AFTERCARE SERVICES FOR DISCHARGED MENTAL PATIENTS

An Initial Assessment of the Services Offered by the After Care Clinic to Patients Discharged from Riverview Hospital

by

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TABLE OF CONTENTS

Appendices:

TABLES IN THE TEXT

ABSTRACT

There has been a growing trend to discharge patients from mental hospitals after short periods of hospitalization. These discharged patients may have unresolved problems and need continuing service in the community if they are to maintain their level of social functioning. The After Care Clinic in Burnaby was formed to provide continuing service to the patient. However there is much concern about the high readmission rates to the hospital and the adequacy of the aftercare services.

The present study is a pilot study to examine the services provided by the After Care Clinic. The researchers reviewed aftercare literature and utilized hospital records. Information was obtained from questionnaires to patients, clinic staff and other agency staff. From these sources the social, work, and home needs of patients and the treatment given were examined. Opinions about the aftercare services and possible improvements were also examined in an attempt to assess the adequacy of the services provided by the After Care Clinic.

The findings showed a large number of patient needs and nominal service given. Treatment was medically oriented with brief supportive therapy. Only one person in the sample of 45 saw a social worker. The staff of the clinic and other agencies were aware of the lack of services for the discharged patient but differed in their perception of their roles and their expectations of an adequate service. The clinic staff thought that responsibility for aftercare services should be shared between hospital and community agencies. However community agencies felt that the hospital should assume responsibility. These findings indicate the present gaps in the aftercare services and the need for responsibility and leadership. It seemed apparent that it should be the role of the mental health branch to take responsibility for leadership in the development of a coordinated and comprehensive aftercare service.

Acknowledgements

We wish to convey our appreciation to the Administration of Riverview Hospital for making appropriate background information available and wish to acknowledge the consultative assistance given by the personnel of the Hospital and of the Aftercare Clinic, Burnaby, B. C.

We would like to express our most sincere appreciation to Mrs. Helga Hicks, our thesis adviser, who gave so generously of her time and knowledge and without whose invaluable help this study could not have been completed.

AFTERCARE SERVICES FOR DISCHARGED MENTAL PATIENTS

CHAPTER 1

THE DEVELOPMENT OF AFTERCARE

A. Introduction

As an introduction to Chapter 1 of this thesis, the basis for the writers' selection of topic - namely After Care Services to the mentally ill - should be made known to the reader.

1. Adequacy of Service

Firstly, the writers, two having worked in the mental health field, felt a concern over the quantity and quality of follow-up care available to patients after discharge. This problem, which had existed for many years, became even more acutely accentuated as a result of current improved treatment methods and the current practice of returning the patients rapidly to the community following remission of their symptoms. More than ever, follow-up care extending from the hospital into the community became essential in the treatment continuum if the gains made by the patient during his hospitalization were to be maintained: Hence, the After Care Clinic was established for the purpose of sustaining discharged mental patients in the community. As stated, the writers felt the adequacy of this service might profitably be assessed particularly in view of some of the more evident problems, for example, high re-admission

rates, procedure, policy and staffing, and co-ordination with community resources, to name a few.

2. Research Problem

Therefore, in this study, the intent of the writers will be to obtain the judgements of those patients, members of staff, and community agencies acquainted with the After Care Clinic on the ways in which the program meets and/or fails to meet the needs of mental patients discharged from the Riverview Hospital.

To conclude this introduction, the writers, in electing to utilize the After Care Clinic, Burnaby, B. C. for this study, were hopeful their explorations might reflect certain problem areas which would merit further research and lead eventually to an improved service. The Hospital Administration have shown considerable awareness of the problem and this awareness certainly is reflected by their willingness to allow the writers free scope to examine the various aspects of the dilemma. The writers will, at this point, move into the main body of Chapter 1 which is concerned with the background and development of After Care Clinics in North America with specific reference to the After Care Clinic in Burnaby.

B. General Background of Aftercare Development

1. Changing Concepts of Mental Illness

As a beginning the writers invite the reader to take a brief look at the changing concept of mental illness. In

order to do so, one should know how the medieval concept sought to comprehend the mentally ill person in terms of being "possessed by the devil". The problem was viewed as a religious rather than medical one. Prayers or exorcisms to expel the devil were the universal means of dealing with the personal fear which mental illness generated in the sane populace. At a somewhat later point the medieval concept altered - mental derangement then was considered the result of "sin". The "sinner" was "locked up" until such time as remission of his symptoms might occur. At this point his "punishment" being over he was released to face the opprobrium of the community.

While traces of the medieval concepts still exist down to the present in state hospitals and community alike, certainly, care of the mentally ill has gradually improved with the growth in understanding of mental illness. As long as "cure" was regarded as a matter of chance, however, a sense of hopelessness in the area of mental illness prevailed. The break through the veil of pessimism cloaking mental illness occurred with the advent of the "wonder" drugs.

2. Advent of "Wonder" Drugs

Chance discovery of the tranquilizing effect of these drugs, originally developed for the treatment of tuberculosis, created the basis for a more optimistic outlook in the mental health field. The tranquillizing drugs, along with other forms of treatment, for example, electro-convulsive

therapy and coma insulin, were highly effective in control of the gross symptoms of mental illness. Also, awareness sharpened to the fact that, underlying mental illness were poor interpersonal relationships, that confinement in a mental hospital apart from the illness itself was socially crippling, and, that the expectations of persons in the community, i.e. of family, and social groups were consequential in the restorative process.

3. Changing Role of Mental Hospitals

In the past it had been the role of mental hospitals to protect the community from the mentally ill. Now, with the emergence of new and more optomistic concepts concerning the nature of mental illness and its treatment, a shift occurred in the attitudes of state hospital administrators and practitioners alike, away from the traditional custodial orientation. To clarify, the former "psyche" oriented approach yielded to a "socially" oriented approach; the traditional custodial function of the mental hospital gave way to short term treatment function. Patients received brief intensive treatment utilizing drug or electro-convulsive therapy. Following remission of symptoms, they were quickly returned to the community. Unfortunately over half of the patients discharged to the community just as quickly succumbed to the stress of adjustment, and, failing to maintain the gains made during hospitalization soon relapsed and were rehospitalized.

4. Need for Follow-up

The need for follow-up service to discharged patients as an extension of hospital treatment into the community had become glaringly apparent. It was on the basis of this need that the concept of aftercare programs took shape.

The reader here should not have to stretch his imagination to envisage some of the problems, both old and new which were exacerbated and created respectively by the extension of the hospital treatment into the community in the form of After Care Clinics for the follow-up of discharged patients. The reader has only to remember the traditional hiatus between the Mental Hospital and the community to gain some idea of the magnitude of the problem of providing a co-ordinated, integrated, and continuing service to the discharged patient in this community. Thus, with the establishment of aftercare programs many immediate problems loomed up necessitating decisions on the part of administration concerning the coverage and quality of service, the type of patients for referral, the eligibility for service, the maximum length of service offered, the disciplines to be involved in programs, and the serious problem of staffing, in view of shortage of trained professionals. Also, many long range problems involving the expansion of the service, co-ordination, and consultation with other community agencies, development of various resources to meet diverse patient needs, and determination of areas of responsibility - these problems, too, required attention.

Many of the problem areas which have been briefly mentioned here will be examined later in relation to the writers' study of the present After Care Clinic in Burnaby. At this point, the writers wish to direct the reader's attention to the general historical development of aftercare programs on this continent, and to the specific development of the After Care Clinic with which this study is involved.

C. Historical Background of Aftercare

1. Beginning Development in U.S.A.

The historical background of aftercare in North America began in 1873 when under the Charities Act Association in the State of New York the first aftercare program was organized on a lay basis. In 1908, the Committee on Aftercare of the Insane became the Committee on Prevention and Aftercare, and thereafter was concerned with the rehabilitation of mental patients. In 1910 the name was changed to the Committee of Mental Hygiene of the State Charities Association and since has continued to be, "a Committee of a Citizen's Organization concerned with the development of resources for the treatment of any person in the state who is in need of care for a mental or emotional handicap".[1] The significance of this statement lies in the fact that the value and desirability of citizen participation is recognized and an organization is set up and

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1. Gamble, J.E. "The After Department, Ontario Hospital, London," Excerpt from The Social Worker, June, 1951.

authorized by the state to promote public understanding, education, and interest in the mental hospital and its programme, and in the mental health of the community.

In the opinion of the writers, the approach taken by the Committee of Mental Hygiene of the State Charities Association clearly gives recognition to the role of the community in the rehabilitation of the discharged mental patient. It corroborates the feeling of these writers and others that After Care Clinics cannot begin to operate effectively in isolation but must be co-ordinated with other social resources within the community. Certainly, the expressed goals of the Committee of Mental Hygiene of the State Charities Association were very commendable. The writers believe more promotion and education in the field of mental health is essential if public understanding and the development of suitable rehabilitative resources within the community are our ultimate goals.

2. After Care and Social Service

The development of this interest has led to "After Care" and Social Service becoming an integral part of the treatment programs of hospitals in the United States and, to a lesser extent, in Canada. The fact that most of the early follow-up work with discharged patients was done by the mental hospital social workers whose competence lay in the area of the family and community, would explain the natural affinity between the Social Service and After Care development. In short, we would naturally expect Social Service to have a major role in the program of aftercare. It will be of inter-

est to the reader to study the findings of this thesis in regard to this one aspect of Social Service role in the program. Certainly, if nothing else, it does verify that aftercare programs differ widely as to their organization and objectives and are dependent on such factors as staffing, funds, geographical location, and the degree of current enlightenment on the part of both hospital and community. The writers wish at this point to continue their review of the historical background. This review will include some comments regarding the aftercare situation prior to 1950, the period of increasing aftercare development from 1950 on with emphasis on the Canadian scene, concluding the section with an account of aftercare development in this particular area of Vancouver.

3. Prior to 1950

Prior to World War II, if the reader were to peruse the literature, he would find little evidence of interest in psychiatric rehabilitation. In Mental Hospitals generally, practitioners---this applied not only to the medical staff but to the social workers as well who, by training, were "socially" oriented---were too involved with the in-hospital "team" approach to be active outside. Among the earliest efforts perhaps were the solitary attempts made within the individual State or Provincial Mental Hospital in the late 1930's and during the 1940's to activate patients who were becoming withdrawn. Rehabilitation

programs, prior to his, were largely designed for the physically handicapped.

In psychiatry, it was the problem of the schizophrenics, who comprised half of the hospital population, that had long provided a real challenge especially in terms of rehabilitation. It was the difficulty in normal communication and the resulting impoverishment in social relationship that often, over the years, had taxed the mind and imagination of the professional in working with the schizophrenic. Early rehabilitation programs were directed to assisting the chronic patients move out of hospital and back into the community. Primarily, they were attempts to provide the quieter schizophrenic patient who no longer required to be hospitalized with a more pleasant environment and to reduce the pressure of overcrowded wards. They involved a process of re-education in appropriate behavior which in many instances began within the Mental Hospital itself.

4. Family and Foster Care Programs

Thus evolved the program known as "Family" Care. In effect, this program consisted of placing suitable mental patients in selected private homes in the community. Foster home care of the mentally ill received its impetus in the early 1930's, mainly through the efforts of Hester B. Crutcher, director of Psychiatric Social Services for the New York State Department of Mental Hygiene. Owing largely to her activity, New York finally ruled in 1935 that selected mental

patients could be placed in private homes. At a later date, other sections of the United States and Canada followed suit in the development of foster home care programs.

5. The Nature of Aftercare

Before the writers proceed to describe generally aftercare developments of the 1950's in Canada, and specifically, the developments of the After Care Clinic in Burnaby, British Columbia, they wish to formulate for the reader a perspective on the nature of aftercare gleaned from some of the written articles on the subject.

> "Aftercare is defined as a program designed to maintain or strengthen the improvement attained by a patient during his hospital treatment and to increase his likelihood of making a good adjustment to community living."[1]

At this point, the writers would like to state, that, in surveying in the literature a number of aftercare programs in various parts of the country, they believe that, by and large, aftercare is a service in name only. So much in the literature emphasizes the inadequacy of the service. A marked lag in aftercare development is evident and reasons to explain this lag are manifold. Prominent among them are the lack of adequate funds and the staff shortages; the inadequacy of health and welfare agencies and their anxiety in coping with ex-mental patients; the absence of an educated community; the stigma which is imposed by mental illness; the complexity of

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1. Stokes, A.B. "The Provision for Appropriate Aftercare: Hospital and Community Collaboration." Excerpt from Mental Hospitals, February, 1961.

the illnesses themselves; the size of the problem in terms of the number of patients affected; the patients own desire following discharge to 'shake the dust of the hospital off their feet'; and finally, the patients own anxiety regarding the attitude of the community.

Schwartz and Schwartz speaking of the development of aftercare have described aftercare as a "'nominal' service rendered in compliance with the law or the policy attending the release of patients from State Mental Hospitals and observe that for the majority of patients there is little or none of it."[1] Also they state, "that old assumptions and practices are now widely questioned, and programs are being specifically designed for particular types of ex-patients. The old and new exist side by side so that aftercare is a patchwork quilt of old ideas and new theories, with experimental programs implementing both."[2]

The writers will have to agree with the above commentary on general aftercare development as it exists at the present time. Certainly a wide variation in aftercare programs does occur but most of the programs appear to have in common a very primitive stage of development particularly in regard to any comprehensive and co-ordinated community-involved approach. Without a doubt, a dilemma does exist for hospital administration. Improved treatment methods have

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1. Schwartz, Morris S. and Charlotte Green. Social Approaches to Mental Patient Care, Columbia University Press, New York and London, 1964.

2. Ibid.

meant a greater turnover of the patient population, hence a greater need for beds. From the viewpoint of beds therefor, as well as the matter of much higher costs for in-hospital care, administration undoubtedly has the greatest interest in returning patients to the community. From the point of view of the patients interests however, the writers question the current policy of returning the patient to the community on the grounds that in many cases it is neither to the patient's, nor to the community's benefit. What is gained for example, in moving a chronic type patient from the secure, and often more stimulating environment of the Mental Hospital and placing him in the static 'vegetative' atmosphere of a commercial boarding home in the community.

Well, the reader will have ample opportunity to question the remarks, later conclusions, and recommendations made in this study and hopefully it will stimulate him to draw a few conclusions of his own. Meanwhile, the writers will move on to the final section of this, the first Chapter, in which we wish to cover briefly the situation of Canadian and Vancouver aftercare development.

6. Post Discharge Programs Across Canada

In Canada as elsewhere, the situation pertaining to the development of Aftercare services really only gathered momentum in the late 1950's and early 1960's. This holds true for all of the Provinces. A report published by the Mental Health Division, Ottawa, in 1960 indicates that all of the

post-discharge programs then established, operated as out-patient departments of Provincial Mental Hospitals and/or General Hospitals and that post-care programs were still very much in the experimental phase. In conjunction with the out-patient departments all of the provinces sponsored travelling mental health clinics. Day hospitals or day care centres had been established in a number of the Provinces at this time, notably in Ontario with three Provincial sponsored day care centres and three non-provincial sponsored centres; Montreal, with four day care centres, Newfoundland with one day hospital, and British Columbia with one day hospital. Night hospitals were to be found only in the Montreal area where two were operating on a time-limit basis.

As one might expect, it is in the larger centres where, because of the numbers of patients alone, more organization of service is to be found, together with more diversity of service and also special services, for example the forensic clinic, designed to meet a diversity of patient needs. As yet, however, nowhere in Canada can any real claim be made to a total aftercare program co-ordinated with community. For the most part, each Province is operating a fragmentary program. For instance, there are the developed foster care programs in Manitoba and in Saskatchewan, or the programs to make more effective use of public health field staff in Nova Scotia, to name two. The aftercare situation in Canada does indeed present the picture of a patchwork quilt with many problems in

way of getting the pieces seamed together.

To conclude this section, preparatory to examining the local scene in aftercare development, the writers do wish to say that, historically, early recognition of the integral part of aftercare in the treatment program prompted Dr. George H. Stevenson, former Medical Superintendent of the Ontario Hospital in London, Ontario, to create a department in the early 1950's known as the Aftercare Department, to operate as a function of the hospital and aimed at offering patients every facility for treatment. In the program, recognition of the basic contribution of Social Work, because of its "social" orientation, to the field of aftercare and rehabilitation, assured social workers an active role in the program. The writers have but one comment to make, namely this, if social workers don't have a basic contribution to make in the field of aftercare and rehabilitation, who, then does?

D. Development of Aftercare in British Columbia

1. Problems of Follow-up

In discussing the development of aftercare in British Columbia and in the Greater Vancouver area, the writers wish at the beginning to state that British Columbia, like other places, had innumerable problems in relation to the post-discharge care of mental patients. Firstly, virtually little follow-up care could be made available to patients discharged from the Provincial Mental Hospital and Crease Clinic. What minimal follow-up there was, mainly fell to the Social

Service Department within the hospital to provide. Secondly, where before 1950, social workers employed on a full-time basis in the Mental Health Services, had been utilized somewhat more extensively in follow-up care in the community and were in closer contact with the family doctor, the public health nurse, and the families of discharged patients, in the years that followed 1950, the "team" approach became the therapy unit of operation. As members of the team, social workers attached to the Mental Health field were withdrawn from community follow-up service to work full time on the in-hospital based program. The result of this, of course, was that from 1950 on there was even less follow-up care available to discharged patients. Thirdly, the Social Welfare Branch, the City Social Service Department, and other community social agencies had never happily nor effectively assumed much of a role in providing follow-up care to discharged mental patients and as a matter of fact, felt quite inadequate to do so.

2. Division of Responsibility

This was the situation in British Columbia when Miss A. K. Carroll first took office as the Provincial Supervisor of Psychiatric Social Work in 1951. It was her early and continuing efforts in the Mental Health Service Division to ignite the spark that weighs more than any other single factor in the later development of the After Care Clinic in the 1950's. Throughout the 1950's however, let it be stated,

that a serious struggle was being waged in the area of follow-up care. Heavily banded together on one side were the Social Welfare Branches, The City Social Service Department, and other community social agencies, increasing the pressure of their demands for clarification in the matter of responsibility for follow-up services to patients discharged from the Provincial Mental Hospital and Crease Clinic. On the other side was the Provincial Mental Hospital. In between in the struggle was the Social Service Department of the hospital trying to cope with the frustrations of planning for discharged patients in the face of increasing difficulties in dealing with the Social Welfare Branch and the Municipal Agencies.

By 1957, the situation concerning follow-up and the rehabilitative needs of discharged patients had reached the point where it could no longer be ignored. In a memo to the Superintendent, re: After care needs of patient's discharged from Provincial Mental Hospital and Crease Clinic, Miss Carroll reiterated that "a top level administrative meeting was needed for the purpose of clarifying responsibilities, functions and services related to the aftercare and rehabilitation of patients discharged from the Institutions of the Mental Health Services. It is my opinion that such interdepartmental exploration of responsibilities and the formation of policy regarding these responsibilities can no longer be postponed."[1]

Some of the situations referred to as being in need of clarification at that time concerned residence requirements and the objections on the part of at least one Social

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1. Hospital Memo, May 8, 1957.

Assistance Administrator in an area handling fifty percent of the patients discharged to administering social assistance to individuals whose residence was not that of the City of Vancouver. Another problem concerned the needs of the aged patient for nursing and boarding home care, who was unable to meet the prohibitive cost of such service which the municipality was unable to subsidize.

The other main area for delineation of responsibility concerned itself with adequacy of support and supervision of patients discharged to the community but still carrying psychiatric residuals. The Director of Welfare and Social Service Administrators expressed concern regarding patients who were unable to manage their own affairs and who were discharged from the hospital without adequate planning or follow-up service.

3. Proposal for Districting

It was at this time that Social Welfare Administrators put forth the suggestion that psychiatric social workers from the Provincial Mental Health Services be appointed to work in the local Social Welfare Branch district offices in those areas of highest patient incidence. The purpose of this proposed plan was to supervise patients with psychiatric residual and co-ordinate with both health and welfare services in the provision of pre-admission and aftercare services to patients and their families, not only in relation to the mentally ill, but to the mentally retarded as well.

Again it was through the efforts of Miss Carroll, who met with local Welfare Administrators, that initial exploration and formulation was undertaken for implementation of the foregoing proposal re: districting of psychiatric social workers from the Mental Health Service in Social Welfare Offices on a part-time basis to supervise and follow-up the more complicated and difficult cases. While the Provincial Government probably did see the need at this point for such a plan, there were no funds forthcoming to finance the four additional social workers required to carry it out.

4. First Attempted Aftercare Program

In the following year of 1959, a not too successful attempt was made to put the in-hospital ward-oriented social worker back into the community with the aim in mind of providing more and better follow-up care to patients in the community. An old house was purchased for the experiment in a section of Vancouver where it was hoped patients could come for more active follow-up service with scheduled office and home visits, collateral consultation, and development of resources. While some good work was done in the area of boarding homes, and in the area of communication with the general practitioners, public health nurses, and community agencies, a number of factors mitigated against the success of this first aftercare venture. Among these were the location of the premises itself which tended to lie away from the main hub of population in Vancouver; the ineffectiveness

of one centralized spot for all of the Vancouver area as compared with the more desirable arrangement of various units located, for example, as are the Public Health Units, in a number of different districts; the 'team' approach which involved the hospital social worker in ward activity rather than community service; and lastly, despite the trend towards extension of the hospital into the community, the prevailing feeling on the part of the hospital medical staff that their responsibility was to treat the patient when he first came into hospital and that, once the patient was discharged, responsibility became properly that of the community.

In essence, the improved treatment methods which greatly shortened the in-hospital phase, made it increasingly difficult to draw a sharp line of distinction between what was a psychiatric problem and what, a social problem. More than ever, the need for extending treatment as a continuum from hospital to community became apparent. When the first Mental Health Centre opened in 1955, it was hoped that the Adult Clinic could be utilized as an After Care Centre for patients from the Provincial Mental Hospital and Crease Clinic, but as the years rolled by up to 1961, it became evident that the Mental Health Centre viewed their role as something quite different. Theirs was to be a few case-intensive therapy approach.

5. Establishment of After Care Clinic

So it was, that on December 4, 1961, The After Care

Clinic of the Provincial Mental Hospital and Crease Clinic was opened for the purpose of giving a follow-up service to ex-patients of the hospital who were living in the community.

6. General Policy

The general goal of the unit was simply, to maintain patients out of hospital and in the community functioning up to their capabilities. This would suggest a fairly extensive service but like many general statements that are not spelled out much is left to the imagination of the reader. The expectations of the aftercare project, however, were spelled out as follows:

(a) Admissions to the After Care Unit will likely be upwards of five hundred patients per year.
(b) Shortening of in-patient hospitalization.
(c) A decrease in in-patient re-admission rates for the Crease Clinic and Provincial Mental Hospital.
(d) A reduction of social tensions of patients in the community.
(e) Better adjustment of patients in the community socially, economically and occupationally.[1]

Results of aftercare in other areas of the country showed:

(a) Reduction of re-admission rates by one-half.
(b) Reduction of duration of hospital stay after re-admission.

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1. Hospital Memo, December, 1960.

(c) The cost of aftercare is approximately one tenth that of in-patient services.[1]

The decision to establish an After Care Clinic for provision of follow-up care to the mentally ill, as aforementioned in an earlier section on general aftercare development, can be traced to a change in attitude of a therapeutically hopeful sort on the part of the professional staff within the hospital. The growth in emphasis on community care for the mentally ill, plus the awareness of the harmful effects of prolonged institutional care, were strong factors as well in the decision. Also, within the community itself, a more enlightened public and professional opinion towards the establishment of such a service added pressure from outside of the hospital. Additionally, there were concrete factors such as the demand for hospital beds occassioned partly by the lessening of stigma and fear of hospitalization owing to better community understanding of mental illness, partly, to shortened hospitalizations, and partly, to the high admission and re-admission rate for patients discharged to the community, many of whom were still carrying considerable psychiatric residual. Activation of long term patients and subsequent discharge of these patients to community augmented the need in the area for community care. Finally, a remaining factor was the knowledge that between seventy and eighty per cent of the discharged patients lived in areas

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1. Ibid.

that were accessible to the After Care Clinic, and that of this group of patients, at least one in four requiring follow-up care would not receive service from other professional facilities.

The procedure of the After Care Clinic evolved in what seemed a functionally practical service operation. The staff comprised one full time senior psychiatrist with direct responsibility to the Hospital Clinical Director, and one full time social worker. This team together with a nurse attached to the Clinic, handled the main operation of After Care. Additional visiting teams of resident doctors and social workers from the hospital provided a visiting service on a half day per week basis and had responsibility for ex-patients discharged from their particular hospital area.

In the basic policy statement, two services available in the aftercare program were delineated as follows:

(a) A sustaining minimal type service with provision of drugs which would also offer limited consultative advice to other professional groups caring for discharged patients.

(b) A more intensive service providing "supportive" individual, group psychotherapy, social activities, etcetra, would be provided by the Mental Health Centre, Burnaby.[1]

It is not the purpose of this thesis to examine minutely the organizational problems of the After Care Clinic. Such

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1. Hospital Memo, December, 1960.

problems as staff or line administration, involvement of staff in the aftercare program, resignations of staff, summer relief, adequate facilities, --- all were present in the aftercare program development. Suffice to say that the After Care Clinic which commenced operations December 1961, operated out of a two storey house located in proximity to downtown Vancouver, was compelled within two years to relocate because of the rapid increase in the aftercare patient group whose numbers from April 1962 to March 1963, had jumped from four hundred and six to eight hundred and fourteen. As a measure of expediency to offset the overcrowding, office space for continued operation of the After Care Clinic was rented from the Burnaby Mental Health Centre and operations moved into the new quarters in April of 1964. Despite the somewhat inaccessible location for many patients, aftercare operations up to and including the period in which this thesis study is being done, have remained as described in regard to location, facilities, staffing, policy, procedure, and general goal. It should be mentioned in conclusion, that a sincere effort on the part of the Deputy Director of Mental Health Services towards co-ordinating the After Care Clinic with the Vancouver General Hospital, the other main community psychiatric resource, was not fruitful--but does reflect the impasse and insurmountable problems that at the moment exist in terms of extending and co-ordinating the aftercare service with other city health and welfare services.

This concludes Chapter I of this Thesis. In this chapter, the writers have attempted to describe the main trends in general aftercare development, with specific reference to the development of the After Care Clinic, Burnaby. Chapter II of the Thesis will concern itself with a review of the literature on aftercare.

CHAPTER 2

REVIEW OF LITERATURE

A. Introduction

Whenever a problem is taken under study it is desirable to examine experience elsewhere. The question of providing adequate aftercare services is not unique to British Columbia by any means. The problem is world wide. In Canada each year, approximately 37,000 persons are discharged from mental hospitals. Many are able to maintain their improvement outside the hospital but a large percentage relapse and must be rehospitalized. Experience has shown that if a patient is to continue any therapeutic gains made during his hospitalization, he must be provided with a continuity of services, extending from the hospital into the community.

The trend of the quick return of the patient to the community has been established for some years now and many problems have emerged. However, follow-up studies are still relatively scarce in psychiatric literature. Besides the usual difficulties involved in obtaining the actual data, there are further difficulties created by the complexity of interpersonal relationships, environmental changes, the association of time and mental state. Also, when the group of patients involved covers a wide extreme of ages and diagnostic categories, this, in turn, makes comparable statistics

from one group of patients to another sub-group of questionable validity.

However, there are three available studies that are appropriate for our purposes:-

1. Five State Study[1]
2. Minnesota Follow-up Study[2]
3. Mental Health Survey of Los Angeles County[3]

The first two studies were conceived to attempt to evaluate the effectiveness of various aftercare programs, and the conclusions of these studies are of significance to us in our study. The third, the Los Angeles County Study, while primarily an inventory of the mental health resources of that County and suggestions for future planning, contains one section extremely valuable for this present study, namely, the area of unmet needs of former patients of mental hospitals.

Due to limitations of time and information available for making an intensive review, the writers restricted themselves to offering a brief appraisal of the salient findings of the three above-noted studies and any summarized findings by authorities of aftercare programs that are appropriate to this thesis.

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1. Free, Spencer M. and Dodd, David F. Aftercare for Discharged Mental Patients. Philadelphia, Smith Kline & French Laboratories, 1961.

2. Minnesota Department of Public Welfare. Minnesota Follow-Up Study: Final Report. Nov. 1961.

3. California Department of Mental Hygiene. Mental Health Survey of Los Angeles County, Los Angeles, California, 1960.

B. Five State Study and Minnesota Follow-Up Study

1. Purpose and Characteristics of the Studies

In 1959, five states decided to participate in a co-operative study of intensive follow-up care, or "aftercare", of discharged mental patients, to determine whether it is medically and economically sound. The study, involving more than 600 patients, was conducted in Colorado, Kentucky, Michigan, Pennsylvania and Virginia. In May 1960 the participants were able to discuss their findings.

There were considerable dissimilarities both of a geographical and organizational nature in the aftercare programs of the five states. It is interesting to look at these differences to see how different programs evolve when different circumstances prevail and different facilities exist.

In Colorado the study was conducted in a General Hospital with patients coming from the state mental hospital 110 miles away. The program, set up by the psychiatric service of the City and County of Denver, operated independently of the state hospital. It included a sizable number of alcoholics, a group of patients excluded from studies in the other four states.

In Pennsylvania, the study was conducted in the psychiatric unit of a large urban general hospital. The inpatients of this unit were given short term intensive therapy and most admissions were voluntary. Aftercare included home visits and represented close follow-up outpatient treatment

of patients who had been in the hospital.

Kentucky, whose program encompassed a rural population, utilized travelling clinics and the patients travelled 40-50 miles for treatment. A community aftercare program had been initiated at a state hospital in 1957 whereby a travelling psychiatric team held monthly clinics in the rural counties. The study program was integrated with this program.

Michigan, with its state hospital located 45 miles from Detroit, served the metropolitan area of this city. No aftercare program had existed prior to the study. The program was set up on the basis of a monthly visit by the patient to the out-patient clinic at the state hospital.

In Virginia, a well-organized aftercare program was already functioning in community clinics operated by the state hospital. A state hospital team paid weekly visits to the clinics and the study program was incorporated into the existing program.

The second study being examined, The Minnesota Follow-Up Study, was carried out by professional personnel of a state mental hospital from November 1958 through January 1960. The findings were presented at conferences in August 1960 and March 1961. The study, concerning 205 former psychiatric patients, was conceived to determine whether certain factors would significantly affect the quality and duration of a patient's post-discharge adjustment. Such factors considered were:

1. a period of special planning for the patient's discharge begun at the time of his admission.

2. intensive effort directed at mobilizing existing community treatment, counselling, casework, recreational, job placement and other rehabilitation facilities for use by the released mental patient.

3. pre-discharge planning in combination with the mobilization of existing community rehabilitation services.

The "extra" pre-discharge planning and aftercare were to be provided by interdisciplinary teams located in the state hospital and in the community. A second purpose of the Follow-Up Study was to attempt to determine some of the factors that could be shown to be related to the post-hospital adjustment of the state hospital patients.

Approximately two-thirds of the sample of 205 patients lived in urban areas, the rest in rural communities and on isolated farms.

Both the Five State Study and the Minnesota Study involved two groups of patients, a "control" group and an aftercare group of similar patients who actively participated in a program set up to more nearly exemplify each state's version of ideal care for discharged patients. The former lasted ten months and the latter, with three community follow-up interviews, extended over a period of approximately six months.

2. Findings

(a) Use of Drugs in Aftercare

Since tranquilizing drugs first made their impact in the treatment of the mentally ill in the 1950's, there has

been controversy as to their importance in helping the patient maintain his adjustment outside of the hospital. Both the Five State Study and Minnesota Follow-Up Study contain expressions of opinions concerning the importance of psychopharmaceuticals in aftercare services. The Five State Study came to the conclusion that, on the one hand patients who continue to take drugs while out of the hospital are more apt to maintain their improvement than those who do not but that, on the other hand, twice as many patients in the study group, regardless of taking drugs or not, were able to maintain adjustment outside of the hospital. In their opinion, therefore, although drugs are important in the rehabilitation of the mentally ill, the social, therapeutic support provided by psychiatrists and social service workers is much more effective than drugs alone. In the Minnesota Study, no conclusive evidence could be found that patients remaining on a tranquilizing drug regime did any "better" than patients who did not take drugs; there was no significant difference in the rehospitalization rate, nor was there any significant difference in their functioning in the community. The researchers came to the tentative conclusion that tranquilizers might "help" the patient in the hospital, speed his discharge, but that after discharge, psychological and societal rehabilitation apparently play a more significant role than purely medical rehabilitation in his recovery.

(b) Relative Costs of Hospital Care and Aftercare

One very important aspect of any program, particularly one under Government auspices, and even more so in the mental health field which more often than not has low priority regarding services and facilities, is cost. The low cost of aftercare services as compared to hospitalization is one of the most significant features about it. Although no figures were available from the Minnesota study, we might assume that the ones from the Five State Study with their extremely wide variety of services and facilities are typical. The participating states of the Five State Study concluded that cost of aftercare services for discharged mental patients was about one-tenth of the hospital rates.

Such figures do not take into account the savings to the state by individuals remaining economically self-sufficient rather than being hospitalized. Also there are the gains in human dignity to the individual who is able to remain self-supporting.

(c) Problems Encountered.

Various problems arose in the different types of aftercare programs.

In Colorado, the psychiatric service of the General Hospital where the aftercare program was conducted found that the lack of sufficient data sent from the State Mental Hospital hampered their ability to plan intelligently for the patients. It was difficult to contact some of the

patients who had moved from the addresses given by the hospital. Further, there were some problems in working with the local agencies in that the latter did not have sufficient knowledge of mental illness. Although Kentucky had no problems with agencies as none existed, they did have difficulty in getting the patients to the clinics as the distance was time consuming and costly to them. Michigan also found that distance was a big obstacle for patients and further, patients were often reluctant to take advantage of the services offered, such as drugs without charge, monthly outpatient visits, counselling, family and job problems, due to fear of rehospitalization.

The Minnesota researchers found that the design of the research which dictated that pre-discharge and aftercare be treated as distinct and different operations constituted a continuous difficulty. They came to the conclusion that the most effective rehabilitation of the mental patient could be brought about by staff which, even if small, could bridge the gaps between the hospital and community, between patient and family, and between patient and agency.

(d) Significant Factors

We were impressed by the significance of several comments made by the researchers of the studies. They noted for instance, the inability of community agencies to provide services needed by the mentally ill, the fact that often patients have given up helping themselves by asking for help. It was noted that the great majority of discharged patients

do have needs although they may not be able to express them or bring them to the attention of others.

One of the almost universal needs of discharged mental patients was found to be the need to "do something." Few of the patients of the Minnesota Study found employment, partly because of the employment situation. But quite a few of them did not even have chores, or small responsibilities in the home. The researchers noted that when they were given some responsibility, it generally had a very good effect on their wellbeing. Their feeling was that undoubtedly something could be done in the community to help this group of people develop interesting and meaningful leisure time activities.

For the purposes of this study, we believe it is extremely important that so often in the general comments made by the researchers of the two studies, the word "community" appears. The concept of community involvement is carried a step further by the suggestion of one of the conferees of the Five State Study that the community should really assume responsibilities for the continuity of treatment of psychiatric patient to a much greater extent and that the real solution is the community-based aftercare clinic.

It is quite surprising to learn that the findings of different states with quite dissimilar aftercare programs tend to be so similar.

Dr. James Harris of Pennsylvania observed

> We find that our general results pretty much conform to the results of all the

> different states in the project. Regardless of the fact that we give short-term intensive treatment, live in an urban community, that we have easily available outpatient facilities, and so forth, our results are quite similar to those obtained in other states.[1]

Dr. Funkhouser, commenting on the Virginia findings stated

> . . . our after-care program was apparently better organized than some, and yet we come up with the same sort of figure as the rest of the states.[2]

(e) Major Conclusions

The major conclusions of the Five State Study were summarized:

1. Organized follow-up care of discharged mental patients can cut readmission rates by about half. As a corollary, it is much less costly to maintain a patient in the community, through aftercare, than it is to maintain him in the hospital.

2. No two states, or even hospitals, have the same situation relative to follow-up care, so there is no standard procedure that can be followed in setting up such programs.

3. An aftercare program cannot exist by itself, but must be closely integrated with the community and community resources.

4. Such seemingly mundane problems as transportation and communication can be of major importance to an aftercare program.

5. Patients who continue to take psychopharmaceuticals while out of the hospital are more apt to maintain their improvement than those who refuse them.

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1. Free and Dodd, op. cit., p. 5.

2. Loc. cit.

6. Patient cooperation is crucial for a follow-up program. One source of reluctance to cooperate appears to be fear that the program will return them to hospital. Adequate orientation and planning with patients and family are of utmost importance.[1]

The Minnesota Study arrived at the following major conclusions:

1. The data collected in the Study suggest that the introduction of extra pre-discharge planning and extra follow-up care are effective in increasing the percentage of patients who are able to maintain themselves outside of the hospital. It seems impossible, as yet, to say whether such extra services may be most effectively applied before or after discharge.

2. Data from the Study also suggest that re-hospitalization is affected greatly by the tolerance of deviance of persons in the patient's immediate environment while a number of other factors seem to have an effect on the quality of the patient's post-hospital adjustment.

3. For a sizeable group of patients (almost 1/3 of the sample) placement in a nursing or foster home was successful, in terms of their being able to maintain themselves in the community.[2]

C. Mental Health Survey of Los Angeles County

1. Purpose of the Study

In April 1960 the text of the Mental Health Survey of the Los Angeles County was published. This was a detailed inventory of the existing mental health treatment resources and also a specific blueprint indicating the lines along

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1. Ibid., pp.5-6.

2. Minnesota, op. cit., Section F, p. 17.

which development and community organization should proceed in the effort to meet the mental health needs of its population.

The report is an extremely comprehensive survey felt to be unique at the time. As noted earlier, the section that is of significance for our purposes is the one concerning the unmet needs of former patients of mental hospitals. First, however, a brief comment will be made about the resources that are available to former mental hospital patients, such as clinics, outpatient services, rehabilitation services and facilities.

2. Clinic and Outpatient Services

These two terms tend to be used interchangeably by the general public and occasionally by medical institutions themselves. In the Los Angeles County area there are three main types of clinics, the community, the proprietory and the public. The service of the community clinics is free or part pay and is oriented to psychotherapy, group or individual, and would be similar to that given at the Burnaby Mental Health Center. A relatively small proportion of their referrals are from inpatient hospital services. The proprietory clinics, privately owned and operated, charge fees, and their referrals from hospital inpatient services are extremely small in number. Their purpose and function vary widely. The services of some are similar to community psychiatric clincs and others are specifically limited to a certain function only

such as marriage counselling. The public or outpatient services are beginning to treat more patients referred from hospitals and it is expected the numbers will continue to rise in the future. Fees are collected from those able to pay. No information is available as to the service offered in the public clinics although it is stated that the personnel is similar to that of the community clinics and some proprietory clinics - psychiatrists, clinical psychologists, psychiatric social workers and nurses.

Approximately 10 percent of the total number of patients who attend the above clinics are referrals from hospital inpatient services. As we can see, the services they offer do not appear to be designed to meet the broad needs of patients who are discharged from mental hospitals. From the first chapter of this study, the services required and offered by aftercare services would appear to be broader, i.e. more in the direction of rehabilitation. What would rehabilitation services consist of?

3. Interpretation of Rehabilitation Services

The California State Department of Mental Hygiene[1] state that psychiatric rehabilitation consists of services provided under psychiatric direction with the major and primary intent of such services being to restore, establish and/or maintain an optimum level of social, emotional, vocational, and/or physical functioning consistent with the

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1. California, op. cit., p. 253.

limitations imposed by the sequelae or residuals of mental illness, mental retardation or emotional disorder.

Psychiatric rehabilitation, under psychiatric direction may provide the following approaches: 1. Psychological testing. 2. Supportive psychotherapy, social casework, pastoral counselling, psychological counselling - group and individual, with patient and with patient's family. 3. Physical therapies. 4. Corrective therapy. 5. Vocational or educational training. 6. Social group activity. 7. Sheltered environment (social, vocational). 8. Community planning, interpretation and co-ordination of rehabilitation needs.[1]

The Committee of the Los Angeles Survey recognized that agencies differing widely in structure and purposes were rendering one or more rehabilitation services such as the ones noted above, to persons with mental or serious emotional disturbances. They found that they could classify the agencies in Los Angeles County into two main groups as follows:

a. Primary Agencies - those whose total caseload consists of persons recovering from psychiatric disorders such as (1) the hospitals (sometimes offering day and night hospital care), (2) outpatient psychiatric clinics (actually almost exclusively treatment focussed), (3) the Bureau of Social Work of the State Department of Mental Hygiene (foster home care and supervised work placements are among the major functions) and (4) halfway houses and day centers designed exclusively

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1. Ibid., p. 254.

for the mentally ill.

b. Secondary Agencies - those whose caseload included some persons recovering from psychiatric disorders. This category includes the agencies whose primary function is in an area other than rehabilitation and also the rehabilitation agencies serving chiefly persons with other (non-psychiatric) types of disabilities. It included (1) The Bureau of Public Assistance, (2) The Vocational Rehabilitation Service of the State Department of Education, (3) sheltered workshops, (4) families and children's agencies, (5) the school, and (6) group work and recreation agencies.

It is most significant to note that, as in the Five State Study and the Minnesota Follow-Up Study, two types of resources are felt to be required in an aftercare program: - those devoted to the follow-up psychiatric treatment of mental or emotional disorders and those devoted to the social, economic, and vocational rehabilitation of patients.

Certainly the services offered by the above agencies are many and varied and there would supposedly be a vast number of resources available to the former psychiatric patient. How were the resources meeting the needs?

4. Opinions on Unmet Needs for Rehabilitation Services

The researchers of the Survey recognized that the unmet need for almost any type of community service is, for all practical purposes, unmeasureable. They believed it might be possible to come close to an accurate measurement

in the field of rehabilitation of the post hospital mental patient, if every hospital had adequate discharge planning, and if it could be determined at the point of discharge the specific community rehabilitation services and facilities the patient might require. He might remain a stabilized statistic for a while if it turned out he was able to use each facility and service along a planned continuum and of course, provided he did not suffer a relapse. At least his needs would have been expressed. "It is the unexpressed need, still unarticulated as demand, that is the unknown quantity; for it there is no realistic yardstick."[1]

With the above in mind, the survey researchers decided on an interesting approach. They felt it would be most useful to consult the experience closest to the problem of securing adequate rehabilitation resources for their patients. The opinions of a variety of professions and agencies dealing every day with the seriously emotionally disturbed or the mentally ill were therefore sought.

(a). The Medical Profession and Other Private Practitioners in the Mental Health Disciplines.

Over 1500 professionals, doctors, medical specialists, the psychiatrists, the psychologists, the social workers in private practice, were contacted. Ninety-three out of a hundred reported a shortage of all kinds of rehabilitation facilities in Los Angeles. In answer to related questions

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1. Ibid., p. 299.

concerning community planning for mental health needs, the need for recreational and camping facilities, the shortage of day hospitals, night hospitals, of foster homes for mental patients, were all noted.

(b) Selected Outpatient Psychiatric Clinics

Staffs of such clinics are another group whose treatment responsibilities require knowledge of rehabilitation facilities available to their patients.

Ten clinics, representative of this type of facility, were asked with respect to a specific type of rehabilitation such as sheltered employment or the halfway house to indicate the degree to which it was available. There was no type of rehabilitative facility or service which some clinic administrator did not find in short supply.

(c) Bureau of Social Work of the State Department of Mental Hygiene

As the largest single agency in Los Angeles directly concerned with the rehabilitation of the mentally ill, working entirely with patients from the state hospital, the Bureau of Social Work was requested to secure the opinion of its 37 caseworkers regarding the availability of rehabilitation and facilities. The following are the findings:

1. The caseworkers reported 2,296 unmet individual needs for rehabilitation services, with some patients needing more than one service.

2. The largest number of patients, 477, were described as in need of social or recreational services which would normally be the responsibility of social group work agencies.

3. Outpatient psychiatric services were needed by 396 of their patients to enable them to remain in the community (various kinds of medical care, for supervising patients using tranquilizing drugs and for prescription of the drugs themselves).

4. Almost 84 percent of the casework staff stressed the need for community jobs, vocational training, sheltered employment and similar work focused services.

5. Almost 40 percent of the caseworkers said their clients stood in need of more casework services.

6. Over half of the casework staff identified patients (55) who needed family care homes and an additional 41 patients were believed to be in need of the halfway house type of care.

7. More than a third of the caseworkers emphasized the current need for day hospitals and night hospitals for those patients on leave in the community.

8. About a half dozen of the bureau caseworkers offered spontaneous comments about the great need to co-ordinate community services on behalf of the mentally ill.

(d) Bureau of Public Assistance

It was not feasible to survey the entire roster of public assistance recipients to determine the number of diagnosed mental patients on the rolls who were currently in need of rehabilitation services. In lieu of such an overall survey, the Bureau selected 20 experienced caseworkers whose background and training qualified them to identify those in need of such services. The caseworkers identified 229 individuals as needing psychiatric rehabilitation services. Of these, 41.5 percent had been former patients in mental hospitals. Close to one-third had been treated in clinics

or outpatient departments of hospitals and the remainder, 28.8 percent, had received psychiatric treatment from other sources such as private practitioners. This distribution points up that the need for rehabilitation services cannot be measured in terms of the post-hospital patient alone. There may, in fact, be more diagnosed and treated individuals needing rehabilitation services who have never been in hospitals than there are post-hospital patients with similar needs.

(e) Vocational Rehabilitation Service

The opinions of six selected counsellors were requested concerning the unmet service needs of 99 clients who were in the process of vocational rehabilitation. The 99 cases were distributed as follows:

Status A (former patients of mental hospitals) . . .	17
Status B (clinically diagnosed but not hospitalized)	47
Status C (judged to be seriously disturbed)	35

The six rehabilitation counsellors identified 44 different clients needing a total of 145 rehabilitation services, unavailable either through the Vocational Rehabilitation Service or outside sources at the time of the study. Several clients were in need of two or more kinds of service beyond those they were receiving. The unmet needs of the 17 former patients of mental hospitals were those such as psychotherapy, sheltered work, maintenance for the client during training, job placement, maintenance of family member(s) during program, rehabilitation transportation, occupational tools, equipment, license, social casework, and vocational training.

5. Findings of the Survey

The Survey researchers found that the supply of rehabilitation facilities for the mentally ill in Los Angeles County is not adequate and that there is not the systematic co-ordination of efforts essential to the effective distribution and use. More specifically, their opinions concerning the inadequacies were:-

1. Only one Agency, the Bureau of Social Work reaches any substantial number of patients once they come out of hospital and it is seriously hampered by the acute shortage of community facilities in every area of service and program essential to the achievement of its goals.

2. Evidence suggests that many people are discharged by the hospitals and other types of psychiatric institutions, whose rehabilitation is nobody's special responsibility. For most of these patients there is no plan of follow-up care.

3. Frequently the institutions the patients leave operate in isolation from the community resources and make no effort to connect the patient with the services he needs.

4. There is a confusing array of existing facilities, most of which are designed primarily for a clientele other than the mentally ill. Many of these agencies endeavor to serve some mental patients along with their other clients. The majority offer only a part of the service required for total rehabilitation of the patient and do not have the necessary liason with other agencies in order to ensure that the rehabilitation task is completed.[1]

D. Conclusions and Implications

From the three studies surveyed there are certain findings that are particularly significant in our study of the

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1. Ibid., pp.304-305.

aftercare services offered at the Burnaby Mental Health Centre. Summarized very briefly they are:-

1. Organized follow-up care of discharged mental patients can cut readmissions rates by about half.

2. It costs about 1/10 of the hospital per diem rate to treat the patient out of hospital.

3. The continuity of services for the patient from the hospital to the community is of great importance.

4. Aftercare programs must be integrated with the community and community resources.

5. Community resources must be able to provide services needed by the mentally ill. They must, in other words, have some familiarity with psychiatric illness or have adequate psychiatric consultation.

6. Patient cooperation is the crux of the success of any program. They must be thoroughly assured of the goals and the cooperation of their families must be obtained.

7. The actual value of psychopharmaceuticals cannot be gauged. Although believed to be helpful in maintaining adjustment outside of the psychiatric hospital, the psychological and societal rehabilitation apparently play the most significant roles.

8. Everyday problems of communication and transportation have great effect on the success of the programs.

9. Rehabilitation touches on all the important areas of the former psychiatric patient's life - physical, mental, emotional, economic, vocational and social and therefore, requires a wide range of services to meet his needs adequately.

These studies have been helpful to us in planning our approach to our own study of the Burnaby After Care Clinic and have had some bearing on the methodology used in the inquiry.

CHAPTER 3

METHODOLOGY OF THE STUDY

In this chapter we will outline the social work and research problem. We will then discuss in some detail the research instruments and their use in this study.

Social Work Problem

In recent years there has been a growing trend to discharge mental patients after short periods of hospitalization. As elaborated in Chapter 1 this trend is partly the result of new developments in medication and new ideas about mental illness. There has been a growing recognition of the dangers of institutionalization and the need for the patient to have social relationships in the community. Consequently there has been less emphasis by hospital staff on custodial care and more emphasis on short term treatment. The shortage of hospital beds and the high costs of hospital treatment also encouraged short term treatment and early discharge.

However, with earlier discharge, patients leave the hospital with many unresolved problems. In order to keep them in the community and maintain or improve their social functioning, continuing service is needed.

As noted in the first chapter there was some unwillingness on the part of the Greater Vancouver community to accept the discharged patient. Many citizens feared and

stigmatized the ex-patient and social agencies did not wish to provide continuing service because of lack of money and experienced staff. Recognition of these problems led to the formation of the first aftercare clinic and later to the After Care Clinic in Burnaby. However, many problems still remain, as indicated by the high rate of readmission to the hospital.

The hospital is concerned about the services for the discharged patient. In particular, hospital staff are concerned about the After Care Clinic and questions relating to policy, facilities, staffing and co-ordination with other agencies.

Research Problem

A series of discussions were held between researchers and hospital staff in which the aftercare problem was explored. As a result of these discussions, and discussions with university staff, the research problem was selected. The researchers decided to evaluate the services of the After Care Clinic as this was the major service available to discharged patients and was manageable with the limited manpower and time.

The problem chosen for research then was: Are the needs of the discharged patient being met by the After Care Clinic? Throughout the study the researchers were guided by the following questions:

1. What are the social, work, and home needs of the discharged patient?
2. What needs are met by the After Care Clinic?
3. What needs are not met by the After Care Clinic?
4. What role do other agencies play?
5. What suggestions could be made to improve the services to the discharged patient?

The design of the study was exploratory, chosen to stimulate inquiry into the aftercare services in the Greater Vancouver area.

Underlying the research study were factual and value assumptions. The researchers thought that early discharge and rehabilitation in the community was generally desirable. They assumed that an adequate aftercare programme would require adequate policies, facilities and staffing in a comprehensive community programme, and that such a programme would be less expensive in economic and human terms than an inadequate aftercare programme. Generally the researchers felt that the discharged patient has a right to adequate aftercare services. They believed that the community has some responsibility to accept the discharged patient and the hospital; some responsibility to facilitate this acceptance.

These guiding questions and underlying assumptions were formulated after some familiarity with the aftercare problem through consultation with experts and reading of hospital and general literature.

Research Instruments

In essence the researchers wanted to obtain data which would allow them to evaluate the After Care Clinic and answer their guiding questions. They chose therefore to question the individuals who were most involved with the aftercare services: the patients, the clinic staff, and other community agency staff.

Generally patients and clinic staff were asked about patient needs and treatment given. This gave researchers some idea of met and unmet needs. Clinic staff and other agencies were also asked for their comments and suggestions on aftercare services. This was done to obtain information on the role of other agencies and suggestions for improvements which might be made in the aftercare services.

Sources of Information

Hospital memos and communication provided vital information for a historical review of the aftercare services in Vancouver. They also clarified hospital policies and objectives for the After Care Clinic. This background was essential in formulating a knowledgeable questionnaire to clinic and agency staff.

Patient files contained information on the patient and his treatment both in the hospital and at the clinic. This information gave a preliminary view of patient needs and treatment and was kept in mind in formulating a questionnaire to patients. Such background information helped interviewers

to handle the interview more sensitively and allowed for pertinent probe questions. Information on the hospital files such as age and education gave a rough check on the validity of patient responses, while information such as diagnoses provided additional data relevant to patient needs.

A brief review of the literature gave a general orientation to the subject and was useful in defining the research problem and in formulating questionnaires. A more extensive reading provided fuller background on aftercare services in general and in other clinics. In particular we used:

1. Five State Study
2. Minnesota Follow-up Study
3. Mental Health Survey of Los Angeles County

The first two studies evaluated various aftercare programmes and the third study surveyed aftercare resources in the Los Angeles County. These studies provided valuable comparative material. They helped the researchers to assess the services in the Greater Vancouver area and to make suggestions for more adequate aftercare services.

Patient Questionnaire: The Instrument

The patient questionnaire grew out of a perusal of aftercare, hospital, and research literature. The questionnaire preceded the explicit formulation of the research design. The general format was as follows:

1. Social Life (1-5 and 26-33)
2. Treatment (6-25)

3. Work Life (34-44)
4. Home Life (45-46 and 55-63)
5. General Information (47-54)
6. Personality Inventory (64-85)[1]
7. Interviewer Assessment (85-95)[1]

The Patient Questionnaire thus elicited information which would provide a general description of the patients in the sample, an assessment of social, work, and home needs of the patients, and the help given by the After Care Clinic and other agencies.

Questions were phrased as informally as possible and arranged so that the less threatening and more objective questions were at the beginning, the more intense and subjective in the middle, and an interesting but more impersonal question, at the end. The researchers felt that this order would make the client fairly comfortable and facilitate honest responses.

Generally each section in the questionnaire was organized with closed questions first followed by open questions. The closed questions obtained more objective and comparative information while the open questions allowed for greater depth into individual responses and thus provided a check on the preceding closed questions.

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1. The personality inventory and interview assessment were patterned after questions presented in:

Freeman, H.E., Simmons, O. The Mental Patient Comes Home, Wiley, New York, 1963.

The Sample

The researchers were interested in the discharged mental patient. However, in choosing a population, they decided to study only those individuals who had been discharged from the Crease Unit after April '65. This was done because the new Mental Health Act became effective at that date. The researchers further limited the population to those who were referred to the After Care Clinic. This was done because past and present information, including recent phone numbers and addresses were readily available at the Clinic for those referred. Moreover, the researchers felt that including two different groups (those referred and those not referred) would make the study too complicated for the limited time available. It was further agreed to limit the population to those referred individuals who were receiving services from the Clinic. Thus the population excluded those people who were not referred to the Clinic, those who were referred but did not attend, and those who were referred, attended briefly, and dropped out.

The sample size was 45. This number was considered reasonable for the limited time available to the researchers. The sample was drawn by using a random number table.[1] The researchers phoned the people drawn and made appointments.

There was some difficulty in contacting the first

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1. Edwards, Allan L. Statistical Methods for the Behavioral Sciences. Reinehart and Co. Inc., New York, 1954.

45 selected and others were randomly added. However it was only after 140 people were drawn that a sample of 45 was obtained. Thus 30 people were drawn who had no phone, 11 did not answer their phones after repeated attempts to contact them, 16 people lived too far away, 8 people had moved and could not be reached, and 13 people refused to be interviewed. In addition, the researchers excluded 10 people who were not presently receiving services and 7 people who were receiving medication only. In total then 95 people were drawn and not included in the sample.

It would appear from these rejections that our sample is biased in favour of those individuals who are more settled, who had phones, who did not move, and who kept in contact with the Clinic. In addition the researchers biased the sample by excluding, in some cases, individuals who attended sporadically or who received only medication. In general then it appears that our sample favours the more fortunate discharged patient, the one who is receiving most service from the Clinic and who may be more stable. The reader should take this bias into account when reading the study.

Comments

The patient questionnaire was pretested at the After Care Clinic. Each researcher interviewed two patients and the results of the interviews were discussed. Some questions seemed too long or complicated for the patients;

these questions were shortened or subdivided. Other questions patients found hard to understand; these were re-worded to make their meaning more clear. The order of presentation was also changed to give a smoother flow to the interview. However, in spite of the pre-testing some flaws in the questionnaire and in the interview procedure remained. One question was too complicated and led to inconsistencies in response. Thus the number of people who said they had a problem sometimes did not correspond to the number of people who indicated what kind of help they received for that problem. There were no categories for undecided or inapplicable, which would have been useful in tabulations. Other categories overlapped which again led to difficulties in tabulation.

Some subjective questions might have been supplemented with objective questions. For example in question 55 "Would you say your living accommodation is satisfactory?" a question on the number of people and rooms might have been added. Similarly, with question 53 and 54 on financial worries an additional question on the level of income would have given the answers more meaning.

In general the time allowed for the discussion of the pretest results was insufficient. The meaning of terms in the questionnaire was not gone over and interviewers independently omitted and added categories which led to some inconsistency in the results.

The interviewers did not discuss beforehand their manner of approachg and interviewing patients and it was

later seen that there were differences. Two of the researchers favored a fairly aggressive approach while a third favored a more permissive approach giving the patient more chance to refuse to be interviewed. The interviewers also differed in their method of interviewing. One interviewer asked questions in a straightforward manner while the other two cushioned questions with considerable support. The researchers agreed that the interview should be made as comfortable as possible for the patient, but had different interpretations of how this might be done.

One of the researchers knew some of his interviewees from work with them at the hospital. It would seem that this former relationship might influence the answers given, but it is difficult to know the extent or direction of this influence.

Despite the differences in interviewing, in general it seemed that patients were more relaxed towards the end of the interview. The following chart taken from the rating made by the interviewers shows the distribution of attitudes at the start and at the close of the interview.

Table 27 Interview Attitude

Attitude	At Start	At Close
Hostile	5	0
Suspicious Guarded	18	13
Friendly	17	21
Solicitous	2	8
Other (Accepting)	3	3
Total.	45	45

From the general correspondence of the answers given with information received from the hospital, concerning age, number of hospitalizations, and education it would seem that the questions were answered with considerable honesty. Unfortunately, time did not allow for a more accurate individual check on validity.

Staff Questionnaire

The staff questionnaire was designed by a member of the research team who is working at the hospital. His familiarity with the hospital and After Care Clinic added to the sophistication of the research instrument.

The Instrument

The questionnaire was 3 pages long and contained 12 questions. It inquired into the character of the service, basic therapies, type of patient referred, participation of staff, and amount of contact with patients. All these questions were closed. In addition, open questions were included to obtain opinions about the clinic purpose and suggestions for the improvement of service.

The Sample

The population from which the sample was taken was determined to be all those staff who had work experience at the After Care Clinic. The sample size was set at 10. The researchers decided to choose 5 social workers and 5 psychiatrists as this would give two important and perhaps different

outlooks. The researcher then selected those individuals he considered to be most experienced with the Clinic. The sample so chosen contained almost the total population.

Comments

The questionnaire was not pretested, but it was given to two experts at the Clinic for suggestions. The revised questionnaire was then given to each staff member to be completed at his earliest convenience.

Only one question was somewhat ambiguous and in general the questionnaire was well understood.

It was felt that the working relationship which existed between the researcher and the staff facilitated an open expression of opinion that might otherwise have been difficult to obtain. The response served the questionnaire's purpose; it helped researchers evaluate the Clinic service and gain a better appreciation of aftercare problems and possibilities.

Agency Questionnaire: The Instrument

The agency questionnaire was only one page long and had 8 questions. It asked for opinions on the present after-care services and the liason between that agency, other agencies, and the After Care Clinic. Generally it sought to obtain an understanding of the way in which agencies perceived the division of responsibility between community agencies and the After Care Clinic. All questions had an open part to allow agencies to express their views more fully.

The Sample

The researchers decided to mail questionnaires to all agencies in the Greater Vancouver area who might have contact with the discharged patient. Accordingly questionnaires were mailed to provincial and municipal social welfare offices, Metropolitan Health Clinics, Childrens' Aid Societies, Canadian Mental Health Associations, and the Family Service Agency. In all 12 questionnaires were mailed.

Comments

Responses were received from all 12 agencies. Generally the responses were detailed and gave a good picture of agency orientation to aftercare services. This response was useful in understanding the gaps and obstacles to an adequate community aftercare service and in visualizing some bridges to a more adequate service.

In conclusions we have briefly outlined the social work and research problem and indicated some of the steps that were taken in this study to obtain relevant information. We shall now present in detail the findings of the patient questionnaire.

CHAPTER 4

PRESENTATION OF DATA OF THE PATIENT QUESTIONNAIRE

In this chapter we will present data from the patient questionnaire supplemented to a limited extent by data from hospital files. All tables are taken from the patient questionnaire except where indicated otherwise. Tables not included in the text are found in Appendix B.

We will first give a general description of the sample and the help given. Then we will describe the social, work, and home needs and the help given in each of these areas.

A. General Description of the Sample and the Help Given

In this section we will describe the marital status, living arrangements, age, education, source of income, mental health, and stated problems of the sample. We will follow this description of the sample with a statement of the help given by the After Care Clinic and other agencies.

Marital Status

Our sample contained 26 women and 19 men. Twenty-five individuals were married and most of these were women. Most of the 11 single persons were men and the 8 separated, divorced, and widowed people were all women with one exception.

TABLE 1. Marital Status and Sex

Marital Status	Sex		Total
	Men	Women	
Married	8	17	25
Separated	1	3	4
Widowed	0	3	3
Divorced	0	1	1
Single	10	2	12
Total	19	26	45

Living Arrangements

In the following presentation of data we have used only single and married categories. We grouped the separated, widowed and divorced individuals with single individuals. We chose to do this because it seemed that their social, work, and home needs would tend to be more similar to those of the single person than to the married person. However, as you will notice in Table 2, there is a wide range of living arrangements. Thus some separated individuals with children may more closely resemble married people with children. Because there is a wide range of situations any simple grouping will be unsatisfactory. The reader should take the bias of our particular grouping into account as he reads the following tables.

As can be seen from Table 2, 8 single people were living alone, 3 in boarding homes and 4 with their friends or

relatives. Two single men lived with their mother, 2 married people lived with their parents, and 2 separated women with children also lived with parents. One woman lived alone with her children. The majority of the married people lived with their spouse and children. (Appendix B, Table 2)

Age

There was quite a large age range: from individuals in their twenties to those in their seventies. More than half (25) fell within the thirties and forties. There were 25 people in that range, 7 were younger and 13 older.

TABLE 3. Distribution of Age by Marital Status and Sex

Age	Men		Women		Total
	Single	Married	Single	Married	
20-29	2	0	1	4	7
30-39	5	2	1	3	11
40-49	3	2	2	7	14
50-59	1	1	4	1	7
60 & Over	0	3	1	2	6
Total	11	8	9	17	45

It is interesting to note that the largest group of single women were 40 and over, while the largest group of single men were under 40. The reverse is true for the married people. Here very few of the married women were over 50

while half of the married men were. Thus the single women and the married men were generally older.

Education

Four individuals had less than grade 6 while 13 had over grade 12. The bulk obviously falls in between with the most frequent category being those individuals with grade 7 to grade 9. The single men are the most poorly educated, followed by the married men. Married women were the best educated. (Appendix B, Tabes 4 and 5)

Source of Income

Out of our sample there were 13 people with jobs and 15 who lived from their husband's income. Government pensions supported 8 and 10 were on Social Assistance. Thus we have 28 individuals who were living on their own or immediate family resources and 18 individuals who were being supported by the government. Other sources of income were also noted and some individuals had more than one source. (Appendix B, Table 6)

In summary then, if we looked for the most characteristic person in our sample, we would find a married woman living with her spouse and children. She would be in her forties and have a grade 7-9 education. She would be supported by her husband.

Mental Health

We explored the mental health of our sample by noting the number of admissions to the hospital (Riverview only), the hospital diagnoses, client and interviewer ratings of mental health and symptoms, and a personality inventory.

According to the questionnaire, 9 people were hospitalized for the first time. Nineteen had been hospitalized 2 or 3 times, and the rest more than 3 times (7 were unknown). This information corresponded fairly well with hospital data. (Appendix B, Tables 7 and 8)

Table 9. Diagnoses by Sex and Marital Status[1]

Hospital Diagnoses	Men		Women		Total
	Single	Married	Single	Married	
Schizophrenic Undifferentiated	4	1	3	7	15
Schizophrenic Paranoid	4	2	4	1	11
Manic Depressive		3		1	4
Neurotic Depressive			1	4	5
Psychotic Depressive		1	1	1	3
Other Depressive	2	1		2	5
Chronic Anxiety	1				1
Personality Trait Disturbance				1	1
Total	11	8	9	17	45

From Table 9 it is apparent that most people were diagnosed as schizophrenic. The remainder were all depressive reactions except for 2 who were diagnosed as personality trait disturbance and chronic anxiety. Most single people were schizophrenic while most of the married people were depressive reactions.

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1. These diagnoses are from hospital files and pertain to the last hospitalization only.

The interviewers assessed the patients' mental health according to these categories:

Grossly Disturbed - Needing hospitalization

Disturbed - Symptoms severe, may need hospitalization

Somewhat Disturbed - Symptoms controlled, functioning minimally in community

Slightly Disturbed - Some discernable symptoms, functioning in community

Not Disturbed - No discernable symptoms, appears to be functioning normally

If we consider this assessment as parallel to ratings of Very Poor, Poor, Fair, Good and Very Good we can compare interviewer and client ratings as follows:

Table 10. Comparison of Interviewer and Client Assessments of Mental Health

Assessment	Interviewer	Client
Very Poor	2	0
Poor	8	3
Fair	17	12
Good	13	26
Very good	5	3
Undecided	0	1
Total	45	45

Thus we see that clients tend to rate their mental health better than interviewers. This is substantiated by the interviewers' comments on the question about symptoms. (Appendix A, Question 13)

There were a number of people who denied that they had symptoms. The interviewers noted that these people were often schizophrenic paranoid patients or patients with con-considerable anxiety. For each symptom listed in Table 11, there were about one-third affirmative responses. Feeling depressed, anxious, and tired were the most frequent responses followed by difficulty in sleeping and forgetfulness. In answer to the question 14, "What worries you most about your mental health?" some stated their inability to function in the community, their lack of concentration, low energy, and confused ideas. Many feared rehospitalization. Thus it appeared that at least one-third of the sample were suffering from residual symptoms of their illness.

It is interesting to note that in the personality inventory, optimism was the most frequent response and fatalism the least frequent. Either this inventory was an inadequate measurement of personality or patients retained considerable hope despite their mental difficulties.

In summary, when we looked at the mental health of our sample we found that most individuals have been hospitalized at least 3 times and are usually diagnosed as schizophrenic. Most clients rated their health as good, but the interviewers rate most as only fair or good. Many people did not admit to symptoms and a personality inventory found optimism to be the most frequent response.

Clients were asked about financial, work, personal, physical, marital and other family problems. Many people

did not admit to any problems. Those who did, noted financial, physical and other family problems most frequently. (Appendix B, Table 12)

In the probe question clients elaborated on their problems. Some worried about their marginal income, others about their spouse or themselves losing their job. Some worried about their work performance, their lack of drive, coordination and the pressure on the job. Some people had physical problems, ulcers, polio, back trouble and the physical problems accompanying old age. Many people were in conflict with their spouse.

Help Given by the Clinic

We shall estimate the help given by the Clinic by looking at the kind of help the clients indicated they received, the clients' estimate of this help, and their estimate of their improvement since coming to the Clinic.

Only one person was seeing a social worker. The overwhelming majority of people saw a psychiatrist, but usually less than once a month and for only 1-15 minutes. A few people saw their psychiatrist more than once a month for interviews lasting at least 30 minutes. A few people were seeing a psychologist for intensive group treatment.

None of the people were involved in any social activities offered by the Clinic, but most (38) were receiving medication. Some said that the medication was keeping them away from the hospital.

Asked if they thought the Clinic was giving them any help with their problems, clients replied as follows:

Table 12. Client Estimate of Clinic Help

Problem	Yes	Help Given		
		No Help	Some Help	Lots of Help
Financial	13	10	4	1
Work	18	11	3	0
Personal	9	6	3	1
Physical	13	7	3	0
Marital	8	7	0	1
Family	12	6	3	1
Total	72	47	16	4

Most people who felt that they were receiving financial or physical help were referring to the medication they received free from the Clinic.

In the probe question it appeared to the interviewers that many people were receiving medication and some supportive help. Some people said that the doctor "encouraged" them and that "talk with the doctor helped", "someone listened." A few people thought that the doctors didn't have enough time for them. Quite a few people didn't want help. A few expressed a desire to try to get along by themselves, and a number didn't think they needed anything from the Clinic but medication. When asked whether they thought their difficulties

had improved since coming to the Clinic 9 people were unable to answer and 12 felt that they had not improved at all. Sixteen people, however, felt they had improved somewhat and 8 thought they had improved a great deal. (Appendix B, Table 13)

To summarize, the help given by the Clinic, it appears that only a few individuals get more than medication and a brief visit with their psychiatrist. Of those who admit to problems, most estimate that they receive no help from the Clinic. However, most people do feel that their difficulties have improved in some degree since coming to the Clinic.

Help Given by Other Agencies

Thirteen people said that they were getting help from other agencies. Ten out of the 13 said they were satisfied with this help. Most of the people thought that they were getting some help from these agencies and others felt that they were receiving a lot of help. (Appendix B, Table 14) Most people who thought that they were getting some help indicated that this help was for financial or physical problems. However, those who indicated that they were receiving a lot of help indicated that this help was for personal and marital problems. Thus it would appear from client estimates that other agencies do give some or a lot of help with financial, physical, personal, and marital problems.

B. Social Needs and Help Given

We turn now from the general description of the sample and the help given to an assessment of the social, work, and home needs and help given in each of these areas.

In this section on social needs we will outline the social problems by describing the client recreation, contact with neighbours, relatives, and friends, interviewer estimate of social contact, and client desire for social contact. We will consider the social needs of the single men and women in more detail and look at their statement of problems and help given.

Recreation

The most common recreation was watching TV and listening to the radio. Movies and drives were the next most popular. Most people indicate their involvement with sports is mainly through TV. It is difficult to say how this would compare with the average Vancouverite, but certainly it does point out the frequency of recreation that is passive rather than active. (Appendix B, Table 15) It is interesting to note that most people (26) felt that they would like to be more active.

Contact with Neighbours, Friends, and Relatives

Only one person thought that the people in his neighborhood were unfriendly, while two-thirds thought that their neighbours were friendly or fairly friendly. Fourteen people were undecided about their neighbours or thought they were indifferent. Nine people had no close relatives, 12 said they

had no friends. Of those who did have relatives, 15 saw them at least once a week, while only 12 saw them less than once a month. Of those who had friends, 17 saw them at least once a week, while 10 saw them less than once a month. (Appendix B, Tables 16 and 17) We can see from this that some people appear to have quite a lot of contact with friends and relatives. Others, however, may have no friends or relatives or visit them less than once a month.

Interviewer Estimate of Social Contact

The writers looked at the social contact for each person and arbitrarily assigned a rating of poor, fair, and good contact. Generally, this was a combination of the number and quality of contact. However, because it was done impressionistically, it is subject to error, and the reader should keep this in mind in reading the following material.

Table 18. Social Contact by Sex and Marital Status

Social Contacts	Men		Women		Total
	Single	Married	Single	Married	
Poor	5	1	3	5	14
Fair	5	6	6	11	28
Good	1	1	0	1	3
Total	11	8	9	17	45

From this table we see that most people do have fair social contacts. Some people have only poor contacts and 3 have good. There does not seem to be any significant differ-

ences between men and women, married and single. This may be due to the wide range of living arrangements for patients in each of these categories.

About half of the clients said that they wanted more contact; another half did not. Again, about half thought their social life was satisfactory and half thought it was unsatisfactory. A few people were undecided.

When we examined the probe questions on social contact we find that some people were doing quite well. They seemed to have quite a number of activities and friends and got along with these friends. Of those who thought that their social life was not satisfactory some were fully involved with their families and could not manage more contact with ease. Others wished it was more like "the good old days" when they had more friends and "used to know everybody." Some wanted to be a "part of something." Others just wanted a few people they could talk to. However there were drawbacks to seeking more contact. Some complained of lack of money or transportation; others felt that they just didn't know what to do. Some felt that their age and physical problems held them back while others felt tied down at home. A good many people were too tired to do anything and others found it difficult to talk to friends, who didn't understand them. They felt different from normal people.

Other people who were satisfied with their social life had minimal contact with others. They thought that they "weren't bored"..."don't want to be bothered with people" or

were indifferent. Many of those who did have some contact, had minimal communication. They didn't like to express their opinions, "never argue with friends." The interviewers commented that some people were too preoccupied with neurotic symptoms to tolerate people.

In summary then, we find that most people have fairly passive recreation. About one-third considered their neighbours unfriendly, indifferent, or were undecided. About 20 people had no friends or saw them less than once a month: 20 had no relatives or saw them less than once a month. The interviewers rated about one-third as having poor contact and most as only fair contact. Most people indicated that they wanted to be more active and almost half desired closer contact with people and thought their social life was unsatisfactory.

Social Needs of the Single Man

Of the 11 single men in our sample, 7 had been in the hospital 3 times, 2 more often and 2 less often. Five were assessed by the interviewers to have poor social contact, 5 to have fair, and 1 to have good social contact.

All 5 of those with poor contact were schizophrenic. Three were in their thirties, and 2 in their forties. Two lived by themselves, 2 in boarding homes, and 1 with a brother. Four were on Social Assistance, and 1 was on Disabled Person's Allowance.

One person stated that he had a physical problem and

was receiving some help from another agency for this. No one else was receiving any help from the Clinic or other agencies for any physical, personal, or family problems. One person, who lived with his brother, stated personal and family problems. Another person who stated that he had no problems, was not receiving medication.

Of those 5 who had fair contact, 3 were schizophrenic, 1 suffered from a chronic anxiety state and another from a reactive depression. Four were in their twenties, and thirties, and one was in his fifties. Three were living by themselves and the other 2 were with their mothers. Two had jobs, one was on Social Assistance, and the other two were supported by relatives or their own savings.

One of the above people stated he had a personal problem, but he was not on medication. Two, who lived with their mothers, stated personal and family problems. One of these was not taking medication. Other men did not state any personal, physical, or family problems. None of these men with fair contact was receiving any help from the Clinic for personal, family or physical problems.

The individual with good contact was a separated man in his forties who suffered from a depressive reaction after his wife left him. He was now living with friends and had a job. He did not state any problems or help and was not on medication.

Social Needs of the Single Woman

There are 2 single, 3 separated, 3 widowed, and 1 divorced woman in the sample classified as single women. The interviewers assessed 3 to have poor contact and 6 to have fair contact.

The 3 women with poor contact had 2, 3, and 6 hospitalizations. These 3 women are all over 40. One lives by herself, another with her sister, and the third with her mother and daughter. None had jobs.

None of the above mentioned women stated any personal problems. The woman with the older daughter stated a family problem. Not one was receiving any help for social problems. The woman who lived alone was rehospitalized shortly after the interview. She was not taking medication.

Those 6 women who have fair contact range in age from 20 to over 50. Three had been hospitalized once: the others 3, 4 and 6 times. Two lived with children, one with a sibling, one in a boarding home, and 2 lived by themselves. Three have jobs, 2 are on Social Assistance and one has a pension.

Three of the women with fair contact admitted no problems and were not getting any help from the Clinic. Of the others, 3 stated that they had personal, physical or family problems and were receiving some help from the Clinic.

In summary then, we see that none of the single men were receiving any help for their social problems. None of the women with poor social contact were receiving any

help. Some of these people were not taking medication.

Those three who were helped were women who stated problems and who had fair social contacts. Two were young women with children, and one was an older university woman who was living by herself and working.

C. Work Needs and Help Given

In this section on work needs we will consider the work problems and help given by the Clinic and other agencies. We will discuss the sources of income and felt financial problems. We will briefly consider the work problems for those working, looking for work and not looking for work. We will then examine in some detail the work problems of the single and married, man and woman and the help given each of these groups.

Source of Income

Table 19. Source of Income by Marital Status and Sex

Source of Income	Men		Women		Total
	Single	Married	Single	Married	
Job	3	4	4	2	13
Social Assistance	5	1	2	1	9
Pension	1	2	0	1	4
Spouse	0			13	13
Other	2	1	3	0	6
Total	11	8	9	17	45

We notice from Table 19 that many of our sample live on marginal incomes. Nine live on Social Assistance and 4 on pensions. Other sources of income include minimal savings. We do not know the occupations of husbands of patients but many of these families appeared to the interviewers to be living on marginal incomes.

Financial Problems

In reply to the question on financial worries, 26 indicated that they were not worried at all. Only one person considered himself very worried, and the remaining 18 felt that they were worried or somewhat worried. The most frequent financial worry was for the lack of money in the future. However, only 10 people expressed that fear. Still fewer expressed the worry of lack of money presently or worry of old debts. A scanty 3 people were worried about being dependent on other people.

Work Problems

The trend is generally for less people to be employed after hospitalization and for more work to be unskilled, part time and irregular. (Appendix B, Table 20)

Of the 13 individuals who were presently working, 10 felt that their fellow workers and boss were easy to get along with. Six felt that they did have work problems. Asked if anything bothered them at work, 2 complained of lack of coordination and energy, 2 of slowness and fear of making

mistakes. One person thought the job did not pay enough and 2 complained of the pressure on the job.

Five people were looking for work. Three went fairly regularly to the employment office and 2 made some attempt to find work. These people thought that more jobs available, more education, and more confidence would be useful in getting work. "More experience would be useful. Once employers knew that you had been in hospital it made things more difficult."

Others who were not looking for work were women with children, those who were too old, and those who thought that their emotional problems were too severe. Some explained that they were afraid they would "not measure up", "lacked the confidence" and "didn't have the spunk."

In summary, we see a number of people on marginal incomes, and notice the tendency for those who work to get worse jobs after hospitalization. Nineteen people worry about finances and most of these worry about future financial difficulties. Most people stated that they got along with the people they worked with, but almost half thought that they had some work problems. Only 5 people were looking for work, most of these hesitantly. Some others who were not looking for work, were fearful.

We shall now look in detail at the work needs of the single man, single woman, married man and married woman. We shall consider the needs and help given for those who are working, those who are looking for work, and those who are not

looking for work.

We will describe each group so that the reader may have some understanding of the capacity for work. We will usually enumerate age, education, diagnoses, number of hospitalization, and work experience.

Work Needs of the Single Man

The 11 single men in our sample are fairly young. Seven are in their twenties or thirties. Most have been hospitalized 3 times. Five have grade 10-12 education, 4 have from 7-9 and the others have less. Only 3 are skilled workers. Three were working, 2 looking for work, and 6 not looking for work.

Those 3 who did have jobs had large age and educational range. All were unskilled. Two were diagnosed as depressive reactions, and one was schizophrenic. Two indicated that they were having work problems, but were not getting any help. One did not state any problems or any help. Two men were not on medication.

Both men who were looking for work were young and lived with their mothers. They had grade 12 education and were unskilled. They were diagnosed as schizophrenic and had 3 and 5 hospitalizations. Both had work experience. Each stated that he had work and financial problems, but thought he was getting no help from the Clinic or any other agency. One of these men was not receiving medication.

Of the 6 men not looking for work 5 were on Social

Assistance and 1 on Disabled Person's Allowance. They had a large age and educational range. All were schizophrenic except for one, and most had been hospitalized at least 3 times. Only one had worked before. Five indicated that they had a financial problem, and most said they were getting help from other agencies. Three stated that they had a work problem, but were receiving no help from the Clinic or any other agency. All were on medication.

Work Needs of the Single Woman

The 9 single women in our sample comprised 3 who had grade 7-9 education, 3 who had grade 10-12 and another 3 who had some university. Two stated that they had jobs, 3 that they were looking for work, and 4 that they were not looking for work.

The two working women had a large age and educational range. One felt that she had no work problems. The other mentioned work problems, but felt she was receiving some help for this problem from the Clinic. Both were receiving medication.

Three women were looking for work. Two had dependent children and both were young. One had a grade 9 education and the other had a grade 12 education. One was diagnosed as schizophrenic and was hospitalized 7 times; the other was diagnosed as a depressive reaction and had been hospitalized once. The former woman stated both financial and work problems and felt she had received no help from the Clinic or any other

agency. She was on medication. The latter woman stated financial and work problems, but thought she was getting some help from the Clinic for her work problem. The third woman was in her forties and had a grade 8 education. She was living on Social Assistance. She had been hospitalized once and felt she was getting no help for her work problem.

There were two older women who were not looking for work. One was on a pension and the other received money from her husband's estate. Neither had any financial or work problems. A third younger women on Disabled Person's Allowance stated she did receive financial help, but thought she had a work problem for which she was not receiving help. Our fourth woman was in a very confused state and was rehospitalized as mentioned earlier.

Work Needs of the Married Man

Of the 8 married men four men were working, and the remaining 4 were not looking for work.

One of the working men was in his thirties, 2 were in their forties, and the other in his fifties. Two were diagnosed as schizophrenics and 2 as depressive reactions. One was a university graduate and the others had grade 9 or less. Two were unskilled, one skilled, and one professional.

One person stated that he had financial and work problems and was getting no help. Another stated work problems and no help given. One felt he had no financial or work problems and a fourth stated work problems, but thought he

was receiving a lot of help from the Clinic and therapy group for this difficulty.

Three people not looking for work were all over 60 and were retired. They stated no financial or work problems. The remaining person not looking for work was a young man with 3 children. He was living on Social Assistance, was diagnosed as schizophrenic, and had been hospitalized twice. He had a university degree. He thought he had financial and work problems, but was not receiving any help. All were taking medication.

Work Needs of the Married Woman

There were 2 married women with jobs. All the rest were not looking for work. One woman had obtained her job with the help of the Clinic. Both working women stated financial problems and no help given.

There were 15 women not looking for work. Six thought that they had no financial or work problems. One stated a financial worry and a lot of help given by another agency. Two stated financial problems and no help given, and 3 stated work problems and no help given. Other women indicated that their husbands were receiving Social Assistance, Workmen's Compensation, Veteran's Allowance, or Old Age Pension. Of these women a few stated financial problems and work problems and no help given from other agencies.

In summary then we find the following problems and help given.

Table 22. Statement of Work Problem and Help Given

Work Problem Stated By	Help Given by Clinic
1 Single Woman Working	YES
1 Single Woman Looking for Work	YES
1 Married Man Working	YES
3 Married Women with Husbands on Some Assistance	YES
6	Total
1 Single Man Working	NO
1 Single Man Looking for Work	NO
2 Single Women Looking for Work	NO
1 Single Woman Not Looking for Work	NO
2 Married Men Working	NO
1 Married Man Not Looking for Work	NO
3 Married Women Not Looking for Work	NO
11	Total

C. Home Needs and Help Given

In this section on home needs we will consider the interviewer and client estimates of housing and housekeeping problems. We will then look at the client and interviewer assessment of family relationships. Finally, we will examine the home needs of married and single men and women with particular attention to those with children and those who were,

according to interviewer estimates, coping, not coping, or partially coping.

Client and Interviewer Estimate of Housing Problem

The overwhelming majority of the clients rated their accommodations as satisfactory. The interviewers estimated housing and neighbourhood as very poor, poor, fair, good, very good, and excellent. They found 30 individuals to have fair or good housing, 9 fell below that and 5 were above. Similarly with neighbourhood, 32 people were rated as living in a fair or good neighbourhood. Seven were in poorer areas, while 5 were in better areas. (Appendix B, Table 21)

Asked about their accommodations some people complained that there was not enough room. Several people had more than 2 people sharing one bedroom. At least 5 accommodations were in the skid row of downtown Vancouver: dingy single rooms generally unattractive and dirty.

Usually people lived in their residences for some time. Thirty had been in their home over a year. The overwhelming majority of people had been out of hospital under 6 months.

Client and Interviewer Estimate of Housekeeping Problems

The interviewers also rated the housekeeping standards. They considered 30 to have fair to good housekeeping, 7 to have poor or very poor, and the remaining 7 to have very good. (Appendix B, Table 21)

About half of the people prepared meals themselves, handled the grocery money, and did the cleaning. About one-third did the shopping and laundry. Some people shared these tasks, notably the cleaning. In other situations, others took household responsibility, especially for the shopping and the handling of grocery money. Only 5 people said they were unsatisfied with the housework situation. Thirty thought that they were satisfied or fairly satisfied. (Appendix B, Tables 23 and 24)

In the probe questions about a dozen women complained of the housework. Some said they had no interest in it, others said they had no energy to do it and no ambition to keep it up. About a half dozen people lived in filthy conditions and were satisfied with the housekeeping. Many of these were single people, but some had families. Those who lived in boarding homes or with friends or relatives had relatively satisfactory living conditions.

Interviewer and Client Assessment of Family Problems

Most people felt that they understood others and that others understood them. When we compared understanding of others with others understanding them, we found that people generally felt that they understood others more than others understood them. In the probe questions it seemed to the interviewers that many of these people had a rather superficial understanding of the people they lived with. (Appendix B, Table 24)

Only 7 people thought that their relationship with their family was poor or very poor. The remaining 27 thought that they got along well or very well. Only one person stated that he often thought of leaving, although about one-third considered it sometimes.

According to the interviewers, it seemed that about half a dozen people had good relations with their spouses. The spouses were realistic and supportive. Several people had adjustment problems, but were managing. A number had little contact: they were "leaving each other alone." Another half a dozen were continually quarrelling, fighting over money problems, and drinking heavily.

Children presented some problems. Some worried about older children: their rebellion and "boy crazy" behavior. Smaller children were discipline problems and a source of frustration to some of the married women.

Other individuals were living with their family of orientation. There were frictions in these homes.

Home Needs of the Single Man

For home needs we will consider any statement of personal, marital, or other family problems. The interviewers assessed 4 individuals as not coping, 5 as partially coping and 2 as coping. Again background information is provided on each group to help the reader make a fuller assessment.

The 4 individuals who were not coping ranged in age

from 30-50 years. Three were schizophrenic and only one had been hospitalized less than three times. Three lived by themselves and none was working. None of these men stated any personal or family problems and no help was indicated. One man was not taking medication.

Those partially coping ranged in age from 20-40 years. All had been hospitalized 3 times or more. Most were schizophrenics. One lived by himself, one boarded, one lived with a brother and 2 lived with mothers. Two had resided at their present addresses less than 6 months and the other 3 had not moved from their families. Only one had a job. Three persons stated a personal problem. Three listed other family problems. None of these men said that they had received any help. Three were taking medication and 2 were not.

The two men who could cope both had jobs. One lived with friends and the other by himself. No problems were stated by these 2 men and no help given.

Home Needs of the Single Woman

There were 3 women who the interviewers estimated were not coping, 5 who were partially coping and one who was coping.

The 3 women who were not coping were older. All were schizophrenic and had been hospitalized 2, 4, and 6 times. Two lived by themselves and one with a sister. One had recently moved and the other 2 had lived in their residence for over one year. One had a job. Two of these women said

that they had no problems and were receiving no help. The third stated a personal and other family problem and thought she was getting some help from the Clinic for these problems.

For those partially coping there was an age range from 20-70 years. Three were diagnosed as schizophrenic and 2 as depressive reaction. They were hospitalized from one to 7 times. One lived in a boarding house, one with her sister, one with her mother and daughter and one with her parents and son. The fifth lived alone with her children. Three of these women said they had no problems and were not getting any help. The other two women both had children and stated personal and other family problems. Both felt that they were getting some help from the Clinic.

One person was coping. She was 50 years old, had been hospitalized only once. This person had a job and lived in a hotel. She stated no problems and no help given.

Home Needs of the Married Woman

Twelve of the married women had young children, 2 had older children and 3 had no children in the home. The interviewers found that 6 were coping, 8 partially coping and 3 were not coping.

All 3 of those women not coping had children. One woman said she had no problems and received no help. Another mentioned a physical problem and was getting no help. The third stated marital and other family problems. She thought that she was getting some help for these problems from other agencies.

One woman was not taking medication.

Two of the 8 women who were partially coping had no children. Both expressed physical problems and one a personal problem. No help was received. There were 2 young women in their twenties and 4 older women in their forties. Two of the older women said they had no problems. Two other older women said they had marital problems. No help was given. Both young women thought they had marital and other family problems. One said that she was obtaining some help for these problems and the other said she was receiving a lot of help from the Clinic and from other agencies.

One woman without children was coping. She expressed physical, marital and other family problems. She thought she received some help for her other family problems.

There were 5 women with children who were coping. Three people expressed physical problems: 2 felt they were receiving some help. Four women stated personal problems and 3 thought they had help given. Three listed marital problems but none were getting any help for this problem. Three stated other family problems and again no help was given. All these women were on medication.

Home Needs of the Married Man

Four of these 8 men lived with their spouses only, 3 with their spouse and children and one with his spouse and parents. There were only 2 men who had dependent children. One of these with children had a job and the other was on

Social Assistance. Both of these men had university degrees and were in their thirties and forties.

Four people stated no problems and no help given. One man stated a marital and other family problem. Another stated a personal problem and a third stated physical and other family problems. None of these people received any help. One man considered that he had a marital problem and said he got a lot of help through group therapy.

In summary we find:

Table 26. Statement of Home Problem and Help Given By Clinic

Home Problem Stated by	Help Given by Clinic
1 Single Woman Not Coping	YES
2 Single Women Partially Coping	YES
1 Married Woman Not Coping	YES
2 Married Women Partially Coping	YES
6 Married Women Coping	YES
1 Married Man	YES
13	Total
3 Single Men Partially Coping	NO
2 Married Women Not Coping	NO
4 Married Women Partially Coping	NO
2 Married Women Coping	NO
3 Married Men	NO
14	Total

In this chapter we have examined the characteristics of the sample and explored their social, work, and home needs. We have divided the sample into married and single, men and women and discussed each group separately. We have tried to give the reader some background information on each group that would prove useful in assessing the potential of these people for treatment.

In the next chapter we will discuss the significance of our findings in regard to an assessment of the services presently provided for the discharged patient.

CHAPTER 5

SIGNIFICANCE OF THE FINDINGS OF THE PATIENT QUESTIONNAIRE

A. Introduction

In examining the findings of our patient questionnaire, one must be cautioned to avoid making generalizations about the sample. In the first place, some problems arose in the selection of the sample so the 45 subjects do not constitute a truly random sample. Secondly, this is, of course, an exploratory study and there is no control group with which to compare the research sample. Some of the needs that we believe are characteristic of our sample, could well be characteristic of persons in the general population.

Because of the inconclusiveness of data, the writers are often only able to speculate on problems and unmet needs that appear to be present. We do believe, however, that the questions posed in this chapter are indicative of the necessity for further study concerning unmet needs of discharged mental patients and the organization of community services to meet these needs.

To look at our sample more specifically, we believe that one of the most significant features is the fact that 58 percent were diagnosed as schizophrenic. This percentage is in line with the generally accorded incidence of the

diagnoses of all those patients attending the After Care Clinic in Burnaby, B. C. The debilitating effects of the disease must constantly be kept in mind.

> It is often insidious in onset, preceded by gradual failure in a number of areas of life. Although treatment brings about a remission of acute symptoms, it might be thought of an essentially a chronic, phasic disorder rather than as a relapsing disorder because it often leaves a defect that continues to handicap the afflicted individual between acute episodes.[1]

Throughout the analysis of our patient questionnaire, the fact that there is such a high percentage of our subjects with the diagnosis of schizophrenia, is reflected in many of the questions raised and suggestions made.

Initially, we are interested in the general picture presented of the services given at the After Care Clinic.

B. Services Rendered

To go back to the time of discharge of the sample from the mental hospital, we find it quite surprising that in 34 percent of the cases the subjects state that the hospital had made no leave plan for them. We might speculate on several reasons for the apparent omission of this essential phase of rehabilitation. First of all, it might be as the patients state, that no leave plans were made. Secondly, it might be that if made, they weren't communicated adequately to the

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1. Cumming, Elaine and John. "Some Questions on Community Care." Canada's Mental Health, 13(6), p. 9.

patient or thirdly, perhaps the subjects we interviewed were rather hazy on what had been done. It is considered that contact by the hospital psychiatrist or social worker with relatives is also an essential factor in discharge planning but according to some of the patients this contact was not always made.

The subjects of our sample express 72 problems that they are concerned about. It is interesting to observe that the After Care Clinic is giving assistance on 20 of these problems whereas the community agencies are giving help on 35 of the problems. Such community agencies and individuals are the Public Health Nurse, school counsellors, Provincial Department of Rehabilitation, City Social Service, Department of Veterans Affairs, Outpatient Department of the Vancouver General Hospital. We might wonder in what way these agencies became involved with the patients, i.e. if referrals were made by hospital or After Care Clinic personnel. Initially, of course, the making of referrals is the responsibility of the hospital at the time of discharge of the patient. One of the most significant concepts that is noted again and again in the literature is that of the necessity of continuity of care. "The principle of continuity of care requires the closest possible co-operation and integration between the various services and professional staff."[1]

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1. Canadian Mental Health Association. More for the Mind. 52 St. Clair Ave., Toronto, Ont., 1963, p. 44.

When asked the question as to whether their difficulties had improved since coming to After Care, 12 persons of the total 45 reply "not at all" and 16 say "somewhat." Although it is difficult to assess the validity of their replies, we might look at the facts of the services available, i.e. 34 of the 45 patients see the psychiatrists for 1 - 15 minutes and for all practical purposes no social service help is givem to them.

The writers cannot help but feel that it is somewhat incredible that 44 subjects of the 45 total sample state that they have no contact with a social worker. Many of the problems the subjects note - financial, employment, marital, family - for which they receive no help would require the particular compentence of the fully-trained social worker to deal with - the capacity to understand the patient and his family, the knowledge of the community and its resources, and the skill required to bring patient and rehabilitation services together. Once again, we feel that we must repeat that with the rapid discharge policies now in effect, the patient cannot be expected to maintain any therapeutic gains made in hospital unless he receives adequate aftercare service.

If the community as a whole is to be served, treatment in most cases must be based mainly on supportive, reality-oriented therapy plus pharmacological and environmental lines. As stated above, 74 percent (34) of the sample see the psychiatrist 1 - 15 minutes. His

treatment then is going to be limited to dispensing medication and very brief, supportive "therapy." This may, of course, be the coming trend.

> Should the physician perhaps, be responsible for diagnosis, medical treatment and follow-up and leave to others who may be more skilled and more appropriately trained the problems of dealing with the social, vocational and other aspects of the patient's total needs?[1]

We are suggesting, then, that one of the most obvious lacks in meeting the needs of the patients of the After Care Clinic is the almost total absence, at least in our sample, of essential social work, counselling or rehabilitative services.

We stated that 58 percent of our sample were diagnosed as schizophrenic. This mental disorder is the outstanding problem for comprehensive community psychiatric services. Hospitals can readily obtain a remission which justifies discharge, yet all too often this is followed by early relapse in the community. It is true that we really don't know to what extent a comprehensive community service can relieve the chronic handicaps of schizophrenia. However, it is generally agreed that an aftercare service increases the chances of patients being able to remain in the community. Some studies[2] show that organized follow-up care of discharged mental patients can cut readmission rates by about half. Therefore, although there are great gaps in knowledge concerning a mental

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1. Roberts, C. A. "Community Psychiatry - Integration or More Specialization?" Canada's Mental Health, 13(6), 1965.

2. Free and Dodd, op. cit.

disorder such as schizophrenia, the problem remains of providing as effective an aftercare service as is possible at the present time.

Eighty-four percent of our sample are taking medication. As noted in Chapter 2, although the continued use of medication is felt to be helpful, the psychological and societal rehabilitation apparently play the most significant roles. Once again, as will be repetitiously noted through this study, we must point at the lack of social service contact. We might query what beneficial effect the drugs are really having on these 38 patients when for most of them there is an absence of the rehabilitation services believed to be the most important.

Sixty percent (27) of the sample are believed by the interviewers to be functioning minimally or less than minimally in the community. Although the accuracy of this figure can be questioned, it does seem to be of significance in bearing out the opinions of former patients of the mental hospital that their needs are not being met adequately.

C. Needs of the Sample

1. Work Needs

"Fundamental to adequate social adjustment is the ability to carry on a life task. For most adult men this means engaging in a gainful occupation; for women it may be either homemaking or employment outside the home."[1] With this

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1. Rose, A. Mental Health and Mental Disorder. W. W. Norton Inc., New York, 1955, p. 508.

in mind we wish to look at the employment pattern of our subjects. While we recognize that any conclusions must be tentative because of the size and selection of the sample, we feel justified in making certain comments about employability factors that appear to stand out rather sharply.

To look at the general employment picture, we find several aspects that could be significant. We note for instance that six of the 13 persons working complain of slowness, lack of energy and co-ordination. Five unemployed people express considerable hesitancy about looking for work and others are afraid to look at all. It might be wondered if these problems could be due to temporary or long-term residual effects of the mental illness, effects of any medication they are taking or to loss of their former ability to function more adequately.

We have a picture here then of approximately one-third of our sample expressing unmet needs. We can only speculate what would be necessary to meet these. It might be that the overall effect of the medication should be examined, that work assessments should be made, that re-training or sheltered work placements should be explored.

Of the 11 single male subjects, seven are unemployed whom we might normally expect to be employed in our society. To look at this more closely, we are able to ascertain some of the possible reasons for unemployment. We have a picture of frequent relapses in mental illness and several of these

subjects have limited education. Of the seven, six have been diagnosed as schizophrenic. As noted earlier, schizophrenia often leaves a defect that continues to handicap the affected individuals between acute episodes. We have to consider that many of these persons may not have acquired work skills or an employment history helpful in planning any rehabilitation. Although we might assume that possibly several might not be able to meet the demands and pressures of private industry, they might be able to do a limited amount of work under sheltered conditions. We have to remember, of course, that frequently the problem is characterized less by the necessity of finding work for the patient than the need to sustain him psychologically so that he will not have to return to the hospital.

As far as the married men are concerned, one man only is on Social Assistance. This man aged 34 has a specialized University education. His diagnosis was schizophrenic reaction, paranoid type. He is, of course, a very isolated case, but the complexity of problems in rehabilitation and treatment are pointed out here - the necessity to look at the severity of illness, the home situation, cultural background, pressures of responsibility. All of these factors would be of importance in his capacity to be employed and would have to be taken into consideration in order to be able to plan adequately to meet his needs. The subject in question stated he was not receiving any help for his employment problems from either the After Care Clinic or any other agencies.

Two of the nine single women are on Social Assistance and both require considerable help. Both were diagnosed as schizophrenic. One, a young woman of 26 has a history of seven or more hospitalizations. She has less than a Grade nine education and no special work training. She lives with her parents. From the files we know that it is believed her environment is not conducive to her improvement. Alternative accommodation in a halfway house had been arranged for her at one point but she had declined to try it and returned to her family's home. Now that the patient has returned, the writers suggest that her needs might be best met by giving casework services to the family and by endeavoring to psychologically sustain her in the community. The other woman on Social Assistance, aged 41, has Grade eight education only, has done housework at one time, and was at the time of our contact from the interviewer's impression, incapable of holding a job.

Both of these two single unemployed women state that they are not receiving any social service help through the After Care Clinic or from any other community agency. One, however, feels she receives some help from her psychiatrist at the After Care Clinic for her personal problems.

Concerning the married women, a significant fact for the purposes of our study is brought out. Some of the women subjects who state their husbands are on Social Assistance or are receiving pensions of some type, indicate there are financial and work problems in the home. We might wonder to

what extent the women's mental illness is affected by their economic situation or conversely, to what extent the work status is affected by the illness. We might ask who is responsible for giving these families some type of service? Would it be community agencies or the After Care Clinic? Because of uncertainty, would no one feel responsible?

2. Social Needs

There are two aspects that should be borne in mind when assessing the social adjustment of our sample. In the first place our middle class Canadian culture is strongly oriented toward social activity. However, not all persons who are discharged mental patients come from such backgrounds and their values and those of their families may differ from the middle class norm. Secondly, although a pattern of social activity might seem quite restricted to the interviewers, it has been found that former patients who feel that their existence, although it might be lonely and inactive, is consonant with their preferences, adjust significantly better than do those who seem to prefer a greater or lesser activity level.[1] We have to keep in mind, also, that those who have numerous activities and interests display a more successful level of adjustment in general.

Five of the single men in our sample who have very poor social contacts had the diagnosis of schizophrenia and none are receiving any help in the socialization area. Per-

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1. Minnesota, op. cit., Section D, p. 9.

sons suffering from this disorder usually find it hard to relate to others. Part of the treatment in hospital is directed to their resocialization, but unfortunately, any therapeutic advances made during hospitalization may well disappear if following discharge the patient has no further opportunity for social contact. In all of Vancouver, there is only one socialization resource with services specifically for patients discharged from Riverview Hospital. This is the White Cross Social Center of the Canadian Mental Health Association.

An interesting point to the interviewers is that none of the single men and women who are felt to have very poor socialization activities are being given any help by the Clinic or any other agency. Yet the three single women who have been helped, have fair social contacts, and are able to state that they have problems. We might ask if any help that is given is directed to the individuals who have more hopeful prognoses and who are able to verbalize their difficulties, and the persons with the least hopeful prognoses and poorest communication abilities, are neglected. We might suggest that the lack of help given seems bound to be reflected in the high re-hospitalization rate and could assume the form of a vicious circle.

We observe that most people are not satisfied with their social life and we receive a rather general feeling of hopelessness in the comments made concerning their entire situation. We might remember that it is in the very nature

of mental illness that patients give up helping themselves or or often even seeking necessary assistance. They therefore require a reaching-out service. We are suggesting then, that these people are expressing unmet needs, that some service must reach them if they are to be more "in" the community, not just on the periphery.

A very significant point in line with the above is that not one of the patients is involved in any social activities that the After Care Clinic sponsors at the Burnaby Mental Health Center. For one thing, the Clinic is located in a place very awkward to reach except by automobile. It is also of note that the Clinic is located in Burnaby, while the greater portion of the patients live in Vancouver. The California Survey[1] observed that it appears that the likelihood of utilizing a community psychiatric clinic productively decreases in proportion to the distance the patient must travel to reach it. We know that the inconvenient location, the distance and cost of the transportation make it difficult for many patients to come to the Clinic for treatment. Therefore, unless he has ready transportation and happens to live near the Clinic, he is unlikely to utilize any social activities.

3. Home Needs

There are several factors it is helpful to keep in mind while looking at the home needs of the subjects. One is

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1. California, op. cit., p. 7.

that studies have shown that in families where there is a high emotional involvement between the psychotic patient and one or more family members and where contact with them is as long as 35 hours a week, the hospital readmission rate is significantly higher than for low-involvement, low-contact patients.[1] The Minnesota Study researchers[2] stated that one of the important factors affecting hospitalization of the patient is the tolerance felt by relatives in his immediate environment for his behavior. It was found for instance, that the patients placed in nursing and foster homes, although they might have had a longer period of hospitalization and were considered a "poor risk" had a significantly lower re-hospitalization rate. The operators of the homes had a greater tolerance of deviance. At the same time, the study concluded that an optimal balance of tolerance and anticipation of normal behavior is important in the ex-patient's adjustment.

Looking at the picture in general concerning home needs, we see that 24 of the 45 subjects have had three hospitalizations or more. Of the 24, seven have had seven or eight hospitalizations. Fifteen of the 24 were diagnosed as schizophrenic. Only one of these 15 is living by himself, in

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1. Titmuss, Richard M. "Community Care of the Mental Ill: Some British Observations." Canada's Mental Health, Supplement No. 49, Nov.-Dec. 1965, Department of National Health and Welfare, Ottawa, Can. p. 5.

2. Minnesota, op. cit., Section D, p. 14.

a boarding home. The remainder are living with their spouses, parents, mothers, relatives and friends. They are going to be inevitably involved in the interpersonal relationships in the home. We are justified in asking whether it is possible that the environment is a factor in the number of hospitalizations of these persons, and whether an alternative environment is less likely to produce exacerbations.

We further note in this connection that two young single men are living with their mothers and one young woman with her parents. The total number of hospitalizations for the three is 15. Current theories of the etiology of schizophrenia in regards to the effect of familial environment emphasize even further the reason for exploring the environment of these persons. None of the three are currently receiving assistance concerning family relationships, although we know attempts had been made to help the young women in the past.

Freeman[1] states that the trend of discharging patients to the community who would be formerly kept hospitalized due to chronic mental illness can mean that the burden shed by the hospital will be passed on to the family and will eventually be seen in various kinds of secondary breakdowns in family members. Repeated relapses of patients with all their assoc-

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1. Freeman, Hugh. "Community Mental Health Services and the Mental Hospital." Presented May 3, 1963 at a Conference held by the Pueblo Association for Mental Health in Pueblo, Colorado, p. 164.

iated social disruptions will exhaust the tolerance of relatives and of the community in general.

What about the subjects with children? Of those with three or more hospitalizations, (24), eight have children of school age or under. We might ask ourselves what the repeated hospitalizations are doing to the children. Who looks after them when the mother of a family is hospitalized? Homemaker service is almost non-existent in comparison to the needs of the area served by the After Care Clinic. There are often only two adults in the family unit and it is very difficult for the duties of either one to be taken over by the other. Frequently it is the children in the family who suffer most when a parent is hospitalized because of mental illness. Not only are there the immediate problems in relation to the care of the children, but there are the long range effects to be considered. One study[1] indicates that children coming into the care of a child welfare organization are three times more likely to have a mentally ill parent than those with an ordinary background. Of the 12 married women with preschool or school age children, none seem to be obtaining any specific help from the After Care Clinic regarding the care of their children. Assistance to discharged mothers with children would seem to be an essential of any adequate aftercare program.

In connection with carrying the responsibility of

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1. Titmuss, loc. cit.

homemaking tasks, we note that only six of the 17 married women seem to be coping adequately. What happens to the 11 persons in the roles of mothers and wives? We might ask ourselves if the tolerance of the families is not being strained.

D. Conclusions

From the data of our patient questionnaire and the opinions of the subjects as to the ways the program meets or fails to meet their needs, the following salient points have emerged:

1. The subjects express 72 needs, financial, work, personal, physical, marital, and others, such as family problems. They state they are receiving no help from the After Care Clinic for 47 of the needs but some help for 16. On the other hand, they say they receive some help for 17 of these needs and considerable for 18 from community agencies.

2. Fifty-eight percent of the sample were diagnosed as schizophrenic. This fact must be kept in mind when considering how their needs must be met and that a wide range of services will be necessary.

3. In 34 percent of the cases, the hospital made no leave plan for the patients and there was a lack of contact with "significant others."

4. Seventy-five percent of the patients state they see their psychiatrist for 1 - 15 minutes, usually once a month.

5. Ninety-eight percent of the patients do not receive social services.

6. Sixty percent of the subjects, according to the interviewer's impressions, are functioning minimally or less than minimally in the community.

7. Fifty-three percent of the sample have had three hospitalizations or more. Fourteen percent have had seven or more hospitalizations.

8. Of the 11 single men, seven are unemployed and we have a picture of frequent hospitalizations and limited employment opportunities due to lack of education and training. It seems unlikely that several would be able to function in the usual work setting. Only one of these persons receives any help from the After Care Clinic or community agencies in this regard. Two single women are on Social Assistance. One states she receives some help through her psychiatrist at the Clinic concerning work problems.

9. Five of the single men in the sample have very poor social contacts but state they are receiving no help in this area.

10. The After Care Clinic social program held at Burnaby, B. C. is not utilized by any of our sample. The writers suggest that distance from Vancouver might be a reason.

11. The subjects, in the writers' opinions, are directly and indirectly expressing a wide range of needs that are not being met, such as employment, possible sheltered work placements. There are needs for marital and family counselling, socialization and recreational activity, halfway houses. It is the unexpressed need, still unarticulated as demand that is the unknown quantity.

We have posed a number of questions in this chapter that we judge as legitimate. We are aware, of course, that we have not been able to obtain all the facts that are of importance in the questions raised. However, we do feel justified in taking note of various factors that appear to be of significance in meeting the needs of discharged mental patients through an aftercare program. In our next chapter, we will look at the opinions of professional personnel from Riverview Hospital with regard to the present aftercare program at Burnaby Mental Health Center and also the opinions

of various community agencies that have contact with some of the discharged psychiatric patients.

CHAPTER 6

QUESTIONNAIRE TO STAFF

In order to ascertain staff attitude towards present After Care program and the purpose of After Care, a questionnaire was submitted to five staff doctors and five social workers who are either presently or were formerly attending the After Care Clinic. Results of the enquiry indicate very decidedly that the service is inadequate. (Question 1 - Appendix C).

A. Findings

1. Purpose of the After Care Clinic.

In the opinion of the ten professionals questioned the main purpose of the After Care Clinic was to provide the discharged patient referred to the service with an immediate post-hospital contact, thereby filling his dependency needs, and, helping control acute symptoms. In the opinion of at least half of those questioned, symptom relief, and the prevention of rehospitalization were the main aims of the After Care Clinic (Question 2 - Appendix C). Pharmacotherapy was heavily emphasized in the After Care program (Question 4 - Appendix C). The main therapies employed were listed as (a) medication, (b) individual supportive therapy, and (c) brief reality therapy (Question 3 - Appendix C).

2. Character of Service

Both the quantity and quality of the present service was felt to be unsatisfactory by a majority of the professionals. (Question 9a and 10 - Appendix C).

3. Types of Patients Referred

Main categories of patients referred to, or seen at After Care were schizophrenic, schizoid, and depressed. Many of the other problem types, for example, alcoholics, inadequate personalities, marginally adjusted skid road patients, and sociopaths, in particular, were not usually seen at After Care. (Question 5b and Appendix C). Obviously there are many patients who do not receive support from After Care nor from any other agency in the community.

4. Participation of Staff

Attendance at the After Care by the professionals interviewed was less frequent than might be expected. As a point for serious speculation three of the five social workers were attending not at all. (Question 5a - Appendix C). Among the reasons given by the social workers for not attending were: "too involved with in-hospital caseload", "not convinced of the value of the present After Care set-up."

5. Extent of Contact

The average time spent with a patient by the visiting doctor, who saw an average of 8 patients in three hours, was 15 minutes. Actual time spent by the doctor with the patient would be reduced by time utilized to write up daily

prescriptions and brief dictation on each patient seen. Visiting social workers spent an average of 30 minutes with each patient and saw an average of four patients in three hours. The permanent staff psychiatrist of the After Care program averaged 20-30 minutes per patient and saw 20-30 patients each week. The permanent staff social worker spent an average of 30 minutes per patient with the 30-40 patients seen on the average weekly. (Question 6 - Appendix C).

6. Other Resources

Community resources regarded to be chiefly involved in shared responsibility for any adequate program of after-care in the community of Greater Vancouver included the two main psychiatric units, namely, the Burnaby Mental Health Centre and the Vancouver General Hospital. Other health and welfare agencies such as Metropolitan Health, the Family Service Agencies, and the Department of Social Welfare were viewed as related parts in the total aftercare picture. The private psychiatrist, and the general practitioner were also seen as fundamental resource persons to the program. These findings relate to Questions 7 and 8 - Appendix C of the Questionnaire. As designed, these questions, unfortunately, proved too complicated and as a consequence, tabulations have been omitted.

7. Basic Therapies

Questioned as to the type of therapy regarded to be essential in an adequate aftercare treatment program, the

doctors listed individual supportive therapy as foremost therapy; the social workers listed co-ordinated rehabilitation planning. This probably reflects the particular orientation of each discipline. Medication and brief reality oriented therapy were definitely regarded to be important in the after-care program and reflected the most commonly employed forms of therapy in the present nominal After Care service. Family therapy and group therapy as far as both doctors and social workers were concerned, were seldom embarked upon but were viewed as important forms of therapy in any adequate after-care service. Long term extensive psychotherapy was regarded by both disciplines as the one "unessential" therapy form for aftercare. (Question 2a and 2b - Appendix C).

8. Staff Attitude

It goes without saying that the basic philosophy of the therapist considerably affects the treatment approach. As evidenced from the findings of the questionnaire, the marked trend towards a medical-pharmaceutical therapy orientation would narrow the base of service mainly to an extension of in-hospital treatment with heavy emphasis on medication. As a consequence, professional sights on the overall social and rehabilitation goals are desultory and lacking in any consistent sharp focus. This situation is best reflected in the limited role of the social worker in the present aftercare program.

9. Suggested Improvement of Service

Ways in which the aftercare services can be improved were suggested. The open question (Question 12 - Appendix C) evoked some interesting and constructive ideas of a more comprehensive sort together with other, briefer, unelaborated responses. In their comments, doctors and social workers alike expressed ideas cogent to the concept of an adequate aftercare service. These ideas involved the area of organization of aftercare services with its related problems of staffing, locating and service coverage. Ideas were also expressed which are central to comprehensive aftercare programming - total co-ordination of aftercare resources, development of resources tailored to the needs of the patients, decentralization of After Care Clinics, and broad community involvement. Also mentioned were the establishment and utilization of community-centered treatment resources such as Pre-Admission Service, Day Care Units, and a brief 2-3 day In-Patient Clinic.

B. Analysis of Findings

1. An Analysis of the Staff Questionnaire

An analysis of the Staff Questionnaire reflects the concensus of professional opinion that the present aftercare is giving only nominal service in both coverage and diversity. The findings have indicated that many patients who may require contact with the After Care Clinic are discharged from Riverview Hospital without referral for aftercare services. These are the patients who exist in the community largely as social

rejects, appearing as frequent clients at the Vancouver General Hospital Out-patient's Department or as re-admissions to Riverview Hospital. Additionally, many patients who could derive benefit from group discussion or marital counselling are denied this help owing to the limited nature and aims of the present aftercare program. In essence, if as the literature suggests, an adequate aftercare service is based on the 'spectrum' idea of offering a diversified service to a variety of different clients, then the doctors and social workers are justified in concluding that in its present state, the After Care Clinic cannot, by any means, be regarded as adequate. At present the aftercare service is essentially a medically focused service and as such offers the social worker a very limited role in the total program. This largely would explain why not all social workers attend the Clinic and why the Social Service Department as a whole is not more active in the aftercare program.

2. The Idea of Co-ordination

The idea of co-ordination - a close link between hospital and the community - recurred throughout the questionnaire. It seemed obvious from the comments of both doctors and social workers than an aftercare program cannot operate in isolation but should be integrated with the community and the resources therein. In the local area at the moment, it is evident we have not yet consolidated the first step towards better co-ordination and that integration of After Care Clinic with other community resources in Vancouver is as yet a far cry from reality.

3. Leadership

The conviction comes through in the questionnaire that the Mental Health Services must provide leadership in the development and co-ordination of aftercare services with other community resources. It is illogical, after all, to expect a resistent and poorly informed community to assume the leadership role. The implication is that without considerable support to develop services for the mentally ill, the community will not only resist involvement but may well mobilize its hostility, and end up by closing its door more tightly on the problem.

QUESTIONAIRE TO AGENCIES

A. Introduction

In an attempt to elicit an opinion concerning the division of responsibility between aftercare and community agencies, the adequacy or otherwise of the aftercare service from the viewpoint of the community agencies, the major problems in planning as seen through the eyes of the community agencies, letters were submitted to twelve community agencies. In sending questionnaires to these community agencies, the writers hoped to obtain a feedback which would shed further light on the adequacy of aftercare services and which also would assist in validating the findings of our study.

B. Agencies Selected

The agencies selected fell within the catchment area in which the group of patients in the sample for this study were namely drawn. Our inquiries were directed to the following agencies, most of whom had a responsibility in accordance with the agency function to meet the needs of discharged patients living in their area. Inquiries were directed as follows:

Metropolitan Health Services	4
Social Welfare Departments	3
Children's Aid Societies	2
City Social Service Department	1
Canadian Mental Health Association	1
Family Service Agency	1

C. Responses Obtained

In response to our inquiry, all of the agencies contacted replied. Two of the agencies returned most comprehensive, well considered reports. The remainder showed varying degrees of awareness of the function and responsibility of the After Care Clinic. One social welfare department administrator stated that he had little knowledge of aftercare. Partly this lack of knowledge can be attributed to the fact that his particular agency had been involved minimally in planning for discharged patients, and partly to the fact that very little effort has been made by hospital administration to publicize or interpret the service to the community.

D. Findings of Questionnaire

1. Adequacy

Tables of the Agency Questionnaire will next be reviewed. The ideas and attitudes of community agency administrators and personnel are reflected in this section via the questions. With one exception, all of the agencies replying to the questionnaire termed the service provided by the After Care Clinic inadequate in their opinion. Among the reasons most commonly put forth were: the distance involved in getting to and from the After Care Clinic: the lack of sufficient coverage in numbers of patients discharged to the community and still requiring follow-up: the brevity and

infrequency of contact between the patient and aftercare following discharge from the hospital: the problem of patient motivation: the emergencies which arise after hours and on weekends when no aftercare help is available: and finally, the lack of adequate community resources to deal with the variety of problems presented by the different types of discharged patients. (Question 1 - Appendix D).

2. Liason

Insufficient liason was felt to be a problem by more than half of the agencies both in regard to other agencies and to the After Care Clinic. Lack of referral by the agencies and hospital alike occurred all too frequently. Failure by the hospital to notify appropriate agencies of termination of in-hospital treatment and discharge of patients to community was likewise, a frequent omission. Communication difficulty was listed as the third main problem area for community agencies, with staff shortages and diverse discipline orientations at the base of the difficulty. (Questions 2 and 3 - Appendix D).

3. Division of Responsibility

Division of responsibility for provision of services to discharged patients is covered under (a) own agency responsibility, (b) other agency responsibility, and (c) After Care Clinic responsibility.

(a) Own Agency Responsibility

Own agency responsibility included mainly

financial help to patients - social assistance, boarding placement, clothing. The second major service given by a number of the agencies to discharged patients and their families was concerned with the care and protection of children. One Vancouver agency functioned to meet the social and recreational needs of ex-patients. Limited supportive casework was only once mentioned as a given service and reflects one of the greatest gaps in on-going community help to the discharged patient. Family counselling service (if appropriate following assessment) was mentioned as being a function by one agency. (Question 4 - Appendix D)

(b) Other Agency Responsibility

Other agency responsibility it was felt should be determined by the needs of the patient. Mentioned as agencies which should assume responsibility for meeting the needs of ex-patients were: The Family Service Agency for casework services, The Community Neighbourhood Houses for group work services and group activities, The Metropolitan Health Clinics in the case of pre-school and school children, and The Canadian Mental Health Association in the area of socialization and recreation. (Question 5 - Appendix D)

(c) After Care Clinic Responsibility

After Care Clinic responsibility was viewed critically by the various agencies contacted. Most felt the After Care Clinic should provide active consultation to other community agencies as well as giving an on-going

quantitative and qualitative supportive therapy to discharged patients. The need for a more frequent contact with the family doctor was emphasized as well as a more aggressive and sustaining follow-up service by the After Care doctors and social workers. One agency felt better control ought to be exercised by After Care over the unmanageable or dangerous patient. (Question 6 - Appendix D)

4. Major Planning Problems

Major problems in planning for discharged patients were cited by the community agencies as follows: rapid discharge with inadequate discharge planning; lack of sustained contact following discharge and lack of adequate follow-up by both doctors and social workers; unproductive referrals to the family doctor; and lack of adequate referral to the community agencies involved. Insufficient planning for needed service was coupled with the lack of suitable community resources (i.e. appropriate jobs, suitable living arrangements) and an insufficiency of trained professionals. Also, the point was expressed of insufficient concern for the protection of the community and the inability of community agency personnel to provide adequate supervision. (Question 7 - Appendix D)

5. Other Comments

Other constructive suggestions included: emphasis on prevention using the Mental Health Centre for referrals and screening to avoid unnecessary hospitalization; an estimate

of present and projected needs for service so that services on an on-going basis might be provided; responsibility for the development and provision of these services to the mentally ill; adequate medical supervision on a twenty-four hour basis, with home visits when necessary; tailored resources such as small living units operated by qualified people, sheltered workshops, suitable job placements, and the opportunity for socialization. (Question 8 - Appendix D)

E. Analysis of Findings

Analysis of the Agency Questionnaire indicates in many instances, sharp awareness on the part of community agency administrators where the problem of the mentally ill person in the community is concerned. As a matter of fact, one feels the views expressed reflect a realistic interest in the current trend towards comprehensive community psychiatry.

1. Responsibility in Development and Provision of Service

In general, administrators of social agencies are keenly aware no array of therapeutic and supportive programs exist to meet the needs of patients discharged to the local community. Existing resources are slim, and more often than not, lacking altogether. Each agency sees itself giving only its primary service--not including psychiatric follow-up. It seems apparent that the community agencies, involved as they are in their own particular sphere of function, are not going to take the initiative for developing and providing services to the mentally ill. This means of course, initially, the

major responsibility for the development and provision of aftercare services must inevitably lie with the Mental Health Service Division. The implication here is that if the community agencies are expected eventually to carry their own programs for aftercare, then considerably more effort by the Mental Health Branch must be made to educate, involve, and support the community agencies to equip them to handle the problems of the mentally ill.

2. Coordination and Control

Further, from the comments made, agency administrators feel keenly about the inadequacy of their staff to cope with the problems of the mentally ill in the community. They state, all too often when patients are discharged, the "felt" anxiety on the part of the community and of the community agencies themselves, is entirely disregarded by hospital administration. To expect the community, without adequate support, to assume responsibility where "threat" exists is wrong, particularly, when one stops to think how badly needed is a "therapeutic" community if patients are to be rehabilitated to that community. In this light, it would seem that coordination of services between the Mental Hospital and the community agencies is a must if control is to be brought into the present unstable situation between the community with its social agencies and the Mental Hospital.

3. Current Dilemma

In terms of post-discharge planning, a definite

schism appears to exist between what the hospital medical staff feel to be adequate treatment and planning and what the community agencies see as adequate. While, undoubtedly, community expectations are perhaps too high, the same may be said of hospital expectations in terms of what behavior is acceptable to the community or what community agencies can accomplish with limited staff and resources in terms of assisting patients in their social and vocational adjustment. Certainly the family doctor to whom many patients are referred for follow-up service, is in no better position than the community agency as far as time and training, but is able to provide medication. The crux of the matter would seem to be that the current trend of brief intensive treatment and rapid return of patients to the community has produced a dilemma in the provision of adequate aftercare services. This dilemma is reflected in the comments of community agency administrators on problems in planning.

CHAPTER 7

CONCLUSIONS

A. Introduction

From the beginning of this century there has been a persistent shift of the locus of psychiatric care toward the community and it is now generally believed that psychiatric patients should be treated early, speedily and close to home - 95 percent of general adult psychiatric cases, it appears, can be treated with, or without, hospitalization and can be maintained in the community with adequate treatment and supportive services.[1] Two patterns of community psychiatry are presently apparent. The first is the plan based on a community mental health center and the second, the integration of the mental health services with other community health and welfare services.

At the moment, the Burnaby After Care Clinic of the Provincial Mental Health Services is in the unique position of being somewhat in the center of two such patterns with no blueprint for the future visible. There seems to be no plan at the present of developing a community-based mental health center in Vancouver. The integrated approach of psychiatric services, based on general hospitals, although it has been in the discussion stage, has so far not materialized.

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1. Roberts, op. cit., p. 3.

Along with the conflicting opinions concerning the above two approaches, an extremely important factor to take into consideration is that of the recommendations of the Royal Commission on Health Services.[1] The Commission has made a number of important recommendations that are inevitably going to have considerable influence on our present services for the mentally ill. Some of the recommendations concern training grants for professional personnel, psychiatric wards or units in or attached to general hospitals, that such psychiatric units have out-patient departments, in-patient treatment and consultative service, 24 hour emergency service and "day" and "night" care programs. Another important factor is that a national health scheme will give free psychiatric service to everyone. It is expected that psychiatric coverage will be available under such a plan to 40 percent of the population for the first time, that percentage not covered now by pre-paid plans.

We hope and in fact expect that in time most of these recommendations will be implemented. However, we know that none of the recommendations will come into effect until July 1967 and that a great percentage of them will in all probability take at least several years.

In the meantime, we are faced with problems that must at this time be coped with. Ways must be found to meet the

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1. Canada, Royal Commission on Health Services, Report, Ottawa, Queen's Printer, 1964.

problems in caring for mental illness in the community and developing rehabilitation resources and also, the trends that are visible in mental health programming must be kept in mind.

In this thesis we have looked at, amongst other things, the needs of the patients served by the After Care Clinic, the opinions of the professional personnel regarding services and also those of the community agencies who see a portion of former mental hospital patients. Certain important ideas have emerged concerning the scope, co-ordination of services and the division of responsibility for those services.

B. Scope of Service

Aftercare is defined as any service which promotes the adjustment of the discharged patient as he starts life anew in the community. We have illustrated from our patient questionnaire that the needs of the former psychiatric patients are many and varied. Numerous resources are required to meet them. Treatment must be based mainly on supportive, reality-oriented therapy plus pharmacological and environmental lines if the community as a whole is to be served although intensive psychotherapy both individual and group, should be one of the treatment facilities available. Some of the newer aftercare facilities that are considered to be essential are specialized day and night hospitals, half-way houses, day centers, vocational rehabilitation resources, foster family homes, sheltered workshops, group and recreational outlets.

The professionals who are engaged in providing services at the After Care Clinic agree that medication and brief reality oriented therapy are the most commonly employed forms of therapy. However, they indicate that they believe a more diversified service that would include such facilities as noted above must be provided to meet the various treatment needs of the patients and further that the base of the service should be broadened to cover a wider range of patients.

It is recognized that there is almost a complete lack of the services that are considered a sine qua non of any comprehensive aftercare program. However, there are certain specific deficiencies we feel justified in noting.

1. Location

One of the greatest drawbacks of the After Care Clinic is the fact that it is not located in the center of population and undue hardship is imposed on many patients because of this. The Clinic does offer services one evening a month but the distance that most patients have to travel is a discouraging factor that adversely affects the full utilization of these services.

2. Emergency Night Time and Weekend Service

This type of service is not available to the patients of the After Care Clinic. The Amsterdam Municipal Psychiatric Service[1] which offers a 24 hour service found that well over 70 percent of emergency calls do not result in hospitalization.

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1. Lemkau, P.V. and Crocetti, G.M. The Amsterdam Municipal Psychiatric Service. A Psychiatric Sociological Review, American Journal of Psychiatry, Vol. 117, pp.779-783, 1961.

The Montreal General Hospital offers the same range of services and have found that the great majority of psychiatric emergencies take place during the night hours. In their experience close to 50 percent of all psychiatric emergencies do not require treatment in hospital. We feel that it is legitimate to suggest that the rehospitalizations of a number of After Care patients might be prevented if emergency service were available.

We mentioned that the Clinic is open one evening a month. Formal daytime hours of clinics are believed to have an adverse effect on the employment status of patients. If more patients had readily available and accessible evening services, they might be more able to fulfill their working responsibilities.

3. Exclusion of Certain Diagnostic Categories

Certain categories of patients from Riverview Hospital are more or less routinely excluded from referral to the After Care Clinic. These include, for instance, alcoholics and character disorders. We are not suggesting that these groups should be the responsibility of the Clinic. We are, however, saying that they most frequently do not receive any assistance whatsoever from the Clinic or the community, and that some form of service should be developed for them.

Another group of patients that the hospital seldom refers to the After Care Clinic is the one composed of those eligible for M. S. A. insurance. Referral to the Clinic

is at the discretion of the individual hospital psychiatrist and is highly subject to bias. Private psychiatric services are not always the answer to the rehabilitation problems of the discharged mental patients and there is also the consideration of the cost of medication. The Clinic dispenses medication free of charge.

4. Availability of Psychotherapy

It is not practical to expect the After Care Clinic to offer psychotherapy to discharged mental patients. However, as noted earlier in this section, such a service should at least be available in a comprehensive aftercare program. The Burnaby Mental Health Center does offer such a service but it is highly selective and not always readily available to former patients who might be referred from Riverview.

5. Group Therapy

This is a sadly neglected facet of the After Care Clinic. In our patient questionnaire, two of the patients who said they were receiving considerable service from the Clinic, were in group therapy with a psychologist from Riverview Hospital who assumes aftercare responsibilities. Group therapy is well recognized as a significant trend in treating mental patients. If we are to provide better service to the increasingly large numbers requiring it, this type of treatment seems to be a natural line to follow.

6. Social Work Service

One of the most significant findings of our

questionnaires is that 44 of 45 of our sample are not receiving social work services and that three of the five social workers queried about aftercare services do not attend the After Care Clinic. Since the needs of the patient are of such a varied nature, it would seem desirable to expand the involvement of social workers in an aftercare program.

These are only a few facets that we believe to be of significance in the scope of services offered. We believe that readily accessible emergency service is essential. We further feel justified in stating that certain forms of service could be implemented without too much difficulty and also that a critical eye should be cast at certain procedures of the Burnaby Mental Health Center and Riverview Hospital.

C. Co-ordination of Services

1. Within the Hospital

As in all large mental hospitals, Riverview Hospital has within its structure many problems of co-ordination which the present administration is trying to work out. In a specifically medical setting, the Social Service Department functions as an ancillary service. Problems of co-ordinating the treatment aims of the medical staff and the rehabilitation goals of the social workers have always existed and in some measure will continue to exist. It would appear many of the problems in co-ordination stem from the lack of unity among the various professional disciplines.

2. Between the Mental Health Services

Co-ordination between the Riverview Hospital and the Mental Health Center has relevance for this study, if for no other reason than to reflect the difficulty of co-ordinating related services within the Mental Health Services Division. A current problem of co-ordination prevails between the Burnaby Mental Health Clinic which generally provides therapy for a small number of selected patients and the After Care Clinic which must provide therapy for a maximum number of patients in relation to a small part time staff.

3. Between Riverview Hospital and Community Agencies

Some of the significant findings of the Agency Questionnaire involved vital factors in the whole process of co-ordination of services. Among the factors mentioned were liason between agencies, adequate referral service, relaxed communication, co-operation, and consultation. We must face the fact that for a number of reasons the communication between the Riverview Hospital and the community agencies generally has been scant. We are of the opinion that ease in communication between services coincides with good co-ordination of the services each has to offer.

4. Between the After Care Clinic and Community Agencies

At the moment any semblance of co-ordination between the After Care Clinic and other community health and welfare agencies is practically non-existent. An attempt on the part of top hospital administration to co-ordinate the After

Care Clinic with the one other main community psychiatric resource, the Vancouver General Hospital has not been too successful. It did open the door however for future negotiations so that now at least there is the possibility that an accessible aftercare service could conceivably be established in the community of Vancouver proper working in conjunction with this one other major psychiatric resource. We would envisage in this sort of aftercare program many of the services recommended by both the staff and agency personnel in their respective questionnaires, namely, pre-admission service, walk-in clinic, night hospital, emergency service, and the like.

5. Referrals for Service.

In no other area does the inter-disciplinary bias show so clearly as in the area of referrals. As previously mentioned in this section referrals have a significant relationship to co-ordination of service.

Under the present aftercare arrangement the main body of referrals from the hospital to aftercare come from the doctors themselves. We would expect this to be the case since each doctor has the responsibility for providing aftercare services to those of his patients whom he feels requires them. One would question what happens if a particular doctor has a particular bias towards a patient.

It is significant that few referrals to the After Care Clinic are made by the hospital staff social workers. One would wonder whether the hospital social workers do not

feel they have a contribution to make in the area of follow-up and rehabilitation.

As the referral system is structured at present private psychiatrists and general practitioners in the community can and do make a number of referrals of patients to aftercare. In the case of community social agencies however the present general policy governed by factors such as the size of aftercare staff, does not encourage expansion of the service through community referrals.

D. Division of Responsibility for Aftercare Service

If we are to consider where the division of responsibility for the provision of aftercare services lies, we must first determine to what extent the community agencies are willing to participate in a comprehensive aftercare program. At the moment community agencies prefer to remain outside of the program giving only their primary service to discharged patients but not the psychiatric follow-up which patients usually require. Rather, from their questionnaire comments about responsibility, community agency administrators tended to expect the Provincial Mental Health Services to take the responsibility of providing aftercare services to discharged patients.

The Riverview Hospital, on the other hand, while it has extended service into the community through the After Care Clinic would prefer that community health and welfare

agencies share responsibility with the hospital in the provision of aftercare services to the many patients discharged to the community. In particular, the professional personnel of Riverview Hospital saw the Burnaby Mental Health Centre and the Vancouver General Hospital as sharing the responsibility.

Here then is the picture: On the one hand of community agency personnel feeling that responsibility for the provision of aftercare service should be that of the Provincial Mental Hospital while, on the other hand hospital personnel feel the aftercare service should be a shared responsibility. Because the division of responsibility for provision of aftercare services was not clearly agreed upon by the respective agencies concerned, it seemed to us that many patients discharged from hospital to community were not receiving service from either resource.

Another aspect which must be considered is the special nature of the service itself. Many social agencies in the community employ a large number of untrained personnel who are ill-equipped to provide the specialized casework services which the discharged patients would require. As a matter of fact, even the experienced social worker, generically trained, could quite conceivably feel out of his depth in coping with the problem of giving aftercare services to the mentally ill. Might this illustration not point up the need for specialized casework training for social workers going into special fields, the field of mental health being one of them?

Disadvantaged as most of the community agencies would appear to be through lack of trained staff and limited resources it is not particularly unusual that they should look to the Mental Health Services Division to provide the leadership required to educate the community and to provide the guidelines for participation in the development of resources tailored to meet the needs of the discharged mental patient. This responsibility, we believe, the Mental Health Services Division should assume. Might not trained social work staff from the Mental Health Services Division be districted in community health or welfare offices to assist as educators, psychosocial diagnosticians, and therapists?

Future developments in the provision of aftercare services may also affect the division of responsibility between medical and social work staff. There is the suggestion that doctors in future may function primarily within the hospital settings to diagnose and treat leaving the area of aftercare and rehabilitation to the social workers and other specialists.[1]

This trend of development could well pose a serious problem to a continuity of care in the service of aftercare. Although felt to be highly desirable, actual continuity of care is seldom possible for a number of reasons. It would seem imperative if the responsibility between doctors and

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1. Cumming, op. cit.

social workers were divided in this manner, however, to establish within the community a complement of highly skilled psychiatric social workers in order that continuity of care for discharged mental patients will be provided.

To conclude, some of the suggestions made here may be particularly relevant where engaging community agencies and the community at large in a comprehensive aftercare program is concerned.

E. Future Trends

As we have noted, there is an uneasy state of flux at the present time in mental health programming between the Provincial Mental Health Services and the Vancouver General Hospital. Although the integrated approach to community psychiatry has not materialized so far, we might speculate that with the influence of the recommendations of the Royal Commission on Health Services, such an approach could be instituted.

Aftercare services would no doubt be a facet of such an integrated pattern. We have noted the recommendations concerning out-patient departments, twenty-four hour emergency service and "day" and "night" care programs. Another recommendation is that the proposed psychiatric units of general hospitals develop a rehabilitation service properly staffed with psychiatric social workers and psychiatric nurses and that this service be fully co-ordinated with other community health and welfare services.

We have made mention of the current problems concerning scope, co-ordination and responsibility for aftercare programs. We believe that internal and external stress will be characteristic of our mental health services for some time to come.

Along with the possible future developments in providing services there are other trends to consider, such as those of population. Since we have the ability to project population growth and demographic trends, it is essential that such projections be used for rational planning to meet mental health needs of the future. We are in a time of extremely rapid social change in Canada and it is safe to assume that much of this change will have a bearing on the mental health of our population and mental health services required. There is reason to believe, for instance, that workers displaced by automation may suffer mental as well as economic distress. Dr. Hugh Keenleyside[1] recently predicted that divorce and alcoholism rates will double and the suicide rate will triple within the next ten years. From our patient questionnaire it seems that many of our former mental hospital patients have unmet needs and we have felt justified in making assumptions as to what effects the lack of a comprehensive aftercare is having on the rehabilitation of the patients. Even though private psychiatric care will be available to many more citizens in the future under the proposed national

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1. "Keenleyside Paints a Gloomy Future," Vancouver Sun, Vancouver, 5 March 1966, p. 2.

medicare plan, there will still remain many persons requiring services of an aftercare program. With our experience in mind then, and such gloomy predictions as those of Dr. Keenleyside, we see it as essential that as adequate an aftercare program as is possible under the present confused state of services, be developed.

It is vital further, that increased funds be made available for the expansion of co-ordinated programs of research into the causes of mental illness and that community programs and present treatment of services in the mental illness field be continuously evaluated. A better understanding must be gained of the consequences of various activities directed towards the improvement of mental health and the prevention and control of mental disorders.

No ambitious plans, of course, can come to full fruition without the proper number of people to do the job. If mental health facilities and programs are to accomplish the purpose for which they are designed, they must be centered in people. Along with the present population trends there must be a commensurate increase in the recruitment and training of mental health manpower.

APPENDIX A

A QUESTIONNAIRE UNIVERSITY OF BRITISH COLUMBIA SCHOOL OF SOCIAL WORK

We are doing a study on the After Care programme and need to know something about the people who go there.
FIRST WE WOULD LIKE TO KNOW SOMETHING ABOUT HOW YOU SPEND YOUR SPARE TIME. IT IS HARD TO ANSWER THESE QUESTIONS EXACTLY SO A GENERAL REPLY WILL BE FINE.

1. Could you tell me if you spend no time Some time A lot of time on the following:

	NO TIME	SOME TIME	LOT OF TIME	WITH SELF	WITH OTHERS
LISTENING TO THE RADIO		21	7	-	11
GARDENING		7	5	10	2
HOBBIES		15	2	9	6
SPORTS		14	2	5	10
MOVIES		19	4	4	17
DRIVES		17	4	2	19
CLUBS		7	3	-	11
WATCHING T.V.		20	14	7	25

2. Now would you tell me if you do these activities mostly with yourself or mostly with others.

3. Generally would you like to be
more active YES 26 NO 17 UNDECIDED 2
less active YES _____ NO _____

4. What activities would you like to do more of _____
_____
less of _____
_____

5. Would you say you have any problems in occupying your spare time as you would like?
EXPLAIN _____
_____
_____
_____

I WOULD LIKE TO ASK FOR: YOUR OPINIONS ABOUT THE AFTER CARE PROGRAMME. AGAIN, IF YOU CANNOT BE SPECIFIC A GENERAL IDEA WILL BE MOST APPRECIATED.

6. Do you know if the hospital had a leave plan or list of recommendations made for you when you were discharged from the hospital? YES 29 NO 15 UNDECIDED 1

7. If yes, Who were these plans discussed with? YOURSELF 21
RELATIVES 10 FAMILY DOCTOR 5 OTHERS 8
UNDECIDED 14

8. Was this your first hospitalization? YES 9 NO 36

9. If not, how may previous hospitalizations have there been?

Number of hospitalizations	
(1 - 9	patients
(2 - 8	"
(3 -11	"
(4 - 5	"
(5 - 4	"

10. How long is it now that you have been out of hospital?
1 month - 3 months - 17 patients
4 months- 6 months - 18 "
Over 6 months - 10 "

11. How long is it that you have been coming to the after care clinic?
1 month - 3 months - 20 patients
4 months- 6 months - 17 "
Over 6 months - 18 "

12. Would you rate your mental health now as:
VERY POOR ___ POOR 3 FAIR 12 GOOD 26 VERY GOOD 3
UNDECIDED 1

	YES	Undecided
13. Do you have problems about SLEEPING	15	
FEELING TIRED	18	
BEING FORGETFUL	13	1
FEELING DEPRESSED	20	1
FEELING ANXIOUS	19	
EATING	8	

INTERVIEWER'S COMMENTS _____

14. What worries you most about your mental health?

15. Do you feel that your difficulties have improved since coming to after care? NOT AT ALL 12 SOMEWHAT 16 QUITE A BIT 4
A GREAT DEAL 4 UNDECIDED 9

	How Often	How Long
16. About how often do you see a social worker How long would you spend with him each interview?	Less than once a month-1 Not at all -44	1-15 minutes-1 -

What about a psychiatrist

	HOW OFTEN		HOW LONG
	Once a month - 12	Less than once a month - 25	1-15 minutes - 34 16-30 " -- 5 Over 30 " - 3
	More frequent - 5	Not at all - 3	
A NURSE	-	-	-
PSYCHOLOGIST	2		1-3 hours - Group Therapy

17. Are their any social activities at the after care clinic that you attend?

Yes - NO 45

18. If so, what are they? N/A

19. How often do you attend?

20.

Do you have any	YES	NO	UNDECIDED	N/A
FINANCIAL PROBLEMS	13	31	1	
WORK PROBLEMS	18	27		
PERSONAL PROBLEMS	9	21		15
PHYSICAL PROBLEMS	13	30	2	
MARITAL PROBLEMS	8	21		16
OTHER FAMILY PROBLEMS	12	31	1	1

INTERVIEWER'S COMMENTS

21.

Do you feel that you are getting for these problems at the clinic	NO HELP	SOME HELP	CONSIDERABLE HELP	UNDECIDED
FINANCIAL	10	4	1	
WORK	11	3		
PERSONAL PROBLEMS	6	3	1	
PHYSICAL PROBLEMS	7	3		
MARITAL PROBLEMS	7	-	1	1
FAMILY PROBLEMS	6	3	1	2

ADDITIONAL COMMENTS

22. Are you taking medication? YES 38 NO 7

23. Are you getting help for your problems from any other agency (give examples of agencies) YES 13 NO 32

Which agencies? Dept. of Veteran Affairs, Social Service Departments, Public Health Nurse, School Counsellors, Workmen's Compensation Board, Provincial Dept. of Rehabilitation, Outpatient Dept. - Vancouver General Hospital, Disabled Person's Allowance Dept.

24. What kind of problems do they help you with and to what extent:

	No Help	Some Help	Lot of Help
FINANCIAL	1	8	1
WORK	1	2	2
PERSONAL PROBLEMS		1	3
PHYSICAL PROBLEMS		4	1
MARITAL PROBLEMS			3
FAMILY PROBLEMS		2	1

25. Are you satisfied with the help these other agencies are giving you? YES 10 NO 2 UNDECIDED 1

Explain: _____

NOW COULD I ASK YOU A LITTLE MORE ABOUT YOUR SOCIAL LIFE?

26. Would you tell me if the people in your neighbourhood are generally: Friendly 25 Fairly Friendly 5 Indifferent 8 Unfriendly 1 Undecided 6

27. About how many close relatives do you have in this area? None 9 1-3 15 4-6 11 6-12 4 Over 12 6

28. Do you get to see these relatives at least: Once a week 15 Once a month 12 Less often 12

29. What about friends; how many do you have approximately: None 12 1-3 16 4-6 8 7-12 9

30. How often do you see them: Once a week 17 Once a month 9 Less frequently than once a month 10

31. Would you like to have closer contact with people? Yes 20 No 21 Undecided 4

Explain _____

32. Concerning your social life, generally speaking, are you: Satisfied 24 Unsatisfied 20 Undecided 1

Explain _____

33. Do you feel you have differences with your friends concerning religion, sex, money, health, others _____

I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT WORK. AGAIN I DO NOT EXPECT THAT YOU WILL BE ABLE TO SAY EXACTLY, SO GENERAL ANSWERS WILL DO.

34. Would you tell me if you were working before hospitalization? Yes 15 No 8

35. If yes: Full time 13 Part Time 1 Irregularly 1

36. What kind of work did you do? Unskilled 10 Skilled 3 Professional 2

37. Have you worked since being discharged from hospital? Yes 18 No 20

38. If yes: Full time 10 Part time 5 Irregularly 3

39. What kind of work do you do now? Unskilled 13 Skilled 2 Professional 1

40: IF WORKING:
How about your fellow workers? Are they easy to get along with 10 fair to get along with 3 hard to get along with 0

41. Ordinarily, is your boss easy to get along with 10 fair to get along with 3 hard to get along with 0

42. In general, does anything bother you at work? Yes 6 No 7
Explain:(probe) _____

43. IF NOT WORKING:
Are you presently looking for work? Yes 5 No 27
Explain:(probe) _____

44. What would be most useful in your getting employment? More education or training 4 More confidence 4 More skill 1 More luck 1 More jobs available 4
Explain: _____

45. Would you tell me who does the following household work in your home?

	SELF	TOGETHER	OTHER	UNDECIDED
PREPARING THE MEALS	25	9	11	
DOES THE GROCERY SHOPPING	14	9	18	4
HANDLES THE GROCERY MONEY	21	17	17	
DUSTS, SWEEPS AND DOES OTHER USUAL CLEANING	24	2	9	10
TAKES CARE OF LAUNDRY AND MENDING	18	6	11	10

46. Concerning the housework situation, Are you SATISFIED 30 FAIRLY SATISFIED 10 UNSATISFIED 5
Explain: _____

NOW I WOULD LIKE TO ASK YOU SOME GENERAL PERSONAL QUESTIONS:

47. Would you mind if I asked you your age? Are you between 20-29 8 30-39 14 40-49 11 Over 50 12

48. Are you married 25 Separated 4 Widowed 3 Divorced 1 Single 12

49. If married, how many pre-school children 8 School children 11 Working children home 2 Children not at home 10

50. What grade did you complete? 1-6 4 6-10 20 10-12 8 Over 12 13

51. Have you had any special training? Yes 19 No 26
If so, what _____

52. Would you mind telling me what sources of income you have:

	Yes	No		Yes	No
Job	13		Relatives	1	
Spouse	15		Social Assistance	10	
Old Age Pension	3		Old Age Asst.	1	
Veterans Allowance	2		Disability Allowance	2	
Other (specify): Estate 2			C.P.R.Pension	1	

53. Do you worry about your financial position: Not worried 26 Somewhat worried 4 Worried 4 Very worried 1

54. If worried, what bothers you about your financial condition: Debts 6 Lack of money now 5 Lack of money for future 10 Being dependent on others 3

NOW COULD I ASK YOU SOME PERSONAL QUESTIONS ABOUT YOUR HOME LIFE

55. Would you say your living accommodation is satisfactory? Yes 35 No 10 Explain _____

56. How long have you lived at this place?
Under 6 months - 9 patients
7 months to 1 year - 6 "
1-3 years - 12 "
Over 3 years - 18 "

57. Do you live by yourself 10 Parents (if one, specify) 4 Brother(s) 1 Sister(s) 1 Spouse 11 Children 2 Friends 1 Others (specify) 1 _____ Spouse and young children 14

58. How would you say you get along with these people? Very well 11 Well 16 Poorly 6 Not applicable 4 Alright 7 Very poorly 1

59. Do you feel that you have differences with the people you live with concerning religion, sex, money, health, other? Yes 17 No 24 Not applicable 4
Explain: (probe) _____

60. Generally, do you feel that you understand the people with whom you live? Yes 28 No 6 Undecided 4 Not applicable 7
Why? _____

61. Do you feel that they understand you? Yes 18 No 9 Undecided 9 Not applicable 9
Why _____

62. Have you ever thought of leaving these people? Never 18 Sometimes 13 Often 1 Not applicable 10 Undecided 3

63. What are some of your most important problems in living with these people?

WE ARE NEARING THE END OF THE QUESTIONNAIRE NOW. I HAVE A NUMBER OF SAYINGS TO READ TO YOU AND I WOULD LIKE YOU TO ANSWER AS BEST YOU CAN WHETHER YOU THINK THE SAYING IS MOSTLY RIGHT OR MOSTLY WRONG.

	Mostly Right	Undecided	Mostly Wrong	
64.	21	4	20	What young people need most of all is strict discipline.
65.	27	4	14	Sometimes its hard to tell whether one likes something or not.
66.	33	5	7	There's no reason to anticipate trouble or worry about what may never happen.
67.	12	8	25	Man's life is completely under the control of fate.
68.	18	3	24	There's little use in writing to public officials because they aren't really interested in the problems of the average man.
69.	21	4	20	It is easy to classify most things as either good or bad.
70.	23	4	18	Any good leader should be strict with people under him in order to gain their respect.
71.	38	2	5	It is worth at least a thousand dollars a year to have the habit of looking on the bright side of things.
72.	23	6	16	In spite of what some people say, the problems of the average man are getting worse.
73.	32	5	8	Nothing is so foolish as to anticipate misfortune.
74.	19	5	21	Whatever you do must be done perfectly.
75.	15	4	26	Whatever may happen to a person, it was prepared for him from all eternity.
76.	36	4	5	To fear the worst is to go through life with an unnecessary burden.
77.	13	5	27	Once your mind is made up, don't let anything change it.

QUESTIONS 64-77

	Yes	No	Undecided
Authoritarianism	44	38	8
Goal Dichotomy	35	47	8
Pessimism	30	50	10
Fatalism	27	51	12
Anomie	51	30	9
Optimism	74	10	6
Rigidity	32	48	10

WOULD YOU INDICATE IF YOU THINK THESE SAYINGS COULD GENERALLY APPLY TO YOU OR NOT?

78. I daydream instead of doing work Yes 13 No 30 Undecided 2

79. I am often just miserable for no sufficient reason Yes 17 No 26 Undecided 2

80. In general, I'm self-confident about my abilities Yes 29 No 12 Undecided 4

81. To avoid arguments, do you usually keep your opinions to yourself? Yes 26 No 17 Undecided 2

82. Do you feel somewhat apart even among friends Yes 17 No 26 Undecided 2

83. Ideas run through my head so as to prevent sleep Yes 20 No 23 Undecided 2

84. My feelings alternate between happiness and sadness without reason Yes 11 No 32 Undecided 2

85. I worry about being successful in life Yes 20 No 22 Undecided 3

QUESTIONS 78-85:

	Yes	No	Undecided
Autism	33	53	4
Cycloid Thinking	28	58	4
Self Confidence	44	39	7
Withdrawal	43	43	4

RATINGS TO BE MADE BY INTERVIEWED IMMEDIATELY AFTER INTERVIEW

86. Informant interest in interview:

	At Start	At Close
Lack	12	2
Mild	26	31
High	7	12

87. Attitude towards interview:

	At Start	At Close
Hostile	5	0
Suspicious, guarded	18	13
Friendly	17	21
Solicitous	2	8
Other (Accepting)	3	3

88. Informant's tension level:

	At Start	At Close
Nervous	19	11
Sporadic nervousness	14	19
Mostly relaxed	12	15

89. Informant's impression of emotional condition:

Grossly disturbed	2
Disturbed	8
Somewhat disturbed	17
Slightly disturbed	13
Not disturbed	5

90. Distraction during interview:

	Outside sources	Interview Sources
Much distraction	5	2
Some distraction	21	15
No distraction	19	28

91. Interviewers estimate of

	Housing	Housekeeping Standard	Estimate of Neighbourhood
Very poor	2	4	3
Poor	7	3	4
Fair	15	16	18
Good	15	14	14
Very good	4	7	4
Excellent	1	0	1
Not seen	1	1	1

92. General Comments: _____

_____

_____

_____

APPENDIX B

Table 2. Living Arrangements by Marital Status and Sex

Living Arrangements	Men		Women		Total
	Single	Married	Single	Married	
Self	5		3		8
Boarding Home	2		1		3
Relatives	1		2		3
Friends	1				1
Parents	2				2
Spouse		4		3	7
Spouse and Children		3		13	16
Children			1		1
Spouse and Parents		1			1
Spouse, Children, and Parents					1
Children and Parents			2		2
Total	11	8	9	17	45

Table 4. Education

Education	Client Response
Grade 1-6	4
Grade 7-9	20
Grade 10-12	8
Over Grade 12	13
Total	45
Special Training	19

Table 5. Education by Marital Status and Sex[1]

Sex	Men		Women		
Education	Single	Married	Single	Married	Total
1 - 6	2	1			3
7 - 9	4	4	3	8	19
10 - 12	5		3	6	14
University		2	1	2	5
Trade		(2)	(3)		(5)
Total	11	9	10	16	46

1. From hospital files.

Table 6. Source of Income

Source of Income	Client Response
Job	13
Spouse	15
Old Age Pension	13
Veterans Allowance	2
Disability Allowance	2
Old Age Assistance	1
Social Assistance	10
Relatives	1
Estate	2
C.P.R. Pension	1

Table 7. Number of Hospitalizations by Marital Status and Sex[1]

Sex	Men		Women		
Number of Hospitalizations	Single	Married	Single	Married	Total
1	1	1	3	4	9
2	1	4	1	3	9
3	7		1	3	11
4	1		2		3
5	1	2			3
6 + over		1	2	3	6
Total	11	8	9	13	41

Table 8. Number of Hospitalizations

Number of Hospitalizations	Client Response
1	9
2	8
3	11
4	5
5	4
Over 5	1
Unknown	7
Total	45

1. From hospital files.

Table 11. Client Estimate of Symptoms

Symptoms	Client Response
Sleeping	15
Tired	18
Forgetful	13
Depressed	20
Anxious	19
Eating	8

Table 13. Client Estimate of Improvement

Improvement	Client Response
Not At All	12
Somewhat	16
Quite a Bit	4
A Great Deal	9
Unknown	4
Total	45

Table 14. Client Estimate of Help Given For Specific Problems by Other Agencies

Problems	YES	Other Agency Help		
		No Help	Some Help	Lot of Help
Financial	13	1	8	1
Work	18	1	2	2
Personal	9		1	3
Physical	13		4	1
Marital	8		0	3
Other Family	12		2	1
Total	72	2	17	11

Table 15. Client Estimate of Time Spent in Recreation

Recreation	Time Spent		Total
	Some time	Lot of time	
Radio	21	7	27
T.V.	20	14	34
Movies	19	4	23
Drives	17	4	21
Hobbies	15	2	17
Sports	14	2	16
Clubs	7	3	10
Gardening	7	5	12
Other	14	7	21

Table 16. Client Contact with Relatives and Friends

Number	Friends	Relatives
0	12	9
1-3	16	15
4-6	8	11
7-12	9	4
Over 12		6
Time	**Friends**	**Relatives**
Once a Week	17	15
Once a Month	9	12
Less Often	10	12

Table 17. Client Opinion of Neighbours

Opinion	Client Response
Friendly	25
Fairly Friendly	5
Indifferent	8
Unfriendly	1
Undecided	6
Total	45

Table 20. Comparison of Employment Status and Type Before and After Hospitalization [1]

Work	Before Hospitalization	After Hospitalization
Yes	15	18
No	8	20
Unskilled	10	13
Skilled	3	2
Professional	2	1
Full Time	13	10
Part Time	1	5
Irregular	1	3

1. It was not always easy to classify skilled and unskilled . However, generally, we used trades and white collar work as skilled; others as unskilled.

Table 21. Interviewer Estimate of Housing, Neighbourhood and Housekeeping[1]

Interviewer Estimate	Neighbourhood	Housing	Housekeeping
Very Poor	3	2	4
Poor	4	7	3
Fair	18	15	16
Good	14	15	14
Very Good	4	4	7
Excellent	1	1	0
Total	44	44	44

1. Generally the rating was fairly impressionistic but there was agreement between the interviewers to rate very poor and poor as skid row and poor industrial neighbourhood, delapidated housing and filthy and grossly disordered housekeeping. Fair was reserved for low income neighbourhood just adequate housing and generally clean but disordered housekeeping. Good was considered normal working class area, housing in good shape and clean and well kept housekeeping. Very good was considered to be good residential area, modern, spacious home and careful personal housekeeping. Excellent was reserved for upper income homes and neighbourhood.

Table 23. Responsibility for Household Tasks

Tasks	Persons Responsible			
	Self	Share	Other	Undecided
Meals	25	9	11	
Shopping	14	9	18	4
Handles Grocery Money	21	7	17	
Cleaning	24	2	9	10
Laundry & Mending	18	6	11	10

Table 24. Client Satisfaction With Household Tasks

Satisfaction	Response
Satisfied	30
Fairly Satisfied	10
Unsatisfied	5
Total	45

Table 25. Client and Home Member Understanding

Client Response	Understand Others	Understand You
Yes	28	18
No	6	9
Undecided	4	9
Total	38	36

APPENDIX C

QUESTIONNAIRE TO STAFF

1. Do you see the present After Care Clinic services as:

	Dr.	S.W.
Adequate	1	0
Inadequate	4	5

2. (a) Which of the following do you think would be essential to an adequate After Care treatment program? Indicate order of importance - 1, 2, 3, etc.

Doctors	Social Workers	
2nd	3rd	1. medication
1st	2nd	2. individual supportive therapy
5th	5th	3. group therapy
4th	6th	4. family therapy
3rd	4th	5. brief reality oriented therapy
		6. long term extensive psychotherapy
6th	1st	7. coordinated rehabilitative planning
		8. others - state _____

(b) Which of the following do you think would be unessential for an adequate After Care treatment program? Mark 'U'.

Doctors	Social Workers	
		1. medication
		2. individual supportive therapy
		3. group therapy
		4. family therapy
		5. brief reality oriented therapy
		6. long term extensive psychotherapy
x Unessential		7. coordinated rehabilitative planning
		8. others - state _____

3. In your opinion, which form of therapy does the present After Care Clinic seek to provide? Please list in order of emphasis.

Doctors	Social Workers	
2nd	1st	1. medication
1st	3rd	2. individual supportive therapy
5th	6th	3. group therapy
4th	5th	4. family therapy
3rd	2nd	5. brief reality oriented therapy
		6. long term extensive psychotherapy
6th	4th	7. coordinated rehabilitative planning
		8. others _____

4. In your opinion, what main purpose is being served by the present After Care Clinic?

Doctors	Social Workers
1. Immediate brief post-hospital contact.	1. Brief follow-up, Emphasis on medication.
2. Fills the dependency needs of patients.	2. Medication. Meeting crises.
3. Prevent rehospitalization. Control of acute symptoms.	3. Dispensing medication. Maintaining contact to spot relapse.
4. Doling out of medication.	4. Medication. Check patient's progress in community.
5. Help patients readjust to home, job, problems.	5. Medication. Observation. Minimal support. Occasional referral to community resources.

5.a Do you attend the After Care Clinic?

	Doctors	Social Workers
Daily	1	1
Weekly	2	1
Bi-Monthly	1	
Monthly	1	
Not at all	0	3

5.b What types of patients do you <u>mainly</u> refer to After Care?

Doctors	Social Workers		
		1.	patients with a chronic schizophrenic history or schizophrenic residual.
x	x		
		2.	single, schizoid patients with few social contacts.
x			
		3.	(character disorder) patients, for example, problem passive aggressive patients.
x		4.	paranoidal patients.
		5.	neurotics.
		6.	patients with marital adjustment problems.
		7.	marginally adjusted skid road patients.
		8.	alcoholics.
		9.	adolescent adjustment problems.
x	x	10.	depressed patients.
		11.	sociopathic personalities.
		12.	others.

6. If you attend the Clinic, how much time do you spend, on the average, with each patient?

	Average Time Spent
Doctors	20-30 minutes
	15 "
	15 "
	10 "
	20 "
Social Workers	30 minutes
	30 "
	30 "
	30 "
	20 "

How many patients, on the average, would you see?

	Average No. of Patients Seen
Doctors	2-30 patients per week
	8 patients - 3 hours
	8 patients - 3 "
	8 patients - 3 "
	7-10 patients - 3 "
Social Workers	30-40 patients per week
	5 patients - 3 hours
	2-3 patients - 3 hours
	6-7 patients - 3 hours
	4 patients - 3 hours

7. What community resources would you see being involved in an adequate hospital after care program?

For Example - V.G.H. _____
- Metropolitan Health _____
- Burnaby Mental Health Clinic _____
- Other community agencies _____

1. Medication
2. Supportive Therapy
3. Individual Therapy
4. Group Therapy
5. Family Therapy
6. Brief Reality Oriented Therapy
7. Long Term Extensive Psychotherapy
8. Coordinated Rehabilitative Planning
9. Other

TABULATIONS WERE OMITTED OWING TO PROBLEM IN INTERPRETATION OF QUESTION

8. Which disciplines do you see as having a key role to play in post discharge adjustment of patients? For example, psychiatrist, General Practitioner, Public Health Nurse, psychiatric social workers, other agency social workers, psychologist- Please list in order of importance.

Concerning:-

1. Medication
2. Supportive Therapy
3. Individual Therapy
4. Group Therapy
5. Family Therapy
6. Brief Reality Oriented Therapy
7. Long Term Extensive Psychotherapy
8. Coordinated Rehabilitative Planning
9. Other

TABULATIONS WERE OMITTED OWING TO PROBLEM IN INTERPRETATION OF QUESTION

9. Do you think the quantity of service at the After Care Clinic is on the whole:

	Doctors	Social Workers
Satisfactory	2	2
Unsatisfactory	3	3

10. Do you think the quality of service at the After Care Clinic is on the whole:

	Doctors	Social Workers
Satisfactory	2	1
Unsatisfactory	3	4

11. Some people believe that the main services rendered by the After Care Clinic are:

(a) relief of symptoms.

Would you agree?	Doctors	Social Workers
YES	3	1
NO		

(b) prevention of rehospitalization.

YES	2	4
NO		

12. In what way do you think the After Care services can be improved?

(For analysis)

APPENDIX D

QUESTIONNAIRE

1. Generally do you feel that aftercare services in this community are adequate 1 Inadequate 7 Unknown 1 No answer 4 (Metropolitan Health Agencies).
   In what way? _____
2. Would you say that you have sufficient liason with other agencies involved with the discharged patient? Yes 3 No 5 Unstated 1 No answer 4
   Explain _____
3. What about the Aftercare Clinic in Burnaby. Do you feel that you have sufficient liason with them?
   Yes 4 No 5 No answer 4
   Explain _____
4. What responsibility do you feel your agency has for the discharged patient? _____
   _____
5. What other agencies do you feel ought to be involved with the patient? _____
   _____
6. How about the Aftercare Clinic? What responsibilities do you feel they should assume for the treatment of the

patient? _____

_____

7. What do you see as the major problem in planning for the discharged patient? _____

_____

8. Other remarks, suggestions, comments.

THE UNIVERSITY OF BRITISH COLUMBIA

SCHOOL OF SOCIAL WORK

Vancouver 8, B. C.

Dear

We are Master of Social Work students at the University of British Columbia. Our MSW Thesis is an evaluation of after care services given by the Aftercare Clinic in Burnaby.

As your agency has contact with many patients discharged from Riverview Hospital, Essondale, we would find it most helpful to have your opinion about after care services. Could you complete the enclosed questionnaire and return it to us at your earliest convenience.

Thank you so much for your help.

Yours truly,

APPENDIX D

AGENCY QUESTIONNAIRE

		AGENCIES
1.	In what way?	
	Inaccessibility and distance to After-care Clinic	3
	Lack of coverage in service	3
	Lack of adequate staffing	3
	Lack of emergency service	1
	Lack of sustaining contact and follow-up.	4
	Lack of adequate facilities and resources	1
2.	Explain.	
	Referrals slow, minimal, or lacking	4
	Inadequate discharge planning	1
	Difficulties in inter-professional communication	1
3.	Explain.	
	Lack of referrals	2
	Lack of staffing	1
	Lack of communications.	2
4.	What responsibility do you feel your agency has for the discharged patient?	
	Provision of social assistance, boarding homes, etc.	5
	Provision of social and recreational needs	1
	Provision of protection services to children	2
	Provision of family counselling service	1
	Provision of limited supportive casework service	1
	Provision to parents of casework in neglect cases	2
5.	What other agencies do you feel ought to be involved with the patient?	
	Dependent on the needs of the patient	2
	Gap between the needs of patients and resources	1
	None	1
	Metropolitan Health Service, public health nurses.	2
	Family Service Agency	2
	Canadian Mental Health Association.	1
	Neighbourhood Houses and Community Centres	3

AGENCIES

6. How about the Aftercare Clinic? What responsibilities do you feel they should assume for the treatment of the patient?

Counselling and casework service to patients	2
Consultation services to other agencies	2
Adequate follow-up and supervision	5
Total responsibility	1
Continuum in treatment	2
Appropriate referrals	2

7. What do you see as the major problem in planning for the discharged patient?

Lack of adequate community resources	7
Lack in diversity of therapy	1
Lack of adequate staffing	2
Lag in the development of services	1
Lack of adequate discharge planning	3
Lack of adequate follow-up service	4
Lack of adequate inter-professional communication	1
Inadequacy of community agency personnel to cope	1
Rapid discharge and need for adequate treatment	3
Adequate supervision and community protection	2
Lack of sustaining contact for patients	1

8. Other remarks, suggestions, comments.

Emphasis on prevention, screening and pre-admission service	1
Estimate of present and projected needs, on-going service	1
Medically supervised emergency service 24 hr. basis	1
Diversity and individualization of resources	2
Responsibility for development and provision of service	1
Total treatment planning	1

APPENDIX E

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