tasks that are descriptive of such a service have been included with each statement. Remembering that a number of agencies may be involved in providing these services, not just the agency for which you work, please indicate how important is it that each of the following services be included in the care of the chronically mentally ill?

CIRCLE the number which best describes your opinion.

- | | 1 | 2 | 3 | 4 | 5 |
|---|---------------|--------------------|----------------------|-----------------|---------------------|
| | Not Important | Slightly Important | Moderately Important | Quite Important | Extremely Important |
| 1. Identify clients/patients, whether they are in the hospital or in the community. (e.g. - Be aware of all patients who have been hospitalized. - Locate chronic patients who are living in nursing homes, boarding homes, etc.) | 1 | 2 | 3 | 4 | 5 |
| 2. Reach out to offer appropriate services to all chronically mentally ill. (e.g. - Make more than one home visit to patients who are inconsistent in treatment compliance. - Continue to contact those patients who have dropped out of treatment.) | 1 | 2 | 3 | 4 | 5 |
| 3. Provide assistance to clients/patients in applying for income, medical and/or other benefits. (e.g. - Help patients understand social service procedures. - Provide documentation for disability benefits.) | 1 | 2 | 3 | 4 | 5 |
| 4. Provide twenty-four hour crisis assistance in the most beneficial setting possible. (e.g. - Provide telephone coverage at all times - See patients outside of an office setting (in the neighbourhood, at their homes, etc.) | 1 | 2 | 3 | 4 | 5 |
| 5. Provide psychosocial rehabilitation services. (e.g. - Teach patients community living skills such as housekeeping, budgets. - Help patients develop social and leisure time skills) | 1 | 2 | 3 | 4 | 5 |
| 6. Provide medical and mental health care. (e.g. - Conduct individual psychotherapy or counselling. - Monitor psychotropic drugs.) | 1 | 2 | 3 | 4 | 5 |
| 7. Provide back-up support to family, friends and other community members. (e.g. - Assist in the development of support groups for families. - Arrange "respite" care for families who look after patients.) | 1 | 2 | 3 | 4 | 5 |
| 8. Provide supportive residential services that are available to the patient indefinitely. (e.g. - Establish half-way houses. - Supervise patients living in independent apartments. | 1 | 2 | 3 | 4 | 5 |
| 9. Involve community members in the planning and provision of services. (e.g. - Work with volunteers in socialization clubs. - Invite community members to help develop alternatives in jobs and housing.) | 1 | 2 | 3 | 4 | 5 |
| 10. Provide supportive vocational services that are available to the patient indefinitely. (e.g. - Represent the rights of patients with landlords or employers. - Advocate for services that are not available.) | 1 | 2 | 3 | 4 | 5 |
| 11. Protect clients/patients rights both in the hospital and in the community. (e.g. - Represent the rights of patients with landlords or employers. - Advocate for services that are not available.) | 1 | 2 | 3 | 4 | 5 |
| 12. Provide case management to assist the patient in utilizing available services. (e.g. - Have a consistent contact with patient during periods of both hospitalization and community living. - Monitor each patient's experiences in other agencies.) | 1 | 2 | 3 | 4 | 5 |

SECTION B - FEASIBILITY

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Using the same twelve statements found in Section A, please indicate how feasible it is that each of the following services be available to all chronically mentally ill in Nova Scotia, no matter where they reside.

Please remember that a number of agencies may be involved in providing these services, not just the agency for which you work.

CIRCLE the number which best describes your opinion.

| | Definitely Not Possible | Probably Not Possible | Uncertain Feasibility | Probably Possible | Definitely Possible |
|---|-------------------------|-----------------------|-----------------------|-------------------|---------------------|
| 1. Identify clients/patients, whether they are in the hospital or in the community. (e.g. - Be aware of all patients who have been hospitalized. - Locate chronic patients who are living in nursing homes, boarding homes, etc.) | 1 | 2 | 3 | 4 | 5 |
| 2. Reach out to offer appropriate services to all chronically mentally ill. (e.g. - Make more than one home visit to patients who are inconsistent in treatment compliance. - Continue to contact those patients who have dropped out of treatment.) | 1 | 2 | 3 | 4 | 5 |
| 3. Provide assistance to clients/patients in applying for income, medical and/or other benefits. (e.g. - Help patients understand social service procedures. - Provide documentation for disability benefits.) | 1 | 2 | 3 | 4 | 5 |
| 4. Provide twenty-four hour crisis assistance in the most beneficial setting possible. (e.g. - Provide telephone coverage at all times - See patients outside of an office setting (in the neighbourhood, at their homes, etc.) | 1 | 2 | 3 | 4 | 5 |
| 5. Provide psychosocial rehabilitation services. (e.g. - Teach patients community living skills such as housekeeping, budgets. - Help patients develop social and leisure time skills.) | 1 | 2 | 3 | 4 | 5 |
| 6. Provide medical and mental health care. (e.g. - Conduct individual psychotherapy or counselling. - Monitor psychotropic drugs.) | 1 | 2 | 3 | 4 | 5 |
| 7. Provide back-up support to family, friends and other community members. (e.g. - Assist in the development of support groups for families. - Arrange "respite" care for families who look after patients.) | 1 | 2 | 3 | 4 | 5 |
| 8. Provide supportive residential services that are available to the patient indefinitely. (e.g. - Establish half-way houses. - Supervise patients living in independent apartments. | 1 | 2 | 3 | 4 | 5 |
| 9. Involve community members in the planning and provision of services (e.g. - Work with volunteers in socialization clubs. - Invite community members to help develop alternatives in jobs and housing.) | 1 | 2 | 3 | 4 | 5 |
| 10. Provide supportive vocational services that are available to the patient indefinitely. (e.g. - Represent the rights of patients with landlords or employers. - Advocate for services that are not available.) | 1 | 2 | 3 | 4 | 5 |
| 11. Protect clients/patients rights both in the hospital and in the community. (e.g. - Represent the rights of patients with landlords or employers. - Advocate for services that are not available.) | 1 | 2 | 3 | 4 | 5 |
| 12. Provide case management to assist the patient in utilizing available services. (e.g. - Have a consistent contact with patient during periods of both hospitalization and community living. - Monitor each patient's experiences in other agencies.) | 1 | 2 | 3 | 4 | 5 |

SECTION C - PRIORITIES

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This section includes statements concerning priorities and the chronically mentally ill in Nova Scotia. Please base your response on your opinion of what is appropriate for the Nova Scotia setting.

Please CIRCLE the number that most closely reflects your opinion.

Decrease
Significantly
Decrease
Slightly
Remain the
Same
Increase
Slightly
Increase
Significantly

1. I would prefer that the percentage of my clinical time spent working with this population . . . 1 2 3 4 5
2. Within the resources presently available for all mental health services, the priority given to the chronically mentally ill in Nova Scotia should . . . 1 2 3 4 5
3. The emphasis on treating the chronically mentally ill in the community rather than in institutions should . . . 1 2 3 4 5
4. The priority for the development of community services for the chronically mentally ill should . . . 1 2 3 4 5
5. The priority for the development of institutional services for the chronically mentally ill should . . . 1 2 3 4 5

BACKGROUND DATA

Please check.

1. Professional Category -

☐ Nurse ☐ Psychologist ☐ Other (Specify)
☐ Psychiatrist ☐ Social Worker

2. Sex -

☐ Female ☒ Male

3. Which of the following qualifications do you possess?

☐ Nursing Diploma ☐ Doctoral Degree (Ph.D.)
☐ Bachelor's Degree ☐ Medical Degree
☐ Master's Degree ☐ Other (Specify)

4. In what type of setting do you presently work most frequently?

☐ Inpatient (Dept. of Health)
☐ Outpatient, Day Hospital or Community
☐ Regional Rehabilitation Centre

5. How many years have you been working with mentally ill patients?

Specify _____

6. Do you work -

☐ Full-time ☐ Part-time

7. What percentage of your present clinical time is related to care of the chronically mentally ill? (Specify) _____

THANK YOU FOR YOUR HELP WITH THIS STUDY.

APPENDIX B

LETTER TO PROFESSIONAL POPULATION

Box 1060
Wolfville, N. S.
BOP 1X0

October 25, 1983

Dear Colleague

As part of my doctoral studies in the Atlantic Institute of Education-Dalhousie program, I am conducting a study on services for the chronically mentally ill in Nova Scotia. Mental Health professionals throughout the province have been asked to participate. This study will provide information that will be useful in future planning for this population. The results of the study will be available to you on request.

The study has been designed so that no individual, hospital, institution or agency will be identified in the report. It is important however, that I know if all areas are adequately represented in the study so you will note a coding symbol on the return envelope. The questionnaires themselves are not coded so anonymity can be maintained.

I realize how busy your schedule can be, but I would appreciate you giving approximately 20 minutes of your time to complete this questionnaire. The results of research of this kind are useful only if there is a high rate of response from you the participant. Please place the completed questionnaire in the attached envelope and return to the person identified on the front of the envelope by Thursday, November 3rd.

The person identified on the return envelope has kindly agreed to collect the questionnaires from the participants in the study and return them to me.

I would like to thank you for your kind co-operation.

Sincerely

Margaret J. Bayer, B.N., M.Ed.

APPENDIX C

FOLLOW-UP LETTER

Box 1060
Wolfville, N.S.
BOP 1X0

November 19, 1983

Dear Colleague

In October I sent you the enclosed questionnaire to the majority of Mental Health Professionals in Nova Scotia who work with the chronically mentally ill. I mentioned in the previous covering letter that the return envelopes were coded to ensure there was adequate representation in the study from all areas. The return rate shows greater representation is needed from your area.

As you may remember the purpose of this study, on services for the chronically mentally ill, is to provide information that will be useful in future planning for this group. The study has been designed so that no individual, hospital, institution or agency will be identified. The enclosed questionnaire and return envelope is not coded so there is complete anonymity.

If you did not complete this questionnaire previously, would you do so now. It is important that the results of the study reflect your views as well. I have included a self-addressed, stamped envelope for your convenience.

Thank you for your co-operation and support.

Sincerely

Margaret J. Bayer, B. N., M. Ed.

APPENDIX D

TABLES OF F RATIO VALUES FOR PRIORITY QUESTIONS

Table 19

F-Ratio of Main Effect, Interactions and Covariates of
Preferences for Changes in Clinical Time by Profession and Work
Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| <hr/> | | | | | |
| Covariate | | | | | |
| Sex | .012 | 1 | .012 | .011 | .915 |
| Qualify | .029 | 1 | .029 | .029 | .866 |
| Years | .482 | 1 | .482 | .470 | .494 |
| Employ. | 2.990 | 1 | 2.990 | 2.914 | .089 |
| Time | 4.888 | 1 | 4.888 | 4.763 | .030 |
| <hr/> | | | | | |
| Main Effect | | | | | |
| Prof | 1.048 | 3 | .349 | .340 | .796 |
| Setting | 10.745 | 2 | 5.372 | 5.235 | .006 |
| <hr/> | | | | | |
| Interact | 2.189 | 6 | .365 | .355 | .906 |
| <hr/> | | | | | |
| Explained | 22.934 | 16 | 1.433 | 1.397 | .142 |
| Residual | 290.436 | 283 | 1.026 | | |

Table 20

F-Ratio of Main Effect, Interactions and Covariates of
Preference for Changes in Overall Priority by Profession and
Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | .655 | 1 | .655 | 1.151 | .284 |
| Qualify | .226 | 1 | .266 | .396 | .530 |
| Years | .027 | 1 | .027 | .047 | .828 |
| Employ. | 3.695 | 1 | 3.695 | 6.942 | .011 |
| Time | .098 | 1 | .098 | .172 | .679 |
| Main Effect | | | | | |
| Prof | 1.817 | 3 | .606 | 1.064 | .365 |
| Setting | 5.381 | 2 | 2.691 | 4.727 | .010 |
| Interact | .356 | 6 | .059 | .104 | .996 |
| Explained | 14.077 | 16 | .880 | 1.546 | .083 |
| Residual | 161.069 | 283 | .586 | | |

Table 21,

F-Ratio of Main Effect, Interactions and Covariates of
 Preference for Changes in Emphasis on Treatment in the Community
 by Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|--------|--------------|
| Covariate | | | | | |
| Sex | .197 | 1 | .197 | .276 | .600 |
| Qualify | .781 | 1 | .781 | 1.094 | .296 |
| Years | 6.960 | 1 | 6.960 | 9.755 | .002 |
| Employ. | 2.047 | 1 | 2.047 | 2.869 | .091 |
| Time | 1.733 | 1 | 1.733 | 4.428 | .120 |
| Main Effect | | | | | |
| Prof. | 1.756 | 3 | .586 | .821 | .483 |
| Setting | 15.742 | 2 | 7.871 | 11.031 | .001 |
| Interact | 3.196 | 6 | .533 | .747 | .613 |
| Explained | 32.429 | 16 | 2.027 | 2.841 | .001 |
| Residual | 201.918 | 283 | .713 | | |

Table 22

F-Ratio of Main Effect, Interactions and Covariates of
Preference for Changes in Priority for Community Services by
Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|--------|--------------|
| <hr/> | | | | | |
| Covariate | | | | | |
| Sex | .223 | 1 | .233 | .634 | .426 |
| Qualify | .009 | 1 | .009 | .026 | .872 |
| Years | 1.037 | 1 | 1.037 | 2.945 | .087 |
| Employ. | 2.698 | 1 | 2.698 | 7.665 | .006 |
| Time | 1.096 | 1 | 1.096 | 3.144 | .079 |
| <hr/> | | | | | |
| Main Effect | | | | | |
| Prof | .639 | 3 | .213 | .605 | .612 |
| Setting | 9.871 | 2 | 4.935 | 14.021 | .001 |
| <hr/> | | | | | |
| Interact | 1.361 | 6 | .227 | .644 | .695 |
| <hr/> | | | | | |
| Explained | 17.781 | 16 | 1.111 | 3.157 | .001 |
| <hr/> | | | | | |
| Residual | 99.616 | 283 | .352 | | |

Table 23

F-Ratio of Main Effect, Interactions and Covariates of
 Preferences for Changes in Priority for Institutional Services by
 Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|--------|--------------|
| Covariate | | | | | |
| Sex | .052 | 1 | .052 | .032 | .858 |
| Qualify | .218 | 1 | .218 | .135 | .713 |
| Years | .618 | 1 | .618 | .384 | .536 |
| Employ. | 2.596 | 1 | 2.596 | 1.612 | .205 |
| Time | 21.010 | 1 | 21.010 | 13.043 | .001 |
| Main Effect | | | | | |
| Prof | 23.538 | 3 | 7.846 | 4.871 | .003 |
| Setting | 1.007 | 2 | .504 | .313 | .732 |
| Interact | 11.144 | 6 | 1.857 | 1.153 | .332 |
| Explained | 62.859 | 16 | 3.929 | 2.439 | .002 |
| Residual | 455.888 | 283 | 1.611 | | |

APPENDIX E

TABLES OF F RATIO VALUES FOR IMPORTANCE QUESTIONS

Table 24

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Psychosocial Rehabilitation Services by
Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| <hr/> | | | | | |
| Covariate | | | | | |
| Sex | .468 | 1 | .468 | 1.018 | .314 |
| Qualify | .001 | 1 | .001 | .002 | .965 |
| Years | 3.592 | 1 | 3.592 | 7.815 | .006 |
| Employ. | .023 | 1 | .023 | .050 | .824 |
| Time | .616 | 1 | .616 | 1.341 | .248 |
| <hr/> | | | | | |
| Main Effect | | | | | |
| Prof | 1.339 | 3 | .446 | .971 | .407 |
| Setting | 1.532 | 2 | .756 | 1.666 | .191 |
| <hr/> | | | | | |
| Interact | 1.350 | 6 | .308 | .671 | .673 |
| <hr/> | | | | | |
| Explained | 10.058 | 16 | .629 | 1.368 | .157 |
| <hr/> | | | | | |
| Residual | 131.912 | 287 | .460 | | |

Table 25

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Services to Provide Health Care By Profession and
Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | 3.278 | 1 | 3.278 | 5.337 | .022 |
| Qualify | .353 | 1 | .353 | .575 | .449 |
| Years | 1.223 | 1 | 1.223 | 1.991 | .159 |
| Employ. | .752 | 1 | .752 | 1.224 | .269 |
| Time | 2.367 | 1 | 2.367 | 3.855 | .051 |
| Main Effect | | | | | |
| Prof. | 2.034 | 3 | .678 | 1.104 | .348 |
| Setting | 1.695 | 2 | .847 | 1.380 | .253 |
| Interact | 5.484 | 6 | .914 | 1.488 | .182 |
| Explained | 19.850 | 16 | 1.241 | 2.020 | .012 |
| Residual | 178.117 | 290 | .614 | | |

Table 26

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Support to Others by Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| <hr/> | | | | | |
| Covariate | | | | | |
| Sex | 4.579 | 1 | 4.579 | 9.194 | .003 |
| Qualify | .691 | 1 | .691 | 1.387 | .240 |
| Years | 3.211 | 1 | 3.211 | 6.447 | .012 |
| Employ. | .172 | 1 | .172 | .345 | .558 |
| Time | .272 | 1 | .272 | .547 | .460 |
| <hr/> | | | | | |
| Main Effect | | | | | |
| Prof | 1.683 | 3 | .561 | 1.126 | .339 |
| Setting | .196 | 2 | .098 | .197 | .821 |
| <hr/> | | | | | |
| Interact | 1.209 | 6 | .201 | .405 | .876 |
| <hr/> | | | | | |
| Explained | 12.528 | 16 | .783 | 1.572 | .075 |
| <hr/> | | | | | |
| Residual | 144.423 | 290 | .498 | | |

Table 27

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Residential Services by Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | .159 | 1 | .159 | .285 | .594 |
| Qualify | .114 | 1 | .114 | .204 | .652 |
| Years | .174 | 1 | .174 | .311 | .577 |
| Employ. | 1.499 | 1 | 1.499 | 2.687 | .102 |
| Time | 1.066 | 1 | 1.066 | 1.911 | .168 |
| Main Effect | | | | | |
| Prof | .410 | 3 | .137 | .245 | .865 |
| Setting | 3.131 | 2 | 1.566 | 2.807 | .062 |
| Interact | 3.521 | 6 | .587 | 1.052 | .392 |
| Explained | 9.945 | 16 | .622 | 1.144 | .341 |
| Residual | 161.755 | 290 | .558 | | |

Table 28

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Reaching Out Services by Profession and Work
Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|--------|--------------|
| Covariate | | | | | |
| Sex | 8.316 | 1 | 8.316 | 12.622 | .001 |
| Qualify | .001 | 1 | .001 | .002 | .963 |
| Years | .023 | 1 | .023 | .035 | .851 |
| Employ. | .176 | 1 | .176 | .267 | .274 |
| Time | .791 | 1 | .791 | 1.201 | .274 |
| Main Effect | | | | | |
| Prof | 10.112 | 3 | 3.371 | 5.116 | .002 |
| Setting | 2.885 | 2 | 1.442 | 2.189 | .114 |
| Interact | 5.193 | 6 | .865 | 1.314 | .251 |
| Explained | 36.260 | 287 | .659 | | |
| Residual | 189.079 | 303 | .744 | | |

Table 29

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Services to Assist Patients Obtain Benefits by
Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| <hr/> | | | | | |
| Covariate | | | | | |
| Sex | 2.894 | 1 | 2.894 | 5.163 | .024 |
| Qualify | .013 | 1 | .013 | .022 | .881 |
| Years | .007 | 1 | .007 | .012 | .911 |
| Employ. | .007 | 1 | .007 | .012 | .912 |
| Time | .289 | 1 | .289 | .516 | .473 |
| <hr/> | | | | | |
| Main Effect | | | | | |
| Prof | .349 | 3 | .116 | .207 | .891 |
| Setting | .387 | 2 | .194 | .345 | .708 |
| <hr/> | | | | | |
| Interact | 4.159 | 6 | .693 | 1.237 | .287 |
| <hr/> | | | | | |
| Explained | 11.687 | 16 | .730 | 1.303 | .194 |
| <hr/> | | | | | |
| Residual | 160.839 | 287 | .560 | | |

Table 30

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Services to Protect Patient Rights By Profession
and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | .058 | 1 | .058 | .069 | .792 |
| Qualify | .050 | 1 | .050 | .060 | .806 |
| Years | .001 | 1 | .001 | .001 | .979 |
| Employ. | .001 | 1 | .001 | .001 | .976 |
| Time | .143 | 1 | .143 | .172 | .679 |
| Main Effect | | | | | |
| Prof | 5.024 | 3 | 1.675 | 2.016 | .112 |
| Setting | .230 | 2 | .115 | .138 | .871 |
| Interact | 4.303 | 6 | .717 | .863 | .522 |
| Explained | 10.443 | 16 | .653 | .786 | .702 |
| Residual | 241.778 | 291 | .831 | | |

Table 31

F-Ratio of Main Effect, Interactions, and Covariates of
Importance of Vocational Services by Professional and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | 1.824 | 1 | 1.824 | 2.818 | .094 |
| Qualify | 4.262 | 1 | 4.262 | 6.583 | .011 |
| Years | .393 | 1 | .393 | .606 | .437 |
| Employ. | .002 | 1 | .002 | .004 | .951 |
| Time | 1.071 | 1 | 1.071 | 1.655 | .199 |
| Main Effect | | | | | |
| Prof | .418 | 3 | .139 | .215 | .886 |
| Setting | 3.164 | 2 | 1.582 | 2.444 | .089 |
| Interact | 5.823 | 6 | .971 | 1.499 | .178 |
| Explained | 14.313 | 16 | .895 | 1.382 | .149 |
| Residual | 187.758 | 290 | .647 | | |

Table 32

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Case Management Services by Profession and Work
Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| <hr/> | | | | | |
| Covariate | | | | | |
| Sex | 5.351 | 1 | 5.351 | 7.460 | .007 |
| Qualify | .250 | 1 | .250 | .348 | .556 |
| Years | .143 | 1 | .143 | .200 | .655 |
| Employ. | .423 | 1 | .423 | .589 | .443 |
| Time | .099 | 1 | .099 | .138 | .711 |
| <hr/> | | | | | |
| Main Effect | | | | | |
| Prof | 3.099 | 3 | 1.033 | 1.440 | .231 |
| Setting | 2.129 | 2 | 1.025 | 1.484 | .228 |
| <hr/> | | | | | |
| Interact | 2.687 | 6 | .448 | .424 | .711 |
| <hr/> | | | | | |
| Explained | 15.661 | 16 | .979 | 1.364 | .158 |
| <hr/> | | | | | |
| Residual | 208.764 | 291 | .717 | | |

Table 33

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Crisis Services by Profession and Work Setting

| Source of Var. | Sum of Squares | DE | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | 2.433 | 1 | 2.433 | 2.837 | .093 |
| Qualify | .081 | 1 | .081 | .094 | .759 |
| Years | .489 | 1 | .489 | .571 | .451 |
| Employ. | .007 | 1 | .007 | .008 | .927 |
| Time | 1.285 | 1 | 1.285 | 1.499 | .222 |
| Main Effect | | | | | |
| Prof | .676 | 3 | .225 | .263 | .852 |
| Setting | 5.549 | 2 | 2.775 | 3.236 | .041 |
| Interact. | 3.455 | 6 | .576 | .672 | .673 |
| Explained | 20.315 | 16 | 1.270 | 1.481 | .106 |
| Residual | 246.106 | 287 | .858 | | |

Table 34

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Services of Involve Community Members by Profession
and Work Setting.

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| <hr/> | | | | | |
| Covariate | | | | | |
| Sex | .384 | 1 | .384 | .529 | .467 |
| Qualify | .079 | 1 | .079 | .108 | .742 |
| Years | .398 | 1 | .398 | .550 | .459 |
| Employ. | 1.984 | 1 | 1.984 | 2.737 | .099 |
| Time | .059 | 1 | .059 | .082 | .775 |
| <hr/> | | | | | |
| Main Effect | | | | | |
| Prof | 4.007 | 3 | 1.336 | 1.843 | .139 |
| Setting | 2.253 | 2 | 1.126 | 1.554 | .213 |
| <hr/> | | | | | |
| Interact | 3.337 | 6 | .556 | .767 | .596 |
| <hr/> | | | | | |
| Explained | 12.545 | 16 | .784 | 1.082 | .372 |
| <hr/> | | | | | |
| Residual | 210.152 | 290 | .725 | | |

Table 35

F-Ratio of Main Effect, Interactions and Covariates of
Importance of Services to Identify Patients by Profession and
Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | 3.242 | 1 | 3.242 | 3.831 | .051 |
| Qualify | 1.028 | 1 | 1.028 | 1.215 | .271 |
| Years | .237 | 1 | .237 | .280 | .597 |
| Employ. | .000 | 1 | .000 | .000 | .985 |
| Time | .037 | 1 | .037 | .043 | .835 |
| Main Effect | | | | | |
| Prof | 7.516 | 3 | 2.505 | 2.961 | .033 |
| Setting | 3.887 | 2 | 1.943 | 2.297 | .102 |
| Interact | 4.257 | 6 | .710 | .838 | .541 |
| Explained | 20.059 | 16 | 1.254 | 1.482 | .105 |
| Residual | 242.859 | 287 | .846 | | |

APPENDIX F

TABLES OF PERCENTAGES FOR IMPORTANCE QUESTIONS

Table 36

Importance of Psychosocial Rehabilitation:
Percentage of responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|-----------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.0 | 0.8 | 9.0 | 29.6 | 60.6 | 0.8 | 90.2 |
| Nursing(231) | 0.0 | 0.9 | 6.9 | 29.0 | 63.2 | 0.9 | 92.2 |
| Psychiatry(37) | 0.0 | 2.7 | 18.9 | 29.7 | 48.6 | 2.7 | 78.3 |
| Psychology(41) | 0.0 | 0.0 | 9.8 | 24.4 | 65.9 | 0.0 | 90.3 |
| Social Work(42) | 0.0 | 0.0 | 9.8 | 34.1 | 56.1 | 0.0 | 90.2 |
| Inpatient(192) | 0.0 | 1.6 | 9.4 | 30.7 | 58.3 | 1.6 | 89.0 |
| Community(96) | 0.0 | 0.0 | 10.5 | 30.5 | 58.9 | 0.0 | 89.4 |
| Rehabilit.(60) | 0.0 | 0.0 | 6.7 | 25.0 | 68.3 | 0.0 | 93.3 |

Table 37

Importance of Medical And Mental Health Care:
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|-----------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.3 | 2.5 | 9.0 | 28.5 | 59.6 | 2.8 | 88.1 |
| Nursing(231) | 0.0 | 1.3 | 7.9 | 27.9 | 62.9 | 1.3 | 90.8 |
| Psychiatry(37) | 0.0 | 2.7 | 13.5 | 24.3 | 59.5 | 2.7 | 83.8 |
| Psychology(41) | 2.4 | 7.3 | 7.3 | 34.1 | 48.8 | 9.7 | 82.9 |
| Social Work(42) | 0.0 | 4.8 | 14.3 | 26.2 | 54.8 | 4.8 | 81.0 |
| Inpatient(192) | 0.5 | 2.6 | 8.4 | 30.0 | 58.4 | 3.1 | 88.4 |
| Community(96) | 0.0 | 4.2 | 10.4 | 22.9 | 62.5 | 4.2 | 85.4 |
| Rehabit.(60) | 0.0 | 0.0 | 8.3 | 33.3 | 58.3 | 0.0 | 91.6 |

Table 38

Importance of Support to Family and Community Members :
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.0 | 1.1 | 10.7 | 33.5 | 54.6 | 1.1 | 88.1 |
| Nursing(231) | 0.0 | 0.9 | 10.0 | 32.2 | 57.0 | 0.9 | 89.1 |
| Psychiatry(37) | 0.0 | 2.7 | 16.2 | 43.2 | 37.8 | 2.7 | 81.1 |
| Psychology(41) | 0.0 | 2.4 | 14.6 | 34.1 | 48.8 | 2.4 | 82.9 |
| Social Work(42) | 0.0 | 0.0 | 7.1 | 33.3 | 59.5 | 0.0 | 92.9 |
| Inpatient(192) | 0.0 | 1.6 | 9.4 | 34.6 | 54.5 | 1.6 | 89.0 |
| Community(96) | 0.0 | 1.0 | 13.5 | 31.3 | 54.2 | 1.0 | 85.4 |
| Rehabilitat.(60) | 0.0 | 0.0 | 11.7 | 31.7 | 56.7 | 0.0 | 88.3 |

Table 39

Importance of Supportive Residential services :
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.3 | 1.1 | 11.8 | 31.8 | 54.9 | 1.4 | 86.8 |
| Nursing(231) | 0.4 | 1.3 | 10.9 | 33.5 | 53.9 | 1.7 | 87.4 |
| Psychiatry(37) | 0.0 | 0.0 | 13.5 | 32.4 | 54.1 | 13.5 | 86.5 |
| Psychology(41) | 0.0 | 0.0 | 17.1 | 24.4 | 58.5 | 17.1 | 82.9 |
| Social Work(42) | 0.0 | 2.4 | 9.5 | 33.3 | 54.8 | 2.4 | 88.1 |
| Inpatient(192) | 0.5 | 1.6 | 7.8 | 30.7 | 59.4 | 2.1 | 90.1 |
| Community(96) | 0.0 | 1.0 | 19.8 | 29.2 | 50.0 | 1.0 | 79.2 |
| Rehabilitat.(60) | 0.0 | 0.0 | 11.7 | 40.0 | 48.3 | 0.0 | 88.3 |

Table 40

Importance of Reaching Out Services:
Percentage of Response to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|-----------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.6 | 3.4 | 10.1 | 32.0 | 53.9 | 4.0 | 85.9 |
| Nursing(231) | 0.0 | 2.6 | 7.8 | 28.1 | 61.5 | 2.6 | 89.6 |
| Psychiatry(37) | 0.0 | 0.0 | 10.8 | 40.5 | 48.6 | 0.0 | 89.1 |
| Psychology(41) | 4.9 | 7.3 | 19.5 | 51.2 | 17.1 | 12.2 | 68.3 |
| Social Work(42) | 0.0 | 7.1 | 11.9 | 28.6 | 52.4 | 7.1 | 81.0 |
| Inpatient(192) | 0.5 | 2.1 | 7.8 | 27.6 | 62.0 | 2.6 | 89.6 |
| Community(96) | 1.0 | 5.2 | 17.7 | 34.4 | 41.7 | 6.2 | 76.1 |
| Rehabilit.(60) | 0.0 | 5.0 | 6.7 | 43.3 | 45.0 | 5.0 | 88.3 |

Table 41

Importance of Assisting Patients Obtain Benefits:
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|-----------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.0 | 0.8 | 11.2 | 41.6 | 44.4 | 0.8 | 86.0 |
| Nursing(231) | 0.0 | 1.7 | 7.4 | 45.5 | 45.5 | 1.7 | 91.0 |
| Psychiatry(37) | 0.0 | 5.4 | 13.5 | 43.2 | 37.8 | 5.4 | 81.0 |
| Psychology(41) | 0.0 | 4.9 | 26.8 | 29.3 | 39.0 | 4.9 | 68.3 |
| Social Work(42) | 0.0 | 4.8 | 14.3 | 28.6 | 52.4 | 4.8 | 81.0 |
| Inpatient(192) | 0.0 | 2.6 | 10.4 | 42.2 | 44.8 | 2.6 | 87.0 |
| Community(96) | 0.0 | 4.2 | 15.6 | 33.3 | 46.9 | 4.2 | 80.2 |
| Rehabilit.(60) | 0.0 | 1.7 | 16.7 | 53.3 | 38.3 | 1.7 | 91.6 |

Table 42

Importance of Services to Protect Patient Rights :
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.8 | 3.1 | 18.1 | 27.9 | 50.1 | 3.9 | 78.0 |
| Nursing(231) | 0.9 | 3.9 | 17.8 | 26.1 | 51.3 | 4.8 | 77.4 |
| Psychiatry(37) | 2.7 | 5.4 | 27.0 | 24.3 | 40.5 | 8.1 | 64.9 |
| Psychology(41) | 0.0 | 0.0 | 24.4 | 29.3 | 46.3 | 0.0 | 75.6 |
| Social Work(42) | 0.0 | 0.0 | 4.8 | 40.5 | 54.8 | 0.0 | 95.2 |
| Inpatient(192) | 1.6 | 4.2 | 15.2 | 27.2 | 51.8 | 5.8 | 79.1 |
| Community(96) | 0.0 | 2.1 | 20.8 | 27.1 | 50.0 | 2.1 | 77.1 |
| Rehabilitat.(60) | 0.0 | 1.7 | 23.3 | 28.3 | 46.7 | 1.7 | 75.0 |

Table 43

Importance of Rehabilitation Vocational Services :
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.0 | 3.7 | 14.6 | 40.4 | 41.3 | 3.7 | 81.7 |
| Nursing(231) | 0.0 | 4.8 | 14.7 | 41.1 | 39.4 | 4.8 | 90.5 |
| Psychiatry(37) | 0.0 | 0.0 | 18.9 | 32.4 | 48.6 | 0.0 | 81.1 |
| Psychology(41) | 0.0 | 0.0 | 9.8 | 53.7 | 36.6 | 0.0 | 90.2 |
| Social Work(42) | 0.0 | 2.4 | 14.3 | 35.7 | 47.6 | 2.4 | 83.3 |
| Inpatient(192) | 0.0 | 5.2 | 15.6 | 20.8 | 55.7 | 5.2 | 79.2 |
| Community(96) | 0.0 | 2.1 | 17.7 | 44.8 | 35.4 | 2.1 | 80.8 |
| Rehabilitat.(60) | 0.0 | 1.7 | 6.7 | 50.0 | 41.7 | 1.7 | 91.7 |

Table 44

Importance of Case Management Services : Percentage of
Reponses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.0 | 2.8 | 20.8 | 34.0 | 42.4 | 2.8 | 76.4 |
| Nursing(231) | 0.0 | 3.0 | 18.2 | 32.9 | 45.9 | 3.0 | 78.8 |
| Psychiatry(37) | 0.0 | 5.4 | 35.1 | 29.7 | 29.7 | 5.4 | 59.5 |
| Psychology(41) | 0.0 | 2.4 | 26.8 | 39.0 | 31.7 | 2.4 | 70.7 |
| Social Work(42) | 0.0 | 0.0 | 14.3 | 38.1 | 47.6 | 0.0 | 85.7 |
| Inpatient(192) | 0.0 | 3.1 | 16.7 | 32.8 | 47.4 | 3.1 | 80.2 |
| Community(96) | 0.0 | 4.2 | 24.0 | 34.4 | 37.5 | 4.2 | 71.9 |
| Rehabilitat.(60) | 0.0 | 0.0 | 30.0 | 36.7 | 33.3 | 0.0 | 70.0 |

Table 45

Importance of Twenty-four Hour Crisis Services:
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|-----------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 0.6 | 5.1 | 18.5 | 31.2 | 44.7 | 6.7 | 75.9 |
| Nursing(231) | 0.4 | 3.9 | 15.2 | 30.7 | 49.8 | 4.3 | 80.5 |
| Psychiatry(37) | 0.0 | 8.1 | 27.0 | 32.4 | 32.4 | 8.1 | 64.8 |
| Psychology(41) | 2.4 | 4.9 | 26.8 | 36.6 | 29.3 | 7.3 | 65.9 |
| Social Work(42) | 0.0 | 9.5 | 19.0 | 28.6 | 42.9 | 9.5 | 71.5 |
| Inpatient(192) | 0.1 | 2.6 | 15.6 | 29.7 | 51.0 | 2.7 | 80.7 |
| Community(96) | 0.0 | 11.5 | 25.0 | 30.2 | 33.3 | 11.5 | 63.5 |
| Rehabilit.(60) | 0.0 | 1.7 | 18.3 | 36.7 | 43.3 | 1.7 | 80.0 |

Table 46

Importance of Services to Involve Community Members :
 Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|--------------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.6 | 2.8 | 20.6 | 42.5 | 33.5 | 3.4 | 76.1 |
| Nursing(231) | 0.9 | 3.5 | 18.3 | 41.3 | 36.1 | 4.3 | 77.4 |
| Psychiatry(37) | 0.0 | 2.7 | 32.4 | 40.5 | 24.3 | 2.7 | 64.9 |
| Psychology(41) | 0.0 | 2.4 | 29.3 | 43.9 | 24.4 | 2.4 | 68.3 |
| Social Work(42) | 0.0 | 0.0 | 14.3 | 50.0 | 38.7 | 0.0 | 85.7 |
| Inpatient(192) | 1.0 | 2.6 | 19.8 | 38.0 | 38.5 | 3.6 | 76.6 |
| Community(96) | 0.0 | 3.1 | 21.9 | 46.9 | 28.1 | 3.1 | 75.0 |
| Rehabilitation(60) | 0.0 | 3.3 | 23.3 | 48.3 | 25.0 | 3.3 | 73.3 |

Table 47

Importance Of Services to Identify Clients:
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 1.4 | 6.0 | 17.9 | 40.9 | 33.8 | 7.4 | 74.7 |
| Nursing(231) | 1.3 | 6.5 | 15.7 | 43.5 | 33.0 | 7.8 | 76.5 |
| Psychiatry(37) | 0.0 | 0.0 | 16.7 | 36.1 | 47.2 | 0.0 | 83.3 |
| Psychology(41) | 4.9 | 4.9 | 29.3 | 39.0 | 22.0 | 9.8 | 61.0 |
| Social Work(42) | 0.0 | 10.0 | 17.5 | 30.0 | 42.5 | 10.0 | 72.5 |
| Inpatient(192) | 1.6 | 5.8 | 13.2 | 42.3 | 37.0 | 7.4 | 79.4 |
| Community(96) | 2.1 | 5.3 | 26.3 | 37.7 | 31.6 | 7.4 | 66.3 |
| Rehabilitat.(60) | 0.0 | 6.7 | 20.0 | 48.3 | 25.0 | 6.7 | 73.3 |

APPENDIX G

TABLES OF F RATIO VALUES FOR FEASIBILITY QUESTIONS

Table 48

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Services to Assist Patients Obtain Benefits by
Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | .659 | 1 | .659 | 1.042 | .308 |
| Qualify | .146 | 1 | .146 | .230 | .632 |
| Years | .878 | 1 | .878 | 1.387 | .240 |
| Employ. | .615 | 1 | .615 | .972 | .325 |
| Time | .013 | 1 | .013 | .021 | .886 |
| Main Effect | | | | | |
| Prof | 1.878 | 3 | .359 | .568 | .637 |
| Setting | .971 | 2 | .485 | .767 | .465 |
| Interact | 2.547 | 6 | .425 | .671 | .673 |
| Explained | 7.137 | 16 | .446 | .705 | .789 |
| Residual | 183.541 | 290 | .633 | | |

Table 49

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of services to Provide Health Care By Profession and
Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| <hr/> | | | | | |
| Covariate | | | | | |
| Sex | 1.874 | 1 | 1.874 | 2.190 | .140 |
| Qualify | 4.612 | 1 | 4.612 | 5.391 | .021 |
| Years | 5.674 | 1 | 5.674 | 6.632 | .011 |
| Employ. | .000 | 1 | .000 | .000 | .993 |
| Time | .196 | 1 | .196 | .229 | .633 |
| <hr/> | | | | | |
| Main Effect | | | | | |
| Prof | .247 | 3 | .082 | .096 | .962 |
| Setting | 10.217 | 2 | 5.108 | 5.971 | .003 |
| <hr/> | | | | | |
| Interact | 2.584 | 6 | .431 | .503 | .806 |
| <hr/> | | | | | |
| Explained | 21.863 | 16 | 1.366 | 1.597 | .069 |
| <hr/> | | | | | |
| Residual | 247.251 | 289 | .856 | | |

Table 50

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Psychosocial Rehabilitation Services by Profession
and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|--------------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | 1.980 | 1 | 1.980 | 2.499 | .115 |
| Qualify | 1.421 | 1 | 1.421 | 1.793 | .182 |
| Years | 3.108 | 1 | 3.108 | 3.922 | .049 |
| Employ. | .043 | 1 | .043 | .055 | .815 |
| Time | 1.705 | 1 | 1.705 | 2.152 | .143 |
| Main Effect | | | | | |
| Prof | 6.033 | 3 | 2.001 | 2.525 | .058 |
| Setting | 6.576 | 2 | 3.288 | 4.149 | .017 |
| Interact | 3.383 | 6 | .564 | .711 | .641 |
| Explained | 23.755 | 16 | 1.485 | 1.874 | .023 |
| Residual | 229.809 | 290 | .792 | | |

Table 51

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Services to Protect Patient Rights by Profession
and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|--------------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | .516 | 1 | .516 | .502 | .479 |
| Qualify | .003 | 1 | .003 | .003 | .957 |
| Years | 1.285 | 1 | 1.285 | 1.249 | .265 |
| Employ. | 2.999 | 1 | 2.999 | 2.914 | .089 |
| Time | .277 | 1 | .277 | .269 | .604 |
| Main Effect | | | | | |
| Prof | 2.981 | 3 | .994 | .996 | .409 |
| Setting | .759 | 2 | .380 | .369 | .692 |
| Interact | 4.499 | 6 | .750 | .729 | .627 |
| Explained | 14.142 | 16 | .883 | .858 | .618 |
| Residual | 299.436 | 291 | 1.029 | | |

Table 52

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Support to the Others by Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| <hr/> | | | | | |
| Covariate | | | | | |
| Sex | .176 | 1 | .176 | .194 | .660 |
| Qualify | .630 | 1 | .630 | .696 | .405 |
| Years | 2.769 | 1 | 2.769 | 3.057 | .081 |
| Employ. | .407 | 1 | .407 | .449 | .503 |
| Time | .000 | 1 | .000 | .000 | .587 |
| <hr/> | | | | | |
| Main Effect | | | | | |
| Prof | 3.810 | 3 | 1.270 | 1.402 | .242 |
| Setting | 1.052 | 2 | .526 | .581 | .560 |
| <hr/> | | | | | |
| Interact. | 3.590 | 6 | .598 | .661 | .682 |
| <hr/> | | | | | |
| Explained | 11.979 | 16 | .749 | .827 | .655 |
| <hr/> | | | | | |
| Residual | 261.773 | 289 | .906 | | |

Table 53

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Services of Involve Community Members by
Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|--------------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | 3.224 | 1 | 3.224 | 3.958 | .048 |
| Qualify | 2.484 | 1 | 2.484 | 2.957 | .087 |
| Years | .524 | 1 | .524 | .624 | .430 |
| Employ. | 1.879 | 1 | 1.879 | 2.237 | .136 |
| Time | .117 | 1 | .117 | .140 | .709 |
| Main Effect | | | | | |
| Prof | 10.630 | 3 | 3.543 | 4.218 | .006 |
| Setting | .882 | 2 | .441 | .525 | .592 |
| Interact | 1.121 | 6 | .187 | .222 | .969 |
| Explained | 18.750 | 16 | 1.172 | 1.395 | .143 |
| Residual | 242.756 | 289 | .840 | | |

Table 54

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Services to Identify Patients by Profession and
Work Setting.

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | .347 | 1 | .347 | .268 | .592 |
| Qualify | .015 | 1 | .015 | .013 | .911 |
| Years | .272 | 1 | .272 | .226 | .635 |
| Employ. | 5.878 | 1 | 5.878 | 4.890 | .028 |
| Time | .014 | 1 | .014 | .012 | .915 |
| Main Effect | | | | | |
| Prof | .611 | 3 | .204 | .169 | .917 |
| Setting | 1.773 | 2 | .887 | .738 | .479 |
| Interact | 15.870 | 6 | 2.645 | 2.201 | .043 |
| Explained | 25.733 | 16 | 1.608 | 1.338 | .173 |
| Residual | 348.566 | 290 | 1.223 | | |

Table 55

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Case Management Services by Profession and Work
Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|-------------------|-------------------|-----|-----------------|--------|-----------------|
| <hr/> | | | | | |
| Covariate | | | | | |
| Sex | .329 | 1 | .329 | .321 | .517 |
| Qualify | 7.697 | 1 | 7.697 | 7.509 | .007 |
| Years | 7.166 | 1 | 7.166 | 6.942 | .009 |
| Employ. | 1.128 | 1 | 1.128 | 1.100 | .295 |
| Time | 1.119 | 1 | 1.119 | 1.092 | .297 |
| <hr/> | | | | | |
| Main Effect | | | | | |
| Prof | 3.771 | 3 | 1.257 | 1.226 | .300 |
| Setting | .293 | 2 | .147 | .143 | .867 |
| <hr/> | | | | | |
| Interact | 4.891 | 6 | .815 | .795 | .574 |
| <hr/> | | | | | |
| Explained | 24.614 | 16 | 1.538 | -1.501 | .098 |
| <hr/> | | | | | |
| Residual | 298.269 | 291 | 1.025 | | |

Table 56

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Reaching Out Services by Profession and Work
Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | .713 | 1 | .713 | .561 | .454 |
| Qualify | 1.874 | 1 | 1.874 | 1.474 | .226 |
| Years | .365 | 1 | .365 | .287 | .593 |
| Employ. | .000 | 1 | .000 | .000 | .986 |
| Time | .229 | 1 | .229 | .180 | .672 |
| Main Effect | | | | | |
| Prof | 2.960 | 3 | .987 | .776 | .508 |
| Setting | .384 | 2 | .192 | .151 | .860 |
| Interact | 11.340 | 6 | 1.890 | 1.487 | .182 |
| Explained | 23.010 | 16 | 1.438 | 1.132 | .325 |
| Residual | 368.501 | 290 | 1.271 | | |

Table 57

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Residential Services by Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|--------------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | 2.088 | 1 | 2.088 | 1.878 | .172 |
| Qualify | 4.790 | 1 | 4.790 | 4.308 | .039 |
| Years | 1.410 | 1 | 1.410 | 1.268 | .216 |
| Employ. | .460 | 1 | .460 | .414 | .520 |
| Time | 1.324 | 1 | 1.324 | 1.191 | .276 |
| Main Effect | | | | | |
| Prof | 2.397 | 3 | .799 | .719 | .542 |
| Setting | .749 | 2 | .375 | .337 | .714 |
| Interact | 6.111 | 6 | 1.018 | .916 | .484 |
| Explained | 20.252 | 16 | 1.266 | 1.138 | .319 |
| Residual | 321.307 | 289 | 1.112 | | |

Table 58

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Vocational Services by Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|--------------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | 1.193 | 1 | 1.193 | 1.159 | .283 |
| Qualify | 1.433 | 1 | 1.433 | 1.393 | .239 |
| Years | 1.483 | 1 | 1.483 | 1.441 | .231 |
| Employ. | .008 | 1 | .008 | .008 | .930 |
| Time | 5.267 | 1 | 5.267 | 5.188 | .024 |
| Main Effect | | | | | |
| Prof | 3.273 | 3 | 1.091 | 1.060 | .366 |
| Setting | 7.505 | 2 | 3.752 | 3.646 | .027 |
| Interact | 9.054 | 6 | 1.509 | 1.466 | .190 |
| Explained | 30.464 | 16 | 1.904 | 1.850 | .025 |
| Residual | 297.419 | 289 | 1.029 | | |

Table 59

F-Ratio of Main Effect, Interactions and Covariates of
Feasibility of Crisis Services by Profession and Work Setting

| Source of Var. | Sum of Squares | DF | Mean Squares | F | Signif. of F |
|----------------|----------------|-----|--------------|-------|--------------|
| Covariate | | | | | |
| Sex | 1.237 | 1 | 1.237 | .908 | .341 |
| Qualify | .775 | 1 | .775 | .569 | .451 |
| Years | 6.920 | 1 | 6.920 | 5.081 | .025 |
| Employ. | .439 | 1 | .439 | .322 | .571 |
| Time | 2.239 | 1 | 2.239 | 1.644 | .201 |
| Main Effect | | | | | |
| Prof | 1.442 | 3 | .481 | .353 | .787 |
| Setting | 1.132 | 2 | .566 | .416 | .660 |
| Interact | 15.639 | 6 | 2.607 | 1.914 | .078 |
| Explained | 31.489 | 16 | 1.968 | 1.445 | .120 |
| Residual | 394.954 | 290 | 1.362 | | |

APPENDIX H.

TABLES OF PERCENTAGES FOR FEASIBILITY QUESTION

Table 60)

Feasibility of Services to Assist Patients Obtain
Benefits : Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 0.3 | 4.8 | 8.2 | 46.2 | 40.6 | 5.1 | 86.8 |
| Nursing(231) | 0.4 | 5.2 | 6.5 | 50.0 | 37.8 | 5.7 | 87.8 |
| Psychiatry(37) | 0.0 | 2.7 | 16.2 | 45.9 | 35.1 | 2.7 | 81.1 |
| Psychology(41) | 0.0 | 7.3 | 7.3 | 31.7 | 53.7 | 7.3 | 85.4 |
| Social Work(42) | 0.0 | 2.4 | 11.9 | 35.7 | 50.0 | 2.4 | 85.7 |
| Inpatient(192) | 0.0 | 5.8 | 7.9 | 48.7 | 37.7 | 5.8 | 86.4 |
| Community(96) | 0.0 | 4.2 | 9.4 | 39.6 | 46.9 | 4.2 | 86.5 |
| Rehabilitat.(60) | 1.7 | 3.3 | 3.3 | 51.7 | 40.0 | 5.0 | 91.7 |

Table 61

Feasibility of Services to Provide Medical and Mental
Health Care : Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|-----|------|------|------|----------------|------------|
| Total(351) | 1.4 | 5.9 | 10.7 | 37.9 | 44.1 | 7.3 | 82.0 |
| Nursing(231) | 2.2 | 6.9 | 10.0 | 38.5 | 42.4 | 9.1 | 81.0 |
| Psychiatry(37) | 0.0 | 5.4 | 10.8 | 45.9 | 37.8 | 5.4 | 83.8 |
| Psychology(41) | 0.0 | 2.4 | 14.6 | 41.5 | 41.5 | 2.4 | 82.9 |
| Social Work(42) | 0.0 | 4.8 | 11.9 | 26.2 | 57.1 | 4.8 | 83.3 |
| Inpatient(192) | 1.6 | 7.8 | 13.5 | 40.6 | 36.5 | 9.4 | 77.1 |
| Community(96) | 0.0 | 1.0 | 8.3 | 33.3 | 57.3 | 1.0 | 90.6 |
| Rehabilitat.(60) | 1.7 | 8.3 | 5.0 | 36.7 | 48.3 | 10.0 | 85.0 |

Table 62

Feasibility of Psychosocial Rehabilitation Services :
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 1.1 | 5.3 | 14.0 | 45.8 | 33.7 | 6.5 | 79.5 |
| Nursing(231) | 0.9 | 4.3 | 12.6 | 46.3 | 35.9 | 5.2 | 82.3 |
| Psychiatry(37) | 2.7 | 2.7 | 32.4 | 48.6 | 13.5 | 5.4 | 62.2 |
| Psychology(41) | 2.4 | 4.9 | 9.8 | 43.9 | 39.0 | 7.3 | 83.0 |
| Social Work(42) | 0.0 | 14.3 | 9.5 | 42.9 | 33.3 | 14.3 | 76.2 |
| Inpatient(192) | 2.1 | 5.7 | 16.7 | 45.3 | 30.2 | 7.8 | 75.5 |
| Community(96) | 0.0 | 6.3 | 11.5 | 47.9 | 34.4 | 6.3 | 82.3 |
| Rehabilitat.(60) | 0.0 | 3.3 | 8.3 | 41.7 | 46.7 | 3.3 | 88.3 |

Table 63

Feasibility of Services to Protect Patients' Rights :
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 2.0 | 7.9 | 21.3 | 35.1 | 33.7 | 9.8 | 68.8 |
| Nursing(231) | 2.6 | 7.4 | 21.6 | 34.6 | 33.8 | 10.0 | 68.4 |
| Psychiatry(37) | 2.7 | 10.8 | 21.6 | 45.9 | 18.9 | 13.5 | 64.9 |
| Psychology(41) | 0.0 | 4.9 | 24.4 | 26.8 | 43.9 | 4.9 | 70.7 |
| Social Work(42) | 0.0 | 9.5 | 16.7 | 35.7 | 38.1 | 9.5 | 73.8 |
| Inpatient(192) | 2.5 | 8.3 | 18.2 | 40.1 | 30.7 | 10.9 | 70.8 |
| Community(96) | 0.0 | 7.3 | 24.0 | 33.3 | 35.4 | 7.3 | 68.7 |
| Rehabilitat.(60) | 3.3 | 6.7 | 26.7 | 21.7 | 41.7 | 10.0 | 63.3 |

Table 64

Feasibility of Services to Support Family and Community :
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 0.3 | 10.4 | 21.4 | 43.1 | 24.8 | 10.7 | 68.9 |
| Nursing(231) | 0.4 | 11.3 | 19.1 | 44.3 | 24.8 | 21.7 | 69.1 |
| Psychiatry(37) | 0.0 | 13.5 | 32.4 | 37.8 | 16.2 | 13.5 | 54.1 |
| Psychology(41) | 0.0 | 7.3 | 24.4 | 36.6 | 31.7 | 7.3 | 68.3 |
| Social Work(42) | 0.0 | 7.1 | 21.4 | 47.6 | 23.8 | 7.1 | 71.4 |
| Inpatient(192) | 0.5 | 14.7 | 19.4 | 39.8 | 25.7 | 15.2 | 65.4 |
| Community(96) | 0.0 | 5.2 | 22.9 | 46.9 | 25.0 | 5.2 | 71.9 |
| Rehabilitat.(60) | 0.0 | 5.0 | 26.7 | 45.0 | 23.3 | 5.0 | 68.3 |

Table 65

Feasibility of Services to Involve Community Members :
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 0.0 | 9.6 | 31.5 | 37.5 | 21.4 | 9.6 | 58.9 |
| Nursing(231) | 0.0 | 9.6 | 32.6 | 36.5 | 21.3 | 9.6 | 57.8 |
| Psychiatry(37) | 0.0 | 16.2 | 43.2 | 27.0 | 13.5 | 16.2 | 40.5 |
| Psychology(41) | 0.0 | 2.4 | 19.5 | 51.2 | 26.8 | 2.4 | 78.0 |
| Social Work(42) | 0.0 | 11.9 | 23.8 | 38.1 | 26.2 | 11.9 | 64.3 |
| Inpatient(192) | 0.0 | 11.5 | 27.7 | 35.6 | 25.1 | 11.5 | 60.7 |
| Community(96) | 0.0 | 9.4 | 30.2 | 41.7 | 18.8 | 9.4 | 60.4 |
| Rehabilitat.(60) | 0.0 | 5.0 | 43.3 | 38.3 | 13.3 | 5.0 | 51.7 |

Table 66

Feasibility of Services to Identify Clients : Percentage
of Responses to each Options

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 3.9 | 16.9 | 12.4 | 43.9 | 22.8 | 20.8 | 66.7 |
| Nursing(231) | 3.9 | 19.6 | 11.7 | 42.6 | 22.4 | 23.5 | 64.8 |
| Psychiatry(37) | 2.7 | 5.4 | 24.3 | 51.4 | 16.2 | 8.1 | 67.6 |
| Psychology(41) | 4.9 | 22.0 | 12.2 | 36.6 | 24.4 | 26.8 | 61.0 |
| Social Work(42) | 4.8 | 9.5 | 4.8 | 52.4 | 28.6 | 14.3 | 81.0 |
| Inpatient(192) | 1.6 | 23.4 | 16.7 | 37.5 | 20.8 | 23.0 | 63.9 |
| Community(96) | 5.2 | 10.4 | 13.5 | 55.2 | 15.6 | 15.6 | 70.8 |
| Rehabilitat.(60) | 1.7 | 20.0 | 10.0 | 38.3 | 30.0 | 21.7 | 68.3 |

Table 67

Feasibility of Case Management Services : Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 1.7 | 14.9 | 22.8 | 39.4 | 21.3 | 16.6 | 60.5 |
| Nursing(231) | 2.6 | 18.2 | 21.6 | 38.1 | 19.5 | 20.8 | 57.6 |
| Psychiatry(37) | 0.0 | 10.8 | 29.7 | 43.2 | 16.2 | 10.8 | 59.5 |
| Psychology(41) | 0.0 | 7.5 | 27.5 | 30.0 | 35.0 | 7.5 | 65.0 |
| Social Work(42) | 0.0 | 9.5 | 16.7 | 50.0 | 23.8 | 9.5 | 73.8 |
| Inpatient(192) | 2.1 | 16.1 | 21.4 | 42.2 | 18.2 | 18.2 | 60.4 |
| Community(96) | 0.0 | 10.5 | 24.2 | 38.9 | 26.3 | 10.5 | 65.3 |
| Rehabilitat.(60) | 1.7 | 18.3 | 26.7 | 28.3 | 25.0 | 20.0 | 53.3 |

Table 68

Feasibility of Reaching Out Services : Percentage of
Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 2.5 | 25.0 | 14.0 | 40.0 | 18.0 | 27.5 | 58.4 |
| Nursing(231) | 1.3 | 23.4 | 13.4 | 40.3 | 21.6 | 24.7 | 61.9 |
| Psychiatry(37) | 5.4 | 18.9 | 21.6 | 48.6 | 5.4 | 24.7 | 54.1 |
| Psychology(41) | 4.9 | 34.1 | 17.1 | 31.7 | 12.2 | 39.0 | 43.9 |
| Social Work(42) | 4.8 | 31.0 | 7.1 | 40.5 | 16.7 | 35.7 | 57.1 |
| Inpatient(192) | 1.6 | 23.4 | 16.7 | 37.5 | 20.8 | 23.4 | 58.3 |
| Community(96) | 5.2 | 28.1 | 11.5 | 44.8 | 10.4 | 33.3 | 55.2 |
| Rehabilitat.(60) | 1.7 | 26.7 | 11.7 | 43.3 | 16.7 | 28.3 | 60.0 |

Table 69

Feasibility of Supportive Residential services :
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 3.4 | 19.5 | 24.3 | 38.4 | 14.4 | 22.9 | 52.8 |
| Nursing(231) | 2.6 | 19.2 | 23.1 | 40.2 | 14.8 | 21.8 | 55.0 |
| Psychiatry(37) | 8.1 | 29.7 | 27.0 | 24.3 | 10.8 | 37.8 | 35.1 |
| Psychology(41) | 4.9 | 14.6 | 22.0 | 39.0 | 19.5 | 19.5 | 58.5 |
| Social Work(42) | 2.4 | 19.0 | 31.0 | 40.5 | 7.1 | 21.4 | 47.6 |
| Inpatient(192) | 4.2 | 19.5 | 22.6 | 37.9 | 15.8 | 23.7 | 53.7 |
| Community(96) | 3.1 | 18.8 | 28.1 | 38.5 | 11.5 | 21.9 | 50.0 |
| Rehabilitat.(60) | 0.0 | 21.7 | 21.7 | 43.3 | 13.3 | 21.7 | 56.7 |

Table 70

Feasibility of Vocational Services : Percentage of
Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp ^a 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|-----------------------------|------------|
| Total(351) | 2.2 | 23.9 | 24.7 | 35.1 | 14.0 | 26.1 | 49.1 |
| Nursing(231) | 2.6 | 23.4 | 22.5 | 36.8 | 14.7 | 26.0 | 51.5 |
| Psychiatry(37) | 0.0 | 32.4 | 35.1 | 21.6 | 10.8 | 32.4 | 32.4 |
| Psychology(41) | 2.4 | 19.5 | 22.0 | 36.6 | 19.5 | 22.0 | 56.1 |
| Social Work(42) | 2.4 | 23.8 | 33.3 | 33.3 | 7.1 | 26.2 | 40.5 |
| Inpatient(192) | 2.6 | 29.2 | 22.9 | 29.7 | 15.6 | 31.8 | 45.5 |
| Community(96) | 2.1 | 17.7 | 32.3 | 38.5 | 9.4 | 19.8 | 47.9 |
| Rehabilitat.(60) | 1.7 | 13.3 | 20.0 | 48.3 | 16.7 | 15.0 | 65.0 |

Table 71

Feasibility of twenty-four Hour Crisis Services :
Percentage of Responses to Each Option

| Group(N) | 1 | 2 | 3 | 4 | 5 | Not Imp 1+2 | Imp 4+5 |
|------------------|-----|------|------|------|------|----------------|------------|
| Total(351) | 3.4 | 28.7 | 19.9 | 28.9 | 19.1 | 32.0 | 48.0 |
| Nursing(231) | 3.0 | 29.9 | 16.5 | 27.3 | 23.4 | 32.9 | 50.6 |
| Psychiatry(37) | 5.4 | 29.7 | 27.0 | 21.6 | 16.2 | 35.1 | 37.8 |
| Psychology(41) | 4.9 | 26.8 | 17.1 | 41.5 | 9.8 | 31.7 | 51.2 |
| Social Work(42) | 2.4 | 26.2 | 33.3 | 31.0 | 7.1 | 28.6 | 38.1 |
| Inpatient(192) | 3.6 | 28.6 | 20.8 | 25.5 | 21.4 | 32.3 | 46.9 |
| Community(96) | 5.2 | 29.2 | 16.7 | 36.5 | 12.5 | 34.4 | 49.0 |
| Rehabilitat.(60) | 0.0 | 25.0 | 21.7 | 30.0 | 23.3 | 25.0 | 53.3 |

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