POST-DISCHARGE NEEDS OF MENTAL
PATIENTS WITHOUT FAMILY RESOURCES

A study of a group of women who
were formerly long-term patients at
Provincial Mental Hospital, B. C.,
1957 -- 1958

by

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ABSTRACT

This study surveys the personal circumstances and situations upon discharge, of young women who have been in the Provincial Mental Hospital a number of years, and have no home to which to return. It was found that nine out of ten patients without usable family resources have problems of such a nature on discharge as to require the services of a social worker. Their problems include obtaining work or maintenance to meet their basic needs of food, clothing, and shelter. They also need personal assistance and encouragement in obtaining employment, making new friends and acquaintances, and participating in recreational activities.

The method used was to compile pertinent information from the hospital files of patients aged thirty-five and under, who left on "probationary discharge to self" during a given one-year period (actually, July 1, 1957 to June 30, 1958). Eighteen patients were found to meet this criteria, whose cases could be studied extensively.

The findings suggest that the average patient without family resources has come from a home in which there has been much stress, and is limited in educational, vocational, and social skills (e.g., lack of friends and acquaintances, relationships with the opposite sex, etc.). Social workers, both at the hospital and in welfare agencies throughout British Columbia, were active in helping approximately 90 percent of these patients meet their needs. Such help included making arrangements for finances, job finding, accommodation finding, transportation, and providing emotional support.

Only 56 percent of these patients were able to make an adjustment that did not result in re-admission to the hospital; which suggests that follow-up, and after-care programs should be strengthened to include more extensive use of hostels (such as the Vista in Vancouver), and of family care programs. The possibility of smaller local centres for psychiatric care is another idea that merits consideration, to avoid prolonged separation from the community in which the patient is to return.
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POST-DISCHARGE NEEDS OF MENTAL
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CHAPTER I

REHABILITATION OF THE MENTALLY ILL

It is often argued that no one can enjoy a complete lifetime with perfect mental health. Mental illness, however, will be thought of as involving a disturbance of sufficient intensity and duration as to require a person's admittance to a psychiatric hospital.

The U.S. National Institute of Mental Health reports that in 1954 the number of persons found in state mental hospitals was 340 per 100,000 in the general population. This is 0.34% of the population. The total number of mentally ill is certainly greater, however, considering that hospitalization in a state institution is often only a last resort used for the most extremely disturbed people. There are an uncounted number cared for in out-patient clinics, or by private practitioners, and many also are making a marginal adjustment with the aid of a social agency or are bearing their illness without assistance. Many informed sources maintain that one out of every ten persons will at some time require professional assistance in dealing with his everyday personal problems. Another source mentions that mental illness strikes one family in five in the community.

Much the same situation exists in Canada. On December 31, 1956


2 Province of British Columbia, Department of Provincial Secretary, Mental Health Services Annual Report, 1957, Queen's Printer, Victoria, B.C. P. Q 57.
there were 71,000 patients receiving psychiatric care in mental hospitals.\(^1\) This is nearly 0.42% of the entire Canadian population. In British Columbia on March 31, 1957 there were 6,279 mental patients in residence in the Province's institutions.\(^2\) Of these, 226 were hospitalized at Crease Clinic at Essondale and 3,533 were hospitalized in the Provincial Mental Hospital at Essondale.\(^3\) At the Provincial Mental Hospital 176 were under the age of twenty-five, 1,784 were in the age bracket twenty-six to fifty, and 1,766 were age fifty and over.\(^4\)

At first it may seem surprising that so few patients hospitalized at the Provincial Mental Hospital are under the age of twenty-five. One would suppose, however, that those under this age are given opportunity for treatment at the Crease Clinic, in the Child Guidance Clinics, and Mental Health Centre. Also, the younger people are responding to newer treatments early in the course of illness; and this is evidence that the population in long-term treatment units tend to be an aging population.\(^5\)

Not so long ago the layman's conception of a mentally ill person was that he would have to spend the remainder of his life in a public mental hospital, were his illness so severe that hospitalization were required. The actual fact is that patients have been discharged from these

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3 *Loc. Cit.*

4 Ibid., pp. Q 137--Q 139.

5 Personal Communication with Social Service Supervisor of East Lawn Unit, Mr. Jack Ellis.
same hospitals for many years. It is entirely true that admission rates have shown steady increases throughout the years, but, only recently, discharge rates have shown a slight increase over the admission rates. This, of course, is not due to one factor alone, but to a number of causes. Increased knowledge has been gained regarding mental illness, and improved treatment techniques have been devised, notably in the areas of psychiatry, social work, psychology, and pharmacology.

What is the actual situation in British Columbia today? Roughly one-third of the patient population is being discharged from the Provincial Mental Hospital annually. During the fiscal year from April 1, 1956 to March 31, 1957 there were 1,148 patients discharged in full from the total resident population of 3,533. The disposition of these discharges is even more significant. From this total of 1,148 patients discharged, 883 went home, three went to a general hospital, 206 went to another mental hospital, and 56 were discharged under "other" circumstances. More will be said later about the residual classification, "other", as it is in many ways the theme of this thesis. It may be noted that 386, or 34%, of all that were discharged were under thirty-five years of age.

Hospitalization a phase of illness: The foregoing statistics clearly indicate that mental illness incapacitate many persons only during a temporary period in their lifetime. Hospitalization, then, is not necessarily a permanent life plan for a person should he become mentally ill. The evidence is that most patients admitted to the Provincial Mental

1 Province of British Columbia, Department of Provincial Secretary, Mental Health Services Annual Report, 1957, Ibid. , p. Q 140.

2 Loc. cit.

3 Ibid., pp. Q 142—Q 143.
Hospital become sick while living at home, are then hospitalized, and then return to their home when they are better. This obviously, is exactly the same pattern as for most other illnesses.

As with other illnesses there are some that are more permanently incapacitating than others, and therefore some patients will need some form of hospitalization for very long, indefinite periods of time. Included in this group are persons for whom science as yet does not have sufficient knowledge to help them make even a social recovery. An example of such a person would be one who is severely disorganized due to extensive, irreversible brain damage. The fact remains, however, that patients requiring permanent hospitalization are not the bulk of patients admitted to mental hospitals; most patients are hospitalized only temporarily.

Other patients, for one reason or another, do not return home after their illness; indeed, some have no home in which to return. This certainly does not mean that they must remain in hospital permanently. This is the group of patients selected for the present study.

Evolution of Community Responsibilities.

In a sense, people have always been concerned about the mentally ill. Because of their unusual behaviour, which until comparatively recent times was thought to be beyond human understanding, the mentally ill were viewed with all sorts of superstition. Their healthier contemporaries all too often viewed them as being possessed with spirits, demons, and devils. Prevailing attitudes throughout history tended to place mentally ill persons far apart from the human race. Sometimes they were placed in temples and worshipped—as though their behaviour was that of divine inspiration.

1 A social recovery refers to the situation in which a patient, although still evidencing mild symptoms of mental illness, is able to hold a job, enjoy friends, and so on. The quality of this adjustment is still impaired by illness, however.
More frequently they were associated with the forces of evil, and execution in the most hideous of manners was deemed right and proper.¹

Even with the spread of more enlightened philosophies regarding the dignity of the individual, people were all too quick to have the mentally ill removed from their midst. Gradually the mentally ill were placed in various institutions; jails, workhouses, poorhouses, and other receptacles for humanity. For the most part, conditions in these institutions were appalling, and the person so confined was kept in chains and treated much like a wild beast. In the latter part of the eighteenth century, there was some movement toward the development of welfare measures. As pointed out by Sutherland, these followed "in the wake of progressive forces released by the political and social revolutions in America and France (1776 and 1789)."² Albert Deutsch presents an interesting account of the setting in which Philippe Pinel undertook his great reforms in the treatment of the mentally ill at the Bicerte Asylum in Paris.³ Pinel was given the post of Superintendent at that institution by two of his friends, Thouret and Cabanis, both of whom were elevated to the top of the Paris hospital system by the French revolutionary government.⁴ This was in 1792 when the French Revolution was at its height.⁵ The same year Pinel shattered all present traditions by removing the chains from the patients, and thus introduced the method that was later designated as "moral treatment".


⁴ Ibid., p. 89.

⁵ Ibid., pp. 88—89.
The method of "moral treatment" was the use of humane procedures in caring for the mentally ill. It refers to the then popular concepts of providing patients with calm retreat in the country and protection from severe physical abuses.¹

The time was ripe for reform and the rise of the era of moral treatment at the end of the eighteenth century. Working quite independently at the same time were Tuke, in England; Rush, in America; and Chiarugi, in Italy.² Not only were chains and shackles removed from the mentally ill, but other practices such as bloodletting were questioned, and abolished in at least one institution.³

Legislation was finally enacted in the nineteenth century for the public provision and responsibility for all severely mentally ill persons. "Moral treatment" was not marked by continuous progress, however. In North America during the first three decades of the nineteenth century, it was not uncommon for mentally ill persons to be sold at public auction along with paupers. In some areas where local communities took responsibility for the care of the poor, confused people were often taken and "dumped" in neighbouring towns in the hope that someone else would care for them.⁴

The 1840's saw the influence of Dorothea Lynde Dix, whose social reforms gradually spread internationally. At the age of forty-one she was appalled by the conditions of the mentally ill in the jail at East Cambridge, Massachusetts, and was moved to such fervor that for the next forty years

¹ Loc. cit.
³ Loc. cit.
⁴ Ibid., p. 124.
she travelled through the United States, Britain, Canada, and many European countries as "the apostle of the insane"; her gospel being the humane treatment for the mentally ill. It has been said that wherever she travelled, a new mental hospital was built.

A further step toward state responsibility for the mentally ill occurred during the nineteenth century. Horace Mann, in addressing the Massachusetts State Legislature in 1828 declared "the insane are the wards of the state". During Mann's time, however, "state care" implied little more than that the duty of the state was to provide special asylum, or custodial, care to those who required it. The third decade of the nineteenth century witnessed a strange phenomenon. Because of an unfortunate series of events a large number of people at that time believed that ninety percent of the mentally ill could be cured with the methods then at their disposal. This idea, plus other developments, led to a wave of asylum and hospital building in the western world. Although many events transpired, the ultimate outcome was toward large, centralized care for the mentally ill. This most often being on the state or provincial level.


2 It is hoped that ultimately at least 90 percent of the mentally ill will be "curable". It is unfortunate that this erroneous idea became prevalent in 1830 because it later caused a damaging wave of enlightened pessimism. Even with over another century of tremendous progress, the year 1959 still can not claim 90 per cent curability of all mental illness.

3 The events that occurred were few in number, but widely publicized. The recurrent mental illness of King George III of England, who probably suffered from a manic-depressive psychosis, was claimed to be "cured" by his physician, Dr. Willis, during periods of rather normal remission of this disease. Widely publicized statistical errors and biased reports also led to this era of wishful thinking. For an interesting account of this, the reader is referred to Deutsch's chapter entitled "The Cult of Curability". Ibid., pp. 132--157.
The late nineteenth and early twentieth centuries witnessed many great men emerging in the newly recognized field of psychiatry. Men such as Kraepelin, Freud, and Bleuler are some of the most significant, and it was then realized that much could be done if more knowledge were known. The work of these men helped considerably in laying the framework for a sound and rational basis for treating, and later rehabilitating mental patients. This period is also known for the beginning development of the facilities and techniques for professional training of staff, the development of appropriate research techniques; the rise of out-patient departments, the rise of psychopathic hospitals for acute cases, and the beginnings of the employment of professional social workers.

Closely allied with treatment and rehabilitation of the mentally ill was the growth of the concept of the prevention of such ailments. The name most closely associated with the development of prevention is that of Clifford Beers. Mr. Beers, himself once a mental patient, founded the Mental Hygiene Movement in 1909. He set for himself the task of developing a working partnership between the public and psychiatry. His work was especially useful in that it, among other things, opened the door for the integration of mental hygiene thought, philosophy, and practice into such disciplines and fields as (general) medicine, social work, education, religion, and industry. Although his work started in the United States, the concept of prevention and maintenance of mental health soon spread to

1 A psychopathic hospital is defined as "one for early diagnosis and treatment of mental disorders. The patients need not be subject to commitment as insane . . . . The psychopathic hospital emphasizes study of the individual patient (rather than custody). The term is sometimes used for a receiving hospital."

Canada and other parts of the world. As a result, many organizations are now in existence furthering these concepts on the basis of community planning.

Mental Hospitals and the Social Services

It is common practice today for psychiatrists to look to social workers for help in the study of personality in relation to environmental situations. Conversely, social workers look to psychiatrists for assistance in understanding difficult problems of attitudes and behaviour. This is manifest in that most efficiently-operated psychiatric clinics and hospitals employ social workers and most efficiently-operated social agencies employ psychiatric consultants.

With the growth of humanitarian understanding has come an international movement to build mental hospitals, but many reformers have had to press for social action in this area. The realization of the social needs as well as the individual need, however, is still incomplete. As Dr. Gordon Hamilton has written, "there is always a polarity in social planning -- to look at society from the basis of the whole and from the basis of the individual". It was at this point that psychiatrists and social workers joined forces and started to operate as a team in mental hospitals. Gradually from this has developed vital interest in after-care, i.e. in the circumstances which face parents when they leave hospitals, or complete institutional treatment.

Lois French writes:

"The first unorganized beginnings of this 'focussing' or drawing together of . . . psychiatry and social work are difficult to trace. . . . Before our present day type of social work was organized, psychiatry here and there had for

probably a century done a kind of social work under the name of after-care. As far back as 1860 there appeared, in annual reports of certain state hospitals, recognition of the need for consideration of the social problems at the time of a patient's discharge. Such reports also show that some 'social investigation' was done by the doctors themselves, particularly of patients placed in boarding homes.¹ ²

The physicians who made these early efforts to help patients after they had left the mental hospital found that they were faced with a lack of knowledge in helping with social problems. Shortly after the turn of the twentieth century, Dr. William Mabon of the Manhattan State Hospital said, "After-care should be . . . closely connected with hospitals. . . . The field workers, whether physicians of laymen, should have had special training in social service and should know something about insanity."³

The first record of social service departments in psychiatric hospitals seems to be the year 1905. It was in 1905 that the social service departments were formed in the neurological clinics of Massachusetts General Hospital, Bellevue Hospital, and Cornell Clinic in New York City. The first time a social worker was affiliated with a State mental hospital was in April, 1906, and was known as "after-care agent". This first worker was a graduate of the New York School of Philanthropy (later called New York School of Social Work), was employed by the State Charities Aid and worked in the Manhattan State Hospital. The first social workers in mental hospitals were also known as "field workers", their duties being to "attend clinics, visit homes of patients, and


2 One can trace the after-care movement further back than 1860. The name first associated with the movement is Dr. Lindpainter who put forward this idea in 1829 in Germany. The purpose sought was "to provide adequate financial, medical and moral assistance to patients discharged from mental hospitals". See Deutsch, Op. cit., p. 289.

cooperate with the Board of Education. By May, 1914 there were workers employed in eleven state hospitals.

One of the early pioneers in psychiatric social work was Miss Mary C. Jarrett, who was appointed director of social service in the spring of 1913 at the newly formed Boston Psychopathic Hospital. She defined the function of her department by saying the social service department was organized to assist in the study and treatment of mental disease, and treatment was "construed in its broadest sense to mean restoration of capacity for normal living or provision for the greatest possible comfort."

Most of the duties the early psychiatric social workers, like Miss Jarrett, set for themselves remain as standard practice today, although many refinements and experimentation in procedure has taken place since then. Special duties connected with the outpatient work were "taking the social history of new patients, assisting in discovering and dealing with social problems, seeing that the family of the patient understood the physician's directions, acting as a liaison agent between the physician and social workers in the community." Miss Jarrett, as early as 1914, saw part of her duties as training new workers. She accepted students on her staff from the Simmons College School of Social Work, and also took an active interest in developing of a training course for psychiatric social workers at Smith College in 1918—1919. It was also Miss Jarrett who, in 1920, helped with the formation of an organization called the Psychiatric

1 Ibid., p. 35.
2 Loc. cit.
3 Ibid., p. 38.
4 Ibid., p. 39.
Social Workers Club, the forerunner of the American Association of Psychiatric Social Workers, 1

The need for trained workers became very apparent during the time of World War I, and this need has persisted constantly since then, despite the fact that many schools of social work have since been organized. In Canada, the first course for psychiatric social workers was inaugurated at the University of Toronto in 1919. 2

Dr. Adolph Meyer, a psychiatrist, in 1922 gave added impetus to the trend of studying patients in relation to their social environment. Dr. Meyer insisted on the study of the environment from whence the patient came and to which he might return. 3 His works also had the impact of stressing the psychosocial aspects of human behaviour and this greatly influenced the practice of psychiatric social work.

This close association of social work with psychiatry was instrumental in shifting the emphasis of social workers during the 1920's in their approach to social problems of human beings. Sutherland states:

"Their focus of concern shifted from the broader environmental factors underlying social ills to the developing of casework techniques arising from a deeper understanding of individual personality afforded by dynamic psychiatry. There was a gradual modification from an exclusive interest in external problems toward inclusion of treatment of personality difficulties." 4

The Great Depression of the 1930's brought with it many socioeconomic problems for large numbers of individuals. Faced by the stress of unemployment and destitution, social workers returned to many of their

1 Ibid., p. 296.
sociological approaches to social need, for the emphasis on resolving personality and financial difficulties, while important, did not solve the urgencies that were present. In later years there has been a growing blend of the two approaches. Concern with families and communities as well as individuals has also influenced psychiatry considerably. Psychiatrists nowadays characteristically go beyond the individual patient in terms of diagnosis and treatment. Their concern is moving "to the complex weave of the interrelations of individual, family, and wider community." ¹

Perhaps the types of problems patients bring to social workers today are not fundamentally different from those at other times in history. Certainly not those of patient readjustment after discharge. The historical beginnings of social work in mental hospitals was concerned with the patient's re-adjustment to life away from the hospital, and this is still a very important consideration to present-day social workers. Unfortunately, patients still suffer a stigma when leaving such a hospital and employers, family, and acquaintances often needlessly mistrust the ex-mental patient. The patient often needs considerable help and emotional support in making his re-adjustment, and social workers strive to help the patient meet this need. Experience has shown that frequently when such help is not given, the patient often suffers a relapse due to social handicaps.

Socio-economic difficulties are often present. If the patient is indigent, arrangements must be made to overcome this problem, either through social assistance or employment, and occasionally social assistance is a first step toward the patient being again employable.

Social workers are also concerned with the family situations of patients. Attempts are made to offer help to families at various stages of hospitalization. Perhaps the first contact with a relative will be prior to the patient's admission to hospital, or shortly after he is received. Usually a social history is recorded at this time and some interpretation is given to the relative as to what can be achieved or expected of hospitalization. Ideally, there is contact with both the patient and his family throughout all aspects of hospitalization, and both are prepared for the day when the patient returns to his home.

But some patients have no home in which to return. Some are homeless after a long period in the hospital. Other homes are so disorganized that it is unwise for a patient to return there. Still other patients might find it advantageous to leave the hospital and establish themselves in geographical communities other than the ones from which they came. Perhaps their original communities may have deep-seated bias against the patient for actions and behaviour he committed before being hospitalized. For all practical purposes such a patient has no family resources he can use. These are the situations which make what will be referred to in this study as a "non-family patient": What more should we know about such people? What special assistance do they need on leaving the hospital and in making a subsequent adjustment, and how can the social worker provide, directly or indirectly, this special assistance.

Social Work in the Psychiatric Hospital

In each state or province, when a mental hospital has been built, an almost universal pattern has developed. The hospital was filled to capacity almost as soon as the doors were opened. In most places the

number of patients far exceeded the supply of adequate staff. Quality of service, however, is as important as quantity of service. Each profession, psychology, medicine, social work, and nursing has struggled to develop its own standards of professional practice and codes of ethics.\(^1,2,3\)

For social workers the relevance of this is that a program of high quality means better care for patients, decrease in length of treatment required, reduction in number of re-admissions, and improved public relations.\(^4\) In the psychiatric hospital there are five main functions with which the social service department should engage itself. These are: (1) the practice of social casework and group work; (2) participation in program planning and policy formulation; (3) participation in the development of social and health programs in the community; (4) participation in the educational program for professional personnel; and, (5) social research including (a) follow-up studies of groups of patients, and (b) evaluative studies of the effectiveness of the activity of the social work department.

The professional principles upon which social workers base their work with clients, as put forth by the American Association of

1 Official documents on this subject from both the American Association of Social Workers, and the Canadian Association of Social Workers are utilized as the source material for the above.


3 A Statement of Standards to be Met by Medical and Psychiatric Social Service Departments in Hospitals, Clinics and Sanatoria, Canadian Association of Social Workers, Ottawa, 1952.

4 The Canadian Association believes that the social service department in the psychiatric hospital should include all of the social workers within the institution, and its director should be responsible only to the hospital's top administrator.
Social Workers, are:

"1. Firm faith in the dignity, worth and creative power of the individual.

2. Complete belief in his right to hold and express his opinions and to act upon them, so long as by so doing he does not infringe upon the rights of others.

3. Unswerving conviction of the inherent, inalienable right of each human being to choose and achieve his own destiny in the framework of a progressive, yet stable, society."

These principles hold good for mental patients as they do for others, but they are often hard to interpret. Naturally the patient is closely examined regarding such matters as impairment of judgement and mental competency; nevertheless, the patient must be encouraged to exercise all the self-determination of which he is capable. This again is not an easy task.

In mental hospitals, social workers are usually responsible to the medical superintendent via the director of the social service department. This is certainly the case in the particular setting in which this study occurs. In such a setting, a clear division of function must exist between the various professional disciplines. The physicians must assume the psychiatric and medical responsibility for each patient; social work responsibilities remain to be established between the Director of Social Service and the Clinical Director of the hospital.--(Usually in a mental hospital, the senior psychiatrist appointed by the Medical Superintendent, for the purpose of establishing and supervising the over-all medical program). In the staff-and-line management, these general policies are transmitted down to the ward physicians and social workers who treat individual patients. It is within this framework that individual practitioners of differing disciplines collaborate on the specific details of their work. How far this may require development for discharge
planning will be considered in the concluding section of this study.

Discharge Needs of Mental Patients and the Concept of Rehabilitation

Rehabilitation, as defined by the National Council on Rehabilitation, New York, has been frequently quoted. In their terms it is the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable. Mental illness for most patients is a severe handicap, and large numbers who are well enough to be released from the hospital carry, to some degree, residual effects of their illness. Even those who are fortunate enough not to have a residuum of illness often must have considerable assistance to realize their full physical, mental, social, vocational, and economic usefulness.

What is meant by "discharge"? As the term is used in hospital parlance, it refers to the time when a patient severs his physical ties with the hospital, and leaves to re-establish himself elsewhere. Unfortunately, in many mental hospitals, the term can take on a number of different meanings. A patient is usually admitted to a mental hospital on the basis of a written agreement called a commitment. The commitment may be either voluntary or one made by court order and signed by a magistrate. The voluntary commitment is an agreement that the patient himself signs, should his own request for admission to a mental hospital be granted. The voluntary


2 An exception to this is the rarely used device of admitting a person as a "guest" of the hospital, and no formal agreement is made. This, however, is most often used as a temporary device until a more formal arrangement is made.
patient may also demand and receive his release from hospital under terms outlined in the agreement. The patient hospitalized under court order is usually released at the discretion of the medical superintendent, unless a special "detainer" is added whereby release must also meet with approval of the court. Discharge always occurs when the commitment is closed and no longer exists.

Most hospitals, however, find it advantageous to all concerned to allow the patient to leave the hospital on a trial basis, to determine the extent of his adjustment before actually "discharging" or terminating the commitment. Another way in which this might be used is in instances when an overnight visit to family and friends is used for therapeutic purposes. The old term for these types of separations, a term everyone understood, was parole. In recent years, however, the term "parole" was unfortunately thought by some to be an undesirable word. In its place a whole host of terms are now used to designate parole periods. Some of these are to mention only a few; "trial visit", "temporary leave", "convalescent status", "furlough", "terminal leave", and "discharge on probation" (as contrasted with "discharge in full").

To confound the term "discharge" even further, mental hospitals and courts often add a qualifying word after it. The intent is to make a statement regarding the competency of the patient when terminating the commitment. Thus, there are terms like the following in common usage: "discharged, recovered", "discharged in full, able", "discharged, improved", "discharged, unimproved", "discharged in full, unable", and so on. Depending on which state or province is referred to, there may be civil connotations attached to the qualifying phrase after the word "discharged." These connotations can sometimes affect a patient's legal right to buy or rent property, contract for marriage, be responsible for criminal actions,
Another controversy this writer has witnessed is a medico-legal one, if a court of law or designated magistrate by committing a patient to a mental hospital thus removes his legal and civil rights, can the medical profession restore these on discharging a patient? The answers are by no means universally in agreement. Discharge, however, is regarded as important, and is commonly determined by medical staff meetings, rather than by one individual medical practitioner.

All of the patients selected for the sample of the present study were on a parole or "probationary discharge" status before either being discharged in full or re-admitted to the hospital. No attempt was made to select patients exclusively in one of the foregoing classifications, nor was it necessary to do so. No non-family patient is released directly from the area of the hospital studied without first serving a probationary period, and maximum probationary period at the British Columbia Provincial Mental Hospital at Essondale is six months.

Hospitalization may mean many things to a mental patient. Probably the great majority verbally state they want to leave the hospital, but many find that "getting out" is not always a pleasant matter. Many suffer a sort of "separation anxiety" when the time comes for them to leave, especially when they have been in an institution for many months or years, as had all the patients who are studied here.

Patients in such a setting are completely dependent on the hospital for food and shelter. Many are clothed by the hospital as well. Forced into group living, most have made an adjustment to a fairly rigid routine in such matters as when meals are served, when to arise in the morning, when to retire at night, what type of clothes to wear, and so on. In other words, there are little demands for the patient to take on more
than partial responsibility for his daily affairs. Other patients often become his closest friends while he is in the hospital. "Outside" becomes indeed another world.

Thus, on leaving the hospital, the patient must change his way of living drastically. There are such matters as housing, employment, friends, and recreation to consider. His behaviour and personal conduct is also more important, as often what is tolerated in the hospital is not tolerated elsewhere. All human beings tend to resist change, especially when it means a complete change in one's way of life. Many patients who "want to leave the hospital", find it difficult when making the change because imminent, and they may at this stage develop resistances and ambivalences.

Needs on discharge must be distinguished from services on discharge, although services offered are intended to be related to need. Some of the more common needs of patients are a place to live, food to eat, clothes to wear, employment, finances, emotional support from friends, satisfaction from one's activities, and so on. When a patient leaves the hospital, resources must be present to meet his needs if he is to survive and sustain himself. The details of this story are developed in the chapters which follow.
CHAPTER II
THE NON-FAMILY PATIENT

The Provincial Mental Hospital and the Crease Clinic of Psychological Medicine are both located at Essondale, B. C. The difference between the Provincial Mental Hospital and Crease Clinic is that the former may accept all kinds of mentally ill patients, but usually accepts patients where illness has been present for a considerable length of time and fairly long-term treatment is indicated. Of the two institutions, although their functions overlap, the Mental Hospital tends to accept patients whose illness is chronic or recurrent. Patients are admitted to this institution on an indefinite commitment, terminated at the discretion of the medical superintendent.

The Provincial Mental Hospital is divided into units, each with a certain amount of autonomy. The "Centre Lawn" building with a capacity of approximately 500 beds is the reception unit for new patients and also contains semi-acute treatment facilities. Both male and female patients are housed in the Centre Lawn Unit. The "West Lawn" Unit contains

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1 The early methods of caring for mental patients in the Province of British Columbia and the establishment and history of the Provincial Mental Hospital are very well described elsewhere. For the reader interested in this aspect of the setting, it is suggested reference be made to the theses of Richard J. Clark and Robert M. Sutherland. Full titles of these references are listed in the Bibliography (Appendix B).

2 Crease Clinic of Psychological Medicine is designed as an acute treatment centre. Commitment, either by voluntary admission or by court order, must be terminated at the end of four calendar months. Patients sent to this institution generally have a better prognosis for their illness, and concentrated services are offered.
approximately 900 beds and is for male long-term patients. The "East Lawn" Unit has a capacity of approximately 1200 beds and is for female long-term patients. The East Lawn Unit contains its own social service department and medical staff. All patients leaving East Lawn between July 1, 1957 to June 30, 1958 were studied in relation to the criteria described in the following pages.

It was found that most patients leaving the Provincial Mental Hospital have families to whom they return. It was obviously not feasible to study the entire hospital population, and the choice to study the female non-family patients in the East Lawn Building was made, on the basis of several considerations.

First, patients who have been hospitalized for long periods of time -- normally for several years -- would be more likely to be without adequate family resources when they are ready to leave the hospital. This hypothesis was not proved entirely true: the greatest majority of women patients apparently returned to their relatives. The proportion of non-family patients was greater for this group, however, than for the total hospital population being discharged. Only those non-family patients under age thirty-five were studied. Nineteen of these patients were found from the total of 234 patients from all age groups discharged on probation from the East Lawn Unit. This is 8.1 percent of the total, and the figure would be higher if the age limit had not been set in obtaining the sample group.

1 The North Lawn Unit was recently built and has a capacity of 257 beds. It was originally intended as a unit for mental patients with infectious diseases, such as tuberculosis. Within a short distance of the Provincial Mental Hospital and Crease Clinic is the Home for the Aged, Port Coquitlam. The Home for the Aged is also part of the Provincial Government's Mental Health Services, and serves to reduce the senile population in the Mental Hospital, especially in the reception and treatment of newly referred geriatric cases.
This compares with 4.9 percent of all patients discharged from the hospital to "other" circumstances (see page 3).

The second reason for studying the East Lawn Unit only is that this unit has had by far less professional staff turnover than the other units during the time under consideration.

The third reason is that with the resource of the Vista in Vancouver, a community living arrangement for female mental patients re-establishing themselves in the community, findings of this study could be compared with the study of Sophie Birch. Johnson describes the Vista as "an auxiliary service of the Provincial Mental Hospital and the Crease Clinic and was originated to meet the need of particular women patients who are ready to leave hospital, but who have no resources of family, friends, and finances to see them through the initial period while obtaining employment and accommodation." Since this study chose to review only patients under age thirty-five from the East Lawn Unit who have been discharged on a probationary status, no statistics are available of how many non-family patients are still hospitalized. It could well be that patients with family resources have a better chance of being considered for trial away from the hospital than those who do not. This, however, could well be the subject of a comparative thesis.

Method of Study

The principal area of study is the discharge situation of the non-family patient. By discharge situation is meant the circumstances in

which the patients were living upon leaving the hospital. Some attention is given to services offered after the patient left the hospital and to subsequent changes in circumstances. Unfortunately much of this information was not available in many of the hospital files, therefore, most of the following pages are concentrated on the immediate discharge situation as such.

This study is divided into two fairly distinct areas. The first, (expanded upon in Chapter II) is an attempt to secure additional information regarding what constitutes a non-family patient. To determine this, such matters as age, marital status, place of birth, occupation, length of hospitalization, and social and medical diagnosis are reviewed. The second area, (which constitutes the bulk of Chapter III) is the study of the patient's circumstances on leaving the hospital, and what social services he required to meet his needs. Some of the types of problems studied in this area include the person to whom the patient was responsible during the probationary period, housing, employment, financing, socialization, and a qualitative description of the patient's success in these endeavours.¹

The sample that was sought was for a one-year period, (actually from July 1, 1957 to June 30, 1958). From the hospital's weekly bulletin of population changes, an extensive list of names was obtained of patients who had been discharged on probation from the East Lawn Unit. Ruling out those patients age thirty-five and over was done by consulting a master card file of patients in which their birthdates were listed.

A staff member was consulted to rule out names on the list where it was known that the patient had returned to a family situation. The

¹ See also Appendix A.
remainder of the names were checked with each patient's hospital files. The assembly of material was organized on the lines of the schedule appended in Appendix A. Most of the information gathered on the schedules was taken directly from the hospital files, except in two or three instances when information was gathered directly from the social worker who worked directly with the patient. No direct contact was made with any of the patients.

The purpose of the following material is to present a sketch of the non-family patient as a person, and in relation to their personal circumstances at time of discharge. A number of important personal and social characteristics are not measured, such as appearance to others, socio-cultural background, concept of social roles and habits. Such information can hardly be judged without seeing the patient in person, and this unfortunately was not possible. But where recorded, such information is incorporated in the social diagnosis.

Primary Facts

The ages of this group of patients ranged from twenty to thirty-five years, the median age being 30.5 years, and more of the group being over thirty than under this age (Table 1). This is not surprising, in view of the facts already set forth. For patients being discharged from the East Lawn Unit, a group of "long-term" or continued-care patients, the median age would in all probability be much higher had no maximum age limit been set for the sample group.

1 The case records of patients, or unit files, are a comprehensive compilation of the impressions and services of professional staff members who have contact with the patients. The file includes ward notes of physicians, dental reports, records of nursing and treatment staffs, notations by the social workers, and psychological reports. In addition there is a separate correspondence file. Each time a patient is re-admitted after being discharged in full a new file and "case" is established. There are many patients who each have more than one file in their name.
Table 1: Age Distribution of Patients

<table>
<thead>
<tr>
<th>Age, in years</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 to 23</td>
<td>3</td>
</tr>
<tr>
<td>24 to 27</td>
<td>4</td>
</tr>
<tr>
<td>28 to 31</td>
<td>3</td>
</tr>
<tr>
<td>32 to 35</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 2: Nativity of Patients

<table>
<thead>
<tr>
<th>Place of Birth</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>9</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>4</td>
</tr>
<tr>
<td>Alberta</td>
<td>3</td>
</tr>
<tr>
<td>Quebec</td>
<td>1</td>
</tr>
<tr>
<td>Foreign born</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 3: Marital Status of Patients

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>15</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>
All the patients except one were Canadian born (Table 2). Not having a home in which to return after leaving the mental hospital certainly can not be attributed to immigration, inspite of the high post-war immigration rate. Half of the patients were born and lived most of their lives in the Province in which this study took place. Nine out of ten of these patients without adequate family resources were born and lived most of their lives in the three Western Canadian provinces.

The majority of the patients were single. Most had never married, but two were divorced and one was widowed (Table 3). From this it may be concluded that for 83 percent, the only home these patients had was their parental home. Seventeen percent had an established home of their own, but had lost it through marital difficulty and misfortune.

Education and Occupation

Education of these patients ranged all the way from only Grade I to University (Table 4). At the top level, one was a school teacher with a "normal school" education. Unfortunately "normal school" was not further defined in the recorded material. Of the remaining three with education beyond Grade XII, one had one year of University and the other two had some professional training (nursing, commercial art).

The median number of school years completed, however, remains at Grade VIII. In North American society this is considered a basic or minimum amount of education a person needs for most types of skilled employment, and is considered inadequate even for many unskilled jobs.

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1 Between the years 1946 to 1954, 1,111,000 persons migrated to Canada, nearly 6.7 percent of the entire Canadian population. (Corbett, David C., Canadian Immigration Policy, University of Toronto Press, Toronto, 1957, P. 167).
Table 4: Educational Attainment of Patients

<table>
<thead>
<tr>
<th>School Grade</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 6</td>
<td>5</td>
</tr>
<tr>
<td>7 - 9</td>
<td>7</td>
</tr>
<tr>
<td>10 - 12</td>
<td>2</td>
</tr>
<tr>
<td>Beyond Grade 12</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

Wilensky and Lebeaux state, "Because work in modern society demands greater abilities, education is becoming the main barrier to opportunity."\(^1\) This statement is certainly true, and is reflected in this study in noticing that most of the patients held unskilled and semi-skilled jobs both before and after discharge from the mental hospital. There is a fairly obvious connection between the Grade VIII median here and the unskilled jobs these patients held. The people with training beyond Grade XII it may be added, did not return to professional occupations, but drifted into less-skilled types of employment. This is further referred to in employment in Chapter 3, where the discharge situation is discussed.

Medical and Social Diagnosis

Diagnosis, as the term is used here, refers to the classification of an individual on the basis of observed characteristics. Within the terms of this broad definition, two types of diagnoses are singled out for

presentation. These are (1), the psychiatric medical diagnosis, and (2), the social diagnosis of these patients. 1. **Psychiatric diagnosis:**

The function of a medical diagnosis has three essential aims: a) To indicate the site of disease, b) To indicate the causes, and c) To indicate the nature of the functional disturbances. In psychiatry, however, it is seldom that a complete diagnosis can be made in this sense with the present information available about these diseases. 2. The term "psychiatric diagnosis", then, refers to a statement classifying a person in relation to a specific mental disorder.

**Table 5: Psychiatric Diagnosis of Patients**

<table>
<thead>
<tr>
<th>Psychiatric Diagnosis</th>
<th>Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>paranoid type</td>
<td>8</td>
</tr>
<tr>
<td>simple type</td>
<td>1</td>
</tr>
<tr>
<td>hebephrenic type</td>
<td>1</td>
</tr>
<tr>
<td>undifferentiated type</td>
<td>3</td>
</tr>
<tr>
<td>Chronic Brain Syndrome</td>
<td>4</td>
</tr>
<tr>
<td>associated with epilepsy</td>
<td>2</td>
</tr>
<tr>
<td>associated with metabolism</td>
<td>1</td>
</tr>
<tr>
<td>associated with spastic paraplegia</td>
<td>1</td>
</tr>
<tr>
<td>Sociopathic Personality Disturbance</td>
<td></td>
</tr>
<tr>
<td>antisocial reaction</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>

It is interesting to note that only three major psychiatric entities are represented in this group of patients (Table 5). Two fairly common psychiatric illnesses are not represented at all; psycho-neurosis,


2 *Loc. cit.*
and manic-depressive psychosis. Schizophrenia was the psychiatric diagnosis of 72.2 percent of the patients. For a group of "chronic", or continued-care, patients, as are all East Lawn Patients, this may be considered a typical sample. This idea is strengthened by the statements of Noyes and Kolb:

"Schizophrenia is one of the most frequent forms the major psychoses, constituting from 15 to 20 percent of the first admissions to public hospitals for mental diseases. Because the disorder tends to chronicity and in many instances does not shorten life it will be found that 60 percent of the population of state hospitals is made up of schizophrenic patients."

Regarding the nature of schizophrenia, Noyes and Kolb state:

"While it is relatively easy to describe some of the more striking characteristics of schizophrenia, no definition of this mental illness has yet received universal assent. Although one of the commonest of serious mental disorders, its essential nature is probably the least understood."

Although writing in the year 1911, Eugen Bleuler has given one of the classical accounts of this illness. Bleuler was impressed by the splitting, or disorganization of the thought processes, and the splitting between thought and emotion—hence, his term "schizophrenia" (literally meaning split-mind). In his book, *Dementia Praecox or the Group of Schizophrenias*, he presents a detailed account of the person's altered thought associations, affectivity (mood), ambivalence, and relation to reality. In the total of 26 accessory symptoms that he lists are included such phenomena as hallucinations, delusions, and stupors.

4 There are many excellent volumes written on the subject of schizophrenia. The reader is especially referred for a more complete account of this illness to the works by Bleuler, Leopold Bellak, Silvano Arieti, W.F. McAuley, and David Shakow. Complete listing of these books are found in the Bibliography (Appendix B).
Organic brain damage was a factor to be considered in other cases. As indicated in Table 5, (with qualifying phrases) was the psychiatric diagnosis for four patients. The term, Chronic Brain Syndrome, per se, is so vague that it means little without being further qualified. Many of the textbooks on psychiatry do not list it as a separate entity. Henderson and Gillespie list it under the heading "Organic Reaction-Types". They state:

"The organic reaction-type as a whole comprises the following changes:

(1) In the intellectual sphere there is impairment of comprehension, interference with elaboration of impressions, defects in orientation and retention, difficulty in activation of memories and marked fluctuation of the level of attention.

(2) Affective disorder in the form of emotional instability, the patient laughing or weeping without sufficient cause, and often in an explosive way.

(3) Character-change in the form of conduct foreign to the patient's natural disposition, e.g., indecent behaviour in a hitherto self-respecting individual."

With the Chronic Brain Syndrome, there is usually a qualifying phrase. The qualifying phrase may include anything from alcoholism to epilepsy.

The third classification that appeared in this study was Sociopathic Disturbance, antisocial reaction. This, too has tended to be an ambiguous classification. The term is used for classifying persons "who, though neither insane nor intellectually defective, behave socially in an abnormal way." It traditionally encompasses many (though not all) criminals, delinquents, and sexual deviates. The term "moral insanity"


was first used for this entity, and was coined by Prichard in the year 1835. A term replacing "moral insanity" was psychopathic personality. The trend now is to call it sociopathic disturbance.

Social diagnosis: Turning to the social diagnosis of the patients, there is even more difficulty in precise classification. Social Work as yet does not enjoy the advantages of being able to classify social pathologies in one or two short phrases. There are some moves in this direction, however, as discernable patterns are beginning to emerge in at least two areas; namely, unmarried parenthood, and the "hard-core" or multi-problem family. But in the present state of our knowledge, the social diagnosis is a series of descriptive statements setting forth the client's problems in the social and cultural context in which they occur, and the ability of the client, through his strengths and weaknesses, to solve the difficulty.

Mary Richmond has said:

"Most types (of social diagnosis) will have to include, in addition to a general description of the difficulty, a statement of those peculiarities of circumstance and personality which differentiates the case under review from all others. Then should come an enumeration of the causal factors, so far as known, in the order of their importance. It is a help to clearness of thinking to set them down, at this early stage of treatment, to be only tentative. And last should come the . . . appraisal of the assets for reconstruction discovered in the course of the inquiry —those within our client, within his immediate family, and outside."

Some distinction should be made at this point between a social diagnosis and a social evaluation. Dr. Gordon Hamilton makes this distinction quite clear in the following statements:

1 Loc. cit.


"Diagnosis and evaluation are complementary intellectual processes directed toward eliciting the meaning of a case; both begin at intake and continue to be used with varying emphasis throughout treatment . . . 'What is the matter?' calls for a diagnostic formulation. At intake, also, we make some estimate of the person's capacity or incapacity, readiness or unreadiness to use help, cultural factors, and so on, and these social judgements are known as 'evaluation'.

When the interpretation is directed, not toward defining the problem, but toward analyzing how the person is meeting the problem, the result would appear to be an evaluation rather than a diagnosis . . . Diagnosis is concerned with causal inter-action; evaluation with social purpose . . . Diagnosis is to problem and situation, as evaluation, both of personal potentiality and social resources, is to treatment."

All in the present sample had the presenting problem of being ready to leave the mental hospital, and did not have a family willing and able to provide accommodation. Also, the families were extremely limited in ability to furnish financial means for the patients to live elsewhere.

In examining the diagnostic situation closer, it was found that all eighteen patients had difficulty in relation to their parents. Six, or one-third, were from broken homes, i.e., homes broken through divorce, separation, desertion, death, and so on. Another six were from very large families (eight siblings, and over) or had some background of poverty and neglect. An example of this was one patient who was from a family of ten, living in a three-room shack where "the parents fought continually". This particular patient left the parental home at the age of thirteen. The remaining six patients had a variety of family difficulties of similar effect.

Six patients had, prior to admission, exercised faulty judgement in their relationship to men, or tended to be promiscuous. Two had been unmarried mothers, one having two illegitimate pregnancies, the other having three. One of the unmarried mothers was subsequently sterilized,

medically. Homosexuality was a diagnostic factor with another two patients.

It can be seen that most, if not all, of these patients were from family backgrounds where there had been considerable social pathology. Almost half (eight patients) developed symptoms of an "acting-out" nature, manifested in the sexual behaviour just described.

It is interesting to note, however, that from the large poverty-stricken families, most members of these families were not considered to be mentally ill to the extent of needing to go to hospital. Yet, such a family could be of very little help in assisting a patient who has been mentally ill to become re-established in any community.

In all of the eighteen cases there appeared no way of modifying the family influences and relationships by any means other than separation. It is noted, indeed, that some of these patients had on previous occasions attempted to live in their own homes, but with unsuccessful results.

Previous Hospitalization

The number of times these eighteen patients had been hospitalized for mental illness ranged from one admission to five admissions. The median number of admissions was 2.5. Nine, or one-half, of the patients had been at one time or another admitted to the Crease Clinic of Psychological Medicine, and had been given extensive treatment there. The other half had been hospitalized only at the Provincial Mental Hospital.

Length of hospitalization ranged from nine months to fifteen years. The median number of years hospitalized was 2.5. The effects of such long periods of hospitalization have already been referred to; but their effects are easy to anticipate. Many had become dependent on the hospital as a way of life; moreover, after being away from family and friends for long periods of time, emotional ties which may never have been
very tight were now often very much weakened.

Responsibility for Probationary Discharge

The practice in most mental hospitals is to discharge patients, wherever possible, to a relative, guardian, or to some person who is supposed to keep the hospital advised of the patient's progress. Usually this is a written contract signed by the person who is taking the patient, and the contract is made at the time the patient leaves the hospital. Frequently such contracts include a clause stating that the responsible person will return the patient at his or her own personal expense, should this become necessary. In practice this procedure is not always followed. Quite often, no word is received from the person responsible unless some emergency arises. Patients are also frequently returned by a peace officer, or by hospital transportation. Just what proportion of people assuming responsibility for mental patients actually keep the hospital advised of the patient's progress at periodic intervals, and the reasons for it, could well be the topic of a special study. Many mental hospitals with a shortage of staff must inevitably be more concerned with patients presently in their care than with those who have left, unless a specific situation is brought to the attention of the staff. This, of course, does not hold true where there is a social worker assisting a discharged patient, but all patients do not have the benefit of a social worker when they leave the hospital. A recent survey made by the Social Service Office of the East Lawn Unit revealed that only 40 percent of patients discharged on probation between June 30, 1957 to December 31, 1957 were assigned to a social worker.\(^1\) With a larger staff, this percentage would be greater.

\(^1\) Information received from the Social Service staff, (December 5, 1958).
Of the present sample, sixteen of the eighteen patients were discharged on probation "to themselves". In other words, there was no relative, friend, or guardian held responsible for their well-being. The Department of Indian Affairs took responsibility for another patient, while the last one was released to a cousin (but accommodation was arranged elsewhere).

An attempt was made to find specific reasons why these patients were not returning to live with relatives. These are classified in Table 6.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional friction between relatives and patient</td>
<td>12</td>
</tr>
<tr>
<td>Relatives unable</td>
<td>3</td>
</tr>
<tr>
<td>No employment in rural B.C.</td>
<td>1</td>
</tr>
<tr>
<td>No relatives available (death, foreign country)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

Inability of relatives to help the patients sometimes overlapped with emotional tension in the family and vice versa, therefore, parts of this classification are somewhat arbitrary. Some of the patients absolutely refused to consider living with their relatives, but yet were considered well enough to leave the hospital.
Conclusions

A composite picture of the non-family patient studied here can be presented as follows. Such a patient is a single woman 30\(\frac{1}{2}\) years of age, born in British Columbia, has a Grade VIII education, is employed as an unskilled laborer, has many emotional tensions within her own family, has been hospitalized at least twice and has spent over two and a half years in the mental hospital with paranoid schizophrenia. She has hardly any friends and is leaving the mental hospital responsible only to herself and what help she may receive through social workers. Chapter 3 outlines many of the situations in which she may find herself.
CHAPTER III

THE DISCHARGE SITUATION

Patients leaving a mental hospital are not a race apart from other people. They use many of the same social resources as others, when they are in need. They often seek aid from such facilities as the National Employment Service, Social Assistance Departments, commercial recreation, boarding houses, housekeeping rooms, apartments, and so on. However desirable or not it may be, many use the same beer parlors. That they seek in this way to be "ordinary people" is the way it should be.

Yet, for many homeless patients, the use of such resources is not enough. Some special facilities are often needed. Among the most important is the personal element which can be given by social workers well acquainted with helping people in need, who understand psychiatric illnesses, and who know the routines to be followed in many social agencies and institutions. This is all the more relevant if there is marked personal difference. In spite of the common factors among homeless patients, they are in this respect a very heterogeneous group. One task of giving differential help to many can not be discharged unless there is enough staff for individual interviews.

For those who are planning to live in the Greater Vancouver area, some are fortunate enough to be able to use the facilities of the Vista—a special hostel for female mental patients.¹ The Vista operates as an

¹ A similar hostel exists for male patients. It is called the Venture.
auxiliary service of the Provincial Mental Hospital and Crease Clinic. It was originated to meet the need of particular women patients who are ready to leave the hospital, but have no resources of family, friends, and finances to see them through the initial period while obtaining employment and accommodation.

The Vista first came into being in January, 1944 through the efforts of Mr. E. E. Winch, M.L.A., after hearing the plight of one patient without family resources and taking the patient into his own home to live. The Vista is a large house in a residential area in the City of Vancouver. In March, 1947 Mr. Pearson, Provincial Secretary, speaking for the Executive Council agreed to take over Vista, and since this time it has been under the administration of the British Columbia Provincial Government. It presently has accommodation for nine patients, and the average length of time a patient stays in Vista is three or four weeks. Occasionally there is a waiting list, the average wait being two or three weeks, sometimes there are vacancies. There is a matron and an assistant housekeeper who are in charge of its daily operation. In addition to the social workers, the matron and housekeeper also offer helpful suggestions to the patients regarding the implementation of their discharge plans. The Vista accepts patients on the basis of a medical referral which is made by the hospital physician in charge of the patient's case. The criteria on which a patient is referred to Vista, according to Birch, is: a) "patients who have no families or whose families are interested but are not in a position to assist actively in the rehabilitation, b) patients whose families have rejected them completely, c) patients for whom it is felt
inadvisable to return to their families because of unsatisfactory physical environment and poor family relationships, d) patients for whom it is thought that therapeutic value can be derived from a visit prior to their returning to homes beyond the city or just for a holiday from the hospital, and e) patients who go to Vista for observation to ascertain if they can hold their improvement before proceeding with plans for their rehabilitation.

Good accommodation is the first essential to a patient's adjustment in any society; for the type of patients studied here, this is frequently the primary problem of rehabilitation. Moreover, it affects employment; for many patients from Essondale, a Vancouver address is of utmost importance while a job is being sought. Many employers are still very skeptical of hiring patients who can give only a mental hospital as their place of residence. As rents are usually payable in advance, temporary shelter is paramount until the patient becomes financially independent.

The use of the Vista, then, is directly helpful when a patient can be employed soon after discharge. Another use of the Vista is that it provides patients with a short period of convalescence in a large city, and at the same time they are still in a protected environment.

Seven of the eighteen patients studied here used the Vista as a resource, before finding accommodation and employment. This is almost half, and it provided an excellent service for these patients. Three other:

1 Information gained from Birch, Op. cit., pp. 12-14, 34, and from consultation with the Provincial Mental Hospital social workers.

2 Birch, Ibid., p. 18.

3 Loc. cit.

4 Loc. Cit.
patients were discharged directly to rural British Columbia, possibly for this reason Vista was not used as a resource in these instances. It is not known why the remaining eight did not use the services of this hostel.

Most of the patients studied did not have established roots in any community. This being the case, it is not surprising that several of them changed their circumstances fairly quickly after leaving the hospital.

Six patients lived at their place of employment as domestic servants. This is one-third of the entire group, and was the most frequent type of accommodation (and employment) that was found. Two of the six did not stay as domestics in a home. One found employment as a hotel chambermaid, and lived at the same hotel. Two (including a former domestic) lived in hotels, but this did not prove too satisfactory as was evidenced from their subsequent social mal-adjustments. One changed employment, and lived with friends in a private house in rural British Columbia on a board-and-room basis, and found employment as a waitress. Four patients found accommodation in commercial boarding houses. Only three or so lived in private homes. One of these was helped in finding accommodation in rural British Columbia by the Department of Indian Affairs, and very brief information was given to the hospital. The second lived for a time with a distant relative, but this ended in re-admission to the hospital. The third lived in the home of her employer (but was not employed in the home).

Information is not recorded regarding the type of shelter in which two of the patients were living (although the addresses were available). No information at all is recorded for six regarding how accommodation was found. Nine patients (one-half of the group) were instrumental in finding their own accommodations, and four received direct assistance from social workers in finding shelter (i.e., social workers directly contacting landlords). Regrettably, more efforts should have been taken to interview
the social workers regarding how accommodation was found when the informa-
was being gathered, and this remains an unfortunate oversight. It must be
pointed out, however, that social workers, when active with a case, are
always satisfied that a patient has an abode upon leaving the hospital;
this is hospital policy. In addition, the doctor in charge of a patient's
case also has the responsibility to see that patients have some arrange­
ments made for shelter. For therapeutic reasons, though, patients may be
permitted (and in some cases, encouraged) to find their own shelter; this,
however, is done with adequate safeguards. For example, patients may be
living at the Vista while looking for more permanent accommodation, and
their activities in this respect supervised by the social worker assigned
to the patient.

Employment

Upon being discharged on probation, one-third, (or six) patients
became employed as domestic servants in private homes. Only four of these
six patients stayed with this type of work, however. One of the two that
changed became a hotel chambermaid for awhile, the other changed first to
waitress then "orchard" work, (probably fruit picking) in rural British
Columbia.

Two found their immediate employment as restaurant waitresses,
and a third patient also had a spell at this type of work. Only one on
leaving the hospital was able to secure a job as skilled as a clerk in an
office: Another became a salesgirl in a store. Two were not considered
employable, or at best very marginal workers and actually found no emplo­
ment. Another was considered employable at the time of leaving the hospital,
but it was not learned whether she finally gained employment, as she was
referred to another agency. Others found employment which sounds casual in
nature -- as "baby-sitting", "working in a bowling-alley", and "photography work".

Employment is apt to be a neglected area -- certainly judged by descriptional inadequacies. There is all too clear evidence here, however, of low-grade and perhaps discouraging employment prospects. As far as the information goes, the comparison between the patients' first job on probationary discharge from the hospital with their occupation prior to admission to the mental hospital is listed in Table 7. In the greatest majority of cases, the patients either returned to essentially the same kind of work, or to lower grade work than before.
Table 7: Occupations of Women at Time of Admission and After Discharge.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Occupation at Time of Admission</th>
<th>First Occupation After Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None</td>
<td>Not employable</td>
</tr>
<tr>
<td>2</td>
<td>Marginal employment</td>
<td>Unemployed</td>
</tr>
<tr>
<td>3</td>
<td>Marginal employment</td>
<td>No information</td>
</tr>
<tr>
<td>4</td>
<td>Domestic service</td>
<td>Domestic service</td>
</tr>
<tr>
<td>5</td>
<td>Domestic service</td>
<td>Domestic service</td>
</tr>
<tr>
<td>6</td>
<td>Laundress</td>
<td>&quot;Bowling-alley worker&quot;</td>
</tr>
<tr>
<td>7</td>
<td>Practical nurse</td>
<td>Domestic service</td>
</tr>
<tr>
<td>8</td>
<td>Practical nurse</td>
<td>Clerk-typist</td>
</tr>
<tr>
<td>9</td>
<td>Seamstress</td>
<td>Domestic service</td>
</tr>
<tr>
<td>10</td>
<td>Factory work</td>
<td>Unemployed</td>
</tr>
<tr>
<td>11</td>
<td>Food packer</td>
<td>Baby sitting</td>
</tr>
<tr>
<td>12</td>
<td>Waitress</td>
<td>Domestic service</td>
</tr>
<tr>
<td>13</td>
<td>Waitress</td>
<td>Domestic service</td>
</tr>
<tr>
<td>14</td>
<td>Salesclerk</td>
<td>Salesclerk</td>
</tr>
<tr>
<td>15</td>
<td>Nurse's aide</td>
<td>Hotel chambermaid</td>
</tr>
<tr>
<td>16</td>
<td>Nurse's aide, teacher</td>
<td>Questionable employability</td>
</tr>
<tr>
<td>17</td>
<td>Filing clerk</td>
<td>Filing clerk</td>
</tr>
<tr>
<td>18</td>
<td>Commercial artist</td>
<td>&quot;Photography work&quot;</td>
</tr>
</tbody>
</table>
In concluding this section it is noted that most of these patients are employable. Eight of these patients were discharged on probation between January 1, 1958 and June 30, 1958; a time when the unemployment in British Columbia was high, yet, in spite of this, most were able to find some kind of employment. The fact must also be remembered that these are patients who have been hospitalized both for a long time and many on a number of different occasions.

Several patients were referred by the hospital social workers to the National Employment Service, but only two were able to obtain jobs through this method. It must be remembered, however, that there are a variety of ways a patient may obtain employment. Although not stated as such in the hospital records, patients often use such resources as answering newspaper classified advertisements, directly contact prospective employers and sometimes use private employment agencies. It is also a well-known fact that many job vacancies never come to the attention of the National Employment Service, especially during times of widespread unemployment. Patients are often encouraged to look for jobs on their own, and many do just this while either staying at a hostel such as the Vista, or while living away from the hospital (in a boarding home) and receiving social assistance. On other instances the hospital social worker may discuss the employment prospects with a patient, and thus provide a little vocational counseling, but the patient is then likely to be encouraged to make his (or her) own contacts.

Income and Financial Resources

No patient in this group had financial resources of her own enough to maintain herself without a job, or maintenance from friends or relatives; social assistance would be her only hope. Only one patient
had a small amount of money saved, and then this proved inadequate to meet her needs.1 Only three of the patients, while not living with relatives, did receive some financial support from them.

As noted earlier, several of these patients changed their circumstances often. Some were self-supporting for a while, and some of the others who were referred to other assistance-giving agencies were employed for brief periods.

Friends and Social Contacts

The lack of information on recreational interests, friends and social contacts generally may be indication of the deprived lives of these women, or of the lacking program in the institution, but it is certainly a regrettable gap in the social information. For five of the eighteen patients, no information at all is recorded regarding friends and social contacts during the probationary discharge period. The information that was obtained in this area is impossible to classify. In none of the cases studied was a formal referral actually made to a social group work agency or other recreation agency. One patient, on her own, did frequent the Alcoholics Anonymous recreation center, but also engaged in other forms of commercial entertainment. Others found casual acquaintances in beer parlors. One "occasionally engaged in sports". Several had some close friends. Others "tended to be seclusive" and did not seek friends outside of the places they were living. Several "enjoyed television".

1 Obviously, a woman who is hospitalized for a long period of time, is unable to earn money, except under very unusual circumstances. Most mental hospitals, including Essondale, charge a minimum monthly fee against any financial resources a patient may have. After a long period of hospitalization these charges have generally taken most of a patient's money. The remainder is usually spent by the patient for small luxuries such as tobacco, cosmetics, snacks, and other small items.
In many instances, the social workers counseled patients regarding their social contacts. At no time did the workers either actively participate with the patients in social situations, or make referrals to agencies for this purpose.

There are several reasons why this is a difficult situation to assess. Social contacts (intimate friendships, casual acquaintances) constantly change in quality and content; therefore, are much more intangible than concrete situations like housing, employment, and finances. In casework situations, patients are seldom seen during non-working hours when they are more apt to socialize and engage in recreation.

Perhaps a partial remedy would be use of the "life-space" technique with patients on probationary discharge. The technique is to be with patients during difficult crisis situations, and to give help the moment it becomes needed. This, however, involves knowing the patient in more than just an office-interview type situation. The purposes of the life-space interview being "to aid the ego in moments of (1) acute frustration, fury, guilt, or panic; (2) to throw support around the ego when it is faced by sudden violent retreat from relationship; and (3) to help a (person) steer his way safely through some complicating and confusing 'social and behavioural traffic jams' and decision-making crisis." This is a valuable technique, but would involve a social service staff many times larger than presently exists in the East Lawn Unit at the Provincial Mental Hospital.

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1 This is only stated as fact. It is not being advocated that workers actively participate with individual patients on less than a professional basis. Social workers, like other people, certainly need a life of their own after working hours.


3 Ibid., p. 13.
Social Services

Intake services such as case history recording and helping patients adjust within the hospital setting are important, but the services most relevant to this present study are those relating to discharge. Social work activities in a mental hospital include preparing patients for probationary discharge, as well as participation in helping them after leaving the institution.

A variety of services were undertaken with these eighteen patients by the East Lawn social workers. The first step taken was an assessment and evaluation of the patient's circumstances. In some instances, reports were sought from other agencies, when the patient was not returning to the Greater Vancouver area. The two agencies outside of this geographical region where referral was made were the Social Welfare Branch and the Department of Indian Affairs. Counseling patients in individual interviews regarding their plans was frequently undertaken. Referrals, in some cases, were made to social assistance agencies for financial help. Referrals, in other cases, were made to the National Employment Service, and to the Provincial Mental Health Centre.\(^1\)

Casework services were offered in a variety of ways. Emotional support was a frequent objective. Clarification to the patient of her situation, and helping the patient test reality were other objectives.

\(^1\) The Provincial Mental Health Centre is a division of the Province's Mental Health Services, and is located in Burnaby, British Columbia. It functions as an out-patient treatment clinic and also as a "day hospital" (that is, patients come to the clinic for a day, receive treatment, and then return to their own homes in the evening). Shortly after coming into existence it quickly developed a large clientele from people living in the Greater Vancouver area. With such a large demand for services it is difficult for the Mental Health Centre to operate extensively in the follow-up and after-care of patients discharged from the Provincial Mental Hospital. It was, however, actively providing out-patient treatment to one patient studied in this sample.
Seeing relatives of patients for the purpose of assessing and seeking their readiness and ability to support the patient was also undertaken by social workers, when this action was indicated. In one case, the social worker made extensive use of collateral contacts; seeing former employers, interviewing hotel clerks and landladies, and so on.

Of the eighteen patients studied, all had been seen by a social worker at one time or another during the time they were hospitalized at Essondale. The majority (fifteen) received social work assistance in preparation for probationary discharge. The special circumstances of the other three are noteworthy. One was believed unable to make a social adjustment away from hospital, and services were not offered, the patient was nevertheless released by the medical staff. The second was "awaiting assignment" to a social worker in preparation for discharge, but was released by the medical staff before a worker could interview the patient. She was returned to the hospital after being away seven months. The third was offered services while being on escape from the hospital, and her status was then changed to "discharge on probation".

Twelve, or two-thirds, of the patients were formally referred to other agencies for help in facilitating their discharge plans. Two of these twelve were referred to more than one agency.

Six patients were referred to the National Employment Service for job placement (Table 8). Only two of these six patients found employment as a result of referral to this agency, however. Three of the remaining four found employment through other means.

Two patients were referred to rural districts of the Social Welfare Branch for assistance in job placement, accommodation finding, and resolving other social difficulties. As soon as the Social Welfare Branch accepted their cases, the hospital social workers closed their case in the hospital,
although the patients were still classified as being discharged on probation, this status being effective for six months. Unfortunately, no information regarding the patients' adjustment was returned to the hospital; therefore, no evaluation of the patients' adjustment can be made.

One patient was referred to the Department of Indian Affairs for placement in rural British Columbia. Little was known about the type of placement, and what information that was secured was made known when the patient had to be returned to the hospital.

One patient was referred to the Mental Health Centre for casework and psychiatric services after she left the hospital. Since the Mental Health Centre is part of the Provincial Mental Health Services, this referral amounted to an inter-departmental transfer, and the patient's case is still active.

Three patients were referred to the Vancouver City Social Service Department for financial assistance and accommodation finding. As with the Social Welfare Branch, the hospital social service case was immediately closed upon the social assistance agency's acceptance of it, and there was little communication between the two agencies regarding the patients after they had left the hospital. The usual procedure being to provide detailed information to the social assistance agencies in the letter of referral.

Regarding one patient, considerable contact was maintained between the hospital social worker and a children's agency regarding the patient's illegitimate children. The patient, in this instance, would not release her children for adoption, and this posed somewhat of a problem both from the standpoint of the children and from the standpoint of the patient. The patient could not provide a home for her children while in the mental hospital, nor could she do so immediately on discharge. Her desires were often unrealistic regarding her children from the standpoint of what she could offer them.
Table 8: Referrals Made to Other Agencies to Facilitate Discharge Planning

<table>
<thead>
<tr>
<th>Agency</th>
<th>Number of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Employment Service</td>
<td>6</td>
</tr>
<tr>
<td>Social Welfare Branch (rural)</td>
<td>2</td>
</tr>
<tr>
<td>Vancouver City Social Service</td>
<td>3</td>
</tr>
<tr>
<td>Department of Indian Affairs</td>
<td>1</td>
</tr>
<tr>
<td>Catholic Children's Aid Society</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health Centre</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14 (a)</strong></td>
</tr>
</tbody>
</table>

(a) Two patients were referred to more than one agency. The fourteen referrals were for twelve of the patients.

It is noticed that no referrals were made by the hospital social workers for these patients to be seen by group work and recreation agencies. One patient, however, made her own contact with Alcoholics Anonymous, and participated for a while in that agency's recreation program. The patient that made this contact was not diagnosed as an alcoholic, but evidently thought she had a drinking problem.

The discharge situations of these eighteen patients may be summarized as follows: Less than half used the services of the Vista in Vancouver in meeting their needs for accommodation. Becoming employed as domestic servants solved the problems of both housing and employment for one-third of the patients. One-half found their own living accommodations largely through their own efforts, but were either placed in a position to
do this for themselves by the social workers assigned to them, or by providing evidence to the doctor in charge of their case that they would have a place to stay on discharge. Most of the patients are employable, even though they have been hospitalized for a considerable length of time, but most found employment on discharge as unskilled, or semi-skilled laborers. None of the patients had adequate finances of their own to sustain themselves without either employment or social assistance.

Many of the patients were counseled regarding socialization and recreation. Due to lack of recorded information regarding this area, it is impossible to fully evaluate the extent of this counseling. There was no direct participation by social workers in helping these patients socialize in groups following discharge.

Casework counseling and referrals to other agencies constituted the bulk of social work activity, although some work with collaterals was done in isolated instances. The counseling activities included giving the patients emotional support and encouragement, and helping them test their reality situations.

Assessment of the Discharge Situation

Pulling together the threads of this survey we can now say that this special discharge situation is that of single women of limited education and employment skills who have considerable pathology in their social backgrounds. All eighteen patients had suffered from psychiatric conditions which had been thought to have reached a more or less chronic state. This is evidenced in that most of these patients had been hospitalized on at least two or more occasions and were patients in a long-term, or continued care unit of the mental hospital. The majority had previously received treatment in the short term units of Crease Clinic and Centre Lawn, before being transferred to the East Lawn Building. The average period of hospitalization
was 2.5 years.

Only three major psychiatric entities were represented: schizophrenia, chronic brain syndrome, and sociopathic personality disturbance-anti-social reaction. 72.2 percent were schizophrenics.

All had shown improvement in their mental conditions, presumably enough to warrant consideration for discharge. Unfortunately, the recorded material did not elaborate, to any great extent, on the residual of mental illness these patients still had at time of discharge. Presumably, too, they also had the capacity to cope with their social situation with the assistance of social workers when they were discharged from the hospital.

Pre-discharge planning and assessment took place between the social workers and fifteen of these patients (one was offered services after an unauthorized leave, and two others were discharged on probation on approval of plans to the doctor; their cases not being active with social service at time of discharge). Their emotional needs were also taken into careful consideration. This includes such things as fear of leaving the hospital, and fear of the unknown. The hospital social workers are especially aware of such anxieties patients may have, and often deal with this by discussing the realities of the patient's prospective situation.

The early histories of these patients are significant. Some came from large poverty-stricken families, others from homes that were broken through death, separation, and desertion. Yet others had been the victims of parental neglect. These factors undoubtedly had an adverse influence on the patients' personality and mental illness. It was also found that all eighteen had disturbed relationships with their parents, manifested in such reactions as fear of parents, continual arguments, and so on. For those who did have homes, they either refused to return, or such a plan was considered to be anti-therapeutic.
All eighteen patients had made a marginal social adjustment prior to admission to the mental hospital. How much of this was due to mental illness, or to what extent the mental illness was due to the social adjustment is difficult to answer. One would suspect, however, that the mental illness and social adjustment is closely interwoven, and an improvement in one area would note improvement in the other as well. The most striking area of marginal social adjustment prior to admission was in sexual relationships. This was true for at least half of the patients. This included promiscuity, unmarried motherhood, and homosexuality. Others tended to be withdrawn and had few friends.

The general conclusion that must be drawn is that this is a group of relatively unstable, unskilled young women who are leaving the mental hospital. They are to assume the major responsibility for their actions. As the discharge situations indicate, most are employable. The majority had no financial resources on discharge.

In the light of these findings, these women have special needs, only a part of which can be met in any institutional setting. Apart from the basic needs of food, shelter, and clothing, which are apparent, they have other needs which stem from their social background and long history of mental illness. They need the satisfactions which can be obtained from performing activities (such as work) that are useful to themselves and others. They need congenial surroundings, people at home, work, and recreation in whom they can become interested and who will take an interest in them. On the whole, this has been lacking in their past.

Psychosis, by definition, involves a distortion of reality. Considering the long duration, and severity, of their psychoses, it is only logical to assume that these women need special safeguards in continuing
to see their lives in true perspective. They have a need to exercise especially good judgement in personal, social, and economic matters. This is especially so in light of peoples attitudes in the everyday world. Mental illness is still a stigma (despite the growth in advanced thinking), and eccentricity on the part of these women could well add to their problems. On the other hand, if their judgement remains strong, they can well be the ones to prove, both to themselves and others, that mental illness need not be a stigma.

Another special need some of these women encountered was that of establishing residency in the municipality in which they chose to live. This was true of the women from rural localities who wished to become established in the Greater Vancouver area. In most instances, a temporary job and a place to stay would satisfy the residence requirements in those instances where social assistance was needed, and residency could not be established.

Discharge situations of patients: One-third of the patients solved both their employment and housing needs by accepting jobs as domestic servants immediately upon leaving the hospital. The remainder obtained shelter in commercial boarding homes, hotels, light housekeeping rooms, and a few in private homes. The employment they obtained was mostly unskilled or semi-skilled work.

It was noted that (significantly) one-third of the patients were referred to the National Employment Service for assistance in obtaining a job, but only two of the eighteen actually received their first employment on discharge from this agency. Few indications appeared here as to why this situation should exist, but this, in itself, would indicate a need to explore in more detail the practice of referring this type of patient to such an agency.
What this study did show, however, was that at least thirteen, or 72.2 percent of the patients, were actually hired by employers. This is a significant percentage, considering the "chronicity" (or alleged chronicity) of these patients, and also remembering their lack of family resources. Although the categorical type of employment is known, it would be extremely helpful to have more information regarding the qualitative aspects of the patient's employment; that is, how satisfactory was the job to the patient, how well did the patient perform her duties, what was the salary that was paid, and so on.

This is definitely a gap in recording, and not due to a lack of services. Social workers at the Provincial Mental Hospital enable patients to use newspaper advertisements and to make application for employment. Frequently this "enabling" takes the form of providing transportation to prospective employers, helping patients find renewed encouragement after rejection from a prospective employer, and so on. The matron and housekeeper at the Vista also help encourage patients in finding employment, and offer suggestions.

The most common type of employment these women engaged in was domestic service. In view of the lack of specific information, it is possible to indulge in some speculation about this type of work. Housekeepers are difficult to obtain, even during times of widespread unemployment, and because of the nature of this type of work, few controls are possible as to the amount of time spent on the job, the way in which directions are given, and so on. There is also the element of interpersonal relationships between employer and employee which is more important for this type of work than for many other types. Another speculation is that possibly these patients were looking for a family, considering their
own lack of one, and the acceptance of such a job may be based on quite subtle factors. Still another speculation is that some of the domestic servant jobs were a form of family care, although the women did receive wages. In fact, it was learned from the social workers at the Provincial Mental Hospital, that some women patients without families are actively encouraged to take a domestic service job, so that they will then be living in a family situation; such a job (if the right situation is found) is thought to be highly therapeutic. Sometimes the social worker must "sell" this type of situation to a patient.

Not very much information was found regarding the patients' socialization and recreational activities. It is possible to speculate that the other problems these patients possessed seemed greater than their social and recreational needs, also, more information could be obtained easier in the other areas. In no instance was mention made of referral to a social group work agency, or to a recreation agency such as a community centre. It is possible to speculate further, regarding the social group work agencies. There are very few of them in existence, and those that do exist select their clientele within very narrow, rigidly defined, geographic borders.

The need for special forms of recreation may be alleviated to some extent in the near future. The Canadian Mental Health Association will be opening a social centre in Vancouver soon for people who have been mentally ill.

One way of determining a patient's success in considering whether return to the hospital for further treatment has been necessary. Eight, of the eighteen patients were returned for this reason. This is 42.2 percent. This is contrasted with the return rate of 26.3 percent of all
patients leaving this unit.

The principal reason, that is, return of symptoms of psychiatric illness, is not fully elaborated upon in terms of causation. Perhaps much more information regarding psychiatric illness is needed before it can be stated why symptoms should return in one patient, and not in another. The idea is held, though, that poor social conditions are a contributing factor in the development of psychiatric symptoms. Experience of others has shown that wise and intelligent planning by social workers with patients can do much in reducing the re-admission rate.

It was noted that it was exceptional for a patient to be seen regularly by a social worker from the hospital during the full six months of the probationary period. It would seem that active services were terminated after the patient's basic needs were being met; that is, after she was employed, was apparently satisfied with her living accommodations, and did not express a need to discuss emotional aspects of her situation.

Because change of employment, and residence was not uncommon for these patients, and also because the re-admission rate is higher for the women not living with their own families than it is for the women returning to their own homes, there is a good case for more intensive follow-up services. Regular visits during the full probationary period would undoubtedly yield much qualitative information that would be of value in helping future patients who are not returning to their own home.

Perhaps one reason why more follow-up of the patients is not being done is due to shortage of social workers, and a large demand for services from patients still in the hospital. Shortage of professional social workers is not a problem related only to Essondale; it is a problem that faces practically every social agency. The policy at the Provincial Mental Hospital
is to keep caseloads small enough so that a high quality of service may
be given, but as a result of this, patients often have to wait for the
services of a social worker unless there is a question of urgency involved.
It is, therefore, understandable that the closing of active services is
made at a time when it is believed the patient is well-situated enough to
function independently.

When cases are referred to social assistance agencies (namely,
the Social Welfare Branch, the Department of Indian Affairs, and the
Vancouver City Social Service Department), the tendency is for those agencies
to take major responsibility for the patient on acceptance of the case.
Such referrals are made by letter or conference in advance of the patient
leaving the hospital when the social service department has been active with
the patient. When active services are closed by the hospital social workers,
the option of further consultative help to the active agency is always given
in the referral letter. For example, if a case is referred to the Vancouver
City Social Service Department, and if the case requires the services of
a hospital worker to see the patient for the maximum time of six months
(the probationary period) with the City Social Service Department pro­
viding financial help only. Such safeguards are needed; as Emily Johnson
has pointed out, the City Social Service Department can not continue ser­
vice when patients become employed and are no longer in need of financial
assistance.  

In counting the number of patients discharged on probation from
the East Lawn Unit during the year studied (July 1, 1957 to June 30, 1958),
it was found that 234 patients were so discharged.  

1 Johnson, Op. cit., p. 69
2 The count was made through use of the hospital's weekly bulletins showing
changes of census.
by the East Lawn Social Service Department it was found that social workers were active with 40 percent of the patients discharged on probation from July 1, 1957 to December 31, 1957. This present study shows that 88.9 percent of the non-family patients that were discharged on probation were assisted by social workers during this same period of time. This would imply that there is more of a recognized need for the assistance of a social worker for "homeless" women going to the outside world. It is significant, too, that all eighteen patients studied had been seen by a social worker at one time or another during their period of hospitalization. The conclusion drawn from this is that the whole group generally have more pressing and urgent social difficulties on discharge than the average patient population.
CHAPTER IV

THE NON-FAMILY PATIENT AND HER FUTURE

When this study began, there was no way of telling in advance what the proportion of non-family patients would be in relation to the total number of patients in the unit being studied. It was a surprise there were only nineteen under the age of thirty-five. As expected, much time and effort were spent by social workers with this group, and this type of patient was most frequently referred to social service. One definite conclusion that emerges is that there is presently a larger proportion of non-family patients on social service caseloads than the proportion of such patients in relation to the general population of the East Lawn Unit of the hospital.

Further Implications of the Findings: Three different ways, or perspectives can be used to study these findings. They can be related to:

(a) the individual patient who does not return home; (b) the community in which the patient is to live; and, (c) the programs of the Provincial Mental Health Hospital.

(a) The Patient's Standpoint: What does it mean to leave a mental hospital after being there for a long time, and when one has no home to which to go? Without money, in most cases no personal friends on the 'outside', these patients needed a place to stay and enough income to

1 As stated earlier in the text, one patient was discharged on probation for only one day, hence, only eighteen were studied in detail.

2 This fact, undoubtedly, influenced the writer's earlier thinking that great numbers of non-family patients existed.
eat. There was also the difficulty of finding new friends as people are often needlessly fearful of ex-mental patients becoming violent (employers oftentimes believe this, too).

Certainly much courage is needed to do this, and more personal decisions will have to be made, such as taking responsibility for rising on time for a job, and actually competing with others who have not been distressed with mental illness. The social workers at the hospital will see to it that the patient has transportation to where he can live, at least temporarily, perhaps the Vista in Vancouver is a possibility. (38.9 percent used the Vista).

A solution in solving this problem that was used in one out of three instances was for the patient to take a job as a domestic servant in a private home. Perhaps the newspaper want-ads were the quickest way of finding such a job, or perhaps both private and public employment agencies were used. In some instances, emotional needs of patients are met in such a setting — e.g. need for the security of a family situation.

Much is uncertain. Maybe the employers will be dissatisfied with the patient’s work and dismissal comes suddenly, and after a short period of time. A new job must quickly be found in order to eat and have living accommodations. Possibly arrangements for emergency social assistance must be made in this event. The thought of having a social worker fully acquainted with all of the details, and who can be contacted readily to help make emergency arrangements would be very comforting indeed. At best, the non-family patient has realistic anxieties about very basic needs that the average patient with home and family does not have.

Even in the event that a boarding home or foster family is used, with social assistance temporarily removing financial insecurity, there is
often a concern by the patient whether she will like the people with whom she is to stay, and wonder if friends can be made out of such "strangers". If previous home life has been distasteful, will this be the same?

It is hardly a surprise that the re-admission rate (mentioned earlier) is higher for non-family patients than for patients with homes. Yet, with adequate assistance and knowledge on the part of the social worker, the re-admission rate can be kept reasonably low.

(b) The Community in which the Patient is to Live: Most people have homes. But there are two kinds, (a) the "parental" home, (Home in which you are spouse or breadwinner). Then there are (b) homes where you are welcome and homes where you are not. If a person doesn't have one, it is natural to wonder why. Unfortunately the attitudes of employers, co-workers, and others toward the patients was not recorded to any great extent. Yet, if such a question were asked such a patient, it would be difficult to give a truthful answer without revealing circumstances about which there is much emotion.

Again, most people are not acquainted with the severe forms of mental illness. Acquaintances, and others, are often dismayed by bits of unusual behaviour. This can only aggravate the situation for the patient. The people in the average British Columbia community, however, would probably take the attitude that mental patients not "cured" would be best off to remain in the hospital. There is also a feeling that mental hospitals should "look after" their people when they are "out", and the average person in contact with ex-patients thinks that the hospital should be the logical agency to make the decision if more treatment is required.

It is well recognized that there are varying limits as to how much mental illness any community will tolerate before action is taken.
to remove the person. This is certainly brought forth in Chapter One in the reasons for establishing mental hospitals in the first place, and at public expense.

Recent thinking, however, is that every community has responsibility for the rehabilitation of the mentally ill -- and that further interpretation of this fact must be made to the general population. Psychotics who are not too disturbed are sometimes better off away from the mental hospital, given the right (or favorable) situation.

(c) The Programs of the Provincial Mental Hospital: It would seem that it is the non-family patient that puts the hospital's programs to the most severe tests. Because of the severe discharge problems these patients encounter, the treatment programs are put to more of a test in terms of lasting adequacy.

The concern here, however, is more with the discharge programs as such, than with the treatment programs. Many argue that no great distinction should be made between intake programs, treatment programs, and discharge programs. In principle, perhaps, this is correct. Yet, it seems to this writer, discharging a patient from long-term treatment means that a drastic change in environment occurs. Patient resources should be checked again at this time, and implemented as necessary.

Patients with families often can expect their responsible relatives to do much of this. For example, clothing needs, transportation needs, shelter, finances, and the like are no great problem.

What are considered small, but important, details most often do

1 Information gained from members of the social service staff at the Provincial Mental Hospital, Essondale, B. C., on April 13, 1959.

2 Ibid.
not get recorded. As a general rule, patients are never taken to the front door of the hospital and discharged on the spot, when left entirely to their own resources. An apparel shop exists to outfit patients with suitable clothes and lack of relative responsibility to provide this is the only criterion used in determining a patient's eligibility for this service. The Apparel Shop is operated by volunteers in conjunction with the Canadian Mental Health Association's programs.

Similarly, financial need is met to a limited extent, although mental hospitals do not enjoy budgets to the extent that anything approaching social assistance can be offered. Based on patient need, a small cash gratuity is given a patient when leaving the hospital. The amount is usually five or ten dollars. The ward physician is the person who must approve all gratuities, although ward nurses and social workers may recommend to the doctor that a gratuity be granted. The gratuity is granted as a temporary measure when it is certain that the patient will have income from either a job, or from social assistance.

Information is not available to state conclusively that the eighteen patients studied here received apparel and gratuities. Because of the circumstances described, it is assumed that most, if not all, received this. Thus, from the standpoint of dollars and cents, it costs more to discharge a non-family patient, in that many necessities have to be provided, than one with a family (albeit, this is cheaper than providing indefinite in-patient care).

Social workers have access to the hospital's fleet of automobiles to transport patients to areas adjacent to the hospital, or to transportation to more distant localities. On cases where a social worker is active, patients are taken via this means to places where they are to live, to the
National Employment Service (after referral has been made in advance) to look for work, and so forth. In the case of the non-family patient, it is again suspected that more use was made of this service, than for the average patient being discharged on probation. A detail such as transportation, however, is another one of the points not considered a major item for recording in most social agencies.

Because of all of the many reasons mentioned, a non-family patient requires much time, effort, and professional skill to relocate from the mental hospital to any community. It follows, therefore, that with a limited staff and available services at a premium, plus from the humane standpoint, that every effort should be made to make the patient's rehabilitation a success. When failure occurs after the patient is away for only a short time, and the discharge procedure is repeated a number of times, this can be damaging.

Selection of suitable patients for rehabilitation, when such choices have to be made, is important. To spend time that results in failure is hardly justified. Patients must be well enough to leave the hospital in the first place. Secondly, the discharge situation, itself, must be adequate and certain enough not to produce anxieties in a patient to the extent that this will become a contributing factor in a return of psychiatric symptoms of sufficient intensity to require re-admission.

The findings show that severe mental illness existed with these patients over a long period of time, the average hospitalization being 2.5 years. The Grade Eight average educational level also suggests that these patients are only fitted for the lowest and most uncertain kinds of employment. Therefore, the challenge is great in helping these patients find a suitable discharge situation. The question might well be raised, for example, whether this group could benefit from programs such as
vocational re-training, or whether more emphasis should be placed on carefully selected forms of employment where the possibility of termination of employment wouldn't pose such a dire threat to the total well-being of the patient.

The findings also reflect that follow-up could be more carefully undertaken with these patients. There are definite gaps in the recorded material where gaps should not occur. More should be known about the conditions under which these patients are living. Seldom did an evaluation of this appear.

For patients returning to rural British Columbia, quite another situation occurs. Often other agencies are involved such as the Social Welfare Branch and the Department of Indian Affairs. Information was not always made known to the hospital regarding what help was given during the probationary period, nor if the referral was in the best interest or not. Better communication between such community agencies and the hospital is indicated.

The re-admission rate of the non-family patient being as high as 42.2 percent, while all other patients being re-admitted in the same unit is at 26.3 percent, suggests that even stronger efforts be used in helping the homeless patient. It would be interesting to note, if another study were done using experimental and control groups, if the re-admission rate of such patients could be reduced through more follow-up services.

Professional and Community Contributions

At this point consideration should be given to some prevalent ideas about state-supported mental hospitals, and the implications for the discharged patient.

One view put forth by Dr. Ivan Belknap, and gaining much support,
questions the whole concept of (retaining) the large, centralized hospitals (of which the Provincial Mental Hospital at Essondale, B.C. is an example.)

Dr. Belknap has said:

"One of the curious things in the history of attempts to improve the numerous abuses in . . . (state hospitals) has been the failure of reformers to ask whether a large-scale, centralized, and partly self-sufficient institution is in fact able to function effectively in the treatment of the mentally ill. These features of the hospital were perhaps once conducive to a short-run economy in the care of paupers, but what relation do they have to modern concepts in the treatment of the mentally ill?"

Dr. Belknap and others are, in other words, favoring the abolition of the large, centralized, mental hospitals. In the place of such hospitals, it is advocated that small, local, treatment centres be established, much on the same principle as are secondary (high) schools. The argument frequently put forth by advocates of this plan, is that by so doing, the patient in smaller centres may be kept closer to the family unit.

It would seem that the implication of this idea for many of the non-family patients studied here would have both negatives and positives. The negatives, obviously, would be around the fact that patients would then be close to an unwanted family situation; one that is unhealthy and unmodifiable. Another negative is that many ideas such as sheltered workshops, are not practicable unless sufficient numbers of patients can be involved. This is a small problem in large, urban areas such as the Greater Vancouver area, but may be a sizable problem in rural British Columbia.

The positive aspect of this idea would be that the non-family

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patient, because of the lack of having ties with people away from the hospital, could develop such ties easier in a smaller, less centralized setting.

An idea, once prevalent, was the desirability of placing psychiatric workers in community social agencies. Community, in this sense, referring to various geographic localities, regions, or districts. This is not the issue it once was, considering that modern psychological principles are now part of standard training for social workers, teachers, nurses, and physicians. Yet, something still can be said for the idea of making administrative changes within the hospital administrative structure for changing the present ward-centred type of assignment of patients to professional staff in the large mental hospital that would serve people from the various geographic regions. For example, certain psychiatrists and social workers would work only with patients from, say, region one, rather than with caseloads where all geographic regions are represented. Ideally, the staff would extend themselves into the regions they serve on regular visits, and become thoroughly acquainted with their regions. The non-family patient, then, would be assigned immediately, on entering the hospital, to staff representing the region where future living accommodations may be sought.

Using this idea, public health departments and social agencies also could become more acquainted with the hospital, and on various visits to the institutional setting, could become well-acquainted with the patients long before the time of discharge occurs. This would help eliminate the evils in referring patients to complete strangers, in strange regions.

This is still valid thinking with respect to district offices where heavy, generalized caseloads prevail.
Still another idea would be to establish specialized departments that care only for discharged mental patients. An example of this plan is presently in effect in the State of California. In 1938, "after-care" services were organized in the California Bureau of Extramural Care by the State Department of Mental Hygiene. In 1950, this department employed about 100 social workers, and workers in this department maintained liaison between the patient and the psychiatric and social work staffs of the mental hospital where the individual had received in-patient treatment. Within such a system as this, no patient could become "lost" after leaving the mental hospital. The disadvantage of this idea, however, lies in the fact that yet another state agency is established, and the patient may have just one more additional organization to deal with, plus the others he may have, in order to obtain needed services.

The same advantages and objections as the foregoing plan would exist were a private agency, or foundation, established to provide services to discharged mental patients.

**Rehabilitation and Research**

The problem of having long-term patients without a home in which to return is certainly not a phenomenon peculiar to British Columbia. This writer has experienced the same problem elsewhere. Every large state and provincial mental hospital probably has its share of such patients. Unfortunately, there does not seem to be studies comparable to this one; therefore, it is difficult to compare the findings presented here with similar situations elsewhere.


2 *Loc. Cit.*
The general topic of rehabilitating the mentally ill has received a great deal of attention in recent times, however. It is not a new problem, as mentioned in Chapter One, for the rationale for bringing in social workers to state hospitals as early as 1905 was to help with "after-care". That is to say, the discharge situations of patients always has been regarded as important, although for various reasons services seldomly have been adequate to meet the discharge need of patients.

The State of Oregon is presently engaged in research for the purpose of developing a coordinated program for rehabilitating mental patients. "The Oregon Study of Rehabilitation of Mental Hospital Patients", has its headquarters in Salem, Oregon, and is under the directorship of Dr. John James. The project, "encompasses a coordinated effort between community and hospital in the rehabilitation of a wide variety of patients ... The Division of Vocational Rehabilitation, Public Welfare, Public Health, and the State Hospital are the cooperating service agencies." The research is presently in progress, the test period being from September 1, 1957, through August 31, 1960. The analysis and preparation of reports will be made during the six-months' period of September 1, 1960 through February, 1961. It is hoped this research will uncover further implications for the non-family patients, as well as for all classes of patients.

The State of Minnesota is also conducting an extensive research program in the follow-up of mental patients. The name of this project is: "Minnesota Follow-up Study" and is under the directorship of Dr. Joseph C.

1 Information obtained from personal correspondence with members of the Oregon Study of Rehabilitation of Mental Hospital patients (September 24, 1958).

2 Loc. Cit.
Lagey. Work has been just recently started on the project, and the plans are to study all patients for five years after the patients leave Moose Lake State Hospital.¹ There is no information presently available regarding their findings, but again, when the results are made available, there probably will be implications regarding non-family patients. It is interesting to note that one of the hypotheses made by the people engaged in the Minnesota study is that "a better and more enduring post-hospital adjustment will be possible for a patient who returns to his own home and is genuinely needed in the home."²

Limitations of the Present Study - Further Studies Needed

The primary intent of this study has been to survey the needs of long-term female mental patients who either did not have a home, or could not return to a home, upon leaving a mental hospital. Within the time allotted for this study, it is now apparent that many gaps in information appear. Many of these gaps in information could be closed, but not without time-consuming effort.

A look backward over the pages makes it clear that these patients have indeed a difficult situation in life. For various reasons they have been, over a period of years, in and out of the mental hospital on a number of occasions.

This survey has tried to see these patients as persons who, on being judged well enough to leave the mental hospital by the staff psychiatrists, have become established elsewhere. Statistical information regarding the patients was readily available in the hospital files, as was

¹ Information obtained from personal correspondence with members of the Minnesota Follow-up Study (September 26, 1958).
² Loc. Cit.
also background information. This included such information as birthdates, marital status, nativity, social and medical history, and so on. After the patients left the hospital, the recorded material was scarce in disclosing how these patients became established, and what methods were used. One of the gaps not mentioned, for example, was answers to the question of how many employers a patient interviewed before obtaining a job, and what effect refusal of a job had on such a patient.

Undoubtedly, much more of this information could have been obtained by questioning the social workers more carefully about this, and also by requesting additional follow-up reports in instances where referrals had been made, especially the referrals to agencies located away from the Greater Vancouver area. This also suggests that a more careful job could have been undertaken in drafting the schedule that was used in obtaining information (Appendix A). Even with this, perhaps, the actual interviewing of patients would have yielded even more accurate information regarding their circumstances.

The size of the sample group is an obvious limitation. From only eighteen cases, the conclusions that can be drawn must necessarily be guarded. Were the study extended over a five-year period, rather than a one-year period, more cases would be obtained, and, therefore, a more comprehensive picture would emerge.

It was mentioned earlier that there was no way of knowing in advance how many such patients existed, therefore, limitations as to age and time were set that now, it is seen, were unnecessary. As a suggestion, should the circumstances of the non-family patient be studied again, the limitations of age and time should be less rigidly applied.
The Future of the Non-Family Patient

The findings reflect that six out of ten non-family patients will remain out of the mental hospital, and will take some part in the daily affairs of the British Columbia population. More than likely, most of these patients will remain as single people. The question could well be raised regarding how many of them could function otherwise; that is, how many could satisfactorily perform the roles of mothers and wives? It was learned, nevertheless, that one patient, after being away from the hospital for the full six-month probationary discharge period, was engaged to be married.

Perhaps, too, the responsibilities these patients must assume for themselves, has therapeutic aspects for those who can meet this challenge successfully. Considering the stressful social backgrounds, and the long backgrounds of mental illness, success is certainly a great achievement.

The role of the social worker is also exacting in helping these people with such difficult circumstances achieve the independence and self-sufficiency they say they so greatly desire. As has been seen, a great many social resources are often needed for these patients, and these resources must be used in the best possible way to help the patient.

Many measures are presently being taken to strengthen the programs relating to the mentally ill. The concept of vocational rehabilitation is one such measure that is becoming increasingly important. In the United States, vocational rehabilitation programs for the mentally ill are now largely financed by the Federal Government. The Provincial Mental Hospital has had a "rehabilitation officer" assigned to its staff, and it could well be that much more will be done to prepare patients
vocationally through training programs both while they are in the hospital, and after they are discharged.

The use of domestic service jobs to provide patients with some measure of family care may well be the forerunner of a comprehensive family care program. Such a program is certainly needed, and especially for many of the type of patients as the women who were studied here.

The Canadian Mental Health Association is also engaged in developing programs for the ex-mental patient. This organization has operated in British Columbia since June, 1953, "White Cross Open Door Service", which is an information centre on mental health topics and personal problems in the area of emotional disturbance. The service is free of charge and persons consulting this agency are referred to the proper facilities, with assistance offered to put such persons in touch with that facility. In addition to the office in Vancouver, other British Columbia branches are located in Victoria, Nanaimo, and Trail. Another three branches are expected to be in operation within the coming year. The social club soon to be opened for ex-mental patients (mentioned earlier) is part of a pilot project to offer direct services to these people. The majority of people interviewed in conjunction with this study expressed a need for such a facility.

As a final word, new methods in psychiatry, and psychopharmacological therapy in particular, have opened the doors of the mental hospital much wider for the long-term patients. In the changing world of today, it is now more important than ever to maintain the human element in assisting patients. Social workers, therefore, can and are doing much

1 Information gained through personal correspondence with the Canadian Mental Health Association, British Columbia Division.
to help the former long-term patient. As more becomes known regarding these patients, and as more techniques are devised to assist them, the better and more useful citizens these people will become. This survey regarding the circumstances of the long-term non-family patient, then, is another effort in the direction of adding to the knowledge that is so desperately needed.
APPENDIX A

SCHEDULE

1. Name (File number)
2. Age  
   2a. Place of birth
3. Marital Status
4. Education
5. Occupation
6. Diagnosis (Medical and Social)

7. Length of Hospitalization

DISCHARGE SITUATION

A. Discharged to whom?
   (e.g., Self, Friend, To a community resource (nursing home, etc.),
   to an employer, etc.)

B. Housing
   Type of accommodation (also location, and how financed).
   1. Boarding house
   2. Apartment (By self, sharing, etc.)
   3. Hotel
   4. Private house (own, renting, anyone else in home?)
   5. Other
   6. Was Social Service instrumental in finding accommodation?
   7. Comments

C. Employment
   1. Type

   2. Previous job or new?

   3. Unemployed?
      (Is patient employable?)

   4. Was Social Service instrumental in helping patient find employment?

D. Reason for not living with relatives.
E. Success of Probationary Discharge Situation
1. Is patient still out of the Hospital?
2. Reason for return
3. How many times has return been necessary in the past

F. Socialization
1. Nature and type of friends
2. Nature and type of recreation
3. Comments
   -- Degree of social work participation in helping patient socialize

G. Financial Situation
1. On social assistance
2. Self-supporting
3. Has adequate finances without work
4. Other

H. Summary of Social Services Administered and comment about benefits derived therefrom.
APPENDIX B.

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