CRITERIA FOR SUCCESSFUL REHABILITATION

A review of selected literature directed to diagnostic and prognostic casework services for the physically handicapped.

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ABSTRACT

Much has been written on rehabilitation but as yet there is little standardization of definition whether in general literature or clinical practice. The present study examines a representative group of writings to discover how far there is agreement as to the criteria for successful rehabilitation. The most important references include writings of Howard Rusk and his collaborators in the United States, and the findings of T.M. Ling and C.J.S. O'Malley and collaborators in Great Britain. Specific reference is also made to relevant theses completed at the School of Social Work, University of British Columbia. To preserve a sharp focus, the study is confined to cases of physical handicap, a medical setting, and the particular role of the social worker, in the rehabilitation team and in relation to the client. The background of other varied concepts of "rehabilitation" is considered at the outset.

The factors on which there is agreement can be best reviewed by classifying them in two main areas, which may be broadly termed: (A) the inner resources, and (B) the external resources of the person concerned. Inner resources can be further analyzed in terms of: (a) initial assessment, (b) variables with rehabilitation potential, and (c) dynamic characteristics with rehabilitation potential. The external resources are analyzed as: (a) the family strength, (b) financial standing as a rehabilitation resource, (c) the criterion of leisure-time activities, (d) the rehabilitation centre and team as a resource, and (e) the community resources.

The findings are evaluated particularly as they serve as diagnostic and prognostic aids for the caseworker. They are tested tentatively by application to a small number of cases drawn from the experience of Shaughnessy Hospital, Vancouver, of the Department of Veterans Affairs. These particularly show the importance of balance and interaction between "inner" and "external resources", and some implications may be drawn for other areas of rehabilitation. No attempt is made to assess the relative weights of the individual criteria, which is one of the indicated directions for future research.

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CHAPTER I

WHAT IS REHABILITATION? THE GENERAL APPROACH

"Rehabilitation" is one of the most widely used words in health and welfare today. Rehabilitation evidently also means many things to many people. And the concept of rehabilitation itself has been enlarged to touch on all areas of life - the physical, social, economic and psychological areas. The community organization worker speaks of urban or neighbourhood rehabilitation. "As the urban renewal program produces more examples of citizen participation in neighbourhood rehabilitation, it may be pertinent for political scientists to investigate ... citizens' political attitudes and voting behaviour."[1] The group worker and the caseworker deal with several varieties of rehabilitation. In adult correctional work, the aim is to assist the offender by rehabilitation and reform, rather than punishment.[2] Work with juvenile delinquents is focused on rehabilitation and prevention. Services for the retarded child and chronic mental illness are referred to as rehabilitation of the mentally handicapped. Rehabilitation therefore can no longer be regarded as applying only to the physically handicapped where industrial accident cases and war casualties first made it a specialized field. Rehabilitation can reach to all facets of living in which adjustment problems arise.

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[1] W.C. Loring, F.L. Sweetser, C.F. Ernst, Community Organization for Citizen Participation in Urban Renewal, Housing Association of Metropolitan Boston, Inc., Massachusetts Department of Commerce, 1957, p. 236.

[2] H.E. Barnes, and N.K. Teeters, New Horizons in Criminology, Prentice-Hall Inc., Englewood Cliffs, N.J., 1959, Chapter 36.

Finally, public assistance programs have broadened in scope. The emphasis is on change in the individual and family away from incompetence and dependence to a more effective pattern of self reliance, self-help, participation in bringing about improvements - whether in employment, the family budget, or parental relations.

In all these programs, there is a common rehabilitation concept. The rehabilitation plan must not be imposed upon the individual. There is the belief on the part of the workers that change in the client will come with an interpretation of the philosophy of the program. In addition there is an awareness of personal and environmental resources if success is to be achieved. The problems of rehabilitation are not only the concern of the particular group being helped, but should also be the concern of the community. An example of the provision and development of community resources is as evident in work with the aged. Provision of low-rental housing, financial assistance for the retired and an accepted place in the community removes many of the difficulties facing the elderly in their present adjustment.

The provision of trained staff, adequate facilities and services along with a use of the legal limits of the program will add to its effectiveness.

> Even though rehabilitation has been at the core of social work philosophy since the profession began, the current emphasis upon rehabilitation as a distinct process involving a variety of professional skills requires that social workers take a fresh look at their place in the total rehabilitation effort.[1]

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[1] R.D. Abrams and B.S. Dana, "Social Work in the Process of Rehabilitation", Social Work, Vol. 2, No. 4, October 1957, p. 10.

Self-examination, however, is more revealing if the focus is on part of the larger operation. Work with the physically handicapped in a medical setting is one part of social work practice in rehabilitation and is the focus of this study.

Hippocrates, the "father of medicine" professed to treat the whole man - taking into account not only his disease but his total environment. In the centuries that followed and particularly the last 150 years, increased knowledge has led to specialization. The disease has been treated often with little thought of the value and influence of those positive factors in the patient's environment - his personality, motivation, and his family. Today there is once more an increasing awareness "of man's relationship to his social and cultural environment and (we) are appreciating the very importance of these factors in his life".[1] Once more medicine is taking into account man and his total environment.

> For more than a generation now, great physicians have been preaching that man is not a machine put together on an assembly line, but one complex and mysterious whole. Slowly we are re-learning the ancient truth that if a part is ill, the whole is ill.[2]

With this renewed awareness of man, the medical profession no longer regards rehabilitation as an extracurricular activity of medicine. Today modern rehabilitation practice is aiming to keep abreast of modern medicine which has "increased the survival of the seriously disabled persons who

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[1] T.M. Ling and C.J.S. O'Malley (ed.). Rehabilitation After Illness and Accident, Bailliere, Tindall and Cox, London, 1958, p. 9.

[2] Arnold Hutschnecker. The Will to Live, Permabook, New York, 1956, p. xii.

are challenging medical practice anew by their added numbers and complexity of their conditions".[1] There is now seen a new concept, that of "medical rehabilitation" which "has frequently been termed the 'third phase' of medicine, following 'preventative medicine' and 'curative medicine' ... In contrast to 'convalescence' in which the patient is left alone to rest through the period while time and nature take their course, medical rehabilitation is a dynamic concept and action program".[2]

In defining the total picture of rehabilitation medicine and the length of treatment Dr. Rusk has said:

> The first objective of rehabilitation medicine is to eliminate the physical disability of that is possible; the second, to reduce or alleviate the disability to the greatest extent possible; and the third, to retrain the person with a residual physical disability 'to live and to work within the limits of the disability but to the hilt of his capabilities'.[3]

Then medical care is complete.

From the Baruch Committee on Physical Medicine has come the most widely accepted definition of rehabilitation. "The goal of rehabilitation is to achieve the maximum function of the individual and to prepare him physically, mentally, socially, and vocationally for the fullest possible life compatible with his abilities."[4] With the objectives of rehabilitation as noted by Dr. Rusk and with this definition in mind, it may be said

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[1] B. Primeau, "The Medical Restoration Component in a Comprehensive Rehabilitation Program", Medical Services Journal, Vol. XIV, No. 10, Nov. 1958, p. 716.

[2] Howard Rusk. Rehabilitation Medicine, C.V. Mosby Company, St. Louis, 1958, p. 7.

[3] Loc. cit.

[4] George Rohn. Rehabilitation of Arthritis Patients, Master of Social Work Thesis, University of British Columbia, Vancouver, 1953, p. 5.

that rehabilitation is not complete until the patient has learned to live, and, if possible, to work with what he has left. This the person who is confined to a respirator, the quadreplegic who may move only his head, or the person who can only attain self-care - each of these may be classed as rehabilitated if they have accepted and learned to live within their limitations. "To be able to work again" is a good measuring-rod which is often used in talking about rehabilitation, particularly, for example, for industrial accident cases; but work is by no means the only measurement. What of the housewife? Does she need to be trained to work outside the house? If she is enabled to carry on her duties as wife and mother, rehabilitation has been meaningful in a practical way. However, if this is not physically possible, her return home where she can, on a managing and organizing level, fulfill her former duties would also be of practical value.

At this point it should be noted the goals in rehabilitation vary depending on whether the client is a man or a woman. There are of course other variables, such as age, intelligence and background experience which are considered in Chapter II but the implications of these variables are the same for both sexes. Rehabilitation goals related to vocations, will differ for men and women.

Rehabilitation is a positive concept for health concerned with the maximum functioning of the individual after the disease has been treated. In this regard "the therapy should not stop until the patient has recuperated his fullest potentiality or to the point where the patient's

life is best adapted to the permanent disability".[1] This adaptation then is the goal of rehabilitation. Vocational achievement is but one way of expressing the attainment of that rehabilitation goal.

In summing up modern rehabilitation, a recent bulletin issued by the Canadian Department of Labour had this to say:

> Modern rehabilitation practice recognizes that a comprehensive assessment and evaluation of the whole handicapped individual should precede the start of any treatment or training program. Evaluation is designed to predict a disabled person's ability to benefit from specific rehabilitation services.
>
> The keystone of modern rehabilitation practice is flexibility in dealing with the specific problems of individuals whose needs are as numerous and diverse as are their personalities and their emotional and physical problems.[2]

Rehabilitation begins on the diagnosis by the doctor. Often the prognosis cannot be too definite because the prognosis must take into account the whole man. However, although rehabilitation starts with the diagnosis, the process of rehabilitation will not become a fact until the individual willingly enters into the program. In other words, a person cannot be rehabilitated without his participation, and conversely, it is difficult to imagine an individual rehabilitating himself without some outside help. Therefore it is recognized that the goals in rehabilitation are in terms of psychological, social and economic as well

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[1] Primeau, op. cit., p. 716.

[2] Tower, Published by Institute for the Crippled and Disabled in New York, cited in "Rehabilitation in Canada", Bulletin of Civilian Rehabilitation, Department of Labour, Canada, September-October 1959, p. 16.

as physical needs. The attainment depends upon an integrated inter-disciplinary approach which cuts across professional lines. The team approach therefore is a dynamic concept of rehabilitation.

Reference in Chapter III is made to the role and contribution of the team members in a rehabilitation center or hospital. Emphasis in this paper will focus on one member of this team - the social worker.

Implications for the Social Worker

By definition a social worker is an "enabling person" and therefore carries this characteristic into the rehabilitation process. Dr. Rusk of the Department of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, has said of the social worker:

> Her[3] contribution is primarily to enable the patient to use the services within the hospital or to use the appropriate services outside. Of equal importance is her work with the families and the sharing of her findings with other team members so that the best possible service can be given to the individual patient.[1]

The Curriculum Study for the Council on Social Work Education has defined the role of the social worker in rehabilitation in keeping with the medical profession's definition as expressed by Dr. Rusk.

> Social workers in the widest range of service settings contribute to the rehabilitation of the handicapped, cooperating with others on the rehabilitation team, addressing themselves in particular to those needs of clients which have to do with difficulties of social functioning.[2]

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[1] Rusk, op. cit., p. 255.

[2] John L. Horwitz, Education for Social Workers in the Rehabilitation of the Handicapped, Council on Social Work Education, New York, 1959, p. 3.

[3] For convenience in this thesis, the social workers are referred to as she and clients as he.

The focus here is on the area where the social worker has knowledge and skill - that of social functioning of the client.

The Study has defined rehabilitation "as a process whereby a handicapped individual achieves an enlargement of physical capacities, social competence and personal satisfaction. Concerted services, designed to comprehend a complexity of needs, are commonly required if such a person is to achieve the full life".[1] It would seem the important words here are "achieves an enlargement". This implies growth and development and learning to live within one's limitations.

How does the caseworker aid in determining the individual's potential for rehabilitation? This requires consideration of (a) the caseworker's role in the use of efficient and optimal rehabilitation services; (b) identification of one area within the individual and within the services where improvement is needed. Both of these necessitate examination of what are the criteria of rehabilitation. How do we judge it? How do we recognize it when or if it is achieved?

"Criteria" are defined in Webster's New World Dictionary as "standards or tests by which judgments of something can be formed". Such "tests" become a diagnostic tool, if they can assist the caseworker in assessing a client's potential, and the areas of need for success in relation to his disability. The criteria required for this are not so much of rehabilitation as for rehabilitation. The caseworker is interested

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[1] Loc. cit.

in the degree of success of the patient's rehabilitation, it is true, but the primary concern is in the direction of services for rehabilitation. "Criteria for rehabilitation" is, therefore, standards or tests by which the caseworker can measure the client's potential and the environmental potential so as "to form judgments", that is, arrive at the best plan for the individual client. With this in mind, it must be remembered that "rehabilitation is not a method of doing something. It is not what is done for a person, but is offered to a person for his own use."[1] By means of a measurement (criteria), having assessed the factors of a case, the worker is in a better position to know what to offer that person.

The Social Worker, An Enabler

As has been noted, there have been great changes in the medical approach to illness and rehabilitation. Similarly, social work as a profession has, and still is, undergone changes in the approach to rehabilitation with continued emphasis on the positive aspect. In 1852 Dorthea Lynd Dix drew attention to the fact that "every man and every woman possessed of sound health is wealth to the State, every individual diseased and disabled is a draft both directly and indirectly on its riches and prosperity. It is cheaper to cure than it is to support, even at the very lowest rate".[2] Since then research studies

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[1] Kenneth Holt, A Rehabilitation Programme for Polio Patients, Master of Social Work Thesis, University of British Columbia, 1952, p. 9.

[2] Catalogue of Courses, State of Maryland Department of Mental Hygiene (1955), 3, quoted in Education for Social Workers in the Rehabilitation of the Handicapped, op. cit., p. 7.

have shown that the cost of illness to the State in terms of the social assistance paid out to former wage earners, now sick and/or disabled, far exceeds the cost of rehabilitation to return them to the labour market.

These changes in the approach to rehabilitation correspond with changes in society's attitudes to the disabled. In the book Rehabilitation After Illness and Accident, the authors cite three changes or stages on the part of society. First there was the savage stage in which the disabled member of the tribe was left to his fate or was even liquidated. This was followed by the charitable stage with the great religions of the world taking over. Finally, the third stage has evolved where the State occupies a major part of the process of rehabilitation.[1] In Canada income maintenance programmes help to meet some of the needs of those persons who are physically impaired. Examples of these are in the Blind Persons Pension and the Disabled Persons Allowance which are supported by both the Federal and Provincial Governments in Canada.

"In the period since the second World War, both organization of rehabilitation services and the techniques employed have been virtually revolutionized. Physiatrics has been well established as a medical speciality, and advances both in rehabilitation methods (e.g. with paraplegics) and in public health (tuberculosis, syphillis) have been impressive."[2] These medical advances plus a changed attitude in society

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[1] Ling and O'Malley, op. cit., pp. 1-8.

[2] Horwitz, op. cit., p. 11.

and in the professions have resulted in new direction for rehabilitation. "Nowadays we are not satisfied with the maintenance of the disabled person or even with his medical recovery, we are satisfied only with his rehabilitation as far as practicable to a full and normal life of work and leisure."[1]

As was noted in the Curriculum Study, "during the past decade, the social work profession has manifested a growing interest in the rehabilitation field, and in the problems of role definition in the newer rehabilitation service settings".[2] With this growing interest there is the controversy regarding the place of social work in rehabilitation. Is it a new profession as is being suggested in some quarters? In the United States the National Rehabilitation Association (1956) supports the view that rehabilitation is a new specialization and says "'Give us specialists, not generic social workers capable of moving into a variety of settings.'"[3] Further, it is suggested that other fields such as "schools of education and departments of health were moving to create curriculum and field work that would meet the needs of rehabilitation agencies".[4]

In response to this changing approach to rehabilitation, schools of social work are refocusing the belief in the generic approach. "'Let us move in the direction of the generic, but while doing it, let us take funds from the specialized groups and continue to hold on to much that

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[1]Ling and O'Malley, op. cit., p. 1.

[2]Horwitz, op. cit., p. 11.

[3]Arthur Dunning, "Rehabilitation: A New Specialization?", Social Work, vol. 2, No. 4, October 1957, p. 9.

[4]Loc. cit. Ibid.

implies specialization.' In the rehabilitation instance, that would be rehabilitation field work and perhaps some specialized rehabilitation courses."[1]

An article by social worker M. Bruce McKenzie draws attention to the fact that theoretically rehabilitation and social work should work "hand-in-glove". He notes the following similarities between the two:

> The clientele which rehabilitation serves is one in which social work has a legitimate long-standing interest.
>
> Social workers in general are very interested in the results which rehabilitation has been able to achieve, noting in particular its effectiveness in removing cases from public assistance roles.
>
> The objectives of rehabilitation ... and aims of social work ... are complementary ... in the client's self-determination, self-motivation and self-help as providing the key to successful social adjustment.
>
> The social worker on the rehabilitation team ... reports back to the team in order that the social treatment will be integrated with the team objective.[2]

The Curriculum Study for Social Workers in Rehabilitation maintains a similar approach. Social work as a profession has a contribution to make to rehabilitation. Therefore the social worker must assess to what extent her approach and that of the agency or the social service department within the center or hospital is generic. "Generic" meaning that "the basic knowledge of social factors and dynamic psychology for

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[1] Ibid., loc. cit.

[2] M. Bruce McKenzie, "Rehabilitation and Social Work," op. cit., pp. 57-58.

effective operation in any setting, calls for the same essential skills".[1]

Perlman has said of the nucleus of casework that it is "A person with a problem comes to a place where a professional representative helps him by a given process".[2] This definition could easily be translated to rehabilitation. In Chapter II the patient or client with a rehabilitation problem has been assessed. In Chapter III the client's family, resources, the rehabilitation setting and in particular the staff have also been assessed. The social worker as an individual must also be assessed, before assessing the contribution of the social worker as part of the rehabilitation process.

In Common Human Needs the author draws attention to the fact that, in work with the handicapped client, it is important how the worker feels about handicaps.

> Adult attitudes toward disabled persons are characterized by an inability to take handicaps for granted, by over-protective tendencies, and by a degree and kind of emotional involvement which tends to set the disabled person apart, ... to view these individuals in terms of their disabilities and to plan for them primarily with references to their differences, thereby frequently enhancing their discomfort and feelings of isolation.[3]

In addition to assessing one's own feelings regarding the handicapped client, the worker must be able to view the client as a total person.

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[1]Gordon Hamilton, op. cit., p. 116.

[2]Helen Harris Perlman, Social Casework, University of Chicago Press, 1957, p. 4.

[3]Towle, op. cit., pp. 78-80.

> We will help the handicapped individual as a person, not only the needs created by his handicap but also those which he has in common with other human beings ... The same principles which we use in helping people with other problems are appropriate in work with those who are ... physically handicapped.[1]

Therefore, in the rehabilitation process man is viewed as a whole human being "who brings to the present situation a significant past and aspirations for the future".[2] The social worker will then be able to place emphasis not only upon knowing the individual patient but also upon knowing the resources of family, friends and community as they have affected the patient and will continue to affect his outcome of the rehabilitation efforts.

Having assessed her own feelings, with regard to the handicap, and the handicapped person, the social worker must then assess her place on the rehabilitation team. The social worker must accept her role on the team, be comfortable in that role, and make no apologies to other professions in stating diagnosis and opinions which the worker has arrived at by knowledge of her own profession.

> The social worker needs to understand her own role, accept it and be proficient in it. It is only in this way that the team members use each other properly.[3]

In referring to assessment of self-knowledge, so essential if one is to carry out one's role efficiently as a team member, Dr. Hamilton has said that "if one is to use self, then one must be aware of how

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[1] Ibid., loc. cit.

[2] Ruth Abrams and Bess Dana, op. cit., p. 10.

[3] "Teamwork: Philosophy and Principles", op. cit., p. 26.

self operates".[1]

How then does self operate? By what given process does the professional representative help the client? The Curriculum Study on Education for Social Workers in the Rehabilitation of the Handicapped set this out under Assessment, Planning, and Team Operations and Follow-up. The first three divisions compare with the social work approach of Study, Diagnosis, and Treatment with diagnosis figureing very prominently in the assessment and planning. However, the use of the term "Providing Services" seems to imply greater client involvement than Treatment. Usually treatment is by one person of another. But providing services may be seen as making the services available for the person's use. Thus the client must be more active and not as passive as when receiving treatment. Perlman refers to this as allowing the client to be a producer rather than merely a consumer.

The objectives of social casework per se as defined by Swithon Bowers, O. MI., are transferable to social casework in rehabilitation:

> Social casework is an art in which knowledge of the science of human relations and skill in relationship are used to mobilize capacities in the individual and resources in the community appropriate for better adjustment between the client and all or any part of his total environment.[2]

Knowing herself and the area of operation, that of social work in rehabilitation, the worker must evaluate her method. First, therefore,

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[1]Hamilton, op. cit., p. 41.

[2]Swithon Bowers, O. MI., "The Nature and Definition of Social Casework Part III", Social Casework, December 1947, p. 417.

there is the evaluation of the assessment of the situation. The worker "must first of all be skilled in assessing the impact of disability upon the social functioning and the relevance of social resources to needs as she and the client perceive them".[1]

Recognizing that "every disabled person is entitled to know about and be considered for rehabilitation services according to his needs and interests" ... the worker "... established and perpetuates relationships with agencies, professional people, and all others and receives from these sources appropriate referral cases".[2] She then assesses the degree to which the client fully understands the general nature of the rehabilitation process and what the client's part in it will be.

In gathering facts and endeavouring to arrive at a social diagnosis, the Curriculum Study outlines areas for the worker into which the worker must inquire. In so doing the worker "appreciates the importance of assembling complete historical and evaluative data about the client ..., she understands principles and techniques of interviewing; and selects appropriate consultative, diagnostic and evaluative resources within and outside the agency".[3]

The first area of importance is that of the client and his family. In this there must be an awareness of the client's roles in the family; responsibilities within the family; relationships with other family

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[1] Horwitz, op. cit., p. 19.

[2] Thompson, Role of the Workshop in Rehabilitation, op. cit., pp. 3 and 4.

[3] Ibid., p. 19.

members and how the client's role performance affects other members' roles; and ascertain the extent of the behaviour of the social functioning of the total family and of this as related to the client's disability and where there is need for modification.

Secondly, there must be a consideration of how the disability impinges on the client's overall development. This will be reflected in the impact of the disability upon the client's capacity to make use of the rehabilitation services and other social resources.

In the area of work performance and goals the worker endeavours to understand the goals the client has set for himself. In this, the worker seeks to appreciate the attitudes and mood of the client in relation to his limitations. "In some cases the counsellor used the counselling interview to assist the client to modify emotional attitudes that result in social maladjustment, with the client being aware of the personality reorganization through which he is going."[1] This assessment requires close consultation with a psychiatrist.

The worker also assesses and defines a realistic appraisal of the client's physical, emotional, intellectual, and social potential after assembling the results from the studies of the physician, psychiatrist, psychologist and other team members. She views this in the light of the client's past history and the worker's own awareness of human behaviour.

Finally, in this assessment of the situation, the worker takes inventory of the support that can be expected from the family -

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[1]Benney, op. cit., p. 119.

non-material and material; the help the agency can give; what may be expected from community resources - noting for future reference the lack of resources.

The worker then, as the case moves ahead, makes an assessment of the planning. In this she must be aware of the degree to which the client is being involved in planning and that planning is moving at the client's pace. In this regard it is important that when a plan of social treatment is formulated "the worker returns to the client to discuss the plan in total, or in part depending on the complexity of the situation, and the client's readiness to take the necessary steps".[1]

In this the worker identifies immediate goals and relates these to long-range perspectives. In the matter of goals, it must be remembered:

> Over-optimism has its dangers. Social workers should recognize when a case is hopeless vocationally and not let themselves be pushed by the unrealistic aspirations of patient, family, and community toward goals that cannot be realized. At the same time, because social work has always been concerned with setting goals for improvement in all areas of living, the social worker should be alert to the fact that in the evergrowing, everchanging rehabilitation field the unrealizable goal of today can become the realizable goal of tomorrow.[2]

This line between optimism and reality is a tenuous one and the worker must constantly assess it. In this regard there is a tendency "to sell the client short" and to forget the client as an individual has the right to make his own choices.

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[1] McKenzie, op. cit., p. 57.

[2] Abrams and Dana, op. cit., p. 12.

In planning the worker must also assess the extent to which the variety of services are being used where necessary to help in the rehabilitation process.

Finally, in an assessment of Providing Services, it must be noted that "failure in practice to achieve the ideal of rehabilitation is, obviously, occasioned by the practical limitations of the helping person and of the resources available. These resources that are available in the disabled person's own abilities, and in his environment, must be utilized to their fullest possible extent".[1]

Moving out from the worker/client relationship, the worker must assess the rehabilitation team. Team operations are of major concern in provision of social services to the handicapped, because the needs of these clients commonly require specialized skills of several disciplines. Patterns of leadership of the team vary with the agency. The social worker may be the leader in one agency while in another shoulder only the responsibilities directly concerned with the client's needs which require social work skills. However, in the rehabilitation setting of the physically handicapped and where, hopefully, the social worker is entering the beginning phase of rehabilitation, the physician would be the leader of the team. Like other team members, the worker takes other team members' goals into consideration and he aids in keeping communication channels open as well as having a willingness to share information.

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[1]Hagerman Thesis, op. cit., p. 4.

One writer views the clinical team as democratic and therefore does not see that there should be one designated team leader.

> The team needs leadership, it is true, and, in a sense, each one assumes leadership commensurate with the nature of the responsibility involved. In fact, the quality of leadership should be a factor in the selection of a team member. However, there are certain functions which might be assigned to someone whom the groups select as a good chairman. On the other hand, it may assign chairmanship on a rotating basis.[1]

However, this concept of team leadership does not seem to be in general use. Rather the physician is the team "captain". The social worker must be aware of the type of leadership and responsibility of members and work within these limitations. She must also be aware of the wide variation of types of team leadership.

In regard to the team operations, the social worker, in addition to knowing the roles of the other members, must assess the team relationships. As Dr. Rusk points out, the social worker is responsible for the "social management" of the team.

In brief summary, the following points illustrate the social worker's participation on the team:

> Evaluates the patient's social and family setting.
> Helps in the short and long-range planning.
> Interprets the team's findings and recommendations to patient and his family.
> Makes referrals to community agencies.
> Assumes responsibility for follow-up and continuity of service.
> Helps with financial assistance.

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[1] Social Work Practice in Medical Care, op. cit., p. 10.

Takes part in team's periodic evaluation.
Helps patient and his family prepare for discharge.
Aids in programs of group counselling for patient and family.
Interprets periodical problems to family and to patient.[1]

Finally, the social worker must assess the Follow-up service for clients on discharge. In this regard, the Curriculum Study points out that the worker "evaluates and encourages the client and endeavours ... to help him find satisfying peer group experience; and to involve him in community organizations".[2] The length of the time a worker may follow a patient after discharge will be determined by the agency policy. If there is a good co-ordination of community resources for the handicap, one follow-up interview after discharge and/or referral to another agency may be sufficient before closing the case.

Method and Scope

This study undertakes a review, not of all that has been written on rehabilitation (which would be an enormous subject) but of a sampled cross-section of the more relevant findings of most recent writings. These include the Journals of Social Casework, the Archives of Physical Medicine, journals and periodicals specifically on rehabilitation, the Service Treatment Bulletins of the Department of Veterans Affairs (Canada). Specific works include the most relevant theses completed

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[1] Helen M. Wallace, "Role of Social Work in the Rehabilitation of the Handicap", Social Casework, January 1957, p. 15.

[2] John J. Horwitz, Education for Social Workers in the Rehabilitation of the Handicap, Council on Social Work Education, New York, N.Y., 1959, p. 30.

at the University of British Columbia in the School of Social Work, the writings of Kenneth Hamilton, Howard A. Rusk and his collaborators in the United States, and the findings of T.M. Ling and C.J.S. O'Malley and collaborators in Great Britain.

The literature has been evaluated in terms of its usefulness to the social caseworker as a team member in the program of rehabilitation of the physically handicapped. The focus is on the diagnostic work of the caseworker in rehabilitation.

The original plan was to study the caseworker in rehabilitation per se on the assumption that the casework approach is the same in all areas of rehabilitation. As Hans Selye in his book, The Stress of Life, speaks of a "syndrome of being sick" regardless of the disease, the writer suggests there is possibly a "syndrome of being rehabilitated" regardless of the disability - physical, mental, or financial. Because of the limitations of time, this study has been confined to rehabilitation of the physically handicapped. The terms "patient" and "client" are used inter-changeably within the scope of this study.

Two sets of criteria for rehabilitation have been devised from this review of the literature. These criteria have been assembled in relation to the client and to his environment. In Chapter II attention is drawn to those internal factors which the client brings to

the rehabilitation program. These Internal Criteria are those positive qualities which it appears are essential for successful rehabilitation. By having a check-list, or guideposts, at the outset of the rehabilitation casework services, the social worker, from her point of view, arrives at a more realistic prognosis. However, more important than the prognosis, the list would indicate areas of strengths and weaknesses within the individual. This therefore would give direction to the casework services.

In Chapter III attention is drawn to those external factors over which the client has little, if any, control, and yet these have an impact on the rehabilitation process. These External Criteria suggest a check-list to assess the client's family, financial resources, the rehabilitation center, the team and the community resources available for the rehabilitation program. Also in this regard the role of the team members is discussed and their contribution to the service. Here too there is a check-list which will aid the caseworker in determining the direction of the services for the client. Both client and worker would have a more realistic view of the limits of rehabilitation if this is seen in relation to the community.

No attempt has been made to assign weights to these criteria. It has, however, been helpful to see what criteria are aids to the social worker. The application of these criteria to numerous cases and analyses of rehabilitation process would be necessary if these

criteria are to be weighted. This was beyond the scope of this study.

In Chapter IV an attempt has been made to score actual completed case records against these pre-determined criteria. These case records have been selected independently of the study. The case-workers in the Medical Social Service Department of Shaughnessy Hospital, Vancouver, were asked for a list of those cases they would classify as successful rehabilitation from a physical handicap, and also for a few unsuccessful cases. From these, six successful and one unsuccessful cases were chosen. The selection of these cases was on the basis that the records showed the greatest degree of movement and involvement. An attempt was made to score the cases at the start of the casework services and later near the completion of the service. It was expected this would give an indication of the movement in the case and also at what time the criteria should be apparent. Movement in relation to the criteria was so varied it was difficult to draw a dividing time-line.

The reason for an emphasis on successful cases rather than unsuccessful is expressed in the following reference to the psychiatric emphasis in study of mainly the abnormal rather than the normal:

> The 'normal' and seemingly uncomplicated rehabilitative cases, studied intensively and in number, might yield a great deal of useful information, and increase our skill with the more difficult, perplexing and time-

> consuming problems which necessarily are immediate and critical concern. By neglecting the intensive study of those rehabilitative cases which proceed smoothly and apparently without incident, an opportunity to learn much is lost.[1]

These case studies however are primarily supplemental to the paper and therefore this cannot be said to be an intensive study of successful cases. Nevertheless much has been learned by illuminating the positive factors.

Such an approach - studying the theory as completely separate from the practical - has made integration of the two parts more difficult. In addition, by applying the criteria to the cases, it is possible other factors than those referred to had an influence on the rehabilitation process. These criteria, however, would be overlooked as other specified factors were being searched and evaluated.

Further, this approach has presented a challenge to the writer. There was always the possibility that Chapter IV would disprove some of the findings of Chapters II and III. Although it became apparent that all the criteria were not essential in every case, there were many factors which appeared in all the illustrations. The significance of possibility of giving value or weights to these criteria presents a further challenge.

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[1] H.A. Robinson and J.E. Finesinger, "The Significance of Work Inhibition for Rehabilitation", Social Work, vol. 2, No. 4, October 1957, p. 24.

CHAPTER II

INNER RESOURCES: THE CLIENT

The client for this study is a person whose normal functioning has been limited by a handicap, which is physiological or organic in origin rather than psychological or mental. There are numerous definitions of handicap. The one which is more encompassing is that stated by Kenneth Hamilton:

> A handicap is the cumulative result of the obstacles which disability interposes between the individual and his maximum functional level. It is an individual thing, composed of the barriers which the handicapped person must surmount in order to attain the 'fullest physical, mental, social, vocational and economic usefulness of which he is capable.[1]

This definition clearly separates handicap and disability. A disability is a "condition of impairment, physical or mental, having an objective aspect that can usually be described by a physician. It is essentially a medical thing".[2] The client in this study is one whose handicap is the result of a physical disability which has been diagnosed and defined by a physician. In this definition the author draws attention to the fact that the handicap is the result of a number of factors. This, therefore, implies the handicap will affect the client's functioning on a variety of levels.

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[1] Kenneth Hamilton, Counselling the Handicapped in the Rehabilitation, Ronald Press, New York, 1950, p. 17.

[2] Ibid., loc. cit.

The disability causes barriers to the handicapped person and these barriers may be the negative aspects in rehabilitation and must be considered by those helping the client. However, on the other hand, there are positive aspects in the client and in his environment which may off-set these barriers and aid the client in surmounting the obstacles. These positive aspects are the "criteria for rehabilitation" which must be assessed if rehabilitation is to be successful.

A survey of the literature on rehabilitation indicates the need for effective team work, adequate facilities, employment opportunities, the importance of the disabled person's family and the value of mobilizing all these forces in the rehabilitation process. However, in all this the client himself, as an individual having rights and feelings, must not be forgotten. There is little value in the work of the rehabilitation team if in the final analysis the patient is unwilling to co-operate with the team, or not in the need of the team's efforts, or unable to make use of the team's efforts. As has been stated, rehabilitation requires the patient's participation. The Council on Social Work Education has stated that:

> The student (in social work) should learn that in as much as not every disabled person is handicapped, he may in practice encounter disabled individuals who after careful assessment prove not to be in need of rehabilitation services. He should also have the opportunity to study the situation of individuals who, though handicapped, present an essentially unrehabilitatable picture at the present stage of our knowledge and resources.[1]

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[1] John J. Horwitz, Education for Social Workers in the Rehabilitation of the Handicapped, Council in Social Work Education, New York, N.Y., 1959, p. 47.

A. Initial Assessment

The first task to be undertaken therefore is an assessment of the client in terms of the need for rehabilitation. The first criteria would be a positive answer to the question: Can this person make use of the rehabilitation services? This fact is so basic as to be ignored to the point that it has been stated that too late one may "well wonder how often exaggerated rehabilitative measures have been designed for a gratification of the needs of the doctor rather than those of the disabled".[1] Such a statement could apply to any member of the rehabilitation team, not only the doctor.

To arrive at these criteria the client should be assessed as to (1) his need for rehabilitation; (2) his motivation; and (3) his physical ability to enter into a rehabilitation program.

Once it has been determined that the client has a physical disability and that limitations from the disability constitute a substantial handicap to employment and further that there is reasonable expectation of achieving vocational rehabilitation, the client's physical eligibility has been affirmed. The first assessment step is completed.

As this is primarily a medical concern, the client's eligibility will usually be determined by the physician who, in most rehabilitation centers, is considered the head of the team. (His role is more fully elaborated in Chapter III.) The degree of limitation, discussed later,

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[1]Bruce Thomason and Albert Barrett, Casework Performance in Vocational Rehabilitation, U.S. Department of Health and Education and Welfare Office, of Vocational Rehabilitation, May 1959, p. 1.

is not of concern in this first assessment but rather is a factor determining the scope and direction of the rehabilitation. At this point, however, the worker must be aware of the patient's physical limitations and prognosis for physical improvement. In the initial stage the worker must rate the level of physical improvement as to whether it is Good, Moderate, Poor, or Not Yet Diagnosed.

The client as an individual must be then considered. "One of the strongest forces within the disabled person which opposes his whole-hearted participation in the rehabilitation process is his intense desire to be treated like anyone else."[1] This attitude is closely connected with the client's acceptance, not only of the disability "but rather his acceptance of the fact of being disabled along with the consequences of such a state".[2] The work "acceptance" implies the active and individual process of "agreeing to" or having a "consenting mind".

> Translated into symptomatology commonly encountered in physical rehabilitation, the term is usually applied to three aspects of the subject's rehabilitation: physical, social and psychological. Physically acceptance implies that the patient is well aware of the nature of the disability, its origins, its complications and its prognosis. Socially, it implies that the patient is realistic toward his job, toward housing, toward family and other relations. Psychologically, it implies that the patient is showing no serious emotional symptoms referable to his disability.[3]

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[1]Robert Savard,"Casework and Resistance to Vocational Rehabilitation", Social Casework, December 1958, p. 564.

[2]Ibid., loc. cit.

[3]Rehabilitation Monograph II, "Psychiatric Aspects of Rehabilitation" The Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, 1952, p. 55.

Until the client has accepted his disability, it will be of little use to mobilize the rehabilitation program. The implication here then is for casework services to help the client come to the point of being able to make use of a resource - the rehabilitation program.

It should be noted here that society on the whole may also react to disability to the detriment of the rehabilitation of the disabled person. Acceptance is a two-fold program involving the patient's inner struggle as well as that of society. Society's impact on the program will be discussed later in Chapter III.

At this point it is important for the social worker, or any team member, to appreciate that denial is a common place factor in most illnesses and especially in chronic and disabling diseases. The denial may be intense and a major defence mechanism depending on the meaning of the illness to the patient. Denial may arise from an inability to understand the exact nature of the organic condition. Even being told the prognosis does not always bring understanding because the patient cannot find any place in his body image for the deformity. "Patients will deny deformity. There may be feelings of unreality and de-personalization. This symptomatology is essentially a defense which the ego unconsciously sets up to maintain its integrity in the face of the body image disturbance. The struggle is a painful one and, above all, is of an individual nature."[1]

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[1] Ibid., p. 58.

Another similar assessment which must be considered as a primary step is the client's motivation. There may be little or no indication of denial and the patient may, from outward appearance, have accepted the disability. This acceptance, however, may only be on the intellectual level and the individual will show little drive or determination to overcome the disability. In a recent article on the need of co-ordinating services for rehabilitation it is noted:

> As important as the improved physical function is the spirit or motivation of the handicapped. Even the most successful physical restoration is of little value in making the disabled individual socially and vocationally independent if that person lacks the determination to succeed.[1]

Between the need, which is the lack or deficiency, and the goal, which is the end result, there is the behaviour that leads to the goal. This "determiner" is the motivation.

A vivid example of the importance of this determination is seen in the biographical account of Lis Hartel's triumph over a paralyzing attack of polio in 1944. In referring to her illness after she had placed second in the riding competition at the 1952 Olympic Games, she said, "apart from the thought of getting better, there burned in me the urge to ride again".[2]

Where possible in assessing incentive, the worker should attempt to learn the individual's motivational history. An understanding of what

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[1] "Rehabilitation in Canada", Civilian Rehabilitation, Department of Labour, Canada, September-October 1959, p. 23.

[2] Sir Ian Fraser, Conquest of Disability, Odhams Press Ltd., London, 1956, p. 21.

has been the individual's determining tendency in the past with regard to motives and deterrents for job selection should be known.

The chart below is suggested for an initial appraisal of the client's ability, acceptance, and motivation just described. This assessment indicated the individual's ability to use rehabilitation services or whether casework service must remain at the level of preparation for rehabilitation. A basic principle of social work is to start where the client is. This schedule indicates this starting place.

Schedule A - Elements in Initial Assessment

Date: Elements	Level of Attainment			Service	
	Good	Moderate	Poor	Casework	Rehabilitation
Physical ability to enter program					
Acceptance of need for rehabilitation					
Motivation, incentive, etc.					

Often indications of an individual's awareness and acceptance of his disability may be found in the handicapped person's identification with prominent personalities similarly afflicted, or even with acquaintances who are handicapped. Such instances are seen in biographies or autobiographies of handicapped persons in recounting their progress during rehabilitation.[1] Among such personalities, the late President

[1]Sir Ian Fraser, Conquest of Disability.

Franklin D. Roosevelt stands out as the individual whose example has influenced many. However, it should be remembered that this identification must come from within the individual himself and not be imposed by an outsider.

B. Variables in Rehabilitation Potential

This initial appraisal of the client is an assessment of his eligibility for rehabilitation. That is, his level of motivation toward and readiness for rehabilitation. The social worker must, secondly, assess criteria necessary for successful rehabilitation. These pertain to the more factual aspects of the client's make-up. Most of these, pertaining to his past, may be referred to as "pre-determined". They can of course be positive or negative in characteristic, and be assessed dynamically. The criteria listed below are not in order of their importance to the rehabilitation, but rather they are those facts which can easily be collected even before a client/worker relationship has been established. Mr. Hooson in his study[1] lists groups of variables as factors affecting rehabilitation. These are reproduced here as guideposts to give direction to the rehabilitation services. These indices may have positive or negative value depending on many circumstances. These therefore must be considered on an individual basis.

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[1]William Hooson, The Rehabilitation of Public Assistance Recipients, Master of Social Work Thesis, University of British Columbia, Vancouver, 1953, pp. 108-115.

Age is easily obtained, and of prime importance. It is particularly relevant where the client is older, as his physical stamina may be affected as well as his resistance to infection, especially if his disability is due to spinal leision where kidney infections may be a factor. Further, employers in our society seem to militate against even the healthy older persons. However, there are instances where one of the requirements is dependability and the older, more mature person may qualify over the younger competitor. Age therefore is relevant, depending on the person, his disability, his potential and the goal.

A person's ethnic background or ethnic group must also be assessed. Psychologists and sociologists have done studies on group behaviour in various cultures. Some of these have been related to illness and the behaviour patterns in times of crisis and stress. The worker would better understand the client's behaviour when this is viewed against that of his ethnic group. With regard to employment, it is unfortunate but true, that one's colour or racial group may have an effect on job opportunities. Language may also be an employment barrier. Fortunately education will help overcome the language problem while education of the general public may relieve the colour problem.

Religion is another factor to be considered. Some religions have restricted patterns which may cause the client's withdrawal from the rehabilitation plan if the worker made a wrong suggestion. An example of

this might be seen where a social worker, or vocational counsellor, secured a potential job for client with a brewery only to find the client refusing because his religious beliefs would not permit his working for the firm. Religion also may have a more positive influence in the rehabilitation of the client and the social worker should be aware of the client's beliefs. One minister, stricken by blindness, wrote that he believed in healing by prayer, but such healing was not always evident. When it was not, he said, "accept the position, and get on in His strength with the adjustment and the victory".[1] Another writer showing the positiveness of religion said, in referring to having lost his own religious belief, "even without religion it is possible to overcome disablement" but no doubt with faith "it would have been easier still".[2] Religion must, therefore, be assessed as to its influence. For some it will be that force which supports their drive and motivation leading to mature and reasonable acceptance of the disability. For others, however, it may bring about self-recrimination and despair leading to unmotivated acceptance of the disability because it is God's will.

The client's innate intelligence must also be known. This can and should be determined by psychological testing administered by a qualified person. This is essential for the physical content of the vocational training and/or re-training program will be different for

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[1] Ibid., p. 8.

[2] Ibid., p. 217.

the mental defective than for the person of average or above average intelligence. The role of the psychologist and the testing will be referred to in Chapter III. This aspect of the client is referred to here as it is an important internal criteria which must be considered early in the rehabilitation process.

Closely allied with intelligence is the client's educational background. The record of past educational achievements, including apprenticeships, vocational and specialized training as well as formal schooling, give clues as to the type of training that may be embarked upon and also some indication of duration of time this phase of rehabilitation may require.

At this point it is also necessary to assess the employment skills and work history of the client. A review of the work history of the client can be helpful in determining his stability in a competitive situation, and, when related to the employment skills, can serve to indicate the individual's probable ability to undertake a new learning situation.

The client's pre-morbid personality must also be assessed, especially with regard to how he reacted to emotional stress in the past. "If a good estimate can be made of his pre-disability pattern, it is relatively easy to forecast the kind of reactions which he is likely to show during the changing phases of rehabilitation."[1] It is now recognized that

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[1]Ling and O'Malley, Rehabilitation After Illness and Accident, p. 6.

reactions of patients to any type of illness depend largely on previous personality make-up. The degree of reaction also depends on the meaning of the trauma to the person concerned. Over the years an individual may develop a pattern of behaviour when under stress. The individual's present strength or weakness will be better understood when considered in light of his past experiences. Because of the time factor of this criteria, it is not as easily determined as the criteria already referred to. A history of this type would not be possible until a firm client/worker relationship has been established. This takes time. However, the worker must be aware of its importance and be alert to it. It is mentioned here, for like the data collected to date, it is of the past and at this point in time unchangeable. The meaning of these criteria to the client will be of major importance in the course of the rehabilitative process. However, the facts themselves are definite and are internal criteria which affect the direction of the rehabilitation services. Diagnostically they are of utmost importance to the social worker in the initial assessment of the client.

The chart listed below offers a convenient visual assessment of the client to date. The advantage of putting in the age would be of use to the worker when planning future employment and the young adult would be considered an asset while those over 50 years of age, this would be classed as a liability. This, of course, depends on the employment potential of the client as well.

Schedule B - Variables in Rehabilitation Potential

Pre-determined Criteria	Asset	Questionable	Liability
Age			
Ethnic group			
Religion			
Intelligence assessment			
Education			
Employment skills			
Previous work record			
Pre-morbid personality			

C. Dynamics in Rehabilitation Potential

The remaining internal criteria directly related to the client as an individual are those which should be assessed as early as possible and are those with potential for change. Because of this possible change, these criteria should be assessed periodically during the rehabilitation service as they are evidence of where the client is at a given point in time. Such an assessment would also be helpful in determining the lack of movement.

As need for rehabilitation has arisen from physical limitations, the caseworker must at all times be aware of the physical limitations and capabilities of the client. Dr. Rusk in the book Rehabilitation Medicine draws attention to the program known as "Activities of Daily

Living" as being essential in rehabilitation service. "Activities in Daily Living (A.D.L.) is the terminology used to denote the basic activities which are inherent to carry on daily life, including getting to and from work, and how these activities are related to the individual patient."[1] The social worker is not expected to evaluate a patient's A.D.L. but must be aware of his level of achievement. From the physician, physio and occupational therapists, will be learned the answers to those questions asked by family members, potential employers, and the general community. When does the patient need help? What kind of help is necessary? Changes in this area may be quick or slow depending on the individual. The social worker must be alert to these so as not to under-estimate the client's ability and perhaps undermine his growing self-confidence, and also so as not to over-estimate the client's ability and thereby reinforce his awareness of his limitations. Different degrees of independence can be concretely understood by reference to Schedule D. This shows the classification used at the New York University-Bellevue Medical Center in New York City, and gives special attention to ambulation, self-care and other functional activities.

Closely related to Activities of Daily Living there is the need to know the patient's functional activity as related to future work placement. Such a classification is given in the book Rehabilitation After Illness and Accident:

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[1]Howard Rusk, Rehabilitation Medicine, C.V. Mosby Co., St. Louis, 1958, p. 136.

Schedule C - Work Classification[1]

Group	Description
Class I	Patients with cardiac disease resulting in slight limitations
Class II	Patients with disease resulting in slight limitation of physical activity - physical activity results in fatigue
Class III	Patients with disease resulting in much limitation of physical activity - less than ordinary activity causes fatigue
Class IV	Patients with disease resulting in inability to carry on any physical activity without discomfort

Classification will aid in the direction of casework services and focus on the need in rehabilitation.

As there can be expected changes in the physical development, so too can there be expected changes in the client's emotional maturity. Both areas are of interest to the social worker but she is perhaps more directly concerned with the emotional attitudes and morale of the client. "The paraplegic is faced with a great physical rehabilitation problem with which the medical staff is directly concerned. But he is also faced with a mental and social readjustment which is independent of the

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[1]Ling and O'Malley, op. cit., pp. 34-35.

Schedule D - Activities of Daily Living[1]

CLASSIFICATION OF PATIENTS ACCORDING TO INDEPENDENCE			
	FUNCTIONAL ACTIVITIES		
GROUP	PATIENT NEEDS HELP		PATIENT IS INDEPENDENT
	LIFTING	ASSISTANCE	
I	All A.D.L.	Patient not ready for any functional activity	
II	A.D.L. Bed	and wheel chair activities:	Self-care activities
III		A.D.L. Bed activities Wheel chair activities Self-care activities Eating activities Dressing activities Toilet activities Travel: Private care (from wheel chair)	
IV		A.D.L. Travel: Placing wheel chair into car. Ambulation in parallel bars: To standing position Standing and walking	A.D.L. Bed and Wheel chair activities Self-care activities Travel: Private care (from wheel chair)
V		Ambulation: 30 feet inside Climbing: 3-inch steps with rail	A.D.L. Bed and wheel chair activities Self-care activities Travel: Private car (from wheel chair) Placing wheel chair into car
VI		Ambulation: Climbing: 3 to 8-inch steps with rail 2 to 6-inch curbs	A.D.L. Bed and wheel chair activities Self-care activities Travel: Private car (from wheel chair) Placing wheel chair into car Ambulation: 40 feet inside
VII			A.D.L. Bed and wheel chair activities Self-care activities Travel: Private care (from wheel chair), (standing). Elevation: wheel chair, bed, toilet Ambulation: 40 to 80 feet inside Climbing: 10 to 12 8-inch steps with rail 6 to 8-inch curb A.D.L.: Wheel chair and ambulatory Ambulation: 80 to 120 feet continuously Cross street while light changes including curbs Climbing: 12 to 15 8-inch steps with rail Travel: Private car; public transportation (bus).

[1] Rusk, Rehabilitation Medicine, op. cit., p. 146.

physical. The success of one depends on the success of the other."[1]

In listing those factors affecting rehabilitation Mr. Hooson in his Thesis noted that emotional attitudes must be assessed. By this he means that until the client has learned to cope with anxiety, fear, tension, hostility and guilt, he will never be able to fully participate in plans for rehabilitation.

In addition, it is pointed out that morale must also be considered. Morale appears to be closely related to self-worth. Good morale is typified by the expression of a sense of belonging, of purpose, of objective recognition of capacities, achievement, and limitations on the part of the individual.

Also given in the Hooson thesis, there is an elaborate schedule for rating the emotional maturity of the client. For this thesis, by highlighting the criteria which would seem to be essential for successful rehabilitation, a more simplified schedule of emotional maturity has been devised.

Mr. Hooson also draws attention to the fact "that one area which does not appear to be given sufficient consideration is that involving the emotional attitudes of the handicapped person".[2] He further elaborates that much of the success of rehabilitation lies within the individual himself and that is the area of concern of the social worker.

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[1] D. George Petrie, "Readjustment of Paraplegics to Family and Society", Treatment Services Bulletin, November 1958, Department of Veterans Affairs, Ottawa, p. 44.

[2] William Hooson, The Rehabilitation of Public Assistance Recipients, Master of Social Work Thesis, University of British Columbia, Vancouver, 1953, p. 6.

Mr. Petrie, a paraplegic and practising lawyer, substantiates this opinion stating "that mental adjustment is largely up to the patient, but is contingent upon the other two factors of physical limitation and social background".[1]

It is assumed that today all qualified social workers are aware of those factors which determine emotional maturity. This list is concise and is not concerned with varying demonstrated degrees of emotional maturity. Rather it is concerned with what is normal or average maturity. Further, this thesis is focused on criteria for rehabilitation and not concerned with the dynamics of the casework method.

Sexual adjustment is listed first. In the area of sexual adjustment, it is suggested that the emotionally mature person enjoys heterosexual relationship, and has the capacity to give and to receive love and affection.

Secondly, there is achievement. This is typified by the display of good sense of goal with clarity of purpose on the part of the individual.

Social consciousness is seen when an emotionally mature person expressed a sense of give and take in his inter-personal relationships.

Finally, self-worth is when the mature person has a good opinion of himself as shown by his display of self-esteem, self-respect, and by his

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[1] D. George Petrie, op. cit., p. 44.

self-confidence in his own abilities and potentialities.[1]

Miss Beck in her study has devised an analysis schedule in relation to "Participation in Interviews".[2] This could usefully be included as part of a summation compilation of important significant emotional attitudes, morale and emotional maturity, which are brought together in Schedule E. It is suggested that a client's ability to verbalize his feelings appropriately and take an active part in the interview indicates his acceptance of the rehabilitation program and his willingness to participate.

These criteria in Schedule E are arranged in such a way as to be useful for the initial and subsequent interviews as it is expected there will be some change in the course of treatment.

The casework services in rehabilitation require direction and purpose. An assessment of the client is therefore important if a balance of his strengths and weaknesses is to be maintained. Those factors directly related to the client must be understood. Internal criteria, as assessed in this chapter, may be conveniently understood in three "areas": (a) initial assessment of the client in terms of his ability, acceptance and motivation; (b) an awareness of the positive and negative aspects of those variables with rehabilitation potential related to age, ethnic group, religion, intelligence and

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[1]Hooson, op. cit., pp. 134-141.

[2]Dorothy Beck, Resistance of the Adolescent to Casework Services, Master of Social Work Thesis, University of British Columbia, Vancouver, 1954.

Schedule E - Emotional Attitudes and Morale

CRITERIA OF PERSONALITY DEVELOPMENT	INDIVIDUAL'S BEHAVIOUR DURING			
	Initial	Later	Later	Later
Emotional attitudes: 1. Ability to cope with anxiety. Inability to cope with anxiety. 2. Ability to cope with hostility. Inability to cope with hostility.				
Morale: 1. Sense of belonging. Sense of rejection. 2. Recognition of capacities. Little recognition of capacities.				
Emotional maturity: 1. Sexual adjustment: average below average 2. Achievement: average below average 3. Social consciousness: average below average 4. Self-worth: average below average				
Participation in interview: High degree Moderate degree Moderate resistance High resistance				

education, work record and his pre-morbid personality; and (c) those dynamic characteristics with rehabilitation potential found in the client's ability to fulfill daily routine activities of self-care and ambulation, the work classification and the individual's personality development as noted in his emotional attitudes, morale, and emotional maturity.

It has been said that "there are few stumbling blocks in the rehabilitation of a patient other than those created by the patient's emotional problems. The handicap consists of how a person feels about being ill, together with the emotional value in remaining incapacitated."[1] Further, it is recognized that when ill a patient is removed from his family and this usually will cause additional stress and pressures. "The full understanding of an illness is incomplete if this important factor and its implications are overlooked."[2] This will be covered in Chapter III. It is acknowledged that the assessment of the client will be greatly affected by his position in his family and his responsibilities. The criteria set forth in this thesis are by no means in order of importance or a chronological assessment. All contribute to the total assessment of the client and the criteria for his rehabilitation.

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[1] Ling and O'Malley, op. cit., p. 13.

[2] Ibid., loc. cit.

CHAPTER III

EXTERNAL RESOURCES: THE CLIENT'S ENVIRONMENT

The client is an individual with a disability which has limiting effects requiring adjustment. The word adjustment implies a subject and an object, that is, someone adjusting to something. This chapter is concerned primarily with the client's adjustment to his environment, which is part of the object of adjustment, and to those who help or hinder the adjustment.

Once again a continual assessment and appraisal of these factors must be known to those working in the rehabilitation process. These factors may be considered as the external factors. "Rehabilitation is an integrated process ... concerned with his (patient's) physical condition, his position as a member of society, his outlook on life, and his occupational placement."[1]

This chapter therefore is concerned with those external factors in the client's environment over which he has limited control. These factors must be considered in order to have a total picture of the client. The client in a sense is set aside, having been assessed, and his environment is now considered. In actual practice these two areas, the internal and external, cannot be so categorized for each impinge upon the other. However, for this study purpose, this has been done. These factors are considered from the point of view of

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[1]Kenneth Holt, A Rehabilitation Programme for Polio Patients, op. cit., p. 2.

their positive value as aiding the client's endeavours to surmount the barriers which Mr. Hamilton referred to in his definition of a handicap. In addition, these factors are indications of areas where the casework technique of "environmental modification" may be needed if rehabilitation is to be a reality for the client.

Because "it is his body that is crippled, his family that suffers, his place in society and industry that has changed, rehabilitation diagnosis is compiled from the physical, social, mental and vocational diagnosis".[1] What then are these external criteria that must be assessed or diagnosed? Each will be looked at from the social worker's point of view.

First and foremost, the client's family must be assessed. Mr. Hooson[2] in his thesis draws attention to this, for he sees the family as a source of financial aid and, perhaps more importantly, assisting by their attitudes to the client and their emotional support and praise of his efforts to improve his situation. In Miss Hagerman's thesis, The Family as a Rehabilitation Resource, the purpose is "to explore and assess the ability of families to meet certain needs of their disabled breadwinners ... and to indicate ways in which the family might be enabled as a resource to improve the disabled breadwinner's rehabilitation potential".[3] More specific reference will be made later in the contribution of the findings of this thesis to this present study.

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[1] Ibid., p. 13.

[2] William Hooson, The Rehabilitation of Public Assistance Recipients, op. cit.

[3] Goldie Hagerman, The Family as a Rehabilitation Resource, Master of Social Work Thesis, University of British Columbia, December 1959, p.i.

The client's financial status must also be assessed as this will influence his motivation. In this regard the resources available in the community must also be known by those planning rehabilitation.

Another factor influence in the client's general well-being is his use of leisure time. Mr. Hooson[1] draws attention to the fact that community organizations, like service clubs and church groups, may assist in the overall rehabilitation program by raising the general morale of the client through his group participation.

Not only is the client's rehabilitation affected by his family and those he associates with, but also his progress is directly related to the rehabilitation team members. In considering this aspect of the client's environment, the social worker as an enabler shall be considered separately from the other team members. The rehabilitation center will be considered with special emphasis on the value of the team approach. Finally, the value of community resources will be assessed as a means of helping to meet some of the client's needs.

A. The Family as a Rehabilitation Resource

An English psychiatrist in a paper on mental health and work draws attention to the fact that surnames are derived from "patronymics, place names and occupations. It looks like our family, our place of origin, and the work we do, are the three important elements in our

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[1]Hooson, op. cit., p. 115.

very sense of identity."[1] The family is the basis of our society and therefore in assessing the external factors concerning a person in rehabilitation, his family of origin and his family of procreation must be considered. "In order to modify attitudes and behaviour one must relate not only to early developmental experiences that have shaped the personality and created the present self-image, attitudes and defenses of the client - one must also understand the emotional forces that continue to act upon and influence the client."[2] Miss Hagerman in her thesis points out that if the family is overlooked as a resource, the rehabilitation services are inadequate and the process of rehabilitation is handicapped from the beginning. The family is also seen as a part of the rehabilitation team, apparently viewing the family as an extension of the treatment team. In this regard, Dr. Millet is quoted from his address to the Institute on Rehabilitation in June 1956 at Bryn Mawr College:

> The structure and attitudes of the family as well as their economic status, should be fully and economically investigated by the social worker on the team, whose role is to act as an ambassador from the rehabilitation team to the family and to see that the family is made to feel a part of the team.[3]

Miss Hagerman in her thesis illustrates that all families do not

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[1]G.R. Hargreaves, "Mental Health and Work", Mental Health, National Association for Mental Health, London, England, Summer 1959, p. 44.

[2]M.R. Gomberg, "Some Dynamics of Interprofessional Practice in Rehabilitation", Social Casework, July 1958, p. 389.

[3]Hagerman, op. cit., p. 75.

necessarily mean strength. There are weak families as well as strong families. The client's family must be assessed as to how it will aid or inhibit rehabilitation. "The caseworker may prepare a patient-family diagnosis which should indicate the means to strengthen the family as a group and as a resource to meet the patient's special needs."[1] A schedule[2] is therefore submitted in the thesis as a means of assessing the criteria of family strength. This assessment is based on the family's ability to meet the patient's physical needs by (a) income provision and (b) personal care, and on their ability to meet the patient's emotional needs by (a) their acceptance of dependence and (b) their encouragement of independence. The assessment range was Strong, Some strength, Borderline, and Weak. From this chart in the Hagerman thesis which was used to compare the families studied, a scale has been devised to rate the client's family.

SCHEDULE F - Family Strength

PATIENT'S NEEDS	FAMILY'S CONTRIBUTION					
	+2	+1	0	-1	-2	Total
Income provision						
Personal care						
Acceptance of dependence						
Encouragement of independence						

The scoring values are determined by the family's contribution.

[1] Ibid., p. 79.

[2] Ibid., p. 57A.

That is, +2 would indicate a positive answer, while -2 would mean the family was unable to assist. A score of +1 would indicate that the family was willing to help but could offer only limited assistance; while the score of -1 would indicate a family's assistance being given but in an unwilling or reluctant manner. A score of 0 would mean the client was able to meet this need himself. Such scoring, however, is relative and dependent on the social worker's ability to assess the known facts. Nevertheless, it would indicate to the worker the amount of assistance that it would appear is available from the client's family. This would also show the need for modification of the client's environment if the family were weak. Further, if financial help and/or personal care were needed and not to be found within the family, the worker would be aware that other resources would have to be investigated. An illustration of the value of knowing what to expect from the patient's family was seen in one of the cases studied. It was noted by the worker that the patient required assistance to move from his wheelchair to the car. This would fall in the area of personal care. Preliminary steps were taken by the worker to arrange for an orderly to be on hand to do this when the patient went home on a week-end pass. It was then learned that the patient's family, also being aware of the patient's need for assistance, had built into the family car an arrangement of ropes and pulleys so that the patient's wife could easily assist him in and out of

the car. Fortunately this was discovered before the orderly was dispatched to help. The worker had underestimated the ingenuity, ability and willingness of the patient's family and had in a sense "wasted" her own time in making unnecessary arrangements. (The word wasted is in quotation marks for an experience should not be termed wasted if some value is learned from it!)

Miss Hagerman also draws attention to the fact that the family's effect on the patient's employability is conceived to occur through activities and attitudes related to the physical and emotional needs, especially with regard to his dependency needs and the family's support of his plans for independence.

In this regard the section of the thesis, "Patient-Family Diagnosis and Treatment in a Clinical Setting" indicates means of aiding the family in engaging in the patient's treatment. This is an area essential to casework service in rehabilitation but is not elaborated upon in this paper as the focus here is primarily on the patient and assessing the criteria which will aid or inhibit his rehabilitation.

With regard to the patient and his family, the patient's role[1] in his family must be assessed. An example of this is when the

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[1] Note: "Role" refers to "the way in which an individual perceives himself and is perceived in relation to the expectation of society". Dr. H.D. Stein, "Socio-cultural Concepts in Casework Practice", Smith College Studies in Social Work, February 1959, Smith College School for Social Work, Northampton, Mass.

disabled person is the breadwinner in the family. "The breadwinner role in the family is generally regarded in North American culture as the prerogative and obligation of the male who derives status from adequate role performance. When this role is discontinued, emotional disturbance may result, not only from insecurity attendant upon loss of income. This may be evidenced in the behaviour of each family member and in the inter-family relationships. To these stresses, caseworkers must be sensitive in order to help the patient sort out and clarify the roles with which he experiences stress so that attendant conflicts may be resolved."[1] There is the danger on the part of the worker in helping the patient to resolve the difficulties for him. That is, his role as patient may become so important to the worker as to overshadow his role within the family. Even during illness or in rehabilitation process, the patient's family role does not change. Some of the responsibilities of necessity are removed but the patient's opinions regarding decision-making are still as important as when he could carry these decisions into action. His responsibility as father or husband to do all that is within his power to provide for his family holds true whether the individual be active or temporarily incapacitated. Miss Towle draws attention to the fact that workers may tend to "stress the handicap as though it were the total person rather than merely an aspect of him" and thus "the worker saw Mr. D. as a tuberculous patient

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[1] Hagerman, op. cit., p. 42.

rather than as a man who had been the head of his family and who still had both the inclination and the capacity for participation in the management of family affairs".[1]

An understanding of the client's family role will also indicate the responsibilities ascribed to that role. The worker must assess which of these responsibilities the client can still perform and evaluate these in terms as to whether they will aid in the client's motivation to improve or whether they are responsibilities which he would prefer to avoid and which would inhibit his motivation. Therefore, any information on how the family functioned as a group prior to the present situation will give further indications of the family's strengths and weaknesses.

Thus it can be said that two of the most important external criteria which will affect the rehabilitation process are (a) the strength of the patient's family and (b) the patient's familial role and its effect on his motivation for rehabilitation.

B. Financial Standing as Rehabilitation Resource

What then of the patient's financial standing? This is very closely connected with the patient's family responsibilities. Such details as to the patient's medical insurance coverage and community

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[1]Charlotte Towle, Common Human Needs, National Association of Social Workers, New York, N.Y., 1957, p. 74.

provisions to offset medical expenses may be routinely recorded by the accounting office. However, the worker must be aware of how expenses are being met; how the patient feels about his financial situation; and the worker must know what community funds may be called upon to meet emergencies. If the patient is the breadwinner, his loss of salary may mean the family will need Social Assistance and in all likelihood the patient and his family will need help in accepting the realities of this fact.

Mr. Rohn, in his thesis[1], draws attention to the fact that all economic levels are affected by medical and rehabilitation costs. The lower a patient is on the economic scale, the harder the problems press upon the individual. In addition, direct medical costs, rehabilitation costs, and problems are multiplied when the individual is the breadwinner and his family must be maintained.

With regard to hospitalization costs, protection to the individual varies in Canada depending upon the medical coverage for adults in each of the provinces. In Newfoundland there is "prepaid public ward hospital care for all residents under the federal-provincial hospital insurance plan which began in July 1958".[2] There is no universal coverage in Quebec. However, some special groups receive assistance on a means test so that "persons in Quebec unable to pay for hospital services during the acute or post-acute phases of poliomyelitis receive

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[1]Rohn, Rehabilitation of Arthritis Patients, op. cit.

[2]Rehabilitation Services in Canada, Part II, Provincial and Local Programs. Health Care Series Memorandum No. 9, Research and Statistics Division, Department of National Health and Welfare, Ottawa, February 1959, p. 4.

free care under the Quebec Public Charities Act".[1] Then in British Columbia it is noted that:

> Under the British Columbia Hospital Insurance,[2] all residents of the province are entitled to public ward hospital care, including physiotherapy and certain diagnostic services, in active treatment hospitals at a nominal 'co-insurance' charge of $1.00 per day.
>
> Care in chronic hospitals and nursing homes is not covered by the Hospital Insurance scheme, but the Social Welfare Branch pays costs for social assistance recipients, a substantial portion of the in-patients population.[3]

In addition there are certain national groups which provide financial assistance to sub-groupings within this category of the disabled. Such groups are the Workman's Compensation Board, Department of Veterans Affairs, Canadian Paraplegic Association, Canadian National Institute for the Blind, Canadian Arthritis and Rheumatism Society and the Canadian Foundation for Poliomyelitis, to name but a few of these national organizations.

Another factor in relation to the financial aspect of rehabilitation is the re-classification of a patient from acute stage of illness to that of being classed as chronically ill. This classification is often necessary and is defined by legislation related to financing of care under the various provincial departments of Health. An illustration of the meaning of this classification to the patient was

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[1] Ibid., p. 79.

[2] Hereafter referred to as B.C.H.I.S.

[3] Rehabilitation Services in Canada, op. cit., p. 195.

noted in the Holt thesis already referred to. A few years ago in British Columbia a poliomyelitis patient after three months in hospital would be classified as "chronically ill" and therefore no longer eligible for B.C.H.I.S. coverage. However, the patient often was not told of this re-classification immediately. But what can this mean to the patient when he finally is informed?

> The anger which is aroused by the ruling is often intensified by the delay in notification. The knowledge that he has been ruled to be no longer acutely ill is not as disturbing to the patient as the fact that he owes the hospital several hundred dollars. Nor is it as disturbing as the implication that his condition has been classified as chronic by a person who has never seen him.[1]

Fortunately today the practice is that the hospital is immediately notified of the re-classification, the doctor is informed and he tells either the patient or the social worker. Then the worker, with the patient's co-operation, will seek financial assistance, if it is needed.

The area of finances must be considered as an external criteria in rehabilitation. This must be assessed in terms of (a) the financial status of the patient as it affects his treatment and the welfare of his family, (b) those financial resources which may be called upon for assistance, and (c) the meaning of these financial considerations in relation to motivating or inhibiting the patient's

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[1] Holt, op. cit., p. 38.

progress. It must not be forgotten that "the absence of economic security of many patients is an important factor affecting their way to recovery".[1]

C. Leisure-time Activities as a Criterion

Among the social needs of the disabled "is the need for satisfying relations with his family and friends".[2] Recreation facilities and leisure-time activities are those which will take the patient out of himself and put him in contact with his family and friends. The patient's use of leisure-time activities therefore is another external factor which must be assessed. "The recreational service gives the patient an opportunity to participate with others in various social activities. If the patient does not use this service, it is important to understand why he does not. Very often he will avoid social contacts at home if he does so at the center."[3] However, before assuming that the patient's avoidance of social contacts is withdrawal which is unhealthy, the worker must assess why he is doing so. In this regard it must be known: What were the patient's social activities before his disability? Does he have friends and interests apart from the hospital? Would he perhaps be better advised to maintain these friends and interests rather than being encouraged to enter a program in which he would not take an interest?

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[1] Rohn, op. cit., p. 24.

[2] Rusk, op. cit., p. 255.

[3] Rusk, op. cit., p. 259.

As in all other areas of rehabilitation, the worker must guard against "pushing" a patient into a social activity. Perhaps some "environmental manipulation" can create a situation which will encourage socialization. An incident might best illustrate this:

> Prior to admission to the Center, S had never gone out-of-doors in her wheel-chair. Social activities had been restricted to gatherings at home or at parties with friends. At the end of the first month at the Center, it was necessary that she and another patient buy shoes for their braces. It was suggested that the girls could go by taxis to the village and do their shopping.
>
> The girls decided perhaps they would enjoy having supper at the village hotel and so obtained permission for an extended pass. As the hotel was just two streets from the shoe store, they decided to "push over" on their own. Neither of the girls had counted on the slippery and icy streets, and literally got stuck in a snow bank. Two of the villagers came to their rescue and the girls were given a push to the hotel. They returned to the Center by taxi.
>
> Later: This was the first of many social outings for S.

Leisure-time activity is another criteria and should be assessed in terms of (a) what are the hobbies, interests, and social activities of the patient; (b) what facilities are available for him to carry these into action; (c) what use is he making of these facilities; and (d) if he is not using the facilities, why not? There seem to be few limitations in activities for the disabled. The blind are taking up bowling and those in wheel-chairs are taking part in basket-ball games and square dancing.

D. The Rehabilitation Center as a Resource

The setting for the rehabilitation is another external factor over which the patient has limited control and yet this is the prime factor in the rehabilitation process. It may be a rehabilitation center, a general hospital, a chronic hospital, or any other setting where there are professional people assisting in the patient's rehabilitation. Although the tendency since World War II has been for independent rehabilitation centers, Dr. Rusk draws attention to the need for expansion of rehabilitation services in general hospitals:

> It is also within the general hospital that much service can be brought to the patient at the earliest possible time and costly and damaging physical, emotional, social, and vocational sequelae of the acute disease process or trauma be alleviated or minimized.
>
> To ignore the development of rehabilitation services within general hospitals is to guarantee the continued deterioration of many less severely disabled persons until they, too, reach the severely disabled and totally dependent category.[1]

Within this setting the principal factor to be assessed is the rehabilitation team. The value of this team lies in its ability to integrate the findings of the various team members. This, therefore, implies that each member is aware of the particular role[2] of the other members. The principal responsibilities of the various team members are based primarily on those defined by Dr. Rusk and in

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[1] Rusk, op. cit., p. 19.

[2] Role here refers to the major functions a person carries at a given time with its broadly designated behaviours and responsibilities.

use in the New York University-Bellevue Medical Center. These are spelled out in this paper because it is expected that the social worker will be responsible for "social management" in the rehabilitation setting and "it is necessary for her to establish good working relations with the other team members. Thus, understanding of the other team members is essential. There may be interchange of roles frequently among team members, ... and rigid adherence to roles serves no constructive purpose."[1] The specific aspects of the social worker's role was defined earlier in Chapter I. At this point it should also be noted that the social worker may be called upon to answer the patient's questions regarding the roles of other team members and so a general awareness of these roles is needed.

"The rehabilitation physician is in charge of his patient, just as he is in the standard patient-doctor relationship. He decides on admission and discharge with help from other team members."[2] It is also said of the doctor that he should be "the initiator of all forms of rehabilitation, but if he is to fulfill his function he must develop an attitude of mind that will enable him always to regard the patient and his disease against his background of everyday living and his place in the community as a whole."[3]

The physical and occupational therapists work closely with the patient. "The nature of their work causes the patient pain and

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[1]Rusk, op. cit., p. 258.

[2]Rusk, op. cit., p. 258.

[3]T.M. Ling and C.J.S. O'Malley, op. cit., p. 41.

anxiety and emphasizes to the patient his physical inadequacy. The situation calls for skill and understanding on the part of the physical (and occupational) therapist. It becomes clear at times why the patient misses his program - to avoid pain and anxiety, not just treatment."[1]

The nurse in rehabilitation is seen in a new role of helping the patient to do for himself rather than doing things for him. The ward becomes for the patient the place "where he is expected to practise what he has learned in class. ... In such a situation ... the patient may feel there is lack of understanding for his pain and anxiety. For this reason there may be excessive complaints about nurses."[2]

"The psychiatrist is responsible for the diagnosis of mental and emotional illness. He is a consultant for all team members and agency representatives, and he engages in psychotherapy."[3] This specialist treats the patient against the background of his environment, and in the light of the personal, interpersonal, and social meaning of the illness. "Illness representa a serious threat to the patient as a self-sufficient, intact individual, and hidden forces operating within him may have much to do with its course and outcome. These influences cannot be ignored in any treatment program for any illness

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[1]Rusk, op. cit., p. 258.

[2]Loc. cit.

[3]Rusk, op. cit., p. 259.

or any handicap; they spell the difference between success and failure in our efforts and they are indeed basic materials with which to work."[1] In many instances the psychiatrist may work more closely with the social worker in the management and understanding of patients needing intensive casework. However, whether this phase of treatment is carried out by the psychiatrist and/or the social worker it is necessary that basic to his or her effort "is the principle that the disability is not so much what the examiner perceives it to be, as it is what the patient perceives it to be".[2] The worker can discover this dynamic element by getting to know the patient and his problems and by application of knowledge and skills in inter-personal relations.

In summary, a psychiatrist has said of his role in the team:

> The psychiatrist is but one of the team of specialists and auxiliary workers active in the rehabilitation field. Although he must assume important diagnostic and therapeutic functions in the more difficult and complex cases, his role is predominantly advisory and educational.[3]

"The vocational and psychological services offer counselling to the patients to help them to adjust to the services, as does social service, until they are able to plan vocationally. Since patients come primarily for physical reasons, timing is essential in prevocational

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[1] Francis J. Braceland, "The Role of the Psychiatrist in Rehabilitation" reprint from Journal of the American Medical Association (September 1957), as a supplement for Canada's Mental Health, June 1959, Ottawa, p. 2.

[2] Ibid., p. 6.

[3] Ibid., p. 11.

training."[1]

One writer has described the role of the welfare rehabilitation:

> To help the client to understand his own capacities, to kindle within him the desire to take his place in productive community life, to aid him to take full use of community rehabilitation facilities, and ultimately to select with him a suitable type of work and to plan the approach to the prospective employer.[2]

To do this the counsellor will enlist the aid of the client, the National Employment Services (Special Placements Division), employers and community groups and if possible work toward a coordinating committee.[3] In many instances the counsellor's work will overlap that of the rehabilitation social worker. It is therefore important that they work together toward the same employment goal for the client.

"The psychologist has specific tools to use in and contributions to make from his psychologic testing. His projective technics are diagnostic aids aimed at uncovering unconscious conflicts. Understanding gained from an evaluation of these areas is of vast importance in determining the personality limitations and potentialities of the patient."[4] A three-year study (1948-1951)[5] in New York brought forth some very interesting and noteworthy results, especially with regard to

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[1]Rusk, op. cit., p. 259.

[2]M.E. Steinberg and M. Bluestone, "Rehabilitation is a Public Welfare Agency", Social Casework, December 1955, p. 470.

[3]Bruce Thomason and Albert Barrett (ed.), Casework Performance in Vocational Rehabilitation, U.S. Department of Health, Education, and Welfare, Office of Vocational Rehabilitation, Washington, D.C., May 1959, p. 39.

[4]Rusk, op. cit., p. 259.

[5]Rehabilitation Monograph II, "Psychiatric Aspects of Rehabilitation". A three-year study (1948-1951) financed by The Commonwealth Fund and conducted under the auspices of the Departments of Psychiatry and Physical Medicine and Rehabilitation of New York University-Bellevue Medical Center.

psychological testing. The Rorschach Ink-Blot Test and Thematic Apperception Test were used in the evaluation of the patient's personality, defense mechanisms employed by the patient, his areas of difficulty, and his present level of adjustment. The following areas mentioned attributes of personality structure correlate highly with success in rehabilitation:

> Ego strength - The individual's relation to his environment and his ability to interpret reality. This factor was especially important in estimating the patient's acceptance of his disability.
>
> Ability to relate to other people - This ability was estimated on the basis of human perceptions and emotional spontaneity. An evaluation of the Rorschach records suggested that a greater ability to relate to people tended to make for a better prognosis.
>
> Integration of personality - The ability to handle emotions and anxieties in a realistic manner.[1]

Other aspects of the Rorschach test was of value in predicting success or failure in rehabilitation. It was also as an aid in vocational guidance where the tests were based on personality structure, analysis of thinking process, and analysis of drive and ambition.

The Wechsler Bellevue Intelligence Scale for Adults was found to be the most satisfactory test for evaluating intelligence. It was also of interest to note that the results to this study "indicate that intelligence, as measured by the I.Q., was not correlated very highly with degree of success in rehabilitation. Discrepancy between functioning

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[1] Ibid., p. 49.

level and intellectual endowment was a more noteworthy factor in predicting success in rehabilitation."[1]

The California Interest Inventory was used in this study but it was found that it did not always give a complete picture of the individual. It was therefore recommended that this test alone could not be depended upon for vocational placement.

An awareness of the tests being administered and their reliability is of value to all team members, and especially the social worker.

For the patient who cannot communicate through speech and has severe hearing losses, there is great limitations in his ability to adjust. "The speech and hearing services offer a unique contribution. The anxieties which arise from speech and hearing losses present serious problems of frustration and misunderstanding between the patient and his family."[2]

The recreational director provides opportunities for the patient to participate with others in various activities. Reference has already been made to the importance of social activities for the patient. These are mentioned again so as to show the place of the recreational director on the rehabilitation team. This member may not always be a professionally trained person but his contribution to the patient's total welfare and to the team's understanding are his qualifications for attending team conference.

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[1] Ibid., p. 50.

[2] Rusk, op. cit., p. 259.

"The prosthetic services also play an important role in the rehabilitation, since the patient's use of a prostheis indicates his ability to come to terms with his loss. At times, the service is called upon to meet a social problem of magnitude. If a person cannot learn to walk with artificial limbs, should they be secured for him? From a social worker's point of view, the dignity and independence of the human being is violated if, for no other reason that cosmetic reasons, the legs cannot be secured."[1] A problem such as this shows the importance of all team members discussing the meaning of the limb for the patient and the recommendation for its purchase even though it will serve no useful walking purpose.

However, it is not enough that these various specialists know their role and that of each other. The members must in addition function as a democratic team. Dr. Frederick A. Whitehouse in an article, "Teamwork: Philosophy and Principles", clearly defines the operations of this clinical team:

> I would define such a team as a close, cooperative, democratic, multiprofessional union devoted to a common purpose - the best treatment for the fundamental needs of the individual. Its members work through a combined and integrated diagnosis; flexible, dynamic, planning; proper timing and sequence of treatment; and balance in action. It is an organismic group distinct in its parts, yet acting as a unit, i.e., no important action is taken by members of one profession without the consent of the group ... the professions act, think, interpret, and contribute toward a diagnosis which is the product of all, and a

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[1]Rusk, op. cit., p. 260.

> treatment plan which is dynamic to accommodate the changes which a human organism is constantly making.[1]

As has been suggested, the components of the team must be assessed. Of equal importance for assessment is that of the team function as a unit. The members individually and as a team are external factors which will aid or inhibit the rehabilitation process.

Good communication is another essential if the team is to contribute to the rehabilitation. Formal discussion and written reports are essential. However, it must be recognized that "most of the real teamwork goes on through the day and the week in small conferences and exchanges, ... and with a perceptiveness and alertness to what observations will be useful to them (team colleagues)."[2]

The dangerof one profession working in isolation and not communicating his plans with the rest of the team is cited by Dr. Whitehouse:

> I have seen people prodded from wheel-chair, to crutches, and thence to canes, because it made the medical department happy about progress, when it did more harm than 'good' to the individual's psychic balance and even employment opportunities.[3]

E. Community Resources

The rehabilitation center for a time provides the means and

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[1] Social Work Practice in Medical Care and Rehabilitation Settings, Monograph II, Frederick Whitehouse and Miriam Collier, "Teamwork: Philosophy and Principles", American Association of Medical Social Workers, July 1955, p. 8.

[2] Ibid., p. 15.

[3] Ibid., p. 16.

facilities to meet the patient's needs. Food, clothing and shelter are supplied by a staff of people primarily interested in the welfare and progress of the patients. But what of that group of people outside the center - the community to which the patients will be discharged. What are the means and facilities this community will provide? In addition to assessing these sources which will aid the discharged patient, a worker must also be aware of those resources which are available for use while the client is a patient in the center. Both client and worker look to the community for financial assistance, housing facilities, vocational facilities and employment opportunities.

"Community resources needed by the physically disabled are not always available to him after he leaves a rehabilitation center."[1] An assessment of the internal and external factors as previously described would not be complete if the external features of the community were ignored. The community beyond the rehabilitation center, the hospital or the rest home is the place to which, hopefully, the person will be returned, or to which and for which he is rehabilitated. If the community cannot, or will not, accept the rehabilitated back into society, has rehabilitation been realistic? This is not to suggest that the level of rehabilitation should be determined by the level of acceptance of community understanding, especially where the community at large lags behind the medically known and professionally

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[1]Rusk, op. cit., p. 263.

accepted level of rehabilitation possibilities. However, attention is here focused on the necessity for both the rehabilitation team and the patient to be aware of the community resources which will aid or inhibit the rehabilitation process.

It has been said of modern medicine, "We have added years to life; it is our responsibility to add life to years".[1] Adding life and meaning to rehabilitation would seem also to be the task of the community. "In many instances in the patient's total adjustment encountered after discharge, such as in housing or employment, may nullify much of the benefit previously achieved."[2] When there is an inadequacy of facilities, or resistance in the community, there is the danger of "staff losing their enthusiasm for improving function in patients just so that they could remain in the institution", and the possibility of the patient losing interest in "making the effort which in the long run led to nothing".[3] The goals of rehabilitation are stated in the terms of psychological, social, economic and physical needs. The attainment depends upon integrated inter-disciplinary approach which cuts across professional and agency lines.[4] The community should therefore be assessed in terms of its ability to meet the social, economic and physical needs of the disabled. The level of these will be an indication of the level of the community to meet also the psychological needs.

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[1]Howard Rusk, "Sick People in a Troubled World", Laryngoscope, June 1956, p. 1094.

[2]Morton Heberman & Charlotte Springer, "Rehabilitation of the 'Permanently and Totally Disabled' Patient", Archives of Physical Medicine and Rehabilitation, vol. 39, April 1958, Chicago, Illinois, p. 240.

[3]M.B. McKenzie, "Rehabilitation and Social Work", The Social Worker, vol. 26, No. 2, January 1958, p. 59.

[4]Celia Benny, "Role of Casework in Rehabilitation", Social Casework, Mar. 1955, p. 119.

Of prime importance in this assessment and exerting an impact on the rehabilitation process will be the degree of community co-ordination of rehabilitation resources. This co-ordination is necessary so that each service is aware of its area of prerogative and attempts to mesh its contributions within the local community structure. "The disabled individual is an whole man who happens to have a disability, and ... since one (agency) cannot afford to supply him with the necessary services, it must as a fragment of the whole body of community reserve, join with others in the common effort to preserve the self-dependence of the individual."[1] It is therefore necessary that the whole community plan for rehabilitation needs, and aim at a program of comprehensive services. Dr. Whitehouse draws attention to an oversimplification of rehabilitation.

> Quite a few communities are in the early stages of enumerating their assets and comparing them with their needs, and are attempting to determine what their real needs are. Unfortunately, up to this time there has been but little help available to them. Some have invited prominent persons in the rehabilitation field who have sold them upon an oversimplification version of rehabilitation - chiefly, physical medicine. The local hospital has added a wing, called it a Department of Physical Medicine and Rehabilitation, and the community had relaxed. The more perceptive, however, are recognizing that the problem has hardly begun to be solved, and perhaps this was not necessarily the first step.[2]

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[1] "The Evolving Concept of Rehabilitation", Social Work Practice in Medical Care and Rehabilitation Settings, A.A.M.S.W., July 1955, Monograph I, p. 29.

[2] Ibid., p. 30.

In Vancouver at present the Division for Guidance of Handicapped of the Community Chest and Council is an illustration of co-ordination of services at the community level. There are over 80 organizations associated with this committee. To date this Committee has "set up a special camp for disabled persons operated by the Indoor Sports Club; other projects underway include a rehabilitation resources directory, a city center for the handicapped and homebound services. The Goodwill Industries employ 10 persons in a sheltered workshop."[1] This group has also served as an advisory body on rehabilitation to the provincial government.

On the broader community level, that of co-ordination province-wide of rehabilitation services for adults and children there is the Bureau of Special Prevention and Treatment Services of the Provincial Health Branch, located in Vancouver. The responsibilities of this Bureau are defined by legislation:

> The Assessment Provincial Health Officer, who directs this Bureau, broadly co-ordinates special provincial health services with the work of voluntary health agencies, local health services and other government departments. Under terms of the federal-provincial co-ordination agreement, the Co-ordinator of Rehabilitation has assisted in an organization of a case-finding and referral system, and helped to co-ordinate the work of various organizations and committees concerned with rehabilitation. He works in close association with the Medical Consultant on Rehabilitation, who handles medical rehabilitation aspects, and with the Chairman of the Medical Advisory Panel to the Handicapped Children's Registry, who co-ordinate services for children.[2]

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[1] Rehabilitation Services in Canada Part II, op. cit., p. 197.

[2] Ibid., p. 191.

This assessment must be done not merely on the level of awareness of the variety and number of services for the patient. More importantly is the awareness and use made of these services in the rehabilitation of the total individual.

Next, there must be an assessment of the resources to meet the specific needs of the patient. In this regard reference has already been made regarding the finances needed to aid rehabilitation. Few patients have adequate personal means, whether through savings or insurance benefits, to meet the financial cost of the rehabilitation. Being aware of the patient's inadequate financial standing, the worker who has assessed the community's resources will use these to meet the patient's needs. However, before money can become a "tool in treatment" it may often be necessary to interpret to the patient who the money is available for and of his right to make use of it. "Ordinarily getting money from others involves giving something in return", thus "the client may feel he is sacrificing his independence".[1]

In Canada there is social assistance available for the unemployed employables, and for the unemployable unemployed. In addition there are special provisions for some categories of the handicapped. The Disabled Persons Allowance program, commenced in April 1955 under a federal-provincial sharing agreement, has served to locate disabled persons as well as providing financial assistance. In British Columbia

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[1]Gordon Hamilton, Theory and Practice of Social Case Work, Columbia University Press, 1956, p. 93.

"by March 31, 1958, a total of 1281 persons were receiving disability allowances" and "approximately 62 applicants had been referred to the G.F. Strong Rehabilitation Center for assessment of rehabilitation potential ,up to October 1957".[1]

Another federal-provincial scheme makes provisions for the vocational training for both disabled and non-disabled persons. Applicants under Section "R" of the Agreement are referred to and approved by the Co-ordinator of Rehabilitation and are then submitted to the Medical Consultant on Rehabilitation of the Health Branch. "Training allowances for single trainees are $54.00 per month for those living at home, and $75.00 for those away from home, while those with one dependent receive $108.00 monthly, and an allowance of $12.00 for each additional dependent is made."[2]

The British Columbia Workman's Compensation Board was amended in 1943 "to authorize any measures 'to assist in lessening or removing any handicap' resulting from a workman's injuries. Its aim is to provide a complete rehabilitation service from the time of the injury until the workman is able to return to work ... The maintenance allowance is either $160. a month or full compensation, plus $25 a month for a single man, or $50 for a married person if under treatment away from home."[3]

In addition community service clubs and private agencies have funds available on a grant basis or for loan. These funds where used with discretion and when necessary may serve as a "treatment tool".

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[1] Ibid., p. 194.

[2] Ibid., p. 196.

[3] Ibid., p. 198.

Of equal importance is the assessment of housing facilities. This is particularly relevant for physical handicapped persons who are limited by cane or crutch walking or confined to a wheel-chair. In such instances stairs are of vital importance and where a wheel-chair is used by the patient, the width of hallways and doors will determine the usefulness of a house for the paraplegic. In addition the bathroom presents the greatest number of difficulties - if the doorway is wide enough for a wheel-chair to pass through, often the layout inside the room is such that there is no room for the chair; or the obstacles may be reversed. These housing features must be specified. For the able-bodied these are taken for granted and for that reason may be easily overlooked by a worker in her eagerness to find suitable housing accommodation.

It is also important that a housewife who has been disabled has the opportunity for re-training in facilities in the kitchen and household if that is the area to which she is returning. It is hoped that a "living unit" is available at the center for re-training and further that these conditions may be found at her home, or easily reconstructed.[1]

Housing features which limit the mobility of the individual, like stairs for the paraplegic and cardiac patients, also cause frustrations and re-inforce feelings of inadequacy. Discharge plans should not be made until adequate housing is available.

Finally, in the area of community resources, there must be an assessment of the vocational facilities. This assessment is of the

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[1] Ling and O'Malley, op. cit., p. 96.

three components of vocational need of the patient: job placement; training, or re-training; and sheltered employment.

Vocational services to meet the job placement need include (a) finding a job for the patient; (b) seeing that he is placed in the job; and (c) follow-up contact to ascertain if placement is mutually satisfactory. The importance of finding a job cannot be minimized. To return to the world of work is an important component of the overall rehabilitation goal. This need to work appears to be culturally determined.

> In our society, status has a partially economic base. The dependent individual is considered to be one on a lower social and personal level than the economically independent. Our culture accords dignity and prestige to productivity and economic independence.[1]

As has been stated before, rehabilitation must have an object. Likewise, vocational rehabilitation must be "to what job?" and "where". This the patient will realistically ask, and the counsellor, or social worker, must as realistically answer. Just as a lack of adequate housing will cause frustration at discharge, so will the patient feel his inadequacies if he is fully prepared, trained and ready for employment but an employer cannot be easily found.

Today, despite education and enlightenment, there are still those who regard the crippled and disabled "almost as the work of the devil ... and in consequence many find difficulty in securing employment ... Research has shown that both concepts (disabled cannot do a good day's work,

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[1]Nellie Thompson, Ed., The Role of the Workshop in Rehabilitation, The National Association of Sheltered Workshops and Homebound Programs, Washington, 1958, p. 47.

and that disabled are accident prone) are fallacious but the myth continues in many quarters."[1] These facts were found to be true in England where the Disabled Persons Act is enforced.

At a recent meeting of the Guidance of the Handicap Committee held in Vancouver, the statement was made that a list of potential employers would be valuable to vocational counsellors and placement officers.[2] Such a list would be of necessity in assessing job placement in the community. In addition to knowing placement potentials, the counsellor must be aware of the physical facilities of the company as well as the physical requirements of the job. This may seem so obvious to some that reference to it seems unnecessary. However, it is surprising how many counsellors might overlook the fact that a narrow door into a public bathroom would make employment questionable for a wheel-chair client even where all other facilities were suitable. Such a place would be available to a person using canes or to a cardiac patient. At all levels, rehabilitation is still a problem-solving process on an individual basis.

In 1955 Mr. Wynn Parry stated the aims of vocational rehabilitation or resettlement as it is better known in England:

1. The job should be within the patient's mental and physical capabilities.
2. The job should offer reasonable security and, if possible, good prospects.
3. The job should be related to the patient's previous experience and individual talents.

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[1] Ling and O'Malley, op. cit., p. 5.

[2] Statement by K.J. Tettamanti, Executive Director of Youth Counselling Services for British Columbia, at meeting of the Guidance of the Handicap, Vancouver, on February 22, 1960.

4. Its achievements should give the patient emotional satisfaction.[1]

However, all of these aims cannot be fulfilled without some training, or retraining. Hopefully retraining should be related to the patient's previous experience, interest and talents, but this is not always possible. In one case record it was recommended that the patient having a severe limp should change occupations. Prior to World War I he had been a machinist and the records showed that ten years later, after attending university, the veteran was practising law. Nevertheless, everyone is not so adept at making the necessary adjustments. As was noted in Chapter II, an assessment of the patient's previous employment skills must be noted along with the intellectual abilities. An awareness of the patient's interests coupled with these other facts might give an indication of areas for retraining.

Here again, assessment is necessary with regard to the training facilities. The types, costs and physical layout of these places must be known. These like all other internal and external factors will have an impact on the rehabilitation process. It has been noted in one article[2] that timing is important in vocational planning. There is a tendency to delay planning so as to work with the patient in the area of his domestic and social relationships. There is the fear that too early a concentration on vocational planning may push the patient beyond his readiness to give up his dependency needs. The individual patient will provide the

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[1]Ling and O'Malley, op. cit., p. 6.

[2]Ruth Abrams, and Bess Dana, "Social Work in the Process of Rehabilitation", Social Work, vol. 2, No. 4, October 1957.

best clues as to timing and selection of vocational goal. Even while still in bed a patient may prepare for and even write prerequisite courses for the vocational area he may enter.

Finally in this area of vocational needs, there must be an assessment of the community sheltered workshop resources. For some, employment on the open market, on a competitive basis, may never be possible. However, employment in a workshop may make the difference between success and failure. A satisfactory work experience is a major part of good health. Work also brings people into close and friendly relationship with others, an experience so often lacking for the handicapped who is labelled a "shut-in". A workshop may not mean all things to all employees but the potential for broader experience may be found there.

Dr. Whitehouse refers to several kinds of workshops but contrasts two opposite types. One is the sheltered or terminal type "which provide remunerative employment, but which frequently do not have the philosophy, or the qualified professional personnel, to do a rehabilitation job, and the consequence is that although the individual may benefit from the experience, he may never leave the shop, or quit when he sees no progress ... The individual who is seeking dependency has now found shelter."[1]

The other type Dr. Whitehouse calls a rehabilitation-workshop and should have four important characteristics. These are: (1) "a positive philosophy of rehabilitation, ... one which recognizes a need to treat the

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[1]"The Evolving Concept of Rehabilitation", op. cit., p. 32.

whole person; (2) an individualized method ... through assessment of the client's physical, psychological, social, vocational and economic needs, and the personnel to do the job; (3) well organized program ... as close to normal, as is commensurate with the amount of pressure that is required for each individual's growth and progress; and (4) is coordinated with the rest of the community, ... not compete with similar services, and should ... expand its services to deal with areas of deficiency."[1]

The value of workshops for the handicap, which may fall into either of the types above, or in between these extremes, is still a debatable question. Many argue that the sheltered shops are too costly to be practical while an establishment like Abilities Inc. has "within five years grown to a million-dollar business with some 300 employees".[2] Other independent organizations known in Canada which operate for the severely disabled are: Unlimited Skills Inc., Montreal, and those shops that are affiliated with the Goodwill Industries of America.

In assessing the vocational facilities in the community, it must be remembered "a work setting undergoes many changes when a disabled person is introduced into it, and the rehabilitation worker should take into account the impact these changes may have both on the rehabilitated person and his co-workers".[3] The workshops referred to above can never wholly duplicate this situation. It is therefore essential that there be some follow-up after employment. There should therefore be an assessment of

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[1] Ibid., pp. 32-33.

[2] Henry Viscardi, Jr., Give Us the Tools, Erikssan-Taplinger Co., Inc., New York, N.Y., 1959.

[3] H.A. Robinson and Jack E. Finesinger, "The Significance of Work Inhibition for Rehabilitation", Social Work, October 1957, vol. 2, No. 4, p. 30.

follow-up resources. The placing of a person in a job does not always complete the rehabilitation.

These external resources are many and varied. They include the family, familial roles, finances, leisure-time activities, the rehabilitation centre and team; and the community resources such as housing and vocational facilities, employment opportunities and follow-up services. This environment is one over which the client has limited control. However, the environment must be assessed in terms of its resources and their effect on the rehabilitation process.

The goal in rehabilitation is for the handicapped person to attain "fullest physical, mental, social, vocational, and economic usefulness of which he is capable". In most cases - certainly where a social worker is part of the team - the task is to take maximum advantage of the client's internal and external resources, and to minimize or offset the areas where they are weak. A more definitive assessment of the client's resources, internal and external, therefore, is needed both to give meaning to the rehabilitation process and better direction to casework services.

CHAPTER IV

APPLICATION OF CRITERIA AND IMPLICATIONS

This study has been concerned primarily with the search for accepted criteria applicable to physical rehabilitation. The testing out of these could be the subject of considerable further research. However, to illustrate their application, they have been applied to a limited number of cases from one source, namely Shaughnessy Hospital. This testing can serve at least two purposes. Firstly, the concern is to evaluate in at least some degree the validity of the internal and external criteria or factors which an appraisal of the literature indicates should be present in successful rehabilitation. Secondly, the case records can be assessed in terms of "What factors were responsible for the successful rehabilitation?" It was hoped, originally, that these factors derived from the literature would be found in the case recordings. As might be expected, however, actual cases show that application of criteria is more difficult in practice than was anticipated in theory.

Setting

Because of the special circumstances of a Department of Veterans Affairs[1] Hospital, a brief description of D.V.A. and Shaughnessy Hospital is necessary. A more detailed account is found in Appendix A.

The eligibility requirements for veterans to be admitted to a D.V.A.

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[1]Department of Veterans Affairs - for future reference - D.V.A.

treatment center are defined in Treatment Regulations (see Appendix D). Eligibility requirements are the same for both male and female veterans.[1]

With regard to rehabilitation of the disabled veterans, the D.V.A. accepted the following definition as a guiding principle:

> Rehabilitation is the restoration of the disabled to the maximum physical, mental, social, economic, and vocational capacity of which they are capable.[2]

In addition to Land Settlement and Re-establishment Credit there is medical and rehabilitation treatment for the veteran on disability pension and the recipients of the War Veterans Allowance. The latter benefit is available for a front line veteran who is unable to provide for himself.

The Medical Social Service Department at Shaughnessy Hospital serves the main hospital and the domiciliary care and convalescent care units. The department is established for a staff of seven and two stenographers. Caseworkers are allocated to specific wards and to the other units.

As much of the service is done on a team basis with the other hospital disciplines and with Welfare Officers, case recordings may be done in duplicate, triplicate or more, depending on the nature of the

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[1]A veteran, as defined in the Statutes of Canada, 1945, is:
i) A person who has been on active service in the Canadian forces or in receipt of active service rates of pay from such forces during the war;
ii) A person domiciled in Canada who served in the forces of (His) Majesty other than the Canadian forces and was so domiciled at the time he joined any such forces for the purpose of war, and who has been discharged from such services.

[2]A.D. Temple, "Rehabilitation as it Concerns the Physician", Treatment Service Bulletin, November 1950, vol. V, Department of Veterans Affairs, Ottawa.

need for this information and for the welfare of the veteran. There is a District Office records for every veteran. This file contains recordings from all D.V.A. departments which have been involved with the veteran at any time whether in hospital or in one of the Districts. A separate Hospital file records a veteran's medical history and provides a quick reference for the medical recordings. The District Office file, however, being compiled in chronological order gives a complete picture of the veteran's association with medical staff, welfare officers, service record and discharge, all correspondence with the veteran and/or on his behalf, and his association with the medical social service department. This District Office file provides an excellent means of communication between the various team members. In many instances team conferences may not be held and yet this record will serve as an indication of the activities and direction of service on behalf of this veteran. In addition the majority of veterans are aware of this file and its use.

Because of the personal and highly confidential nature of much of the medical social service recordings, these records are usually summarized on the District Office file. The complete recording is kept in the Department files.

For the most part the case illustrations in this paper were summarized from the Medical Social Service Department files. However, in many instances it was seen that the multi-discipline approach was an aid in the rehabilitation of the veteran under study. It is no doubt the District Office record was used by the social worker when the case was active and these illuminated the various aspects of the team members. Without these

recordings, in many cases, the decisions and activities of the other team members would not have been known as team conferences were a rarity rather than a rule.

Case Illustrations

Each case was assessed by using as a guide the criteria derived in this study. These criteria are set out in summary form in Appendix E.

Mrs. N.S. - Number 1

This patient was admitted to hospital in 1957. Some months previous she had suffered a broken hip which had mended but she had great difficulty walking. The referral to the Medical Social Service Department[1] under the Assessment and Rehabilitation program.

Mrs. N.S. was a 69 year old widow with no children. She dated the onset of her social problems to the time of her husband's death two years before her accident. She reported that she had no family or friends who could help her. Her only sister was an in-patient at the Home for the Aged. Mrs. N.S. had planned on taking care of her sister as soon as she was physically able to do so.

The patient had been a nurse in the Canadian Army during World War I and since her husband's death had returned to her profession. Since her accident, patient had been unable to do nursing and was in receipt of the War Veterans Allowance.[2] As she had been living with friends, her expenses had been kept to a minimum and she had saved about one hundred dollars.

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[1]Medical Social Service Department - for future reference - M.S.S.D.

[2]War Veterans Allowance - for future reference - W.V.A.

Mrs. N.S. had no church or other group affiliation. She saw the hospital as a haven but expressed sincere desire in her rehabilitation back to the community. The patient was seen by the social worker on a weekly basis until her discharge to a housekeeping room approximately a year later.

Assessment by application of the criteria:

In assessing the internal criteria affecting the case, it was seen that her physical limitations improved, with physiotherapy, from "poor to moderately good". Her acceptance of the disability and its limitations was also an asset. This acceptance was at first on an intellectual basis but with an increased awareness of her capabilities Mrs. N.S.'s motivation changed from "passive to active".

Although her previous nursing education and work history, from a re-employment point of view, could not be classed as an asset, her nurse's training was an asset in her understanding of her present situation. This contributed to a "good to average" assessment of her emotional attitudes, morale, and maturity.

Patient's family was scored as "weak". It also indicated casework services would be needed on a supportive level in helping Mrs. N.S. accept the fact of her sister's need for institutional care.

The patient had no income apart from the W.V.A. This allowance may be classed as a community resource, being available to veterans who have no other financial means of support. At the age of 70 years, Mrs. N.S. received the Old Age Security, another community resource. Her income,

however, did not increase as the W.V.A. is reduced by the amount of the Old Age Security.

Due to her age and previous training, vocational facilities were of limited value to patient. However, Mrs. N.S. had done some fiction writing and she was encouraged to review this interest. It was also a source of a limited income.

The social worker's principal contribution was in her acceptance of the patient as an individual and in her assessment of the situation. In addition the worker served as a co-ordinator of the services and resources available for the veteran. When Mrs. N.S.'s sister died, the worker brought this to the attention of the medical staff. In addition, worker helped with the funeral arrangements. Other indications of co-ordination and team work were contacts with the Veteran Welfare Officers[1] regarding temporary additional financial assistance from the Hospital Superintendent's Fund when patient needed new shoes and later at the time of her sister's death.

With regard to follow-up service, Mrs. N.S. was encouraged to contact the social worker after discharge. In addition, as patient was in receipt of W.V.A., a V.W.O. worker would contact the veteran on a routine basis.

If the criteria in this case were weighted, it would appear that the rehabilitation team, the D.V.A. financial resources and the availability

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[1]Veterans Welfare Officers - for future reference - V.W.O.

of medical treatment were of utmost importance. These external resources contributed to the already existing internal resources of the individual. Both internal and external factors were necessary for the success of this rehabilitation process.

While in hospital, Mrs. N.S. placed an application with some of the low-rental housing projects. Unfortunately this community resource was not available due to a long waiting list of applicants.

Miss D.F. - Number 2

After her discharge from the Canadian Army, Miss D.F. made a good adjustment to civilian life. In 1954, however, she underwent surgery for Crohn's disease. During the next five years much time was spent in and out of hospital due to bowel disfunction and sinus of the abdomen. Patient continued to deteriorate until in 1958 she was transferred to Shaughnessy Hospital from an out-of-town civilian hospital. It had been decided that further active hospital treatment would not improve her condition and that she would require chronic care. Nursing home care had been planned when it was learned Miss D.F. was a veteran and transference to D.V.A., under Section 29, was arranged.

Thus at the age of 37 years, this patient was referred to M.S.S.D. for Assessment and Rehabilitation. At the time of referral the W.V.A. report noted that this is "a serious illness, no rehabilitation action appears to be indicated at present", and medical report classified patient as "permanently unemployable". Thirteen months later the W.V.A. report read "it is not anticipated any difficulty will be encountered in placing this young woman for employment if and when her doctor gives her work

clearance". A month later the District Office[1] file noted termination of the W.V.A. as veteran was employed full time as a bookkeeper.

Assessment

What were the criteria contributing to the success in the rehabilitation of this veteran?

With regard to physical limitations, the inconvenience of bowel disfunction was in many ways a social limitation. With increased sinus infection of the abdomen on admission to hospital patient could not attend to her personal care. Miss D.F. accepted her disability possibly with resignation as she saw no other alternative but institutional care. With encouragement that rehabilitation back to the community was possible, patient was motivated to attain this goal. In this matter the social worker recorded "she expected to require institutional care for the rest of her life, and it has taken a great deal of adjustment to think in terms of rehabilitation back to the community". That patient was able to do this supports the favourable assessment of her emotional attitudes, morale, and maturity. Patient's age, no doubt, was also of positive value.

Miss D.F. had only one sister. She could not offer any financial or personal-care assistance. However, she did give support to patient in her endeavours to attain independence.

The patient had no financial resources due to her extended illness. A small income from a Health Insurance plan, however, gave patient a degree of independence so that she did not have to rely on W.V.A. immediately -

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[1]District Office file - for future reference - D.O. file.

a resource she was reluctant to accept as she viewed it as "charity".

Miss D.F.'s intelligence was rated "good" in the psychological testing and it was noted that she had a "high ability to learn". In making arrangements for vocational training this fact plus her previous work record as a price clerk were of additional value.

On admission, the physician reported he was "not satisfied with nursing home care for this young woman" and set the goal of rehabilitation. From the D.O. file the effectiveness of the team's operation was evident. There were no formal conferences but verbal communication plus good use of members' reports kept the team informed. These members consisted of the physician, internes, welfare officers, psychologist and social worker. The team used the facilities at hand and in the community for the benefit of the individual. These facilities included, apart from medical services, psychological testing, occupational therapy, refresher course in typing, bookkeeping course, and use of W.V.A. and other government financial resources. Although there was no formal workshop on the premises, Miss D.F.'s work tolerance was assessed through the Out-patient department.

The welfare officers provided follow-up service while the social worker encouraged patient to keep the M.S.S.D. informed of her progress.

In this instance the lack of a community resource proved an asset. If nursing home care had been accessible, it is questionable as to whether this young woman would have entered a rehabilitation program. It is unlikely a private nursing home could have provided the resources and facilities available through D.V.A.

It would appear the rehabilitation team, the D.V.A. financial resources and adequate use of the medical and vocational resources were the criteria of importance. These plus the internal resources of Miss D.F. combined to bring about successful rehabilitation.

Mr. A.W. - Number 3

The patient was referred to the M.S.S.D. from a D.V.A. hospital in Eastern Canada. Mr. A.W. and his young daughter, Claire, were to arrive in Vancouver two days before the veteran's admission date to Shaughnessy Hospital for treatment of a dermititis condition. Patient requested boarding home care for his eight year old daughter. He had assumed responsibility for his child when her mother deserted soon after the child's birth. It was suggested in the referral that the Children's Aid Society[1] could be contacted in this regard.

The C.A.S. provided boarding home care for Claire. While in hospital Mr. A.W. received disability pension allowance of $120 per month and contributed $40.00 per month for the care of his daughter.

This veteran's rehabilitation has been a continuing process over a six year period. Despite periodic skin flare-ups, giving the patient an "unsightly appearance", he is classified as successfully rehabilitated. He is self-employed and has accepted the limitations of his disability. Over the years this veteran has become more co-operative with C.A.S. by being more understanding of their efforts on behalf of his daughter who is still in their care.

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[1]Children's Aid Society - for future reference - C.A.S.

Assessment

What are the criteria which the social worker assessed and worked with in this rehabilitation process?

Mr. A.W.'s age, 43 years old, and previous work records as night-watchman were of positive value in his securing work on discharge. His varied employment background plus his intelligence score of "superior" were assets in his finally organizing his own patrol service company of watchmen. His formal education level of Grade X was also an asset.

Mr. A.W.'s motivation was one of ambivalence due to finances. On discharge his disability pension was reduced to $25.00 per month. At times he spoke of the advantage of remaining in hospital while at other times he was anxious to go into business and set up a home for himself and his daughter.

Patient's pre-morbid history did not indicate too many strengths. He appeared to be very dependent on women, having had three marriages and one common-law relationship. His first marriage ended with the sudden death of his wife and a child. He reacted to stress by "running away" until he found someone to lean upon. His present personality indicated an inability to cope with anxiety and hostility and his morale and emotional maturity were below average.

In addition, Mr. A.W.'s family had no strength value. However, his role of father and its responsibilities appear to be a motivating factor. He showed genuine concern and love for his daughter.

The positive criteria in this situation are to be found in the

more consistent external factors. Adequate provision and use of these resources stand out the clearest. The C.A.S. provided a necessary service as did the medical, financial and vocational services of the D.V.A. The team function made this effective. Communication between physician, V.W.O., placement officers and social worker facilitated movement. Formal team conferences were not held but the D.O. file and personal contact provided the means for exchange of team members' information and opinions.

Close co-operation between M.S.S.D. and the C.A.S. was also an asset. Clarification and interpretation to the patient of the function and purpose of C.A.S. was often necessary. This was more evident as Claire became older and behaviour problems were more serious.

Follow-up service was provided by V.W.O. workers. Over the years patient has kept in touch with the social worker and so a type of follow-up service has been maintained.

Rehabilitation has been successful because of both internal and external factors. Mr. A.W. was able to make use of the resources in the community made available to him through the team operations.

Mr. G.O. - Number 4

This 30-year old married veteran was referred to M.S.S.D. for a medical social history. Mr. G.O. had been discharged from the Canadian forces in 1942 with pulmonary tuberculosis and in the ten years since then had spent much time in and out of hospital. On this occasion, after two months in hospital, patient had asked for help toward rehabilitation.

In the preliminary interview he indicated there was "basic tension in the home". This was patient's second marriage and there were two children aged 4 and 6 years. Mr. G.O. described his marriage as one of "bickering and fighting and jealousy".

Patient, at his own request, was seen by the psychiatrist. Consultation with the psychiatrist revealed that patient had a need to be accepted and had a fear of rejection. Mr. G.O. was also asking that someone tell him what to do. However, he refused to allow his wife to be involved as he wanted to achieve his rehabilitation on his own.

Patient's record indicated rehabilitation was successful in that Mr. G.O. returned to the community, secured a position for which he had trained, and his marital situation improved as he gained some understanding of the difficulties. In 1954 it was recorded that patient "states V.W.O. who has seen him several times pointed out advantages to veterans in various jobs. Patient states he is trying to overcome accepting veterans' benefits since he wants to be accepted as an ordinary citizen."

Assessment

In assessing the internal criteria, it would appear there were not too many of positive value. Mr. G.O.'s acceptance of his disability was on an intellectual basis due to his having been a hospital orderly at one time. He tended, however, to deny his limitations. His premorbid history revealed he was withdrawn, self-concerned and blamed others in times of stress. Closely allied with this he scored low in emotional attitudes, morale and maturity. His age was an asset.

Patient's family role was that of husband and father but this did not seem to be a sufficient incentive for improvement. Patient's wife was a nurse and returned to her profession during his convalescence. This relieved some of the tension at home but also tended to make him feel more inadequate.

Of contributing value was the financial assistance of patient's 100 percent disability pension. He reported his being in a D.V.A. hospital and his pension gave him a feeling of security.

Patient's leisure time activities were reading and music. These helped to take his mind off himself.

The external resources of a co-operating rehabilitation team, financial pension security, adequate medical provision, and use of vocational facilities appear to have given balance to this rehabilitation process.

Follow-up contact after discharge was maintained by the V.W.O. In addition, the Vocational Institute in the community kept both the social worker and V.W.O. informed of the veteran's progress in the stenographic and bookkeeping courses. The T.B. Control provided medical follow-up.

Just prior to discharge patient's mother required surgery for carcinoma. Patient became very concerned but was able to give his mother support in her illness. He explained he was trying to give her the same support and understanding he had received from the social worker. The worker in an interview soon after discharge recorded that "patient showed more genuine feeling than he has ever shown during contact with him over the

past two years". It would appear that patient's role as a son had more positive value than had been previously noted.

Mr. D.M. - Number 5

Mr. D.M. had been hospitalized during the last year of World War II for pulmonary tuberculosis. During the next few years he had been in and out of hospital for varying lengths of time. At the time of referral, August 1950, patient had been in Shaughnessy Hospital, T.B. Unit, for 18 months. He had spinal involvement of the tuberculosis and the possibility of spinal fusion was under question. Patient was confined to bed.

Patient had expressed having marital difficulties and was referred for assistance in solving a problem which was possibly hindering his rehabilitation. Patient explained that he had married during the war but had been legally separated for the past two years. He now had reason to believe his wife had obtained an American divorce and was re-married. Patient had started divorce proceedings as he too was planning on re-marrying. This engagement, however, was on the point of terminating when referral was made.

What are the internal and external criteria which contributed to the success of this man's rehabilitation despite a prolonged hospitalization, spinal operation, a complicated divorce and a broken engagement? His present file indicates patient has re-married, has four children and has maintained his teaching career with a high degree of competence.

Assessment

During treatment Mr. D.M's physical and functional activities increased from poor to good. He did not deny the seriousness of his disability but his acceptance of the disease was as a stigma rather than an illness. At 33 years of age with a teaching degree and a good work history, the patient was well motivated toward rehabilitation. With increased awareness of his good prognosis and an assurance of the social worker's acceptance and interest in him, there was a marked improvement in patient's emotional attitudes, morale and maturity.

There was no direct contact with the patient's family of orientation. However, there were indications to score this a strong family willing to give personal care, if needed, and they accepted the patient's dependence while encouraging his independence. Mr. D.M.'s broken marriage was a source of concern.

Because of patient's 100 percent disability pension, there was no financial problem, especially while hospitalized.

Patient's leisure time activities had always been in the creative line and the Arts and Crafts department of the hospital were an asset here. He was also interested in music and with the co-operation of the Occupational Department a recorded player was borrowed.

The social worker being aware of the patient's internal resources and needs made appropriate referral to D.V.A. resources. There were only a few conferences with team members but the social worker sought out team members when the patient indicated concern, need for information, or needed specific assistance. These latter instances included contact

with the Arts and Craft, Occupational Therapy, clarification from V.W.O. regarding pension standing and vocational training facilities in art work.

The patient showed great concern and need to be kept informed of his physical improvement. He often felt the medical staff were neglecting him. This was brought to the attention of the physicians on numerous occasions. With the doctor's permission the social worker interpreted to the patient his medical treatment. On one occasion the patient was able to read his medical chart which had been left on his bed. Soon after this incident there was a noticeable increase in the patient's acceptance of medical treatment and he had a more positive outlook. He had secured the information he wanted.

A criteria of positive value was the fact that the patient had a job to return to in the community. This was of great significance to Mr. D.M. who considered T.B. as a stigma.

Follow-up services have been maintained through the Pension Commission with medical follow-up by the T.B. Control Unit.

Mr. J.G. - Number 6

Mr. J.G. was referred to M.S.S.D. when he was in hospital for reactivation of pulmonary tuberculosis. Patient was a 36-year old married veteran and had expressed concern regarding the financial assistance available for his wife and children. As patient was on 100 percent disability pension, his family received assistance from D.V.A. and there was no need for social assistance allowance.

On transfer to the Jericho T.B. Control Unit, patient became disturbed and was referred to psychiatry. His condition was diagnosed as "psycho-neurosis anxiety state". It was recommended that patient be transferred back to the Chest Unit at Shaughnessy Hospital as psychiatric help was more accessible there. This was done and patient was referred to M.S.S.D. from the social worker at the Jericho Unit.

In addition to medical treatment, patient was also seen by the psychiatrist and also received casework services from M.S.S.D. Two years later it is noted in the M.S.S.D. recording that "patient finds it less difficult to go into the community and today appears exceedingly fit and as usual fastidious in his personal appearance". He was on 100 percent disability for six months after discharge but as soon as released for work secured employment. This success overcame the barriers of physical limitations, inadequate vocational training, his wife's illness, and his daughter's committal to Woodlands School because of mental retardation. What then were the contributing factors that made rehabilitation possible?

Assessment

Of the internal resources, it would appear this man's family role with his accepted responsibilities added to his motivation. Before his wife's illness, his family was scored as being strong in all areas, except financial. However, even when ill Mrs. J.G. still was able to accept her husband's need for dependence while at the same time encouraging his

independence. At the time of his daughter's committal the M.S.S.D. record read "It is interesting to note that each parent believes the other needs help in understanding and accepting the diagnosis of this child." This indicated the strength of the family unit.

Although the patient did not have financial security from earned income or savings, his pension offset this deficit.

Mr. J.G.'s acceptance of the disability, his motivation, emotional attitudes, morale and maturity tended to fluctuate. In this regard the psychiatric service and casework, with consultations, helped to raise his potential to the point of being able to cope with his anxieties and eager to undertake vocational training.

Some of the external resources needed in this rehabilitation plan have already been indicated. These were best used through a co-operating team of physicians, nursing staff, psychiatrist, occupational therapist, vocational counsellor, V.W.O. and social worker. The community resource offered by the Child Guidance Clinic was of additional importance in the assessment of the patient's daughter. Much time was spent in team conferences at Shaughnessy and at the Child Guidance Clinic. Communication and co-operation between the team members was of the highest calibre at that time.

The contribution of the social worker as a team co-ordinator and instigator of team conferences was of utmost importance. Numerous team contacts were noted and there were many detailed recordings in the patient's D.O. file. Community resources were also of positive value.

The V.W.O. efforts regarding vocational training and employment were an essential criteria. Follow-up service was assured through the T.B. Control, V.W.O. and the Pension Commission.

Mr. C.R. - Number 7

Patient was transferred from an out-of-town hospital in November 1958 for institutional care and rehabilitation. Mr. C.R. was a 40-year old veteran who attempted suicide, on impulse and probably under the influence of alcohol. In the fall patient had suffered lower lumbar area injury with sensory and motor involvement of the lower limbs below the knee. He was classed a paraplegic and had no bladder control. Patient had undergone physiotherapy treatment prior to transfer and this was continued at Shaughnessy Hospital.

Mr. C.R. was considered totally and permanently disabled being unable to care for himself, and had no friends or relatives to provide the care he required. He was admitted under Treatment Section 29.

Two years after his injury Mr. C.R. was still under domiciliary care and made no attempt to return to the community.

Assessment

What were the internal and external resources available in this rehabilitation case?

Within a year the patient's physical abilities and A.D.L. improved from Group I to Group VI on the A.D.L. Classification.

Patient verbally accepted his disability and appeared cheerful and bright. In the course of treatment, however, he accepted his limitations

more readily than his improvements, admitting his willingness to be dependent on D.V.A. In reference to patient's motivation, the psychologist reported "he shows little anxiety about the future, but doubts D.V.A. will turn him out if he has no money or place to go".

Psychological testing indicated an above average intelligence with some organic involvement due to alcoholism in the past. Patient has completed Grade XII in his formal education. He also showed in testing agressive emotional attitudes with a tendency to act out and he had mood swings which affected his morale. He was scored as being psychologically immature.

A review of the D.O. file indicated he had been a chronic alcoholic and his wife had taken him to Family Court on one occasion. He was divorced a few years before his injury. Mr. C.R.'s work history had been sporadic and he had been a truck driver, salesman, clerk, and dancing teacher.

Patient had one brother in Vancouver but patient did not get along with his sister-in-law. There is no indication of any support from this source.

Mr. C.R.'s interests were in music and theater. He gave no indication of his endeavours to maintain these interests.

Patient had no financial resources or hospital insurance and was therefore accepted into domiciliary care.

Of external resources endeavouring to aid the rehabilitation process, the hospital and D.V.A. team did much on his behalf. Patient's treatment was under the department of physical medicine. He received the services

of the physiotherapy and occupational therapy departments, prosthetic services supplied braces and shoes and he was offered the services of the psychiatrist, psychologist, V.W.O., vocational rehabilitation officer and the social worker. Patient, however, was reluctant to make use of these facilities. He complained of being too tired after physio to attend occupational therapy, and was not consistent at physio "because of bladder control" and preferred to use the wheelchair to crutches. He became disinterested in his bookkeeping course stating he "would rather be an elevator operator in the new hospital wing". The social worker recorded he "could not get close to patient's real feelings". One of the reasons for this was Mr. C.R. missed his appointments due to "attending O.T., physio or because I was at the Red Cross Lodge".

With regard to community resources, patient requested a transfer to G.F. Strong Rehabilitation Center. As the Center's program was similar to that at Shaughnessy, the doctor saw no value in the transfer. Financial resources were made available through the D.V.A. Patient indicated his membership with the Canadian Paraplegic Association but there was no evidence of co-ordination with this group.

There would seem to be sufficient external resources available for this man. In addition he appeared to have some internal potential. However, Mr. C.R. would not co-operate with the rehabilitation team and this prevented the utilization of resources on his behalf. Patient seemed to have little positive motivation preferring the security of D.V.A. In addition, he had no family responsibilities and little, if any,

encouragement from his brother and wife.

This illustration indicates rehabilitation requires both internal and external resources if rehabilitation is to be successful. The social worker endeavoured to co-ordinate resources but was prevented by the patient.

Findings and Implications

A review of these case illustrations indicates the need for both internal and external resources if rehabilitation is to be successful. With regard to internal criteria an assessment of the client's personality related to his acceptance of the disability, his motivation, and his emotional attitudes, morale and maturity is essential. An assessment of the pre-morbid personality is also an asset. An understanding of the patient's family and his familial role is necessary. These cases indicate that those individuals who "scored" below average in emotional attitudes and personality had internal balance because of a strong family. In other instances, the reverse of this was true.

Financial security was a constant positive factor in all these cases. This would indicate a necessity of assured financial assistance to all patients and their families during the rehabilitation process. However, this assistance has more value if it is accepted as the individual's right and not as charity.

A high level of intelligence, education and work history were of positive value in re-employment whether in the same type of position or in a new vocation. This therefore implies the need for assessment of

these internal resources plus the need for educational facilities and vocational training services. Financial resources must also be made available from the community for these.

In most instances the individual's leisure time activities were not taken into account. Where these activities were known, they were a positive resource. This implies the need for research and assessment of the value of such activities. If leisure time activities are of definite positive value, the community should be encouraged to support such activities.

The value of a medical centre of high calibre and with a well-qualified staff is a criterion beyond question. The positive contribution of the rehabilitation team was seen in every case. This team clearly functioned for the benefit of the patient. There is evidence, however, that a more co-ordinated team with structured conferences would have been time-saving, especially for the social worker, who apparently put many hours into communication with team members relaying information from one to another.

Co-ordination and use of community resources was a decided asset. In a private setting, not usually equipped or organized to the extent to be found in D.V.A., this co-ordination would be much more necessary. Financial security, educational and vocational counselling and resources would have to be found in the community. These would be located in a variety of agencies, implying the need for co-ordination of community services.

A review of all these recordings after discharge of the patient indicates the value of follow-up service to ensure the continued value of the rehabilitation process. When minor family or employment difficulties arose, the veterans returned to the Welfare Officer or the social worker to discuss these difficulties and receive assurance. The implication is clear that where usual agency policy does not allow long-term contact after the case is closed this is a basic community need.

Research Recommendations

The application of these internal and external criteria to seven cases is too limited to prove validity of the criteria. It is suggested therefore that these criteria be applied to a group of rehabilitation cases which are presently active.

In addition a thorough analysis of case recordings should be undertaken using the criteria as guideposts. These two studies would indicate the value of these criteria. Such studies would also be needed if the criteria were to be given weight. When accurately weighted, the criteria could serve a more objective purpose.

The value of the rehabilitation team is acknowledged in the literature and seen of value in practice. A study of this group, its contributions, means of communication and mode of operation would give added proof of its value. This would be within the area of a social group study.

Co-ordination of services is of positive value in rehabilitation. A social work study of community organization of these resources and facilities would highlight the need for services and indicate the best use to be made of existing services.

Another factor common to cases numbered 1, 3, 4, 5, and 6, was the presence of an additional stress situation. This was a stress unrelated, apparently, to the disability problem. It could be questioned here whether research might show that this unrelated factor had some bearing on the success of the rehabilitation. Perhaps the services offered to the client had an added value beside that of helping to relieve the presenting problem. Mrs. N.S. received support and understanding during her sister's illness and death. Mr. A.W.'s daughter was a source of worry and concern, especially as her behaviour problems increased. Mr. G.O.'s mother required surgery for carcinoma and he became very concerned for her welfare. Mr. D.M.'s divorce proceedings had many complications. He refused direct assistance but did express his feelings about this matter in casework interviews. The severity of the illness of Mr. J.G.'s daughter presented many problems. Both he and his wife received support and co-operation at that time.

That an extra stress factor could be a criterion of positive value would seem unlikely. However, the question of its influence suggests a possible need for research.

These criteria were common in cases with a variety of medical problems. That these criteria are necessary in all rehabilitation processes regardless of the problem - medical, financial, mental health, juvenile delinquency, corrections - is by no means shown in this study. However, the application of these internal and external resources and the relation between these criteria in a variety of cases may indicate there are common criteria for successful rehabilitation.

Whether rehabilitation is a new specialization in social work is still debatable. That it requires an awareness of a variety of factors and demands special skills with regard to co-ordination and communication is evident. As the Council on Social Work Education typifies, schools of social work will certainly continue to place emphasis in rehabilitation and its specific demands.

Appendix A

A Brief Description of the Department of Veterans Affairs and Shaughnessy Hospital

Because of the special circumstances of a Department of Veterans Affairs[1] Hospital, a brief description of D.V.A. and Shaughnessy Hospital is necessary. It must be acknowledged here that summaries of Shaughnessy Hospital and its Medical Social Service Department may be found in other social work theses completed in this setting. These have served as a guide. There are two charts in the Appendix which illustrate the functional organization of the Department of Veterans Affairs' Executive Branch and Administration Organization at Head Office (Appendix B); and The Position of the Medical Social Service Department in the D.V.A. Organization and within Shaughnessy Hospital (Appendix C). In addition, there is a listing of the D.V.A. Treatment Categories (as of April 1955) found in Appendix D.

The provision of medical treatment facilities and services for the veteran in Canada dates back to 1915. Many changes in treatment services and eligibility have occurred since then. There are now four main treatment category centres: active treatment hospitals, Health and Occupational Centres, Special Institutions and Veterans Homes. Resources may vary in these institutions but these include services of physiotherapy, occupational therapy, welfare services,

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[1]Department of Veterans Affairs - future reference - D.V.A.

medical social service, religious guidance and institutional training.

Special reference should be made to the War Veterans Allowance[1] as this allowance figures rather prominently in rehabilitation. In brief the eligibility requirements are:

Service Requirements
a) If they served in a theatre of war; or
b) If they are in receipt of a service disability pension, or have accepted a commuted pension; or
c) If they served in both World Wars and were honourably discharged from the last enlistment in each; or
d) If they served in the United Kingdom during World War I for at least 365 days prior to November 12, 1918.

Veterans of His Majesty's forces, other than those of Canada, and of the forces allied with His Majesty, must have the service or pension status outlined in (a), (b), or (c) above AND they must have domiciled in Canada at the time of joining such forces, or alternatively, have resided in Canada for at least 10 years.

Age Requirements
Male veterans become eligible for allowance at the age of 60, and female veterans at the age of 55. Both groups, however, may be awarded allowances at earlier ages if they are considered to be:
a) Permanently unemployed because of physical or mental disabilities; or
b) Unable to maintain themselves due to a combination of economic handicaps and physical or mental disabilities or insufficiency, and are unlikely to become able to do so.

Financial Requirements
Though he may be otherwise eligible, he may not be qualified for an allowance if he has personal property valued at more than:
a) $1000 if eligible for single rates; or
b) $2000 if eligible for married rates.[2]

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[1]Summary of provisions may be found in publication "War Veterans Allowance Act and the Assistance Fund" 1957, D.V.A., Ottawa.

[2]Ibid.

A study for the need for social workers was undertaken and in 1948 the Welfare Services Branch was set up. The policies of the Branch provided for social workers whose main responsibilities were:

> Providing consultation to Veterans Welfare Officers, and not necessarily dealing with social problems at first hand, operating a teaching programme with the object of improving all welfare services maintaining a liaison with community agencies; providing case-work services on a non-continuing basis in respect to social problems which were of concern only to the department, assisting in research co-operation with the research division. The Branch also assumed responsibility for administering the Assistance Fund devised to meet emergency needs of War Veterans Allowance recipients.[1]

The Veterans Welfare Officers are classified under three divisions depending on their setting. The group most directly concerned with the needs of the medically disabled are known as Casualty Welfare Officers. The responsibilities of these officers are laid down in their Welfare Manual.[2] Part of their responsibility is to interpret and explain to the veteran the benefits available for him under the Veterans' legislation. In addition to this they are directly involved in helping veterans find solutions to specific problems such as employment.

The Casualty Welfare Officers also contribute to the rehabilitation team in the hospital in helping to solve problems not directly related to treatment. Method of this co-operation with other

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[1]Ellen Bateman, Social Casework for In-Patients in a Veterans' Hospital, Master of Social Work Thesis for University of British Columbia, 1957, p. 14.

[2]Casualty Welfare Officers' Manual, King's Printer, Ottawa, 1950.

disciplines is illustrated in the Manual.

> Instances will occur where veterans undergoing treatment place before Welfare Officers problems, which the solving of will better the veteran's lot, but will in no way affect his treatment. On the other hand, when veterans receiving D.V.A. medical care confront Welfare Officers with situations which may affect their treatment, these should not be furthered until discussed with the Doctor, who will instruct the Welfare Officer to proceed, whether alone or in co-operation with the Medical Social Service, or may decide the matter is one to be dealt with entirely by the Medical Social Service.[1]

In May 1947 the Medical Social Service was separated from the Welfare Social Service and made responsible to the Director General of Treatment Services. The general policy was set forth in a circular letter.[2] Each Medical Social Service Department became an integral part of the hospital set-up and responsible to the hospital superintendent.

The function of a D.V.A. Medical Social Service Department is consistent with the generally accepted standards[3] for social service departments in other hospitals. It differs, however, in that it is authorized to provide services for veterans under D.V.A. medical care.

Shaughnessy Hospital[4], located in the suburbs of Vancouver, is

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[1] Ibid.

[2] Circular Letter 1947-138, December 6, 1947, Medical Social Service - General Policy. Refer to CL. 1927-122, October 21, 1947.

[3] Note: A Statement of Standards to be Met by Social Service Departments in Hospitals, Clinics and Sanatoria, American Association of Medical Social Workers, Washington, D.C., 1949.

[4] Note: A history of the development of Shaughnessy Hospital is given in: Mary E.A.B.E. Clohosey, Social Implications of Re-Admissions of Veteran Patients to Shaughnessy Hospital, Master of Social Work Thesis, University of British Columbia, 1954.

an active treatment D.V.A. hospital. Provision is made for patients requiring convalescent care in ancillary units and domiciliary[1] care is provided in the "Extension". (The "Extension" until the Spring of 1960 was housed in separate group of buildings situated on the hospital grounds.) Active treatment is accommodated in the main building or in the Jean Matheson Memorial Pavilion. Since the Hospital building programme of 1960 this Pavilion has been attached to the main building.

In addition two other institutions provide special services for veterans. "Hycroft" which may be classed as a "Veterans Home" provides adequate care and supervision for usually older men who are ambulatory but for whom no other care was available. The "George Derby Health and Occupational Center", on the other hand, was setup to accommodate veterans who required only a limited convalescent period before returning to the community. "However, over the years since World War II, with the average age of the veteran increasing and more permanent care facilities being needed, it has been found that a high percentage of the patients are older veterans with some permanent physical limitations."[2]

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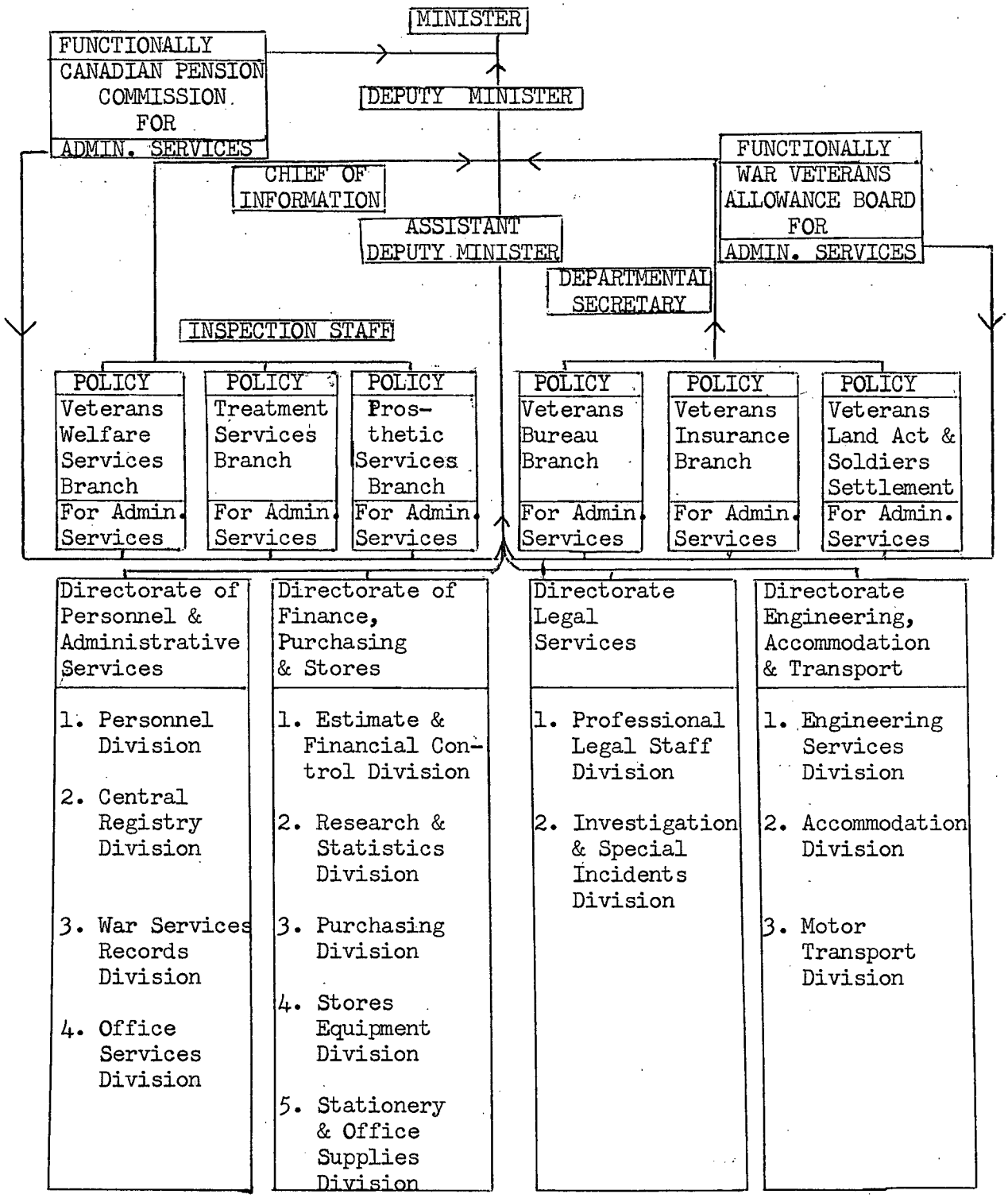
[1]Note: Domiciliary care is special service for veterans who require total care on a more or less permanent basis because of infirmity or disability.

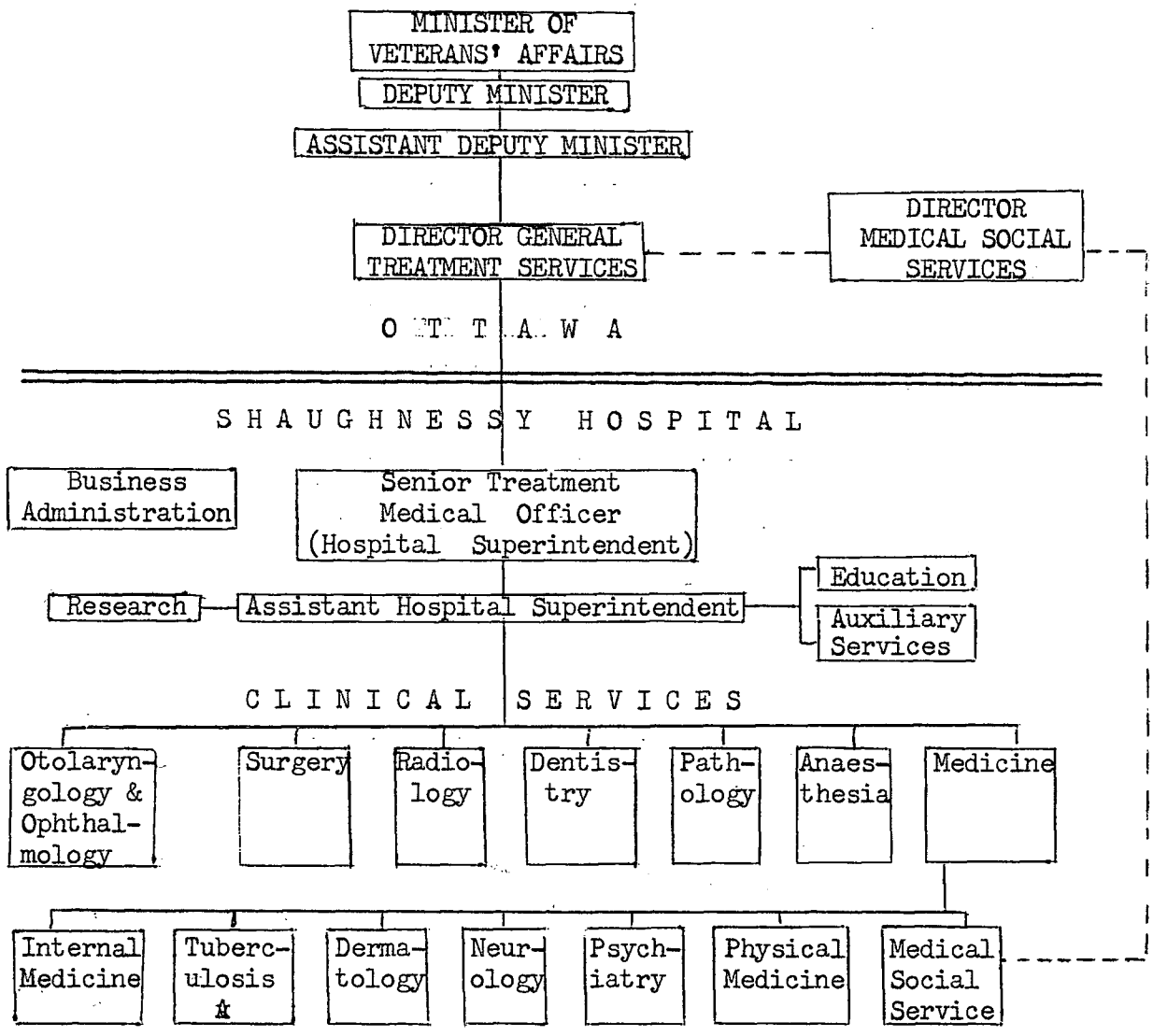
[2]Oldham, Heather Patricia, Social Services for Female Veteran Patients, Master of Social Work Thesis for the University of Toronto, 1958.

Appendix B



Department of Veterans Affairs: Executive, Branch and Administrative Organization at Head Office.

Appendix C



✱ Since early 1956 patients with active Pulmonary Tuberculosis are treated by Provincial T.B. Control

The Position of the Medical Social Service Department in the D.V.A. Organization and within Shaughnessy Hospital

Appendix D

D.V.A. TREATMENT CATEGORIES (as at April 1955)

Section	Definition
5	Treatment of a veteran for a service disability
6	Treatment of a person for a disability which pension is paid by reason of service in the Red Cross and other non-military organizations a) Allied Pensioners b) South African, Fenian Raid, and North-West Rebellion veterans c) Civilian war pensions from various auxiliary services
7	Treatment for a disability for which pension is paid under Newfoundland Special Awards, or for a service disability incurred in the regular forces of Canada or R.C.M.P.
8	Hospitalization for a Pensioner in Jail
9	Treatment of a veteran for a disability present at the termination of his service in the Special Force Trainees
10	Trainees
11	Permanent Force: Disability existing at time of discharge
12	War Veterans' Allowance Cases requiring active remedial treatment
13	Treatment of a veteran who has no other entitlement and qualifies because of inadequate income or resources
14	For Psychiatry
15	Treatment of venereal disease, or its sequalla, if it has been ruled that it was incurred during service
16	Pensioner when uncertainty exists in diagnosis
17	Staff - Infectious disease cases
18	Persons referred by Department of National Defence
19	Persons referred by the Royal Canadian Mounted Police
20	On request by financially responsible person
21	On request of any department of the Government of Canada
22	On request of Imperial or other Allied Government
23	Examination and treatment of a veteran for a non-entitled condition where he guarantees payment of hospital account and is personally responsible for payment of medical services
24	Too ill to turn away. Admitted and charged
25	In hospital. Diagnosis changed to non-entitled condition
26	Hospitalization for research purposes
27	Pensions Medical Examination - for observation
28	Examination of veteran or other person at the request of the Department, Prosthetic Services, War Veterans Allowance Board, or for completion of examination for the purposes of Pension Commission
29	Domiciliary care, and treatment when needed while receiving such care, subject to both total physical disability and financial agreements

Source: Compiled from D.V.A. Treatment Regulations contained in The Veterans Charter and Ammendments.

Appendix E

Summary List of Criteria used for D.V.A. Cases.

INTERNAL RESOURCES

1. Physical abilities
2. Acceptance of disability
3. Motivation
4. Personality
    a) Age
    b) Ethnic group
    c) Religion
    d) Intelligence
    e) Education
    f) Work history
    g) Pre-morbid history
5. Activities of Daily Living
6. Work Classification
7. Personality Development
    a) Emotional attitudes
    b) Morale
    c) Emotional maturity
8. Leisure-time activities
9. Family role

EXTERNAL RESOURCES

1. Family strength
2. Financial situation
3. Rehabilitation team
    a) Physician
    b) Nurse
    c) Physio
    d) O.T.
    e) Social Worker
    f) Psychiatrist
    g) Psychologist
    h) Speech Therapist
    i) Vocational
    j) Prosthetics
    k) Recreational
    l) Others
4. Community co-ordination aspects
5. Financial resources (Provincial and Federal)
6. Housing facilities
7. Vocational facilities
8. Workshops
9. Follow-up services

Appendix F

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