After-Care Problems of the Discharged Mental Hospital Patient:
A Trend Report on Recent Literature and its Implications for Practice

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This study takes the form of a critical review of recent research on the problems of the discharged mental hospital patient. Its principal objectives may be stated as follows: (1) to delineate the difficulties faced by the ex-patient in his attempts to re-adjust to life in the open community and maintain a satisfactory level of mental health; (2) to summarize the main trends in recent social and medical research on the nature and source of these difficulties, and to specify their implications for the tasks of community mental health planning; and (3) to examine the question of the proper role of social workers in the context of research and practice alike, in this field of mental health services.

A study of this kind acquires especial timeliness from the fact that the number of mental hospital patients discharged to the community in recent years, who would formerly have required long-term or permanent hospitalization, has been increasing in an unprecedented way. This development is attributed primarily to the rapid growth in the use of chemotherapeutic techniques.

The main findings of the study are, first, that - although there is ample scope for their skilled and specialized participation - social workers have so far played little part, and taken little initiative, in the developments under review; and, secondly, that the many changes now taking place in the treatment of mental illness (particularly on an out-patient basis) will require extensive and radical modifications in the training, the therapeutic orientations and the role relations of the mental health professions.
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In this introduction I will present the reasons why I am choosing this specific topic for my thesis, the purpose it has in the frame of reference of social work, the scope of my investigation and the method by which I think my purpose can be accomplished.

In December 1962 I found that I was unable to obtain from the Department of Vital Statistics the correlated data which I needed for a research project on which I had worked since the summer. The proposed plan had been to analyze the differences in socio-medico characteristics between a group of former mental hospital patients who had succeeded in remaining in the community and a group who had returned to the hospital within less than six weeks. Both groups belonged to the population which had been discharged from Essondale (Provincial Mental Hospital) from December 1961 until June 1962.

At that late date in the academic year it was necessary to formulate another topic which enabled me to use what I had read and learned while I was preparing for my piece of research.

Fortunately, my study of literature in the mental health field coincided with the publication of numerous research projects which were promoted by the American Government's planned "Action for Mental Health"¹. I think that I have had an extraordinary opportunity to become acquainted with

the latest emerging changes and the challenging findings regarding mental illness, therapeutic methods and after-care problems.

My own personal inclinations and biases have, over the years, made me more impressed by some factors than by others. I have found it very exciting to discover how much the individuals' as well as the groups' thoughts and actions were influenced by their specific cultural environment. My interest led naturally to a study of sociology, anthropology and psychology. Furthermore, it was encouraging to discover that the more I knew about these subjects, the better I could practice my profession. I "learned" that it was possible to become sensitive to my clients' culturally and socially determined motivations, values, norms and goals in spite of my own idiosyncratic cultural "fixation".

It should be understood in order to prevent misconception that the understanding of the structure and function of cultural patterns must be differentiated from the specific, clinical, psychodynamic understanding of an individual. The former concept encompasses interpersonal problems while the latter focus is on intrapersonal problems. However, both aspects are interdependent and necessary for a holistic view of human nature in its environment.

As the profession of social work builds its methods on concepts borrowed from the behavioural sciences, their development will demand and promote changes in the functions of social work. It takes humility as well as sagacity to
incorporate new scientific knowledge in an applied science in a manner which is scientifically sound as well as culturally acceptable.

I think that the steady development of methods and scope in social work testifies to the fact that the profession has always been in close co-operation with the behavioural disciplines. When the Freudian theories came to this continent, the profession incorporated the psychodynamic theories in casework methods. Likewise, sociological concepts are currently being introduced in order to develop a better understanding of family dynamics and other matters.

While I was studying the numerous important publications in the mental health field, I became interested in and impressed by two factors. First, I found that the plight of the mentally ill who had been confined for years in mental institutions had stimulated psychiatric and behavioural scientists to a multi-disciplinary approach to this very complex issue. Secondly, that sociologists, anthropologists, psychiatrists, statisticians, occupational therapists, nurses and social workers were working on teams together because only an interdisciplinary effort could accomplish their new purpose.

The purpose of their united effort was bi-dimensional. They wanted to study together all conditions of mental health and mental illness in order to develop more effective means of prevention, treatment and rehabilitation. They are succeeding on both fronts. Gradually, it is becoming clear that several types of mental illness which formerly have been
considered untreatable are curable or at least manageable under the influence of organic and psychic therapies. Therefore, the need for custodial treatment is rapidly decreasing while continued research is badly needed for the development of better after-care planning.

These facts have gradually convinced me that the focus as well as the possibilities for psychiatric social work are respectively changing and increasing. Not only can I see an immense development in the operational body of knowledge which is highly pertinent to the problems of planning for the rehabilitation of the ex-patient facing social readjustment problems, but also that the social worker has an important role to play in further the research as well as applying its findings.

Thus, instead of studying the literature in order to build up testable criteria for my research project I found that it would be purposeful and appropriate to investigate the consequences of these new demands on the role of the social worker. I see it as a mutual interaction. We cannot only ask: What can the social worker today know about the re-socialization problems of ex-patients? We must also ask: How can this knowledge be incorporated in the traditional principal concerns of social work? As I see it, we have an interdependent development, where the parts can only be separated for the purpose of conceptual expediency during a descriptive analysis. Social work contribution to research
will inherently have the utilitarian note which looks to the application of the results of research to treatment.

It will be necessary to limit the scope of my investigation. I will in this thesis focus on the development of after-care services for the ex-patient. By so doing I will outline the changing and emerging role of the psychiatric social worker. It has always been difficult to arrive at an agreement about the role of psychiatric social work because its functions were blurred by the overlapping role pattern of the clinical team. However, such dilemmas are inherent factors in the emergence of new roles. The role incumbent must go through degrees of marginality before its functions can become culturally acclimatized and publicly approved. The division of labour is usually slow and tortuous. Nevertheless, I think that it is a professional obligation to seek the means which will establish yet clarify such changes because the effectiveness of service depends primarily on a complementary set of role expectations among the professionals themselves, as well as between the public and the professionals.

My study endeavours neither to promote dislocation of old role patterns nor to dispute the function of psychiatric social work. I will simply show where I have found that new trends in psychiatry are demanding that social workers extend their traditional role to new or at least different areas. Moreover, I will clarify what I think are now the principal professional obligations in view of these recent developments in the mental health field.
By using the word "clarification" I do not mean that I can present my questions and my answers in a fully organized fashion, with clear-cut arguments for or against a proposal. The theories and the empirical findings of the psychiatric field are in a continuous flux. Anything one person might say for a given method, a second person might just as easily say for another.

My study must therefore become a descriptive exploration by means of which I move from one point to another in order to convey to my reader the atmosphere of creative confusion which is the condition of the contemporary mental health field. Such disorder would be intolerable if it were not that the very inability to systematize the relationships between mental health and mental illness indicated an infinite range of combinations of solutions for this, perhaps the most threatening problem of human existence. The piecemeal and eclectic method of studying human dysfunctioning is the only one useable and applicable at present.

In the first chapter of the study, there will be a brief review of the contemporary scene in order to make a distinction between the specific concern of this thesis and the other major subdivisions of the mental health field.

In the second chapter, I will focus on the dilemmas of the ex-patient. A number of suggestions concerning the problems of re-socialization in the community will be presented. The gaps in social work services will be localized and described.
The manner in which it appears, according to recent research, that resocialization can be planned and attempted most successfully will be the topic for the third chapter.

Finally, I will summarize what I see as the desirable conditions for a development of social work in the mental health field which would result in the creation of new and better services for the ex-patient.
Chapter I.

In my introduction I have dealt with the questions at issue in and the purpose behind my research. In this first chapter, I will present some of the more puzzling yet pertinent factors which arise the moment one begins to study mental health problems.

Conceptual Difficulties

It has been shown very definitely by M. Jahoda and others that mental health and mental illness are not concepts which can easily be defined. The nosological approach used in clinical diagnostics fails in the area of psychiatry because it has been found that there is not a clearly defined borderline between the pathological syndrome and the marginal conditions of mental health. As one of the critical signs of mental illness is deviency, we need the abstract framework of a fully developed system of behavioural theory in order to define what we can observe along the multilevel continuum of normal and deviant behaviour. But, such a system is not yet available. If we scan the literature we find that the two words 'mental health', "alternately or simultaneously refer to a state, an attribute,

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5As '4'.

a movement, a social cause, an interrelated body of facts and theories relating to that state or attribute, a group of techniques and skills associated with promoting that state.\(^1\)

The fact that conceptualization is difficult should not keep us from seeking an understanding of the problem. We know that we can often communicate experience which we cannot demonstrate empirically or conceptualize in abstract terms.\(^2,3\)

I am certainly not advising that we should make a compromise with our scientific conscience. But I think it is reasonable to refer to the common scientific experience that we must first learn to perceive the existence and the nature of individual phenomena\(^4\) in a piecemeal fashion before we can conceptualize our observation and co-ordinate theory.

**Operational Concepts**

I am not here discussing the matter of definition only as an academic exercise. The difficulty of saying precisely what mental illness and mental health are has important practical consequences.\(^5,6,7,8,9\)

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research team) can begin to work, the members will have to choose some definite criteria in order to communicate with each other and with others about the problems at hand or to develop measurable categories\(^1\). Likewise, it is necessary that between the writer and his reader there exist some areas of common understandings from which to exchange points of view. The recent developments in psychiatry and the behavioural sciences have fortunately placed this problem the multivariate causation of mental illness\(^3\), squarely before the mental health specialist. However, it has been a problem of independent difficulty to formulate terms which communicate realistically and sensibly, pertinent facts about mental health and illness to patients and members of the community.

The Nosological Approach

The manifestations of mental illness which guided Kraepelin\(^5\) in his nosological approach to the classification and treatment of the subject were generally exacerbated cases at their point of culmination. Many scientists, and notable among them, numerous European psychiatrists\(^6\), maintain that the empirical approach, the method of observation, is the only


acceptable way of establishing medical criteria and that it is a "too valuable method to be entirely discarded even by the most fanatically psychodynamic school"\(^1\).

These statements and assumptions by the scientists of the "classical school" have divided the mental health professionals into two camps. One school believes that all men are carrying in them a powerful psychic force which is the main potential for mental health as well as for mental illness\(^2,3,4,5\), the other school sees mental pathology as a condition "suis generis"\(^6\).

The Classical School

In spite of this disagreement, all psychiatrists today adhere to the theory of the importance of "moral treatment" \(^7,8\), as Pinal\(^9\) called it when, at the end of the eighteenth century, he laid the first foundations of systematic psychological theory of mental disorder. No modern doctor will deny the influence of the patient's feelings and of the social conditions on the sequence of his illness\(^10,11\). The main

\(^3\)Bernard, J., Social Problems at Midcentury.
\(^6\)Same as \(^1\) above.
\(^7\)Alyarez, W., Minds that came Back. Lippencott, New York, 1961.
basis of contention is perhaps the influence of the Freudian concept of unconsciousness and its various theoretical entailments.

**The "Middle-Road" Approach**

The average psychological physician, for all practical purposes, nevertheless sees health and illness on a continuum. His point of departure will be the illness as its symptoms appear to correspond with his professional judgement, his diagnostic tools. His goal will be the patient's health, which is to say, for the most part, the state of absence of pathology.

It is the physician's professional responsibility to compare treatment methods and maintain a hospitable attitude to all seemingly useful approaches. Modern psychiatrists in North America feel that mental illness must be studied and understood in the frame of reference of society and culture. With this posture of mind, it is understandable that many mental health therapists welcomed the Freudian theories.

Freud discovered the effect of the unconscious while he was nosologically studying the linkage between physiological manifestations and hysterical behaviour. He grasped, more firmly than any earlier student of human nature, the connection

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between the biological and the psychic forces of man. He and his followers have been richly aware of the need for establishing the missing link between the two. However, the empirical test for these insights is difficult to make. The fact that each social action is a specific and unique event with dynamic effects impedes experimental repetition of similar actions.

**Criticism of Psychoanalysis**

Psychoanalysts are inclined to think that the comparison of numerous verbally recorded analytical treatments which reveal similar patterns of conscious and unconscious functioning are adequate proofs of the "psychodynamic function". But this view is opposed by quantitatively-oriented scientists who think that it is not only difficult to understand the inferences the psychoanalysts are making from patients' communications, but also that these inferences are non-scientific evidence of non-scientific causes. While we are on the subject, it is worth noting parenthetically that although these discussions generally take place between scientists, the public hears enough about the differences of opinion to become confused and

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fearful about the strange and intractable pathology which causes so much discord amongst the learned.\textsuperscript{1,2}

**Genetic and Biological Investigations**

It might be that recent developments in the study of human biochemistry\textsuperscript{3} will finally provide the long-sought-for understanding of the condition we call mental illness.\textsuperscript{4,5}

It has been found that man's normal growth and development from the moment he is conceived depend on the equilibrium of his metabolism. Apart from anything else, these findings suggest that the "classical school" is correct when it holds that mental pathology, no less than any other form of illness, indicates that the body is reacting against some "foreign presence". It is beyond all doubt that abnormal metabolic processes often accompany mental illness.\textsuperscript{6} Moreover, the new drugs enable patients to repress psychological reactions which previously were unmanageable on a conscious level.\textsuperscript{7} Finally, the patient's tolerance for social intercourse can be kept at a level where he can benefit from psychotherapeutic treatment while he remains in his usual environment.

\textsuperscript{1}Foerster, H.V., ed., *Cybernetics in Biological and Social Systems*. J. Macy, New York, 1952.


\textsuperscript{7}Brill, H. et al, "Analysis of Population Reduction in New York Mental Hospitals during the First Four Years of Large Scale Therapy with Psychotropic Drugs", *A.J.P.*, 116, p. 495.
A Historical Note

So far, I have been writing about the practical and the conceptual problems inherent in assessing and describing mental illness and mental health. Before I discuss the functions of the various services comprised in the contemporary mental health field, I must briefly mention its historical background.

Zilboorg indicates that there is a cyclical tendency in social attitudes towards the mentally ill up through the centuries. Pinel’s reform came at a time when the insane usually received very cruel treatment and were rejected as social outcasts. However, we know that during the fifteenth century there existed several hospitals on the European continent which treated disturbed patients very well. Thus it would be wrong to generalize that nobody has ever cared about the mentally ill. We know that in some cultures, mental illness would be accepted as the blessing of the Gods, while in others it was considered a work of the devil. Some of the great men of historical record were severely mentally ill, but their societies did not always crush the development of their special talents. On the contrary, some of these men have demanded and received consideration. It is also evident that not a few mental institutions did a surprisingly good job of curing their patients.

if we may judge their success by their discharge rates.

The Beginning of Reform

Insulin and electroshock therapies did not being until 1935. In the beginning it appeared as if these new treatments were mixed blessings for both the patients and the reputation of the therapeutic agent. Very few patients recovered permanently or satisfactorily in terms of social adjustment. The crudity of the physical therapies and the lack of a systematic rationale for their effectiveness and use caused much resistance among patients as well as physicians. The Freudian psychoanalysts staunchly claimed their treatment methods to be preferable because only their patients' cure would be permanent and, in a special sense, rational. However, the actual results of psychoanalytical treatment have not been such as to convince the sceptics. Moreover, the vast numbers of mentally ill in hospitals, along with the daily incidence rate of new cases, indicate clearly that time-consuming analytical treatment could never become the sole treatment method for mental disturbances.

3Same as '2' above.
8Tyhurst, S., "Rehabilitation, Sharing the Job with the Community". Reprint in Mental Hospitals. Vol. 9, No. 5, May, 1958.
The Combination of Organic and Psychic Therapies

During the Second World War a number of psychiatrists tried to combine the organic and psychic treatments. Sodium amytal was the first drug which was used to remove repression and enhance the patient's ability to speak about the traumatic events which had triggered the onset of acute psychiatric pathologies. Since then, and especially over the last seven years, drugs have become the main therapeutic agents. At the present time a mental institution will generally treat its patients with a combination of psychotherapy, drugs and shock, depending on the patient's degree and length of illness, as well as on the medical staff's allegiance to one method rather than another. Scientifically, there still do not exist any criteria on which to make an objective decision.

The results of these new treatments can, however, be assessed by the increased discharge rate. The large custodial types of hospital now find that they have a great turnover of patients. Not only are a larger number of patients discharged because they have recuperated to the point where hospitalization is unnecessary, but many of the mentally ill as never before because they or their families hope (and have reason to hope) that they can be cured. Moreover, as the

mental patients' behavioural problems become more manageable, the custodial aspect of institutionalization becomes obsolete as well as - what it has no doubt always been - detrimental. We have learned that mental health depends among other things on the dynamic relationships between men. It is therefore important that the mental patient lives in a therapeutic milieu which can bring out or enhance whatever capacity or motivation he has for a reciprocally satisfactory adjustment.

The "Growing Pains" of Reform

The growing conviction that the recovery of the mental hospital patient depends not merely upon specific treatment procedures, but perhaps even more on the socio-psychological characteristics of the hospital has led to the development of novel departures from the traditional pattern of hospital care. The trends are visible in the preoccupations of professional conventions, which are dealing with such themes as: The Mental Hospital as a Small Community, or the Mental Hospital and Community Services. Likewise, book titles such as: The Community as a Doctor, Human Problems of a State Mental

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4Rapaport, R., Community as a Doctor. Tavestock, Britain, 1960.
5Canadian Mental Health. Monthly publication by the Federal Mental Health Department, Ottawa, June, Sept., Dec., 1962.
7Same as 14, above.
Hospital, Mental Patients in Transition, and Frontiers of Psychiatry indicate that these problems are being energetically and widely discussed.

Nobody will expect that practical changes can follow in step with theoretical developments. It is understandable if the staff in the mental hospitals who have worked for years with the conviction that it was their responsibility positively to manage the lives of mentally ill patients hesitate when they are told to let the patients show initiative. They will not easily accept the idea that it is therapeutic to let the patients make their own decisions when they have once learned that the mentally ill do not have the legal right to conduct their own business or manage their most personal affairs. And how will they be able to perceive that the patients' seemingly unaccountable actions and thought-processes have a meaning which can lead the sensitive investigator to the crux of the patients' psycho-dynamic problems.

It would be reasonable to expect that a treatment system which for so many years has encouraged authoritarian practices would attract as employees, people who were authoritarian.

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personalities; and indeed this is often what has seemed to have happened. Moreover, the traditional relationship between staff members in any great bureaucracy, and especially in a medical setting, is not conducive to flexible treatment procedures. First of all, the bureaucratic structure can be a very poor setting for the cultivation of supportive and creative relationships; secondly, such an organization does not give the individual staff member scope enough to give to the individual patients the required measure of secure, consistent support.

In the light of the magnitude of these problems, it is both gratifying and surprising to discover that many leaders in the management of mental hospitals have bravely grasped these nettles. Indeed, they have frequently gone to the length of inviting social scientists to assess and investigate the desirability and the feasibility of preserving social equilibrium during the reorganization of the hospitals' social and medical conditions and structure\textsuperscript{1,4,5}. One outstanding example of this eagerness for reform and landmark of its achievement is the American Government's Mental Health Bill of 1955, which ordered an investigation into the total field of mental health needs and services\textsuperscript{6}.


\textsuperscript{5}Jones, M., \textit{The Therapeutic Community}. Basic Books, New York, 1953.

The specialists in the field are the first to admit that the current knowledge of mental health and mental illness is inadequate and that the basic scientific theories required for proper planning in the areas of prevention, treatment and aftercare are therefore lacking.

It is widely agreed that the causes of psychiatric illness are for the most part multiple. If may be taken, therefore, as the root principle of planning in the field of mental health - both to remedy the shallowness of our understanding referred to above and to make the fullest possible use of the resources we do have - that it is infallibly necessary to secure the cooperation of all the scientific disciplines that can contribute to the activities of treatment, research and administration.

The Major Dimension of the Treatment of Mental Illness

It is my impression that probably the largest single number of published reports in this field deal with the treatment of the adult patient in private or public hospitals. However, the disturbed child\(^1\),\(^2\),\(^3\),\(^4\) and the adolescent\(^5\),\(^6\),\(^7\) have also received much attention. Because of the marked increase in

\(^4\)Harrow, G.S., "The Effects of Psycho-drama Group Therapy on Role Behaviour of Schizophrenic Patients" Group Psychotherapy 3 1951, p.316-320.
longevity in recent years, the scientific searchlight has for
some time also been trained on the problems of the aged\(^1,2\).
Moreover, the possibility that the new drugs have brought about
the discharging of large numbers of chronically inadequate pa-
tients has challenged the rehabilitation specialist\(^3,4,5,6,7,8\).
As the retarded person can benefit from re-training services
which are similar to those used for the mentally ill, several
studies in the mental health field include patients who are
also retarded\(^9,10,11\). Forensic psychiatry however has not
yet received the attention it deserves\(^12,13\). There exist, for

1Goffman, E. "Characteristics of Total Institutions", Symposi­
um on Preventative Social Psychiatry. 1957, p.43.
3Patton, G.D., "Foster Homes and Rehabilitation", Can­
4Pettit, L., "Attitudes of Relatives of Long Hospital­
ized Mental Patients Regarding Convalescent Leave", Mental
Hygiene 40. 1956, p.251.
5Hollier, N.W., "Home Care Program", Mental Hygiene 40.
1956, p.274.
6Lamson, W.C., "Integrating Mental Health Services into
the County Health and Welfare Program", Journal of Psychiatric
7Hock, P.H., "Drugs and Psychotherapy" American Journal
8Mosely, L., "Returning the Ex-Patient to Employment",
9Fish, L, "Needs of the Emotionally Ill", Journal of
Rehabilitation 17. September, October 1961, p.23-34.
of Patients discharged during 1951-53 in Massachusetts", Mental
11Weinstein, M.D., "Survey of Out Patient Individual
Psychotherapy", Archives of General Psychiatry. Vol. 7, No. 1
July 1962, p.21.
12Sturup, G.K., "The Treatment of Criminal Psychopaths in
Herstedvester." The British Journal of Medical Psychology.
13Sturup, G.K., "Treatment of Sexual Offenders in Scandina-
via", U.N. International Review of Criminal Policy, No. 4.
1953.
example few clinics which provide treatment for sexual deviates. On the other hand, in view of the necessity for the psychiatrist to develop social acceptable and scientifically valid criteria for distinguishing sane and insane actions which accord with the requirements of legal procedures, a number of behavioural scientists have begun research which it is to be hoped will soon provide us with a satisfactory substitute for the rigid and obsolete McNaughten Rules.

My particular concern in this thesis, the re-socialization of the ex-patient, has acquired prominence and received attention largely on account of the view that hospitalization has to be very brief in order to keep the patient's social competence unimpaired, or at least to keep him exposed to

1 Frisbie, L.V., "Treated Sex Offenders and What They Did", Mental Hygiene. Vol. 43, No. 2, April 1959, p.263.
his normal social and cultural influences and controls. It is my opinion that along with research and treatment in the area of re-socialization comes the need for developing preventative programs for better mental health. For someone whose major professional concern is with work in the community rather than in the enclosed world of the hospital, these two issues go hand in hand. The only difference I can see is that programs for prevention of mental illness and the improvement of mental health must be composed and directed in such a manner that they can also appeal to the non-patient in the community.

Unfortunately, many of the programs for public education in the mental health field have so far not produced the expected results. Probably, we have failed to assess correctly what people already know about mental illness or how much they can tolerate to learn without experiencing a threatening

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anxiety. The Cummings found during their demonstration project in Saskatchewan that there exist prejudices and misconceptions which bring about a solidarity of the sane against the insane. The result is that not only a great confusion, but literally a lack of understanding about mental illness can be found amongst all socio-economic classes of lay-people as well as amongst the professionals, the lawyers, judges and physicians.

Needs and Demands for Mental Health Services in the Community

There are various forms of psychiatric treatment involving biological, psychological and interpersonal procedures which can be used as well in a hospital setting as in a clinic for ambulatory patients. A community-based mental health program is mandatory. It should offer services tailored to the

10Tyhurst, S., "Rehabilitation, Sharing the Job with the Community". Reprint in Mental Hospitals, Vol. 9, No. 5, May, 1958.
conditions of all hospital patients, as well as those who might be able to regain or sustain their health as outpatients.

It is important that mental health services be co-ordinated as a complete network which offers preventive measures, active treatment and resocialization programs.

Effective community mental health planning begins with prenatal psychiatric services. Although not much is known about inheritance, fetal development and the child's reaction to birth, a psychiatric team can assist the family, especially the mother, when anything unusual places them under stress.

Another mental health service should be associated with those community services which serve the people with special social, economic, educational or medical needs. As examples we have the public assistance agency, probation service, family court, marital counselling, church welfare, foster home services and special schools. These institutions deal with people under different degrees of stress. At times the service will suffice to alleviate the tension, at other times

it will not$^{1,2,3}$. Perhaps the service is psychodynamically inefficient, or it might be that the root of the client's trouble is mental illness$^4$.

The bulk of psychiatric services would of course encompass people who seek or need treatment for mental illness and after-care services$^5$. The present system of large mental hospitals, often situated some distance from the more heavily populated areas, is not to be recommended. A residency of more than four hundred patients complicates or renders impossible the creation of a therapeutic milieu. It is considered altogether detrimental to his welfare to cut the patient off from his friends and relatives who will often be unable to afford the time and money to travel regularly to an out-of-the-way hospital. In the future, our aim should be to establish psychiatric units in general hospitals$^6,7$.

By contrast, little attention has, as far as I know, been given to the reform of services for the many severely ill, chronic patients who can no longer benefit from drugs or

$^7$Canadian Mental Health. A Monthly Publication by the Federal Mental Health Department, Ottawa, January 1962.
other therapies\textsuperscript{1,2,3,4}. The large number of patients who are, clinically speaking, not especially ill, but who are nonetheless socially severely handicapped, should gradually be retrained for discharge to home-care in the community. Only a few hospitals have begun therapy with such patients\textsuperscript{5,6,7} or placed them in hospital units where they are given opportunity to learn to look after themselves and their rooms\textsuperscript{8}. As a stepping stone on the way out into free society, many communities\textsuperscript{9} have provided halfway houses, shelters, protected workshops, supervised boarding home or foster home care\textsuperscript{10,11,12}. The


\textsuperscript{2}Bloomberg, W., "A Proposal for a Community-Based Hospital as a branch of a State Hospital". \textit{American Journal of Psychiatry}. Vol. 116, No. 9, 1960, p. 814.


\textsuperscript{8}James, J., \textit{The Oregon Study of Rehabilitation of Mental Hospital Patients}. Div. of Vocational Rehabilitation, Salem, Oregon, 1960.


\textsuperscript{11}Crutcher, H.B., \textit{Foster Home Care for Mental Patients}. The Commonwealth Fund, New York, 1944.

ex-patient's psychiatric condition is only one indication of what type of service can be most useful.

The problem of returning the ex-patient to gainful employment is complex. The sheltered workshop\textsuperscript{1,2} is only efficient for certain types of patient who can find satisfaction in a limited work situation\textsuperscript{3}. The value of retraining depends on so many factors that we are still trying to formulate the criteria which would make rational planning possible\textsuperscript{4,5,6,7}. The after-care clinic is the prophylactic measure intended to sustain the ex-patient in the community\textsuperscript{8}. Here he can meet on a periodical basis, both the staff members and the fellow-patients he knew in the hospital, collect his prescription and obtain a measure of relief and support through talking about his condition.

It is the role of the mental health clinic, the day-hospital and the night-hospital to keep hospital admissions

\textsuperscript{1}Benney, C., "Casework and the Sheltered Workshop in Rehabilitation of the Mentally Ill". Social Casework. Vol. 59, No. 9, November 1960, p.465.
\textsuperscript{5}Wheat, W.D., Rehabilitation of Chronically Ill Psychiatric Patients. Report from J. Hopkins University, 1960.
and readmissions to a minimum\(^1\). These institutions can treat the patient while avoiding disruption of the very important linkage between the socially dysfunctioning individual and his accustomed social contacts. The achievement of an understanding of the patient's "natural milieu" and the proper use of this milieu is in my opinion, the most crucial issue, both in the resocialization process and in preventive activity.

Chapter II.

The Ex-patient, the Community and the Social Worker.

This chapter has four objectives: 1) to present the problems of the ex-patient who either foresees or experiences difficulties in resuming his pre-hospitalization roles, 2) to suggest the more important sources of dysfunctioning in the interaction of the ex-patient and his environment, 3) to describe the community resources which are available for the use of the handicapped and the deviant, 4) to ascertain if these resources are competent and adequate in dealing with the specific problem of the resocialization of the ex-patient.

Before I begin my presentation of the former patient's problem, I should mention that the largest number of patients discharged as either cured or greatly improved will usually return to their old environment without requesting social services. 1, 2, 3, 4. This fact does not mean that some form of social service would not have been helpful to them. 5, 6, 7, 8. Then there is a group of ex-patients who do not request service even though we know that they have readjustment problems.

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because their dysfunctioning has provoked public intervention\(^1\), \(^2\), \(^3\). Finally, there is the third group with whom the social worker either is planning for the future or is called in to work out an actual, acute readjustment problem.

It should be noted, too, that there are certain "special" groups - disturbed children, the senile, the criminally insane are all examples - who present problems too idiosyncratic for consideration within the terms of this somewhat more generally focused study. For the same reason I have decided to ignore the rather special case of the well-to-do, and to confine myself instead to the three lower socio-economic classes with the greatest emphasis, in deference to the facts themselves, on patients coming from the lower middle class\(^4\), \(^5\), \(^6\), \(^7\), \(^8\), \(^9\), \(^10\).

From an administrative point of view, an ex-patient is a person who has left the hospital. A high discharge rate is

\(^1\) Linzer, E., "Mental Health Services for Business and Industrial Executives" N.A.M.H., New York, 1962.
\(^7\) Milbank Memorial Fund, "Epidemology of Mental Disorder" Papers presented New York, 1949 and 1952.
usually a sign of effective treatment and rehabilitation\(^1,2\). About twenty per cent of the American and the Canadian hospitals have introduced the so-called "open door policy"\(^3\) and the therapeutic milieu treatment, while the rest of the mental hospitals continue to treat their patients principally with drugs and shock treatments\(^4\).

**The Process of Alienation**

A very rough estimate of current admission policies\(^5\) shows that at least two-thirds of mental hospital patients will go through the distressing experience of being committed against their will and understanding, at a point in their lives when they have become too ill to relate "normally" to their environment.

Dr. Jack R. Ewalt who is the director of the American Government's Joint Commission for "Action for Mental Health" has this to say about mental hospitals\(^6\):

"The Mental Hospital represents the end result of society's failure to cope with, even to care much about, the mental and emotional problems of its members until their illnesses reach such critical proportions that the sufferer is no longer capable of functioning in the wear-and-tear, anxiety-producing climate of everyday life."

Custodial care has, of course, a purpose. We have long believed that it was "good" for the mentally ill person to get away from his anxiety-provoking environment and in some

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\(^3\) Cameron, D., "Modern Methods of Treatment" *Modern Hospital*. Vol. 74, 1950.

\(^4\) Canadian Mental Health. A monthly publication by the Federal Mental Health Department, Ottawa.


instances this is in fact true\textsuperscript{1}. Many people live under such stressful conditions that only a separation can provide relief from the tension which appears to be giving rise to the illness\textsuperscript{2}. But we know also that the large monolithic structures which were the fruits of Dorothea Dicks'\textsuperscript{3} fight for treatment centres for the mentally ill, have a tendency to ignore or suppress the very forces which are needed in order to rebuild a damaged human personality\textsuperscript{4,5,6}. Even if our patient has been admitted to one of the reformed mental hospitals where everybody from the bottom of the bureaucratic ladder to the top has accepted the principles of a therapeutic community, he will usually legally as well as practically be classified as a person who has no rights and no responsibility because the legal admittance procedure enforces such judgements\textsuperscript{7}. With these feelings about himself, he has to go through an assimilation process\textsuperscript{8,9} with a group of other patients who are in

\textsuperscript{1}Messinger, S.L., "The Mental Hospital and Marital Family Ties", Social Problems. Fall, 1961, Vol. 9, pp.140-155.


\textsuperscript{7}Mental Health Legislation. The Provincial Acts from British Columbia, Saskatchewan, Quebec, Nova Scotia, Newfoundland.

\textsuperscript{8}Allport, G.W., Becoming. Yale University Press, 1955.

a similarly dependent and opprobrious position\(^1,2\). He must give up his personal belongings, his tastes, his routine. He learns that the better he can conform to the hospital regulations, defer to the staff, and get along with the other patients, the greater his chances for early discharge\(^3,4,5\).

It is not only the patient who suffers but his family also. It is very hard for relatives to take the steps which commit one of their kin to a mental institution. The many delays and difficulties in getting legal and medical documents completed are very real sources of frustration, and play their part in giving mental institutions a bad reputation with the general public\(^6\). Moreover, the distaste or guilt provoked by this legally necessary action will often make relatives ambivalent about the return of the patient, fearing as they do that they will have to go through it all again\(^7,8,9\).

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Meanwhile, in the hospital, the resocialization process goes on slowly but steadily. When the patient has to give up his own pre-institutional beliefs and habits, he will acquire institutional values and norms which belong to his hospital reference group\(^1\)\(^2\). Sometimes, for example, his language becomes subject to change, since he will seek acceptance or security by using institutional jargon. If he badly fears his own illness he will often project his feelings about it in the form of a stigma which he expects to find on the "outside". Patients who have experienced the withdrawal of family or some kind of stigmatization\(^3\) on account of this illness, tend to shut their senses off from the world or immerse themselves in the routines of the hospital. They can become very compulsive and irrational fearful of any change, be it in food, smell or ward routine\(^4\).

The mental hospital which has accepted the new outlook on treatment\(^5\) will do what it can to prevent "hospitalitis", the popular term for alienation. Its staff will consider this form of de-culturation a disgrace to good mental care. However, the fact that the patients are mentally ill people who are trying


\(^3\) Lemkan, P.V., "Stigma Declining?" A Survey at Hopkins University mentioned in Canadian Mental Health, April 1962.


to find out why and how their thinking is unlike that of others, works against their best endeavours\(^1,2\). The patients come to think, feel or believe that their well-being depends wholly on the good will of the staff. Their daily experience teaches them that the numerous personal privileges which are so important in a "total institution" can only be obtained by submitting to those in power\(^3,4\). Moreover, in a mental hospital it is very easy to confuse treatment with rewards for behaviour. In other words it is not the patient who is \textit{well} who receives shock treatment, is placed in isolation or is demoted to a disturbed ward.

**Planning for Discharge**

Theoretically, the custodial treatment is provided in order to give the patient an opportunity to recuperate\(^5,6,7\). It is therefore important that planning for discharge begin at the moment he is admitted. This point is frequently mentioned to the relatives and the patient, but it is only at very few hospitals in fact that it is a matter of policy to incorporate


\(^{2}\)Langner, T.S., "Environmental Stress Degree of Psychiatric Impairment and Type of Mental Disturbance" \textit{Psychoanalysis and Psychoanalytical Revue}. Vol. 47, Winter 1960 p. 3-16.

\(^{3}\)Pearlin, L., "Sources of Resistance to Change in Mental Hospitals" \textit{American Journal of Science}. Vol. LXVIII. No. 3, November, 1962.


discharge planning with other forms of treatment. As the ratio of staff to patients is rarely adequate, each patient can expect to receive little personal attention\textsuperscript{1}.

Those patients who are ready for discharge are generally classified according to their medical and social condition\textsuperscript{2}. However, this classification has far less systematic importance in planning for discharge than one might expect since the baseline for these judgements is set by the particular therapist according to his personal impression of the patient in the hospital.

**Problems in Making a Social Diagnosis**

An investigation of any phenomenon is always conditioned by explicit or implicit theories. The mental health team which in the hospital treats the patient and prepares him for the day of his discharge will focus on the abatement of psychiatric symptoms. These can be present on a biological, psychological or social level of understanding. However, the whole dynamically integrated pattern of the patient in his family, occupational and sickness roles is seldom understood\textsuperscript{3}. This is very unfortunate as the person's life pattern of differentiating and integrating goal-directed behaviour depends not only on his psycho-dynamic characteristics but on a variety of social and cultural controls\textsuperscript{4,5}. The holistic approach is in fact

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\textsuperscript{3}James, J., *The Oregon Study of Rehabilitation of Mental Hospital Patients*. Salem, Oregon, Division of Vocational Rehabilitation, 1960.


basic to the tasks of social rehabilitation.

It is important, in order to establish an etiologically sophisticated psychiatry, to know if mental illness is an internally generated phenomenon with external implications\(^1\),\(^2\) or is an externally (socially) produced phenomenon with observable biological and psychological symptoms\(^3\). However, in order to determine the methods best suited to the resocialization of the ex-patient, the central focus must be his social competency\(^4\), and this will be true whichever the direction in which the problem of etiology be eventually resolved.

**Therapeutic Purpose as a Criterion of Intellectual Relevance**

This change of focus unavoidably involves certain value judgements\(^5\), since we cannot identify the facts we need to know until we have clarified our purposes and goals from an administrative point of view\(^6\),\(^7\),\(^8\). Is the hospital merely interested in a high discharge rate? If that is the case, what could the


\(^{8}\text{Minnesota Department of Public Welfare, Minnesota Follow-Up Study: A Summary. November, 1961.}
consequences be for the ex-patient as well as for the community? Is the community likely to have something awkward to say about the difficulties in accommodating former mental hospital patients? Or will the hospital blame the community for the re-admission rate? Has the patient reached his maximum level of functioning in the hospital and must the environment try to fit him into a milieu which can sustain this level? Perhaps the purpose with discharge is to provide further rehabilitation and it is important to ensure that the environment's expectations are challenging the former patient to better and better performances. Finally, we must also know if the former patient lives under conditions which are consistent with our convictions concerning respect for the individual and his rights to independence and self-fulfillment.

Who knows if ex-patients are successfully readjusting to their roles as father, son, wife or daughter? Or to what extent are ex-patients satisfied with their work relationships, their community arrangements and the available use of their leisure time? If the ex-patient becomes an isolate, or is rejected by the community, even though he was able to socialize satisfactorily in the hospital setting, is it his fault? And, in such circumstances, should we recommend his re-admission?

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The Difference in Expectations about Post-Hospital Behaviour

We are faced here with a very complex and fundamental problem, namely, that we do not know what the differences are between the condition of ex-patients who return successfully to the community and the conditions of those whose symptoms reappear when they are confronted with the demands of the larger environment$^{1,2}$. It is widely, if reluctantly, agreed that the psychiatric team cannot at present predict the outcome of a discharge. The attempt to assess the patient's condition by combining a staff opinion of his hospital adjustment with his psychiatric diagnoses and such social characteristics as age, education, marital status and means of support, has been grossly inadequate as a means of forming valid prognoses$^{3,4,5}$.

It is the mutual reaction between the ex-patient and his milieu which we must scrutinize$^6$. Some of the varied potentials of that reaction will be presented in what follows.

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Many former patients do not carry any residue of the illness which necessitated hospitalization; yet they are still not shown by the outside world the trust and confidence they so badly need because the fact of their having once been mentally ill seems to create a fixed expectation that they may at any time begin to behave abnormally again. The opposite might also happen. The patient himself is unable to form realistic expectations about his own role performance capacities because the illness was more frightening for him than it was for his relatives and friends. It is not rare for both the patient and those he meets to be unrealistic about his social competence since they refuse alike to recognize the former behavioural abnormalities as symptoms of mental illness. And since the hospital cannot provide clear and objective standards for the assessment of the medical status of the patients, it is understandable that the family, the relatives, employers, friends, even the non-psychiatric professionals with whom


the ex-patient is dealing in the community, should find it difficult to adjust their behaviour to him on the basis of precise and uniform expectations as to how he himself will behave. Thus the ex-patient has to face the additional stress of a social environment which is unpredictable, precisely on account of the rooted belief that he himself is unpredictable.

The Problems of Adjustment within the Patient's Family

It will be useful to examine these complex issues in the light of Parson's and Erikson's theories about the nuclear family. Parson's descriptive analysis is a combination of sociological as well as psychodynamic insight. Although he deals chiefly with the normal functions of family life, he clearly reveals the potentialities for conflict and pathology. His analytical system is therefore, in my opinion, eminently applicable to the tasks of social work assessment. Erikson's contributions are, I think his ability to provide a holistic framework for integration of the bio-social stages of man as these develop in continuation under the influences of the particular as well as the universal cultural value pattern.

A discharge plan must always give prime consideration to the patient's family as the natural and strategic resource for

for re-integration into the cultural milieu. Virtually all patients have belonged to families in which they were socialized, and their role patterns have been stabilized according to internal as well as external psycho-social influences.

A theory of family dynamics must consider how the macrocosmic pattern of people, times, cultures, seasons and places influence the microcosmic factors of motivation, capacity and opportunity. This process has, as Erikson so aptly states, a cogwheeling effect. There is, between the individual and others, a mutual investment of social learning. One of the paradoxes of human life which presently resists explanation is men's ability to provoke collective action, create their own environment from the very fact of being what they are.

The person in need arouses "concern" in those who are concerned with his well-being, not by the force of argument, but simply by being in need of, in some compelling way, concern.

For theoretical purposes one can distinguish four types of family function over the course of the individual's career, namely: the family of orientation, the family of procreation, the family of extension, and the family "limbo".

Our culture uses the rather isolated nuclear family of orientation as the workshop, as it were, for socialization of children. The mother frequently finds herself cut off from the wider kinship system and from the society at large while

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she is caring for her pre-school children. It is during this period of mutual intimacy and affection that effective social learning on the part of the children takes place. The major elements in the repertory of cultural norms and values become dimensions of character through the process of internalization. The parents' involvement transforms their own infantile needs into more mature aspirations.

The father's occupational role is very important for several reasons. It connects the family with the society at large and it confirms and tests the father's achievements and vicariously endows his wife with his acquired status. This gives her the status satisfaction she needs in order to sacrifice her own inclinations for personal outside accomplishments. Finally, the role of provider establishes the father's power position in the home and helps maintain him in authority against his growing children.

The children's roles are mainly, by affective means, to support and encourage the adults in their goal-seeking achievements, while they themselves become socialized and stabilized in the pursuit of similar ends. They combine in subgroups with the parental figures as well as with each other, in order to keep the dynamic balance of the family, as well as its incidental tensions on the most "productive" possible level.

The family's private and intimate socialization process will widen in scope and become universal at the point when the parents and others feel that the children are ready to begin taking their place in the larger community. The family's
function is now primarily "procreative" as Parson calls it. Because their role is to enhance and further stabilize the children's abilities to become "socializers" in their own right, if the family tried to keep the children at home too long so that its private social pattern becomes too stabilized, the children might fail in adjusting to wider public expectations. There is also a danger of letting the children leave too early and become too independent. It can be threatening for the father and mother both, if the girl or the boy competes in the areas of parental prerogative, that is, as a "home maker" or as a "wage earner".

If the children live at home after they have become emancipated\(^1\) we may have reason to fear the eruption of family conflicts as the power position of the family members are endangered by the embarrassments of newly created and unaccustomed status relationships.

The "extended family" connotes two family types, namely the family which has accepted the care of old parents or unattached siblings, and the unit in which one parent tends to remain excessively attached to his own mother or father. There are potentialities for conflict in both situations. If such constellations are to survive, the "extra" members must play marginal roles. They must remain, emotionally and economically, on "business-like" terms but unobtrusive with the original

members of the nuclear family$^1,2$.

The family "limbo"$^3$ is the state where the nuclear family role pattern has either ceased$^4$, deteriorated, or has broken down. As a result, we shall have a group of any two or more members of the original family, but they will not relate successfully to each other. It is also possible that, by divorce or separation, one member will split off and create a new nuclear family$^5$. The aging couple who have surmounted the departure of the children have an important social function to discharge in symbolizing the consolidation of human growth, development and resignation. The other groupings in this classification are usually unstable and are sources of social dysfunctioning.

This schema can be used in analysing what happened to the ex-patient's roles before hospitalization$^6,7,8$ and why. We might find either that the family is incapable of taking the patient back because the source of stress which provoked

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the onset of the illness is still existent right in the family, or it might be that the family is an unusually capable one which has rallied round the ill person when it found that he was unable to fulfill his role obligations on account of illness\(^1,2,3\). Another possibility is that the fear which the family feels is so strong that they have little motivation to cooperate in the return of the patient. Furthermore, there exists the special danger which I have called "hospitalitis"\(^4\). Has the patient been in hospital so long that he has become de-individualized, disculturated, estranged, desensitized and isolated\(^5,6,7\)? Will he be able to recognize his family and can they recognize him? Finally, some patients will have been admitted to hospital at a crucial time in the development of their family or their social environment. Perhaps the family has moved away or sold their property and have no place for the ex-patient. The children might have grown and become independent individuals who will resent the returned patient's attempt


to relive his old roles. The wife has found another partner because she could not face life alone or the rapid growth of technical changes has made the patient's occupational role obsolete.

The Ex-patient's Marginal Role

It should be remembered that the family unit is only one part of the ex-patient's role network. How does he expect to fulfill his other social obligations? What are his expectations regarding employment, friendship patterns and other social activities? Many of these factors are interrelated. If the patient feels he is successful in one area of life he might gain sufficient confidence to surmount stress or frustration in others.

The transition from the mental hospital to the community is crucial in view both of the admitting procedures and the public stereotypes which depict him as a deviant who had to be separated from his group. It is futile to think that the disappearance of the clinically pathological symptoms will erase the memory of this traumatic event. How can we expect

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that he will dare to repossess his former roles which he knows he was unable to perform before his "illness"? Is it sufficient assurance to know that he was a good patient\(^1\)?\(^2\)? Or does he need to test himself against a group of "normal people" in order to rebuild his confidence?

One of the main principles of Maxwell Jones\(^3\) therapeutic method is that it is the role of the staff members to create an atmosphere of normality in which the patient realizes that he is accepted as well as categorized as a non-patient. Unfortunately, only twenty per cent of most mental hospitals provide patients with this opportunity. Moreover, it is important that the patient shall be able to see a continuity in his life. The psycho-socio re-development should follow a logical, gradual course which gives the patient the possibility of gaining even from his regressions, because he can discover a pattern of gradual re-learning. The therapeutic milieu treatment always exploits the overlap between its concerns and services and those of the community. It would be detrimental to let the ex-patient experience another separation even if it is now from the hospital itself. Therefore, the ex-patients will form a club with meetings at the hospital, or with the staff, or which co-patients who are not yet ready for

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discharge. The contact can also be kept through news bulletins and messages of greeting on the occasion of anniversaries.

One very important rehabilitative service is provided by the occupational counsellor. Numerous rehabilitation programs are doomed to failure because they do not provide vocational counselling, re-education and work-placement. In our culture it is of the greatest importance that a person has a job and an income if he is to gain status in his community. I think, however, that vocational counselling is not a social work function as such. Moreover, I am convinced that neither occupational therapy nor hospital maintenance work are acceptable substitutes for proper, individually planned employment services. The lack of taste and imagination which are evident in much occupational therapy and the monotony and drudgery of work for the institution can only increase the patient's feeling of being a powerless individual doing meaningless work.

All serious rehabilitation must begin as soon as the patient is admitted to the mental hospital. It is only while the patient is in treatment that it is possible to create a controlled therapeutic milieu. Besides, if the family can co-operate from the beginning they will be more amenable to suggestions during times of crisis. Moreover, by working with the family from the beginning of treatment, one can prevent a gap developing between the patient and his cultural background.

In other words, the social worker who takes care of ex-patients either has the privilege of working with a therapeutic-minded hospital which is systematically preparing its patients for discharge; or does the penance of working with a hospital which insouciantly passes the problems of the non-rehabilitated and unprepared ex-patient along to agencies in the community.

Community Services for the Ex-Patient

The Canadian Psychiatric Association's report suggests to classify community services on three levels. There is the informal level which consists of the ex-patient's family, relatives and friends in which he confides privately and informally, but from whom he cannot expect expert advice. Next, we have the official level which is composed of his physician, the social institutions as the unemployment insurance, the pension funds, the educational opportunities of the church.

From these resources the ex-patient might expect professional help, but frequently they know very little\(^1\),\(^2\),\(^3\) about mental illness. Thirdly there are (or there should be) the psychiatric specialist as for instance, a mental health consultant (this role will be discussed later), the sustaining clinic\(^4\) or the patient's psychiatrist who can assist him to progress in effective as well as affective relationships, and can supervise his chemo-therapy\(^5\),\(^6\).

Communities differ greatly in the aspect of size and social service pattern\(^7\). Usually, the large cities have many forms of services, while smaller cities might often have none except perhaps the rudimentary forms of public assistance, unemployment services and public health units.

I will now attempt to draw a picture of the typical services which are available in a larger kind of city. As I have already discussed the problem of the ex-patient's re-integration with the family, and as I think the occupational


\(^5\)Rapaport, R., *Community as a Doctor*. Tavistock, Britain, 1960.


problem largely belongs to another discipline, I will here deal with the problems arising from living apart from the family.

Living Arrangements

The ex-patient can either live alone or in some form of supervised living arrangement. There is an old and valued tradition of providing home-care placements\(^1\) for ex-patients who do not need twenty-four hours a day of hospital care. It is plausibly argued that the home-like atmosphere is more pleasing for the ex-patient than the impersonal regimented life of an institution\(^2\). However, it is a great responsibility to arrange placements for individual ex-patients in private homes. As many ex-patients are both dependent and defenceless, one must assess the home very carefully indeed\(^3\). Some patients, who have become adjusted to life on a large ward, with recreational programs provided by public or private organizations, can find it very lonesome to be confined to a small house alone with an older couple who are perfectly reconciled to a comparatively inactive and withdrawn life. It is not uncommon, moreover, to discover that the patient and his host develop unhealthy neurotic identification\(^4\).

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\(^1\)Crutcher, H.B., Foster Home Care for Mental Patients. The Commonwealth Fund, New York, 1944.


\(^3\)Uhlman, L.P.; Barkman, V., "Family Care Placement of Mental Patients" in Social Work. Vol. 4, April 1959, p.72.

Even when it is not notably difficult to find a suitable group home or boarding home, with the ex-patient one is always faced with this dilemma; that the plan should unequivocally be better than staying in the hospital. Otherwise, it is useless to make the change. Sometimes it looks as if the ex-patient has only moved from a large institution to a smaller one -- which unfortunately is providing less efficient service into the bargain. Moreover, the placement of ex-patients in a network of group homes tends to develop subgroups of outcasts and deviants. While there is need for housing as a stepping stone from the institution to the community it is not yet fully clear whether it is more beneficial to provide ex-patients with separate housing facilities than to encourage them to seek acceptance in general boarding homes along with other people. The latter plan might result in experiences of rejection so that the ex-patient felt more isolated than he would have done if he had at least belonged to a rejected group. The ex-patient's housing problem is a great worry. If we had reliable criteria of social adjustment we might be able to plan more effectively for the ex-patient. But how can we predict the outcome of a living arrangement? It is all too easy to find accommodation which is either so giving that it stifles the ex-patient's attempt at becoming independent, or which rejects him and commits him to an existence without pleasure or purpose.

In working with ex-patients in the search for satisfactory living conditions, it is difficult to say which is the more astonishing -- the number of agencies actually serving these
clients, or the inadequacy of the thought given to their unique problem, namely their alienation from the humane framework in which other citizens find their support, encouragement and happiness.

One major problem which seldom is taken sufficiently seriously is when the former patient and his habitat is remote from the experience of the helping or treating person. Individual incongruities pose formidable barriers to communication and understanding even if patient and therapist share language and nationality.

Many agencies which give casework service to families will refer families with a history of mental illness to psychiatric services — which in turn have long waiting lists. The public assistance agencies see many ex-patients too, but they can seldom give them consistent personal service. The adult, single ex-patient who cannot find work has a very bleak future. He must live in the cheaper and less salubrious parts of town, and as he cannot generally both eat well and get clothes, he must often choose between a good appearance and a full stomach. He is excluded from many cheap or free recreational activities because he cannot afford busfare. Ex-patients who have behaviour disorders come readily and frequently into conflict with the police and other authorities.

There are only a few places where the ex-patient can feel comfortable. The cozy, warm atmosphere of a downtown reading

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room or the public library attracts many ex-patients. Any "odd" sect, be it religious or political, will always count a fair number of ex-patients among their members. The rummage-sales, the breadlines and the morning court for drunks are other rallying places for ex-patients. But all these are often desperate refuges at best.

**Specific Mental Health Services**

The Mental Health Association which was founded by Beer in the U.S.A. in 1908\(^1\) and in Canada in 1928\(^2\) has chapters in nearly all the large and in many of the smaller cities. This organization's main purposes are:

1) To bring about improvements in treatment facilites for the mentally ill and disabled now in Canada's mental hospitals. 2) To bring a standard of mental health services to our communities that is consistent with modern psychiatric and medical knowledge. 3) To provide assurance to the mentally disabled that they are not friendless, alone and unwanted by society; that their fellow citizens want them back, well and healthy. And when they become well enough to leave hospital, to provide community help to regain social skills and confidence often lost in institutional life. 4) To promote and finance urgently needed research into the causes, treatment and prevention of mental illness and disability.\(^3\)

The half-way house\(^4\) is a relatively modern service for ex-patients who can stay there just after discharge or during re-training. These accommodations can serve as useful stepping-stones for the ex-patient who has lost contact with the community and its customs. Much could be said about this intriguing

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3The quotation is copied from Canadian Mental Health Association's pamphlet published in Toronto, 1961.

and promising development, but for our present purposes it can be set down as merely one among the varied facilities which are required for a comprehensive and effective system of after-care.

**Essential Principles in Rehabilitation of Former Mental Hospital Patients**

This description of the ex-patient's problems and the community's response to them is based on the recently published literature and on my own experience over twenty-five years, first as a nurse, then as a social worker in the mental health field.

In view of the special personal character and social disabilities associated with mental illness, it is absolutely necessary that the patient's positive social adjustment be kept as intact as possible during the sequence of his illness -- partly in order to control illness, partly in order to prevent post-hospital malfunctioning. Thus, if segregation in a mental hospital is deemed necessary, the patient should be placed in a therapeutic milieu while the mental health team maintains on his behalf, his essential contacts with the outside world.

During the "Proceeding of an Institute on the Roles of Psychology and Psychologists in Rehabilitation"\(^1\) in Princeton, 1958, the following statements were made:

"The fundamental principle in the rehabilitation process is that the intrinsic value of a human being gives the individual the right to be assisted in the unfolding of his personality. The very nature of life implies that the individuals are endowed with a

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variation of physical and mental needs as well as abilities which for their growth depend on social interaction. Separation is indicated only as a temporary expedient until re-absorption into the community at large is possible. Acceptance on the part of society rather than aversion or fear is the emotional attitude toward which rehabilitation effort is directed.

The personal attributes can be negative and pathological or positive and restorative. Unless special care is taken, being sensitized to the pathogenic factors can leave one inadequately sensitized to stabilizing and maturity-inducing factors.

Difficulties in employment, cultural attitudes and prejudices, conditions of the physical environment, are examples of reality factors with which a person with a disability must cope. The personal affective life cannot be ignored but unless rehabilitation is geared to cope with the many reality factors in the milieu which the patient will live in, treatment will take place in an environmental vacuum.

A comprehensive treatment requires treating the person as a whole. It is necessary to give attention to the individual's physical, emotional and social problems, understanding economic matters and the nature of his interpersonal relations at home and in the wider community.

Differences in the needs of ex-patients with the same or similar disabilities, requires variability in the overall treatment plan. However general laws of behaviour and disease entities are important in understanding the special characteristics of the individual and his needs.

The patient must assume to the degree feasible an active role in both planning and executing his rehabilitation program, whose foremost consequences are the restoring, maintaining and enhancing of the person's initiative and self-respect.

Society is obliged to establish schools, hospitals, recreational facilities and work opportunities that will meet the needs of all its members, also where special needs are evident.

The problems of rehabilitation cover practically all the problems that one might expect to encounter
in human affairs. Consequently, their solution requires the coordinated efforts of many professions.

There is no part at which rehabilitation begins and other phases of treatment end. Rehabilitation is a continuing process and applies to the individuals as long as they need help and to the society as long as the condition exists that interferes with the welfare of any group of its citizens.

The human being reacts cognitively and emotionally to events which befall him and hence, in turn affect the course of events. One is therefore compelled to subject the process of rehabilitation to constant re-examination. The review must check against the psycho-socio-medico forces which are ever present as well as against new knowledge derived from the ongoing research."

Some Exemplary Canadian Mental Health Programs

So far I have dealt with what an ex-patient feels and experiences during the period of re-socialization in somewhat general terms. I have not concerned myself with describing any particular jurisdiction's pattern of services since mental health services differ greatly from place to place. It would require detailed analysis to explain what services would be available in a given community for given patients. Nevertheless, I think it would be useful, in order to give the reader a more vivid feeling of the real situation, to review some of the better systems of mental health care offered by the Canadian Provinces. But it should be understood that, in my opinion, one can say very little about a region's mental health services until one has personally visited its different institutions. The categories of care such as "voluntary admission", "open ward", "therapeutic milieu", "psychotherapy", "group treatment", "occupational
therapy", and the like, can mean very different things to different people. A Province's "needs" for psychiatric services depends, as we have seen already, not only on its incidence rate but also on the morbidity rate of mental illness in the population and the indigenous levels of tolerance for deviance. As there is great variation in the geographical, demographic, ethnic, cultural, religious, economic and social composition of the different parts of Canada, one probably would have to collect a great variety of epidemiological data from each Province in order to determine whether its resources were adequate to and commensurate with its characteristic psychiatric problems (I say "probably" because it might be that a well-controlled survey could yield information which was substantially unaffected by these difficulties).

Since 1955 Dr. Alexander Leighton of Cornell University, has been engaged in an ambitious epidemiological survey of certain counties of Nova Scotia. Two volumes based on this survey have already been published. These contain some exceedingly interesting accounts of the predicaments of the mentally ill, but it is difficult to suppress one's doubts concerning the capacity of the methods Leighton uses to provide a really accurate measure of the rates of patterns of the counties' mental illness. However, the details that would be required

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1Opler, M.K., "Epidemiological Studies of Mental Illness" in Symposium Walter Reid Institute Work. 1957.


for a confident judgement on this matter will not be available until the third volume appears in 1964.

Nova Scotia has for several years had very high standards of mental health services. Since 1924 the director of the department of mental health has encouraged the inhabitants of the different provincial regions to establish local mental health boards which could provide and administer whatever was needed in the way of mental health services with the assistance of grants from the Provincial and Federal Governments. This pattern was presumably nothing new to a people long renowned for their co-operative under-takings. For many years, since 1878 in fact, the municipalities have been responsible for conducting small size hospitals for the care of the long term defective and mentally ill patients in their areas. These cottage-style hospitals were originally planned as halfway stations, the bridge between the hospital and the home. Unfortunately, the reality did not live up to the expectations, mainly because neither staff nor money were available in the quantities and at the levels of competence required. Recently, seventy-two per cent of these homes have been reformed and brought up to modern standards, but twenty-eight per cent still do not have a trained staff, so that the local doctor is the sole professional person on hand for the care of from sixty to four hundred chronic mental patients. The Nova Scotia Mental Hospital in

Halifax receives patients who suffer from acute mental illness. It has 570 beds, receives about 1500 patients each year with an average stay of three months, and has a daily population of 520. About 1050 patients were discharged to their homes and 195 to a municipal mental hospital during 1962. The staff consists of twenty physicians of whom seventeen are psychiatrists. The number of nurses, attendants and doctors is above the A.P.A. standards. However, the number of social workers, psychologists and occupational therapists is a little below. The average per diem cost per patient is the highest in Canada, namely $15.00, but the hospital has also the highest discharge and manpower rate in Canada.

In addition to these two forms of service the mental health boards have established mental health clinics in nine of the ten regions. In some places they have built a new clinic, in others they are renting the necessary space. All the nine regions have their own psychiatrist and social worker who are hired by the Boards which in turn are reimbursed for the salaries by the Governments. Last year the clinics saw 1985 patients, most of whom were treated as out-patients, while others were admitted as short term patients to the local general hospital. Ten of the general hospitals have psychiatric wards, but all of them admit mentally ill patients. It is interesting to note that nine doctors had 10,716 interviews while the social workers had only 3,610.

The mental health department works in conjunction with all the other medical organizations. Dalhousie University has a research consultant who can be enlisted for projects in the
field. The public health department is responsible for the Nova Scotia Mental Hospital, but it has no supervisory power over discharged patients, who are directly referred by letter to their local physician. The family is always contacted and generally participates in discharge planning. The public health department employs four vocational counsellors who also assist in the rehabilitation of ex-patients.

For the last five years all the regions have been considering the possibility of introducing home-care instead of chronic hospital care. In two of the regions, about sixty percent of chronic patients have been discharged to "homes", but the program as a whole is moving slowly because of lack of staff. The psychiatric authorities will not establish a home-care program until they can supervise the operation adequately. Another problem which needs consideration is the supervision of ex-patients on prescribed drugs. The re-admission rate for this group is high because many people who live in comparative isolation and poverty fail to take their drugs regularly.

From the far east of the country we move now to the west, namely to Saskatchewan, to visit another Canadian Province which, since 1951, has been steadily improving its services to the mentally ill.

To conduct Saskatchewan's mental health program of treatment, prevention, research and rehabilitation, the public health department maintains two mental hospitals and three

1Saskatchewan Department of Mental Health: Bibliography, Research Projects 1955 - 61.
psychiatric wards in general hospitals, and in addition, supports the 39-bed psychiatric ward in the University Hospital at Saskatoon. It also has fifteen clinics for ambulatory patients. In 1961 the total hospital population was 3,564, while 2,837 patients were admitted during the year and 2,505 discharged. About one-third of the admissions were re-admittances and the other two-thirds were admitted for the first time. Of the new admissions, thirty-five per cent were over sixty-four years old. The clinics treated approximately 6,000 patients.

The staff-patient ratios for psychiatrists, psychologists, social workers, nurses and attendants are over the A.P.A. standard.

In 1961 the Province introduced a new mental health act with made it possible to be admitted to a mental hospital in the same manner as to any other hospital. If a patient were unwilling to be admitted, he might be required to enter a hospital on the authority of two physicians; but this authority is only good for two weeks. A review board of three - a doctor, a lawyer and a layman - has to renew these orders of commital for successive periods of two weeks each, and if prolonged treatment seems necessary, for periods of one month at a time after proper medical examination, to ensure that no person is held in an institution longer than his treatment requires. The terms of this new act include provision for addicts, epileptics, psychopaths, the mentally defective, and those in the category of psychoneurosis. The explicit recognition of the needs of the last of these groups represents a notable improve-
ment on the earlier legislation which was designed only for the usual range of psychotic patients.

Social workers play an important role in the mental health services of Saskatchewan, since every effort is made to keep in contact with the patient's environment and plan for his discharge and rehabilitation. The attitude is:

"To do everything possible to prevent the patient from losing his close ties with family, employer and community. Rehabilitation in this sense loses its commonly held meaning and becomes a preventive concept. The new approach involves the extensive use of social workers working in the community, in the homes, when the first indications of a mental disorder appear. If admission to a mental hospital is necessary the social worker will prepare the patient and his family for this event, because the rehabilitation properly begins then....It is not practical to attempt much direct treatment at part-time clinics, so in these cases, the problems are diagnosed and the community's own facilities are employed to effect an improvement. For instance, if a child with emotional difficulties is referred to the clinic, a plan of action will be arranged which may involve the family doctor, the teacher, the public health nurse and any other figure important in the child's background in addition to the parents."¹

The department of health had hoped to introduce community psychiatric centres with modern in-patient and out-patient services, day-care and night-care services, and home visiting services. (It is believed that the majority of patients can be treated earlier and much more effectively, with little interruption of their normal pattern of living, through such programs.) But plans for the construction of facilities of this sort were put in abeyance in 1961 on account of financial difficulties.

¹Quotation from a mimeographed pamphlet describing mental health services in Saskatchewan.
One of the most admirable features of the Saskatchewan mental health services is their inclusion of one of the most extensive research programs in Canada. A recent inventory of the department's research activities lists approximately 300 titles. Most of these are concerned with the nature and causes of schizophrenia, but other areas of research include methods of reducing hardening of the arteries in the aged, alcoholism, psycho-diagnostic tests, and far-reaching investigations of the type of surroundings and the form of activities most conducive to the recovery of the patients.

In order to deal with the many chronic patients who represent the inheritance from the old methods of treating the mentally ill, the department is developing a home care program. But, of necessity, it cannot grow faster than the rate of increase in staff resources.

A survey of the annual reports of mental health services in Canada indicates that one Province after the other is introducing gradually either new mental health services.

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legislation, milieu therapy, local mental health clinics which can not only diagnose but can also treat the mentally ill patient who lives at home, residential treatment centres for disturbed children, psychiatric wards in general hospitals or improvements in the care of the chronic cases.

The Department of Public Health in Ontario has surveyed the Province's incidence rate of mental pathologies. This knowledge of the geographical and social distribution of mental illness has enabled the Department to plan for a decentralization of services. During the last ten years, fifty mental health clinics, four day-hospitals and twenty-five psychiatric wards in general hospitals have been opened in the most strategic places.

While the Maritime Provinces seem to be able to discharge a number of chronic patients to the family or to subsidized home-care, other Provinces such as Ontario, Saskatchewan, and British Columbia have still many of these patients in their large mental institutions. Forty per cent of the population in Canadian Mental Hospitals have been hospitalized for ten years or more, twenty-one per cent for twenty years or more. Dr. Hoffer\(^1\) in Saskatchewan thinks that research and modern treatment will prevent chronicity, but other experts are less optimistic. They think that chronicity is one of the features one must expect in certain forms of mental illness and therefore one must give serious and permanent consideration to rehabilitative and sustaining programs.

\(^1\)Private correspondence.
The Canadian situation is summarized in Dr. Tyhurst's report. He suggests that the condition of mental health services in Canada varies greatly from coast to coast. Some of the heavily populated areas have adequate psychiatric coverage in the form of physicians and treatment centers, but only the visible part of the "iceberg" of mental pathology is treated, while the large number of untreated cases continue to create potentials for reactivation of old pathology or onset of acute attacks. In order to reach with preventive measures all potential cases, the services must be extended even to remote areas and the co-operation of general practitioners is mandatory. Moreover, in order to assist the ex-patient, the mental health services need to learn to communicate with the community agencies on many different levels. He thinks that the present re-admission rate of thirty-eight per cent in three months and sixty-two per cent in twenty-four months is mainly due to lack of rehabilitative efforts.

It is customary on this continent to assess social problems in the cost in dollars. In American the expense for mental health care exceeds one billion dollars. If lost earning power is included, the total "expenditure" will exceed two and one-half billions. In Canada in 1960 we spent one hundred sixteen and one-half millions for the care of 148,270 mentally ill patients.

Chapter III.

New Trends in Mental Health Research.

The remaining chapters of this study will consist of a review of the major lessons for practice to be discovered in the current literature on mental illness and its causes. Social work, as it does deal with exigent problems in an environment which places serious limitations on the extent to which social resources can satisfy social needs, must always be ready to search for new knowledge which can bridge this gap\textsuperscript{1,2,3}. It is an immanent feature of social work that the worker be neither fully satisfied with the scope of his theories nor with the results available when he applies his methods and techniques\textsuperscript{4,5}. It may well be said therefore, that wherever and whenever social relationships are scrutinized, social work can benefit\textsuperscript{6}.

The last chapter, in which I described the "average" situation of an ex-patient who for numerous reasons could not immediately return to his usual way of life, showed that when there is serious discontinuity of service between the hospital itself and the outside world, we are likely to "lose" patients in the foggy zone between\textsuperscript{7}.

Such a situation is likely to persist unless we can discover scientifically sound principles of help by means of which we can formulate the procedures and methods that could change, or at least improve, the situation.

My purpose in this chapter is to show: 1) that there are now scientific findings which in an increasingly convincing manner suggest that the incidence rate of mental illness is a function of certain social conditions rather than of endo-psychic factors\(^1\),\(^2\),\(^3\); 2) that the morbidity of mental illness is much higher than our present method of calculation shows\(^4\); 3) that the therapeutic gains obtained by hospitalization seem only partly effective in keeping the majority of discharged patients in the community, and that about thirty per cent of ex-patients in fact cannot stand up to the demands of their posthospital experience\(^5\),\(^6\),\(^7\),\(^8\); 4) that we must take into account when planning for discharge, the existence of non-

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hospitalized but pathogenic family members\(^1\); 5) that the social conditions appear to be more significant for successful re-integration than the medical pathology and genetic endowment as such\(^2,3,4\); 6) that participant observation as well as demonstration projects have contributed valid information in spite of the subjectivity of the investigators\(^5\); 7) that basic applied as well as active research is providing us with information which indicates that some traditional social work tenets and values need critical re-assessment\(^6,7\); and 8) that all these research areas open up new vistas for social work activities while at the same time raising demands for an extension of social work knowledge and function.

As social relationships are dynamic and ever-changing, research on human behaviour must always be conceptualized in terms which include an understanding of the events that have preceded and the events that will follow the moment in the

\(^1\)Lawrence, J., "Termination of Treatment with Ataractic D Drugs: A Rating Scale". Unpublished Paper Presented by Psychopharmacology Service Center of the National Institute of Mental Health. Bethesda, Maryland, September 1960.


\(^6\)James, J., The Oregon Study of Rehabilitation of Mental Hospital Patients. Salem, Oregon, Division of Vocational Rehabilitation, 1960.

lifetime of individuals, communities and societies that we are studying\(^1\),\(^2\),\(^3\). A good analogy could perhaps be found in meteorology, with the exception that there exist objective measurements for meteorologic phenomena, while our field abounds in concepts which are open to the influence of personal bias.

In the socialization process we recognize social and private controls which guide, inform, permit, forbid, encourage or coerce people into a multitude of behavioural patterns which only seemingly are self-sustaining and internally stable\(^4\). Any change in one area will usually promote some changes among other areas of conduct. It is the job of the social researcher to establish and promulgate the laws of these variational processes. Like any other scientist, he will try to observe what happens when over the course of time, different social entities such as norms, values and goals, come into interaction with each other. Sometimes a strong social influence will blend with or confirm the others, but sometimes\(^4\) it will change the others. It might be it can cause the "suppression" of several other social forces and thus change the whole pattern of earlier behaviour. If the community's rules are brittle by age or wear, they might break in odd places and let in new influences of a very "alien" character. There is a "reversible"


possibility in social actions similar to chemical processes. One can re-condition a social process by letting the individuals concerned be re-exposed to certain "old" modes of social controls which neutralize some of the new developments and emphasize others\textsuperscript{1,2,3,4,5}. However, on account of the multiplicity of variables, many of which are latent, the casual observer cannot easily discover or describe these patterns, although he relies heavily on them in his daily social intercourse. We have all internalized many of these processes, with the result that we automatically have certain expectations and responses which blinker our objective intelligence\textsuperscript{6}. In order to get out of this "automatic or internalized framework" and study the ex-patient objectively, the observer must marshall and consult all that he knows about the problem of mental illness, and his own feelings about it.

There are times when, circuitous a route to the truth though it be, one must begin with the "Fall of Man" in order to explain lying. The fact that I am using dynamic models of human relationships necessitates this all-embracing approach. I have gained the conviction that the study of the psychiatric

\textsuperscript{6}Opler, M.K., "Epidemiological Studies of Mental Illness" in \textit{Symposium, Walter Reid Institute Work}. 1957.
field cannot be put in a nutshell, or tidily proceed from one well-defined concept to another. The students of the exact sciences usually hold that they are doing "science for science's sake", and that no other motivation should reign in the breast of a true scientist. In reality, as we know from psychodynamics, motivations are seldom that pure and simple\textsuperscript{1,2}. This fact places important social obligations on the researcher. Any social scientist who deals with what for him are "abstract" social problems, is faced with some very simple concrete questions before he ever can launch his research project; for however objectively he plans to go to work, he will inevitably, along the way, touch on the community's value system.

As the organization will protect its value system by the means of explicit or implicit laws or norms, social scientists must ensure that they have constitutional authority to proceed. They must know what legislation is involved and what procedures have to be followed in order to protect the rights of individuals. From a social point of view, the researcher will be asked, "Who is mentally ill?" "What does that mean for you and me?" "Is somebody to blame for this?" If there is a possibility that the answer to the last of these questions will be "yes", the researcher can expect resistance. On the economic level the question will be, "Who is going to pay for this and why?" "Is the purpose worth the expense?" The political question

\textsuperscript{1}Fenichel, O., \textit{The Psychoanalytic Theory of Neurosis}. Norton, New York, 1945.
might sound something like this, "What will the political result be?" "Is it something our party has to take a stand on?" "And what will we get out of it?" If anybody thinks that it is possible to launch research in the field of mental health without support from the public, he is very mistaken. This need for public acceptance, awareness and interest can be not only "bothersome" but directly detrimental for the project, as it may influence the variables which are to be studied.

A social problem's priority in regard to community services depends on its quantitative spread in the community as well as on its qualitative gravity for the victims. Therefore the services available for the ex-patient are contingent not only on the number of former patients and this misfortune, but also on the general prevalence of mental illness in the community.

The prevalence rate must be related to social and medical factors if it is to become socially meaningful. The psychiatrists who study the etiology of mental illness are trying to trace its appearance, its onset, its sustenance, its crisis, its abatements and its "spontaneous" recovery to their social sources. The morbidity or prevalence rate of an illness must not be confused with its incidence rate which means the number of first admissions for treatments in any one period. The public hospitals have kept records of their admissions and

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discharges for the last hundred years, but this has not been the case with the private institutions or practitioners. Moreover, it has never been a legal obligation to notify the Department of Health about mental illness in the way that it has been required to report venereal or other contagious diseases.

It is only for the last ten years that the multi-disciplinary mental health team has directed its attention to epidemiological studies of the living community. It is now relatively easy to find the proportion of the population that is in treatment at any one time, but attempts to discover the morbidity rate have only been able to lift a corner of the veil of mystery which surrounds mental illness in the community. The obstacles are numerous. It is difficult to obtain the permission of the medical profession and the social agencies to contact the sources of mental illness known to them, as they are bound to protect their patient's rights to confidentiality.


The next problem is the old persistent one discussed in Chapter One, that we have no firm criteria of mental illness and that it is all too likely that different specialists will diagnose mental dysfunctioning differently. Thirdly, a problem arises as to how we can convey to the public what we are looking for without provoking its resistance and what terms can we use to lay people in order to describe the varieties of mental illness in an objective yet systematic manner. Some specialists in the field have said that about eighty percent of mental illness escapes recognition. However, even the twenty per cent has, from a social point of view, great importance. If we can locate the people who compose this twenty per cent and classify them by some crude diagnostic method, we have both the nucleus and the focus for useful social investigation.

Although the issue is still debated, it does appear that mental illness has epidemic features. It has been found, frequently enough to cause suspicion, that mental illness has a tendency to appear in clusters; but it has not yet been possible to isolate the significant variables. The historical descriptions of the flagellants during the Black Death and the

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Witch Hunts in Salem are two classical samples of mass contamination. "Folie a deux" as well as Bateson's "double bind theory" and sociological "alienation theories" are modern views of its epidemic character.

It has taken more than ten years, millions of dollars, and the pooling of scientific knowledge to discover the few general trends in mental pathology on which modern mental health planning rests. In the beginning, much research was vitiated by the mistake of focusing on the course which the disease took in the individual sufferer - owing, no doubt, to a desire to measure the degree of pathology or dysfunctioning that was sufficient to overwhelm the resistance of the specific host. However, it was soon found that it was also necessary to assess the socio-economic factors which might have caused, augmented or prevented exposure, or which might have raised or lowered the individual's resistance. It first became possible to master this complexity of factors when the psycho-genetic scientists joined the anthropologists and sociologists who were examining the links between the pathogenic features of the social system and the resultant behavioural deviancy. Recently, this union of disciplines has become an accepted science in its own right, in the form of the new field of social psychiatry.

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In view of the etiological darkness which surrounds mental illness, there is obviously a premium on our become aware of every social factor that might be implicated when mental sys-
functioning is operating. Furthermore, we need to know what the specific relationship between these two sets of variables is, and what the roles of the other factors might be. It is important to find not only the necessary conditions for the effect, but the sufficient conditions too - a cautionary prin-
ciple which has too often been neglected in this field.

Researchers must purposefully select from the complexity of man's social universe the most theoretically promising and technically researchable patterned regularities. Among these we will find that a distinction can be made between "demographic" and "component" types. The demographic factors are those culturally significant properties or conditions, differentially manifested by all individuals, that provide a basis for classifying a population into a limited series of social segments. The demographic factors can either be bio-social (sex or age) or socio-cultural (status and religion, etc.). Some of the factors will be "independent" in the sense that the host has had no choice in the matter such as sex or ethnic background, while others are interdependent factors like

marital status and religious affiliation. The latter factors might nevertheless have importance in their own right. If it becomes evident that certain marital groups are exposed to a continued high risk of mental illness, an appropriate longitudinal study would help lessen the uncertain significance of the association by following the interdependency pattern through time.¹

The component variables consist in the connections found between certain psycho-socio variants. In the complexity of these connections one cannot easily determine which elements belong to the pathogenic, the eugenic or the euthenic types of influence. However, the component variables must in turn be systematically related to the demographic variables and to the degree of observable mental health. They perform an important explanatory role by showing the nature of the connection between the demographic variables and the mental health variable. As with other interdependent variables a longitudinal study can often resolve the ambiguities of the perceived associations.

The researcher will need interview and observation schedules in order to measure his variables. The construction of such measuring instruments has become a very demanding and highly technical task which utilizes the accumulated knowledge of many research projects and intricate methods of statistical control². It is my opinion that while the actual construction

of such devices is beyond the scope of social work as such, the social worker can play an important role in assessing the informant's reaction to such instruments.

Recent epidemiological findings\(^1\) indicate that there are among the adult population between the ages of twenty and fifty-nine, 23.4 per cent who are mentally impaired. Of the group designated as mentally impaired, only 5.4 per cent had been, during the course of the previous year, to see a mental health professional; 21.3 per cent had been once in their lives and the rest, 73.3 per cent, had never been to any psychiatric service. If we examine mental health as it is related to age it has been found that a substantial process of "slippage"\(^2\) in mental health seems to occur over the years in question. Marital status has always been assumed partly to protect the individual from mental disorders. Srole, however, has found that single women do not differ significantly from married women in regard to mental morbidity. But the single men's impairment rate is twice or more that of single women. In addition, among divorced men and women respectively, one in ten and one in six are mentally impaired\(^3\).

Another piece of research\(^4\), dealing with residential conditions, shows that urban living is not per se more conducive to mental illness than rural living. The higher incidence rate in

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\(^3\)As '1' above.

the cities can probably be attributed to the better opportunities for treatment as well as to a more accepting attitude toward mental illness. In the rural areas, the stigma connected with the illness might restrain the family or the patient from seeking treatment in fear of divulging the illness.

Studies of immigrants indicate that one cannot simply say either that mobility causes mental illness or that mental illness causes mobility. Nevertheless, there are, among migrating populations, certain important types of personality disturbance which might seriously skew the data on total populations. Thus any epidemiological investigation must look for, isolate or control this variable. Cross-cultural\(^1,2\) studies indicate that some societies have "built-in" outlets for stress\(^3\) which can significantly affect the distribution of mental illness between the classes of a population consisting of a variety of "nationalities" or sub-cultures.

It is in the studies of the relationship between socio-economic\(^4,5\) class and mental illness that one finds the most clear-cut trends. There is no doubt that both absolute prevalence and relative incidence increase as one goes down the status scale. This does not prove however, that the low income group is necessarily less mentally healthy than the high income group, since the low income group suffers additionally from a

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poorer chance of obtaining early and adequate psychiatric treatment. In view of the high cost of psychiatric consultation, this is not surprising. But, it is interesting to note that in a survey of psychotic patients it was found that 48.6 per cent of the upper-class group were treated as out-patients while only 10 per cent of the lower class group got this service, and 90 per cent of them being admitted to mental hospitals instead.

It might be that differential treatment opportunities affect the "morbidity" of certain types of diseases more than they do others. For instance, there is evidence that we have a higher proportion of neuroses among the higher than the lower classes; but we have a higher rate of psychoses among the low income group. The availability of treatment seems not to affect schizophrenia and manic-depressive psychoses. The former, for example, appears to be related to stress in any form, be it poverty, mobility or family dysfunctioning.

Jaco, in studying the incidence rate in Texas, which has a population of nearly eight million, found that during two years, 11,298 people or about 7 per cent of the population, were diagnosed as having psychoses for the first time in their lives. He related this illness syndrome to nine demographic, ecological and socio-economic characteristics, namely age, sex, inter-state migration, geographical area, urban-rural residence

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1Mental Care Series Memoranda No. 15, Mental Health Legislation in Canada. Ottawa, 1960, mimeographed copy.
marital status, occupation and educational attainment. The overall results were as follows. The incidence was found to increase with advancing age. Females had significantly higher rates than males. The Anglo-American showed by far the highest incidence, the non-white the next, and the Spanish-American the lowest. Rates (adjusted for differentials in age, sex and subculture) were significantly higher among the low economic sub-regions of the area. The urban areas exhibited consistently higher rates of mental disorder than rural districts. As to marital status, when age was adjusted, the highest rates were found for the divorced, followed in turn by the single, the separated, the widowed and the married. When all other variables were carefully adjusted, it was also found that rates were higher among the unemployed than the employed. In the unemployed group, the professional and semi-professional categories had the highest rate, followed in order by the service, manual, clerical, sales, agricultural, managerial, official and proprietor fields of employment. The correlation with educational level was not significant though variations were found.

I have presented Jaco's results separately because he is relating a recognized, treated, specific medical entity to various socio-economic characteristics, and is not dealing with the notably more elusive matter of prevalence of mental disorder as such. Moreover, he is relying on clinical information obtained solely from psychiatric specialists, and this approach is producing a different set of information from that available from earlier studies.
E.M. Gruenberg's remark about the study of epidemiological causation is, I think, very pertinent. He says:

"The large numbers of prevalence and incidence studies of hospitalized psychotics are inadequate for our purposes on many counts. First of all, they deal with only part of our problem, the seriously ill. Secondly, they deal only with that portion of the seriously ill which becomes hospitalized. Third, they can deal only with those socio-environmental factors which are included on hospital records. These studies are in no sense carefully designed experiments to explore relationships or test hypotheses by means of original data. The researchers have no control over the case-finding process, over the record keeping or even the diagnosis. Rather they are dependent upon the public's uneven willingness to give up its mentally ill members and to support them in institutions, the hospitals' unstandardized record keeping activities and the hospital staff's varied training and skill in classifying disorders. Finally, the studies have not always been made with much perception of sound methodological principles."

The research results mentioned above should be taken as suggestions or clues rather than as final results for the scientists themselves are not satisfied with their findings. They expect that sharper etiologically-based definitions of the pathological syndrome will in time change the picture considerably. Nevertheless, it is still important for the social workers to have some idea of the presently available

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data on the extent and repercussions of psychiatric disease, since knowledge is a prerequisite to all planning for improved and better accepted services for the growing number of discharged mental patients. Just what the practical implications of these findings are is something we shall take up in greater detail later in the essay.

Several investigators have dealt directly with the problems of the discharged patient, and it will be worth undertaking a brief review of their findings with a view to determining whether they cohere sufficiently to give us some insight into the nature of the strategic and recurrent variables.

The very fact that a person has been admitted to a mental hospital tells us immediately that there has been a breakdown in his role pattern. For this reason, an event during the post-hospital period cannot be properly understood until we also know what happened in the pre-hospital period. Research has shown that in many cases, role inefficiency or conflict has been developing over a long period of time so that the patient himself will have felt an inner stress and tension which has led him to seek help in many different ways of which hospitalization is only one. It frequently happens that everybody, the patient as well as his family, has been resisting the idea of hospitalization until the situation for the environment becomes unbearable.

1,2,3,4,5,6,7,8,9,10.

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We cannot, with any sense of security, plan a discharge until we know how the individual and his environment perceive this process of deterioration in relationships. Do they find it intolerable, unfamiliar, strange, frightening or what? Do they think it is a psychiatric symptom or is it masked for them as a physical complaint? Has the patient been able to ask for or secure help or does he reject assistance? Does he isolate himself? How and why did the family finally decide on hospitalization? What is their image of the hospital? Is it viewed as a place where a person can be treated and cured or is it a prison for the non-conforming? Is there, between the patient and any of the family members, a symbiotic or an anti-pathetic role-expectation?1,2,3,4,5?

Studies of families who were waiting for admittance showed that such attitudes and ideas existed and these determined whether they would proceed with their plan, revoke it or search for help somewhere else6,7,8. It was also found in another

study that only 30 per cent of future patients knew about the pending admittance and 20 per cent of those rejected it. However, only 2 per cent of the total number put up actual physical resistance.\footnote{1}

Up to the present time, most research happens to have dealt with the schizophrenic ex-patient\footnote{2},\footnote{3},\footnote{4}. But it is quite possible that similar findings could be found in the role-pattern of other psychiatric syndromes\footnote{5}. The researchers generally do not indicate their findings in "universal" terms because their population has seldom been more than between 80 or 200 cases. Their results are often expressed in the terms "more or less", "few or many" and "frequently or seldom".

It has been found that many marital partners fail to recognize the abnormality of the spouse\footnote{6},\footnote{7},\footnote{8},\footnote{9} while others persist in denying the existence of any mental dysfunctioning even after

\footnote{5}The cause is that the various medical diagnoses, with the exception of organic symptoms, are not reliable indicators of post-hospital performances.
several traumatic admission experiences. Others indicate in their behaviour that they do recognize that the spouse is mentally ill, but they do not verbalize it, mainly because their own role conceptions demand the other's dependency. This kind of pathological role complementarity can be built into the whole family structure. In such cases, nothing is done for the sick member until the patient attacks a relative, or the police are called in to pick up the patient at the request of outsiders.\textsuperscript{1,2} It is not uncommon for a very unhealthy situation to have existed for a very long time before a change in financial or personal circumstances has brought a stranger or a new member into the family, which could not bear this additional strain, so that hospitalization ensued. It has frequently happened that the professional eagerness of public health nurses or child welfare workers has brought such pathological situations to a head. If the purpose of a discharge is to keep the ex-patient out of the hospital, "too much" after-care might not be the best solution.\textsuperscript{3,4}

Several studies have shown that of first admission male schizophrenics, the majority have been living with family members before hospitalization.\textsuperscript{5} In many instances they have not worked during the previous five years, and some of them have

\begin{enumerate}
\item Messinger, S.L., "The Mental Hospital and Marital Family Ties" Social Problems. Fall 1961, Vol. 9, p.140.
\item Simmons, O.T., The Mental Patient and his Family. Hogg Foundation, Texas, 1960.
\end{enumerate}
never held an independent job\textsuperscript{1}. In one group examined\textsuperscript{2}, 45 per cent of the ex-patients lived with parents. They had grown up in an atmosphere of contradictory expectations regarding dependence and independence and cultural or religious values. This dilemma had not been corrected over time by means of heterosexual relationships because the symbiotic demands of one parent prevented the formation of any other relationships, while at the same time the parent had often refused to satisfy the patient's changing needs. Thirty-five per cent of these patients were living with a spouse, 8 per cent with other relatives and only 12 per cent were living alone.

Studies of the intra-familial environment of schizophrenic patients have shown that there is usually one or more "dysfunctioning" person, in addition to the patient, whose needs help shape the family structure. Some patients have had the experience that a long-standing family conflict has ripened to the point of breaking the family group altogether and they think they are personally responsible for parental separation or divorce. Another typical development in this connection is that the patient can become the scapegoat for the other members' pathological attempts to create a united family front against its own miseries. Although nearly all families state that they wish the patient to recover, the reality is that some patients\textsuperscript{1}

\textsuperscript{1}Lawrence, J., "Termination of Treatment with Ataractic Drugs: A Rating Scale", Unpublished Paper Presented by Psychopharmacology Service Centre of the National Institute of Mental Health. Bethesda, Maryland, September 1960.

parents, particularly the mothers, cannot tolerate any change in the patient. It is not uncommon to find that the family will withdraw a son or daughter from the hospital as soon as his ability for independence begins to show.

During the hospitalization, the family is the only visitor or as it tends to conceal mental illness in the family from employers and friends. After two years of hospitalization the visits sharply decrease. It is at the same point that there is a sharp decline in the discharge rates. It is mothers, rather than fathers, who tend to visit even after five years hospitalization.

The hospital, indeed, does not always encourage the family to visit. It often regards relatives as problems to contend with rather than a welcome opportunity to extend the scope of the hospital's usefulness into the family, or to observe intrafamilial influences that require modification or correction. The result is that wives and parents frequently feel that they are rejected and frustrated in their attempt to obtain information about the patient or learn how to anticipate his return. The negative hospital image which perhaps was only vaguely anticipated becomes an ineradicable stereotype. The admission

procedures create an alienation process both for the patient and his family, which firmly affixes the patient with a "non-person" status that is not a transient thing but a whole new way of self and other identification.

The transition from the hospital to the family and the community requires as much of an adjustment as the hospitalization process\(^1,2\). Without pre-discharge planning, patients tend to imagine that no changes have taken place in their homes. If the family has become very dependent upon the hospital, it may tend to return the ex-patient for minor dysfunctional problems which, before hospitalization, they managed to weather\(^3,4,5\).

An investigation of discharge planning has shown that family, patient and hospital personnel frequently disagree about where the patient should live when he returns to the community\(^6\). The patient almost always gets his way, whether he is in coalition with the family or the hospital, or has them both ranged against him. This problem can only be averted if, in proper time the hospital has lined up other suitable plans\(^7\). Rehospitalized patients could not be differentiated from those who


remained in the community in terms of total number of previous admissions, illness duration preceding hospitalization or in length of hospital stay.

Post-hospital performances of ex-patients who have been admitted on a diagnosis of psychosis show that the tolerance of deviant behaviour on the part of the patient's "significant others" is a strategic factor in the post-hospital experience\(^1,2,3\). In order to assess whether or not a former patient will succeed in the community, one can measure his occupational and social performances as criteria of level of functioning\(^4\). It has been found that former patients frequently live in the community while still actively psychotic and socially withdrawn\(^5,6\). A large survey tested the functioning of 182 male patients, originally diagnosed as psychotics, who, after at least 45 days of hospitalization had succeeded in remaining in the community for at least one year. The patients rated as "high performers" had worked full time since discharge and participated in formal and informal social activities with normal frequency. Those rated

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on the low end of the scale had not worked since hospitalization and had not participated in social activities. The ex-patients with high performance were found to live in conjugal families, while those with low performances were found in parental homes. The explanation for this difference is that the low level patient generally resides with a female relative who usually shows a typical characteristic. These relatives tend to be authoritarian, "anomic", frigid, frustrated and withdrawn in comparison with the relatives of the high level patients. But this, paradoxically, gives them a "tolerance" for deviance in others. In addition, parental families with "low level" patients tend to have other male members available to replace the ex-patient in his "instrumental" roles, so that he is neither expected to be a breadwinner, nor is this necessary for the functioning of the family as a whole. The low performers tend to have the sole kin role of daughter or son, while the high performers are expected to occupy "instrumental" roles and perform tasks necessary for the family's maintenance of its place in the community. These families, incidentally, cannot "afford" to be so tolerant, and thus more husbands than sons were returned to the hospital even though the performance rate was higher for the first group than for the latter.


The post-hospital fate of ex-patients depends also on the family's commitment to the dominant values of society\textsuperscript{1,2}. As the degree of adherence to the cultural pattern depends on class identification, religion and ethnic background, it was found that the low class, as well as the marginal groups, showed a far greater tolerance for deviant behaviour than the middle class, who could not summon sustained tolerance for members who neither worked nor participated in social activities.

In order to measure\textsuperscript{3,4} the influence of the variable of role expectations on the performance level, families have been examined as to the "significant others'" expectations of the former patient's post-hospital performance, as well as in regard to the complementarity between the expectations of the ex-patient and the significant other. In general, it was found that the low level patients resided with relatives who did not expect them to work or socialize during the first six months after discharge; while the high level patients lived with relatives who expected them to work within three months after hospitalization. However, when socio-economic class and sex were controlled, it was found that there was a correlation between the spouses' expectations in both the high and the low socio-


economic group; but the middle class wife tended to have a higher expectation of her own performance than it was possible for her to accomplish, while the low class women's expectations and the ability to perform coincided. As the middle class woman's low performance is persistent in spite of high expectations expressed by the couple one must assume more rather than less willingness to tolerate low level performance; and that it appears that the expectation to which the middle class woman is exposed differs qualitatively from that of the working class woman. On the one hand one must conclude that middle class women are less realistic in judging their abilities, but on the other hand, the suggestive power of a mate's and children's expectations can also challenge the patient so that we find a much higher performance level, when such conditions exist. One can almost say that it is self-defeating to act as though the ex-patient is legitimately sick.

A third factor was added to the performance measures, namely the normality of post-hospital behaviour as reported by relatives. It was expected that work performance, social participation and the absence of bizarre behaviour would be strongly related. It was further found however that patients showing abnormal


behaviour lived in characteristically different milieux from those who did not manifest such behaviour.¹

With the increased use of drugs²,³,⁴ it has been possible to extend the chance of adequate post-hospital performance to a much larger portion of the hospital population than before. However, therapy in the community needs careful planning and medical control. For this reason, studies have been carried out on the ex-patients' pattern of out-patient attendance. There is a great variation in the number of patients who do maintain contact with a psychiatric centre. It depends first of all on the effort made by the agency responsible for his treatment. Several studies have shown that patients fear and resent the hospital and its staff. The complaint is always the same,

⁵In some areas the after-care clinics report that 10 per cent of the discharged patients will keep regular contact, while 20 per cent come once or twice. In areas where the clinics are experimenting with drug treatment, some report only a 10 per cent drop out during 12 months, or in other clinics, rising to 35 per cent, increasing to 65 per cent over a 12 month period.
namely that the hospital made him feel like a "non-person" and this feeling has been renewed by each new occasion on which his illness and his symptoms have been assessed by a mental health official (as happens in some areas where it is a legal obligation for patients on probation to contact the hospital at certain intervals). In order to obtain a shift in attitudes, the public health departments in a number of the States have been training some of their nurses to supervise ex-patients on drugs. It is interesting to note in their reports that a great part of their function appears to be directed to assistance with social relationships.

I have been unable to find figures indicating the post-hospital performance of patients on drugs. Several research projects are underway, but the results have not yet been analysed. However, it does appear that the drugs do not interfere with a person's work performance. Moreover, it appears to be the drug, and not the placebo effect of "milieu interest," which sustains the ex-patient on drugs since some groups on placebos did regress and recovered only when drugs were re-instated.

It is necessary to emphasize that the findings presented here regarding post-hospital performances of limited numbers of patients on drugs.

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discharged mental patients do not yet claim to general ability, for the samples are too small, and they are taken, moreover, from a population which appears to have a motivation for treatment, by contrast with the general population of impaired people, of whom only a very few seek treatment. The researchers themselves mention that the particular difficulty of developing adequately comprehensive and precise criteria of social functioning of a kind which will match those used in the medical sphere. If research in this field is to make progress it is important to find means by which the individual's total social competence can be examined. Another qualification is that the variables associated with performance level were studied retroactively. It might have influenced the relative's response if he had been accustomed to having either a high or a low level relative in the household. Likewise, after a re-admittance it must be difficult for the relative to be objective about the performance level and to indicate the nature of the differentiation among role performances, since it is usually psychotically "strange" behaviour which induces frustrations and the need for hospitalization rather than the relatively subtle matter of inefficiency in domestic role as such. Moreover if the relatives consider re-hospitalization as a sign of failure and the ability to stay in the community as a sign of better adjustment, the fact of re-admission might prompt a statement expressive of this feeling failure.

Some researchers have tried to ascertain if it is the relatives' attitudes rather than the patient's performance which is the important factor in determining re-admission. They have
found that re-admitted patients tend to manifest a greater number and range of psychological symptoms than the successful ex-patients; but it seems that there is no consistent relationship between markedly abnormal behaviour and performance level. Yet it is precisely such abnormal behaviour that gives rise to the greatest concern among relatives, and might, therefore, lead in turn to re-hospitalization.

I have now arrived at the sixth purpose of this chapter, namely the examination of a number of rehabilitation projects which have studied the ex-patients' progress while they were receiving additional treatment designed to change and enhance their limited or inadequate social competence.

It cannot be expected, in view of the scope of this study, that I can go into all the matters of interest that such projects present. In this case, as in the discussion of the epidemiological findings and the results of basic research, I must limit myself to the most salient features and ignore the more scrupulous methodological considerations that greater time and space would make it possible if not actually mandatory, to examine. It was easier to be superficial in the two previous cases than in this one, however, because it is here that we find the richest and most suggestive clues to the modification and improvement of practice - not least so far as it concerns the tasks and responsibilities of the social worker.

One of the largest surveys of the post-hospital experience of ex-patients is now in progress in the State of New York.\(^1\)

under the leadership of Dr. E. Kriss. Since 1958, all agencies of the Department of Health have been reporting on their contact with ex-patients\(^1\). At the same time, new services are being inaugurated or old services being improved or better coordinated, in order to ensure continuity in the acculturation and re-socialization processes. So far only interim reports - and these to the participants in the project - have been presented. (It appears from digested reports though, that certain observations already familiar from small group research are being substantiated by Dr. Kriss' findings.)

The Oregon Study which was terminated in 1960, presents, I think, a good picture of such a community project on a minor scale\(^2\).

In 1957 the Oregon Division of Vocational Rehabilitation, the Oregon State Board of Health, the Oregon State Public Welfare Commission, and the Oregon State Hospital, recognized that they carried the major responsibility for the mentally ill in a variety of areas before, during and after, hospitalization. In order to seek a better definition of their respective roles in providing adequate services with a minimum of overlapping and duplication, they undertook a project, the purpose of which was to demonstrate how each could collaborate and cooperate with the others, and how together they could develop the programs and techniques essential for dealing with the rehabilitation of the

\(^1\)Belknap, I., et al, The Epidemiology of Mental Disorders in a Political Type City 1946 - 1952. Milbank Memorial Fund, New York, 1953.

\(^2\)James, J., The Oregon Study of Rehabilitation of Mental Hospital Patients. Salem, Oregon Division of Vocational Rehabilitation, 1960.
mental patient both in the hospital and in the community.

In order to improve the validity of the results, the experimental design included a control group. There were two areas of study, namely the hospital and the field. The planning and the organization was carried out by a research team hired for the purpose, while no change was made in the staff postions in the four agencies. The administrators of the four agencies had absolute discretion in accepting or refusing suggestions from the research team. (In this way the researchers obtained a useful experience in trying to "sell" their mental health ideas to the practitioners in the field.)

The hospital was the most cooperative of the four "agencies". A therapeutic ward was established, and the personnel were able to generate fruitful therapeutic atmospheres. At one point, when an interested doctor left and another substituted, the therapeutic effect rapidly came near to vanishing, but fortunately this episode was short. The new hospital admissions were referred at random either to the therapeutic or to the control ward. The names of those chanelled to the experimental ward were immediately given to the Experimental County Working Committee, which had been established in the field to see what could be done for ex-patients if all outside agencies focused their services on mutually acceptable goals. The Committee was composed of the supervisory public health nurse, the supervisory welfare caseworker, and the vocational rehabilitation counselor. Although the cases then were assigned randomly to either the public health or the welfare agency for the execution of the plans, it was assumed that much could be gained through inter-agency
discussion of the patient's needs. The vocational counselor received his cases later if necessary by way of referral from the two other agencies. Subsequently, after the former patient began to move along in his re-socialization process, the committee reviewed the case to determine whether all was being done that could be done, or whether the case should be referred to one of the other agencies.

Prior to the study there had been little systematic contact between the hospital and the agencies in the community. The experimental program provided close attention to the patient's needs from the moment of his admission. The Committee would see that his family was visited and helped to understand its sick member and to begin planning for his release. Moreover, the field now was able to provide the family with pertinent information about the patient in the hospital — so far as this was consistent with ordinary considerations of confidentiality and intelligibility.

Early in the study it became clear that the field workers felt a keen need for psychiatric guidance. The hospital, on its side, acknowledged that it could not provide vocational rehabilitation, since the information available to it about rehabilitation resources in the community was limited. In 1959 the hospital took a basic step in formalizing the relationship between the hospital and the community by issuing an instruction to its staff to mail a discharge summary on each patient to the agency in the field which would continue his rehabilitation.

In order to integrate the activities of the temporary research organization with the work of the four State agencies
without seriously disrupting the ongoing program of the agencies, while at the same time achieving the co-ordination called for by the purpose of the study, an elaborate committee structure became necessary. The research director appeared as a member of every committee, ensuring continuity between the senior executive positions, the operating agencies and the research staff.

This study was set in a framework of "behavioural" theory, with a sociologist at the head of the research team. In his final report he states:

"The staff members were faced with the introduction of many new ideas and thus one of the most important jobs for the researchers was to create a condition favourable to change. The leader had to contend with two contrary and opposing orientations. The operating agencies are practice oriented and rely on tradition and established regulatory systems. They therefore tend to regard change with reserve and as something to be allowed to come relatively slowly. The situation is directly opposite for the scientists who deliberately criticize and analyse old methods, speculate about and explore new solutions and wish to disarrange the accepted pattern with the express purpose of testing new hypotheses."

In order to give support to the research team and assurance to the agencies, a wide variety of consultants (ranging from psychiatrists and statisticians to social workers) were brought to the project and made available to everybody. In addition, the study group conducted many reviews of its operations and progress reports were prepared at frequent intervals.

As the study was interrupted prematurely because of lack of funds, it was not possible to measure satisfactorily what this combined service had meant for the improvement of ex-patients. Moreover, since the welfare agencies did not systematically complete a schedule which had been constructed to measure social
improvements, the research team was frustrated in its attempt to establish a measurable criterion of change. Nevertheless, some positive factors were obvious. It was found that the re-admission patterns of the experimental, control groups differed in certain observable ways.

The members of the former were re-admitted at a higher rate of frequency than the members of the latter. This fact does not necessarily mean that the rehabilitation programme was per se unsuccessful; but rather that the ex-patient and his family had become more aware of the available resources.

The most obvious gains were those of the Department of Vocational Counseling, which was established as a permanent service in the hospital and received an increased number of referrals from the Public Health and Welfare Agencies.

It was apparent that the Public Health and Welfare Departments each had rather unclear notions of the role of the other, and a somewhat "ethnocentric" attitude in general. Each looked upon the other as limited and inadequate. Each characterized the other as "client-centered" and itself as "family centered".

It was the researchers' opinion that one of the most difficult problems facing the study was to convey to the workers in the field that their knowledge of social behaviour fell short of what it would have been had their training in sociology and social psychology been comparable in rigour to their purely professional studies.

A study of somewhat different character is the Minnesota Follow-Up Study\(^1\) which was initiated in 1957-completed in 1961.

This study too was headed by a sociologist and also had control groups. The purpose was to determine whether more intensive pre-discharge planning and after-care by an independent team would be effective in improving mental patients' post-hospital adjustment. The "extra" predischarge planning and after-care were to be provided by inter-disciplinary teams located in the hospital and in the community. The project design did not spell out what the "extra" would consist of, but assumed that the experimental teams would be able to provide "more" of the services that were ordinarily available to patients, rather than different kinds of services. Although it is impossible to determine from the published facts whether the teams boasted professional or personal skills, it seems certain that the favorable circumstances surrounding the work of the teams made a great difference.

It is the researcher's opinion that:

"Two factors stand out as contributing to the success of the Study: 1) The status of the Study as a completely independent agency which made it possible to cut across existing demarcations of organization. The Study teams rendered few services to former patients that could not be provided by existing agencies; too often however, needed services were not provided in the past because the patient got caught in a web of rules and practices set up by state, county, city and private agencies. The Study was able to "speak for the patient". 2) It has seemed unusually effective to organize the efforts of individuals from a number of disciplines around a common objective: the aiding of the rehabilitation of mental patients. It seems evident that this enabled a more imaginative use of individual skills."

While the social workers, and to a lesser extent, the psychologist, were carrying out their traditional roles, the
public health nurse became a valued liaison with the medical profession in the community, and the recreational therapist became a primary consultant in foster home finding and placement, and later in developing recreational activities for former patients placed in "homes".

The success of the Study was measured in the ability of former patients to remain in the community and develop a higher measure of social competence. The patients who received the "extra" care did meet these requirements to a higher degree than ex-patients in the control groups. The Study substantiated the finding of other researchers that re-hospitalization is greatly affected by the tolerance of deviance in the patients' immediate environments, while a number of other factors seem to have an effect on the quality of the former patients' adjustment. The Study also demonstrates the artificiality of looking at the pre-discharge planning and the after-care as distinct and different operations. Most effective rehabilitation demands a continuity of effort. Moreover, as the ex-patient has partly lost the ability to request services, he tends to become a "lost person" for whom no agencies have planned their services, it was felt that a very small staff, or even one person, bridging the gap between hospital and community, between patient and family, and between patient and agency, would have an appreciable effect.

In September 1957 the John Hopkins University School of Medicine in conjunction with the Maryland Division of Vocational Rehabilitation Service, initiated a pilot study of the
Vocational Rehabilitation of Chronically Ill Psychiatric Outpatients. The purposes were: 1) to improve understanding of the rehabilitation process and to obtain clues on the criteria for selecting patients for different treatment programs; and 2) by studying the Vocational Rehabilitation Service psychiatric population and evaluating treatment results, to ascertain whether a psychiatric service facility associated with the Vocational Rehabilitation Service would be justified. The project was continued for eighteen months. The patients were screened by the project psychiatrist and a social worker before being admitted to the project services, which consisted of casework or group therapy conducted by a psychiatric social worker. The project did not include a control group because the counselors wanted service for all their clients.

All the patients lived in a family setting, but the project could not give family service as there was a lack of staff. It was found that the vocational counselors did not refer a cross-section of their psychiatrically disabled, but only those for whom all resources had been exhausted. The sabotaging effects of poor communication and confusion about counselor and project-staff roles were gradually abated by regular group meetings. As greater understanding and improved communication developed, a smooth pattern of cooperation emerged. Despite the many handicaps of the projects and the

unpromising circumstances of the patients referred to it, 50 per cent made progress vocationally and 11 per cent shifted from total dependence to partial self-support.

The researchers found that it was necessary to re-examine our concepts of psychopathology as they apply to a certain "lower class" personality disorder characterized by a long history of feeling overpowered and trapped and a defence pattern showing low or non-existent ambition\(^1\),\(^2\),\(^3\). The usual casework approach has to be greatly retarded, with expectations and demands scaled to the patient's current use of his available capacities. These capacities often go unrecognized by clinical personnel such as counsellors, social workers and psychiatrists, who easily become frustrated by the patient's lack of response. Group therapy\(^4\),\(^5\),\(^6\) must be action-oriented and structured, rather than leaning to the free interaction and discussion models. Furthermore, it was found that

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"...patients evaluated clinically and by the self-concept scale as having the most positive self concept despite a history of ineffectiveness are poorer risks for rehabilitation than those whose self-concept is more in keeping with reality."

The Vermont project\textsuperscript{1} which is the next study of the rehabilitation of mental patients to be described, is an example of an effective service founded on long experience and enhanced by a fine team spirit. The Vermont State Hospital had begun its program of vocational rehabilitation around 1945 and had established a good relationship with the Vermont Vocational Rehabilitation Department and with the State Department of Education. Two rehabilitation houses had been built in 1956 and 1958 to provide intermediate steps back to the community for patients who were potentially capable of self-support but had no home. Each year the hospital was able to discharge an increasingly large number of patients who had been hospitalized for as much as from six to eighteen years. Emboldened by such results as these, the Hospital applied in 1957 for a research and demonstration grant in order to present to others its experience. The specific aim was threefold:

"First to study by participant research the methods employed and the problems encountered in a coordinated program of rehabilitation of chronic patients within the hospital and in the community. Next, to demonstrate by expansion and intensification of the present rehabilitation program the potential for self-sufficiency in a considerable number of chronic schizophrenic patients who had already been hipped

\textsuperscript{1}Chittick, R.A; Brooks, G.W.; The Vermont Story. (Office Vocational Rehabilitation) Department of Health, Education and Welfare, Washington, 1961.
by tranquilizing drugs and social therapy. Thirdly, the priority in the research was the task of formulating the key positive factors which might explain the 60 per cent successful rehabilitation of chronic schizophrenic patients."

The hospital conducted its own research, having an adequate staff of 7 psychiatrists, 2 clinical psychologists, 3 social workers, 20 registered nurses and 252 attendants for 1175 patients, of whom 50 per cent were schizophrenics. The patients were referred to the rehabilitation program by any staff person in the hospital and even by other patients. By the time patients were discharged to the community, they had been on the rehabilitation ward as long as had proved necessary to secure that level of motivation and capacity which would ensure and enhance their stay in the community. Already, during his stay in the hospital, the patient had discussed his future with the vocational counselors; he would have held a job either in the hospital or in a part-time capacity in the community; and he would gradually have improved his social and vocational aptitudes through the means of occupational therapy and participation in discussion or "action" groups.

The patients would be discharged to a status of more or less independent residential living. The discharge date, however, did not necessarily coincide with the date of cut-off from the hospital. The staff, as well as the patients, could make arrangements for a continuation of services which would be co-ordinated with those obtainable in the community. In many cases, former patients would be asked or would themselves offer to participate in the rehabilitation of patients who were still in the process of progressing towards discharge.
Throughout the study a continuous search and appraisal was made in an attempt to identify the various factors which appeared to play a constructive, positive role in the outcome. It was found that the key person in the therapy of a patient could be literally anybody, the attendants, the occupational therapists, the psychiatrists, the social workers, and so forth. It was not proved, either, that it always had to be a professional person—if one may judge from the reported experience of ex-patients and staff alike. It is the researchers' opinion that:

"There is something special in dealing with mental patients as members of a therapeutic team, which encourages and leads to need fulfillment. The therapist whoever he is and whatever he knows has the feeling inchoately or expressly that he is a surrogate parent and also the feeling of standing in a brotherly relationship with his colleagues. The therapeutic setting seems to have about it many of the aspects of a family which give therapy to the therapist as well as to the patient. This means of course that transference phenomena operate, but in this setting the individual has a chance to express need with less danger and threat than might often be true in a real family or community."

The reason is that mental patients are less threatening to staff people as sources of identification than normals. The patient cannot hurt another as much as a normal person can. We can be delighted when we see progress, and we can be disappointed without being bereft if things do not work out:

"However staff can only work truly effectively if they are given opportunity to deal freely with the patients. This implies that the social setting must be democratic in the sense that not only are the members permitted to express their opinion and participate in decision making, but they are encouraged by obtaining pertinent information about the situation."

The authors of this study emphasize that effective teamwork in the rehabilitation of long-term hard-to-reach patients requires as much time for the team-members to work with each other as for
them to work with the patients. In addition, the therapeutic
organization is not based on one-to-one relationships but in-
volves many staff persons working together with the same patients.
This gives an excellent opportunity for realistic assessment of
patients, who cannot present one face to one therapist and a dif-
f erent face to another. Moreover, the shared nature of the enter-
prise helps to ease the tensions and the burdens of therapeutic ca-
re as the individual therapist, who knows that he is never solely
responsible for the outcome, can better accept failures. Indeed,
an over-conscientious attitude is continually watched for by the
leaders of the hospital, who see it as their major responsibility
to keep constant look-out for and give firm support and counsel to
those who deal daily with the patients, so that they are prevented
from going too far in their concern.

There exist several studies, sponsored by ex-patients' clubs
1,2,3, which aim at measuring the relative post-
hospital performances of those ex-patients who are receiving such
services, and those who are not. Two of the studies known to me do
certainly show that the re-admission rate is lower for patients who
receive the services than for those who do not. Likewise, one can

2Goertzel, V. "Fountain House Fundation:Case study of an Ex-
3Silverberg, S. "Some Significant Components in the Sociali-
zation of Patients Discharged from Psychiatric Hospitals". Presen-
ted at the annual meeting of the American Orthopsychiatric Associ-
find a positive correlation between ex-patients' social activities and their work pattern. Although such studies are obviously important to the agencies providing the service, in that they make it possible to assess both functions and programs, it is important to understand that these relatively modest institutions are seldom in a position to control all the variables that might work for or against a man's re-integration in the community. Thus their findings tend to be valuable only in an operational context. It is believed, for instance, that about 40 per cent of all psychotic patients will recuperate "spontaneously" sometime in their careers. Some authorities have found that this happens during the first two years of illness; others that a spontaneous recovery can happen at any point in a psychotic patient's lifetime. Since many cases are not diagnosed at the point of the onset of the illness and since few patients and even fewer ex-patients are under regular and close observation, no one can really tell what might have caused the remission of their illness.

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Chapter IV.
Implications for the Role of the Social Worker.

The purpose of the last chapter is to present my arguments for the statement I made in my introduction, that: "The new trends in mental health services for the ex-patients are demanding that social workers extend their traditional role to new or at least different areas".

In order to prepare the ground for my arguments, I have undertaken in the foregoing pages to examine the special theme of this study, namely the needs of the former mental hospital patient. Now, I must analyse the problem of the mental health management with emphasis on social work intervention.

The intervention in this case presents two aspects. We have the actual social services described in Chapter Two some of which are directly the responsibilities of social workers; and we have the research projects described in Chapter Three which provides the rationale for such services. I hope that I have succeeded in presenting sufficient evidence to convince the reader that the conceptual and practical problems involved in the re-socialization process have severely if not entirely obstructed a proper development of adequate services.

The Patients' Problems Re-capitulated:

A study of the literature and my own practical experience have convinced me that the ex-patient and his environment, the helping agency included, are facing an anomie situation. The

patient's sufferings are two-fold. First of all, his dilemma is a state of mind in which he feels isolated, disconnected from his past and his present; he feels no purpose, no capacity and no motivation to work for future goals\(^1,2\). Secondly, as a counterpart to this psychological aspect of anomie, comes the sociological aspect which the patient shares with his environment. They are, alike, confronted with latent, and manifest, conflicts between cultural goals and the patient's opportunity to achieve these goals\(^3,4,5,6\).

Lagey describes this problem well when he says, in his report of the Minnesota Follow-up Study,\(^7\) that: "Typically, the discharged patient belongs to a lost population with all what that entails". The patient's background is a closed book and the future does not exist. He has lost his connection with his relatives, with his culture, and even with his illness. His environment has no use for him. They feel they

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\(^3\)Murray, H. *Exploration in Personality*. Oxford University Press, New York, 1938.
have no responsibility for his aberrant behaviour, and his helplessness makes them feel uncomfortable. Therefore, they want to forget what he did and they cannot understand what he does.

A Sociological Interpretation of Mental Health Management

The condition just described is the result of social interaction over a very long time, between the ill, the community and those society has delegated to deal with the problem, let us call this last group the mental health professionals, whose occupation it is to study, to treat, to cure, to protect and to support economically those whose illness has placed them in a position of systematic vulnerability.

My study, although it deals only with a very small part of this social drama, cannot be understood unless it is seen against the background of the total, complex social structure of mental health management. My purpose in examining the interaction of causes in this chapter is not to find any one culprit, but to determine the socio-dynamics for which our culture as a whole is responsible. It is only through the acquiescence of the people that the responsible professionals have sustained and perpetuated what amounts to a social problem of great magnitude.

The Physician's Role Conflict

While our society has recognized the medical profession as the official authority in the management of its sick members, the management of the mentally ill has been shared by a combination of occupations. One of them, the medical specialist, works under the peculiar handicap that his authority is not absolute. His decisions can be questioned not only by another authority of equal or even higher power, the court; but also by his professional non-psychiatric colleagues, as well as by a host of other involved individuals - the patients, the relatives and various service personnel. This situation probably exists on account of the obscurities of the pathology's causes and effects. We do not have any similar ambiguity in the management of other medical problems. One may guess that this unusual and insecure role has led the medical practitioner to take special precautions.

The traditional treatment of choice for mental illness, the removal of the patient from his environment to secluded custody, is undoubtedly inspired by society's need for self-protection. However, it would be wrong not to see that this removal also lessens the risk involved for the psychiatric therapists. Their

1Mental Health Legislation.
inability to deal effectively with certain forms of mental illness could be professionally dangerous and humiliating in a more public and accessible place.

One consequence of the doctor's traditional and stereotyped role as a healer is that the mental hospital's physician usually delegates the management of the violent or disturbed patient, who cannot cooperate or submit to treatment, to somebody else (the police, attendants, the nurses or the social workers) until the patient is ready to use his services\(^1,2\).

This division of labour has produced that peculiar specialization of roles which is described so well in Goffman's book, *Asylums*\(^3\). While institutional caretakers considered themselves to be doing an important job both for the community, whose troubles they carried, and for the doctor, whose reputation they protected, they have never been able to obtain satisfactory recognition\(^4\). Their jobs have had and still have a low status, I think, because what they are doing cannot produce anything of which the rest of us can properly be proud. The psychiatrist who is a partner in this dismal system can protect himself by being first of all a physician, whose status is culturally secure. Secondly he has been able to choose mainly

\(^{2}\text{Austin, L. "Relationships between Family Agencies and Mental Health Clinics" Social Casework. 1955, No. 3, p.51.}\)
\(^{3}\text{Goffman, Asylums. Anchor Books, New York, 1961.}\)
administrative duties which do not involve him in what can be called the "dirty work" in the management of his profession. Thirdly, he can time his appearance on the treatment scene in such a manner as is congruent with his status and dignity.

The arrival on this continent of the Freudian theories placed the role of the hospital psychiatrist in jeopardy. While he, as the administrator of a large population of mentally ill, had a rich opportunity to diagnose his patients according to psycho-analytical theories, he could not plan to treat them in a corresponding fashion because they were assumed (on account of their socio-economic and pathologic typology) to be beyond the scope of the classical Freudian treatment methods. Thus, if the psychiatrist wanted to "live up to" the medical tradition of being a healer of illness, he could only do so in a private practice where he could select the most amenable pathologies and devote the necessary time to their treatment. The existence of such a choice has made the hospital psychiatrist a second-class member of his profession. The consequence often is that only the less well qualified physicians go to work in the mental hospital, or that hospital service becomes the stepping stone to a career in administration.

Social Work as the Psychiatrist's Social Resource

It is, as we know, not only psychiatrists but also social workers who are utilizing psychoanalytical theories. At one time there was a real conversion from "social" social work to psychiatric clinical work. Social workers in public agencies had felt very little satisfaction in working with great caseloads to which they could not give proper attention. Thus in the name of professional duty and interest it became an ambition to work with the psychiatric specialists in clinical work. This change of focus and treatment method was not easily accomplished, because the large welfare caseloads still needed attention and put forth powerful claims to professional loyalty. Moreover, many felt that "psycho-therapy" and its associated methods of help, was a euphemism for "Junior Psychiatry" and not really social work at all. It is my opinion that the social workers accomplished this move only by virtue of their common interest with the psychiatrist, who supported the effort because he needed their help. The psychiatrist required a new

category of auxiliary personnel in order to obtain patients' 
"personal history" which he needed for both diagnosis and treat-
ment. Thus it was in the interest of both professions to work 
together. The psychiatrist who left the hospital and went to 
private practice would continue to utilize social workers as 
auxiliary helpers to do the non-medical work, while the psychia-
tric social workers found someone who supported their claim that 
they had an important role in mental health clinics; and the 
supplemental claim that the drudgery of bureaucratic routine, 
as well as the out-doors chores, could be done by workers less 
well qualified than they were.

Although one can only speculate on why so many social wor-
kers prefer to do "psychotherapy" rather than social work in 
general, it has become evident that the former has far more sta-
tus than the latter. It might be that as long as social workers 
feel that the public identifies them with the poor and the "no 
good", and as long as our culture remains inhospitable to those 
forms of social work which involve welfare expenditure, a tend-
ency will exist for them to associate themselves with an activ-
ity which shares the nimbus which is hovering over the medical 
profession; and which can also provide results which at least 
other psycho-therapists admire and trust.

While the psychiatrist will appreciate the help he can get 
from social workers, he cannot easily admit that he is dependent 
on them. As a result, he is often inclined to emphasize his 

1The Group for the Advancement of Psychiatry. Psychiatric 
Social Work in the Psychiatric Clinic. Report No. 16, September 
professional prerogatives in the relationships; although in the
sphere of psychotherapy, they are rather equivocal, since the
traditional body of medical knowledge and practice has little
bearing on the tasks which constitute the disciplines of psycho-
therapy\(^1\). It has further shaken the role of the psychiatrist
to find that chemicals and electricity could be applied for the
abatement of psychiatric symptoms in a rule-of-thumb manner
which, so far, can claim no sanction in medical theory. However,
as it is the physician's traditional responsibility to protect
the gullible patients against charlatans\(^2\) who might impose on
them when their judgement was weakened by stress or illness,
our culture still accepts the doctor's right to study, select
and prescribe the means which other disciplines have evolved for
the prevention and cure of mental illness. But the physician's
mythical omnipotence as a healer is rapidly decreasing.

The Public Trust and Professional Self-protection

It is a commonly held value that the purpose of all science
ultimately is for the betterment of mankind. However, there is
a difference between sharing scientific knowledge and sharing
the knowledge of scientific practice. Usually an old profession
has developed a pattern of interprofessional norms and values
which more or less ritualize professional behaviour and make it
incomprehensible to outsiders. This "secrecy" enables the group
to become solidified and resist exterior and interior corrosion.

\(^1\)Grinker, ed., Toward a Unified Theory of Human Behaviour.

\(^2\)Goode, W.J. "Encroachment, Charlatans in and the Emerging
Professions" American Sociological Review. Vol. 25, p.902,
December 1960.
A young occupation, striving for professional status is usually to be found eagerly constructing a framework of rules and regulations which serve to rationalize the group's ambition and bid for public trust and acceptance. When this has been accomplished, we say that there exists a social contract between the profession and the public, in which the former promises disinterested, properly qualified, morally acceptable services on the condition that the receivers accept these with unreserved trust. The status of a profession can be measured by the degree of trust it receives from the public.

The mental health team also needs "trust" and social protection, if only because their dignity would be jeopardized if they could not hide the "dirty" aspects of their work. Work can be "dirty" in one or more of several ways. It might simply be disgusting, as in disposing of fecal matter, being spat upon, or having to use force against another person. It might be a symbol of degradation, like working among outcasts, having to use childish language, wearing a uniform or doing something other people will not do. "Dirty work" can also be something which runs counter to the deep-seated moral convictions such as detaining somebody against his will, classifying him as incompetent, or sterilizing people in order to preserve "social hygiene". In mental health planning, the delegation of dirty work, as well as the unspoken knowledge that someone is doing the dirty work, meshes the staff members and the patients into strange and often crucial relationships. It unites all of them, somehow, against a community which has placed on them certain duties which it knows are necessary, but which it pretends are
not necessary. This hypocritical attitude of the public, as well as of the mental hospital staff, has, I think, led to much frustration in social work's bid for recognition as a "professional" and independent occupation.

The Public's Needs and Professional Responsibility

As it is clear that the public's attitude to psychiatric social work is coloured by the feelings its members have about the "usefulness" of the social worker's job, a question now arises as to what effect the recent changes and developments in mental health management have had on the public's image and expectations of the social worker.

I think it is a fair observation that a veritable sequence has taken place. At first we find writings concentrating on the damage done by hospitalization. I think that the criticism raised was difficult to accept and often unjust because so little was said about the dearth of opportunities to do something different. The psychiatric social worker might well have felt a long-delayed and welcome pleasure in that this criticism indirectly vindicated his special competence in working in the community. But this was what he had been saying for years.

Meanwhile, mental health planners understood very quickly that they could and should refer the problems of social re-integration back to the community, and that mental health clinics would have to participate in re-socializing and sustaining the numerous ex-patients who daily left the mental hospital with

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little preparation for settling down to the manner of life which our culture both encourages and approves of. The organization of day or night hospitals is one of the more recent results of the clinical psychotherapist's contribution to community psychiatric services. In these institutions the clinical team can still perform their roles as they developed them while giving out-patient psychotherapy.\(^1\)

However, I wonder if this celebrated innovation is good enough. In my opinion, important changes will have to take place to accommodate large numbers of patients claiming service, the characteristic pathology of these patients, their typical class handicaps and their lack of primary reference groups: all factors which indicate that psychotherapy is not the treatment of choice for this group.\(^2\),\(^3\).

The recent changes in treatment methods have occurred as a result of progress in scientific discovery which was and is both revolutionary and unexpected. It is often very painful for professional people (who, as I mentioned earlier, either have developed or are in the throes of developing codes and methods fitting to their status aspirations) to decide how they can best integrate this new knowledge. It appears to me that social workers are again at a crossroad. The individual worker will have to choose between two directions of professional activity

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which, though not mutually incompatible, nevertheless demand from the practitioner very different attitudes and knowledge. So far, the profession has relied heavily on psychoanalytical theories, which demanded from the practitioner an emphatic attitude and the intellectual ability to analyse behaviour according to this discipline's theoretical concepts. The new developments will require an integration of novel "social science" concepts and methods in social work practice. The practitioner's attitude towards his client will remain empathic to permit understanding of his client's reactions and feelings; but his attitude towards the causation of certain behaviour must become empirical, analytical and critical in order for him to build his practice and methods on psycho-social theories which differ from the pure psycho-analytic theories, in focus and methodology chiefly be relying as much as possible on observable and testable facts. This difference in focus and methods is immediately germane to the problems of professional practice and education.

A profession's goals are generally determined by the community's perception of its own needs, while it is usually left up to the members of the profession to develop appropriate means

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which, in conformity to cultural norms and values, will lead to the accomplishment of the goal. Social work has predominantly been an auxiliary occupation, subservient to either the medical profession or to some prescribed social service pattern over which the practitioners had little or no control. Thus it was natural that social workers, in trying to achieve professional status, should seek the assistance and the protection of the medical profession. In the "social drama of work" such a coalition is only possible and useful if both professions need each other in order to achieve those public purposes that have been entrusted to them.

The Growing Social Component in Psychiatry

The medical profession will still need the social services, especially in the solution of mental health problems, but in a different manner and capacity than previously. I have already mentioned that psychiatric students are devoting more time to social psychiatry. The purpose is to enable them to collect social information from their patients themselves, since the collection of this information is an integral part of psychotherapy. Even if it still will take some time before all doctors have become skilled in social psychiatry, they are on their way to becoming less dependent on the "old faithful" social work raconteur¹.

The Re-Orientation of Social Work to the Community

Along with this development we see another of even greater

significance. It is evident from recent studies of the post-hospital experiences of ex-patients that "the community" wants and needs social work, in its own right, in the field in which social work began - though this time, in a better planned and (dare I say) more sophisticated manner. The problems raised by social researchers demand that social workers share their knowledge and experience with those engaged in studying the basic processes of community life, as well as experiment critically with new and old methods of problem-solving in their own domain.

In the following pages I will present some of the research results which suggest a new social work approach to the solution of the problems of the ex-patient, as well as to the maintenance and enhancement of mental health itself.

The Oregon Study (discussed in the last chapter) found that it was helpful to have a central clearance committee, where supervisory staff from the different agencies could discuss all the discharge cases before they were referred to the field workers. However, in the lower echelons, it was found that the different disciplines continued to be unable to understand each other's services. The studies from John Hopkins and Minnesota showed that much misunderstanding could be dispelled by the persistent intervention and liaison of skilled mental health workers. The ex-patient clubs are solving this problem by providing most of the social services on the spot; the financial assistance being obtained from a public agency, which refrains from giving other service since it is assumed that the club worker will assist the ex-patient in his process of re-adjustment.

Even if we assume that agencies will not be understaffed
and that they will be ready to do their best in the work of collaboration with other agencies, we must admit that in a case like that of the re-socialization of ex-patients, where so many people are involved, the task is fraught with difficulty. One thing is clear, there must be a master mind or plan behind the interaction of the different institutions ensuring that the services are given in a proper sequence, seeing to it that rehabilitation is not a lottery.

But among the many social and medical services, which is the one that should make the plan, delegate the work and supervise its completion? It must be a professional "person" who can counsel others, who knows the community resources, who is a mental health specialist, and who can obtain the co-operation of others.

In recent years a service called "Mental Health Consultation" has developed in the U.S.A. as a part of that country's "Action for Mental Health". Professor Green of the California School of Social Work presented a paper last year concerning the training of Mental Health Consultants in which she stated: "There is an increased conviction that such consultation can help to meet the pressing demand for therapeutic and preventive mental health programs". Dr. G. Caplan, moreover, has emphasized that social workers "...who know the community services and


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the family pattern should be able to do this work, if they would give up their inclination for seeing their clients in offices and re-awaken their interest in communal social services." He thinks that social workers are in the mental health "front line", that they customarily work with people in crisis situations. Every crisis situation has within it the potential for either chronicity or for resolution of the acute problem. But many of the professions which deal with such problems lack the skill and training which are ideally requisite. If social workers, with additional training, perhaps in mental health, could help the other professions deal with the legionary crisis situations which arise in everyday life, much might be done for the promotion of mental health. While consultation is a part of social work, mental health consultation to other professionals demands more knowledge about this subject than is usually taught in the schools of social work.

Miss Green describes the basic concepts in mental health consultation as follows:

"The consultant needs to be willing to lend his knowledge and the strength of his knowledge to another person. That is, the consultant must be able to help another person do a particular job within his direct responsibility - a job which the consultant is in no position to do... The consultant must accept that the consultee is a competent person in his own area of work and that the consultee is free to accept, to reject or to modify the counsel as he sees appropriate.... The consultant must be able to study the request and the situation and to decide if he is

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an expert in the area for which counsel is sought ....The consultant carries no evaluative function concerning an individual performance of the consultee...As the consultant does have expertness to offer he is also responsible for seeing that the administration supports him in his work with the consultees...The consultant must be aware of and make use of, for facilitating the consultation, any feelings the consultee may reflect about himself as an individual, or as a professional helper, and about his dilemma...An essential for help to the consultee is the consultant's skill in engaging the consultee in reacting to and thinking about the ideas which the consultant is able to offer...Just as the consultant actively participates with the consultee in exploring and piecing together his problem situation for its clearer meaning, so also the consultant needs to engage the consultee in discussion of the new knowledge or new awareness and the implications they have for directions and activity."

It is my opinion that these attitudes between consultant and consultee are prescriptive of routine for all social work help-giving. What is needed, as I see it, to become a successful consultant, is that the administrative authorities should agree that such a service could be helpful and give the consultant an opportunity to become acquainted with the structure and function of the agencies which could use such consultation, for the consultant must always begin "where the client is". In addition the consultant's knowledge of mental health problems and their treatment must be evident and convincing.

Cummings has elaborated on the "inadequacy or deprivation syndrome" which in certain studies was diagnosed in 23.4 per cent of those applying for social assistance. These clients had been twice or more in mental hospitals. The hospital file

\[1\text{Cummings, J., et al, "Where are Additional Psychiatric Services Needed?" Social Work, July 1962.}\]
showed that the acute disorder which had brought the patients into hospital was superimposed on a long-term persistent ego defect. Dr. Cummings says:

"While we from the mental clinics are conversant with the incapacitated neurotic with primary failure of the synthetic function of the ego which has caused damage to his executive ability we do not as often consider the possibility of a primary executive failure endangering the synthetic ability in the moment of stress. However in conceptualizing executive failure in terms of an inadequacy syndrome we are able to bring into focus this large group of incapacitated people who can be helped by receiving training in new skills under psychiatric guidance. Skills are for the executive portion of the ego what defence mechanisms are to the synthetic portion. If we cannot control environmental stress, we can add strength to the ego, but only if it becomes psychiatrically respectable to work with the inadequacy problem in ways that are appropriate to it".

When Cummings studied the treatment facilities for such clients in New York City he found that "the less trained workers who worked for large public agencies, had the largest case-loads containing the highest proportion of severely disturbed clients suffering from the inadequacy syndrome." He pointed out that:

"The workers wanted help in the form of consultation and referral privileges, but at each level help is seen as appropriately coming from workers only a little more trained than themselves. These workers in turn would like to refer exactly the same kind of patient to others again more trained than they are. Only those at the top of the training ladder, the mental health clinics, have a different complaint. They complain that other agencies are always trying to refer to them the wrong kind of patient."

In British Columbia where at least 130 patients are discharged each month from the mental hospital in Essondale but

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1 Annual Report of Mental Health Services in B. C. Victoria, 1962.
where 8 per cent of them are back in hospital in less than six weeks and about 52 per cent are readmitted in less than twelve months, it is evident that we need a plan for a better absorption of ex-patients into the community.

Another consideration which I think would argue the need for organized mental health counselling is the experience that families in which one or more of the members is prone to mental illness can be kept from disintegrating with the help of a "family mental health worker". If we consider how important the institution of the family doctor has been to the general health of the community we can visualize that if it was possible to keep a family alert to the danger-signs of the imminent mental breakdown of its members and assist them immediately in time of crisis, the community as a whole would reap the fruits of this attention to predictable weaknesses among its members. Every family in the community has a connection with some public institution, be it the school, the pension board, the family doctor or the public health nurse, which will be aware of its overt or latent mental health problems. The job of the Mental Health Counsellor should be to arrange that the agency which has the most frequent contact with the family would also discuss with it the fact that this danger needs to be watched, and offer it appropriate support and acceptance. The experience is that

from regular contacts with community resources, such families will be able to weather many stresses and crises without having to resort to hospitalization. The main ingredients in the successful management of families with marginal frustration tolerance and a potentiality for breakdown seem to be a stable relationship with an accepting personal counselor\(^1\), and prompt service or treatment in the moment of acute illness.

Social workers have always understood that inter-agency cooperation was vital for competent social services, but I do not think that they have seen it as their role to give "casework" to other helping professions. However, if social workers believe that casework is a versatile treatment method applicable to a broad range of cases of social malfunctioning, why should its use be confined to the problems of dependent clients, and not extended to the more widely consequential (if, admittedly, more complex) problems of professional colleagues and collaterals. Many features of the problem-solving process are the same in both cases. The acceptance of this role will, it must be confessed, demand that social workers acquire trust in their methods and dare to loosen their hold on the medical or bureaucratic "apron strings".

Measuring Results of Social Work Intervention

There is only one way in which social workers can learn to assess their own abilities and to measure the effects of the

\(^1\)Leighton, A.H. My Name is Legion. Basic Books, New York, 1959.
application of social work methods, and that is by observing and measuring the results in a scientific manner\(^1\),\(^2\). Unfortunately, there are not many signs to indicate that social workers are seeking this form of assurance. Dr. James, who directed the Oregon Study (a demonstration project which included social workers) found that social workers preferred the old trusted methods, and looked for their directions to the policy and regulations of their agency. They seemed to fear or even to resist, changes based on objective criteria\(^3\).

In my own search for information on social work research dealing with the post-hospital experience of the ex-patient I found numerous discussions about the trouble these patients or their problem families caused the agencies\(^4\), how expensive and ineffective the social service appeared to be\(^5\),\(^6\), how great the need was for better understanding of the cultural and social factors involved in mental rehabilitation\(^7\), how useful home-care might be\(^8\), accounts of the mental health problems associated with the increased discharge rates\(^9\), the use of public


\(^3\) James, J. The Oregon Study of Rehabilitation of Mental Patients. Salem, Oregon Division of Vocational Rehabilitation, 1960.


\(^8\) Grrutcher, H. Foster Home Care for Mental Patients. The Commonwealth Fund, New York, 1944.

\(^9\) As '7' above.
health nurses and vocational counselors, and the role of the social worker in mental health clinics, private psychiatric practice and psychiatric group work. But very few papers reported studies which applied formal experimental scientific method.

The Smith College Studies often report research projects, but as all of them are based on psychoanalytical assumptions, they add to our ever-growing treasury of unsubstantiated hypotheses rather than to our body of knowledge. I have found only a few studies (by Bates, How, Lane, Shea, Uhlman and Witmer) which attempt to present results that have been obtained through

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10. Lane, D. "Social Group Work with Family Care Patients" Mental Hospital, June, 1961.
relatively controlled and quantitatively precise research techniques.

This is particularly strange in view of the fact that research is not an unknown factor in social work. We hear frequently that social work practice is a research project in miniature. The social worker's contact with his client, his observation, assessment of facts, hypothetical planning or deduction, and final comparison of predicted and achieved results, are the very steps which every researcher is familiar with. The goal of research is to add to the body of human knowledge in a general way, while the goal of social work services is to increase the competence of an individual. The difference is in the scope rather than in the kind of activity. Likewise, numerous monographs and articles have been published on the methodology of social work research, emphasizing that social work treatment methods and assumptions need testing, and regretting that so little has been done to verify the profession's claims to relevance and effectiveness.

Since I am not myself an experienced researcher, but only a social worker who has read a certain amount about research and participated in a minor way in some unsophisticated research

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projects, I can neither discuss the methodology and techniques of research nor criticize the end results. What I think I am capable of doing is to note where social workers, to my knowledge, are meeting their obligations by taking an energetic part in the current programme of research on the problems of the mentally ill.

I have previously in this study observed that research in the mental health field is no longer within the province or competence of any one scientific discipline. The reason for this, of course, is that the many facets of social life, with our increased knowledge of human behaviour, can no longer be grasped through any one theoretical system. Moreover, the multivariate system of investigation has now become more feasible than it ever was before in this field, because of recent advances in (for example) statistical techniques. But that does not mean that all the participants in an interdisciplinary team will always agree about what they observe, or (what is even more difficult) be able to communicate their results to each other and outsiders in a meaningful way. Dr. Gregg, in his preface to Kinsey's famous study of sexual behaviour, states this problem very well when he says:

"Seen from the four points of the compass a great mountain may present aspects that are very different one from the other - so different that bitter disagreement can arise between those who have watched the mountain, truly and well, through the seasons, but each from a different quarter.

1Rapaport, R. Community as a Doctor. Tavistock, Britain, 1960.
Reality, too, has many facets - some too readily disputed or denied by those who rely only on their own experience. Nor can science itself rightly lay claim to finality or the complete comprehension of reality, but only to honesty, and accuracy in the matter of the additional facets it may be permitted to discover and report. I say "may be permitted" since the human race is familiar with the suppression of truth in both small matters and great. The history of science is part of the history of the freedom to observe, to reflect, to experiment, to record, and to bear witness. It has been a perilous and a passionate history indeed, and not yet ended...."

With these general observations in mind, we can hardly wonder that the research director must plan to spend considerable time in coordinating the team members and their efforts. The fact that one of the problems in getting a research team to function is the general lack of mutual understanding of the other members' values, principles and goals, prompts one to ask if, in view of the social worker's role in community organization, he could likewise become a liaison among the members of the research team. The answer to this question depends on the perception of his function among the other members as well as on his ability and knowledge. It is possible for the social worker to obtain the cooperation of business executives who are discussing social problems, because they expect him to be an expert; but in scientific investigation the social worker's specific expertness is not generally accepted or even understood.


by the other team members. I do not mean that they should be expected to regard him as an expert in the methodology of scientific investigation, but rather than, in comparison with the other members of the team, the social worker is the expert in group work and in establishing a liaison between existing needs and resources. However, the social worker will not be able to utilize his ability unless he knows the "rules of the game that he is playing in the particular group". In other words, as coordinator on a research team, he must understand not only the goals and working method of the project as such, but also of the different approach which each discipline will make to the task in accordance with its particular intellectual orientations. Moreover, the social worker as a practitioner must be thoroughly conversant with the specific practical situation which is under examination.

As a research worker's capacity for making a contribution to research as such is the customary criterion for assessing his qualifications, we may have reason to fear, that, among the members of a multi-disciplinary team, the social worker will be "low man on the totem pole". This fact will of course exclude the social worker from any executive function.

In my own review of research projects of a multi-disciplinary nature, the social workers' roles appeared to vary in accordance with the leveled type of the project itself. Most research proceeds through a "pre-research" stage\(^1\),\(^2\) during which random

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observations are made about the relationships which have alerted the curious or critical mind. These random observations will usually permit more precise identification of the problems and the populations which need further exploration. The second stage has as its purpose that of formulating the hypotheses for testing and developing the strategies and priorities of data collection. During this stage the researcher will sharpen his sensitivity to the crucial variables, which as yet are not "controlled". At this point it is important that a prematurely fixed hypothesis should not blind the researchers to the elusiveness and diversity of their observations. They must be flexible and receptive to fresh suggestions.

From this point a research project can go in two directions. It might become a diagnostic or descriptive study of the kind which usually focuses on hypotheses at the level of statistical regularity. The emphasis here is on rigorous considerations of representativeness, sample size, and statistical tests of significance; but "control" is usually not involved.

The other type of research is the experimental study which is concerned with the testing of explicit hypotheses as to cause and effect relationships. The important variables are assumed to be known, and are rigorously controlled wherever possible.

While the experimental study begins in the same manner as the descriptive study, it might be that the latter will use some such method as that of participant observation, whereas the experimental study will always keep its observers outside the
social action of the observed universe. The reason is that the basic factors about which the hypotheses are formulated must not be "contaminated", and the control factors must be kept isolated. This prerequisite for scientific investigation (the non-interference) is difficult to accept for social workers, who see service as an integral and inherent part of their roles. Simmons, Freeman, Passamanick and James, who use social workers only as interviewers, have found that not all social workers have the ability to remain neutral and to accept that they are serving their clients well, although in a delayed manner, by refraining from service which would influence the testing.

In the "participant-descriptive" studies we have examined, e.g., the Oregon Study, the Minnesota Follow-Up Study, the Vermont Story and those executed by Fountain House and similar institutions, the social worker's contribution was so variable and uneven that one can draw almost no definite conclusions about the profession's proper role in such projects. However, one can show what social workers did do, what they failed to do and what they ought to try to do.

When the demonstration projects were headed by sociologists, relatively high expectations were set for a social work contribution, but unfortunately the social workers sometimes failed to respond. The workers in the field could not "spend their time" completing questionnaires or other necessary measuring instruments.

Moreover, they felt that service had to be given to all clients and that to set up "control groups" was both difficult
and unethical\(^1,2\).

The social workers on the research teams were both invited and expected to collaborate during the pre-research and explorative stages. Frequently, they showed lack of sophistication in formulating testable criteria, differentiating between known and unknown variables, constructing adequate controls, and solving problems involving statistical procedures. Some social workers who were able to learn and could remain on the job, turned out to be very good as soon as fundamental knowledge had become accepted, digested and internalized.

In "participant" studies directed by psychiatrists\(^3\), the composition of the research team was similar to the team we already know from mental health clinics, with the exception of the additional statistical specialists. Sometimes anthropologists also joined the team, but it was generally found difficult for sociologists and psychiatrists to work together in a treatment setting. Some studies also mention frictions between psychiatrists and non-psychiatric medical personnel. These conflicts are frequently centered on divergences in the acceptance of particular psychodynamic theories, and subsequently spill over into differences regarding decision-making prerogatives.

The medical profession has had a long tradition in team settings of holding the ultimate decision in its hands. Yet in


\(^2\) James, J. The Oregon Study of Rehabilitation of Mental Hospital Patients. Salem, Oregon Division of Vocational Rehabilitation, 1960.

mental health research it is arguable that psychiatrists have no real foundation for claiming this right. In those epidemiological studies where the knowledge of social scientists and psychiatrists was used in complementary fashion, this was the result of the psychiatrist's acceptance of a social science frame of reference.

Such changes in the attitude of the psychiatrist will have great importance for the social workers on the team. The long tradition of collaboration between social workers and physicians will induce the former to accept any changes sanctioned in the practice and theory of the latter.

The reports from the Vermont and the John Hopkins Studies bear testimony to the excellent work of the social workers in research, as well as to their competence in doing their own job. The novel features of research work as, for instance, the development and strict application of movement scales, the control of variables, and adherence to the rules of empirical investigation, were apparently accepted and understood very well by the social workers in these projects in contrast with the rejection and rebellion exhibited in the course of the Oregon and Minnesota investigations.

Many of the research projects reviewed for this study used social workers as "interview technicians". Usually the project director will drill his own investigators in the use of the instruments developed for the research. Some researchers have

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lauded the aptitude of social workers\(^1\) for this type of work, while others have felt that it was just as good, and more economical, to use volunteers or college students\(^2\). In several studies it was important that the interviewers should be able to work in the evenings so as to be sure of finding the respondent at home\(^3\); and this type of work is convenient for students who want to fit employment into their university schedules. Perhaps the schools of social work should encourage future social workers to join research teams while in college in order to get an "in-service-training" experience at an early date.

As the scientific investigation of mental illness depends upon obtaining data on the diverse social and medical factors implicated in numerous individual "careers", it is important to develop effective and valid methods of record keeping. The development of computer\(^4\) techniques has been of great importance not only for storing such information\(^5\),\(^6\) in a manner which makes the facts easily available, but also in facilitating correlation and correction of the data.

In June 1962, under the auspices of the National Institute


of Mental Health in the U.S.A., a conference on case registers of mental disorders was held in Bethesda\(^1\).

"The conference's purpose was (a) to review the ongoing psychiatric case registers in the U.S.A., their objectives, scope progress and preliminary findings; (b) to discuss common problems in collection, processing, and analysis of data and their solutions; and (c) to develop where possible comparability among registers in coverage of data collected, definitions, and analytical method, with the goal of designing cooperative studies."

While the state departments of vital statistics have for many years collected information about the patient population in mental institutions, very few records existed about mental patients treated privately. The recent acceleration in the development of psychiatric facilities, as well as the increased number of ex-patients living in the community but still receiving some form of social or medical service, have made such records mandatory. But they have also made it more difficult to collect and collate various reports which refer to the same individual. Moreover, mental disorders pose problems of definition and classification which are different from the problems faced in other types of medical care and medical research, and therefore require new solutions and a particularly sophisticated methodology.

As it is impossible to link reports on persons seen by different agencies unless the patient's name is reported, appropriate safeguards must be provided to protect the principle of

confidentiality. One such safeguard would, in my opinion, be the active interest of social workers in this important area of mental health management and research. Moreover, it has been found by the registration agencies that one formidable obstacle in keeping the information up to date is the lack of interest and the inadequate recording systems of the reporting agencies. Thus it appears to be very much to the point that social workers, who are specialists in the collection and assessment of social data, should study this new field in order to make what could clearly be an important contribution to it. For it should go without saying that research output can be not better than the quality of the data input.

This examination of research on the re-socialization of the ex-patient and of the development of new or extended services on his behalf, has, I think, shown that the social work contribution has in some ways been rather limited. It has seemed as if psychiatric social workers had restricted their function to individual psychotherapy in clinical settings and expected that "other agencies" would attend to the psychiatric problems which demanded intervention in the community or in the family setting.

There do exist a few interesting exceptions to this passive approach. A few clinics have experimented, after the Dutch example, with bringing the psychiatric team into the home in

1Freeman, V.J. "Dual Role of the Psychiatric Consultant in the Community" American Mental Association Archives of General Psychiatry. 1959, p.561.
time of crisis1,2,3. As it appears to be therapeutically strategie to treat the acute stages of mental illness at once and to avert hospitalization, these clinics have undertaken to provide immediate "home" services as soon as the case was referred to them. By using "all means known in the book", be they medical, social, psychiatric, psychological, financial or domestic, and by devoting all the time necessary, whenever it was demanded, to help a family, the team found that normal family life could be restored in more than 50 per cent of the referrals - and without such drastic interventions as the use of police, court or separation. In only 20 per cent of the cases was short term hospitalization used, but then only with the cooperation of the patient and the family, and without any form of compulsion. In about 10 per cent of the cases, an arrangement was made for the patient to change residence and to come to the day hospital for treatment. In the remaining 20 per cent of cases, the referring doctor refused to have the patient treated at home and demanded hospitalization.

In such circumstances as the last one mentioned in the last paragraph, the team approach could not be tried.

I think we must understand that it takes not only skill and knowledge but also courage to treat disturbed patients under the


unrestricted, critical and suspicious gaze of the local social environment. But it is my opinion that this courage will make a most powerful contribution towards increased popular understanding, acceptance and cooperation in the treatment of mental illness.

Dr. Chittick\(^1\) of Vermont has voiced the opinion that mental health institutions carry out continued research and program innovation if only because it is the most effective manner in which to convince patients, staff and community of the essential treatability of mental illness. Thus, even if research does not recommend itself to social workers on other grounds, a case can still be made for it as a symbolically dramatic way of communicating a mood of therapeutic hopefulness.

A candid and reasonably full assessment of the demands which the trends described above will make on social workers would require that we also examine the social worker's educational qualifications and the extent to which they presently enable him to meet such demands.

The recent Curriculum Study\(^2\) of the Council on Social Work Education has in general recommended that social work should utilize the findings of the behavioural sciences but develop a specific style of social work research. But it is difficult to understand how this should be done, and the Curriculum Study is not explicit on this point.


M. MacDonald, writing in the 1960 Social Work Yearbook (which is published by the American National Association of Social Workers) affirms the principle that "...the school of social work has primary responsibility for the development of resources for the adequate preparation of research workers." But what are the resources, and what is an adequate research worker. The scientific work usually published by the staff members of schools of social work, for example, rarely rises above the level of "Wisdom Research".

A few social work schools such as those attached to the Universities of Chicago, New York and California, have initiated and cultivated an association with the behavioural disciplines in order to provide their doctoral students with proper academic training and research experience. There seem to be signs that some leading social workers consider a renewal of their old acquaintance with the social scientists they "jilted" when social work became infatuated with psychoanalysts. Dr. Kahn\(^1\) goes so far as to make this observation:

"Social work in the coming years either must formulate and test its own knowledge on a substantial scale, supplementing it with critical use of social science knowledge, or it must surrender its professional functions to new and more rigorous disciplines, thereby assigning its practitioners to the role of useful technicians and abandoning the hope of attaining full professional status for the field. These two possibilities have long been recognized, but the time of choice has now arrived."

It is difficult to assess how many social work educators are facing this challenge. The list of doctoral theses, published each September in the Social Service Review, would indicate

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that the majority of social workers who take this, the highest formal education they can get, prefer to do "Wisdom Research". Is this an indication that some of the most accomplished students of social work, wishing to achieve the highest levels of professional scholarship have, even so, never found their existing theoretical resources questionable or meagre enough to warrant a modicum of hard, empirically-sound testing, or an energetic search for new knowledge? Or can it be that there is an antagonism between the understanding, accepting helper of the poor, the punctilious civil servant, or the devoted assistant to the physician, and an independent, critical search for the powerful and often unexpected social forces which determine human relationships? Or can it be that an occupation which aspires so ardently towards professional status does not think it wise to expose itself to the uncertainties of scientific discovery and prefers those safer prizes of acceptance which are bestowed on the conformist but refused to the inventor? One could continue to speculate but it would not solve the problems which are facing the community right now.
The purpose of this bibliography is to give the reader a view of current thinking and research on the treatment of the mentally ill. Emphasis has been placed on those publications which deal with factors known to be important in the re-socialization of the ex-patient.

A total of some 420 titles has been assembled, all of them containing information pertinent to social work with discharged mental hospital patients. In general, literature published prior to 1955 is not included, except in the case of standard texts or research monographs which have not been superseded or invalidated by work published since that date.

The titles have been grouped under topical headings in order to assist the reader who has some special interest.

5. Rehabilitation: Therapeutic Community, Milieu-Therapy, Re-socialization, After-Care, Home-Care (excluding Casework as such). Numbers 258-302, p.


11. Family Therapy Theories and Treatment Procedures. (The 50 titles mentioned in this section have all been mentioned under one of the previous categories.) P.

The following abbreviations are used:

A.J.O.  American Journal of Orthopsychiatry
A.J.P.H. American Journal of Public Health
A.J.P.  American Journal of Psychiatry
A.J.S.  American Journal of Sociology
A.S.R.  American Sociological Review
A.G.P.  Archives of General Psychiatry
C.M.H.A. Canadian Mental Health Association
C.P.A.J. Canadian Psychiatric Association Journal
I.J.S.P. International Journal of Social Psychiatry
J.A.E.P. Journal of Abnormal and Experimental Psychiatry
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<tr>
<th>Abbreviation</th>
<th>Title</th>
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<tr>
<td>J.M.N.D.</td>
<td>Journal of Mental and Nervous Diseases</td>
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<td>J.M.S.</td>
<td>Journal of Mental Science</td>
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<tr>
<td>J.S.I.</td>
<td>Journal of Social Issues</td>
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<tr>
<td>G.P.</td>
<td>Group Psychotherapy</td>
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<td>M.H.</td>
<td>Mental Hospital</td>
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<td>M. Hyg.</td>
<td>Mental Hygiene</td>
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<td>P.</td>
<td>Psychiatry</td>
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<td>P.Q.</td>
<td>Psychiatric Quarterly</td>
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<td>S.C.</td>
<td>Social Casework</td>
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<td>S.F.</td>
<td>Social Forces</td>
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<td>Social Problems</td>
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<td>S.S.R.</td>
<td>Social Service Review</td>
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<td>S.W.</td>
<td>Social Work</td>
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</tbody>
</table>
Theory: Anthropology, Sociology, Psychiatry, Psychology
(excluding Social Work) Nos. 1-125


Henry, George, M.D. *Sex Deviants, A Study of Homosexual Patterns.* Paul B. Hoeber Medical Book, Dept., Harper and Bros., N.Y., 1941.


Kubie, L. S. "Is Preventative Psychiatry Possible?" *Daedalus,* 88, no. 4, p. 646.


Ojeman, R. H. *Four Basic Aspects of Preventative Psychiatry*. University of Iowa, 1957.


Controversial Issues
Nos. 126-165


Zander, Alvin et al. Role Relations in the Mental Health Professions. University of Michigan, 1957.

Social Work Approach to Research, Treatment and Rehabilitation
Nos. 166-230


Crutcher, Hester B. *Foster Home Care for Mental Patients*. The Commonwealth Fund, N.Y., 1944.


Frisbie, L. V. "Treated Sex Offenders and What They Did." *M. Hyg.*, vol. 43, no. 2, April 1959, p. 263.


Lesser, W. "The Developing Role of Social Work in a Neuro-

Lifschutz, Joseph E. et al. "Psychiatric Consultation in a

Maas, P. "The Role of the Social Worker in Private Psychiatric

National Conference on Social Welfare. Mental Health and Social

Parad, H. Ego Psychology and Dynamic Casework. F.S.A.A., N.Y.,
1958.

Patton, G. O. "Foster Homes and Rehabilitation." Can. Psychiatric

Perlman, H. H. "The Role Concept and Social Casework."

Parad, H. Social Casework. University of Chicago Press,
Chicago, 1957.

Perretz, E. "The Principles involved in the Development of the
Social Work Components in Ontario Mental Health Services."  
S.W., vol. 29, April 1961.

Pettit, Lois. "Attitudes of Relatives of Long Hospitalized
Mental Patients Regarding Convalescent Leave." M. Hyg., 40,
1956, p. 251.

Polansky, A., ed. Social Work Research. University of Chicago

Rapoport, L. "In Defence of Social Work." S.S.R., vol. 34,
1960, p. 62.


Reynolds, Bertha C. "Mental Health Concepts in the Practice
and Teaching of Social Work" in Mental Health Material Center, 
ed., Integration of Mental Health Concepts with the Human

Rockmore, M. J. "A Psychiatric Social Worker in Community Mental
Health." S.W., 3, 1958, p. 86.

Schlesinger, E. A Quantitative Analysis of Social Casework
Services at the Crease Clinic. M.S.W. Thesis, University of
British Columbia, 1954.


Slear, G. "Psychiatric Patients Clinically Improved but Socially Disabled." S.W., vol. 4, April 1959, p. 64.


Mental Health: Background, Action, History, Biographies
Nos. 231-257


Rehabilitation: Therapeutic Community; Milieu-Therapy; Re-training; After-care; Home-care (excluding Casework)  

Nos. 258-302


Psychiatric Treatments: Organic, Drug, Shock, Psychotherapy

Nos. 303-320


Lawrence, J. "Termination of Treatment with Ataractic Drugs: A Rating Scale." Unpublished paper presented by Psychopharmacology Service Center of the National Institute of Mental Health, Bethesda, Maryland, Sept. 1960.


Epidemiology, Ecology and Etiology
Nos. 331-350


Langner, T. S. "Environmental Stress Degree of Psychiatric Impairment and Type of Mental Disturbance." Psychoanalysis and Psychoanalytical Revue, 47, Winter 1960, pp. 3-16.


My Name is Legion. Basic Books, N.Y., 1959.


Opler, Marvin K. "Epidemiological Studies of Mental Illness" in Symposium Walter Reed Institute Work, 1957.


Richman, A. et al. "Mental Hospital Results: Nineteenth and Twentieth Century Comparison." 3rd International Congress of Psychiatry, Montreal, 1961 (mimeographed copy)


Research Projects: Re-socialization Processes
Nos. 351-382.


Lawrence, J. "Termination of Treatment with Ataractic Drugs: A Rating Scale." Unpublished paper presented by Psychopharmacology Service Center of the National Institute of Mental Health, Bethesda, Maryland, Sept. 1960.


"The Mental Hospital and Marital Family Ties." S.P., 9, Fall 1961, pp. 141-55.


"Family Care Placement of Mental Patients." S.W., vol. 4, April 1959, p. 72.

Roles: Role Conflicts; Professional Roles; Attitudes; Alienation
(excluding Family Roles, per se)
Nos. 383-400


________. The Presentation of Self in Every Day Life. Double-day, N.Y., 1959.


Langner, T. S. "Environmental Stress Degree of Psychiatric Impairment and Type of Mental Disturbance." Psychoanalysis and Psychoanalytical Revue, 47, Winter 1960, pp. 3-16.


Linn, E. G. "Drug Therapy in Milieu Change and Release from Mental Hospital." American Medical Association Archives of Neurology and Psychiatry, no. 81, 1961, p. 785.


Zander, Alvin et al. Role Relations in the Mental Health Professions. University of Michigan, 1957.

Statistics and Research Procedures
Nos. 401-428


Canadian Mental Health. A monthly publication by the Federal Mental Health Department, Ottawa.


New Brunswick. "Report of Mental Health Services, 1961" (mimeographed copy).

Newfoundland. "Report of Mental Health Services, 1961" (mimeographed copy).


**Family Therapy**


Rose, C. L. "Relatives' Attitude and Mental Hospitalization." *M. Hyg.*, vol. 43, April 1959, pp. 194-204.


"The Mental Hospital and Marital Family Ties." S.P., 9, Fall 1961, pp. 141-55.


