DISCHARGE PLANNING IN HOMES FOR THE AGED

An Analytical Survey of a Group of Patients hospitalized for Mental Illness in the Homes for the Aged, Port Coquitlam, B. C., 1958.

by

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ABSTRACT

There has been a growing conviction on the part of medical and nursing staff in the Homes for the Aged in British Columbia, which provide psychiatric care for the aged, that some of the residents have sufficient physical and mental health to be discharged. This study makes an analytical survey of some of the needs and resources of a group of patients considered to be ready to leave one of these institutions (the Port Coquitlam Unit). The purpose of the survey was to determine what kinds of resources these people would require to maintain an optimal level of adjustment in the community, as well as to describe the possible contribution social services could make in facilitating their discharge.

The areas selected for assessment were grouped into two broad categories, (1) the patient's needs which resulted directly from his hospitalization and (2) the personal and social resources which he could employ upon discharge. There are two steps involved in selecting the group for study. First, through the use of a questionnaire submitted to the medical and nursing staff in order to determine which patients were judged to be mentally and physically ready for discharge, and second, from this larger number of patients, through the use of routine sampling procedure, a smaller group was selected for study. This final group was assessed by the clinical team in the institution primarily through the use of rating scales.

An examination of the needs and resources of these patients revealed that all of these patients could benefit from the assistance of social work in one or more of the areas evaluated. Although the needs and resources of the group varied considerably, there were some indications that the patient's length of stay had a marked effect upon the type of social work service they could use. Those remaining in hospital for a period of less than two years had usually retained some resources in their former community which could be mobilized to assist them in discharge. On the other hand, the indications for these patients is that they would need an extension of hospital services after they were discharged. The patients who had remained in hospital for a longer period of time, had less need for out-patient hospital services, yet had little in the way of social resources or contacts in their former community to assist them once they had left the hospital. This group also evidenced less motivation for discharge and seemed to regard their hospitalization as a permanent living arrangement.

In conclusion, the study points out the need for further definitive assessments of the areas of function of a social worker in an institution where the aged, psychiatrically ill are treated. Also pointed out is the need for social work programme planning in the light of these assessments, as well as the insurance of adequate provisions for further research to help develop it. Treatment programmes in other psychiatric institutions are mentioned, indicating that with the use of more advanced therapies, an increasing number of geriatric patients with mental illnesses are responding to treatment and are, therefore, eligible for discharge. Thus, there is a growing need for social work contributions in planning with the older person who is leaving hospital. Some indications of community concern in planning for these people are cited as evidence of awareness on the part of both the institutions for the geriatric patient and the community that the change from hospital life to community life must be an uninterrupted process.
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The University of British Columbia, Vancouver 8, Canada.

Date March 4, 1959
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CHAPTER I

THE GROWTH OF THE AGED POPULATION

Almost any literature regarding the aged or the increasing aged population includes statistical surveys indicating that the proportion of our people over sixty-five years of age, when compared with the zero to sixty-five year old group, is steadily increasing. These studies have had a gradual impact on the community as a whole and have given way to a very real anxiety on the part of Social Welfare Authorities occupied with attempting to meet the problems of this particular group.

A brief mention of some of the causes for the increased proportion of aged, and a review of the history of the adjustment of this group during the past three centuries is helpful both in terms of gaining further understanding of the problem, in the present day, and in seeing in its development some possible, partial solutions. (1)

Most recognized authorities on the problem of the aged point to two trends in the evolution of our Western culture that contribute to an increasing number of aged in the population. The first and possibly the most recognized by the layman is the fact that people are living longer. Many developments such as more widespread and advanced

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(1) Of particular interest in this regard is of Shock Nathan, Trends in Gerontology, Stanford University Press, Stanford, California, 1957.
medical care, better nutrition and more ease of living have contributed to a higher standard of physical health and resultant longevity. It should also be pointed out, however, that this increased life span does not in itself contribute solely to the larger proportion of aged. The second and most significant fact in terms of the increasing population of aged is that less children per family are being produced so that, in terms of the total population, the proportion of the aged has steadily increased.

This sterility on the part of the population as a whole has several implications which will be briefly outlined later in terms of welfare costs and programmes and resultant activity of social workers and working with the aged.

Statisticians have produced a great many surveys regarding population trends throughout the Western world. For example, the average number of children born in a marriage has dropped from five or six in the 18th Century to two or three in our present day. (1)

In terms of the population ratio, there is a definite trend toward smaller numbers in the young, economical, productive age group assuming responsibility for a larger proportion of older persons.

The Social Adjustment of the Aged

Some of the causes and implications behind the growth in size of the older segment of the population have already been discussed. This growth constitutes only one facet of the present problems Western society encounters in dealing with the aged.

The following brief historical summary taken from the work of Paul E. Sauvey, a French sociologist, outlines the development of the aged during the past few centuries and points out some of the factors which have contributed to the development of an "old age problem". Sauvey breaks man's social adjustment in terms of the older person into three main phases:

(a) The Family Phase - Many of the problems which today are described as social were formerly resolved within the old patriarchal type family. This was notably so with the care of old people. The care of the old was a task delegated to the older person's offspring or immediate family members and in the average family, which was predominantly large and in a rural area, such a task was no particular problem. It should be added that at this time the proportion of old people was fairly small and was not undergoing any large scale growth as has been characteristic of recent times. This type of family care has extended in some of the more isolated rural communities up to modern times.

(1) Ibid., P. 35.
(b) **Individualistic Phase** - As society became more advanced towards the end of the 18th Century, dislocations became apparent in the institution of the family. There followed a geographic dispersion of the family into smaller, scattered units. Many family members went to work in the towns in factories. There followed also a decrease in parental authority which the sociologists believe helped to bind the family together as a unit. At about this time it became possible to make financial investments with a view to providing for oneself in old age so that theoretically one was responsible for providing this care through long term planning and saving. Such provision for old age for the major portion of the population was impossible because of poverty at this time as well as the lack, for the most part, of the population's ability to foresee the problems of old age.

(c) **Social Phase** - The growing concern on the part of the public of various social problems brought about this phase in which government authorities accepted some responsibility for planning and providing for the aged. The most notable example of this acceptance was in the passing of numerous old-age pension acts throughout the nations of Europe and the Western hemisphere. This period might be said to date from about the time of the First World War up to and including the present.

The author goes on to point out that these periods overlapped considerably in view of the accelerated social movement in some areas and lags in others. In addition he mentions different rates of evolution take place within the various socio-economic class.
In terms of the above analysis a report of a committee having completed a recent study in British Columbia sums up the present level of adjustment of the aged in this area. After reviewing statistical information regarding the growth of the older population (1) this group concluded: "At the same time, through the development of Canada's economy, society has become increasingly industrial and urban, penalizing the elderly, limiting their opportunities for productive activity, restricting their share in the general prosperity and curtailing their participation in community living. Increased mobility and problems of urban housing have served to separate parents and children and have frequently deprived an older person of a secure place and family life. The higher income of post-war years has allowed families to entertain and be entertained - they are "out" to a greater extent than ever before. The desire of young couples to be constantly "on the go" conflicts with the need for elderly parents to have constant supervision and results in the removal of parents to institutions outside the home. Further, urban housing developments call for the smaller house or cottage with enough rooms to accommodate the immediate family. At the same time the development of modern institutional facilities for the older person who can't look after himself or who is in need of nursing care has tended to lag."

(1) From an unpublished report by the Greater Vancouver Health League, A Study by the Nursing Homes Committee, May, 1958. P.1.
Unfortunately, it is very difficult to obtain any statistics on the actual numbers of aged who are living socially or economically independent lives. This paucity of information is especially apparent when one attempts to review the Canadian scene (perhaps because independent citizens seldom find themselves listed on the various roles or records of agencies or organizations.) Some inferences, however, can be drawn from the available figures on the aged in Canada.

In the Province of British Columbia in the year 1956 there were 27,028 people listed as receiving financial assistance supplementary (1) to the Federal Old Age Security Pension of $40.00. This figure compared (2) with 96,701 indicates that over 69,000 had maintained some measure of economic independence or have made financial provision for themselves.

Similarly a survey of the labour force of the USA completed in 1951 (the author has been unable to find similar figures for Canada) indicates that forty per cent of the male population of the United States sixty-five years of age and over were still listed as "active". This same survey indicates that 9.5 per cent of the women from this same age group were still listed on the labour force. In addition, the breakdown of this sixty-five years and over age group in 1953 for

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the USA indicates a similar proportion in the various vocational
categories as that found in the fourteen to sixty-four year old
age group. This would seem to indicate that the aged can carry
on with all the various types of work despite the varying physical
and mental demands made upon them in these jobs. There are many
surveys too numerous to mention about the economic adjustment of the
aged in other countries along with studies of housing, recreational
medical and other facilities for the aged.

The Dependent Aged

Although the proceeding paragraphs indicate that there are
varying levels of adjustment in our older age group, the fact remains
that older age does bring on greater physical and mental infirmities.
Hospital and other institutions devoted to the care of the sick for
example, usually record a proportionately larger number of older
people in residence than any other age group when compared with the
same groups in the general population. Published figures (Table 1)
also indicate that the geriatrics group in British Columbia tends to
remain for a longer period in hospital than those in every other age
group.

(1) Shock Nathan, Trends in Gerontology, Stanford University

(2) These figures usually exclude those figures classified as
births.
TABLE 1

The Proportion of Older People Admitted to General Hospitals in British Columbia in 1954, as compared with

The Age Percentage Distribution of the Total Population of British Columbia and the Percentage of the Total Patient Days Older People were in Hospital during 1954.

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage of General Population</th>
<th>Percentage of Patients Admitted During 1954</th>
<th>Percentage of Patient Days During 1954</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 - 69</td>
<td>4.54</td>
<td>4.4</td>
<td>7.4</td>
</tr>
<tr>
<td>70 - 74</td>
<td>5.26</td>
<td>4.3</td>
<td>8.0</td>
</tr>
<tr>
<td>75 - 79</td>
<td>1.78</td>
<td>3.0</td>
<td>5.8</td>
</tr>
<tr>
<td>84 - 89</td>
<td>0.84</td>
<td>1.6</td>
<td>3.3</td>
</tr>
<tr>
<td>90</td>
<td>0.40</td>
<td>0.9</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Similar findings to these have been recorded in other areas. In Ontario, for example, patients in general hospital in the geriatric age group total only eight per-cent of the total hospital population but accounted for nineteen per cent of the total days in general hospitals. In illustrating these figures, one author made the following comments about the longer stay of older patients:

"For a good many among them the illness or disability which sent them to hospital means the end of a previous living arrangement the impossibility of returning home without a period of intermediate care, or a satisfactory discharge to their homes only if follow-up home care is provided. These are the basic reasons why a good many cannot be discharged at the appropriate time even when their illness does not require a transfer to permanent institutional nursing care."

It would appear then, that perhaps these figures are somewhat misleading in terms of the degree of impairment that many of these older patients may have. Many perhaps could return to the community even though they might have to accept a more marginal level of social adjustment than they previously enjoyed. Miss Bradford went on to comment further, "Positive welfare and rehabilitation programmes should embrace the long stay in hospital and after care in one continuity and the planning of these activities must take into account the fact that many of these older patients do not have the physical homes and immediate families that are generally pre-supposed for younger people."

Again, the social isolation of the older person is seen to play an important part in dealing with other handicaps, in this case, physical illness.

**Psychiatric Care for the Aged**

Older people, as their physical and mental powers begin to wane, seem to be more susceptible to mental illness. Unfortunately, they also tend to have a greater degree of organic and chronic illness. Thus, to the layman and even to many professional people, mental illness in an older person seems to be equated with long term institutional care and poor prognosis, or at best, discharge from a mental hospital with a crippling psychiatric residual and only a marginal adjustment to be hoped for.

Added to this common feeling of a gloomy prognosis in the psychiatric treatment of this group is the difficulty the aged person has in moving back into the community after the lengthy period in hospital that treatment usually entails. Old age is often associated with social rigidity — that the older person is not as socially or psychologically adept in making a different adjustment, having a need to preserve and extend those things they know and with which they are comfortable.

One need not look back over fifty years to find that all mental illness in any age group was viewed as a rather hopeless, irremedial illness and that any patient's recovery was viewed almost as an act of God. Since the turn of the century, however, both psychological and somatic therapies have been used to such an extent that many types of psychiatric illness have an optimistic prognosis; the layman is gradually accepting mental illness, particularly
in the younger age groups, as a treatable illness involving periods of institutional living and a loss of time and money.

Somatic therapies, such as coma insulin, electro-shock therapy and more recently the ataractics (tranquilizers) as well as the use of psycho-analysis and other forms of psychotherapy, to name only a few treatment techniques, have been effectively used in combatting the so-called effective disorders (e.g. schizophrenia, manic depressive disorders, etc.) as well as modifying some of the illnesses with irreversible organic changes (e.g., epilepsy, General Paresis of the Insane, etc.)

Although there seems to be an awakening optimism regarding the treatability of most aged groups and most types of illness, there also seems to be a considerable lag in both the layman and professional groups regarding the treatability of the older age group. One author in commenting on the psychiatric treatment of the aged, describes the result of a survey performed in the State of New York.

"A report of patients on the Books of the New York State Mental Hospitals, 65 years of age and older, as of March 31st, 1953, shows 28,250 such patients. Of these 59.4 per cent have been hospitalized for a period of from five to over twenty years. The diagnostic categories indicate that only 50.3 per cent carried a primary diagnoses which might be said to relate more or less specifically to the process of aging in the sense that these diagnosis were:
Psychosis with Cerebral Arteriosclerosis - senile and Involutional Psychosis. The other 49.7 per cent carried diagnosis that in no way were specific for that age group, instead 32.7 per cent of the total were diagnosed as Dementia Praecox. These figures have tremendous implications for the evaluation of the problem of the type of psychiatric reaction related specifically to the aged factor. (New knowledge of syndromes) should have an important impact on the attitude toward prognosis and treatment. A fatalistic attitude of the inevitability of deterioration has led to a programme of involving custodial care primarily. This new insight opens a completely different vista and must involve a totally different programme of active therapy and research at all echelons.

One can only conclude from these and other studies that there is a growing awareness within the professional disciplines dealing with the psychiatrically ill that many people are treatable and capable of discharge into the community, yet considerable work will have to be done in this area to intensify our efforts in treatment and lift the public level of awareness in this regard.

Treatment in British Columbia

British Columbia, during the past quarter of a century, has developed a vast programme for the special psychiatric care of the aged. A comparison in this regard with all other provinces indicates that this province is the only one outside of Alberta having a small 300 bed institution, which has made any special psychiatric provisions for the aged.

Official recognition of the need and provisions for the care of this group in this province dates back to 1936 when the Homes for the Aged Act was passed by the British Columbia government. This act provided for separate administrative organization and facilities to care for the psychiatrically ill of 65 years of age and over. These facilities were initially made an auxiliary service to the Provincial Mental Hospital in that all admissions to the Homes for the Aged, as they later became known, were screened through the Provincial Mental Hospital.

For several years prior to 1936 the Director of Mental Health Services (Dr. A.L. Crease) had stressed the overcrowded conditions and the need for more space in the Mental Hospital.

(1) Mental Health Services in Canada, Research Division, Department of National Health & Welfare, Ottawa, July 1954, P.P. 102, 103.
(2) For a full description of the early development of the Homes for the Aged see: Clark, Richard James, Care of the Mentally Ill in British Columbia, 1945. PP 92-94.
In response to this need, the Provincial Secretary made two buildings available, which were formerly part of the Industrial School and which were adjacent to the hospital at Essondale. These buildings were quickly occupied by a small group of the older patients from various wards in the Mental Hospital. There were approximately forty patients transferred at that time. Dr. Crease in his Mental Health Services report for the year 1936 commented that this arrangement was most satisfactory and that the buildings were converted to very pleasant living accommodations for this group of patients. In 1939 two more wards were converted from a former Boys' Industrial School building in this same area and these were used to house geriatric patients requiring isolation (for contagious diseases such as Tuberculosis, Syphilis, etc.)

This small unit served to illustrate the efficacy of special facilities for the aged and this experience, coupled with the findings of other institutions of a similar nature throughout the world, created an increasing demand for more units of this kind. Growth, however, was very gradual and in 1945 the annual report (Provincial Mental Health Services) recorded only 132 patients in residence at the Homes for the Aged.

In 1948, in response to this need an additional unit was established at Vernon, B.C. The Vernon unit had formerly been a military hospital and as such was easily converted to house two hundred patients initially. The majority of these patients were transferred from Essondale and the Homes for the Aged itself, and at that time, these patients were selected on the basis of their stamina for withstanding the long train journey and the fact that they would require long term care as a hospital patient.
In 1951, the third unit was established at Terrace, B.C., and at the end of that fiscal year an average of seventy-five patients were in residence. The Terrace home had also been a former military hospital converted for the use of geriatric patients. The three units at Vernon Terrace and Port Coquitlam provided a nucleus for the present geriatric programme British Columbia has for its psychiatrically ill. Each unit has expanded throughout the years with the addition of new buildings or converted older buildings up to the present time when the Homes for the Aged have an approximate total of 1,100 patients in residence (Port Coquitlam - 550, Vernon - 300 and Terrace - 250).

Present Policies

According to the terms of the Act for the establishment of the Homes for the Aged, any person over the age of sixty-five years who is judged to be suffering from changes as a result of old age, can be assessed for admission to these units. The Act and the institutions themselves are administered by a Medical Superintendent who is responsible for the admission and care of the patients and for setting up an administrative organization to provide this care.

Requests for admission to the Homes for the Aged, are made by the applicant's physician in the community. The doctor completes an application form containing his opinion as to the patient's suitability for admission as well as essential medical and psychiatric data, and forwards this to the Medical Superintendent.
As mentioned earlier, there has been a steadily increasing demand for facilities for the Homes for the Aged which these services have been unable to fulfill. (The annual report of the Medical Superintendent has consistently pointed out the shortage of bed space for the past ten years). All requests for admission are, therefore, carefully screened by the Medical Superintendent and are either admitted or placed on a list for admission based upon urgency of their committal). There has been a list of patients awaiting admission throughout the years and these cases are periodically reviewed and assessed to see whether or not there has been any change in their priority rating. During the year 1958, for example, there was a total 266 applications of men and women over sixty years of age. It was possible to accept 252 patients for admission and of these, 111 or forty-two per cent of the number received, were considered urgent so that admission could not be delayed. The remainder are still on the waiting list and hopefully, will be admitted at some later date.

In addition to dealing with official application, the Medical Superintendent has: "Spent many hours during the year interviewing relatives and others by telephone, by mail or in person, who have been burdened or intimately concerned with the problem of caring for disturbed, elderly relatives. Wherever possible, advice and encouragement have been given to maintain
these patients in community as long as possible. In many cases, suitable accommodation or medical treatment has been worked out so that admission to the Homes for the Aged could be delayed or was no longer required”.

Insofar as possible, all applicants are admitted to the unit which serves the area from which they come, i.e., those patients in the Vernon district are admitted to that unit and similarly with the Port Coquitlam and Terrace units. This occasionally results in vacancies in the units serving the less populated parts of the Province (Vernon and Terrace) and may create over-crowding in the Port Coquitlam unit. Thus approximately once yearly, patients are transferred to the Vernon or Terrace units from the Lower Mainland area if they can withstand the rigors of a long train journey and are suitable for the type of care that is given in these respective units.

**Treatment Services**

As previously outlined in mentioning the history of the development of the Homes for the Aged, two of the units (Vernon and Terrace) are converted military hospitals and some of the buildings in the Port Coquitlam district are converted industrial school buildings. These facilities are, for the most part, more suitable for providing custodial, medical and nursing care. Since

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a great many geriatric patients, because of the physical frailities of old age and the organicity of their illnesses require primarily bed care, these wards particularly in the Vernon and Terrace units are kept in full use.

Psychiatric treatment in the Homes for the Aged, at the present time, features, for the most part, custodial, psychiatric, medical and nursing care by an experienced and understanding staff. Heavy use is made of the newer tranquilizing drugs and other pharmacological therapies in all three units "to maintain the patient's maximum improvement and adjustment in the hospital environment, and to provide for the patient's greatest possible comfort and contentment."

Unfortunately, limited use is made of the psychiatric auxiliary services (such as Occupational and Recreational therapies, physiotherapy, Psychology and Social Services) particularly in the Vernon and Terrace units, as there is no provision with staff establishment for these services. In this respect the Port Coquitlam unit differs, in that because of its close proximity to the Provincial Mental Hospital and the heavily populated lower Mainland area, services are more readily available from their sources than in the more isolated areas of Vernon and Terrace.

(1) (Excerpt from treatment aims as set out in a memo sent from the Medical Superintendent to the writer.)
The Port Coquitlam unit is described in the following chapter, the setting for the detailed study. The two other units at Vernon and Terrace have spacious grounds surrounding them, and offer ambulatory patients ample opportunity for exercise or light work in order to maintain optimal physical health. Such activities also aid patients to keep occupied in meaningful activity and contribute to their own feeling of well-being. These units are served medically through the use of private practitioners in the community contracted by the Province. They, therefore, offer constant care and have substitute physicians available if necessary. Surgical and other more extensive medical treatments are provided by transferring patients to the local general hospitals within the area. The nursing staff works full time in these institutions. Regarding occupational and recreational therapy, as previously mentioned, there are no provisions for these activities, although some nurses have been interested in these areas and have obtained some training in handicrafts, hobbies and recreational organization, so that as part of their duties they can give these services to patients. In addition, patients in these units have weekly religious services provided for them through the efforts of local church organizations in the respective districts. Volunteers are also active so that there is a monthly programme using local glee clubs, etc.
Throughout all three Homes for the Aged units there is no provision made for psychological or social services. The Medical Superintendent has consistently requested these services in order to provide better diagnostic evaluations, as well as activity devoted to admission and discharge planning.

**Services Related to Discharge**

The present discharge rate from the Homes for the Aged is extremely low: Out of a population of approximately eleven hundred patients, only fifteen men and four women could be returned to their families or to nursing homes during the year 1958. In commenting upon this the Medical Superintendent stated in his annual report, "It is felt that many more patients could be discharged if social service workers were available on the staff of the geriatric division." This service would provide better liaison with community agencies and families of improved patients whereby suitable arrangements could be worked out to find accommodation away from hospital."

The Medical Superintendent is, in making these statements, not only indicating the need for social workers in these institutions but also expressing the growing conviction on the part of both medical

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and nursing staff that a sizeable group of the patients now in residence are capable of living in the outside community. Although the treatment provided consists of primarily custodial and medical and nursing care, many of these patients have responded to the extent that the symptoms which brought them to hospital are either cleared up, or are under control.

**Focus and Method of This Study**

A random sample was taken of all patients judged to be ready for discharge, with a view to determining the extent that they will require social service activity in leaving the hospital and in maintaining an optimal adjustment in the community. An analytical survey (involving an adaptation of the rating scale method) was made of some of the needs these patients will have in being discharged and potential resources they have relative to their discharge plans. The focus of this survey is on areas in which a social worker could make a contribution in both pre-discharge planning and in follow-up care.
CHAPTER II

AN INSTITUTIONAL POPULATION

It has been observed that not all of the patients are in residence at the Homes for the Aged because they remain psychiatrically ill. Some, for example, who are well enough to leave are unwilling to do so because they are happy in hospital and are reluctant to return to their former community because of the difficulties they may have experienced in getting along prior to their admission. Others because of the lengthy hospitalization and other reasons find they have lost contact with their family or friends and therefore would have no-one to help them if they were to return. Possibly some patients lack the financial resources to be able to afford suitable housing accommodation or medical care.

If there are patients remaining in hospital for any of the above reasons there would appear to be a need for social services to assist them in discharge planning. For example, the social worker could assess with the patient the availability of financial resources provided under existing social legislation, or could contact relatives or friends in order to assess the possibility of help from these sources, to mention only two possible areas of activity.

It would follow, if a social worker were to assist any of these patients in discharge planning, the first step would be to determine which specific patients are dischargeable. One of the ways in which this identification could be accomplished is through the use of an analytical survey of the patient population made in terms of criteria under which these patients are presently in hospital. That is, a survey to determine which patients have responded to treatment to the extent that they now have sufficient mental health to be discharged.
The second step would involve a more definitive assessment of those patients who are judged ready to leave hospital. Such an analysis would include a survey of some of the personal resources these patients possess and how these resources could be used to assist them to leave the hospital. In addition, some of the patient's needs would have to be surveyed in terms of how they could be met if they were to maintain a successful adjustment in the community.

The following outlines the results of a survey of the patient population of the Port Coquitlam unit of the Homes for the Aged. This setting was chosen because it provides a good cross section of the patient population of the three units (nearly one half of the total population of all the Homes for the Aged is in residence in this area) and is easily accessible for study as it is only a short distance from Vancouver.

**An Institutional Population.**

The Coquitlam unit of the Homes for the Aged is situated about twenty-five miles east of Vancouver and is immediately adjacent to the Provincial Mental Hospital. The buildings border the main highway on one side and are bordered by forest lands and mountains on the other. The setting features well-kept grounds (with lawns and shrubs) and winding roadways, and gives the effect of quiet restful spaciousness. Although the hospital seems to be a considerable distance from the city, in terms of present-day transportation (and an excellent road) one can traverse the route in approximately thirty-five minutes. A regular bus schedule is maintained giving visitors and other persons from the community ample opportunity to go to and from the hospital.

The Port Coquitlam unit, being located next to the British Columbia Provincial Mental Hospital and the Crease Clinic, has the use
of the extensive facilities found in these institutions. Considerable use is made of these services in both diagnostic and treatment planning. For example, patients are not admitted directly to the Port Coquitlam unit, as is the case in the Vernon and Terrace institutions, but are admitted as "guests" of the Provincial Mental Hospital while they are given a full diagnostic work-up. Similarly, if intensive psychiatric somata therapy (such as electro-convulsive therapy) or major surgery is required, a patient can be transferred to the mental hospital as a guest.

In addition to using diagnostic and treatment facilities involving patient transfers, patients themselves can use the numerous recreational facilities found at the hospital. Those patients enjoying "Grounds Privileges", that is freedom to go out onto the grounds during specified hours of the day (over one-half of those in residence at Port Coquitlam) may go bowling, swimming, play golf or attend movies and other activities as they are scheduled.

Still another advantage this unit enjoys is the use of any available auxiliary services from the hospital or clinic, within the Homes for the Aged. As will be noted from the brief description below, many of the treatment personnel, not provided for in the staff establishment of the unit, are "borrowed" from these other services to be used in the Geriatric unit on a part-time basis.

As previously outlined (Chapter I) the basic aim of the treatment programme is to maintain in each patient his optimal level of physical mobility and psychiatric health. Basically, the Port Coquitlam unit, along with other units, provides a high level of custodial care along with proper medical and psychiatric treatment. Regarding medical staff, the medical superintendent and one physician work full-time in meeting the medical and
psychiatric needs of the patients. In addition, there are approximately seventy-five nurses and "aides" employed in this hospital.

Regarding auxiliary services, there has of recent years been some provision made for the establishment of several departments which are exclusive to the larger Home for the Aged unit at Port Coquitlam. There is a full time Occupational Therapist on staff and this worker has an active treatment programme in force at the present and many patients are engaged in hobbies or handicrafts. One recreational therapist, on loan from the Provincial Mental Hospital, spends the major part of his working day at the Homes for the Aged organizing various social activities such as parties, card games, etc. and has a marked impact on the spare time activity of the older patient in this unit. The services of a physio-therapist are also on loan from the Provincial Mental Hospital and considerable activity is being maintained in the form of exercising and training various patients to improve their physical mobility and consequently their mental outlook. A psychologist is also available if required to conduct group therapy programmes or provide diagnostic evaluations.

There is no establishment at the present time for a social worker. In cases of emergency, however, the Medical Superintendent has requested and employed the services of the staff of the Social Service Department of the East Lawn Building, one of the units of the Provincial Mental Hospital. However, these services are not frequently used because of the demands on these workers in their own unit.

The Port Coquitlam unit, because of its close proximity to various areas in the Lower Mainland area, maintains very effective ties with the community through the use of a Volunteer Programme. Twice weekly, groups of Volunteers come to the unit, visiting individual patients who have no contact with outside community, conducting sing-songs with patient groups and assisting in ward socials. One example of this activity is to be found in the presentation of a Christmas gift to each patient, thus contributing to the patient's feelings that he is still a part of the larger, outside community. Periodically, bus-loads of patients from the Homes for the Aged, when weather permits, will go on outings and picnic trips to Stanley Park in Vancouver or on mystery bus trips, all of which provides for the patient's enjoyment and well being. Regular ward programmes, as well as special parties on such holidays as Easter, Valentine's Day, etc. In addition the Audio Visual Department at Essondale presents regular weekly movies. Television sets are also in evidence on each ward and contribute a great deal to the patient's enjoyment of their leisure time.

Religious services are held weekly on each ward throughout the year, in addition to the regular Sunday services in the Chapel. Both Protestant and Catholic services are conducted by the regular Chaplain for the Provincial Mental Hospital and pastors of other denominations in the district. A very welcome additional service for patients is that of a beautician assigned to the institution. She is steadily occupied throughout the year doing hair styling, etc., for the female patients. Other services

(1) Mr. Robert M. Ross has made an analysis of the use of Volunteers in the British Columbia Mental Health Services in his A Volunteer Programme for the Patients of a Mental Hospital, 1958. MASTER OF SOCIAL WORK THESIS, University of British Columbia, 1958.
such as barbering and chiropody, are also provided by those employed by the Provincial Mental Hospital, devoting part of their time to the Homes for the Aged.

The Port Coquitlam unit is composed of a total of eight buildings. Of these, seven buildings are used to house and service patients (i.e. cooking, etc) and one building is used as an administrative unit, housing headquarters staff. Five of these buildings were converted from the former Boys' Industrial School which occupied this site, and three buildings were especially structured for the geriatric patient. The older buildings are not too suitable for the hospitalization of aged people because of the steep, narrow stair wells, narrow corridors and small rooms. The newer units, however, were suitably structured with no stairs (replaced by gentle ramps), hand rails in the corridors and in the wards for semi-ambulatory patients, and floor lighting. It would seem rather ironical that the most hopeful or active cases are therefore housed in the older buildings because they are able to adjust to the shortcomings in the construction of these buildings, whereas, the patients with the poor prognosis or more extreme handicaps are housed in bright, new, modern buildings. It should also be mentioned that all facilities reveal considerable concern and activity on the part of all staff in order to maintain a cheerful and bright atmosphere and to cater to the needs of the patient population as much as possible. The following is a breakdown of these wards in terms of the type of patient they house:

1 Male Infirmary Ward
2 Male Wards Ambulant (Part PMH Workers)
1 Female Infirmary Ward
2 Female Ambulatory Patients
The patient population at this time is 434, made up of 142 men and 342 women. This imbalance in sexes is due in part to the fact that Vernon unit has a population of 300 men only so that some of the men are transferred to that unit when the Coquitlam unit becomes over-crowded. Of the patient group, 80 to 85 per cent have been diagnosed as showing senile brain changes with a major portion due to cerebral arterio sclerosis. Approximately 135 patients are considered non-ambulatory and as such occupy two wards.

Unfortunately, little information is available about the social, marital and cultural backgrounds of the resident population of the Homes for the Aged. However, an analysis of new admissions during the past five years reveals some significant data. A very high proportion (about 85%) of the patient group is either Canadian or British born. A similar percentage are of the Protestant faith, attending either Anglican, Baptist or United Churches. The majority of the patients are either single or widowed and are in the 70 - 79 year old age group. As mentioned previously over 85% of the population have been diagnosed as either chronic brain syndromes, senile psychosis or psychosis with cerebral arterio sclerosis. Of the 434 patients in residence, approximately 245 are sufficiently well enough to enjoy grounds privileges.

In selecting a suitable representative group of patients for study of their potential social need, resources and discharge planning, it was essential to keep several criteria in mind: These are listed as follows:

(1) **Psychiatric Qualifications**: Since a patient is admitted and treated in the Homes for the Aged for his or her psychiatric illness, the
first criterion in terms of discharge planning would have to be that their mental health had improved to the extent that they could be considered ready for discharge and that they would maintain a sufficiently high level of mental health once they were out in community.

(2) **Nursing and Medical Qualifications**: Many patients, because of the frailties of old age and physical illnesses accompanying their psychiatric problems, require constant nursing and medical care. As previously outlines, many of the patients in the Homes for the Aged are sufficiently ill physically to require constant bed care. Since discharge to community of the patient requiring constant nursing or medical care would involve finding a situation similar to that of Homes for the Aged such as a private hospital or general hospital setting, it was felt that they would be excluded from the group study, in that the type of car they could receive in community would not differ markedly from that which were already receiving. It was decided that only patients who were physically robust enough to be maintained in a normal community (with some supports such as a moderately sheltered housing or restricted recreational resources) would be considered for the study.

(3) **Representativeness**: Any group selected for this study would necessarily have to be sufficiently representative of the total patient population. This could be regarded in terms of social criteria such as nationality, racial origin, religion, sex, etc. Thus, rather than selecting the "top group" in terms of medical, nursing and psychiatric criteria for study, a random sampling a more representative group would be gathered and therefore would present social problems more common to the entire hospital population.
Selection and Assessment Process.

Four basic steps were taken in selecting the group and in assessing their social potential for rehabilitation to community: These are briefly outlined below.

1. **Screening for Medical and Nursing Criteria:** This first step was taken to ascertain that group of patients within the institution which presented the least problem in terms of the need for nursing and medical care. Approximately six weeks before the sample group was finally obtained, a memorandum was sent to the Charge Nurses of each ward by the Medical Superintendent requesting the names of patients who fulfilled the following criteria with respect to general care and management. (They were asked to divide the patients in terms of group A to include patients who fulfilled the criteria completely and group B to include those patients who were borderline or showed characteristics which might make care outside the institution difficult.)

**Physical Factors:**

1. Ambulatory without assistance.
2. Regular Diet.
3. Able to dress and give adequate care to personal appearance with minimal assistance.
4. No I.V. or I.M. medication required.

**Mental and Behavioural Factors:**

1. Co-operative and amenable to direction and supervision.
2. Behavior not influenced by delusional ideas, hallucinations, etc.
3. Minimal to moderate confusion, disorientation, memory loss.
4. Minimal tendency to wander.
The lists were subsequently returned to the Medical Superintendent's office and indicated that throughout the institution a total of 39 patients fulfilled the criteria of Group A completely and 158 patients were listed under Group B.

Although there was no actual medical assessment made at this time, as will be noted, medical factors are implicit within the questions given to the nursing staff in terms of each patient's need for medical care given by the nurses when ordered to do so by the patient's doctor. When the sample group was obtained, a check was made with each patient's physician as to the validity of the nurses' assessment regarding the dischargability of each patient and it is to be noted that there was no variation regarding the patients' need for medical care; i.e., the nursing criteria as applied to each patient was sufficiently valid in terms of medical criteria for the purpose of this study so that the doctor was only required to check on the nursing assessment.

(2) **Psychiatric Screening:** The group of 197 patients which were screened by the nurses were then assessed by the psychiatrists who were active in these particular cases. This assessment included not only a diagnosis of the patient's mental and physical health, but also such conditions as the patient's emotional reaction to discharge planning, as well as the patient's need for further psychiatric therapy unique to this institution in order to preserve treatment gains made or for further improved mental health which could not be provided in the outside community.

As a result of this screening, a total of 74 patients were selected as being potentially amenable to discharge planning. These patients were from both the A and B groups in terms of medical criteria, as it was the doctor's opinion that some of the patients in group B who had special needs could have these needs met in community
(3) Selecting the Sample Group: Twenty-five patients were chosen from this group of seventy-four through the process of taking every third patient from the list as which was in itself in random form. After this selection was made a preliminary assessment of each patient was carried out by examining the patient's clinical and correspondence files in order to obtain identifying social information as well as to assess some of the areas (such as the patient's financial situation, information from outside community sources, correspondence from patient's relatives, etc.) which was not available to the clinical team in contact with the patient.

(4) Clinical Team Discussion: Each patient was discussed with the Charge Nurse on his or her ward, as well as with the patient's doctor after the files were studies. In addition to these contacts, some informal interviews were held by the social worker with several patients who were on the ward at the time these meetings were taking place.

Although these interviews were not structured they were helpful in giving worker some idea of the type of person being assessed in terms of the patient's ability to relate. Occasionally, some confirming information was obtained from the study, such as the patient's level of motivation for discharge.

(1) A short time after the group was selected one of the patients suffered a severe stroke with the result that she was confined to bed. This patient was taken off the list, so that twenty-four remained.

(2) The contents of the clinical file included the admission papers, medical charts and the notes made by the patient's doctor. These doctors' notes summarize the results of periodic examinations and are recorded from the time of the patient's admission to hospital. The correspondence file records all incoming and outgoing correspondence regarding the patient.
One of the first problems confronting the clinical team was whether or not there was sufficient information about each patient in the group so that he could be adequately assessed. That is, in terms of the focus of this study, could the clinical team evaluate what it proposed to evaluate with any degree of assurance that the results would not be inconclusive because of gaps in the information available. All available data about each patient was therefore assessed in terms of its source, (for example, from the social worker, or the patient himself), and the amount available (that is was there information from social agencies or relatives in the community about the patient, or were the doctor's notes and the admission papers the only sources).
TABLE 2.
The amount of information available on a group of twenty-four patients at the Homes for the Aged, Port Coquitlam, 1958.

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recorded information based upon observations of a professional social worker (1) or doctor during the patient's previous adjustment in the community in addition to the information available on the regular admission forms. This data is supplemented by the psychiatric or nursing recording while the patient is in hospital regarding his needs and resources which is judged by the therapeutic team to be valid.</td>
<td>7</td>
</tr>
<tr>
<td>2. In addition to the admission forms, information written in by relatives or friends or given to and recorded by professional hospital personnel or an assessment of needs and resources as given by patient and felt by the therapeutic team to be partially valid.</td>
<td>14</td>
</tr>
<tr>
<td>3. Recalled information by professional hospital personnel or written and verbal information regarded as only partially valid as submitted by friends and relatives in addition to that found on the admission forms.</td>
<td>2</td>
</tr>
<tr>
<td>4. Incomplete information as found only on admission forms, voluntary letters from friends or relatives or from the patient with a permanent psychiatric residual.</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>

(1) The term "professional social worker" implies any social worker hired by a bona-fide public or private agency.
(2) Those on the therapeutic team include the psychiatrist or patient's doctor the nurse in charge of the patient's ward and/or other nurses familiar with the patient's case and the social worker.
The results of this assessment indicated that for the most part (twenty-one of twenty-four patients) the clinical team considered the information reliable and sufficient for their purposes. 

Who are the Patients?

From the information available on the patient population on the whole, it was considered that the group selected for study was fairly representative in terms of their social background. Information about the resident population in these institutions is, unfortunately, not available to any great extent so that in many areas the writer had to rely on the observations made by the Medical Superintendent and others working with these patients as to whether or not the group selected was representative.

Of the twenty-four patients studied, ten of them were men and fourteen, women. The group was predominantly of Canadian or British extraction. Ten of the group were born in Canada (seven of British parents) six were born in England, four in Scotland and four in other countries. Figures for the population as a whole would indicate that the group selected is not too representative in terms of sex in that the male population represents approximately one-fifth of the total number in residence. It should be pointed out, however, that this figure would be somewhat more representative of the population of the Homes for the Aged, as a whole, since the Vernon unit houses only men. Unfortunately, figures regarding cultural origin concerning patient population are not available. However, it is the Medical Superintendent's opinion that approximately eight-five percent of the total patient population are of British origin which is reflected in the group selected for study.
As might be expected from a group of this age, ten of the group were widows or widowers and only five of the twenty-four were married. Two of the remaining nine patients had been separated or divorced from their spouse and the remaining seven were single. Thus, for one reason or another, nineteen of our group of twenty-four patients had no marital partner which, at the age of 70 or over contributes heavily to further personal isolation. In keeping with policy that the Port Coquitlam unit services people of the Lower Mainland area, all the patients in our sample group had resided in the Vancouver Island or Lower Mainland area prior to their admission to the Homes for the Aged.

The patients ranged in age between 70 and 88 years and were fairly evenly distributed within these years. The average age was approximately 77 years. Although the majority of the group (nine of the twenty-four) were between the ages of 78 and 82 years, there was a considerable "scatter" in aged. For example, three of the patients were between 70 and 74 years of age and ranged between 84 and 88 years.

Similar information about the total population of the institution is not available, as the figures about age are traditionally grouped into ten year periods (i.e. 70-80, 80-90) rather than the two year intervals which have been used for clarity in discussing the sample group. There was considerable variation regarding the length of time (from 6 months - 24 years) that members of the group had spent in the Homes for the Aged.
TABLE 3.

The length of stay of a group of 24 patients at the Homes for the Aged, Port Coquitlam, 1958.

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>1 - 2 years</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>2 - 5 years</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>10+ years</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>10</strong></td>
<td><strong>14</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>

Although the average length of stay was about $5\frac{1}{2}$ years, this figure is somewhat misleading as the group indicated a fairly even spread throughout all the entire population regarding length of stay are not available, but it is assumed through the experience and observations of the clinical team that the sample group is fairly representative.

It is also interesting to note that out of the twenty-four men and women in our group, only two indicated a history of previous psychiatric hospitalization.
The other twenty-two, according to the information available, had not been hospitalized for psychiatric illness prior to their admission to the Provincial Mental Hospital and subsequent transfer to the Homes for the Aged, or admission to the Homes for the Aged after assessment at the Provincial Mental Hospital as a "guest".

One would conclude that many of the patients who had been in hospital for over ten years had been either viewed as having chronic psychiatric illnesses or had not been considered for discharge because of lack of resources in the outside community.

It is extremely difficult to make any meaningful classification of the psychiatric disorders with which patients were diagnosed. An arbitrary classification (Table 4) does illustrate that all twenty-four patients have an organic element in their illnesses which are accompanied for the most part with some behavioural or psychotic reaction.
TABLE 4.

The diagnosis of a group of twenty-four patients at the Homes for the Aged, Port Coquitlam, 1958.

<table>
<thead>
<tr>
<th>Illness</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Senile Brain Disease</td>
<td></td>
</tr>
<tr>
<td>(a) With qualifying phrase--</td>
<td></td>
</tr>
<tr>
<td>Depressive Features (2)</td>
<td></td>
</tr>
<tr>
<td>Psychosis (3)</td>
<td></td>
</tr>
<tr>
<td>(b) Without qualifying phrase (7)</td>
<td>12</td>
</tr>
<tr>
<td>2. Cerebral Arteriosclerosis</td>
<td></td>
</tr>
<tr>
<td>(a) With qualifying phrase--</td>
<td></td>
</tr>
<tr>
<td>Reactive depression (1)</td>
<td></td>
</tr>
<tr>
<td>Behavioural reaction (1)</td>
<td></td>
</tr>
<tr>
<td>(b) Without qualifying phrase (3)</td>
<td>5</td>
</tr>
<tr>
<td>3. Chronic Brain Syndrome</td>
<td></td>
</tr>
<tr>
<td>(a) Due to Cerebral Arteriosclerosis (6)</td>
<td></td>
</tr>
<tr>
<td>(b) With Senile Brain Disease (1)</td>
<td>7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>

Information about the resident population of the Homes for the Aged regarding illnesses is not available. However, published statistics regarding first admissions according to diagnosis indicate that over 95% of first admissions to the Port Coquitlam unit are diagnosed in one of the three categories in the above table.

(1) British Columbia, Report of the Mental Health Services, Queen's Printer Victoria, 1958 P L 119, Table 3.
In summary, the sample group of twenty-four patients is, from the information available, fairly representative of the patient population as a whole in the Fort Coquitlam unit of the Homes for the Aged. In terms of the "average" a typical patient within the group is seventy-seven years of age and has been in hospital between five and six years. He is of British extraction, a Protestant and single. He suffers from an organic illness which is accompanied by changes in his thinking and behaviour.

There are many needs which the clinical caseworker has to consider when assisting these patients in their discharge from a protective institutional setting to that of the outside community. In one the fulfillment of these needs is the responsibility of the institution. In the other, the former patient, as a citizen, must take some initiative and responsibility in finding and using the resources which the community provides. Patients leaving the Homes for the Aged have heightened difficulty in this regard because of the length of time they have spent in hospital and handicaps to adjustment added by their age. During this lengthy period of hospitalization one would expect, because of the dependency fostered upon patients in any institutional setting, some diminution of these patients' ability to look after themselves. In addition to this loss, one would also expect a drastic weakening of community ties, that is, some loss in relationships with friends and family, in community affairs and in community resources.

Coupled with the problems accrued from hospitalization are those of social and community isolation, physical fraility and a tendency toward psychological rigidity. All these must be considered in any discharge planning.
CHAPTER III

NEEDS AND RESOURCES IN DISCHARGE PLANNING

Since it would be difficult, if not impossible, to assess every individual need within the group, some common needs will be examined in terms of the patient's potential in being considered for discharge to community. The preceding considerations suggest that two broad categories must be taken into account.

First there are the needs directly related to the patient's period of hospitalization and which must be met some other way in community to preserve the well-being of the patient. The areas chosen for assessment included: Medical needs (for example, the need for further treatment of physical ailments; for special diets or vitamin therapy); psychiatric casework or counselling needs (pharmacological therapy, psychotherapy or supportive casework are some of the ways of meeting these needs that were included in this category). The need for personal supervision, (that is the need for guidance from friends or relatives in coping with day-to-day problems); and housing needs (the special aspects of housing accommodation required for the older person, such as a sheltered boarding home or a housekeeping room close to community recreation facilities).

The second group of needs selected are more specifically related to the patient's adjustment in the outside community and for which the patient usually has some resources to meet these needs.
Since it is the caseworker's function to assist the patient to use his own personal strength as much as possible, the following factors were considered resources which he can use to facilitate his adjustment in community. Those factors assessed were: physical ability, financial and material resources, social, recreational and religious interests, the number and interest of family and friends and the patient's motivation for discharge. It is apparent, however, that if the patient lacks any of these, the community will have to provide for these lacks and these factors will therefore become needs.

**Psychiatric, Casework and Medical Needs**

Of primary concern to the social worker in any institutional setting of this nature is the need for extending hospital services after discharge or in providing services in community related to the patient's hospitalization or his need for post-discharge treatment. Often the success of the patient's attempt to re-adjust in the outside community depends on the extension of casework services or psychotherapy to him from people with whom he is familiar and feels he can trust. He may need to continue with prescribed diets or medication to maintain his physical or mental health and require support and encouragement to do so.

An attempt was made by the clinical team to assess the patient's psychiatric, casework and medical needs in terms of their social implications. For example, any patient requiring frequent and constant medical supervision would of necessity have to live in close proximity to a medical doctor or medical facilities.
TABLE 5.

The need for casework counselling and psychotherapy of a group of 24 patients of the Homes for the Aged, Fort Coquitlam, 1958.

<table>
<thead>
<tr>
<th>Extent of Need</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Frequent &amp; Intensive</td>
<td>Patient requires weekly or twice weekly contacts by a caseworker and/or psychiatrist in order to interpret or to support the patient in dealing with his adjustment to family or friends or in using medical, social, recreational or religious resources.</td>
<td>10</td>
</tr>
<tr>
<td>2. Supportive &amp; Brief</td>
<td>Monthly or bi-monthly contacts of a brief supportive nature by the psychiatrist or caseworker to assist the patient in coping with any occasional difficulties or to observe and treat any signs of permanent maladjustment in its beginning stages.</td>
<td>7</td>
</tr>
<tr>
<td>3. Occasional &amp; Preventative</td>
<td>Occasional supportive contacts of a routine nature based upon a request by the patient or those in contact with them or at the convenience of the caseworker with the focus on observing and treating any beginnings of maladaptive behaviour.</td>
<td>7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>
The psychiatric and counselling needs were assessed together, so that the focus on the need for casework services would remain on the patient's psychiatric condition. That is, to maintain the gains in treatment which the patient made during hospitalization and enable him to use resources in community to keep up health. Thus casework activity around specific areas such as discharge planning or unforeseen events in the patient's readjustment in community were not included.

"Psychiatric services" implied the use of psychotherapy and the prescribing of tranquilizers and other drugs related to maintaining mental health of the patient. Excluded were the more intensive somatic therapies such as electroshock treatment or surgery.
It is not surprising to note (Table 5) that ten of the twenty-four patients, according to the assessment of the clinical team, need frequent and intensive follow-up care on a weekly or twice weekly basis. It is interesting that the majority of the group do not require counselling of this intensity. Rather brief and occasional contacts would seem to be adequate.

These results, however, do imply that follow-up care is required by the majority of the patient group in order to maintain their present level of mental health and would indicate that if these patients were discharged, some post-discharge treatment facilities would be essential. These facilities should include, according to the results of this assessment, the services of a caseworker to provide the support and encouragement some of these people need.

As in the case of psychiatric treatment and casework counselling needs most people as they grow older require more frequent medical examinations and treatment. Many are restricted to special diets or have to take daily medication. The clinical team assessed the medical needs of this group of twenty-four patients in order to determine whether or not these could be met in the community.
TABLE 6.
The extent of medical needs of a group of twenty-four patients in the Homes for the Aged, Port Coquitlam, 1958.

<table>
<thead>
<tr>
<th>Extent of Need</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Constant Supervision</td>
<td>Patient is required to maintain schedules in taking medicines and to maintain regular (weekly) or fortnightly) contact with the medical doctor and/or Public Health Nurse.</td>
<td>6</td>
</tr>
<tr>
<td>2. Regular Supervision</td>
<td>Patient is required to maintain regular medical schedules, but requires no more than periodic checkups with the medical doctor or Public Health Nurse.</td>
<td>10</td>
</tr>
<tr>
<td>3. Occasional Supervision</td>
<td>Required to maintain no more than normal medical schedules (vitamins, etc.,) and occasional checkups with the family doctor or Public Health Nurse.</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>
It will be noted (Table 6) that no attempt was made to assess the specific needs of each patient. Rather the extent of each patient's medical needs were examined in terms of the demand these patients would make for medical care in the community. In the opinion of the clinical team, eighteen of the group of twenty-four require only regular or occasional supervision so that the majority of the patients would have little difficulty in obtaining suitable accommodation since the demands they would make for care would not be too atypical for persons now in the community of a similar age group.

There was a significant correlation between the extent of need for medical, psychiatric and counselling services and the patient's length of stay.

For example, it was observed that six of the ten patients who had been in hospital for less than two years required "frequent" psychiatric or casework counselling services whereas only one out of five of the group having lived in hospital over ten years required similar services. The remaining four patients staying over ten years required only "supportive and occasional services."

These findings would indicate that the social worker would have to help the patient who has remained for a relatively short time on an intensive basis to find and use the medical and other services provided in the patient's community.
Housing Needs

The provision of suitable housing accommodation for older people is a major problem in most communities in North America at the present time. As previously outlined (Chapter I) during the past few decades older people have become separated from the primary family group and thus have been forced to seek separate housing accommodation. Newer housing units constructed for a smaller family do not provide for other than immediate family members. Coupled with this lack of space in the modern home is the difficulty that older people sometimes have in looking after themselves without assistance from others so that they often are unable to provide for themselves in a suite or light housekeeping room and have to seek a home where they can be partially looked after by others.

The clinical team assessed the selected patient group in terms of how these people could adjust in the various types of housing found in the community at the present time. Each patient was evaluated by the clinical team in terms of his or her adjustment on the ward. That is, the patient's ability to look after his own personal hygiene, getting along with other patients and ability to assume some responsibility for cleaning up the ward and making beds, to mention a few examples. It should be added that the patient's behavior was reviewed over a period of several months in order to obtain some idea of his consistency.
It is rather surprising to note (Table 7) that thirteen of the twenty-four patients required only a "board and room" type of residence rather than the more sheltered type of housing which is provided in the community. Two of the patients who required "sheltered boarding home care", in the opinion of the clinical team would have been better suited to a nursing home in view of their severe physical handicaps. These two patients, both women, would require assistance in almost all activity such as getting up for meals, going to the bathroom, etc. although they did not require constant medical or psychiatric care. Of the three remaining patients requiring the "sheltered boarding home" two needed this type of housing because of their inability to climb stairs, otherwise their physical and emotional condition was good. These two patients would require housing similar to that of any person with a severe heart condition restricting their physical activity.

It would seem significant that most of the group could get along in a "board and room" type of residence in view of the lengthy time most of the patients have spent in the hospital where full institutional care is provided. That is, one would wonder if a long period of hospitalization would not result in a dependency on fully institutional care. Perhaps the answer to this question is that the aim of the hospital staff is to help the patient as much as
possible maintain his or her optimal level of functioning. One of the methods the nursing staff employ (especially when the amount of staff available to care for these patients is considered) is that of encouraging the patient to look after himself as much as he is able. In addition, he is encouraged to help in looking after others or in performing other duties around the ward such as cleaning, serving food or other activities not unlike those required to maintain a normal household.

Although the results of this assessment imply that most patients do not appear to require a sheltered type of housing, a social worker would have to bear in mind that this study was conducted in a setting where sheltered care, although not necessarily required by most of the people in the group, was however implied. Also it must be remembered that there is a ready opportunity for each patient to find support and acceptance through his fellow patients and the staff in performing any duties around the ward. These considerations do not necessarily invalidate the conclusions but might indicate that similar relationships may be necessary to the patient living in a home where board and room are provided, and should be a matter of consideration in the social worker's planning in providing housing for the patients as represented by this group. It would not seem too surprising that only two patients were capable of residing in a suite or light housekeeping room in view of the age and resultant physical infirmities of most of these patients.
Personal Supervision

Most older people, because of their incapacities, need some minor guidance or help in coping with day-to-day problems that younger age groups would have little difficulty in handling. For example, an older person often needs some advice or encouragement keeping within a budget, in answering correspondence or in maintaining contacts with friends or relatives.

Although the patients in the groups were assessed in terms of their need for professional psychiatric and casework counselling services, the clinical team was aware of the need of most of the patient group for occasional, informal and instructed guidance. This evaluation was obtained chiefly from the nursing staff, who have the opportunity to observe the patient's reactions to frustrations during the twenty-four hours of the day and the amount of help they need from other patients or staff.
### TABLE 7

An assessment of the type of housing needed by a group of twenty-four patients in the Homes for the Aged, Port Coquitlam, 1958.

<table>
<thead>
<tr>
<th>Type of Home</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sheltered Boarding Home</td>
<td>Patient requires private room on ground floor close to facilities without being required to climb stairs. Home is in close proximity to medical and/or psychiatric resources.</td>
<td>5</td>
</tr>
<tr>
<td>2. Boarding Home Care</td>
<td>Patient requires social and recreational facilities in the home, but is capable of climbing stairs and in caring for personal household needs.</td>
<td>4</td>
</tr>
<tr>
<td>3. Board and Room</td>
<td>Patient is able to make full use of household facilities in caring for personal hygiene. Social and recreational facilities are needed within close proximity (within 3 or 4 blocks).</td>
<td>13</td>
</tr>
<tr>
<td>4. Supervised Light Housekeeping Facilities</td>
<td>Patient is capable of maintaining light housekeeping room with occasional guidance and supervision. Needs only normal access to social and recreational facilities.</td>
<td>1</td>
</tr>
<tr>
<td>5. Suite or Light Housekeeping Room</td>
<td>Patient is capable of living in and managing a suite or light housekeeping room without supervision. Needs no more than normal social outlets.</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>
TABLE 8
The Amount of Personal Supervision Required by a Group of 24 Patients in the Homes for the Aged, Port Coquitlam, 1958.

<table>
<thead>
<tr>
<th>Extent of Need</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Full Supervision</td>
<td>Patient requires constant supervision in all phases of personal care (i.e. sanitation, meals, etc.) and needs support and encouragement in making use of recreational and social facilities and in all other phases of activity</td>
<td>5</td>
</tr>
<tr>
<td>2. Light Supervision</td>
<td>Patient occasionally requires some guidance in keeping with the incapacities of old age. This would include occasional support and encouragement in using community resources, in housekeeping, etc.</td>
<td>17</td>
</tr>
<tr>
<td>3. No Supervision</td>
<td>Patient is able to function adequately in community and at home with no guidance or supervision, is well motivated and capable of using social, recreational and religious activities and is completely independent in performing normal household functions.</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>
Most of the twenty-four patients, while not requiring constant supervision do require occasional guidance (Table 8). The social worker would therefore be well advised to make certain that the patient had someone in the community who could provide a fairly consistent contact (such as a relative or landlord) and for whom the patient had sufficient respect to accept his guidance or counsel.

Physical Ability

One of the most valuable resources the older person has (as with any age group) is the ability to perform the variety of physical activities essential in maintaining a healthy adjustment. Some physical ability is required to carry on almost any activity, and in the case of the older person, this resource becomes more valuable to him as he realizes that his powers are beginning to wane. In some cases, taking care of one's own personal hygiene requires tremendous exertion. Others may have the ability to enjoy strenuous activities in their leisure time; leisure time which increases with older age because of the loss of employment and the narrowing of social contacts.

The clinical team, in assessing the patient group, evaluated each patient's behavior in terms of the mobility and stamina he manifested in his ward behavior. The scope of activities provided in the hospital offers ample opportunity for the patient's involvement and consequently his physical ability is easily measurable. There is work to be done in the wards or on the hospital grounds requiring various levels of strength and stamina and other organized recreation (bowling, dancing) and informal activities (golfing, fishing) are also available to the patient and provide a ready index of his abilities.
<table>
<thead>
<tr>
<th>Extent of Need</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consistently Active</td>
<td>Patient is able to maintain a normal stream of physical activity in keeping with the frailties of old age. Patient is able to do light work (such as janitorial duties, watchman, etc.) with a minimum of absenteeism or participate moderately in such activities in golf, dancing, etc.</td>
<td>5</td>
</tr>
<tr>
<td>2. Moderately Active</td>
<td>Occasionally able to participate in such activities as listed above including light work on a casual or part-time basis. Patient is consistently able, however, to enjoy such moderate activity as hiking, fishing, etc., and to involve himself in spectator sports.</td>
<td>7</td>
</tr>
<tr>
<td>3. Restricted</td>
<td>Unable to participate in any activities other than walking or spectator activities. Patient is, however, sufficiently mobile to look after personal needs in the home and to moderately participate in such physical activities as found in the normal household.</td>
<td>7</td>
</tr>
<tr>
<td>4. Partially Handicapped</td>
<td>Patient is mobile only to the extent of caring for his own personal needs in the home such as going for meals, going to the bathroom, etc. Occasionally goes out on special occasions or for periodic visits with friends or relatives, etc.</td>
<td>3</td>
</tr>
<tr>
<td>5. Severely Handicapped</td>
<td>Patient is physically able only to partially look after his own personal needs at home.</td>
<td>2</td>
</tr>
<tr>
<td>Extent of Need</td>
<td>Description</td>
<td>Number</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>5. Severely Handicapped</td>
<td>May occasionally need some assistance to come for meals, etc., leaves home only rarely and when absolutely necessary and is always accompanied by an escort.</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>

Although there seems to be little information regarding the level of function of those in a similar age group in the outside community, one would suspect that this patient group is not atypical in this respect.

It is also interesting to note that there seemed to be no correlation between the patient's physical ability and other factors, such as his length of stay or diagnosis. A similar "scatter" is evident in comparing each patient's physical ability with his or her "medical, psychiatric and casework counselling needs", although two patients who are physical "severely handicapped" require "constant" medical and psychiatric care.

In terms of Social Work planning, this patient group indicates a wide range of physical ability seemingly unrelated to other needs and resources found in their respective communities as they indicate sufficient physical ability to make use of these resources, even though, (in most cases), on a restricted basis.
Financial and Material Resources.

Most people, as they approach older age have made some financial provisions for this period in their lives. Because of the loss of ability to be gainfully employed or because of forced retirement schemes most find themselves dependent on the financial and material resources amassed during their earlier years such as income derived from investments, or pensions granted through former employment. A sizeable proportion of the older age group however, have financial difficulties. Some were unable to make provisions for old age and others who did, have found their savings depleted in the last decade because of the diminished value of the dollar through inflation.

It is readily apparent that financial provisions are essential in planning for the discharge of any patient from hospital. Money is needed for clothing, shelter and medical care, to mention only the bare necessities. In addition the older person often requires special facilities for his care and may need more money than the average person to maintain himself.

Because of the importance of these resources, the financial and material possessions of each patient were carefully assessed. It was hoped that this evaluation would help the team determine the amount of financial assistance those in the group would require if they were discharged to community. This assessment was made on the basis of information provided through hospital records and in two cases from interviews with the patient to supplement this information.
At the time a patient is admitted to hospital a statement is taken by the business office as to what financial and material resources the patient possesses. This description of the patient's estate is filed and if no relative or responsible person exists in the community to administer the estate the office of the Official Committee (a branch of the Attorney General's Department) assumes responsibility for administering the patient's affairs.

There was some question about whether the patient's resources and needs should not have been broken down in terms of sums of money. It was felt that such a survey would be extremely difficult to make in that it would be almost impossible to assess the estates of some of the patients in terms of actual cash value. Also, it was hoped that the clinical team measure the patient's resources in terms of the patient's own concept of his social functioning. For example, one of the group, Patient A, was receiving an income of $750. monthly as a pension. Patient B could be receiving a $35. a month pension supplementary to the Federal Old Age Pension. Patient A would have difficulty in considering the income of Patient B as even partially sustaining. In other words, some attempt was made to evaluate the adequacy of the person's resources in terms of his own particular level of social functioning, rather than making this assessment entirely in terms of community standards.
TABLE 10.

The Financial and Material Resources of a Group of Twenty-four Patients in the Homes for the Aged, Port Coquitlam, 1958.

<table>
<thead>
<tr>
<th>Extent of Need</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comfortably Self-Sustaining</td>
<td>Patient has capital investment with a steady income and own home or money to buy own home and other material goods which enable him to live comfortably. Patient has enough resources so that he need not worry about anything other than outstanding expenses such as law suits, etc.</td>
<td>2</td>
</tr>
<tr>
<td>2. Completely Self-Sustaining</td>
<td>The patient has some property, possibly own home, furniture, etc. Sufficient capital to buy property as well as a small income or resources in the form of investment, etc.</td>
<td>2</td>
</tr>
<tr>
<td>3. Partially Sustaining</td>
<td>Patient has limited personal property such as furniture, etc. and some income (excluding Old Age Security). There is a need, however, for some budget control and assistance in extra expenses (i.e. medical expenses, glasses, dentures, etc.).</td>
<td>8</td>
</tr>
<tr>
<td>4. Partially Dependent</td>
<td>Patient has some personal income of a limited nature to supplement Old Age Security or Old Age Assistance (in the case where Old Age Security cannot be granted). Patient has personal property of little significance or value and is dependent on welfare programmes for meeting expenses other than the bare necessities.</td>
<td>1</td>
</tr>
<tr>
<td>5. Completely Dependent</td>
<td>Patient's personal property of an insignificant nature and has no income other than that provided through Government Pension or Welfare.</td>
<td>11</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>
It is apparent (Table 10) that few of the patient groups can be considered completely financially independent. The majority are either partially or completely dependent on financial resources which can be provided through the community. A comparison of these results with the patient's length of stay indicates that most patients remaining in hospital for extended periods of time have correspondingly less resources to employ when they return to the community. There may be several reasons for this condition. One reason could be that patients with more financial and material resources through their own efforts and through the efforts of their relatives and friends may be discharged or transferred to other private hospitals or nursing homes, leaving those with no resources as the major part of those remaining over ten years. This would seem unlikely in view of the extremely low discharge rate.

A second reason for this diminution of these resources may be due to charges levied on the patient's estate by the hospital in terms of payment for their care ($1.50 daily). Although patients who qualify may receive the Federal Old Age Pension and contribute this toward the cost of their hospitalization many of the patients remaining in hospital for a longer period than ten years may have had charges levied on their estate prior to the time these pensions were granted. In addition, (partially because of the lack of services of a social worker in the Homes for the Aged) there have been some delays in receiving the pension so that unfortunately the patient may have had to pay for the cost of his hospitalization for some considerable time prior to receiving it.
Since the majority of this patient group will require financial assistance when they return to the community a great deal of a social worker's time would be required in terms of helping the patient with financial planning. This activity would infer the assessment of each patient's eligibility for financial assistance under the Old Age Pensions Act or other resources as provided within the framework of social legislation as well as some mobilization of any existing resources that could be provided by either family or friends to ease any possible financial hardship. Financial planning for the older person represents a great many difficulties especially in terms of the need in some cases for special and more expensive housing or diets and the occasional need for special recreational activities or assistance in transportation. In other words, incapacities created in growing old often times result in the need for a typical and more expensive resource in order that these people can maintain an optimal level of adjustment.

The Interest of Family and Friends

The patient's contacts in community represent for the most part relationships made prior to his admission to hospital and are to him not only a part of the outside community but also a "bridge" from the hospital where he wishes to return. Friends and relatives, of course, perform many functions for the older person, functions which assume an even greater significance in older years.
"....Let it never be forgotten that the key to physical vigour in so many old people lies in their state of mind and that nothing so surely saps the physical strength of old people than a complete loss of interest in life... It behooves us to pay regard to those factors in the environment which can help to precipitate this peculiar mixture of sadness and apathy. Of these of course, by far the most tragic and by far the most important, is loneliness."

Interested people can perform a counselling, supportive and supervisory activity, and can also be used by the social worker in terms of assisting the patient in his planning or in heightening the patient's level of interest and activity.

The patient's contact with the outside community is actively encouraged at the Homes for the Aged. There are daily visiting hours and evening visiting privileges once a week. Evening visiting is sometimes somewhat restricted because of the lack of extra staff required for dealing with visitors. In addition, any correspondence requesting information about the patient is answered in the hope that these interested parties will maintain contact.

Patients who are able to return to the community for short periods of time are encouraged to take leave from the hospital to visit friends and relatives. Many cases various members of the hospital

personnel maintain contact with friends and relatives of patients, reporting any changes in the patient for week-end leaves, etc.

The clinical team surveyed the number of people who are interested in the patient and the extent of their interest. These two areas, that is the extent and level of interest by others outside of hospital were separately assessed, because, in some cases, patients may have a number of visitors but these visitors may not be too interested in planning with the hospital staff for the care of the patient or in the comfort of the patient during his stay in the hospital.

Information is readily available regarding the number of visitors a patient may have. Each time a person comes to visit a patient, his name and address are recorded in the patient's visitors book and this file is kept in the nurse's office on the ward. In addition, a file card is kept up to date regarding inquiries by interested parties and this also is kept in the nurse's office. Regarding correspondence about the patient, all such inquiries and copies of replies are recorded in the patient's correspondence file, so that the clinical team was also able to evaluate the interest of friends and relatives through their correspondence.
TABLE 11
The Quantity of Family and Friends of a Group of Twenty-Four Patients in the Homes for the Aged, Port Coquitlam, 1958.

<table>
<thead>
<tr>
<th>Extent of Need</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Large Circle</td>
<td>The patient has retained a good number of ties in the community indicating a lengthy period of establishment in this community. Patient has a spouse or children and several long term acquaintances.</td>
<td>2</td>
</tr>
<tr>
<td>2. Moderate Circle</td>
<td>Patient retains a group of relatives or friends in the one community. Has some close relatives and a few friends remaining.</td>
<td>4</td>
</tr>
<tr>
<td>3. Limited Circle</td>
<td>Patient has a few close relatives and old friends in former community.</td>
<td>6</td>
</tr>
<tr>
<td>4. Scattered &amp; Remote</td>
<td>Patient has some relatives or friends whose ties are not close and who are scattered in various communities, has some old friends in former community.</td>
<td>10</td>
</tr>
<tr>
<td>5. None</td>
<td>No relatives or friends in former or other communities. Patient is completely alone and isolated.</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>
Evidently most of the patients had a limited circle of friends or only scattered and remote contacts in the community. (Table 11). It is also not surprising to note that the patient's circle of friends tend to diminish as his length of hospitalization increased. For example, five of the ten patients having been in hospital for less than two years had a large or moderate circle of friends. Of those patients in hospital over five years, eight of the nine people indicated a limited or scattered circle of contacts.

Although this assessment reflects the tendency for all older persons to become socially isolated, these results particularly show the added isolation of the older person in an institution.
The Interest of the Family and/or Friends of a group of Twenty-Four Patients in the Homes for the Aged, Port Coquitlam, 1958.

<table>
<thead>
<tr>
<th>Extent of Need</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strong</td>
<td>Patient has frequent visitors or correspondence from family or friends. Frequent inquiries are received of how the patient's condition is. Patient is granted leaves from hospital on a fairly frequent basis to his friends or family.</td>
<td>8</td>
</tr>
<tr>
<td>2. Moderate</td>
<td>Patient has friends or relatives who visit or correspond on a casual basis and on holidays or festive occasions. (i.e. birthdays, etc). Periodic inquiries are received about the patient and he is allowed week-end leaves to visit relatives or friends.</td>
<td>5</td>
</tr>
<tr>
<td>3. Casual</td>
<td>Occasional visits by a few close friends or relatives and periodic inquiries regarding the patient's condition. Patient is granted leave from hospital on rare occasions (i.e. once or twice yearly)</td>
<td>4</td>
</tr>
<tr>
<td>4. Remote</td>
<td>Annually or semi-annually on a social nature by one or two close friends. Patient goes out on leave only on very rare occasions.</td>
<td>3</td>
</tr>
<tr>
<td>5. None</td>
<td>No friends or relatives visit. No inquiries regarding patient.</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>
Motivation for Discharge

The success or failure of any patient's discharge is dependent in a large part upon his own motivation towards leaving the hospital. If he is anxious to return to his former community, he is quite often able to facilitate his own discharge by mobilizing his own resources or in seeking other resources outside of the hospital. The patient's motivation also influences the role of the social worker to a great extent. Essential to the activities of a social worker is the right to self determination by the client (that is, the help the client to help himself) and if the client lacks the desire to involve himself in planning with the worker, very little progress will be made.

The clinical team, aware of the importance of this area, assessed the patient group to determine these patients level of motivation in terms of wishing to leave the hospital. These patients were evaluated according to their willingness to leave the hospital, including their expressed views. Evaluating the group presented several difficulties to the team. For example, several patients who indicated a good potential for adjustment had never expressed and willingness or desire to leave the hospital. Other patients, when they were disturbed, would request discharge from hospital primarily because they were seeking some solution for their feelings of upset and agitation. This survey therefore of necessity had to include, not only the patient's own expressed wishes about leaving the hospital but some idea of his potential for discharge in terms of his medical and psychiatric condition.
The results of this assessment would indicate that a Social Worker could be of considerable help to most of these patients in making discharge plans.

It is difficult to predict what results would occur if a supportive type of relationship was established with some of the patient's relatives. One would feel that the efforts of a case-worker in this regard would produce very beneficial results by the interpretation of the patient's illness to them, support to the family in terms of follow-up care when the patient was discharged, or through the mobilization of resources available through the relatives or friends to assist the patient in his return home and in maintaining him once discharged. Certainly the assessment does indicate considerable weakening of community ties, as their stay in hospital lengthens.
TABLE 13
THE Level of Motivation of a Group of Twenty-Four Patients in the Homes for the Aged at Port Coquitlam in 1958

<table>
<thead>
<tr>
<th>Level of Motivation</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Patient frequently and regularly has discussed and requested his discharge and indicates a willingness to involve himself in planning.</td>
<td>5</td>
</tr>
<tr>
<td>Good</td>
<td>Patient has expressed some wish to be discharged yet vacillates in terms of his unwillingness to leave the protection of the hospital and to face the difficulties involved in preparing himself for discharge</td>
<td>4</td>
</tr>
<tr>
<td>Fair</td>
<td>Patient seldom expresses any wish to leave hospital yet his adjustment on the ward indicates a potential for mobilizing his resources and as such could be a candidate for preparing for discharge.</td>
<td>9</td>
</tr>
<tr>
<td>Poor or None</td>
<td>Patient has expressed little wish to leave hospital and has made only a fair ward adjustment and indicates little potential for mobilizing his own inner resources.</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>
The patient group (Table 13) indicated a wide range of levels of motivation. Fifteen of the twenty-four were in the "fair" to "poor" categories and the remaining nine seemed to be eager to participate in any plans for discharge. It should be noted that those of the group who had remained in hospital for a period of longer than five years expressed the least willingness to leave the institution; seven of these nine patients expressed no wish to leave hospital even though the team considered them as good discharge possibilities. On the other hand, six of the ten patients remaining in hospital less than two years indicate either a "high" or "good" motivation. It would seem then that the patient's highest motivation for discharge (at least in this patient group) occurs during the first and second year he is in hospital. Perhaps this is the period of time that his communities ties are strongest and foremost in his mind and his psychiatric condition has remitted to the extent that he feels he would be able to get along in the community. After a two year period in the institution the patients would appear to accept hospitalization as a permanent plan rather than a means of improving their health so that they can return to their former type of living. This lack of interest in any other area than the hospital would, of course, be heightened by the gradual withdrawal.
of contacts with friends and relatives and also by the realization of the patient that his needs are being met in the institution and it would be difficult for him to change his way of living that discharge to the community would demand.

The above results have considerable implications to the social worker concerned with assisting these patients in their discharge. All of the patients, however, indicated that before they could be discharged they could benefit through social work activity within one or more areas assessed. As was anticipated those of the group who had remained in hospital for an extended period of time experienced a weakening of their ties in community and a stronger dependency on the institution. Thus the job of the social worker becomes more complex with these people in that they have fewer resources to imply and less willingness to consider the prospect of leaving hospital.

The results of the total assessment also imply a need for casework activity with these patients both during the time they are in hospital and during a post-discharge period.

(1) See Page 65.
It would appear that considerable interview time would have to be spent preparing these patients to face the prospect of leaving hospital, in assessing their resources and the resources provided by the community in order that the patient can enjoy the best possible adjustment. In addition, this patient group evidenced a need for extension of hospital services such as further counselling and medical care. The social worker could play a vital role in this regard as a "bridge" for the patient between the hospital and the community.
CHAPTER IV

SOCIAL WORK TREATMENT OF THE AGED PSYCHIATRICALLY ILL

Summary and Assessment.

At the beginning of this study, the social adjustment of the aged was briefly outlined. It was concluded that, for various reasons, older people are becoming an isolated group and its members regarded by many in the community as having the characteristics common to this group. Thus there is a tendency for older people to be stereotyped as dependent people, incapable of assuming the responsibility for their own care and happiness.

A review of some of the available statistics regarding the economic adjustment of the aging, revealed that not all aged people are dependent people. Many remain productive and self sustaining even though they have become "aged" according to the definition imposed upon them through the implementation of forced retirement schemes and pension plans.

Even though some remain independent, it was pointed out that older people tend to become ill more often and need a longer period of time to recover. Hospital statistics for example, indicate that a larger proportion of the older aged group spend a longer time than any other age group. Although the chronicity of the older patients' illness was acknowledged to be the major reason for lengthy hospitalization there was some question as to the influence of delays in discharge as a result of the lack of community facilities to care for these people during their convalescence.
A brief assessment was made of some of the newer trends in psychiatry with respect to the treatment of the older person. It was concluded that with the development of newer therapies and special treatment facilities for the care of the geriatric patient, many are responding to their hospitalization to the extent that many recover sufficiently from their mental illness to be considered ready for discharge.

This trend is reflected in the British Columbia Homes for the Aged, which provide care for the aged person with mental illness. After a brief description of the development and the present programme of these institutions, it was concluded that, although treatment consisted primarily of custodial medical and nursing care, some of the patients respond to this regime and are thus capable of leaving hospital.

To achieve the purpose of this study - to determine if social services could make some contribution in helping some of these patients leave hospital - it was necessary to select and define some of the areas in which the social worker would be active with the patient. In other words, the first task was to determine some of the needs of the patient that would have to be considered if he were planning to leave hospital.

In order to avoid the confusion of a long grouped into two broad categories: (1) the patients' needs and (2) resources he could employ. Needs were defined as those areas with which the patient required help and emanated directly from his hospitalization. Those selected were medical, psychiatric and casework counselling, personal supervision and housing needs. Resources - those factors which depended in part on the possessions of the patient - included physical abilities, financial and material resources, social, recreational and religious interests and the patient's motivation for discharge.
Twenty-four patients from the Port Coquitlam unit of the Homes for the Aged were selected for the assessment. They had been in hospital for periods ranging from six months to twenty-three years. They were chosen by a routine sampling procedure from a larger group who were judged to be medically and psychiatrically suitable for discharge. This latter group had been determined by the medical and nursing staff, who through the use of a questionnaire surveyed the entire patient population in order to identify those patients well enough to leave the hospital.

Although the results of the assessment of the group selected for study (accomplished primarily through the use of rating scales), indicated that the needs and resources of the group varied considerably, it was evident that all of these patients could benefit from the assistance of a social worker in one or more of the areas evaluated.

There were some indications that the patient's length of stay had a considerable effect upon the type of social work activity they use.

Those remaining in hospital for a period of less than two years had usually retained some resources in their former community which could be mobilized to assist them in discharge. On the other hand, the majority of this group indicated they would need an extension of hospital services if they were discharged. That is most of these people would require either psychiatric, casework or medical follow-up care in order to maintain the gains they had made in treatment.
The motivation of these people to leave hospital was good, perhaps because of the maintenance of strong community ties, which was also evidenced in the assessment.

Those patients who had remained in hospital for a longer period of time, indicated less need for medical or counselling services yet had little in the way of social resources, such as wide social contacts in their former community, or financial and material possessions. This group also evidenced less motivation for discharge and seemed to regard their hospitalization as a permanent living arrangement.

There was no significant correlation with patient’s physical ability or social recreations and religious interests in terms of their length of stay. As previously mentioned the result of the assessment of each of the selected needs and resources indicated that a social worker could make some contribution in discharge planning with each patient. This period in his hospitalization, however, represents only one part of the patient’s total treatment programme. In addition to assessing the patient’s needs and personal resources the social worker would have to include a survey of community resources in order to determine how the patient could meet his needs most effectively. This study therefore reviews only one aspect of possible social service contributions during part of the patient’s institutionalization. Further studies would have to be undertaken in order to determine more fully how a social worker could assist the aged patient hospitalized for mental illness.
A Transition Period.

This study would seem to indicate not only that the patient group would benefit by the services of a social worker, but also a transition period has resulted in the increase in the psychiatric treatability of older persons. The treatment program of this institution (primarily custodial) has reflected the common concept of mental illness in the older person being associated with chronicity and the resultant poor prognosis. However, paralleling the growing awareness in other areas of a newer more optimistic outlook the staff of the Homes for the Aged have indicated that many patients could be returned to their community after suitable treatment. At the present time most of the separations from hospital result from the death of the patient; very few patients are returned to their homes or are discharged to private hospitals or boarding homes.

At the same time, there is a growing list of people awaiting admission to this institution resulting in increasing pressure by the community for these facilities. There is a need therefore, to institute an active program in the hospital focussed on helping patients, who are well enough to return to the community. The results of the study indicate that social service activity would be essential if such a programme were initiated.

The problem of dealing with over-crowding in the facilities for the aged is not unique to the Province of B.C. A study of the needs of older and chronically ill persons in Ottawa completed under the direction of Miss Marjory Bradford indicated similar problems in that City.
In commenting on the results of the committee's survey of institutional facilities for the aged Miss Bradford pointed out: "The present overloading of nearly all institutions, and much excess stay of older patients in hospital, are partly a problem of bottlenecks for which not one, but many new channels must be opened. One of these is a social work services associated with all institutions and hospitals, to help the right people in, help the right people out, and work on patient and family problems in between. No institution dealing with human life in sickness and trouble fails to run into such difficulty, or achieves its highest pinnacle of usefulness without such a facilitating service." The number of patients who are ready for discharge increased significantly as a result of a more active psychiatric treatment programme within mental hospitals.

Recently the results of an accelerated programme in a state hospital at Camarillo, California was published. The author summarized the results as follows: "Since 1952, we have given more than 26,000 electric treatments to over 600 patients between the aged of sixty and ninety-two. We have been able to send on convalescent leave more than 200 patients, twenty-eight of whom had been on the most disturbed geriatric female ward in our hospital.

Before institution of this form of therapy, practically no one from this ward of 100 patients had been able to go on convalescent leave. However, all of these patients are now able to go to the dining room, none require intramuscular sedation, and none are in restraint. Forty per cent are able to go on short home visits or have riding permission with their relatives.

It is readily apparent that such a programme would involve a great deal more contact between the patient and his outside community than in now in evidence at the Homes for the Aged in Port Coquitlam. Social work activity in such a programme would also no doubt show considerable acceleration.

It is interesting to note that the medical and nursing staff of the Port Coquitlam setting eagerly participated in the study of the patient group. They offered many suggestions and ideas as to how further information could be obtained and what other needs could be assessed. The question they most often asked was "when will there be a social service department active in the hospital?"

Although the members of the clinical team have evidenced their willingness to work with patients toward discharge, there remains the problem of the older person being accepted in the community. These people, in addition to being old, have had a mental illness and some will no doubt face added rejection by their friends because of this coupled with the attitude of the community the older person has to face a shortage of essential resources such as suitable housing accommodation and recreational centres.
Thus the social worker would likely find himself very much involved in making a thorough assessment of existing resources and perhaps in developing further facilities in community to help these people.

There are indications of concern in this regard in many communities at the present time. In Vancouver for example the Community Chest and Council Social Planning Section (1) have recently completed two studies which included publication of a handbook for families faced with the care of older people at home and an evaluation of present mental health services for the aged in British Columbia.

Similar concern has been shown in the United States. For example, in the state of Ohio recommendations have been made for further therapeutic resources in the community to be concerned with post hospital social planning for the geriatric mental patient. The author observed that "the change from hospital life to community must be an uninterrupted process". (2) The report of the committee studying needs and resources in the City of Ottawa for the older person included in its recommendations expansion of such resources as casework services provided by public welfare agencies, hospital social services, the use of visiting home-makers and housekeeping aides, and more diversified housing accommodation to meet the particular housing needs of this group. (3)

(2) Post Hospital Planning for Geriatric Mental Patients, Geriatrics Devoted to Diseased and Processes of Aging. Volume 14, Number 3. March 1959. Lancet Publications Incorporated, Minneapolis, Minn. U.S.A.
(3) Bradford, Miss Marjorie, A Study of the Needs of Older and Chronically Ill Persons in the City of Ottawa, the Council of the Corporation of the City of Ottawa, 1954. Paged 71,75.
New Goals for Social Work Research.

At the present time as already indicated (Chapter I) there is no social service department in the Homes for the Aged. Therefore, although there is no body of information available of past social work activity it is hoped that further research in the areas of the need for, and function of, a social service department could result in the establishment of a department of peak efficiency.

In view of the probability that a social work department will be set up in the near future, there is a need for research in two broad areas. First, definitive assessments, perhaps along the lines of this present study, should be made in order to determine more fully, the possible scope of activities of a social worker in these units. In other words, how the social worker would function in all areas of the total hospital programme.

Casework activities in pre-admission services would merit some analysis. As previously outlined (Chapter I) a great deal of time is spent by the hospital staff (particularly the Medical Superintendent) in dealing with the problems of prospective patients, their families and interested social agencies in order to temporarily sustain the patient prior to his coming to hospital or in making effective alternate plans. It would seem that working with these people to help them employ community resources or give support and guidance to those caring for these disturbed elderly people could be competently handled by a social worker knowledgeable of the special problems these people have. Other pre-admission activities which could be assessed include an evaluation of the need for social information in treatment planning and some evaluation of the benefits that could result
from the interpretation of services to patients and their families prior to admission in order to enlist their cooperation in treatment and pre-discharge planning.

Enlisting casework help during the patient's treatment period should also be examined. There are many examples of areas needing analysis including the special problems the aged present in casework treatment, maintaining community ties during prolonged hospitalization and helping the older person remain motivated for discharge.

Further research in pre-discharge planning and following up care would also be essential. The present study represents only a beginning in this area. Other questions have to be answered such as: What specific resources are available to meet these patients' needs in community and how could this be accomplished most effectively? What would be the caseworker's specific area of competence in relation to other members of the Clinical team?

The second major area - that of organizing the Social Service Department to provide the most efficient possible service - also merits considerable attention in terms of research. Assuming that the activities of the social worker in the hospital were clarified: How could he function most effectively? For example, how could meaningful liaisons be made with other agencies and institutions and what referral procedures would be used.

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(1) A qualitative analysis of casework services at the Crease Clinic of Psychological Medicine, a psychiatric institution in British Columbia performed by Mr. E. Schlesinger illustrates some of the contributions a social worker can make during a patient's hospitalization.

Providing for further research is another important area in planning an agency function. Through research, further knowledge is gained with the result that new and better ways of doing things are developed, resulting in turn in the giving of more service to people which is the fundamental goal of social work. A standardized system of recording information, (for example, referral systems and diagnostic summaries) as well as planned research programmes would contribute to an increased efficiency in the Social Service Department.

Present trends in population growth indicate an even greater proportion of older people, as compared with other age groups, for the future. An increased demand for psychiatric facilities to treat those of this group would appear inevitable. At the same time, with the development of newer therapies, the older person has an increasingly better chance of being discharged from a psychiatric institution. All of these developments will bring greater pressure on the community to provide for the discharge patient of older years and as a result a larger demand for social workers to help these people.
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