ADMISSIONS POLICY FOR AN INSTITUTION FOR THE SENILE

A Study of Formal and Informal Criteria for Admission to Valleyview Hospital Essondale, B.C., 1960-61

by

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Programs and facilities necessary for the proper care and treatment of the senile are many and varied. This study is concerned with one of the institutional resources: the policies and procedures governing admission to Valleyview Hospital, an institution designed specifically for the aged with other disabilities of senility.

To apply "operational" tests to policy and procedure, a sample of (30) applicants from the waiting list were selected for study, the purposes being (a) to determine what factors were operative in securing admission, (b) how the stated criteria for assessing priority of admission were utilized.

A number of special personal circumstances affected the appropriateness of the group. Apart from this, it was found that the formal criteria for acceptance of applications to the hospital are employed with reasonable consistency, when measured against the time an individual applicant spends on the waiting list. It was also found that when a community agency initiated the application, admission was granted after relatively short periods on the waiting list, if there was no other resource readily available.

From this study, the roles of the social worker in pre-admission services can be delineated as (a) helping the applicant to find other forms of care over the waiting period, (b) helping the Medical Superintendent to assess priorities for admission, and (c) helping applicants and families to accept the need for hospitalization when this is justifiable.

Recommendations for needed changes in procedures and in legislation are made, particularly in the present cumbersome application arrangements, which require certification of the applicant as mentally ill before an application can be placed on the waiting list. Development in the community of specialized types of boarding and nursing homes for the care of the less severely handicapped by emotional and behavioural disturbances is also recommended.
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CHAPTER I

THE AGED AND MENTAL ILLNESS

Changes in the structure of the populations of the countries of Western Europe and North America have given rise to a great many problems, one of the most urgent of which is the large and increasing number of persons surviving into old age with accompanying hazard of economic dependency, physical and mental deterioration, and social isolation. The extent and significance of this problem can only be seen in reference to the historical and demographic changes of the past two centuries.

During the nineteenth century the populations of the countries of Western Europe and North America experienced a very considerable expansion. Early in the twentieth century, however, a sharp decline in the birth rate set in. This was offset to some extent by a reduction in infant and child mortality, but, nevertheless, the proportion of aged persons to younger persons has risen dramatically.
Table 1. Population Trends in British Columbia

<table>
<thead>
<tr>
<th>Year</th>
<th>Persons Aged 65 Years and Over, per 1000 Population</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1940</td>
<td>64.9</td>
<td>8.1</td>
</tr>
<tr>
<td>1955</td>
<td>142.8</td>
<td>10.9</td>
</tr>
<tr>
<td>1960</td>
<td>158.6</td>
<td>10.0</td>
</tr>
<tr>
<td>1961</td>
<td>186.2</td>
<td>7.0</td>
</tr>
</tbody>
</table>

According to one authoritative source, it is possible to distinguish several typical cycles of population growth. In the first stage, a high birth-rate is in approximate balance with a high death-rate. Most of Africa, Indonesia and parts of South America are presently at this stage of population growth. After this stage, the population starts to expand, as the death-rate begins to decline while the birth-rate is still quite high, as is the case in many Asian countries. In the third stage, the birth-rate begins to decline, but not to the extent that it again equals the death-rate. Thus the population still grows, though not so rapidly as in the second stage. This


is the case in the USSR, Eastern Europe and Japan. Eventually, the birth-rate falls to the point of equalizing, and equalizing a low death-rate, and the population reaches a stable level.

The countries of Western Europe and North America are reaching the end of the third phase, and just entering the fourth, or more stable level, which will not be fully realized for several decades yet, according to the present birth-rate trends and current mortality figures. Therefore, the proportion of people over the age of 65 years must be expected to go on rising for a considerable time.

Paralleling the tremendous increase in the proportion of persons over 65 years of age over the past hundred years there have been striking changes in cultural attitudes and institutional arrangements surrounding the problems of the dependent aged. Within Western Europe, until about the end of the eighteenth century, there existed a predominantly rural, patriarchal type of social organization. Families were, for the most part, large, and recognized obligations existed within the extended kinship group to care for aged and dependent members. Since the proportion of old people was fairly small, this presented no insurmountable problem. Moreover, in a rural economy, not characterized by hand labour, the old person
could carry on productively at his accustomed tasks long after his counterpart today is forcibly "retired" or finds it impossible to secure work because of his obsolescent skills.

With the rise of industrialization and urbanization at the end of the eighteenth and beginning of the nineteenth centuries the whole structure of family life began to change. Housing patterns changed from the self-contained unit providing space, however limited, for all members of a family in the setting in which they and their parents for generations had lived, through the eras of apartment and tenement living to today's small, subdivision house, providing space only for the nuclear, two-generation family. Increasing mobility has undermined traditions of "rooted" community living. Parents and adult children frequently live far apart; usually at least in separate areas of a city, as the adult children tend to move out to suburban developments. It has become very difficult in most cases for an adult child to give the kind of care and supervision many old people require.

The first half of the twentieth century has seen great changes in the expectations which people hold regarding the degree of responsibility for self-support in old age, both for their own, and for parents and relatives. The nineteenth century was noted for equating self-support
with moral worth. It was expected that the upright individual would provide for his own old age, and that of his dependents by means of his own industry. Industrialization takes away the worker's control over his productivity, so that he may very well have no chance to save for his old age. Many persons are unable to face the possibility of a lengthy, unproductive old age, and make no provision for it. In response to these changes the government has gradually extended its services and controls over many areas formerly regarded as the exclusive responsibility of the family, interested neighbours or charity. Gradually, the concept that society has a concern and responsibility for the dependency which often accompanies old age has grown up with a resulting network of services which help, in part, to fill the vacancy left by the breakdown of the self-contained, self-regulating, responsible, extended family system.

Paralleling these changes in expectations regarding responsibility for the care of the elderly, many changes in the social and economic opportunities available to the older person have occurred. A society that bases its delegations of status on the acquisition of the exterior signs of material success cannot fail to affect adversely those of its members who fail to, or can no longer, maintain evidence of continuing prosperity. Many aspects of North American culture tend to decrease
the status and minimize the potential or available activities and satisfactions of older-age groups in our society. Retirement means, in perhaps the great majority of cases, a loss of meaningful activity which has provided much satisfaction and prestige in the past. It also means deprivation of a source of social contact, and a more or less severe curtailment of income. The high population mobility that characterizes the North American culture tends to increase the isolation of the individual; this is particularly significant for the aging individual who lacks resources, and, often, physical strength and psychological flexibility to pursue new social contacts aggressively. On another level, the very cultural climate in which he now lives has changed radically from that to which he was accustomed in his youth and middle age. The external world may appear as vastly different in its customs and attributes, even when he remains in a setting long familiar to him. The aging individual, all too often, becomes progressively more isolated from contact with his surroundings as these become more and more devoid of interest or satisfaction to him.

The Aging Process

Clearly, the life situation of the aged person in North American society is subject to a number of stresses both different and more severe than any experienced
by the individual in his earlier life. Besides the social and economic reverses that the aging person may meet, and which have already been referred to, there are physiological and psychological aspects of the aging process that are inevitable for everyone, although each individual's reaction will, necessarily, differ. According to one definition:

The term 'aging process', as applied to living organisms, is the genetically determined, progressive, and essentially irreversible diminution with the passage of time of the ability of an organism or one of its parts to adapt to its environment, manifested as diminution of its reserve capacity to withstand the stresses to which it is subjected, and culminating in the death of the organism.

Many characteristic physiological and anatomical changes occur in the aging process, some of which are reflected in altered functioning in the elderly individual. Losses in hearing and vision diminish contact with reality, which may be manifested in subtle ways. For example Dr. Ewald Busse cites the common clinical observation that patients who are afflicted with a relatively sudden loss

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1 Busse, Ewald M.D., "What is a Realistic Attitude in Regard to Research in Aging?" First National Conference of the Joint Council to Improve the Health Care of the Aged, Washington, D. C., 1959, p. 6.

of hearing frequently become discouraged and depressed, and that suspiciousness and paranoid behaviour may appear later. C. Eisdorfer\textsuperscript{1} found that there was a significant difference in the Rorschach responses of normal subjects and in those with impaired hearing or with impaired hearing and visual disabilities, although there was no discernible difference in those subjects who had uncorrected impaired vision when compared with normal subjects. (None of these subjects approached total blindness, and all were functioning in the community.) Ramsdell\textsuperscript{2} divided hearing into three levels. The first is the social level, used to comprehend language. The second level or warning level, is that which includes sounds having the connotation of danger. The third or background level, is the primitive level of hearing, which plays a role in our emotional functioning. The deaf person has lost this bridge to reality, and feels the loss of this contact with the living world about him.

Cerebral arteriosclerotic changes are almost uniformly found in the brains of aged persons, but there seems to be no consistent correlation between the degree

\textsuperscript{1} Eisdorfer, C., "Rorschach Developmental Levels and Sensory Impairment in an Aged Population," (to be published).

of arteriosclerotic change, and changes in observed functioning. D. Rothschild\(^1\) demonstrated that the brains of elderly people who have shown normal mental functioning until the time of death often contain senile plaques. These senile plaques are similar to those found in patients with so-called senile dementia. Although he found that the number of plaques tend to correlate with the degree of mental impairment, the correlation is far from a consistent reliable one.

Accompanying this generalized waning in physical adaptability and resources is a corresponding decrease in the amount of psychic energy available to the aging person for the purpose of maintaining his defenses against repressed impulses. Dr. Maurice Linden\(^2\) describes how the elder-rejecting attitudes so current in our culture may be applied by the elderly person to himself, resulting in self-rejection, and initiating a progressive breakdown of personality structure.

The cyclic sequences of social and psychological events that produce elder-discardling attitudes in our society


2 Linden, Maurice M.D., "Emotional Problems in Aging," *The Jewish Social Service Quarterly*, vol. 31, No. 1 (Fall 1954).
eventuate in the lonely and depressed state that progresses into the 'senile decline'. A feeling of isolation, friendlessness, uselessness, lowered self esteem, and reduced self confidence follows. The anxiety and terror thus generated develop into a passively suicidal frame of mind. Much mental energy is then mobilized by the emotionally disturbed aged for the purpose of attempting to re-establish shattered defenses. The mind thus occupied with repairing itself becomes further isolated from the external environment. At the same time the deep panic within accompanied by frenzied efforts at reconstruction propel the individual to a state of exhaustion. This is seen clinically as torpor, lassitude, waning alertness, memory impairment, confusion, disorientation, and feeble restlessness.

According to Dr. Linden, the emotional disturbances of aging are neurotically and culturally induced, and as such, are to a certain degree accessible to treatment, both psychiatric and social, and to changes in social attitudes toward the aged.

H. Warren Dunham has pointed out that the rates of admissions to mental hospitals of persons 65 years of age and older are much higher for the Middle Atlantic states, the New England area and the Pacific states than for any other regions in the United States. This finding,

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1 Linden, op. cit.

he states, "points to the fact that in the older and more urbanized sections of the country where the institution of the family has undergone its greatest strains and tensions are to be found the largest numbers of older people suffering from mental disorders. The high rate in the Pacific area is, no doubt, a partial reflection of the number of older people who have migrated to this section from the Middle Western states. Conversely, the low rates in those divisions most rural in character possibly reflect the traditional tendency of an agricultural people to care for its aged."

He found the same picture repeated when he analysed the rates of admissions to mental hospitals for arteriosclerotic disease and senile psychoses.

The Problem of Mental Illness Among the Aged

The aged in our society are subjected to a number of stresses, both internal and external. Decline in physical capacity, including important losses in ability to communicate with the outer world, may be, considered an inevitable concomitant of the aging process, although advances in medical knowledge and technology can often alleviate defects in some degree at least. Culturally, the aged are subjected to what are often even more threatening losses, such as the dissolution of family ties,

1 Dunham, op. cit., p. 120.
the loss of jobs for men, and the important roles of wife and mother, for women; economic deprivation and changes in standards of living and the losses of prestige and self-respect that so frequently accompany retirement.

The ego of the aging person, therefore, is confronted with an almost overwhelming job in its attempts to maintain a psychic homeostasis. Pathological symptoms appear as a result of the ego's attempts to maintain its integrity. Weinberg\(^1\) divides the symptoms that most frequently occur in the mentally ill aged into three categories; exclusion of stimuli, conservation of energy, and regression. Exclusion of stimuli he thinks, results from the organism's lowered capacity to deal with complex stimuli, both physical and psychological. Exclusion of stimuli, together with conservation of energy, tend to narrow the individual's ability to react appropriately to changing circumstances. Regression—the gradual decline to much earlier, even infantile modes of adjustment and behaviour—tends to make the individual more and more dependent on others, and in need of care and supervision.

It is readily apparent that no one cause can be

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found to explain decline in functioning in the elderly in our culture. It is difficult to find any agreement among writers on the subject as to the point at which the decline in functioning amounts to mental illness. A study in California in 1950 indicated that 35 per cent of the patients who were over 60 years when admitted to a state mental hospital were non-psychotic. A study by J. Florwers and Walter Fox in 1957 examined a group of 40 patients aged 65 and over which was 19.7 per cent of all admissions during the period studied. Of these 40 admissions, only 45 per cent were justifiable admissions, i.e. with a definite need for mental hospital care. Thirty-seven and a half per cent were reported as of questionable justification, because the pre-admission history was not confirmed by the patient's condition at admission. Seventeen and a half per cent were without justification for admission to a psychiatric facility. A further group of 40 admissions were examined by Peters and Fox in 1958, and after these patients had undergone observation on the wards, it was found that 50 per cent were non-justifiable

1 "Background Material on the Aging Population," Mental Hospitals Institute on the Psychiatric Problems of the Aging and of the Aging Mental Defective, mimeographed.

2 Ibid.

3 Ibid.
admissions, and were in need of nursing or boarding-home care only.

In view of these findings, and similar findings in numerous other studies, it is obvious that a very real problem exists in defining and providing adequate and suitable forms of care for the varied types of breakdown in social and mental functioning among the aged in our population. One portion of the problem is the determination of criteria for admission to a mental hospital for the aged. How can it best be decided whether admission to a mental hospital is a suitable, necessary and beneficial form of treatment for a particular, aged individual? What are the procedures of admission to this kind of hospital? How does the hospital see its function, and how can it specify which individuals are to be admitted as patients? If the hospital must resort to a waiting-list for applicants, how does it assess priority of need?

In order to suggest some answers to these questions, this thesis will examine the provisions made in British Columbia for the care of the mentally ill, aged, and will describe admission policies and procedures in effect with the Geriatric Division of the Provincial Mental Health Services.
The Geriatric Division

There are three units in the Geriatric Division of the Provincial Mental Health Services, Valleyview Hospital at Essondale, Dellview Hospital at Vernon, and Skeenaview Hospital at Terrace. Dellview Hospital has accommodation for 110 male patients and 139 women. Skeenaview Hospital has accommodation for 300 male patients only. Valleyview Hospital has presently a bed capacity of 808, including 278 male beds, and 530 female beds. Two older buildings, Valleyview 1 and Valleyview 10 are presently unoccupied and awaiting renovation. When this is completed an additional 100 beds will be available. There are, therefore, a total of 1357 beds in the Geriatric Division, of which 688 are for men, and 669 are for women. All these units operate under the Mental Hospitals Act for the specific purpose of providing care and treatment for elderly men and women, suffering from mental, emotional or behavioural disturbances consequent to senile or arteriosclerotic brain disease.

Dellview and Skeenaview Hospitals were formerly military hospitals converted for the use of geriatric patients. Both hospitals offer ample space for patients who are able to walk, and both provide opportunities for light work on their grounds for those who can benefit from it. There are no trained recreational or occupational
therapists on either staff, but the nursing staff attempt some programming in these areas, and groups of volunteers are active. Medical practitioners in the community under contract to the Mental Health Services give medical care and supervision. Patients must be transferred to general hospitals in the community whenever any extensive medical treatment is necessary.

**Valleyview Hospital**

Valleyview Hospital is the largest unit of the three, with sixteen wards, housed in eight buildings. The beautiful Valleyview Building was opened in May, 1959. It was designed to serve as the Admitting and Infirmary building, providing 328 beds, equally divided for men and women into six wards, two of which are specifically admitting wards. The other four wards are infirmary wards for patients whose physical condition necessitates a considerable degree of nursing care. Valleyview Building also houses the administrative offices, X-ray and laboratory departments, physiotherapy and occupational therapy departments, the main kitchen and dining room, house-keeping services, business office, beauty parlour and the dentist's office. The Auditorium and Chapel are in a separate building and provide facilities for religious services and a wide array of social and recreational activities. The recreational department is housed in a
separate building, the Valleyview Lodge. In this building the Canadian Mental Health Association volunteers run a small restaurant, lounge, and tuck shop where patients may go to dine if they wish. This is a particularly pleasant facility as patients may also entertain their visitors there rather than in the visiting rooms provided on the wards. Valleyview Lodge was at one time a Nurses' Home for the Home for the Aged, and later became the site of the administrative offices for the hospital. The C.M.H.A. hopes to convert the upper floor to a residential centre for visitors who come from long distances to see Valleyview patients.

Visiting of patients by friends and relatives is strongly encouraged. Daily visiting hours are from 2 - 4 p.m. every day, and from 7 - 9 p.m. on Tuesday evenings. Visitors are encouraged to take patients out for car rides or weekends home. Weekend and longer leaves of absence are granted whenever the patient's doctor feels it may be beneficial.

The administrator of the hospital is Dr. B. F. Bryson, the Medical Superintendent. Under him are three physicians who carry responsibility for the medical care of the patients. Consultative services from the consultant staff at Crease Clinic and the Provincial Mental Hospital are available, and patients are transferred to
Crease Clinic or P.M.H. whenever extensive investigation or surgery are necessary. There is a full-time Protestant chaplain, who is assisted by the part-time services of a Roman Catholic priest from the community. The Business Manager has a staff of four; there are a dentist, x-ray technician, and three occupational therapists. There are two recreational therapists, a vacancy for a physiotherapist, a druggist, and a laboratory technician. There are establishments for three social workers, and the positions are filled. There is also a qualified dietician, housekeeper, and a medical records stenographic pool of four.

The Director of Nursing is both a registered nurse and a graduate psychiatric nurse. Under her is the Assistant Director of Nursing, a psychiatric nurse. There are nine supervisors, six of whom are registered nurses, and three of whom are psychiatric nurses. There are three Head Nurses who are registered nurses, and eleven Charge Nurses who are psychiatric nurses. There are a total of 187 psychiatric nurses on the ward staffs, of whom 104 are women and 46 are men. No male nurses or aides work in the women's wards, a few female nurses and aides work on the men's wards.

The specific function of the Geriatric Division has been summarized in a memorandum by the medical
Although the approach to the treatment of emotional disorders of the elderly person differs little to that of the younger psychiatric patient, the special problems, both physical and mental which come with aging, make it desirable to have special geriatric wards for their care. The older person requires a slower pace of life, and much patience and understanding is demanded of the staff who must be tolerant of the physical infirmities, and the mental confusion and memory disturbances which come with normal aging. Treatments and rehabilitation is sought for every patient admitted and every effort is made to preserve mental and physical health, to treat specific emotional disturbances and to find ways to stimulate the patients to develop interests, no matter how simple, which will give each patient a sense of belonging and friendship, a feeling of security and well-being, and a renewed belief that he is needed and can still contribute to the welfare of his friends...

There are always more requests for admission to the Geriatric Division of the Provincial Mental Health Services than can be immediately accommodated. All applications for admission to Valleyview Hospital of patients 70 years of age and older must, under Order-in-Council No. 1124, be approved by the medical superintendent of Valleyview Hospital. Under certain circumstances, however, the admission of a patient 70 years of age or older, to Crease Clinic or to the Provincial Mental Hospital may be approved by the responsible medical superintendents of those hospitals.
The Annual Report of the Mental Health Services of the Province of British Columbia for the twelve months ended March 31, 1961, lists a total of 406 new applications for admission to the Geriatric Division. Of these requests, 304 were for admission to Valleyview Hospital, as the patients concerned were from the Lower Mainland and Vancouver Island. Requests for admission to Dellview Hospital were 91, mainly from the Okanagan and Kootenay areas. From the northern sections of the province, there were 11 applications for admission to Skeenaview Hospital.

Method of Study

This thesis examines the policies and procedures of admission to Valleyview Hospital, and describes its facilities for the care of aged persons who are mentally ill. It describes the formal and informal criteria for admission, and describes the contributions which the social worker can make in assessing priorities for admission, and in arranging alternate forms of care where these may be seen as preferable.

For this study, thirty cases were selected from the waiting list of December 31, 1961, which is one-third of the applicants at that time. Thirty cases were selected as the greatest number of which any detailed examination could be made. A "random" selection, of every third name
An examination was made of relevant social data in each case, i.e., age group, sex, marital status, availability of interested relative or friend, financial status, living arrangements, and information available at application. Each case was classified as to length of time elapsed between date of application, date of admission, and formal criteria under which admission was approved. An effort was made to determine whether any other criteria were involved in ensuring early admission.

A review of the patient's situation was made on June 30, 1961 to determine progress after admission, and whether the apparent need for admission was validated after hospital investigation of the patient.

This material was obtained from a study of each patient's application file, hospital file where admitted, Social Service Department file where contact had been made, consultation with medical and nursing staff, and personal interview with patients and relatives where necessary.

The purpose of this review is to assess the criteria under which applicants are accepted for admission and to develop from this a more informed appraisal of both pre-admission assessment and treatment of appropriate applicants.
CHAPTER II

ADMISSION POLICIES OF VALLEYVIEW HOSPITAL

In 1936 a recognition of the need to give separate care for older, mentally ill patients, combined with a very urgent need for more bed space for mental patients, led to the development of the Provincial Home for the Aged, situated one mile east of the Provincial Mental Hospital on the Essondale grounds. This was known as the Provincial Home for the Aged, Port Coquitlam, B. C. The Provincial Home for the Aged Act was proclaimed, and the Medical Superintendent of the Provincial Mental Hospital was named as the Medical Superintendent of the Provincial Home for the Aged. A number of buildings were released from the Boys' Industrial School for the use of the new branch of the Mental Hospital. Three wards, a nurses' home and a kitchen and dining room were housed in four separate buildings.

In 1946 a more modern building was erected for two women's wards, and in 1947 another building on the same plan was built to provide two additional wards for men. In 1948 the Vernon Home for the Aged was opened,
giving accommodation for 239 patients, 129 female and 110 male, with a medical superintendent appointed. In 1949 two new wards for women were built at the Port Coquitlam unit.

In 1950 the need became apparent to establish some control over the many elderly patients being admitted to mental hospitals in British Columbia. Accordingly, an amendment to the Mental Hospital Act was passed by Order-in-Council Number 1124 on May 16, 1951, which stated, in part, "No person over the age of seventy years shall be admitted to any public mental hospital in the Province unless the Medical Superintendent is satisfied that such person requires care and treatment in a hospital for the mentally ill." This amendment is still in force today.

Its effect is to add a brake on actual admissions to the hospital. There are always so many more applications than there are beds available that the hospital cannot accept all immediately; many are far more urgent than others, so there is a need for the medical superintendent to establish priorities. In addition, many confused, disoriented old persons, though certifiable, and therefore, theoretically at least, mentally ill, do not need mental hospital care, but can be placed quite successfully in other forms of care, according to their individual need.
In 1950 the Terrace Home for the Aged was opened, giving accommodation to 300 male patients only. Dr. T. G. Caunt was appointed full-time Medical Superintendent with jurisdiction over the Port Coquitlam, Vernon and Terrace Homes for the Aged. This was the first time that the Homes for the Aged had not been administered entirely from the Provincial Mental Hospital. Dr. Caunt was also assigned the responsibility for implementing the amendment noted above.

In 1952, in October, Dr. B. F. Bryson became Medical Superintendent for the Homes for the Aged. In 1954, in realization of the need for many more beds and improved facilities at the Home for the Aged in Port Coquitlam, plans were laid for a 300 bed Admitting and Infirmary Unit. In March, 1959, this new building was occupied, and was named the Valleyview Building. During this year the concept of "Unitization" was stated by Dr. A. Davidson, the Deputy Minister of Mental Health Services. "Unitization" is the process by which the varying units, formerly centrally administered, would become relatively independent entities, within the overall structure of the Mental Health Services Branch. The hospital was re-organized to the extent that its administration and staffing became more sharply differentiated from that of the Provincial Mental Hospital and Crease
Clinic than had previously been the case. The hospitals at Port Coquitlam, Vernon and Terrace now form an independent unit of the Provincial Mental Health Services, under the administration of Dr. Bryson.

On January 1, 1960, the Provincial Home for the Aged Act was repealed, and the unit was brought under the jurisdiction of the Mental Hospitals Act. New names were established for the three units. The Provincial Home for the Aged, Port Coquitlam, became Valleyview Hospital, Essondale, B. C., The Vernon Home for the Aged became Dellview Hospital, Vernon, B. C., still with a bed capacity of 239, and the Terrace Home for the Aged became Skeenaview Hospital, Terrace, B. C., still with a bed capacity of 300.

A number of advantages accrued when the Provincial Homes for the Aged Act was repealed, and the homes came under the jurisdiction of the Mental Hospital Act. Transfers of patients between, for example, the Provincial Mental Hospital and Valleyview Hospital, or between Valleyview and Dellview and Skeenaview, became much simpler, and could be arranged according to the needs of the individual patient. This occurs because now that all patients are being treated under the same legislative act, they do not require re-committal or re-certification to conform with the requirements of the Homes for the Aged Act.

In addition, patients can be granted the privilege
of probation, when, in the opinion of the Medical Superintend­
tendent, they have improved sufficiently during treatment in hospital to receive a probational discharge. The advantage of this lies in the fact that for six months following this form of discharge they may return to hos-
pital without the need for any further certifying documents or waiting period, if, in the opinion of the Medical Superintendent their condition is such that they require immediate re-hospitalization. A further advantage in coming in under the Mental Hospitals Act lies in the fact that the privilege of appeal became available to persons in the geriatric units, a privilege which was not granted under the Provincial Homes for the Aged Act. That is to say, that at any time after three months after committal to the mental hospital any patient may request to be examined by two doctors who are not members of the staff of the staff of the mental hospital, and who have no con­nection with the institution. If in their opinion it is desirable, they may revoke the committal to the mental hospital. The patient is then, automatically, free to return to the community.

The changes in name, from the Provincial Homes for the Aged to Valleyview, Dellview and Skeenaview Hospital crystallized a change in concept of the functions of the institutions, from being a "repository for old people", to an active treatment centre. The introduction
of the tranquillizing medications, and their widespread use in the past decade has made a tremendous change in treatment of all mentally ill patients. Weakening of the ego-structure with its defenses is often a part of the aging process, and the particular benefit of this form of medication lies in its effect on the flare-ups of anxiety, anger and aggression that are so often seen in these patients.

A no less important result of the success of the ataractics is the changed, more hopeful attitudes of staff toward patients who were formerly seen as uncontrollable behaviour problems. Thus the concept of active treatment rather than custodial care has come to be a more attainable goal.

Admission Policies: Who is Eligible for Treatment?

Eligibility for admission to the geriatric hospitals for the mentally ill, has been defined as all residents of British Columbia who have been judged to be suffering from mental illness and changes associated with old age, and for whom valid certifying documents have been received and who have been approved for admission by the Medical Superintendent of Valleyview Hospital, acting under the authority delegated him by the Mental Hospitals Act. These persons are, in the opinions of the two
certifying doctors, and the committing judge, suffering from chronic brain syndrome due to senile or arteriosclerotic brain disease associated with neurotic, psychotic or behavioural reactions. Residents of British Columbia over seventy years of age cannot be admitted to a mental hospital until the Medical Superintendent of that hospital has given his approval as outlined in Order-in-Council No. 1124.

This order-in-council specifically exempts mentally ill persons considered to be dangerous or mentally ill convicts. Unfortunately it does not define "dangerous", but the policy is that where persons are considered by a community agency, such as the referring doctor, magistrate, the police or the social agency concerned, to be likely to be really aggressive towards others, careless with fire or otherwise capable of endangering themselves or others, every effort is made towards granting immediate admission to Valleyview Hospital. Where this cannot be arranged, because of a bed shortage, admission is usually granted by the Provincial Mental Hospital. Where a patient is suffering from what his doctor judges to be a more or less acute psychiatric illness which might be treated best in Crease Clinic, admission may be first sought there.

Admission

There are two types of admission to the geriatric
units of the Provincial Mental Health Service, (a) from the community or (b) from other units of the Provincial Mental Health Services. In the official policy statement for the Mental Hospitals for the Aged, admission policy is defined. There are always many more applications for admission to hospital than can be serviced immediately, and so there is always a backlog of applications on the waiting list. Priorities for admission have been set up, so that the more urgent cases do not have to undergo the lengthy waiting period to which less urgent cases are subjected. The priority granted an application for admission depends on the following factors:

(1) The urgency of the case situation in relation to:
   (a) Behaviour and condition of the patient.
   (b) Effect of the patient's condition and behaviour on marital partners, children, other family members, neighbours or community in general.
   (c) Financial burden on family of patient's present care and supervision.

(2) Availability of beds in the Geriatric Division.

(3) Length of time the patient's name has been on the waiting list.
The following cases illustrate the application of these factors.

Case 1

Mrs. New's name was placed on the waiting list for admission to Valleyview Hospital by her husband. She was 74, and living alone with her 70 year old husband in a Fraser Valley community. One of the Victorian Order nurses who had been seeing Mrs. New once a week for two years had instigated the application procedure, when she brought Mrs. New's condition to the attention of a doctor.

The nurse stated that she was usually, though not always, able to persuade Mrs. New to take a bath and change her clothes. This was the only occasion on which Mrs. New received any personal care, as she was quite unable to care for herself, and refused any offers of help from her husband. She was physically very active, and would often wander about on the highway. The nurse said that Mrs. New would occasionally go out on the street naked, and would urinate by the roadside.

After the application forms had been sent in, the hospital social worker visited the News in their home. Mrs. New was wandering about alone in the house, and eventually came to the door. She greeted the worker pleasantly, and took her into the bedroom to introduce her
to the "lady in the mirror" who was, of course, herself. She was dressed only in a cotton dress, open down the front, and a man's old tweed jacket. Her feet and legs were bare.

Mr. New came home after about half an hour. He was an active, pleasant man of 70, who described himself as "getting a little forgetful". He said that whenever he went into town to shop his wife would wander away. Sometimes she would slip out the door and trot down the street towards the highway if he went into another room. His main worry, however, was that he had to go into hospital for some extensive surgery, and there was no one to care for his wife.

Mrs. New might have been a candidate for boarding home care had she not been in the habit of running away. Where this has developed as a pattern in the home, it is unlikely that transfer to a boarding home will do anything but accentuate the tendency. This is too great a risk for a boarding home operator to take in the case of a physically active woman. She was therefore classified as requiring early admission under Criterion 1(a).

Case 2

Mr. Smith's application was initiated by his daughter, who signed the "A" form. He was living alone
with his frail wife, who had refused to consider placement of her husband, as she felt strongly that it was her duty to care for him and she feared the loneliness of living by herself.

According to the daughter, her father had always had a bad temper, but after a few small, recent strokes, had become violent. He frequently hit and kicked his wife, who, however, would never complain against her husband, and who tried to hide her bruises from the children. All the children were married and with their own family responsibilities; none could give the constant supervision their father now required. A week before the application was made, the father had attacked a visiting son, nearly succeeding in knocking him downstairs. The family was afraid that he might seriously injure or kill his wife. They had attempted to find a nursing home, but could find none which would accept him. Medication had been prescribed for him, but he refused to take it, and the wife was unable to administer it.

Mr. Smith was classified as requiring early admission under Criterion 1(b).

Case 3

Mr. French's "A" form was signed by his son.
He was married, and had been a patient in a private nursing home for six months, before his transfer home. His behaviour had changed radically following a stroke, and his wife could not care for him, because of his aggressive, confused behaviour, although he no longer really required nursing home care.

The son's reason for requesting admission was that, although the mother would not sign the "A" form, she would impoverish herself by attempting to pay for her husband's care in the nursing home, as he would have to be removed there again shortly. The Social Welfare Branch could do nothing until the couple's resources were exhausted; then they could finance Mr. French's nursing home care, and place Mrs. French on Social Assistance.

Mr. French's necessary care and treatment would place a severe burden on the family's finances, and he was classified as requiring admission under Criterion 1(c).

Case 4

Mrs. Norris's application was initiated by a police department, as no known relative or friend could be found. Mrs. Norris had been found wandering, nearly naked and in a condition of starvation, and had been taken to a hospital. She spent only a few days there however when the police arranged for her committal to
the Provincial Mental Hospital. As she was considered more suitable for Valleyview care, the Medical Superintendant agreed to accept her as a transferred patient, under Criterion 2.

Case 5

Mrs. Andrew's application for admission was signed by her son. She resided in a small town at some distance from the hospital, so the branch office of the Department of Social Welfare was requested to prepare an evaluation of her social situation. The assessment indicated that she lived with her son, a War Veteran's Allowance pensioner who was still able to care for her. He stated that his mother refused to give up her pension cheque to help pay their expenses, and refused to move to a nursing or boarding home, so certification was required. The district social worker found that there was no urgency in this woman's need for care and treatment, so she was placed on the waiting list with priority under Criterion 3, and will presumably be admitted when a bed, not urgently required elsewhere, is available. She was not admitted during the study period.

Admission Procedure

There is a definite procedure in making application for admission to the geriatric unit. One form
entitled "Application for an Order for the Admission of a Patient to a Public or Private Mental Hospital or to a Provincial Clinic of Psychological Medicine", or, more simply, as Form A is completed by the responsible relative of the patient. If no relative is available to sign this form, it may be submitted by a friend of the prospective patient, or by a hospital administrator, social worker, police officer or any person in the community having knowledge of the individual's need for care. This form requests information of the patient, i.e., his educational and occupational background, date and place of birth, children and relatives, financial resources, and known behaviour.

A second form, Form B is completed by each of two doctors, who are not in practice together and who are not related to the patient. This form is entitled "Medical Certificate" and requires each doctor to state that he has examined the patient within seven days from the date of signing the application, and that he is of the opinion that the patient is a mentally ill person within the meaning of the Mental Hospital Act, and that the condition of the patient is such that he should receive care and treatment within a mental hospital, and not in a clinic of psychological medicine. Each doctor is required to state the facts on which he bases this opinion, e.g.
what the patient said and did, and what his appearance and manner were.

The "A" form and the two "B" forms are sent to the Medical Superintendent of Valleyview Hospital, and comprise the application for the patient's admission. On receipt of these forms, the Medical Superintendent writes to the person who sent in the forms, either the patient's doctor, or the relative, as the case may be, stating that the patient's name has been placed on the waiting list, and that notification will follow as soon as a bed is available. When a bed does become available to the applicant, the Medical Superintendent writes again to the responsible person, informing him that the patient may be admitted, and enclosing the "A" form and the two "B" forms. If the date on which the patient is to be admitted is not more than one month later than the date on which the "A" form and the two "B" forms were signed, the person arranging the patient's admission has the patient seen by a "Judge" who for this purpose may be a Judge or Registrar, or Deputy Registrar of a Court of Record, or a Stipendiary Magistrate or a Police Magistrate or a Justice of the Peace. The Judge must sign a form entitled "Order for Admission of a Mentally Ill Person to a Public or Private Mental Hospital", or, more simply, Form C. This form requires the Judge to state that he has read the application (Form A) and the certificates (Forms B) presented
to him, and found that the application and the certificates comply with the provisions of the Mental Hospitals Act in all respects, and that he has personally examined the prospective patient and is satisfied that he is mentally ill and requires care and maintenance in a mental hospital. The Judge then orders that the individual be removed to the mental hospital, to be delivered into the care of the Medical Superintendent. These four forms, one Form A, two Forms B and one Form C are presented to the Medical Superintendent on the patient's arrival in hospital.

Where more than one month has elapsed between the signing of the first three forms and the acceptance of the patient for admission, these must be completed again, before the patient is presented to the Judge, and the application finalized. This set of four forms, properly completed and signed, then constitute the legal committal of the patient. However, because of the provisions of Order-in-Council No. 1124, a patient, 70 years of age or older, although legally committed, could not be admitted to any mental hospital in the province without the consent of the Medical Superintendent of that hospital.

Most geriatric patients are admitted directly to Valleyview Hospital, and transferred to one of the other units if desired at a later date. Some, however, at the discretion of the Medical Superintendent, may be admitted
directly to Skeenaview or Dellview Hospitals. Attempts are made to place patients in the unit nearest their relatives or friends, but where there are no interested relatives, or friends, some patients, usually those considered non-rehabilitable, may be transferred to Vernon or Terrace to make room in the crowded Valleyview facilities.

Medical Factors in Assessment of Priority

In selecting applications for approval, the Medical Superintendent makes his decisions on the basis of the criteria for admission outlined on page 29. The first of the three criteria has three sections, i.e. the urgency of the case situation in relation to (a) the behaviour and condition of the patient, (b) the effect of the patient's behaviour on others, and (c) the financial burden on the family of the patient's present care.

Medical and social assessments are both relevant and necessary in evaluating an application under these criteria. Criterion 1(a) is both medical and social. On the medical form B the certifying doctors are required to state facts about the patient which are indications of mental illness. The certifying doctors are not required to state a specific diagnosis on the B forms, but frequently do in answering the question which requests evidence or support of the claim that the mental condition
of the patient is such that a clinic of psychological medicine is not a suitable place for his care and treatment. However, even this is not too helpful in assessing the patient's need for care and treatment in the geriatric division, as in fourteen of the thirty B forms filed in the applications of the group selected for this study, the medical reasons given for the patient's need for care in the geriatric division of the Provincial Mental Health Services were in such terms as "senility", "chronic senility", "old age" and "confused, obstinate and aggressive". Medical or psychiatric diagnosis serve to fulfill an eligibility requirement, rather than a criterion for priority for admission.

Social Factors in Assessment of Priority

In Criterion 1(a) "condition" of the patient is purely a medical concern. "Behaviour" is noted only insofar as it substantiates a medical diagnosis of mental illness. "Behaviour" of the applicant is a prime focus of interest, however, for the social worker in the preparation of a pre-admission assessment. The "Outline of Social History for Mental Hospitals for the Aged", which is the form outline for social histories sent out to branch offices of the Department of Social Welfare when their aid is requested in preparing a pre-admission assessment, details the description of the patient and of
his present social situation which are required. These social histories are of great help to the Medical Superintendent in assessing priority of an application.

Criterion 1(b) is of major importance in the social worker's pre-admission assessment. The Valleyview Hospital Social Service Department reaches out to the community, either through the hospital social worker, or through enlisting the aid of the Department of Social Welfare, to determine the effect of the applicant's condition and behaviour on those who care for, or come into contact with him.

Criterion 1(c) is evaluated solely by the social worker, as financial circumstances are not explored by either the certifying doctors or the magistrate. A statement of the patient's finances is requested of the responsible relative or friend who signs Form A, but this gives no indication of the burden which may rest on the patient's family.

Legal Factors in Assessment

No legal factors enter specifically into the assessment of priority for admission, as the magistrate's Form C does not form a part of the application file.
Administrative Factors in Assessment

Administrative factors in assessment are apparent in Criteria 2 and 3, which refer, respectively, to the internal situation in the hospital regarding vacancies, and to the chronological seniority of the patient's application. There are always a number of aged, long term patients in the Provincial Mental Hospital who would benefit from the slower pace and more comfortable arrangements of the Geriatric Division. When beds are available in Valleyview, Dellview or Skeenaview Hospitals, the Medical Superintendent may accept patients from the Provincial Mental Hospital or from Crease Clinic, although they are not formally entered on the waiting list. These patients do not require re-certification, and are termed "transfers."
CHAPTER III

CHARACTERISTICS OF VALLEYVIEW APPLICANTS

Valleyview patients tend to fall into three broad categories. The first are old persons who manifest overt psychotic behaviour. Persons in this class may be hyperactive, aggressive and abusive, or may, on the other hand, be suicidal or depressed to the point of refusing to eat until adequate medication is given. A very few are actively hallucinating or extremely suspicious and persecutory. In the Mental Health Services Annual Report for 1960,¹ it was stated that there were a total of 280 admissions to Valleyview Hospital, of whom 175 were diagnosed as psychotic, and 105 as without psychosis, but with other mental or emotional disorders, such as mental deficiency, chronic brain syndrome with behavioural reaction, chronic brain syndrome and simple senility.

The psychotic patients definitely require treatment in a mental hospital, and they are the group who

¹ British Columbia, Annual Report of the Mental Health Services, Queen's Printer, Victoria, 1961, p. 137.
benefit most from the psychiatric treatment, medication and special therapies given in Valleyview Hospital.

The second group are non-psychotic, but arteriosclerotic brain changes, physical disabilities and emotional factors such as rejection and inability to accept changing social status result in the type of patient who is primarily a behaviour problem. This group is ambulatory but requires varying degrees of supervision of dressing, bathing, and feeding. Many of these would soon wander away if they were not restrained by locked doors, and this presents a real difficulty in community care as boarding and nursing homes are not permitted to lock their doors. Some are incontinent and some are noisy and disturb others, but adequate medication can control this latter group for the most part. A sizable proportion of this group could be cared for in boarding homes if this type of institution could provide good supervision. These old people are often very difficult and demanding but it has been the experience of Valleyview Social Service Department that many applicants can be well settled in a good rest home where the operator is willing and able to give the kindness and conscientious care required.

A third group require not only the personal care outlined above, but also nursing care. They may be completely bed-ridden or may have to be assisted to deck-chairs
as they are unable to walk unassisted. Except for a few very noisy individuals, they differ little from the majority of patients in nursing homes. Some have been Valleyview patients who have gradually deteriorated to this level; some are admitted in this condition from the community. Of the fourteen wards in Valleyview Hospital, four are infirmaries, devoted entirely to the care of this type of patient and a number of other deck-chair patients are cared for on two other wards.

The great majority of Valleyview patients are more or less confused, forgetful and incapable of complete self-care. On admission patients, particularly those living alone or with an elderly spouse, may be ill cared for, dirty and malnourished. Very few have been properly prepared emotionally for their admission, and many are apprehensive and resentful.

Analysis of the Study Group

In order to assess the criteria which are in effect for admission to Valleyview Hospital, thirty cases were selected from the waiting list of December 31, 1960. This number represents one-third of the total waiting list at that time, and was chosen as the greatest number which could be examined in detail. A systematic selection was made by choosing every third name on the list.
The first aspect to be studied was the age-groups into which the applicants fell and Table 2 shows the study group divided into age-categories by periods of five years, and further divided by sex.

Table 2. Study Group – by Age and Sex

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>65-69</th>
<th>70-74</th>
<th>75-79</th>
<th>80-84</th>
<th>85-89</th>
<th>90+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>F</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>5</td>
<td>9</td>
<td>8</td>
<td>5</td>
<td>1</td>
<td>30</td>
</tr>
</tbody>
</table>

There were nineteen women and eleven men in the group studied. Average age for the whole group was 78.6 years; average age for women was 78.6 years and average age for men was 78.5 years.

The greatest number of applicants were between their seventy-sixth and eighty-fifth years; eighteen of the thirty applicants were in this age group. Applicants were almost evenly spaced at either extreme with seven applicants between their sixty-sixth and seventy-fifth years, and six applicants between their eighty-sixth and ninety-fifth years.
Table 3. Marital Status of Study Group by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Married</th>
<th>Widowed</th>
<th>Single</th>
<th>Separated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>F</td>
<td>9</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td>30</td>
</tr>
</tbody>
</table>

Those who were married, or widowed, made up three-quarters of the group, and were equally divided between those with a living spouse, and those who had lost a spouse. Single persons who had never been married made up less than one-seventh of the group. One man was divorced and one had been separated from his wife for many years.

It is interesting to note that, of the seven patients who were noted on admission to be severely malnourished or in a state of starvation, only one was married. All six of the others had been living alone in their own homes, or in rooming houses. In addition, two of these were severely ill with tuberculosis.

According to the accepted policy, the "A" form can be signed by a relative, friend or by any person who
has knowledge of the aged person's need for mental hospital care. Efforts are made by agencies to locate a relative or friend, but often the "A" form has to be signed by an agency official who may have little or no prior knowledge of the applicant.

Table 4. **Person or Agency Signing the "A" Form for the Committal Papers on the Study Group**

<table>
<thead>
<tr>
<th>Signer</th>
<th>Married</th>
<th>Widowed</th>
<th>Divorced</th>
<th>Single</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Child</td>
<td>4</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Social Agency</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Police</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Hospital Adminis­</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Administrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lawyer</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other Relative</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>12</td>
<td>2</td>
<td>4</td>
<td>30</td>
</tr>
</tbody>
</table>

Of the group studied, twenty had interested and available relatives. It is interesting to note that four applications were signed by sons or daughters, although a
husband or wife was available. In three of these cases the husband or wife was a patient in a nursing home, and either too ill to be asked to sign, or incapable of making such a decision. In one case the daughter signed the application form as the wife refused to do so, although there was reason to believe her life was in danger because of her husband's abusive and aggressive behaviour. There are undoubtedly many examples of this in the community where feelings of loyalty and unwillingness to sever even a most unsatisfactory relationship prevent application being made for persons who should be receiving mental hospital care.

In one of the cases where the application was submitted by the local police force, the husband was unable or unwilling to acknowledge his wife's need for treatment, although she was found wandering the streets, starving and nearly naked. In the other two cases signed by the police force, there was no interested relative and no social agency involved.

The administrator of a general hospital will sign forms where there is no interested relative or agency, and where the patient does not require acute hospital care, but cannot be moved to a nursing home because of his mental condition and disturbed behaviour.

Of the group studied, thirteen had had contact with a social agency before admission; three with field
offices of the Department of Social Welfare, six with City Social Service Department of Vancouver, two with Burnaby Social Service Department and one with Vancouver General Hospital Social Service Department, and one with the Royal Columbian Hospital Administration. None had had contact with any community chest agency other than one applicant who had received service from the Victorian Order of Nurses. Nine applicants were in receipt of the supplementary bonus but had had no contact with a social agency in so far as our records showed. The following illustrates the financial status of applicants in study group:

<table>
<thead>
<tr>
<th>Income Type</th>
<th>Number of Applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private income</td>
<td>3 applicants</td>
</tr>
<tr>
<td>Private income plus Old Age Security</td>
<td>8 applicants</td>
</tr>
<tr>
<td>Old Age Security plus Social Assistance</td>
<td>18 applicants</td>
</tr>
<tr>
<td>Old Age Security plus War Veterans Allowance</td>
<td>1 applicant</td>
</tr>
<tr>
<td>Total</td>
<td>30 applicants</td>
</tr>
</tbody>
</table>

Nineteen of these people were living at the bare subsistence level provided by Old Age Security plus Social Allowance, or Old Age Security plus war veterans allowance. Of the three with private means, two of these were under seventy, and one was an eighty-five year old woman who was quite well-off and who had apparently never applied for
Old Age Security. The financial information given on the "A" form is often very scanty, and until the applicant has been admitted, it is impossible to confirm or expand. After admission, the financial affairs of the patient automatically come under the jurisdiction of the Official Committee in Victoria and it has proved extremely difficult for the hospital social service department to obtain adequate information from this department until planning for discharge is being considered. If a relative wishes to retain control of a patient's financial affairs, a complicated and expensive legal procedure must be instituted, after which, at the discretion of the court, a relative may be named Quasi-committee and continue to administer the patient's affairs. This was not done for any of the applicants studied. It is therefore in many cases almost impossible to determine the income of applicants not on supplementary assistance.

Four women and three men were living alone just prior to application; four women were living with their husbands and two men were living with their wives. Two women were living with married children. This makes a total of sixteen persons, ten women and six men, who were not institutionalized prior to admission. Of the persons who were in boarding or nursing homes prior to admission, six were women and three, men. Only three had had the
<table>
<thead>
<tr>
<th>Living Arrangements at Time of Application</th>
<th>Male</th>
<th>Female</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone in own home</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Alone in rooming house</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Living with spouse in own home</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Living with a married child</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>In boarding or rest home</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>In nursing home or private hospital</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>In general hospital</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>In Provincial Mental Hospital</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>19</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

cost of this care supplemented through the Department of Social Welfare, but although one patient on Supplementary Assistance was apparently entitled, her family was paying the cost of her care.

Of the three who were admitted from general hospital, two were male and one female. One man was admitted to Valleyview Hospital because he required tube feeding and at the time application was made, there was no
vacancy in a private hospital that could give this. He had been living with his daughter before admission to the general hospital. One man had been a chronic patient in a general hospital for some time; one woman had been living alone prior to her admission to the general hospital after having been found wandering on the streets in a state of starvation.

Two women were transferred from Provincial Mental Hospital after stays of twenty-one days and seven days respectively. One had been living alone before the police had arranged her committal to Provincial Mental Hospital, after having been found wandering the streets; the other had been living alone and taken by the police to a general hospital where committal was arranged to Provincial Mental Hospital.

The Medical Superintendent approves applicants for admission on the basis of the information available to him. This may be the minimum of the application papers, or may include letters or phone calls from doctors, relatives and community agencies or even full social histories, with professional social work evaluations of the applicant's need for care. The following table shows the contacts between the medical superintendent and persons concerned with the applicant's need for care prior to approval for admission.
Table 6. Information Available When Application was Under Consideration

| Application Forms only                               | 5  |
| Application Forms plus Doctor's letter or Call      | 4  |
| Application Forms plus Relative's letter or Call    | 6* |
| Application Forms plus letter from social agency    | 7  |
| Application Forms plus Social History               | 8  |
| Total                                                | 30 |

* 2 were also accompanied by a doctor's letter.

The following shows the time elapsed between the date of application, and the date of admission, for the study group:

1 - 5 days - 5 applicants
6 - 15 days - 6 applicants
16 - 30 days - 4 applicants
31 - 60 days - 3 applicants*
61 - 180 days - 4 applicants
Not accepted within 180 days - 8 applicants
Total 30 applicants

* 1 applicant was on the waiting list for 228 days but only 42 days elapsed after notification of change in financial status.
Table 7. Comparison of Length of Time on Waiting List and Amount of Information Available

<table>
<thead>
<tr>
<th>Available Information</th>
<th>Length of Time on Waiting List - Days</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-5</td>
<td>6-15</td>
</tr>
<tr>
<td>Application Forms only</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Forms plus doctor's letter or call</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Forms plus relative's letter or call</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Forms plus letter from social agency</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Forms plus social history</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

1 both from administrator of a general hospital.

2 social agency concerned was a police department.

This indicates that where additional information is available from doctors or social workers, time on the waiting list may be appreciably shortened.

Examination of all information available at the
time of the Medical Superintendent's approval for admission of an applicant disclosed the criteria for acceptance, as outlined in Chapter II, i.e.

The Procedure of acceptance of an applicant for admission depends upon the consideration of the following factors in order of importance:

1. The urgency of the case situation in relation to:
   (a) Behaviour and condition of the patient.
   (b) Effect of patients' condition and behaviour on marital partners, children, other family members, neighbours or community in general.
   (c) Financial burden on family of patient's present care and supervision.

2. Availability of beds in the Geriatric Division.

3. Length of time the patient's name has been on the waiting list.

Only twenty-four of the group studied can be classified in Table 8, as six members of the group were not admitted by the date of termination of the study. None of the group studied were admitted under criterion (3). The admission policy of the hospital is that length of time on the waiting list is considered only where two
Table 8. Main Considerations Affecting Admission of Patients

<table>
<thead>
<tr>
<th>Kind of Consideration Determining Admission</th>
<th>Number of Patients Admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Behaviour and condition</td>
<td>8</td>
</tr>
<tr>
<td>1b Effect of patients' condition and behaviour on others</td>
<td>9</td>
</tr>
<tr>
<td>1c Financial burden on family</td>
<td>3</td>
</tr>
<tr>
<td>2 Availability of beds</td>
<td>2</td>
</tr>
<tr>
<td>3 Length of time on waiting list</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
</tr>
</tbody>
</table>

applications of equal urgency in all other respects are being evaluated.

Table 9 indicates that for the group studied a relationship can be established between the priority ratings of the admission policy statement and time elapsed between application and admission; the higher the criterion, e.g. 1a or 1b contrasted with the others, the shorter will be the waiting period between date of application and date of admission.
Table 9. **Priority Rating Compared with Days Elapsed Between Date of Application and Date of Admission**

<table>
<thead>
<tr>
<th>Priority Ratings</th>
<th>Days on Waiting List</th>
<th>1-5</th>
<th>6-15</th>
<th>16-30</th>
<th>31-60</th>
<th>61-180</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td></td>
<td>3</td>
<td>3</td>
<td>1</td>
<td></td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>1b</td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>1c</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>-</td>
<td>1</td>
<td>1</td>
<td></td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>22</td>
</tr>
</tbody>
</table>

**Applicants not Admitted**

All the unsuccessful applications were signed by a relative, i.e. three spouses, four children and one sister were involved. One applicant was in a nursing home at the time of application, and one in a licensed boarding home. One was living with a daughter, three were living with spouses and two were alone in their own homes.

One application was placed by a sister who feared that the applicant's estate could not bear nursing home charges indefinitely. On being advised by Valleyview Social Service Department that supplementation for nursing
home care could be obtained when necessary, the relative agreed to apply for this at a later date and the application was placed on inactive status. One application was made by a son when his mother whom he was looking after refused to sign her old age security and supplementary assistance cheques. A District Social Worker was able to arrange for the cheques to be made out to the son in trust. This appeared to be a satisfactory arrangement, and the son felt that he could continue to care for his mother.

Two applicants were admitted to a private mental hospital. One was treated successfully and was discharged home. The other was considered to be in no urgent need of admission as funds were adequate for this form of care to continue for an indefinite period.

One applicant had just been placed in a rest home from his own home by a municipal social worker and as is so often the case, was very disturbed over the change in his situation. After a month, however, he settled well, and as he was felt to be presenting no problem in the rest home, his application to Valleyview Hospital was considered to be inactive.

Three applicants were placed by their families in rest homes when they became aware of the waiting period necessary before admission to Valleyview. All three
adjusted very well and their applications were considered to be inactive for the time being.

Applicants Admitted

Twenty-two applicants of the study group were admitted to Valleyview Hospital during the six month study period.

The following table relates the length of time on waiting list to the person signing the "A" form.

Table 10. A Comparison of Length of Time on Waiting List with Person Signing "A" Form

<table>
<thead>
<tr>
<th>Signer</th>
<th>Length of Time - in Days</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-5</td>
<td>6-15</td>
</tr>
<tr>
<td>Police</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Administrator of Gen. Hospital</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Social Service Agency</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Lawyer</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Spouse</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Child</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Other Relative</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
The results of this table indicate that early admission can more readily be procured by community agencies who request it, than through efforts of the relatives alone. This is understandable as an application form signed by an official is an indication that there is no relative willing to assume any responsibility for the applicant. An application instituted by the police may be in lieu of legal charge where it is felt that the person concerned is not really responsible for the actions which brought him to their notice. Again, they may institute committal where a difficult elderly person is clearly not receiving adequate care in the community and it is felt that there is no facility other than the mental hospital which can care for him.

Administrators of general hospitals apply when an elderly patient presents real management problems on their wards or when the person is no longer in need of acute care and no nursing home bed can be procured by the hospital or City Social Service Department or the local social welfare office.

Social agencies apply for admission of a person only when they feel no facility in the community can offer the care needed.

There is, therefore, evidence to indicate that an application from a community agency is seen as one of
fairly high priority. This is entirely reasonable as obviously the persons concerned are in urgent need of a type of care which for the time being at any rate, cannot be obtained elsewhere.

Of the thirty applicants selected from the December waiting list, twenty-two were admitted during the following six months. Examination of all the files revealed that seven patients died within six months of admission. Three of these seven patients were admitted from a general hospital, all three died within two weeks of admission and it is therefore possible to speculate that at the time application was made for their admission they were already in terminal illness. All three were admitted within one week from the date of application in order to free an acute-care bed. Although all three were definitely confused on admission, it would seem very poor planning on the part of the general hospital administrator to request transfer of a dying patient to a mental hospital.

Three patients who died between one to four months after admission should have been tried in a nursing home before application was made or accepted for the mental hospital. The patient who died within six months of admission was very aggressive and grossly confused on admission, and was an appropriate admission.
Fifteen of the twenty-two patients admitted to Valleyview were alive six months after admission. Examination of the files, personal interviews and consultation with medical and nursing staff revealed that ten of the fifteen required care in a psychiatric facility, but that three should have been tried in a nursing home and two in a rest home before admission to Valleyview could be seen as desirable. One of the former would have been tried in a nursing home if a bed in a nursing home which could handle tube-feeding had been available at the time when he was ready for discharge from a general hospital. According to the hospital social service, no such bed was available at the time, and he was therefore admitted directly to Valleyview.

Two patients were found on admission to be suffering from tuberculosis and were promptly transferred to the infectious diseases section of the Provincial Mental Hospital. One did not present much difficulty in the way of management, and could probably have been treated as effectively in any hospital providing care for the tubercular, the other hand been cared for in a nursing home which found itself unable to care for her any longer. Her disturbed behaviour, however, quickly subsided on adequate medication and care for her physical illness.
Conclusions

There were thirty persons in the group studied; eight of whom were never admitted to Valleyview Hospital during the six month study. A follow-up of these applicants revealed that they all adjusted well in boarding or nursing home placements. Twenty-two were admitted to Valleyview Hospital during the six month period studied. Seven of these died within six months of admission. The three who died within one month of admission were all admitted directly from a general hospital where they had been under treatment.

In the group of fifteen hospitalized patients who were alive at the end of six months, together with the four who died within one to six months of admission, a total of nineteen, there were eleven persons who were considered as definitely requiring mental hospital care. There is evidence to indicate that six patients could have made a satisfactory adjustment in a nursing home, and two in a licensed boarding home, had placement been tried before admission. One of the group judged suitable for nursing home care would have been placed had there been a vacancy in a nursing home which could provide tube-feeding. One patient could also have been placed in nursing home had finances been adequate, or had he been eligible for supplementation by the Department of Social Welfare. In this
case, however, the couple's assets were such that nursing home care would quickly reduce the spouse to penury and necessitate changes in her standard of living which would have been very hard for her to accept, particularly as she herself was showing signs of depression.

In one case the district social worker involved thought that the applicant, a woman living alone in a rooming house, would refuse transfer to a nursing home and become very disturbed if it was enforced and so requested admission. However, the lady turned out to be relatively easy to care for and she could probably have adjusted well in a nursing home. In some cases the legal committal procedures and locked doors of Valleyview are utilized to obtain care for an old person unable to recognize his need for care, and unwilling to accept placement in a boarding or nursing home. One other patient had been placed in a rather poor nursing home, and the relatives refused to consider transfer to another. In four other cases there had been no contact with a social agency and no attempt at placement.
CHAPTER IV

THE ROLE OF THE SOCIAL WORKER IN THE PRE-ADMISSION SERVICE

The purpose of this study has been to examine the criteria, formal and informal, for admission to the Geriatrics Division of the Provincial Mental Health Services. To this end the study group was analysed in terms of age, sex, marital status, availability of interested relative or community agency, financial status, and living arrangements at the time of application. The formal criteria, used in assigning priorities were stated, and a comparison made between the stated criterion and the time elapsed between the date of application, and the date of admission. From Table 9 there is evidence to show that where it appears that admission is urgently needed because of the applicant's condition and behaviour, admission is very much more rapid than for an applicant whose application is seen as urgent only because of the financial burden his care is placing on his family.

The importance of Criterion 1(b) is less easy to assess, as there was an even distribution in point of time elapsed before admission among the applicants who
qualified on this criterion.

Criterion 2 involved two patients who had been admitted to the Provincial Mental Hospital and who were seen as suitable patients for Valleyview Hospital. Both, however, were fairly recent arrivals in the Provincial Mental Hospital.

There were no admissions in the group studied under Criterion 3, i.e. length of time on the waiting list which would seem to be of minimal importance in the determination of acceptance of applicants.

In an effort to determine whether other factors than the formal criteria might have an effect on approval of applicants for admission, several possibilities were considered. One of these was the person or agency signing the "A" Form and, in Table 10, it was shown that when the Police, the Administrator of a general hospital, a social service agency, or, as in two cases, a lawyer who was the only person available to administer an applicant's affairs, were involved, nine out of ten applicants in this category were admitted in less than fifteen days, although only one-third of the applicants in the total study group fell into this category. Only three applicants whose forms were signed by relatives were admitted in fifteen days or less, although two-thirds of the total group were in this category.
None of the persons whose applications were signed by officials had any relative or friend willing to assume responsibility for planning. Actually, seven persons had no known relative, one had been separated from his wife for many years, and two had relatives in distant parts of the country, who could not be reached in time after the case had come to the attention of an agency.

The role that the family plays is pointed up by the fact that where spouses, children or other relatives were available, there was no "emergency" admission (under six days) and only three in less than sixteen days. In two cases, family members placed the applicant in a private mental hospital, and in four cases the applicant was placed by his or her relatives in a rest home. In one case the woman settled down at home, after help was given by the district social worker in arranging for financial trusteeship, and in one case the applicant remained in her nursing home, after her sister was assured that financial help could be arranged when it became necessary.

The following table compares the appropriateness of admission with the source of referral. An appropriate admission was considered to be one which examination of the files, personal interviews and consultation with medical and nursing staff revealed to be requiring care in a psychiatric facility. An inappropriate admission was one
in which medical, nursing and social work staff considered should have been placed in a boarding or nursing home prior to admission as the patient could almost certainly have been cared for in either of the latter settings.

Table 11. Source of Application Compared with Appropriateness of Admission

<table>
<thead>
<tr>
<th>Source</th>
<th>Appropriate Admission</th>
<th>Not Admitted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required Nursing Care</td>
<td>Required Boarding Care</td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Administrator of a Hospital</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Social Agency</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Lawyer</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Spouse</td>
<td>2</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Child</td>
<td>3</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Other Relative</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>9</td>
<td>2</td>
</tr>
</tbody>
</table>

One striking aspect of Table 11 is that as far as this study group is concerned, the poorest judgment in
requesting admission of patients to Valleyview appears to have been shown by the administrators of general hospitals. In none of these cases was a social worker involved. The results of the comparison, however, would give one some grounds for speculation that persons who come to the notice of community agencies may be generally more deteriorated, mentally or physically, at the point at which application is made, than is the case with those whose families make the application. This suggests that deterioration is noticed much earlier by families and that plans are made for care at a less advanced stage of mental or physical deterioration than for those who must rely on community agencies. The study group is too small to warrant a more definite conclusion but the subject is one which deserves further study.

It would seem likely therefore, that the fact that a community agency is responsible for initiating the application for admission does have some bearing on the time which the applicant's name is on the waiting list before acceptance.

Living arrangements at the time of application could not be considered a criterion, since they correspond fairly closely with the possession of a responsible relative or other person, i.e. persons living alone tended to be fairly isolated in terms of family ties, persons living
in supervised settings invariably had either an interested
family member or social worker, or other interested person
available. A criterion therefore is the quantity and
quality of supervision being given.

In summary, it appears that the formal criteria
for acceptance of applications to the hospital are employed
with reasonable consistency, when measured against the
time an individual applicant spends on the waiting list.
Other factors also play a significant part, such as, for
example, the almost total isolation of an old person who
has no one to look after his welfare and so comes to the
attention of a community agency, and the fact that there
is no alternative placement to offer him.

Another factor which emerges from this study is
the number of what might be termed in appropriate admis-
sions. The most striking of these are the cases who were
on the point of dying when they were admitted.
Horabaczewski\textsuperscript{1} studied admissions to the Saskatchewan
Hospital, in Weyburn, and found that over a 20 month period,
among admissions of patients over 60 years of age, 183 were
suffering from clinical conditions without psychosis,

\textsuperscript{1} Horabaczewski, J., "Admissions of Geriatric Cases to
Mental Hospitals," \textit{Canadian Medical Association Journal},
including uraemia, cerebrovascular accidents, chronic starvation and mild confusion and amnesia of the aged. Sixty of these died within 60 days of admission. Only 98 were admitted with psychotic disorders requiring hospitalization in a psychiatric facility. He feels that the prime responsibility lies on the medical and social welfare services in preventing inappropriate admissions by better diagnosis, and by improved services to the elderly.

From the fact that of a total of twenty-two admissions it was felt that eleven should have been placed in boarding or nursing homes prior to admission, it is clear that the information supplied to the medical superintendent with the application forms, is inadequate. It is to be hoped that the whole process of committal will become obsolete in the near future, as, for the great majority of patients it serves no useful purpose. A very few aged persons may require committal, but this should be the exception, not the only procedure.

It is extremely difficult to distinguish between medical and social grounds for application for admission. Every individual case is different; every case shows some deterioration in mental and physical capabilities, some losses in ability in social functioning, and some degeneration in social situation. Lawrence Kolb states
... there is a preponderance of authoritative opinion that public mental hospitals are being burdened by an increasing number of old people who should be cared for elsewhere. In other words, people who become feeble physically, have failing memory or some slight change in personality, and are financially unable to care for themselves are sent to mental hospitals because no relative is willing or able to care for them and there is no other place for them to go. The diagnosis of psychosis in these cases may be technically correct but it is ethically wrong.

Applications for admission, therefore, may be technically correct in the sense that the person concerned shows changes in mental functioning which render him eligible for certification. This study has shown, however, that certifiability does not necessarily mean that he can be cared for only, or even best, in a mental hospital. This decision should be made by the doctor who knows the patient's mental and physical care needs, and the social worker, who knows how these needs may best be met.

Contribution of the Social Worker in Pre-Admission Services

The social worker in a mental hospital for the aged can make a varied and vitally important contribution prior to the applicant's admission. The social worker obtains an evaluation of the patient's need for care, and

total social situation. If in the worker's opinion, the applicant's need is urgent, and no other resource can be found, a recommendation is made to the medical superintendent, who will then give consideration to early approval of the application.

Many relatives are, not unnaturally, very disturbed after requesting admission of a beloved mother or father; many people, whose feelings towards their parents are still an ambivalent mixture of affection and resentment, suffer a great deal of guilt over their decision. The social worker, by focussing on the reality situation, giving information about the aging process, and offering support and acceptance of their feelings, can do much to alleviate this guilt.

Helping the patient to accept the need for hospitalization is equally important, and much anxiety can be alleviated by describing the hospital and its facilities, as well as by defining its goals of rehabilitation and treatment. This initial contact with a staff person often serves as a bridge over the actual admission and difficult first weeks of orientation.

When the social worker feels that the applicant's condition is such that classification of his application as urgent is unnecessary, she will explore resources within the community which might provide care over the waiting
period. These may take many forms, such as direct referral to a public agency for financial assistance, or for placement in a boarding or nursing home where the applicant is eligible for financial supplementation for care. Where the applicant's or family's resources are sufficient the family may be advised on suitable placements, and helped to involve themselves in the planning, and then to help support the aged person in a new placement. Where the family is unable to do this, the hospital social worker may be directly involved in placement, or may be able to refer to a community agency.

The hospital social worker can make referral to community agencies for provision of visiting nurse service, friendly visitors, or a housekeeper where this is seen as helpful.

In a number of cases, provision of one or more of these services has resulted in such an improvement in the applicant's situation, that admission can be postponed indefinitely. Not the least of the services which the social worker can give her aged clients is consultation with the boarding or nursing home operator or with the family on how the needs of the aging person can best be met in the individual case.

Another function of the hospital social worker
is the interpretation to other professionals, particularly doctors, of the specific functions of the mental hospital for the aged. A surprising number of doctors are unaware of the nature and kinds of existing community facilities for the care of the aged, and of provisions for financial supplementation where this is needed. Frequently suggestions made to relatives and to doctors for referral to social agencies in the community result in successful placements.

Facilities for Care of the Senile

The existing facilities of Valleyview Hospital have been explored to demonstrate the services now considered essential in the care of the aged, mentally ill person. Every kind and degree of physical and mental infirmity can be found among its patient population and treatment resources are fairly complete. Unfortunately, except for the facilities provided by the Department of Veterans' Affairs at Shaughnessy Hospital, there are no publicly operated establishments in the Province of British Columbia offering adequate care to the aged person whose social functioning has deteriorated beyond the point of self-care. The one private mental hospital in the province is beyond the reach of all but the wealthy; most of the private hospitals and nursing homes are almost uniformly unable to provide the range and quality of service
necessary for these patients. Thus, unless an aged
individual is wealthy, entitled to the services provided
for veterans, or certified as mentally ill and admitted to
the Geriatric Division of the Provincial Mental Health
Services, he has access only to the limited services of
the privately operated nursing and boarding homes. These
homes are for the most part inadequate for the care of
anything but minimal disturbances in mental and social
functioning; sometimes they are inadequate for the care of
certain physical infirmities. Many persons now seen as
inevitable candidates for Valleyview Hospital could be
cared for in boarding or nursing homes were the operators
adequately trained and motivated to give this type of
service.

Quite recently a graduate psychiatric nurse with
several years experience in working with disturbed old
people opened a boarding home, staffed with psychiatric
nurses. This boarding home is offering the type of under-
standing care required for this type of patient, and is
handling successfully old persons whose families and other
boarding homes staffed with untrained people have failed
to contain. At the present moment our welfare institutions
licensing requirements differentiate only between boarding
homes offering personal care, such as supervision of
feeding, dressing, and bathing, and nursing homes offering
nursing care. These latter may offer high standards of physical nursing care to the physically severely debilitated, but are not infrequently unable to cope with the behavioural problems presented by confused, demanding old people. The need is not only for more boarding and nursing home facilities, but also for specialized boarding and nursing homes which could care for the less severe types of emotional disturbances in old people, retaining these patients in the community for longer periods, and giving satisfaction to patients and families at considerably less expense than is incurred by the community in maintaining a patient in a mental hospital.

Recommendations for Changes in Procedures and Legislation

A basic concern of social work is the welfare of the individual. All too frequently, however, the individual's need cannot be met because the suitable resource does not exist in the community. This is particularly true of the aged person in our time. When deterioration in physical, mental or social functioning, or any combination of these begins to be apparent, great difficulty may arise in obtaining care for him. The family is unable to care for him; no institution suited to his particular need may exist.

The social work assessment of an individual's problem included his resources, internal and external, as
well as his needs. In planning for the client's treatment, the social worker can utilise only the resources which actually exist. The plan which is finally put into action may be far from the client's real need, where there is no satisfactory way of meeting this.

It was stated in the section on eligibility in Chapter One that prior to admission to the Geriatric Division of the Mental Health Service, an individual must be judged, in the opinion of two certifying doctors and a committing judge, to be suffering from chronic brain syndrome due to senile or arteriosclerotic brain disease associated with neurotic, psychotic or behavioural reaction, and must be approved by the Medical Superintendent. All persons for whom proper application has been made have therefore been so judged by the certifying doctors. The institution of Order-in-Council No. 1124 is in itself an acknowledgement that this does not necessarily secure suitable placement for the aged person in need of help. Ultimately, it is the Medical Superintendent of the Geriatric Division who makes the decision to admit any individual, but he is influenced by all the information which is available to him, and particularly by the information that this admission is necessary because no other suitable form of care can be found for this individual.

Therefore, it would seem reasonable to suggest
that, so long as the committal procedure exists, applications should be processed first through the branch offices of the Department of Social Welfare, or the municipal social service offices. A social worker's assessment of the individual's need for this form of care, and the urgency of the need, would be of great use in assessing priorities for admission.

In the present situation, whereby two doctors must certify the patient to be mentally ill, and requiring treatment in a mental hospital, some almost insuperable difficulties arise. For one thing, rest homes are not permitted to accept mentally ill patients, and nursing homes may do so only under special permission. The two doctors' certificates place the applicant in a most difficult position. He may not be accepted by Valleyview for a lengthy period, and he is not really eligible for any other form of care which exists in the community. The fact that eight out of the certified applicants to Valleyview Hospital in the group studied, were never admitted, but found other forms of care quite successfully, only two of which were in a private mental hospital, indicates just how inappropriate this requirement is.

One strong recommendation that the writer would make, therefore, is the early abolition of the present legislation governing procedures for admission to the
Geriatric Division of the Provincial Mental Health Services. Form "A", as the application form from the responsible relative, is both useful and innocuous. The referring doctor's part of the procedure, however, would be far more useful as a simple medical referral to the Medical Superintendent, for consideration of the applicant's placement in Valleyview. This would eliminate the stigma and awkwardness of certification of mental illness in people who may never have to come to a mental hospital.

At the present time there does not seem to be much chance that legal committal procedures for admission to mental hospitals will vanish overnight. A committal for thirty days only, however, would give the hospital staff opportunity to decide whether a patient needs to be detained against his will in a mental hospital, and would re-affirm the freedom of the individual to choose his way of life, as far as the great majority of patients are concerned at any rate.

It has already been pointed out that eight of the study group settled well in other forms of care. Had they not been protected by the Medical Superintendent's power to approve admissions to the hospital, and the even more effective bulwark of the waiting list, they would inevitably have been hospitalized. This is not to suggest that Valleyview Hospital is in any way a poor or an
inadequate hospital. It is only fair to say that for its purposes it is an excellent institution; certainly its services and its physical facilities are far superior to what can be obtained for the elderly in the community. Wherever an individual retains any power to choose, and to be aware of his surroundings, it can only be wrong to commit him forcefully to a way of life he does not want, if there is an alternate form of care he can approve. The right to self-determination is a basic tenet of social work, and it is the writer's belief that where an individual can profit from care and treatment in a mental hospital he should be kept there only with his willing co-operation, if a resource exists elsewhere which could also serve his need. Widespread changes in community facilities must develop before adequate care can be obtained for the elderly in our society, but, even more importantly, there must be recognition of the need to change our attitudes, which permit existing legislation to go unchallenged. A broad program of social planning to improve the situation of our aged is urgently needed; a constructive first step would be the removal of the stigma of mental illness from those whose condition is not accurately described by this classification, and whose successful treatment is certainly not aided by it.
BIBLIOGRAPHY

Books


Articles, Theses and Reports

Articles


Grabski, Daniel A. "Geriatric In-Patients - The Precipitating Cause of Admittance to the State Mental Hospital." California Medicine, Official Journal of the California Medical Association, San Francisco, California, vol. 94, No. 3 (March 1961).


Theses


Reports


Walker, Helen. A Pilot Study of Older Patients at Cleveland State Hospital. Joint Committee on Facilities for the Aged and Disabled, Cleveland, 1953.