THE HEAD NURSES' PERCEPTIONS OF THE IMPACT OF
DEINSTITUTIONALIZATION ON THE CHRONICALLY
MENTALLY ILL

by

K. LEILA SINNEN, R.P.N., R.N.

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Department of Nursing

The University of British Columbia
Vancouver, Canada

Date April 26, 1993
ABSTRACT

This study describes head nurses' perceptions of the impact of deinstitutionalization on persons with chronic mental illness. A phenomenological approach is the methodology used in this study. Data were collected by use of an in-depth semi-structured interview. The participants in the study were seven head nurses from a large psychiatric institution in Western Canada.

Themes derived from the data were abstracted into three content categories. The content categories are contributing factors, impact on the individual and facilitating factors. Major themes under each of the content categories are described. The findings reveal that head nurses perceive that deinstitutionalization has negative and positive effects on the chronic mentally ill. The negative effects are stigma, homelessness and the revolving door syndrome. Positive effects of deinstitutionalization can be a better quality of life with adequate communication, patient preparation, education and resources/facilities in the community. The findings also show that head nurses perceive that some persons with chronic mental illness may require care in a psychiatric institution for most of their lives. The implications that deinstitutionalization has for nursing practice, education, administration and research are presented.
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CHAPTER ONE

Introduction

Deinstitutionalization of the chronically mentally ill from provincial and state hospitals has been a trend in mental health care for the past thirty years. The effect of deinstitutionalization on the chronically ill and their ability to survive in the community has been documented to some extent. What is lacking is information (or understanding) about the perceptions of nurses on the impact of deinstitutionalization on persons with chronic mental illness.

Background and Conceptualization of the Problem

Deinstitutionalization is "the trend to discharge large numbers of chronically mentally ill patients to the community from psychiatric institutions and the reduction in hospitalization of the chronically mentally ill" (Bachrach, 1984, p. 974). Deinstitutionalization of chronically mentally ill patients from psychiatric hospitals has been a major movement in psychiatry for the past thirty years. A policy of deinstitutionalization was implemented in both Canada and the United States in the 1960s. "In the U.S.A, community treatment programs have multiplied since the 1960s while in Canada the organization of a network of programs did not officially begin until the early seventies" (Hodgins, 1987, p. 8). Brook (1990) states "presently in the Netherlands mental health care is undergoing an extensive revision. Current mental health care policy emphasizes a major
shift from intramural to extramural care." In 1978 major psychiatric reform drastically changed the Italian psychiatric system. Mental hospitals stopped admitting patients and psychiatric units in general hospitals began accepting clients (Berti, Glick & Tansella, 1990).

According to Talbot (1988) there were 560,000 patients in state hospitals in the U.S.A in 1955 as compared to 115,000 in 1987. In England the number of psychiatric patients in hospital in 1954 was 150,000 whilst in 1985 there was a dramatic reduction to 73,000 (Corke, Cushion & Haddock, 1989).

According to statistics Canada (personal communication March 28, 1991) statistics are not available on patients institutionalized in psychiatric hospitals in Canada. However, in 1987 - 1988 the number of discharges of psychiatric patients from psychiatric and acute care hospitals was 194,306 in Canada of which 22,518 were in British Columbia.

The provincial psychiatric hospital in British Columbia, with beds reduced from 4,800 in the 1960s to 900 patients today, has been in a "downsizing phase" for the past four years and is scheduled to complete this phase within ten years. The completed phase will result in a 500 bed hospital for psychiatric patients (The Vancouver Sun 1990; Province 1990; Ministry of Health, 1989). However, the deinstitutionalization experience has not been successful for many chronically mentally ill. Adjusting to life after hospitalization is a major problem among psychiatric patients (Crosbie,
1987). Most of these patients, who have poor coping skills and/or inadequate supports in the community, fail to function and are rehospitalized.

Many people with a chronic mental illness become caught up in the department (personal communication July 13, 1992) this psychiatric hospital admitted 512 patients in the past six months. Of the 512 patients, approximately 98% had had previous admissions to the hospital.

Head nurses who work with people with chronic mental illness in psychiatric hospital settings are aware that their patients require different levels of community support upon discharge to prevent the high rate of recidivism that occurs. In addition, head nurses are cognizant of their patients' needs as they are responsible for assessing, planning, implementing and evaluating nursing care for their patients on a twenty-four basis. In their role as leaders, head nurses have close contact with a large number of nursing staff, multi-disciplinary team members, community health care providers, families and administrators who actively participate in the deinstitutionalization process.

By virtue of their psychiatric nurse training, clinical experience and depth of knowledge gained from working with this population, head nurses have become "experts" and are well equipped to influence the process of deinstitutionalization effectively. As well, head nurses "contribute to both treatment of illness and the maintenance of health. They recognize the high
cost of health care and as professionals endeavour to control expenses" (Parker, 1986, p. 22).

Head nurses at a large psychiatric hospital in Western Canada, are clinically and administratively involved, at the ward level, in the operationalization of deinstitutionalization. Their years of clinical experience and knowledge of the theory of nursing the chronically mentally ill can be useful in the decision-making process affecting deinstitutionalization.

However, it is the experience of this investigator that the expertise of head nurses is not fully utilized and at times their views are disregarded. Often decisions affecting patient care, are made with very little input from the head nurses. Their involvement in decision-making above the ward level regarding the placement of the chronic mentally ill patients in the community would enhance the policy decisions regarding this population.

**Problem Statement**

Head nurses hold a strategic position within the nursing hierarchy to influence the health care of patients. More specifically they can contribute significantly to the decisions affecting the implementation of deinstitutionalization. Yet their knowledge and expertise are not actively utilized. Head nurses need to articulate their perception of the impact of deinstitutionalization on the chronically mentally ill.
Purpose of the Study

The purpose of the study was to determine head nurses' perceptions of the impact of deinstitutionalization on persons with a chronic mental illness. The information gained will assist health care administrators and policy planners to understand the needs of this patient population. In addition this information will contribute to the improvement of patient care and enhance the process of implementing deinstitutionalization.

Research Question

What are head nurses' perceptions of the impact of deinstitutionalization on the chronically mentally ill?

Operational Definition of Terms

Chronic mental illness - mental illness that requires frequent short term or long term psychiatric treatment.

Community living - private homes, government subsidized or private boarding homes, hotels, hostels or places where patients reside upon discharge from the institution with the exception of prison and the street.

Deinstitutionalization - "the trend to discharge large numbers of chronically mentally ill patients to the community from psychiatric institutions and the reduction in hospitalization of the chronically mentally ill" (Bachrach, 1984, p. 976).
Head nurse - registered psychiatric nurse or registered nurse selected and appointed in charge of a ward. The head nurse is responsible for the overall clinical and administrative management of his/her ward.

Impact - a strong or powerful effect or impression.

Perception - insight, awareness and understanding.

**Assumptions**

1. The problems associated with deinstitutionalization are concerns for society.
2. Some chronically mentally ill patients prefer to live in the community while some prefer the institution.
3. Some chronically mentally ill patients do not have the skills for community living.
4. Head nurses possess good clinical and theoretical knowledge of chronic mental illness and the impact of deinstitutionalization on the chronically mentally ill.
5. Head nurses have significant influence on the opinions of a large number of health care providers.
6. Head nurses’ knowledge regarding deinstitutionalization is not adequately utilized in the decision-making process.

**Limitations**

The participants’ perceptions are applicable to patients within the hospital setting only.
The participants' perceptions reflect only those of the head nurses and not other nursing staff.

The participants, graduates of schools of nursing both in Canada and abroad, have different clinical backgrounds and philosophies.

The researcher cannot eliminate her personal views of the phenomenon but is aware of them.

**Significance of the Study**

**Scientific Significance**

Phenomenological research generates a description and deeper understanding of the phenomenon of interest.

The findings of this study will contribute to nursing's body of knowledge. Researchers will be able to select themes that emerge from the findings and conduct further qualitative and or quantitative studies to build on the present knowledge of the phenomenon. Further research on the findings will add to the existing theoretical knowledge as "theoretical knowledge in nursing is dependent on research" Brown (cited in Nicoll, 1986, p. 12).

**Practical Significance**

Knowledge of the phenomenon of deinstitutionalization will increase through the documentation of perceptions of head nurses on the effect of deinstitutionalization on people with chronic mental illnesses. The findings if communicated to other head nurses and levels of staff within the hospital,
will be useful in promoting better patient care. This knowledge will also be helpful in the identification and planning of discharge of patients to the community, so that patients may be selected and placed appropriately. Placements should be based on the patients' needs. The findings of the study should facilitate an increase in communication and consultation between the head nurses and administration in the downsizing of the hospital and the deinstitutionalization process. In addition, the findings of the study may stimulate the head nurses and other staff to conduct further research within the hospital.

Summary

This chapter has provided the background and conceptualization of the problem which is the need to articulate head nurses' perceptions of the impact of deinstitutionalization on persons with chronic mental illness. A description was given of the operational definition of terms, assumptions, limitations and significance of the study. In Chapter two will be presented a review of the selected literature. Chapter three will describe the research design, sample selection and selection criteria, data collection, procedures, data analysis and ethical considerations. Chapter four will present the study's findings. Chapter five will present discussion of the findings. Lastly, Chapter six will discuss the summary, conclusions and implications for nursing practice, education, administration and recommendations for further research.
CHAPTER TWO

Literature Review

In the literature review, the historical perspective of deinstitutionalization, the impact of deinstitutionalization and the current status of the Canadian mental health care will be addressed. Such a review will assist the reader to understand the changes and progress made in the care of the chronically mentally ill over the years.

Historical Perspective of Deinstitutionalization

According to Gralnick (1985) for some two hundred years, the mentally ill in the United States lived in the community or with paupers and the physically ill in jails and almshouses under brutal and inhumane conditions. In the mid nineteenth century Dorothea Dix started a crusade to change the inhumane treatment of the mentally ill. Her efforts resulted in rapid growth in the number of state hospitals. Although the care provided varied from acceptable to poor, the state hospital system flourished.

From the middle of the last century to the middle of the twentieth century the emphasis in the treatment of the mentally ill was on custodial care in large institutions. Usually, these institutions were located in rural settings away from urban centres which they served. The large institutions fulfilled the function for society of keeping the mentally ill "out of sight thus out of mind." Then a shift in the modality of psychiatric care occurred as a result of several factors. One factor was public opinion formed by
"decades of public attack upon state mental hospitals in movies such as 'The Snake Pit' and in books such as Albert Deutsch's 'The Shame of the States', a scathing expose of the state hospitals that aroused great public outcry" (Gralnick, 1985, p. 738). Mental health professionals and the general public had begun to question the philosophy and need for large mental hospitals. There was also public outcry about the expense of caring for the chronically mentally ill and hospitals made efforts to cut costs on their treatment (Polcin, 1990; Talbot, 1988).

Another factor was the emergence of the civil libertarian movement that stressed individual rights. There were concerns that the mentally ill were becoming institutionalized. "The institutionalized being those relegated to the back wards who appeared to be deteriorating, had lost contact with their families and communities and become apathetic to their fate" (Crawford & Conacher, 1988, p. 14). From a humanitarian point of view, it was thought that the chronically mentally ill patients would be better off in the community, as long hospitalizations in psychiatric institutions were seen as promoting chronicity. It was also thought that the mentally ill would be optimally treated in an environment that permits contact with the rest of society and with the mainstream social institutions. They would have closer contact with friends, family members and access to other resources. In addition, it was believed that "community care would prevent mental illness itself" (Gralnick, 1985, p. 738).
The success of the major tranquilizers developed in the 1950's, particularly the phenothiazine, is another factor affecting deinstitutionalization. The tranquilizers have resulted in a large proportion of the mentally ill gaining control of their "aberrant" behaviours to the extent that they have been able to function outside a structured institutional setting (Crawford & Conacher, 1988).

Another factor contributing to deinstitutionalization was the change in the commitment laws of the various states in the U.S.A. The law made the involuntary commitment of psychiatric patients a more complex process. It became more difficult to hold psychiatric patients indefinitely in psychiatric hospitals against their will. Thus an involuntary indefinite commitment of patients to psychiatric hospitals became a thing of the past (Lamb, 1984).

Not the least of the motivating factors was financial. According to Lamb (1984) the state government wanted to shift some of the financial burden for the chronically mentally ill to federal and local government. Aid to the Disabled Act became available to the mentally ill in 1963 making them eligible for the first time for federal financial support in the community. With this Act, psychiatric patients were able to support themselves or to be supported either at home or in facilities such as boarding houses or old hotels at little cost to the state. It was less expensive
to maintain patients in the community than in state hospitals thus deinstitutionalization of the chronic mentally ill patients was encouraged.

**Impact of Deinstitutionalization**

While deinstitutionalization has been a blessing for many patients, for thousands of chronically mentally ill patients and their families it has brought frustration, anguish and despair. These people have been trapped in a system in which neither the communities nor the hospitals can provide adequate care. "Families who sought help for their relatives in community nursing and personal care homes found that they offer little more than a place to live as adequate mental health care is not available in these facilities" (DuBois & Gates, 1990, p. 606).

Homelessness is closely linked with deinstitutionalization in the sense that three to four decades ago most of the chronically mentally ill had a home in the state and provincial hospitals. Today, due to deinstitutionalization, many of the chronically mentally ill live on the streets, under bridges and in "cheap, run-down" hotels and rooming houses (The Vancouver Sun, 1992).

As a result of living on the streets, with little or no support system, most of these patients regress within a short time following discharge from hospital. Their "strange behaviours", fear and disorganization often end in conflict with the law. They often assault others, perhaps to protect themselves, or are assaulted by others. According to a report done by the
American Psychiatric Association task force, Lamb (1984) stated "rather than hospitalization and psychiatric treatment, the mentally ill often tend to be subject to inappropriate arrest and incarceration" (p. 905).

Many chronically mentally ill people due to dysfunctional behaviours, decreased skills and lack of social support, experience unemployment and poverty (Wolf & Fry, 1990). Their lack of money together with their decreased skill in money management make it difficult for them to sustain a social life (Jahoda, Cattermole & Markova, 1990). Sadly, unemployment and poverty contribute to their emotional instability, loss of prestige, feelings of inferiority, expectation of failure and distrust of others. Hence most chronically mentally ill fall "through the cracks" and or are rehospitalized.

The stigma of mental illness is still evident amongst the public. Generally, society believes that the mentally ill are "dangerous" and will jeopardize the public's safety if they are "let loose" in the community. Attitudes have been influenced by movies such as "One Flew Over The Cuckoo's Nest" and from media headlines such as "Mother and Two Children attacked by Mentally Ill Patient" (The Province, 1988). Residents and property owners reject the mentally ill and protest against government plans to build psychiatric facilities in some communities, for example West Vancouver. Unfortunately, society remains hostile to this population. This attitude is reflected in the articles that appear in the local newspapers
entitled "World a Lonely Place for the Mentally Ill", West Vancouver takes up petition against Boarding Home for the Mentally Ill" (Vancouver Sun, 1990).

On the other hand, some chronically mentally ill individuals found community life much better than living in an institution. They adjusted to their new living situation and perceived their lives as improved according to the findings of a research study done by Okin, Dolnick & Pearsall (1983). This research was carried out in Massachusetts between 1978 and 1981. The researchers interviewed thirty-one patients in the experimental group and ten in the control group. The experimental group was patients who were discharged to residential settings with a goal of maximizing personal independence and developing the necessary repertoire of skills for successful community adjustment. The control group was patients who remained in the hospital setting. The community residential program was supplemented with affiliated day services such as drop-in social clubs, treatment programs and sheltered workshops. The state hospital provided less than adequate privacy and little opportunity for tailoring treatment to the needs of individual patients in the control group.

Three different data collection techniques were used in this study. They were case record abstract, patient interviews and staff ratings. Unfortunately the same staff members did not complete the rating scales on each patient at all three points in time, a fact, according to the researchers
that may have introduced some unreliability into the data. Also, the sample was small, especially the control group. Although the findings showed that some patients preferred and adapted well to community living, the findings cannot be generalized to all chronically mentally ill. However, with further research it may be possible to show that with adequate services and facilities the chronically mentally ill could adapt to the mainstream of society.

Friedlob, Janis & Deets-Aron, (1986) assessed a program that focused on developing patient competence in daily living skills in health and hygiene, nutrition, household management, budgeting, interpersonal relationships, community resources, leisure activities and occupational training. Nineteen patients met the criteria for joining this program. The sample group had intensive help and training from two occupational therapists who developed the program.

Five years after treatment, twelve of the nineteen patients remained in the community. Eight of the nineteen patients had no rehospitalizations whilst four patients had multiple rehospitalizations. Of those rehospitalized, the hospitalization period decreased from a three to six month period to a two to four week period. For the majority of the chronic patients in this study the quality of community life improved in terms of living environment, occupational behaviour and length of rehospitalization.
Again, the sample size in this study was too small to generalize the findings. The sample consisted of high functioning patients who were employed, employable and responsible for self medication. These patients were motivated and with intensive follow-up, the chances of success were greater than if they had not been motivated. In addition, the diagnoses among the sample varied from schizophrenia, depression, manic-depression, personality disorder and anxiety neurosis. In this investigator's opinion perhaps the findings would be different if the sample consisted of people with only personality disorders or schizophrenia. However, the literature indicates that deinstitutionalization has affected the chronically mentally ill population in different ways.

**Current Status of the Canadian Mental Health System**

Epp (Health & Welfare, 1988) stated that mental health issues have profound implications for all aspects of human existence. It is not only a concern for professionals but all of society has a stake in mental health issues and a contribution to make. Mental health promotion in Canada is a challenge that requires the employment of a diversity of talents, resources and strategies. In addition it must be looked at on several levels. Epp (1988) states "deinstitutionalization has rarely been followed through in a consistent and logical way" (p. 20). He outlines seven guiding principles for development of public policies that support mental health. The seven principles are "human rights and citizenship, mutual aid and voluntary
service, consumer participation, professional participation, the strength of communities, knowledge development and policy coordination" (Epp, 1988, p. 18).

According to Epp (1988) the principle of strengthening communities means having balanced allocation of resources to enable communities to develop programs and services to help individuals with mental health problems and their caregivers. This process involves community consensus of values, principles and strategies that govern policies for community mental health.

The Canadian Nurses Association (1991) outlines five significant criteria in Canada's mental health care system which are related to the World Health Organization of primary health care. These criteria are "accessibility, public participation, promotion of health and prevention, intersectional cooperation and appropriate technology" (C.N.A. 1991, p. 5). In an attempt to solve these problems in British Columbia, especially with the downsizing of the provincial psychiatric institution, the Ministry of Health has adopted five important "service principles" to provide quality services to the mentally ill. These principles are "comprehensiveness, coordination of care, continuity of care, availability, accessibility and accountability" (Ministry of Health, 1987, p. 3).

Head nurses in mental health services are in a critical position to influence care. Pearlmutter (1985) states that "head nurses have a
cooperative collaborative relationship with members of other disciplines who also network closely with clients" (p. 56). Head nurses at the provincial psychiatric institution in British Columbia are concerned about the promotion of optimal mental health not only for their patients but for families, the community and society. They are actively involved with the treatment and rehabilitation of their patients. Head nurses at the provincial hospital, due to their pivotal role, liaise with professionals and non professionals both within the hospital and in the community in relation to patient care. They are also advocates on behalf of the patients and work towards the success of deinstitutionalization of their chronic mentally ill patients.

Some authors (Long, Mackle & Monaghan, 1989; Friedlob, Janis & Deets-Aron, 1986) are in favour of deinstitutionalization while others claim that the care provided in the community does not meet the needs of the chronic mentally ill (Aviram, 1990; Bachrach, 1984). Aviram (1990) points out that "some of the mental health service system problems are related to social and political factors and fluctuating support for mental health services which traditionally has had to compete with other social welfare and medical programs" (p. 71).

From the literature review, it becomes apparent that there is a need for the improvement of community services but also there is a need for institutional care for some chronically mentally ill people. In addition, to
improve the services already in existence by decreasing fragmentation of services, more collaboration is required among the key players such as government, hospital and community to successfully deinstitutionalize the chronically mentally ill.

In Canada, particularly in British Columbia, deinstitutionalization of the chronically mentally ill is progressing steadily. As stated in the literature review, the Federal Government as well as the Provincial Government have implemented policies and guiding principles for the implementation of deinstitutionalization. Emphasis is placed on community care such as boarding homes, personal care homes for the chronically mentally ill to prevent rehospitalization and to facilitate the downsizing or closure of large institutions. However, the community resources and facilities are less than adequate to cope with the growing needs of this population.

In summary, most of the research on deinstitutionalization is conducted by disciplines other than nursing. Since head nurses in psychiatric hospitals are clinically involved with deinstitutionalization and its repercussions or sequelae, it is therefore, important to conduct a study to gather a thorough understanding of their perceptions of the impact of deinstitutionalization on the chronically mentally ill.
Summary

In order to establish what is known about the impact of deinstitutionalization on persons with chronic mental illness, in this chapter is reviewed selected literature related to the historical perspective of deinstitutionalization, the impact of deinstitutionalization and the current status of the Canadian mental health system.
CHAPTER THREE

Methods

This chapter describes the application of the phenomenological method of inquiry in a study of the head nurses' perceptions of the impact of deinstitutionalization on persons with a chronic mental illness. The implementation of phenomenology is discussed in relation to sample selection and selection criteria, data collection, data analysis and ethical considerations.

Research Design

A phenomenological approach of qualitative research was the selected method used to answer the study's research question. "The phenomenological approach is primarily an attempt to understand empirical matters from the perspective of those being studied" (Munhall & Oiler, 1986, p. 89). According to Omery (1983) the goal of the phenomenological method is to provide an accurate description of the phenomenon under study.

Head nurses at a large psychiatric hospital in Western Canada are presently involved with deinstitutionalization of the chronically mentally ill and are best able to speak to the nurses' perspective of this phenomenon. They see the effects of deinstitutionalization on a daily basis in the clinical area. Their knowledge regarding deinstitutionalization is gained through years of working with the chronically mentally ill and in the implementation of the phenomenon. It is the participant's point of view that
provides the "rich data which must be obtained" (Giorgi, 1975a, p. 100).

**Sample Selection and Selection Criteria**

The participants in a phenomenological study must have lived or be living the experience under investigation. Also they have to be interested in understanding and expressing the feelings which accompanied their experience. The sample for this study was selected by the investigator through purposive sampling. Purposive sampling according to Woods and Catanzaro (1988) is a process in which the investigator selects the cases based on a judgement of the extent to which the potential participants will be most representative of the phenomenon under study. In this study the investigator selected as subjects eight head nurses from a provincial psychiatric hospital in Western Canada who have been in charge of the fourteen wards in the continuing treatment program and in the acute assessment and treatment program. These two programs were more active in receiving new admissions and discharging patients to the community. Hence the head nurses in these programs were more involved with the deinstitutionalization process.

The inclusion criteria for the subjects were (1) they had to be head nurses, and (2) had to be employed at the hospital for a minimum of five years. Since the hospital had been in a downsizing phase for the past four years, the head nurses had a minimum of four years experience with the deinstitutionalization process. First, the investigator wrote a letter to the
Vice President of Nursing Services at the hospital requesting her to seek permission (Appendix A) from the selected head nurses to be approached by the investigator.

The Vice President telephoned the investigator stating that she had given a copy of the letter to the head nurses of the respective programs. With the head nurses permission she also gave the investigator permission to contact the head nurses. One head nurse from the continuing treatment program phoned the investigator to volunteer as a participant for the study. The investigator phoned the head nurses in the acute assessment and treatment program who met the sampling criteria. Four head nurses from that program volunteered to participate. The investigator then phoned three head nurses from the continuing treatment program who volunteered to be subjects for the study. Ethical procedures were followed as indicated in Appendix A and ethical considerations, p. 34.

**Data Collection Procedures**

The interview technique is frequently used in phenomenology. The researcher needs the skill to be a good listener and know how to encourage people to describe their feelings. In order to answer the research question in this study, the data collection process consisted of two face-to-face interviews with each head nurse.

The interviews were conducted in an area convenient to the head nurses. Though the investigator preferred to interview the head nurses
away from their work environment, the head nurses felt that their offices at work were convenient and provided the necessary privacy.

The investigator used five trigger questions (Appendix C) to facilitate exploration of the research question during the first interviews. The trigger questions were open-ended questions that evolved from the literature review. For example, what are the benefits of deinstitutionalization for your patients? Open-ended questions are designed to create a conversational atmosphere and allow for free expression (Van Maanen, 1983).

Additional questions were asked during the first interview to either clarify what the participant said or to further the investigator's understanding of what was being discussed.

The content of the second interview was drawn from an analysis of the material discussed during the first interview. The investigator clarified areas that were unclear and verified emerging themes consistent with Colaizzi's phenomenological methods as outlined by Reimen (cited in Munhall and Oiler, 1986, p. 94-95).

For accurate verbatim accounts of the participants' responses the interviews were tape-recorded. None of the participants indicated that the presence of the tape recorder hindering their ability to speak freely. One of the participants requested that the tape recorder be turned off while thinking through the responses to each question. The tapes were transcribed verbatim by the investigator. After transcription, the researcher
analyzed the interview data. She interviewed seven of the eight potential subjects for the study as no new information was forthcoming after the seven interviews.

**Data Analysis**

The processes of collecting, coding and analysing data were continued until data collection was complete. Then the final stage of analysis became "a period for bringing final order to previously developed ideas" (Lofland & Lofland, 1984, p. 131).

The investigator analyzed the data using Colaizzi’s phenomenological methods as outlined by Reimen (cited in Munhall and Oiler, 1986, p. 94-95).

The procedural steps were as follows:

1. All tape-recorded interviews were transcribed verbatim by the researcher. Each interview was then read through twice to acquire a feeling for them.

2. Then the transcript was read again to extract significant statements that directly pertained to the phenomenon under study. The researcher underlined the significant statements from each description, phrase and statement.

3. From the significant statements meaning units were identified. The researcher wrote the meaning units in the margin of the transcript text. Then the researcher reflected upon the meaning units to ensure there was a connection with the original description.
4. From the meaning units the researcher developed a cluster of themes. Forty seven themes emerged from the meaning units that were common to all the participants’ descriptions. Examples of themes were; unplanned discharges, non-compliance, lack of communication, revolving door syndrome, patients’ rights, patient rehabilitation, individuality and normal environment. Next the researcher referred back to the original descriptions to validate the themes.

At the second interviews the researcher explained to each participant what was being done with the data collected and sought clarification and verification of the themes. Some of the subjects could not believe how "lengthy" their transcripts were. None of the participants disagreed with the beginning analysis of the data. Comments such as "exactly" and "right on" were expressed. Three of the participants requested "to look at" the completed thesis. During the second interview further clarification and elaboration of data occurred which assisted the researcher to ask pertinent questions about the phenomenon under study. The second interviews were tape-recorded, transcribed and analyzed in the same way as the first.

Themes developed from the data were further condensed into three content categories. A diagram depicting the final conceptualization of the phenomenon is shown in Figure 1, p. 32. Next the researcher integrated and synthesized the essential themes to develop an exhaustive description of the
phenomenon. The investigator implemented the validation process as necessary throughout the data analysis process.

The analysis concluded with an exhaustive description of the head nurses' perceptions of the impact of deinstitutionalization on the chronically mentally ill.

**Ethical Considerations**

To protect the rights of the study participants, this research proposal was approved by the University of British Columbia's Sciences Screening Committee for Research and Other Studies Involving Human Subjects and the hospital's research committee.

The participants were informed verbally and in writing of the purpose, the benefit and the risk of the study to enable them to make informed consent. They were also informed of the expected time needed to devote to the study. The participants were told that they faced no risks from the study. They had the right to withdraw from the study at any time without implications to them personally, to their employment or to the hospital. Written consent (Appendix B) was obtained from each participant before commencement of the first interview and for tape recording of the interviews.

The information provided was shared by the researcher's thesis committee but was kept confidential from all others. To maintain anonymity, the participants' names did not appear on any of the materials.
Tape recordings were kept at the researcher's home. Upon completion of the study the tapes were destroyed. During the interviews participants privacy was maintained as all interviews were conducted in their private offices at work.

**Summary**

In this chapter the phenomenological method was discussed. Data were collected through fourteen interviews with seven head nurses employed at a large psychiatric hospital in Western Canada who were involved with the deinstitutionalization of the chronically mentally ill. Sample selection was by a purposive sampling technique. Five open-ended trigger questions were used as a guide for the interviews with the participants. Their rights in terms of informed consent, confidentiality and anonymity were safeguarded throughout the research process. Data analysis was concluded using Colaizzi's phenomenological methods.
CHAPTER FOUR

Presentation of Findings

The accounts given by the seven participating head nurses of their perceptions of deinstitutionalization of the chronically mentally ill will be presented in this chapter. The chapter begins with a description of the participants in the study. Next is an introduction of the conceptualization of deinstitutionalization formed from concepts derived from the data. Then the presentation of the participants' account of their perceptions organized according to the developed framework will be presented. The three content categories are: contributing factors, impact on the individual and facilitating factors. Deinstitutionalization is affected by each category.

What is the head nurses' perception of the impact of deinstitutionalization on persons with a chronic mental illness? The accounts given by the seven participating head nurses of their perceptions of deinstitutionalization of the chronic mentally ill will be presented in this chapter.

Description of the Participants

The seven participants in the study were all employed at a large psychiatric hospital in Western Canada as head nurses in charge of wards in the acute assessment and treatment unit or in the continuing treatment unit. They had worked at this hospital for a minimum of nineteen years in positions such as staff nurse, assistant head nurse and currently as head
nurse. They participated in different committees such as the standards committee, quality assurance and risk management committee, procedure committee, policy committee, nursing service committee and planning committee. One of the head nurses was the coordinator of the bridging program whilst another was the chairperson of a planning committee involved with downsizing.

Four of the seven participants obtained their basic nursing education (R.P. N/R.N) in England whilst the remaining three studied in Canada. Each participant had a minimum of twenty years experience working with the chronic mentally ill population. In addition, as head nurses they had been in charge of wards, other than their present ones, in which the program was different, for example, organic brain syndrome and long term rehabilitation.

**Conceptualization of the Data**

The purpose of this study was to present data which will enhance our understanding of the head nurses’ perceptions of the impact of deinstitutionalization of the chronically mentally ill. Meaning units were identified from the significant statements in the transcripts. Examples of meaning units were patient involvement in planning, discussions with the team about discharge, we give the patient choices in placement, we tell them about resources available and we ask their opinions. From the meaning units, forty seven themes were extracted. Examples of themes
were patient participation, patient choice, patient needs, discharge planning and appropriate facilities. The forty seven themes were further condensed into three major content categories: (1) Contributing factors (2) Impact on the individual (3) Facilitating factors (Figure 1).

The themes placed under the content category: contributing factors, were, hospital mandate to downsize, mental health act, and consumer advocacy. Themes under the content category; impact on the individual were stigma, homelessness, revolving door syndrome and quality of life. Communication, patient preparation, education and resources/facilities were themes placed under the content category: facilitating factors. The presentation of the head nurses' accounts in the three major content categories will allow the reader to follow how deinstitutionalization has an impact on the chronically mentally ill.

**Contributing Factors**

Concepts in the contributing factors category will now be described. Verbatim accounts from the participants will be used for illustrative purposes and to support the concepts derived from the data. The abbreviations used in this chapter to identify the participants are H/N: head
Fig 1. Conceptualization of Deinstitutionalization of the Chronically Mentally Ill
nurse and R: researcher. Names of individuals mentioned in the text of the interviews identified as Mr.X or Ms.X.

Hospital Mandate to Downsize

This hospital is actively pursuing its mandate to reduce the present bed count to a three hundred bed hospital. The head nurses referred to this process as "downsizing." Three of the head nurses stated that downsizing was the "buzz word" used in the hospital. Another head nurse called it "the current theme." The head nurses generally felt that if downsizing were "clinically driven" whereby the patients needs were taken into account, then it would be beneficial to the patient. For example, patients would be appropriately placed where their individual needs would be met. If however downsizing was "financially driven" then the patients would be at a disadvantage because they would be discharged without adequate preparations made to meet their needs in the community.

R: What would be some of your concerns regarding the patients in this process?

H/N: My basic concern, probably the concern of many others, is that their needs as individuals may be overlooked in this process. That is a major concern. Beyond that is the concern for the development of necessary facilities and supports that these people will need if they are moving from the hospital to the larger community.
H/N: It is too financially driven. I am not saying that no thought is given to what is needed for the client but the main thought is financially what are we going to benefit. Because that is the main focus, we are not really thinking of what is needed for that client prior to being deinstitutionalized, what skills do they need to live in the community properly like a normal person. The feeling among the head nurses was that downsizing was a progressive step in the treatment of the chronic mentally ill. To be effective, it should be a gradual, well planned process "in which the patient is the focus."

H/N: We have to guard against over-exuberance in this downsizing. We have to remember the patients' care and needs are primary. If it fits into the downsizing plan of the hospital, fine. If it does not, we have to remember the key issue here and downsizing will not be the key issue for the patient who is not ready yet.

H/N: I think we have to be proactive and not reactive in these fast moving times. If we are going to close beds in this hospital that it is done for the total betterment of the patients, not the opposite.

H/N: As we are under pressure to downsize we try to get the patients out as soon as possible.
The head nurses expressed a feeling that not all the patients were able or suitable to be discharged. Some patients have been institutionalized for many years. Due to the chronicity of their illness and the inappropriateness of their behaviour would require "institution" or "asylum" type of care. The head nurses felt that the need for an institution should be taken into account in the downsizing process.

H/N: I am quite certain that the goal of three hundred beds is unrealistic. Three hundred beds are not very many. It looks as though there are about four hundred patients who needs "asylum" and the new hospital is only supposed to be three hundred beds. The planning for the new hospital came before the patient needs assessment. It should have been the other way around. So I've got some big concerns about that. I think three hundred beds is far too ambitious.

Mental Health Act

The head nurses also described how the mental health act affects the deinstitutionalization process of the chronic mentally ill. Patients admitted on an informal status (patient agreed to be admitted without signed medical certificate) could discharge themselves at any time. Doctors changed the patients status from involuntary (patient admitted with two signed medical certificates) to "informal" as soon as there were clinical signs of improvement. Head nurses could not prevent an "informal" patient from
leaving whether the head nurses felt he/she was fully recovered or not.

Patients were also discharged through the review panel which is an independent review board for patients. The head nurses felt that those "unplanned discharges" had an impact on the way the patients functioned following discharge.

H/N: Patients have a choice of leaving hospital when their certification runs out. This interferes with their preparation. Another way they leave is by going through the review panel.

H/N: Patients who come in certified are decertified as soon as the acute stage is over. Some of the informal patients when they decide to discharge themselves, legally there is not much we can do to stop them. So in terms of discharge planning, follow-up etc. is a questionable aspect.

H/N: We have not sent anybody out that didn’t have well prepared plans to go. The only exception to that are the ones who go on unauthorized absence. They are dropped from the count which I suppose is the downsizing in itself but not the preferable one that we have planned.

Two head nurses felt that the mental health act of 1979 had a positive impact on their patients. The mental health act allows their "informal" patients more freedom whilst hospitalized to go out by themselves shopping and visiting in the community. These were
opportunities they did not have in past years where involuntary patients had to be accompanied outside the hospital by staff or family and those occasions were not often.

H/N: Patients demand to go out on day pass, especially in our program where we encourage them to go out for week ends. If they are certified that would cause trouble. If a patient is certified he cannot go out on day pass or visit leave by himself. He would need someone responsible to come in and at least verbally say that he'll look after the patient while he is out there. So for many programs especially in this division, decertification is a better way to deal with patients going in and out, for visit leave and day pass etc.

The mental health act also affects the care that patients receive in the community. According to the head nurses, patients who had unplanned discharges had no follow-up plans made for continued care in the community to help them function. If and when their condition deteriorated and required treatment, doctors were reluctant to certify patients to receive care. Also if the patient was not certifiable he/she had the right to refuse treatment. In addition, according to one head nurse it was more difficult to admit patients directly to that hospital. All admissions had to go through the general practitioner and the general hospital.
H/N: In my opinion even though the mental health act is there for the good of the patients, it is hindering them in the sense that a lot of patients are not well enough to make informed decisions.

H/N: In the past when we discharge patients we anticipate some difficulty may be because of their past history. We put the patient on visit leave and then extended leave before he/she is actually discharged. By doing so the patient and the community workers have a kind of security that anything goes wrong the patient can come back right away. We don't have that extended leave anymore. If anything goes wrong, they cannot get back in. They have to go through the G.P and to the general hospital. Once they are decertified they have to be certifiable to be committed to hospital again.

H/N: With the mental health act it is very difficult to demand, with all the patient empowerment, you cannot say you have to have these treatment or skills.

**Consumer Advocacy**

The head nurses stated that consumer advocacy and patient rights have given patients more involvement and choice in their care and treatment which have had an impact on the deinstitutionalization process. If patients disagree with their treatment for example, they have the right to
refuse or to lobby for change. In past years, opportunities for questioning their care or to have choices in their care were not available as they are today. If patients were dissatisfied they did not have advocacy groups or an Ombudsman to approach for support. Patients at this hospital have direct access to an Ombudsman with whom they can discuss their concerns and know that action will take place. They also have a patients’ concern committee in the hospital where they discuss patient issues. Pertinent concerns are taken to the hospital administration for further action if warranted. Therefore, if patients are unhappy with their treatment or discharge plans in the hospital, pressure from consumer advocacy groups and/or the Ombudsman contribute to their early discharge. However, patients who are not stable soon deteriorate in the community and are rehospitalized.

H/N: Another point is the legal matters. The patient has the opportunity now that they never had in institutional setting before to discuss with the Ombudsman some concerns they have. They have the opportunity to discuss with the patients’ advocate that they didn’t have before.

H/N: The patients also have another thing that is part of deinstitutionalization and positive. That is they have their own committee, patient concern committee. They get to attend. An example is the new chief executive officer of this hospital, she
attended one of those patient concerns committee not that long ago. It shows the credence that the administration put in the concern of patients. I think that is a valid issue that is a high priority these days, it wasn’t before.

The head nurses also described the presence of consumers and family members representing the patients on planning committees in the hospital as valuable to the deinstitutionalization process. Advocacy from family members and patients allowed the patients more involvement in deciding their own care. In addition health care providers have become more accountable for their actions to family members and patients.

H/N: It also involves the families and in my two teams I’ve got consumers. The families are able to give input as to what they see as lacking. It involves consumers, who are better able to say what they need as the person who had the experience. It gives the consumers a form of independence to say my word means something, what I say is valued.

In summary the deinstitutionalization of the chronically mentally ill from this hospital is the result of a mandate from the provincial government to reduce the patient population from nine hundred to three hundred within the next few years. Contributing to this process is the mental health act which facilitates informal patients to discharge themselves without follow-up plans for treatment. That also applies to
patients discharged through the review panel and unauthorized absence. In addition consumer advocacy and patient rights give the patients more voice in their treatment which contributed to an acceleration of the deinstitutionalization process.

**Impact on the Individual**

The effects of deinstitutionalization on the individual described by the head nurses include: stigma, homelessness, revolving door syndrome and quality of life.

**Stigma**

Three of the head nurses felt that the patients are stigmatized in the community as patients were not allowed to reside in some neighbourhoods.

H/N: Then suddenly there is a mini boarding house put up next to them and that's when you see people picketing about this kind of stuff, "not my backyard; Oh yes, they've to go back to the community but don't put them next to me."

The community does not understand the nature of the patient's illness. Hence, behaviours which might have been appropriate for the patient, could be misinterpreted in a negative way by the community.

H/N: Yes. There is an idea or feeling that patients are violent, so if they are assertive and it's not appropriate this can be scary to people. It can be misconstrued as anger instead of assertiveness. Patients are not always able to express their
assertiveness in the way we would like them to do. In the community that would create anxiety. They wouldn’t know that it is part of the illness.

The head nurses also felt that the patients often lacked self esteem in the community more so if they were unable to work or to participate in activities.

H/N: I think the patients need a sense of purpose, where they can train and also work to enhance their welfare or handicap pension and they should be allowed to earn more than what they are making right now. So it will give them increased self esteem. Along with job training, make some jobs available and that will help patients remain in the community.

H/N: Most normal people have jobs or they go to school to develop skills. These things are needed in order for them to live normally.

Homelessness

All the head nurses identified homelessness as an effect of the deinstitutionalization of the chronically mentally ill. Patients were generally poor, unemployed and could not pay for reasonable housing. Also some patients were not accepted in affordable boarding homes because of their "reputation" or they did not like to live in boarding homes. In addition
there is a shortage of living accommodation for those patients in the community.

H/N: We see people sleeping in doorways and in cardboard boxes. We watch T.V or we walk down to Vancouver now and you see people whose needs are not being met.

H/N: We also see more and more sick people out there on the street.

H/N: Yes. It seems more and more patients are out there now because of this process. Actually the biggest thing for them is housing. They have no place to stay, so they end up in skid row and even on the streets.

Revolving Door Syndrome

All the head nurses stated "the revolving door syndrome" is a result of deinstitutionalization. Non-compliance with medications and follow-up care result in exacerbation of illness thus requiring rehospitalization. The chronicity of patient illnesses also adds to the revolving door syndrome.

H/N: As you know we see the same thing - stop taking medication - I'm feeling good, I'm alright now, I won't take my medications anymore. They decompensate quickly and back they come.

H/N: Some of them may have gone through the revolving door syndrome many times.

H/N: That's been proven over and over again because we have what we call the revolving door syndrome.
H/N: We end up with the revolving door, they go out and come back and still don't have skills.

**Quality of Life**

Though deinstitutionalization has negative effects on patients, it also has positive effects for some patients. The head nurses suggested that deinstitutionalization can provide a better quality of life in "a normal environment" for patients who can "make it in the community." A better quality of life means that the patients regain "dignity", "privacy" and "independence" which they do not have in the hospital. They can be individuals and do whatever they want to do in their own time as opposed to fitting into a routine in the hospital.

H/N: I think the benefit is that it really allows them some type of individuality I really do. I think when patients are in hospital or have been hospitalized a long time a lot of their independence is taken away.

H/N: Benefits - a normal environment and hopefully the patients will progress to independent living. There is more self esteem and personal growth.

H/N: Deinstitutionalization brings about a better quality of life for the patient. It is nice that they can say "I want to watch hockey tonight instead of someone else tuning on a program
and everyone watches it. Individuality is one of the greatest benefits of deinstitutionalization.

H/N: Getting back into their own communities where they will be not only among families but also among their friends whom they grew up with.

In summary, the effects of deinstitutionalization of the chronically mentally ill has negative and positive effects. The negative effects described by the head nurses are stigma contributed, for example, by chronicity and lack of understanding of the illness. Homelessness associated with poverty and lack of adequate affordable housing is also a negative effect. Non-compliance with medication and treatment plan contributes to the revolving door syndrome. However, improved quality of life was described as a positive effect of deinstitutionalization. Living in the community gave the patients independence, individuality and personal growth.

Facilitating Factors

The head nurses described factors that can facilitate the success of deinstitutionalization of the chronically mentally ill. These factors were communication, patient preparation, education and resources/facilities. These factors facilitate deinstitutionalization both in the hospital and in the community. For example, if the resources are available within the hospital to adequately rehabilitate the patient prior to discharge and resources are in place in the community to maintain the patients present level of
functioning, then the patients chances of "making it" in the community are better.

Communication

Generally the head nurses described communication between the administrators in the hospital and themselves as an important factor in the decision-making process regarding deinstitutionalization. They feel that with their knowledge and the clinical expertise about the care of the chronically mentally ill, they can provide constructive input concerning patient needs, patient selection for discharge and resources appropriate for patient level of function to facilitate the success of deinstitutionalization. However, in past years major decisions were made affecting patient care without the head nurses input, resulting in inappropriate placements within the hospital and discharges to the community. Most times, the patients are affected if their needs cannot be adequately met. For example, if a patient requires increased nursing supervision is discharged to a facility that does not have adequate staff to provide the care necessary to maintain the patient's level of functioning, that patient will deteriorate. Eventually the patient will be rehospitalized. Therefore, according to the head nurses, decisions such as those can be avoided with better communication between the administrators and themselves.

H/N: A ward in the continuing treatment program was rather precipitously closed. This was an action that we within the
program had no input into and were not able to influence in any other way other than responding to a directive. This is the chosen area, it will close, now you must do it.

H/N: There again most of the time as a head nurse, quite often in certain programs you get the information at the last minute. I may get told the same day they are closing down the program. From experience and talking with other head nurses, most of them would have similar experiences.

Within the last year the communication in the hospital has improved "a lead in the right direction." The head nurses now have more clinical input into the downsizing process.

R: Have you got much input into what's taking place?

H/N: Not on a hospital-wide level but certainly within this ward and in this division. I've got a say in the way our division takes shape to meet the changing needs of the hospital. So from that perspective I have input.

H/N: The opportunity to give your opinion is there if you want it.

H/N: To a certain extent our voices seem to be heard now more than before. There is a change in management, pressure from the community and may be political too. So more and more head nurses are speaking their minds.
On the other hand, though they have opportunities for communication and input, the head nurses remain sceptical. They question whether their input is utilized above their level in the hospital organization in affecting the deinstitutionalization process.

H/N: I am sitting on a committee that is involved with the downsizing of the hospital. As a head nurse, I would like to think that I have some influence in helping senior management.

H/N: I am on a number of committees and if the opportunities occur I do not hesitate to give my two bits worth. Let's hope they'll listen to us. I just hope they'll listen to some common sense.

Most head nurses feel that communication between the hospital and community regarding the deinstitutionalization process has also improved in the last year. In past years the hospital and the community functioned "as separate entities." They feel it is important "to work together" to prepare the community for deinstitutionalization of the patients.

H/N: I feel strongly that the hospital and the community have to work hand in hand in communicating and planning for the same goal.

H/N: Another thing we can do as a group apart from the administrators is to get the patient groups, community resource workers, community agencies, the professionals in
here as well the consumers and their relatives to actually map out and plan the best steps. Also include the mental health teams and B.C housing.

H/N: I see communication between hospital and community happening somewhat now with the bed reduction program. But I still see a lot of territorialism.

**Patient Preparation**

All the head nurses described patient preparation to be "a vital component" in the discharge planning of the chronically mentally ill to the community. In order for the patients "to make it" "to be successful out there in the community", they must be prepared with coping skills such as daily living and socialization skills.

H/N: We are a social learning program. We have eight different modules in terms of life skills. We have personal care, stress management, anger management, social communication, medication and sexuality. If the patient goes to all the classes he should be well prepared.

H/N: Just the skills of normal everyday living for example, where to obtain things, how to get to places, being independent.

H/N: First of all, patients come into this ward and take part in basic programs like news and views, socialization type activities where they do hands on things. Patients are involved in
talking to each other, talking to staff. When they get used to that type of things, progressively we get them involved in more challenging programs such as community preparation skills programs which involve bus training, vocational information, leisure skills information and how to handle hostility both in hospital and in the community. They actually go out into the community socialization to club houses, local places of interest.

**Education**

Three head nurses described patient and community education about mental illness as an important factor in the deinstitutionalization process. For example, patients would be able to manage better if they could recognize signs and symptoms of their illness and seek help when indicated. The community might be able to support the patients by accepting them if they were knowledgeable about the patients' illness.

**H/N:** I would say teach the resources, about their own symptoms, things that trigger their own decompensation, how to recognize it, know when to go to the doctor and where to go for follow-up.

**H/N:** We want to know if the patient shows some positive signs of understanding the importance of follow-up with medications, follow-up visits with the mental health centres.

Community education about mental illness is necessary for the patients to receive appropriate care in the community. However, according
to three of the head nurses, community education on mental illness is "lacking."

H/N: It is not only our job to prepare the individual patient but citizens of the community have to know about mental illness too.

H/N: In terms of public education I think that is still lacking in some areas. Most people outside don't know what kind of clients we have in here and what type of treatment we offer.

Resources and Facilities

According to all the head nurses another important factor affecting the success of deinstitutionalization of the chronically mentally ill is the lack of resources and facilities. To meet the needs of the patients, the resources should be available, prior to discharge, to prevent "the revolving door syndrome" and "patients falling through the cracks."

H/N: I think No.1 you've got to have personnel in place that have a good understanding of both institution and the community and then bridge that gap as effectively as possible.

H/N: The nursing care in hospital is much higher as we have a lot of qualified staff. Everyone knows in the boarding homes there are very few professional staff.

H/N: We know the resources are limited because we get all the reports from the social workers who visit the boarding homes.
We know the staffing is not satisfactory to fully and adequately meet the needs of the patients.

H/N: Services apart from housing would be places where discharged patients could go to meet other people, such as day hospitals, clubhouses, drop-in centres, sheltered workshops, programs on job training, jobs for discharged patients and other various support services, increased staffing levels in the community.

In summary a description of the head nurses' accounts of the impact of the facilitating factors on the deinstitutionalization process was presented. The four factors communication, patient preparation, education and resources/facilities are important and necessary to meet the needs of the chronic mentally ill following discharge from hospital to community.

Summary

The contributing factors, the impact on the individual and the facilitating factors affect the deinstitutionalization of the chronically mentally ill. One of the contributing factors for deinstitutionalization is the hospital's mandate to downsize the patient population from nine hundred to three hundred patients. The general feeling is that downsizing is a progressive step in the patients' treatment providing the process is well planned, gradual and has the patients' needs as the focus.

The mental health act contributes to the deinstitutionalization process by facilitating the quick discharge of patients. Some of those
discharges came as a result of the review panel's decision, through unauthorized absence or by patients' discharge of themselves. Unfortunately those patients follow-up care was affected. The mental health act also gave the patients more freedom to socialize outside of the institution and to become more community-oriented.

The consumer advocacy movement had improved in the hospital in recent years. For example, the patients have a patient concern committee which the administration supports. Due to consumer advocacy, the patients have direct access to an Ombudsman, an opportunity they did not previously have. Generally the patients have more rights, choices and representations regarding their treatment than they had in past years.

In the content category, the impact on the individual, stigma, homelessness and the revolving door syndrome were identified as negative effects of deinstitutionalization. The community's lack of education regarding mental illness and the patient's chronicity of illness contributed to the stigmatization of the patients. Inadequate housing, job opportunities and poverty resulted in homelessness for the chronically mentally ill in the community. In addition, the deinstitutionalization process also results in the revolving door syndrome mainly due to non-compliance with treatment.

Lastly how the facilitating factors of communication, patient preparation, education and resources/facilities affect the deinstitutionalization process was described. There had been no communication
between the administrators and the head nurses regarding downsizing in the past. Decisions were made to close wards/programs without clinical input from the head nurses. Though they recently have input to some extent, the head nurses remain sceptical about the value of their input.

Patient preparation for discharge including daily living skills, socialization and work skills are important skills for the patients to acquire to help them function in the community. Education about their illness including the importance of compliance with treatment is also necessary to increase their coping abilities in the community. In addition, community education is necessary to promote appropriate patient care and reception and tolerance.

Resources and facilities in the community were described as lacking in adequacy to provide care for the patients following deinstitutionalization. Access to facilities such as housing, drop-in centres, sheltered workshops and recreational activities were also necessary to promote the patients' well-being in the community.
CHAPTER FIVE

Discussion of Findings

The purpose of this chapter is to discuss the findings of the study in relation to the literature. Empirical data were mentioned in chapter 2 where a selection of both experientially and research-based publications were reviewed. In this chapter the discussion focuses on empirical data which either supports or refutes the specific findings of this study.

A number of studies were found on the deinstitutionalization of the chronic mentally ill. However, no research was found that focused on head nurses’ perceptions of the impact of deinstitutionalization of the chronic mentally ill. Therefore, relevant studies about deinstitutionalization of the chronic mentally ill completed by other disciplines will be used in the discussion.

In the discussion of findings the three content categories which are contributing factors, impact on the individual and facilitating factors will be presented. The themes in the contributing factors, hospital mandate to downsize, mental health act and consumer advocacy, will be described. Stigma, homelessness, revolving door syndrome and quality of life will be discussed in the impact on the individual category. Finally, themes in the content category, facilitating factors, communication, patient preparation, education and resources/facilities will be presented.
Contributing Factors

Hospital mandate to downsize

Several authors (Hayes, 1992; Lamb, 1984; Polcin, 1990; Talbot, 1988) have argued that one of the motivating factors for deinstitutionalization of the chronic mentally ill is financial cost. The findings from this study support their argument. The head nurses in this study suggested that the government believes it is cost effective to care for the chronic mentally ill in the community rather than in a large psychiatric institution.

However, the head nurses viewed deinstitutionalization as a good idea if it is "clinically driven" than "financially driven" whereby the patients would be appropriately selected and adequately prepared with the necessary coping skills to help them function in the community. This finding is consistent with Minkoff (1987) who claims that psychopharmacologic and psychosocial interventions assist the ill person to acknowledge, bear and accept his illness. Also psychosocial interventions help the patient to learn new coping behaviours and rehabilitative skills to facilitate the process of adaptation to the illness. Herman and Smith (1989) state that the deinstitutionalization movement can be effective only if more emphasis is placed on rehabilitation and reintegration rather than on cost effectiveness.

The findings from the study also indicate that some chronic mentally ill patients require "asylum" type care due to the severity of their illness and length of hospitalization. This finding is congruent with that of Talbot
(1985) and Bachrach (1984) who state that a portion of the chronic mentally ill require care in an asylum.

**Mental Health Act**

The findings from this study also suggest that the Mental Health Act (1979) has contributed to the deinstitutionalization of the chronic mentally ill. Patients admitted on an informal basis could discharge themselves at anytime against medical advice whether they are clinically improved or not. Also an involuntary patient has the right to apply to the review panel for discharge if he feels he is kept in hospital against his will. According to the head nurses some doctors are also reluctant to certify patients or to change their status to involuntary if the patients were not a danger to themselves or others. This finding is supported by some authors (French, 1987; Lamb, 1984; Roberts, 1989) who report that the different acts governing mental health in the United States of America have resulted in the depopulation of psychiatric hospitals. Committing patients to psychiatric hospitals has become a complex process. In addition it is more difficult to hold patients in psychiatric hospitals against their will.

The findings in this study show that "unplanned discharges" impact on the follow-up care and treatment the patients receive in the community. Most times the patients do not receive follow-up care as no plans are made prior to discharge. On the other hand the patients have the right to refuse treatment. This finding is congruent with Roberts (1989) who stated that
"there are some patients who cannot be subjected to compulsory care under the present laws governing certification and involuntary treatment. It has to do with the decision to allow all persons except those imminently dangerous to accept or reject services offered to them" (p. 297).

The findings also suggest that the Mental Health Act has had a positive impact on some patients. That is some patients have more freedom that enables them to go out and socialize with family and friends in the community as they desire. This finding is supported by Lamb (1984) who said "perhaps one of the brightest spots of the effects of deinstitutionalization is that the mentally ill have gained a greatly increased measure of liberty" (p. 904).

Consumer Advocacy

The findings in this study point to an improvement in consumer advocacy in the hospital as a contributing factor to deinstitutionalization. Krupa, Singer and Goering (1988) support this finding in their statement "the more involved patients are in identifying their own needs and choosing the appropriate resource, the more likely they are to be committed to discharge plans" (p. 15). The Canadian Nurses Association (1991) reports that consumers and their families want to participate, and that they have the right to participate, in the decision-making process affecting their care.
Impact on the Individual

Stigma

The study findings show that stigma affects the care of the chronically mentally ill. Several authors (Lamb, 1984; Herman & Smith, 1989; Sullivan, 1992; Talbot, 1988) point out that the mental illness is not understood by the community therefore the mentally ill are not fully accepted in the mainstream of society. Bachrach (1984) also supports this finding by stating "the chronic mentally ill are ridiculed, discriminated and stigmatized" (p. 975).

Homelessness

The findings of the study suggest that homelessness is a result of deinstitutionalization for some chronic mentally ill patients. In past years many patients were housed in psychiatric institutions whereas today many of them live on the streets, "in doorways and in cardboard boxes." This finding is supported by Aviram (1990), Talbot (1985) and Quick (1990) who point out that many chronically mentally ill patients are homeless and live on the streets. This finding is also consistent with media headlines such as "Housing for Mentally Ill Causes concern" (The Vancouver Sun, 1989).

In addition the findings from the study indicate that some patients did not like living in affordable houses such as boarding homes and family care homes because their perceived needs were not being met. Reisdorph-Ostrow (1989) reports that "these residences provide few of the necessary functional services and rely on the individual to independently navigate the
community mental health system" (p. 6).

French (1987) states that "these residences provide nothing more than a shelter" (p. 503).

**Revolving Door Syndrome**

The findings from this study also point out that the revolving door syndrome is an impact of deinstitutionalization on the chronically mentally ill. The head nurses stated that non compliance with medications and follow-up care in the community contribute to the revolving door syndrome. This finding is congruent with that of other authors (Crawford & Conacher, 1988; Holmstrom, 1989; Reisdorph-Ostrow, 1989) who report that non-compliance with medication and treatment result in regression and in the revolving door syndrome.

**Quality of Life**

Although the findings of this study identify negative effects of deinstitutionalization, positive effects are also found. Quality of life can be improved for some patients in the community given adequate preparation and support services. "Independence", "privacy" and "dignity" can be achieved in the community as opposed to a large psychiatric institution. This finding is consistent with Okin and colleagues (1993) findings which state that some chronically mentally ill patients find community living better than living in an institution. The patients in the study adapted to their new life style and found their lives improved. This current study's findings is also supported by Friedlob et al. (1986), whose study found that
patients with competence in daily living skills, vocational training and
money management had an improved quality of life in the community.
Improvements are in living environment, occupational behaviour and length
of rehospitalization.

**Facilitating Factors**

**Communication**

The findings in this study indicate that there is a lack of
communication between the head nurses and the administrators in the
hospital that could facilitate the successful implementation of
departmentalization. Head nurses can identify suitable patients for
discharge and appropriate placements in the community according to
patients needs. Their clinical input can prevent inappropriate patient
placements that lead to inappropriate care and to rehospitalization. This
finding is supported by Krupa et al. (1988) who state that "head nurses
working in psychiatric hospital settings are aware of a high rate of
recidivism among their patients" (p. 14). Parker (1986) points out that head
nurses in their professional role recognize the high cost of health care and
try to control expenses.

The findings also suggest that communication and "working
together" between hospital and the community is important to effectively
departmentalize the chronically mentally ill and to meet patients’ needs in
the community. Polcin (1990) states that "decisions were made almost
exclusively at high levels of government and mental health administrators. The experience of patients, families, communities and professionals was that something was being done by an indefinable "they" rather than an opportunity being provided for them to help create new systems that they could feel invested in and committed to" (p. 185).

Patient Preparation

The study's findings indicate patient preparation with coping skills as an essential component for living successfully in the community. Activities of daily living, vocational, socialization and money management skills are necessary for patients to function effectively in the community. This is supported by the findings of Okin et al. (1983) and Friedlob et al. (1986) that showed patient competence in these skills were more functional and adaptive in the community.

Education

The findings also reveal patient and community education about mental illness as an important factor in the deinstitutionalization process. This finding is consistent with other authors (Herman & Smith, 1989; Jimenez, 1988; Runyan & Faria, 1992) who state that patient empowerment about their illness and community education concerning mental illness make a difference in the care of the chronic mentally ill. Polcin (1990) claims that "patients are not sufficiently acknowledged and empowered by
mental health systems to adequately understand and respond to treatment conditions offered" (p. 189).

Resources and Facilities

The findings suggest that community resources and facilities are vital components for deinstitutionalization to be successful. Many authors (Bachrach, 1984; Lamb, 1984; Quick, 1990; Runyam & Faria, 1992; Talbot, 1988) have argued that community services have not expanded and are insufficient to meet the growing demands of the chronically mentally ill population living in the community. Wolf and Fry (1990) deem lack of social support in the community is a contributing factor to joblessness and poverty experienced by the chronically mentally ill.

Summary

The findings from this study, corroborated with empirical data and other relevant professional literature have been presented. The findings of the study suggest that deinstitutionalization of the chronically mentally ill have both a negative and positive impact on the well being of this population. The findings identified stigma, homelessness and the revolving door syndrome as negative effects. Improved quality of life was deemed a positive effect of deinstitutionalization. The findings also indicate that facilitating factors such as communication, patient preparation, education, adequate resources and facilities can minimize the negative impact of deinstitutionalization.
CHAPTER SIX

Summary, Conclusions and Implications

The summary and major conclusions of the study are presented in this chapter. Implications for nursing practice, education, administration and research are suggested.

Summary

The impact of deinstitutionalization on the chronically mentally ill was elicited from the head nurses. The study explored an in-depth understanding of the head nurses perceptions of the impact of deinstitutionalization using a phenomenological method. The sample consisted of seven head nurses who had a minimum of five years experience with the deinstitutionalization process. In-depth semi-structured interviews were conducted to gather the data. Five trigger questions were used during the first interviews to begin exploration of the phenomenon under study. Further questions were asked to facilitate clarification of data during interviews. Data were analyzed using Coliauzzi's phenomenological methods as outlined by Reimen (cited in Munhall and Oiler, 1986). Coliauzzi's method stated that the transcripts be transcribed verbatim and read a few times to acquire a feeling for them. Meaning units were formulated from the significant statements of the description. Then a cluster of themes was organized from the meaning units. Next an exhaustive description of the phenomenon was produced from integration of the results of the analysis.
Major themes derived from the data were organized into three content categories which formed the framework for conceptualization of the data. The three content categories were; contributing factors, impact on the individual and facilitating factors.

From the findings of this study, it can be concluded that deinstitutionalization is a result of the hospital's mandate to downsize due to the high cost of caring for patients in large institutions. Also the mental health act has facilitated early patient discharge from hospital to the community whereby informal patients can discharge themselves whenever they wish. Discharges through the review panel also contribute to the deinstitutionalization process. Improved consumer advocacy in the hospital is another factor affecting deinstitutionalization of the chronic mentally ill patients. However the findings suggest that though the mental health act has promoted freedom and liberty for the patients, not all patients can cope with community living. Therefore, some patients will require "asylum" type of care for most of their lives.

Deinstitutionalization has some negative effects on the chronically mentally ill. Stigma has an impact on this population in different ways. Their behaviours are usually misunderstood and misinterpreted to be dangerous to society. Thus, the community shuns them. Homelessness amongst this population is another negative impact. Due to chronicity, lack of skills and job opportunities most of these patients are unemployed and
therefore cannot pay for housing. Added to that, some patients do not like living in affordable facilities such as boarding homes. Many chronically mentally ill patients experience the revolving door syndrome partly due to non compliance with medication and treatment. However, deinstitutionalization can result in improved quality of life for some patients with adequate preparation and support services.

The success of deinstitutionalization can be facilitated with improved communication between head nurses and the hospital administrators. The head nurses have the knowledge and expertise to know which patients are suitable for community living, and to suggest appropriate placements that can meet patients' needs. Their clinical input can assist in preventing patient deterioration and rehospitalization. Communication and "working together" between hospital and community can also facilitate the success of deinstitutionalization.

Patient preparation is another factor that affects the deinstitutionalization process. Patients with adequate coping behaviours and education about their illness function more effectively in the community. Also community education about mental illness promotes acceptance of the chronically mentally ill in the community. In addition, the adequacy and availability of resources and facilities in the community assist the chronically mentally ill population cope with the deinstitutionalization process.
For discussion purposes the findings of this study were compared to other research studies and relevant professional literature. The findings provide a better understanding of the impact of deinstitutionalization on the chronically mentally ill from the head nurses’ perspectives. A number of conclusions can be drawn based on the findings.

**Conclusions**

There are four main conclusions to this study.

1. Deinstitutionalization does not necessarily enhance the quality of life for all chronically mentally ill patients. Some "fall through the cracks."

2. Some chronically mentally ill patients require care in psychiatric institutions for most of their lives due to the severity of their illness.

3. Deinstitutionalization can be successful for some chronically mentally ill patients with adequate and available resources and facilities to support them in the community.

4. Head nurses have the knowledge and the expertise to effectively assist hospital administrators in the decision-making process in the deinstitutionalization of the chronically mentally ill. In this hospital, their knowledge is under utilized or not used in this process.

From the findings and the conclusions the following implications are suggested.
Implications for Nursing Practice

Deinstitutionalization of the chronically mentally ill has implications for all nurses. Nurses should provide opportunities for patients to improve their quality of life in the hospital and in the community by promoting privacy, independence and dignity. Patients should be treated as individuals with unique needs and desires. Inclusion of the patients in their treatment plans would maximise their level of functioning and improve coping skills.

Nurses should advocate for patients' quality care, including appropriate and adequate services and resources to meet their needs. Nurses in the hospital and in the community must engage in regular communication and exchange ideas of treatment and strategies to prevent patients "falling through the cracks." These patients require consistent and frequent follow-up in the community to assess mental status and continuation with recommendations for care.

The nurses may have to go to the patients' places of residence to provide nursing care as these patients may avoid mental health centres and refuse nursing care altogether. Also, due to decreased coping skills, these patients may be unable to gain access to available resources to help them function at their optimal level in the community. Nurses are placed in an important position to maintain and to promote the well being of the chronically mentally ill patients.
Head nurses have an essential role in influencing the care of the mentally ill. They should share their knowledge and skill by lobbying other health care providers within the hospital and in the community to effect changes in the care of this population.

Implications for Nursing Education

It is clear that a large segment of the population is affected by chronic mental illness. It is also clear that nurses have a significant role in the provision of care for these patients. The implication is that nurses must be educated about chronic mental illness to deliver quality care to this population.

This also includes nurses who practice in hospital and in community settings who are not caring for psychiatric patients in their regular work areas. However, they may be required to care for a chronically mentally ill patient on a surgical ward or in a doctor's office. Hence they must be able to recognize signs and symptoms of psychiatric disorders to intervene appropriately. Therefore it is important to include mental health theory and a clinical practicum in all nursing curricula from diploma to graduate programmes. It is particularly important that students and qualified nurses work with these patients in hospital and in the community settings to familiarize themselves with the problems these patients encounter in both areas.
Nurses also have a responsibility to educate the community about chronic mental illness. This can be done by talking to and by distributing literature on mental illness to patients' families and friends when they visit their loved ones. Education may alleviate hostility, reduce stigma and promote acceptance of this population in the community. Community acceptance may break down many barriers these patients face thereby improving their quality of life.

Lastly nurses have a major function to play in educating their patients about chronic mental illness. Knowledge about their illness, the ability to recognize signs and symptoms of regression and the importance of seeking early help will prevent the "revolving door syndrome" for some patients.

Implications for Nursing Administration

Deinstitutionalization of the chronically mentally ill has implications for nursing administration. Nursing administrators in hospital are in a position to make appropriate and well-informed decisions regarding the deinstitutionalization process by utilizing the head nurses knowledge and expertise in this area. Administrators must recognize that head nurses who work with the chronically mentally ill are cognizant of their patients' coping abilities and individual needs required to enable them to function in the community. To reduce financial cost in the care of this population, it it
important to administrators to consult with and include the head nurses in decisions affecting deinstitutionalization.

However, head nurses in their role as leaders, must make their voices heard to effect change in the care of the chronically mentally ill in hospital. Their participation in committees that influences the deinstitutionalization process is one way to share their knowledge and expertise. Advocating verbally and in writing on behalf of their patients is another way to have clinical input in the decision-making process.

**Implications for Nursing Research**

During the research process the investigator became aware of a number of research questions that evolved from the study findings. The sample from the current study is head nurses from a psychiatric institution. It would be interesting to repeat the study using the head nurses from psychiatric units in the general hospital. Such a study will indicate whether those head nurses' perceptions are similar to or different from this study's findings.

One study might address the same phenomenon but from the patients' perspectives, for example, what are the patients' perceptions of the impact of deinstitutionalization on their care? Data collected from the patients themselves would help to identify specific needs necessary for improvement in their care.
Another study might address the phenomenon of deinstitutionalization from the perceptions of the parents of chronic mentally ill patients. A study such as this could potentially guide nurses in helping them understand the grief, loss and stigma that the families experience. From this understanding nurses could teach parents appropriate coping behaviours to maintain their wellness.

One study could document community mental health nurses’ perceptions of the impact of deinstitutionalization on the chronically mentally ill? Since community mental health nurses are responsible for the follow-up nursing care of these patients who tend to be non-compliant with medications and follow-up care, it will be helpful to learn how they cope with these problems.

The above recommendations for further research would provide more information for nurses regarding the impact of deinstitutionalization on chronic mentally ill patients. The information will also add to the body of nursing knowledge that would direct the nursing care of this population. On the other hand, because of this apparently universal trend to deinstitutionalize, soon psychiatric hospitals will house only the very ill or those needing "asylum", and so such research will not be needed in the future.
REFERENCES


West Vancouver takes up petition against boarding home for the mentally ill. (1990, May). *Vancouver Sun*, p. 2.


World a lonely place for the mentally ill. (1990, April) Vancouver Sun.
APPENDIX A

Letter to the Agency

Date

The Vice President
Nursing Services

Dear,

I am a final year graduate student in the Master of Science in nursing program at the University of British Columbia. For my research project, I plan to study the impact of deinstitutionalization of the chronic mentally ill from head nurses' perspectives. Since your hospital is in an active down-sizing phase and the patients are being deinstitutionalized, I thought that the head nurses from your hospital would be able to assist me in my research study.

I am aware that the head nurses from the acute assessment and treatment program and from the continuing treatment programs are involved in the implementation of the deinstitutionalization process. I would appreciate it if you would give permission for me to use your hospital and eight head nurses from the above stated programs as my sample group for this research study.

The purpose of this study is to gain a deeper understanding of the impact of deinstitutionalization on the chronic mentally ill as perceived by head nurses. Although there will be no immediate or direct benefits to your hospital or head nurses, the findings may assist the administrators, policy planners and other disciplines, enhance the implementation of the deinstitutionalization process.

The head nurses face no risks from participation in this study. I will conduct a minimum of two interviews with each head nurse. To guide the interviews the same six trigger questions will be used.

The data provided will be kept confidential. I will require written consent from each head nurse stating their willingness to participate and to have the interviews tape recorded.
Should you need further clarification or information regarding this study, please feel free to phone me at home 941 - 4576 or at work 941 - 3471.

Yours Sincerely

K. Leila Sinnen
APPENDIX B

Consent Form

Date

Dear ,

Thank you for volunteering to participate in my research project entitled "Head Nurses’ Perceptions of the Impact of Deinstitutionalization on Persons with Chronic Mental Illness." I would like to inform you that you may withdraw from the project at any time without penalty. The information you provide will be shared with my thesis committee and will be kept confidential from others. The tapes will be destroyed upon completion of the study.

The purpose of the study is to gather an in-depth understanding of the impact of deinstitutionalization on the chronic mental ill from your perception. There will be no immediate benefit to you from participating, but the findings from the study may assist in improving patient care, particularly nursing care of the chronic mentally ill. The findings may also enhance implementation of the deinstitutionalization process. You face no risks in participating in this project.

I will conduct a minimum of two face to face interviews with you and return to you for data clarification as necessary. I will use five trigger questions to guide the interview. The interviews will take place in a convenient location for both of us, preferably away from your work area. Please call me for further information at 941-4576 or (Bus) 941-3471.

I consent to participate voluntarily in the project.

Signature of participant

Date
I consent to have the interviews tape recorded.

Signature of participant

Date

Yours Sincerely

K. Leila Sinnen
APPENDIX C

Trigger Questions

1. Describe your involvement with the deinstitutionalization process?

2. From your perception how does deinstitutionalization affect your patients?

3. What are the benefits of deinstitutionalization for your patients?

4. From your perception what are the shortcomings of deinstitutionalization for your patients?

5. How can you influence the deinstitutionalization process in this hospital?