A SOCIAL ASSESSMENT OF POST-DISCHARGE ADJUSTMENT

An exploratory rating of the social functioning of patients after discharge from the Activation Ward of the Vancouver General Hospital.

by

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Thesis Submitted in Partial Fulfilment of the Requirements for the Degree of

MASTER OF SOCIAL WORK
in the School of Social Work

Accepted as conforming to the standard required for the degree of
Master of Social Work

School of Social Work
1963

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ABSTRACT

The mounting increase in the number of chronically ill and disabled citizens is a cause of much concern. Accordingly, many different approaches are being taken towards rehabilitation. A vital step in measuring their success is the evaluation of patients' progress after a period of treatment. The present study applies to patients who have received service in the new Activation Ward of the Vancouver General Hospital. Many previous studies have focused upon the measurement of physical and social rehabilitation, but this is an exploratory measurement of the social functioning of such "post-discharge" disabled adults. Specifically, this study is directed to the assessment of the contributions of the social worker, as one member of the treatment team, to the disabled patient and his family.

A small sample of patients were selected for the study; all were interviewed, and material from medical and social service records was collected. A rating scale was worked out, to indicate components of general social functioning. This was used to rate each patient at time of study, and compared with ratings at time of discharge from the ward. The results were tabulated and evaluated according to the criteria established of (a) physical, (b) material, (c) individual and (d) social factors (twenty items in all). "Movement" in social functioning of each patient during the post-discharge period could thus be assessed. Overall as well as individual results are examined, and some case illustrations utilized to supplement the assessment.

The evidence is that assessment of the patients' physical and material factors was adequately made on the ward. There is a relatively poor record of progress after discharge, however. Social factors appear among the more significant reasons. There is evidently need for more thorough evaluation of the personal and social factors, without which the goals of comprehensive rehabilitation cannot be achieved. It is the social worker's function to assess these factors. Further responsibilities of the social worker include the treatment of emotional and social factors, the appropriate use of community resources and social action measures. In further research directed to the development of a comprehensive assessment plan for a comprehensive rehabilitation service, the rating scale initiated here may contribute some guidelines.
We wish to express our appreciation to Miss Eleanor Bradley, Supervisor, Child Health Programme, University of British Columbia, for her warm interest and guidance throughout the preparation of this thesis. The suggestions and direction of Dr. Leonard C. Marsh, Director of Research, School of Social Work, have been of great assistance.

To Dr. Brock M. Fahnri, Director of the School of Rehabilitation Medicine, University of B.C., and Dr. T.H.C. Lewis, our special thanks. We are grateful also for the kind co-operation of staffs of the Activation Ward and Social Service Department, Vancouver General Hospital, and of Mrs. O. Lood, Senior Medical Records Librarian.
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CHAPTER I

REHABILITATION: THE DEVELOPMENT OF
A COMPREHENSIVE PROGRAM

Historical Perspective:

Throughout the history of Western society, it is possible to distinguish three stages in the development of social attitudes toward the disabled person. The first stage resulted from the belief in 'survival of the fittest', in which the disabled were left to their own fate or eliminated because of their abnormalities. With the emergence of the great religions of the Western world, a more compassionate attitude developed, often in the belief that through charity, the benefactors would receive divine favor. However, in this second stage, while some help was offered disabled persons, no attempt was made to raise their status from that of 'second class citizens'. We have now reached a third stage in which the community is assuming responsibility for disabled citizens through its governing bodies rather than through the church or private charity alone. A growing recognition of the vulnerability and interdependence of all members of modern society has made social legislation the most appropriate method of preventing and treating social problems. Moreover, we are no longer 'satisfied with the maintenance of the disabled person or even
with his medical recovery; we are satisfied only with his rehabilitation, as far as practicable, to a full and normal life of work and leisure." 1

Several factors have contributed to this change of attitude. In a practical sense, chronic illness with resultant disability has emerged as a major social problem due to the increase in proportion to the population as a whole. While chronic illness can strike at any age, the existing evidence indicates "that disabling illness is less prevalent in the younger age groups, and becomes about 13 times as frequent in people over 65, as among persons under 45." 2

Each new medical advance carries with it a rehabilitation problem, for many conditions at one time fatal, have been brought under control so that people go on living with residual disability. In past generations, the family was large and lived sufficiently close together to share burdens; but, with the industrial revolution in the nineteenth century and consequent mobility of the labor force, the traditional extended family has become scattered. Thus, the burden must be absorbed by the larger community.


This increased proportion of disabled persons dependent upon the community gives rise to an economic problem. No advanced nation today can afford the luxury of wasted man power. The price is, in fact, doubled by the hidden costs in loss of productivity of the disabled person over and above that of complex medical services. The only answer is rehabilitation to the greatest level of self-help possible. For those who remain dependent, the community must provide services to meet their special needs in order that they, too, can live in comfort and without danger of further decline through lack of care.

Apart from practical reasons for considering chronic illness a social problem, more sympathy toward the needs of this group has been in evidence in the present century. This is due, partly, to a cultural value system rooted in Judeo-Christian principles and democratic ideology. Our mounting concern for the medical, social and economic welfare of all citizens reflects a belief in the worth and dignity of man, his right to develop in freedom to the maximum of his capabilities and his mutual dependence upon his fellow man to achieve these ends.

It is also due to developments in the physical, biological and social sciences which have provided new insights into the causes of illness and disability. Whereas physical pathology was at one time accepted as the only cause of disease, in recent years there has been a marked tendency to abandon
this over-simplification and to take into account all the factors responsible for ill health: physical, biological, psychological and social.

Increased humanitarian concern is a result as well of the impact of two world wars and, in North America, the Depression of the 1930's. Both of these events emphasized the vulnerability of any person to economic and social hazards which could result in loss of earning power. The experience of the Depression stressed the inter-dependence of all citizens in a complex, industrialized and urbanized society. As sociologists have observed, a sympathetic identification with a problem enhances the desire to undertake measures for treatment, control and prevention.

It was the impact of the returned war disabled that initiated a large scale development of rehabilitation services in North America. While World War I produced approximately 400 cases of paraplegia among American military personnel and only two returned home, World War II produced 2,500 cases and, due mainly to the development of antibiotics, 2,100 returned home.3 Thus, there was a significant increase in that proportion of the population who were dependent both physically and economically.

Both wars dramatized the fact that men and women can overcome apparently insuperable limitations to live satisfying lives and make important contributions to society. Early rehabilitation services of the Veterans' Administration focused on physical retraining and vocational placement. However, chronic illness has emotional and social implications as well as physical, and patients vary in their ability to adapt spontaneously. It soon became apparent that successful rehabilitation is affected not only by the physical resources available in the community but also by the individual's own willingness to improve and gain independence. Thus the modern concept of comprehensive rehabilitation includes development of the patient's inner resources - the enhancement of his psychological drive or motivation to work on his problem - as well as the provision of medical treatment in its broadest aspects, and of educational, vocational and other facilities for restoration and development of his capacities.

Contemporary Viewpoint:

Dr. Howard Rusk of New York University-Bellevue Medical Center has defined the aims of contemporary rehabilitation medicine as follows:

- The first objective of rehabilitation medicine is to eliminate the physical disability if that is possible; the second, to reduce or alleviate the disability to the greatest extent possible; and the third, to retrain the person with a residual physical
disability to live and to work within the limits of his disability but to the hilt of his capabilities.  

As this definition suggests, there is a considerable difference in the rehabilitation of a patient with a temporary disability from that of a patient with a chronic disability. In the former case, the emotional impact is less severe; the patient is not required to adapt to a new arrangement of life and activity. Once the symptoms of his ailment or accident disappear and function is restored, he is generally able to resume his normal role in relation to his family, employment and community. In the latter case, the patient may have to learn new skills and adapt emotionally and socially to changed roles. Thus, modern rehabilitation programs are focused on the needs of the whole person as the following definition by the Baruch Committee on Physical Medicine emphasizes:

The goal of rehabilitation is to achieve the maximum function of the individual and to prepare him physically, mentally, socially and vocationally for the fullest possible life compatible with his abilities.

The patient's reaction to his disability demands careful appraisal if this goal is to be achieved. Although it is generally accepted that psychological factors can effect causation of physical illness, it is not so widely recognized

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that they can effect symptomatology and recovery. A disability may mean disfigurement, severe restriction of activities or loss of earning capacity. These and a variety of other implications can pose a serious threat to a person's sense of worth, effectiveness and control. Acceptance of disability and the limitations it imposes does not come easily, therefore. This is especially so in a culture where independence and self-management are highly valued; we admire the person who can 'stand on his own two feet'.

In order to work toward recovery, a person must assume - to some degree - the "patient role". 6 This requires a giving up, temporarily, of some responsibilities, interests and activities. It requires patience, co-operation, an attentiveness to symptoms, and more dependence on others than is, perhaps, normal. At the end of treatment the person in the role of "patient" is expected to relinquish his state of dependency and resume former responsibilities as far as he is able.

A person's ability to take on this role is affected by his capacity for adapting to change and this can often be greatly enhanced in the treatment process. It is also affected by the length of time he is expected to be a patient and by the extent of his disabilities. Here again, the chronically

ill have a greater adjustment to make than the temporarily incapacitated.

Rose Green has identified three gross patterns of reaction to illness or disability. 7 The first is a denial of the disability which suggests that, to acknowledge the condition would profoundly threaten the patient's sense of wholeness, of integrity. The second reaction is one of passivity. In effect, this patient acknowledges his condition but accepts it as something which he cannot or will not change. This patient may be the "martyr"; he may be very dependent or very depressed. Even more misleading is the patient of this type who seems well motivated because of his "conformity, cooperativeness, care in the use of facilities and materials, and individuality of a pleasant and amusing kind." 8 It is usually when discharge plans are being made that the patient reveals his fear of independence by having continual relapses. More easy to detect is the third reaction, that of overt anger or hostility. Criticism of everyone, sarcasm, temper and a demanding attitude often hide a feeling of guilt and a fear of retaliation.


8 Ibid., p. 6.
Sympathy is frequently lacking for the person who assumes the "sick role" and remains more handicapped than the prognosis would indicate. Nevertheless, what is appropriate in these circumstances is not rejection of the person "but increased therapy relevant to the patient's interacting medical and psychosocial needs." 9 The challenge to modern rehabilitation practice is "flexibility in dealing with the specific problems of people whose needs are as numerous and diverse as are their personalities and their emotional and physical problems." 10

Throughout the literature on medical rehabilitation, the importance of the family's motivation for the patient's full recovery is stressed. This also requires assessment and, often, support during the treatment process. The family must be helped to understand the patient's illness, its nature and prognosis. Thereby, anxiety is decreased allowing them to be less protective and more co-operative in helping the patient regain independence.

Successful rehabilitation is dependent upon a continuous process of treatment influencing the patient from the time he becomes ill or injured until he is as independent


as possible. Early treatment helps prevent development of the unhealthy dependency in which the patient becomes enmeshed in the role of the "sick person". In addition, as Dr. Eugene Taylor notes, "it has been estimated that 80 to 90 percent of patients referred to specialized rehabilitation centers are referred for secondary complications or 'overlaid' disability which did not result directly from the basic pathology and which need not have occurred had the patient received early rehabilitation services". It is logical, therefore, that rehabilitation services should be provided within general hospitals and that the rehabilitation concept should be the focus of all treatment given to the patient from the time of his initial medical assessment.

"The rehabilitation setting is basically a medical facility in which life and death factors control the environment. The physician must therefore of necessity be the leader of any treatment team." In the rehabilitation setting particularly, the team comprises two general categories of specialists: those primarily concerned with the medical problems of the patient - medicine, nursing, physiotherapy, occupational therapy, prosthetic services, speech therapy


nutrition - and those whose primary objective is the social and personal readjustment of the patient - social work, psychiatry, psychology, recreation work, vocational counseling and placement.

Medical treatment comes first, naturally, but the ultimate social and vocational potential of the patient must be defined as early as possible so that all efforts of the team can be directed toward the goal of comprehensive rehabilitation.

Because of the prolonged nature of disabling illness, it is also of considerable importance that follow-up services be available either through out-patient facilities or in the home. With regard to the latter, at least fifty home care programs have been developed through the United States. These provide medical, nursing, therapy and social services, medical and sick room supplies, prosthetic appliances, X-rays, laboratory tests, homemaker services and transportation.

Only when a full complement of services is provided to help the patient achieve optimum adaptation to all demands of normal life: physical, emotional and social, will the goals of rehabilitation be realized.

Concepts of Rehabilitation in Relation to Trends in Social Work Practice:

The social work profession, like the rehabilitation
field, has developed in stages. In its early years, the focus was largely on the environmental situation and on improving social policies to ameliorate poverty and social decay. Later, with the advent of Freudian psychology in the 1920's, great emphasis was placed on the individual, especially on his emotional makeup, almost to the exclusion of social factors which influence his reactions. The modern focus is the totality of individual and social factors.

Social work seeks to enhance the social functioning of individuals singly and in groups by activities which constitute the interaction between man and his environment. These activities can be grouped into three functions: restoration of impaired capacity, provision of individual and social resources and prevention of social dysfunction. 13

In the medical setting, which includes rehabilitation services, the specific purpose of social work is to help the patient make full use of medical care, both preventive and therapeutic, and to achieve the fullest possible physical, emotional and social adjustment. Social work shares with rehabilitation the identical goal of enabling the patient to achieve the maximum of self-help and well-being within his potential physical and emotional limitations. But each of

these two disciplines naturally focuses on this goal from its own point of view. Medical rehabilitation puts more emphasis on the patient's physical health and abilities and the best possible development and maintenance of them, whereas social work places more emphasis on the emotional and social factors in the patient and his situation as they are expressed in his social functioning. Thus, each of these disciplines shares the same ultimate goal for the patient being treated. Each one has a particular professional focus which enhances the work of the other and contributes to the overall goal of rehabilitative medicine.

Practical Applications of Social Work in the Rehabilitation Setting.

The basic contribution of the social worker as a member of the treatment team lies in her ability to make an adequate social assessment, and based on that, provide effective planning and treatment for each patient. There are two aspects to social work focus. First, to assist the disabled patient to use the total services to his maximum capacity. Secondly, to enable the patient to become as self-reliant as possible within his physical limitations. Always the social worker's attention is given to the needs and resources of the individual patient and of his family, and to those resources in the community which will aid in the treatment process.
The social assessment, sometimes called the psychosocial diagnosis, is basic to effective social work treatment. Whenever possible, before seeing the patient, the social worker should make a careful review of the patient's medical chart, to know the medical diagnosis and tentative treatment plans. The social worker, as a member of the medical institution, must understand the implications of the disability for the patient and his family. This knowledge is essential to the social worker as a member of the treatment team in assisting the other team members to recognize the psychosocial aspects of the illness in planning the patient's care. 14

Ideally, the social worker assesses the patient at the point he is considered as a possible candidate for rehabilitation services. One aim of the worker is to establish a helpful relationship with the patient, through which he may feel free to express his feelings and attitudes. While the intake interview serves as a beginning step in trying to understand the patient's objectives, it is also utilized for evaluating his capacities to use all the available services. 15

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accomplish this, the social worker notes all the pertinent factors. The worker wants to assess particularly at this point and in her ongoing work with the patient: how the patient reacts to new situations; how he relates to authority figures; what are the strengths in the patient and his family and the relationships between them; what is the meaning of illness and disability to them; how the patient and his family respond to medical care; what are their attitudes toward the various members of the rehabilitation team; what are their attitudes toward the various members of the rehabilitation team; what are their socio-economic status and aspirations and their attitudes toward work - especially as these relate to the patient's motivation, capacity and the opportunity presented to him.

As assessment of his motivation is of special importance to an understanding of the patient and his ability to use rehabilitation services. The major principle in implementing a successful rehabilitation process is the need to secure the maximum participation of the patient and his family, both in understanding the significance of his disability and in accepting the goals and techniques of the medical program.

The concept of motivation is often considered without due thought about its components. It has been simply defined by Dr. Thomas French as "what an individual wants and
how much he wants it." 15 Dr. French speaks of the "push" of discomfort and the "pull" of hope, both of which operate at the same time and are expressed in the behavior of the person seeking some sort of help. 16 We are not, in social work practice, concerned with all of the person's motivations which vary in intensity of need and hope with every different aspect of living. Rather, we are concerned with his drives and abilities to deal with the problem in the center of attention at a particular time. Briefly, the worker's responsibility in the rehabilitation plan is "to identify the direction and the potential strength of the patient's motivation for recovery, training or work, if not for life itself." 17 Identification of this is not enough. The social worker must then help the patient recognize this himself, enhance it, and put it to work in his own interest.

In the social assessment of the patient the following have often been indices pointing to positive motivation and possible success in rehabilitation. However, this list does not pretend to be exhaustive: specific or realistic goals in rehabilitation, fair or reasonable standards of living,


16 Ibid., pp. 51-52.

successful marriage, moderate religious practice, good work history, financial independence at least five years prior to illness, minimal focus on hypochondriacal symptoms, adequate ego strengths and adequate body image. \(^{18}\) Actually, to fully understand a person's motivation, we must know his total personality and situation, including both the conscious and unconscious meaning of his disability to him and his family.

Motivation is helped as well by the attitudes of the team members toward the patient, his family, the disability, and the feelings they have about it. Social work recognizes that the attitudes and feelings of its practitioners toward the individual and his situation influence the effectiveness of social work treatment. \(^{19}\) It is a basic requirement that professional social workers must develop self-awareness in the areas of their reactions to physical handicaps, personality patterns and environmental conditions, so they can best achieve a therapeutic relationship with the person and his

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\(^{18}\) Rusk, op. cit., p. 213. "The "body image" is one we all possess. It is ordinarily outside our awareness and has become endowed with qualities of value or lack of value as a result of developmental and social experiences. Physical illness or deformity may threaten this image, necessitating a change or a defense against the recognition of this change. Since the body image is integrated with personality organization, such a change threatens the equilibrium of the personality."

family. Similarly, the other members of the team can help most by creating, through their attitudes, a climate conducive to recovery. It is a matter of watchful waiting, alertness to cues, encouragement and readiness to support at each point that the patient shows ability to move ahead.

The planning and treatment phases of social work are based on an understanding of the patient learned from the social assessment. Planning, which includes short-range and long-range goals, is always done with the patient, not for him. The patient must be able to become his own 'problem-solver', use his own resources, if effective treatment is to be attained. In other words, his motivations and capacity are evaluated and enhanced in his own use of them.

In planning, provision is made for dealing with the facts considered to be central and critical to the patient's co-operation and maximum improvement. Planning may include anything deemed necessary for effective treatment. It may point the way for a need to work with the patient's resistances to help, his hostilities to specific and significant people; to work with the family's inability to accept a disabled member, or to make referrals to such concrete community resources as financial assistance or homemaker services.

Assessment, planning and treatment are considered the parts, often not clearly distinguishable from each other,
of an ongoing process. Treatment, of course, involves the implementation of aspects of casework plans at the time they are considered to be most appropriate. Social casework treatment embraces four major areas: environmental manipulation, psychological support, clarification, and insight therapy. (The last is not used often and then usually under a psychiatrist's supervision.) One or more of these methods may be used, but only when diagnostically indicated and in light of the overall treatment plan, medical and social.

Treatment, however, does not usually end at time of discharge. Some patients, if they and their families have sufficient strengths, are able to maintain the gains they make on the rehabilitation ward after they leave it. But many others are not able to do this; hence, the need for supervised follow-up treatment is essential to keep these people from regressing physically, emotionally and socially.

Planning for treatment subsequent to discharge is an inclusive part of any good rehabilitation program. It is begun as soon as such plans can be conceived in light of the medical and social assessments. If follow-up plans are to be effective, they must be made with the patient and his family, and must not be made at the time of discharge.

If the rehabilitation setting itself is not geared to carry out comprehensive follow-up treatment, neither are
other community health and welfare resources properly utilized. When the services of any other resources are required, the referral process comes into play and the social worker is the liaison. This aspect of service involves careful preparation of the patient and his family for referral; free sharing, with the patient's knowledge and permission, of pertinent information with the outside agency; the delineation of respective lines of responsibility; and the maintenance of unhindered communication between agencies. When properly utilized, outside resources often prove necessary and worthwhile adjuncts in promoting the treatment process and in helping to maintain the treatment gains.

Setting

The patient sample studied for this thesis had all received rehabilitation services on the Activation Ward (commonly called A4) in the Vancouver General Hospital.

This ward was first established in October, 1961, under the leadership of Dr. Brock M. Fahrni, Director of the School of Rehabilitation Medicine, Faculty of Medicine, The University of British Columbia. It is supported by government only through the B.C. Hospital Insurance Act and does not receive an additional grant as a rehabilitation service. Hence, this ward is termed an "activation" unit with emphasis upon the intensive physiotherapy offered.
Patients are accepted from other services in the hospital after their acute medical treatment has terminated. Any adult patients with physical disability resulting from accident or illness are accepted on the ward, with no distinction given as to ability to pay. Private and staff patients often share the same room. Patients are assessed for treatment on the parent ward prior to transfer there, and must be able to get out of bed and become involved in intensive therapy. Only on rare occasions are patients admitted directly to A4 without first being patients elsewhere in the hospital.

Although the Activation Ward is located in the basement of the hospital, it is painted in bright colours and has a cheerful aspect. It is staffed by an internist, general practitioner, psychiatrist, five nurses, one physical and one occupational therapist, five ward aides, a dietitian shared with other wards, a part-time caseworker. Volunteers of the hospital Women's Auxiliary devote much time to visiting patients and helping with crafts under direction of the Occupational Therapist. They also allocate substantial funds each year for rehabilitation services. The total facilities of the general hospital including specialists in all medical fields are available to the patient. Emphasis is given to keep the patients up, dressed and as active during the day as their physical tolerances will permit. They are encouraged to eat in the dining room and in other ways to work toward as active and independent a life as possible.
Purpose

The purpose of this exploratory study is to evaluate the effectiveness of services given by the Activation Ward of the Vancouver General Hospital. This is done by examining the present social functioning of some of its former patients. In order to do this it was necessary first to define the goals of a comprehensive rehabilitation program. Next, the criteria for measuring social functioning had to be established. Naturally, this study has developed from a social work point of view involving the importance of understanding the very definite role that emotional and social factors play in all life's activities. From this, contributions of the social worker, as one member of the treatment team, are outlined. Specifically, these are the assessment and enhancement of the social functioning of each individual patient.

Scope

The subjects for the study were drawn from the patients who were treated on the Activation Ward of the Vancouver General Hospital during its first ten months of operation (October 1961 to August 1962). This gave an interval of approximately one and one-half years between the date of discharge and the study. The 150 patients admitted to the ward during this period had come from different parts of British Columbia. Therefore, it was practical to
select only those patients who had residence within the limits of the City of Vancouver.

Recognizing that the goals of a comprehensive rehabilitation program are limited for elderly people, the sample excluded patients of both sexes older than seventy. (Appendix B, Table I). The diversity of diagnoses of chronic illness (Appendix B, Table II) made it impossible to select those patients who had a similar illness. Therefore, the patients who had long-term disabilities as a result of their illness constituted the sample. Thirty-eight patients met these criteria.

It was disappointing that only seventeen patients were available for actual study. During the interval between discharge from the ward and the time of study, many patients moved outside the study area; some could not be located; and a few had died. (Appendix B, Table III).

The purpose of the study was introduced to the patients concerned by letter (Appendix A). Data for the ratings on each of the 17 patients was then obtained by means of an interview schedule (Appendix A) which was completed at the time of the home visit. The main focus of the study, an exploratory rating scale (Schedule A, Chapter III), was then formulated, the areas of physical, material, individual and social factors being considered. Ratings of the patients were then made on a good, fair or poor level of performance
in each area. The average performance in overall social functioning was established through totalling the scores for each criterion.

In order to compare level of functioning at the time of interviewing with that at the time of discharge, data were also taken from medical and social service records and the rating scale applied at the time of discharge from A/f. The results are recorded in Chapter III and the implications in Chapter IV.

This study involves only a small number of patients, hence the results are limited. The fact that several different types and degrees of disabilities were found among the subjects affects the exactness of the ratings as well. A further limitation lies in the fact that there was lack of consistency of recording of information on medical and social service files. Frequently, this information was documented in a general and subjective, not a specific and objective, fashion.

Other writers have noted the difficulties in making purely objective ratings of social and emotional factors. Actually, it is considered that the impressions of researchers in investigating these areas are of great

diagnostic importance, but there are limitations to this subjectivity, as well as positive aspects.

The criteria herein developed have not been subjected on a broader scale to experimental research and are therefore presented as an exploratory measuring device.
CHAPTER II

MEASURING THE SOCIAL FUNCTIONING OF THE PHYSICALLY DISABLED ADULT

What is Social Functioning?

Social functioning refers to the totality of an individual's patterns of behavior. These are the expressions of his particular biological and emotional makeup, in interaction with the social environment of family, friends, economic and political institutions. The person's reactions to his present situation are influenced continuously by his significant past experiences and his hopes for the future.

Criteria Established for the Measurement of Physical and Social Rehabilitation

Several criteria for the measurement of various aspects of physical and social rehabilitation have been established in previous studies. However, to the writers' knowledge, none have been developed to measure the social functioning of physically disabled adults. A thesis written by Tomalty defined potential for rehabilitation in terms of inner and outer resources; that is, the physiological and psychological capabilities of the patient, and the resources

within his family and community. However, while capacity for successful rehabilitation was assessed, the measurement of the actual level of the patient's social functioning was not.

Of considerable relevance to this study were the theses written by Varwig and McCallum, in which rating scales for measuring social adjustment were devised. These studies focused upon the social adjustment of handicapped children, but it was feasible to adapt to this thesis, criteria pertaining to the importance of family strengths and socio-economic factors.

McCoy and Rusk inquired into the practical effects of rehabilitation services in a follow-up study of 208 orthopedically handicapped persons discharged from four hospitals in New York City. They answered the preliminary question, "Is comprehensive rehabilitation worthwhile?" by applying the following standard to cases studied:

If the individual gains ability to function to the maximum of the capabilities he has left and uses these capabilities in a way satisfactory


to him and acceptable to the community, it may be assumed that his rehabilitation paid - that it was successful. If not, it did not pay - it was not successful. 5

This inquiry also attempted to determine what factors "appeared most frequently with success and failure." 6 It was possible to adapt some of these criteria to the present study. However, because of the primarily medical focus of the inquiry, it was necessary to develop further criteria in order to measure social and emotional aspects of social functioning.

The most recent and pertinent study on social functioning was carried out by the Family Centered Project in St. Paul, and was concerned with 'multi-problem' families. 7 The socio-economic factors were relevant, and were adapted to the measurement of the social functioning of persons with physical disability.

Explanation of the Criteria Established in the Present Study

From a review of these studies, criteria of social functioning were developed under the main headings: Physical Factors, Material Factors, Individual Factors and Social Factors. 8

5 McCoy and Rusk, Ibid., p. 3.

6 Loc. cit.


8 Refer to rating scale, page 43.
Physical Factors

The first criterion to measure functioning of the physically disabled person is, understandably, that of "limitations imposed by disability on physical functioning". As illness always constitutes a stress, emotional as well as physical, it follows that a chronic condition with reduction of physical capacity will have a significant impact on social functioning. Ratings, therefore, are related to the degree of impairment.

"Health factors apart from disability" is considered to be a second important criterion, again because of the stress-producing and limiting effects of any illness. A limitation of this criterion was the fact that only the patient's assessment of his health was available. Thus, a patient who needed to exaggerate his poor health could reduce the objectivity of the results.

"Actual level of functioning, the next criterion, needed to be measured in order that a comparison could be made between the expected degree of physical impairment and the actual performance of each patient. This comparison has definite implications for the evaluation of rehabilitation although, without all other criteria of social functioning, comprehensive analysis of the patient's level of functioning is impossible. Ratings were made according to the degree to which the patient had attained maximum physical functioning.
**Material factors**

"Household arrangements" included the physical relationships of rooms to one another (for example, bathroom near bedroom, number of stairs); the facilities for washing, cooking and sanitation; and the equipment including self-care gadgets such as additional railings and raised toilet seats. The criterion was rated with regard to the adequacy of arrangements, facilities and equipment for the needs of each patient.

"Employment status", including housework, is another criterion of importance. If a patient was capable of full employment on discharge, his situation was rated good. This rating implies that the patient had retained a very important role in his life. Capability of part-time employment with special arrangements was rated fair and unemployability or lack of employment was rated poor. A limitation of this criterion was discovered when patients were interviewed who had limited capabilities for employment and yet were doing full time and sometimes rigorous work.

"Economic status" was rated with regard to adequacy of income and the degree of independence from financial support. The financially dependent person has lost control over a matter of great importance to his security and is in a position which constitutes a threat to his sense of personal worth. This is especially so if his values include a high degree of self-
sufficiency. The stress of this situation would affect behavior and attitudes toward others and reduce adequacy of social performance.

**Individual factors**

"Attitude toward living arrangements" is an important consideration as the disabled person's sense of security often rests heavily upon his feelings about the adequacy of living conditions. Patients in nursing and boarding homes have an extra adjustment to make to the personal implications of living away from home and in an institutionalized setting.

"Attitude toward disability" greatly affects the person's capacity for social functioning. As discussed in Chapter I, unless the person has a realistic acceptance of what the disability means to him in his life, he will be hampered in his use of those capacities which remain.

Following logically from the last criterion is "attitude toward own role in family (or equivalent)". A disabling condition may prevent the person from carrying out former roles as a family member and the meaning of this to him may significantly affect his sense of worth. Even when no great reduction of activities is involved, the disabled person's feeling of importance to his family can be threatened by illness and the effects it has.
"Motivation" is divided into three aspects for assessment. "Use of time", particularly in the case of an unemployable person, is an appropriate measurement of the person's adjustment to his disability and his life situation.

"Motivation for treatment" refers to the patient's ability to assume the 'patient' role and become dependent upon the treatment team in order to get well, yet retain the responsibility for his own rehabilitation.

"Motivation - reality-oriented or inner-oriented" refers to the goals or lack of goals the person has set for himself. Assessment of whether they are realistic in terms of the actual limitations imposed by his disability is an important clue to the degree of adjustment he has made and to the overall adequacy of his social functioning.

Social Factors

Family (or equivalent) context is the first criterion as the actual presence of significant persons in the patient's life whether family or friends has real implications for his health and happiness.

The next criterion, "family (or equivalent) attitudes towards disability", measures the degree to which family members or friends are accepting of the patient's disability. The reactions of the family and friends to the patient may range
from understanding and acceptance to overprotectiveness and outright rejection of him.

"Family (or equivalent) contributions" relate directly to the degree of emotional warmth and degree of mutual support among the family members. The attitudes of the family affect the degree to which realistic support will be offered by them to the patient. This criterion, applied at time of study, rates the strengths within the family; applied at time of discharge, it measures the family's reactions to the disability, as well as the family strengths.

"Sociability" refers firstly to the patient's responsiveness to others in his life situation and secondly, to his relationships with others since his disability.

"Use of community resources - health, vocational, recreational and counselling" are the last four areas to be rated. These are all rated in terms of how realistic the patients have been in their use of available resources. Two variables in rating these criteria are the inadequacies of some resources in the community, and the differing degrees to which they have been made, or not made, available to the patients.

A limitation in the rating scale is the grouping together of criteria pertaining to external socio-economic
factors (such as "household arrangements" and "economic status"), and criteria pertaining to psycho-social factors (such as the patient's and family's response to problems created by the disability and their interaction with one another). This means that a poor average rating, for example, could be based largely on factors external to the patient rather than to his lack of motivation or family support. In part, this weakness is overcome by the individual case analyses that follow the results of ratings in Chapter III.
CHAPTER III
APPLICATION AND ANALYSIS OF THE CRITERIA
TO SPECIFIC CASES

Cases Selected for Analysis

The rating scale was applied to information regarding a sample of seventeen former patients of the Activation Ward. Of these, the greatest majority had become disabled due to Cardiovascular Accident. Patients with Rheumatoid Arthritis and Multiple Sclerosis constituted the next largest group. (Appendix B, Table II). Nine men ranging in age from 48 to 65 and eight women aged 47 to 68 made up the total group. (Appendix B, Table I). The number of male and female patients rated, therefore, were representative of the total sample.

Measuring Social Functioning at Time of Study

While using the interview schedule to obtain data to measure social functioning, the feelings and attitudes of patients and family members were also noted. All cases were rated once by each of the two writers in an effort to reduce subjectivity. (Appendix C, Table IV).

For all three criteria under Physical Factors, the average rating for the majority of patients at the time of study was fair. Under Material Factors, the total sample
was rated good for "household arrangements", poor for "employment status" and fair for "economic status".

In the area of Individual Factors, "attitude to living arrangements" was, on the whole, good. "Attitude toward disability" and "attitude toward own role in family" were both rated poor. A slight majority of patients had a good rating for "motivation in use of time". The next largest group was rated fair. Again, a slight majority had a good rating for "motivation for treatment" but the next largest group, almost equal in size, were rated poor. The greatest number of the sample obtained a poor rating for "motivation - reality-oriented or inner-oriented". That is, their goals were either quite unrealistic or they had no goals and were generally apathetic.

Under Social Factors, "family context" was rated good; "family attitudes toward disability" was rated fair; and "family contributions" was similarly rated fair. "Sociability" for the sample as a whole was fair. "Use of community resources - health" was good. "Use of vocational resources" was rated poor. Even distribution between good, fair and poor was found in "use of recreational resources", with an equal number of patients having good and poor ratings.

In "use of counselling resources", the largest group rated poor and the next largest rated fair.
Comparison of Level of Social Functioning at Time of Study and at Time of Discharge

As described in Chapter I, Method, all patients were also rated at the time of discharge from Ward A4, according to information obtained from the medical and social service records (Appendix C, Table V). The ratings at the time of study and at the time of discharge were then compared, indicating the movement in social functioning. Figures I and II, page 42 illustrate that the average social functioning of the sample moved from good to fair between discharge and the time of study.

Actual level of functioning was the only criterion under Physical Factors which differed at time of study from time of discharge. The majority of patients moved from a good rating at time of discharge to a fair level of actual physical functioning at time of study. This fact indicates that the gains achieved by the time patients left the hospital were not, on the whole, maintained.

Under Material Factors, "economic status" regressed from good to fair. Speculations as to the reasons for this are: there was incomplete assessment of the actual economic situation while the patients were on the ward; and the high cost of medical care has reduced the number of patients with adequate and independent incomes.
"Attitude toward disability", and "motivation - reality-oriented or inner-oriented", both regressed from a good to a poor rating. Here again, the possibility of insufficient assessment of the patient's attitudes while he was on the ward is indicated. Lack of complete or appropriate casework treatment to help the patient accept his disability and thereby enhance his motivation is also a distinct possibility. Regarding motivation in terms of the patient's goals, it is obvious that if the patient has poor acceptance of his disability, he is unlikely to work toward realistic goals. It may be that this criterion was rated good on the ward because the patient showed a favorable response to the treatment regime and the team members. This assessment, however, does not appreciate the patient's underlying feelings.

"Family context" was rated good at both points in the rating, but in none of the remaining criteria under Social Factors was there agreement in ratings. "Family attitudes", "family-contributions" and the patient's "sociability" all showed downward movement from good to fair. It appears that only "family context" was evaluated accurately on the ward, yet this is not a sufficient assessment of family strengths. It is the quality of family relationships which contributes most to the success of the patient's rehabilitation.

"Use of recreational resources" was rated good on the ward but was not so clearly differentiated between good,
fair and poor at the time of study. On the ward, patients are expected to participate in the recreation services offered. However, the good rating in this area is not necessarily a measurement of the patient's wish to use recreational resources. Often, when the encouragement of staff is unavailable, the patient becomes apathetic.

In summary, the result of ratings at both points in the study indicated that actual level of physical functioning of the majority of patients regressed in the one and one-half year period following discharge.

The greatest downward movement during this period was discovered in social and individual factors. In the opinion of the writers, the reason for this apparent regression was a lack of full assessment and enhancement of these areas at the beginning of and throughout the treatment process.

Case Illustrations

Mrs. A's situation illustrates that of patients who, in the area of "economic status", were rated good at discharge and fair at the time of study. Her retired husband receives a small superannuation but no medical coverage. He appeared quite anxious when answering the question on adequacy of income saying "I have no medical insurance so I have to pay my wife's medical bills myself". He indicated great concern over their fast declining economic status.
Mr. B's rating for "attitude toward disability" and "motivation, reality-oriented or inner-oriented" regressed from good to poor. On the ward he was described as "bright and cheerful". He worked hard both on the ward and after discharge at regaining use of his physical capacities. His illness is such, however, that doctors have ordered part-time employment only. During the interview, it was discovered that he has not followed this suggestion. Instead he works six days a week at heavy labor. His cheerful manner appeared to the interviewer to be an attempt to hide deeper feelings about his condition, probably from himself as well as from others. Obviously, Mr. B. drives himself beyond the realistic limitations imposed by his disability.

The reasons for downward movement from good to fair in the ratings of "family attitudes", "family contributions" and patient's "sociability" was clearly shown in the case of Mr. C. Assessment of the family while this patient was on A-4 was confined to the presence of family members, and their physical ability to help the patient dress and walk. Nothing was noted of the quality of relationships between patient and family. When interviewing, it was observed that the patient had "a pathetic relationship with his wife who is very domineering, aggressive and subtly blames him for their lack of social contacts". Mr. C. has
regressed in all areas of social functioning since discharge. This information suggests that incomplete assessment of family attitudes and contributions (and of the patient's sociability) with consequent failure to enhance these factors, have important bearing on the reasons for Mr. C's regression.

Mrs. D's extreme lack of responsiveness to recreational facilities since discharge from A-4 illustrates the fact that a good use of the facilities on the ward does not always predict adequate use of resources in the community; deeper assessment of motivation and capacity needs to be made. On A-4 this patient responded to the warm support of team members and volunteers and was described as "cheerful and cooperative". She enjoyed arts and crafts and associations with other patients. At home she was depressed and apathetic. She was so preoccupied with the limitations imposed by her disability that she failed to utilize the considerable capacity for work and pleasure remaining to her. As her overall social functioning is steadily declining, her husband fears she will soon require more care than he can give her.

Findings of the ratings and case analyses have implications both for the rehabilitation program and the services of the social worker on the team.
FIGURE I
TOTAL RATING OF SOCIAL FUNCTIONING

At time of discharge.
At time of study—approx. 18 months later.

FIGURE II
TOTAL RATING OF SOCIAL FUNCTIONING IN EACH FACTOR

At time of study—approx. 18 months later.
### SCHEDULE A

**Scale for Measuring Social Functioning of Persons with Physical Disability**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Explanation of Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I Physical Factors</strong></td>
<td></td>
</tr>
<tr>
<td>A. Limitations imposed by disability on physical functioning.</td>
<td>Good: Physical disability or illness is expected to have little or no effect on activities of daily living.</td>
</tr>
<tr>
<td>B. Health apart from disability</td>
<td>Good: Good physical health apart from specific disability.</td>
</tr>
<tr>
<td>C. Actual level of functioning.</td>
<td>Good: Functions up to maximum capacity within limitations imposed by physical disability.</td>
</tr>
<tr>
<td><strong>II. Material Factors</strong></td>
<td></td>
</tr>
<tr>
<td>A. Household arrangements.</td>
<td>Good: Household arrangements, facilities and equipment adequate to meet his needs.</td>
</tr>
<tr>
<td>C. Economic status.</td>
<td>Good: Has adequate, independent resources which provide a level of living sufficient to meet his physical, emotional and social needs.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Good</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>III Individual Factors</td>
<td></td>
</tr>
<tr>
<td>A. Attitude toward living arrangements.</td>
<td>Finds living arrangements comfortable and adequate.</td>
</tr>
<tr>
<td>B. Attitude toward disability.</td>
<td>Has realistic understanding of limitations and has not made them a detriment to living.</td>
</tr>
<tr>
<td>C. Attitude toward own role in family (or equivalent)</td>
<td>Feels role has not altered; or, has adjusted to new role in terms of his limitation.</td>
</tr>
<tr>
<td>D. Motivation - use of time.</td>
<td>Has developed interests for enjoyment of spare time.</td>
</tr>
<tr>
<td>E. Motivation - for treatment.</td>
<td>Is able and willing to use help from others in order to help himself.</td>
</tr>
<tr>
<td>F. Motivation - reality-oriented or inner-oriented.</td>
<td>Has realistic goals for himself and is active in working toward them.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Good</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td><strong>IV. Social Factors</strong></td>
<td></td>
</tr>
<tr>
<td>A. Family (or equivalent) context.</td>
<td>Has family and lives with them.</td>
</tr>
<tr>
<td>B. Family (or equivalent) attitudes toward disability.</td>
<td>Family members indicate an understanding of any limitations imposed by disability and accept them comfortably.</td>
</tr>
<tr>
<td>C. Family (or equivalent) contributions.</td>
<td>Warm family unit. Members pull together in times of stress.</td>
</tr>
<tr>
<td>D. Sociability.</td>
<td>Independent, secure in relationships. Thinks of others as well as himself.</td>
</tr>
<tr>
<td>E. Use of Community Resources: Health.</td>
<td>Uses health resources promptly and appropriately when needed.</td>
</tr>
<tr>
<td>F. Use of Community Resources: Vocational</td>
<td>Uses vocational resources appropriately if required.</td>
</tr>
<tr>
<td>G. Use of Community Resources: Recreational</td>
<td>Makes realistic use of resources which appeal to his interests.</td>
</tr>
<tr>
<td>H. Use of Community Resources: Counselling.</td>
<td>Has positive attitude toward use of counselling if appropriate. May view them with suspicion or resentment.</td>
</tr>
</tbody>
</table>
Contributions of the Study to the Rehabilitation Program

The contributions of all the team members play a vital role in rehabilitation. Their frequent exchange of information is necessary if they are to work as a team for maximum patient benefit. This information must be placed on the medical chart. For treatment purposes, information is shared to determine the patient's physical and mental abilities, his motivation and reactions to his disability. Further, the medical chart is the only complete and permanent record and must be useful for follow-up and research purposes.

While collecting data for this study, it was discovered that current records of each team member were not always placed on the medical chart. This not only made it difficult to collect adequate data, but it limits the services of each member of the treatment team.

While conducting the study, the writers found that the majority of the patients had felt unprepared for discharge from A-4. Many longed to return to the security and comfort of the ward. This indicates that the discharge of a patient to another environment must be carefully planned. After reassurance by the staff of their continued interest in him,
the patient will be able to absorb the idea of discharge. The patient must be reminded that referral elsewhere can be of value to him once his active rehabilitation program is completed. Then, he is usually more ready to accept referral to community resources, if such are indicated, either medical or social. To the patient, arbitrary and abrupt decisions on his discharge mean abandonment and loss of interest in him. For this reason, attempts to refer an abruptly discharged patient elsewhere tend to either fail or create unnecessary difficulties. If such discharge preparation is not made, the dependence of the patient on medical services may be encouraged, resulting often in 'hospitalitis'.

The writers also noted that the average age of the sample was 59 years. The youngest patient (not included in the sample) who was treated on the ward during the period of study was 28 years old. Why was the ward not used as extensively for younger adult patients? Is it that the treatment team considers younger patients more capable of achieving recovery from disabilities independent of rehabilitation services? Yet, the needs of the younger disabled patients are different from those of the older ones. The former require services to enable them to function adequately in all areas, physical, vocational, emotional and social, so that they may make full use of the remaining productive adult years. On the whole, patients in the younger age group are able to
make a more extensive use of physical rehabilitation. In a general hospital, it seems logical to assume that comprehensive rehabilitation services should be extended to these patients.

Implications of the Study for Social Work Practice in the Rehabilitation Setting

From this study, it is obvious that the social worker makes a definite contribution in creating a rehabilitation program which is both comprehensive and effective.

The role of the social worker entails three specific responsibilities. The first lies in the careful assessment of the social and emotional factors in the patient and his family situation. Most important is the assessment of the patient's motivation. It is not sufficient to say that the patient is well-motivated. It is necessary to say what is the degree of his motivation, and for what goals.

This assessment requires considerable gathering of facts and is therefore time-consuming. But exploring and treating the 'feeling' aspect of physical rehabilitation is necessary in order to achieve effective results. Otherwise, attitudes in the patient and his family, and any detrimental factors in their social and economic situation might greatly impede his chances for successful social functioning.

Findings of the study indicate that during the first
ten months of the ward's operation, the social worker's knowledge and skills were not utilized to full advantage. The social worker's attention was focused more upon the family context and the physical arrangements of the home, rather than upon the family relationships and the patient's attitudes toward his social situation. However, it must be noted that many changes have been made on the ward since August 1962 in the program offered. Still, it is the writers' opinion that the social services offered to patients and their families, and the understanding of them by social workers and other team members, could be improved.

The second responsibility of the social worker lies in the utilization of all community resources - in the family and community - which are appropriate to meet the patient's needs. The social worker plays an important role, along with other team members, in preparing a patient for discharge and enabling him and the family to use pertinent outside resources. That several of the sample, when interviewed, were either not aware of or using community resources points up the fact that the social worker could emphasize better this aspect of social service.

A third responsibility of the social worker is to interpret the availability and use of community resources to the other team members. The social worker acts as a liaison between the rehabilitation setting and outside services. She
must implement and maintain the necessary channels of communication between them. This function not only strengthens the services offered by the rehabilitation program but also helps in the creation of effective co-ordination between community agencies, of which the rehabilitation setting is one. Further, when gaps in community resources are apparent, it is the social worker's role to interpret such inadequacies to the other team members, and enlist their cooperation in social action to effect some improvement of them.

In performing all these functions responsibly, the social worker plays a significant part in helping the patient maintain his rehabilitation achievements both on the ward and after discharge. Only by including these functions of the social worker, plus those of teaching and research, will the full comprehensiveness of the program be realized.

Implications for Further Research

An implication of this study is the need for a more accurate assessment of patients' abilities to utilize rehabilitation services. Assessment is the basis upon which all continuing services rest, hence it is the first step to good rehabilitation treatment.

The writers suggest that the criteria established to measure social functioning be further refined to develop a comprehensive assessment plan for the rehabilitation setting.
APPENDIX A

INTERVIEW SCHEDULE

Name .................................................................
Age .................................................................
Family Members ..................................................
Own Home .......................................................B.H..............N.H.........
Description ......................................................
...........................................................................

PHYSICAL FACTORS:

1. How are you able to manage now compared to when you first came out of hospital?
   (Ic)
   - the same ..............
   - better ..............
   - worse ..............

2. Can you do as much now as you expected to be able to do?
   (IIId)
   - yes ..............
   - no ..............

3. Are you able to perform your daily activities:
   (Ic)
   - by yourself with or without the help of gadgets?......
   - with some help from other people?.........................
   - with a great deal of help?.................................

4. How is your health apart from your disability?
   (Ib)
   - good ..............
   - fair ..............
   - poor ..............

5. Have you been readmitted to any hospital since your discharge from A4?
   ...........................................................................
   ...........................................................................
MATERIAL FACTORS:

6. Are there any difficulties in the household arrangements which prevent you from using them?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kitchen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedroom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family recreation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting outdoors</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Interviewer's impression of attitude:

7. Were you employed before your hospitalization? ...........

8. Are you employed now? (including housework)

   Yes  .........................
   No  ..........................

   (If response is "No" omit 9 and 10)

9. What kind of work do you do?

   (IIb)  .........................
   - full time  .................
   - part time  ..................

10. Is this different from the work you did before your hospitalization?

    (IIb)  ........................
If so, in what ways? ..............................................................
..............................................................................................
..............................................................................................
If 9 and 10 answered, omit 11 and 12.

Alternate questions:

(IIb) 11. Is it possible for you to work..............

(IIb) 12. If so, have you tried or had any difficulty in obtaining a job? ..............

13. Are you financially

(IIc)  - independent ......................
  - dependent on others ...........
  - on social assistance ...........

14. Do you find that your income is sufficient to provide for your everyday needs?

(IIC)  - adequate food   
  - housing               
  - medical care         
  - recreation           
  - other services needed

Comments .................................................................
..............................................................................................
..............................................................................................

15. INDIVIDUAL FACTORS:

How has your disability (or illness) affected your way of life?

(IIIB)  - is it a detriment in any way? .........................
  - if so, in what ways? ..............................................................
  - has it changed your whole life completely? .............

Comments: .................................................................
..............................................................................................
..............................................................................................
16. Do you feel your place in the family (i.e. responsibilities and privileges) has changed because of your illness? .................................................................

If so, in what ways? .................................................................

.................................................................

17. How do you spend your spare time? .................................

.................................................................

.................................................................

.................................................................

.................................................................

SPECIAL FACTORS:

(IVb) 18. Have you found your family (or friends) encouraging and supportive? .................................................................

.................................................................

19. Has it been necessary for the family (or friends) to reorganize their duties since your illness? .................................

.................................................................

(IVd) 20. Has your circle of friends changed because of your illness? .................................

21. Do you take part in any outside activities?

(IVg)  - recreation .................................

- church .................................

22. Have you used, or are you now using, any health, social or vocational counselling agencies?

(IVe, f,h)  - which ones? .................................................................

- how often? .................................................................

23. Have you or your family had any contact with social workers since discharge from Ward A4? .................................

.................................................................
January 18, 1963

The Activation ward at the Vancouver General Hospital (Ward A-4) has now been operating for over a year. We are just starting to make a survey to see how our past patients here have fared since discharge from hospital. Knowledge of your present condition and degree of activity will enable us to find ways and means of improving this service both in the hospital and, through the ancillary services in the home.

The first step in this survey will be in the form of a questionnaire which will be brought to you for discussion by one of our social workers (Miss M. DeWolf and Mrs. L. Mansfield). I would be most grateful if you could cooperate in this interview which would be arranged at your convenience when one of the social workers contacts you.

At a later date, I am hopeful that we could arrange for you to come up to the ward so that the activation team including myself could see you in person.

I am

Yours sincerely,

T.H.C. Lewis, M.D.
### APPENDIX B

#### TABLE I

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 45</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>46 - 50</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>51 - 55</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>56 - 60</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>61 - 65</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>66 - 70</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

#### TABLE II

<table>
<thead>
<tr>
<th>Cause of Disability</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Accident</td>
<td>7</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>2</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>1</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>3</td>
</tr>
<tr>
<td>Spondylosis</td>
<td>1</td>
</tr>
<tr>
<td>Asthma</td>
<td>1</td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>
APPENDIX B

TABLE III

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available for study</td>
<td>17</td>
</tr>
<tr>
<td>Unable to locate</td>
<td>13</td>
</tr>
<tr>
<td>Deceased</td>
<td>3</td>
</tr>
<tr>
<td>Moved out of City of Vancouver</td>
<td>4</td>
</tr>
<tr>
<td>Declined</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38</strong></td>
</tr>
</tbody>
</table>
## TABLE IV

Rating Social Functioning in the Total Sample
(a) at time of study.

<table>
<thead>
<tr>
<th>Criteria (Schedule A)</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good</td>
</tr>
<tr>
<td>I. Physical Factors;</td>
<td></td>
</tr>
<tr>
<td>A. Physical limitations.</td>
<td>3</td>
</tr>
<tr>
<td>B. Health.</td>
<td>6</td>
</tr>
<tr>
<td>C. Level of functioning.</td>
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<tr>
<td>II. Material Factors:</td>
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<td>A. Household arrangements.</td>
<td>13</td>
</tr>
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<td>B. Employment status.</td>
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<td>C. Economic status.</td>
<td>4</td>
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<td>III. Individual Factors:</td>
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</tr>
<tr>
<td>A. Attitude toward living arrangements.</td>
<td>10</td>
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<tr>
<td>B. Attitude toward disability.</td>
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<tr>
<td>C. Attitude toward own role.</td>
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</tr>
<tr>
<td>D. Motivation - time.</td>
<td>7</td>
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<tr>
<td>E. Motivation - treatment.</td>
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<td>F. Motivation - reality-oriented or inner-oriented.</td>
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<tr>
<td>A. Family context.</td>
<td>11</td>
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<td>B. Family attitudes.</td>
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<td>C. Family contributions.</td>
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<tr>
<td>D. Sociability.</td>
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<tr>
<td>E. Use of resources - health.</td>
<td>8</td>
</tr>
<tr>
<td>F. Use of resources - vocational.</td>
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<tr>
<td>G. Use of resources - recreational.</td>
<td>6</td>
</tr>
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<td>H. Use of resources - counselling.</td>
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</tr>
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<td>Total Social</td>
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TABLE V

Rating Social Functioning in the Total Sample
(b) at time of discharge.

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<th>Ratings</th>
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<td>Poor</td>
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<td>5</td>
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<td>C. Economic status.</td>
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<td>A. Attitude toward living arrangements.</td>
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<td>-</td>
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<tr>
<td>B. Attitude toward disability.</td>
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<td>C. Attitude toward own role.</td>
<td>4</td>
<td>4</td>
<td>5</td>
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<tr>
<td>D. Motivation - time.</td>
<td>10</td>
<td>2</td>
<td>4</td>
<td>1</td>
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<td>11</td>
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<tr>
<td>F. Motivation - reality-oriented or inner-oriented.</td>
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<td>4</td>
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<tr>
<td>A. Family context.</td>
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<td>4</td>
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<td>1</td>
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<tr>
<td>B. Family attitudes.</td>
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<td>5</td>
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<tr>
<td>C. Family contributions.</td>
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<td>3</td>
<td>5</td>
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<tr>
<td>D. Sociability.</td>
<td>5</td>
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<td>5</td>
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<tr>
<td>E. Use of resources - health.</td>
<td>13</td>
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<td>1</td>
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<td>F. Use of resources - vocational.</td>
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<td>3</td>
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<td>H. Use of resources - counselling.</td>
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<td>Total Physical and Material</td>
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BIBLIOGRAPHY

Books


BIBLIOGRAPHY


Theses

Master of Social Work Theses


BIBLIOGRAPHY


Miscellaneous

(Journals, Periodicals, Monographs, Bulletins and other publications).


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