THE SOCIAL PROBLEMS OF DISCHARGED MENTAL
PATIENTS REFERRED TO A PUBLIC ASSISTANCE AGENCY IN 1954

A Study of the Problems of Fifteen Discharged Mental Patients and the Services Provided to Them by the Social Service Departments of the Crease Clinic and the City Social Service Department

by

EMILY ALICE JOHNSON

Thesis Submitted in Partial Fulfilment of the Requirements Corresponding to the Master of Social Work Course in the School of Social Work.

Accepted as conforming to the required standard

SCHOOL OF SOCIAL WORK

1956

The University of British Columbia
ABSTRACT

The subject of this study is to examine the problems of a group of discharged mental patients and the services provided to them by their referral to a public assistance agency. The study has examined the particular problems presented in financial need, accommodation, and family difficulties, and has attempted to assess whether public assistance services are adequate to effect continuing improvement, in a clinical sense, in the patient's psychological adjustment.

Within the period, January 1st, 1954, to December 31st, 1954, fifteen patients were referred by the Crease Clinic Social Service Department, Essondale, British Columbia, to the City Social Service Department, Vancouver, British Columbia, as being in need of financial assistance. Ten of the patients were in receipt of assistance at the time of their admission to the Crease Clinic. At this point their cases were closed by the City Social Service Department. Upon discharge from the Crease Clinic, re-application to the assistance agency was necessary. This constituted re-referral and they were thus included in this study.

By the use of two Schedules¹ and through personal communication with the Administrators of the Social Service Department of the Crease Clinic and the Social Service Department, data were obtained about the patients' psychosocial background, the problems presented, and the services given by the psychiatric hospital social workers, and the Assistance Agency Staff.

The findings indicated that shortage of social work staff, and heavy caseloads, may in certain severe problem cases, result in uncoordinated and inadequate service. The need for a more adequate definition of responsibility in providing After-Care Services through joint hospital and community planning, was evident, particularly in the cases where the psychological difficulties of the patients, remained unmodified by the services given. This is stressed because of the policy of the City Social Service Department to close their cases when financial need is no longer required. In the cases mentioned the psychological problems would appear to re-activate psychosocial difficulties. An example of a referral policy has been suggested to effect closer liaison between the agencies. A suggestion that the City Social Service Department consider plans to promote preventative services to families and individuals with rehabilitative potential.

¹ See Appendix, pp. 91-92.
ACKNOWLEDGMENTS

I wish to express my appreciation to Miss A.K. Carroll, Miss F. McCubbin, Mr. J.A. Chambers and Miss M. Gourley for their helpful suggestions, and to Mr. A.C. Abrahamson and Mr. A. Marriage of the School of Social Work Faculty, The University of British Columbia, for their constant support and constructive criticism.
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental Illness and Rehabilitation</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Psychiatric and Social Casework Factors</td>
<td>21</td>
</tr>
<tr>
<td>3</td>
<td>Public Assistance Considerations in the Cases Studied</td>
<td>50</td>
</tr>
<tr>
<td>4</td>
<td>Discharged Mental Patients and Plans for Their Care</td>
<td>72</td>
</tr>
</tbody>
</table>

Appendices:

A. Schedule used at the Crease Clinic.
B. Schedule used at the City Social Service Department
C. Brochure of the City of Vancouver Social Service Department.
D. Bibliography
THE SOCIAL PROBLEMS OF DISCHARGED MENTAL
PATIENTS REFERRED TO A PUBLIC ASSISTANCE AGENCY IN 1954

A Study of the Problems of Fifteen Discharged Mental Patients and the Services Provided to Them by the Social Service Departments of the Crease Clinic and the City Social Service Department
MENTAL ILLNESS AND REHABILITATION

Mental Illness Figures

Mental illness is Canada's most serious health problem. Between the years 1948 and 1952, admissions to public mental hospitals showed an increase of over 6,500 patients. It is estimated that over 60,000 mentally ill and mentally defective persons are patients in institutions, and that at any given date mental hospital patients account for almost one-half of all persons hospitalized in Canada." This total does not include the thousands who, each year, seek aid at Out-Patient Clinics in general hospitals; it does not include the children who receive help through child guidance clinic services; it does not include those who seek assistance from private practitioners. It has been variously estimated by informed sources in Canada and the United States, that one out of every ten persons living in these countries will at some time require assistance in facing his everyday problems.

In British Columbia, on March 31st, 1954, the total number of patients in residence in various institutions of the Provincial Mental Health Services was 6,243, an increase of 215 over the previous year. The yearly cost

was $8,765,016.01, with the cost per capita of $1,424.53, or daily per capita cost of $3.90.¹

During the same year the admissions to the Grease Clinic were 1,256. Of the total number of admissions, 594 patients, or 48 per cent, were admitted to the Clinic on a voluntary basis, which:

indicates a better attitude on the part of the general public toward mental illness and also a greater readiness to seek help for the problems. This, of course, results in the patients receiving help for their problems at an early stage in the course of illness.²

While it is recognized that modern psychiatric knowledge and diagnostic treatment facilities have made it possible for the early detection of mental illness, the increasing numbers of admissions to mental hospitals and clinics reflect the inability of modern facilities to meet the growing numbers of the mentally ill in our communities.

The efficient functioning of a modern society is dependent on the provision of facilities for the maintenance of good physical and mental health for citizens. The restoration of the ill to usefulness is essential not only for the individual's own well being, but also to ensure the continuance of the nation's industrial development, and the maintenance of the economic and social order. Thus it will be readily understood that the treatment and rehabilitation of 60,000 mentally ill citizens is of vital concern to the

---

² Ibid., p. R.39.
growth of Canadian society.

**Scientific Contribution to Modern Techniques of Rehabilitation**

One contribution which modern psychiatry has provided is the foundation for the understanding and orderly classification of mental diseases. This contribution has been reflected in the development of modern psychiatric clinics. The clinics have counteracted the popular conception of the complete isolation of the mentally ill from the community.

Recent medical research in the area of chemo-therapy has not only resulted in breaking through the world of the mentally ill, but has also brought better control and management facilities for the patient within the hospital ward and toward speedier rehabilitation of many chronic mental conditions.

Modern concepts of psychiatric nursing, developing in coordination with these facilities, are contributing to the treatment and care of the mentally ill, and by using individual and group aspects of rehabilitative techniques, plays a vital part in the preparation for the return of the patient to the community.

Social work has provided understanding about individual and social problems which give rise to stress within individuals and within the social order in which they live. The social work profession stresses that the organization of social services is most effectively and humanely used when individual, group and community problems are studied carefully
with a view to determining their causation.

The role and function of the social worker is a contribution to the team concept of rehabilitation. A study of the problems of the mentally ill will reveal that all disorders of personality, are compounds of disturbed relationships in which biological, psychological and social processes are always present and interwoven. Personality disturbances may be precipitated by one or by a combination of these processes, whether the impetus stems from physical illness, an emotional crisis, or disruption of family or vocational continuity. Every aspect of an individual's life situation may be thrown out of balance when one of these processes is disturbed. Swithun Bowers, an accepted authority on social work thinking and practice, has stated that:

...the roots of personal security are to be found in the individual's social and communal life. The social services are consistently and constantly engaged in strengthening these roots. Hospitalization is necessary when as a result of inner and outer stresses, the inner turmoil of a fretted mind produces serious inadequacies in relationship.¹

The patient, a human being, is involved at all times in a complicated system of human relationships. Harry Stack Sullivan has described psychiatry as the study of the processes that involve or go on between people. Social work also concentrates on the disciplined use of

relationships. Gordon Hamilton has said that "Casework is grounded in the art and science of relationship."1 "Face to face relations activate intellectual and emotional processes, set attitudes and socialize the individual."2 The social worker, by his training and skill, is thus able to understand the needs of the patient who has suffered from "serious symptomatic inadequacies in relationship."3

The objective of psychiatric treatment is rehabilitation, the return of the patient to his family, and to his functioning in the environment in an adequate and satisfying way. It is within the patient's world of human and social relationships that rehabilitation is finally achieved. The social worker's contribution to the mental patient within the framework of psychiatric treatment and rehabilitation is by use of social casework and social groupwork techniques to facilitate the conscious adjustment of individuals to their situation by means of individual relationships, group experiences, and the provision of social resources. Thus the joint focus of the psychiatrist and the social worker is the rehabilitation of the patient, and with his re-establishment in the community after a period of disruption of normal living due to mental illness.

An acceptable definition of rehabilitation is the general statement of the National Council on Rehabilitation,

2 Ibid., p. 27.
3 Bowers, op. cit.
New York, to the effect that rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable.

In the broad sense rehabilitation includes the entire process of a patient's treatment in hospital and his return to routine civilian living. In this aspect for example:

...the rehabilitation of the mentally ill begins immediately upon admission to hospital and all subsequent examination, treatment, nursing care, psychotherapy, and social work (casework and groupwork) are aimed at promoting normal social integration, and preparing the patient and relatives to make an accepted adjustment.¹

The term social rehabilitation, as used in this study, will refer to the aspect of treatment which embraces plans for the post-discharge period when the patient is referred to a public assistance agency.

Prior to 1951 Canada had isolated rehabilitation programmes in existence which provided services to specific groups of people. The Department of Veterans Affairs' Rehabilitation programme was restricted to the handicapped veteran. In February 1951, the National Advisory Committee on the Rehabilitation of Disabled Persons was set up by Order-in-Council. The first meeting of this committee was held in February 1952, and was served by representatives

¹ Psychiatric Services, Physicians Manual, Mental Health Services, Province of British Columbia, Chapter 12.
from voluntary agencies, organized labour, employer groups, the medical profession, representatives of Universities and others. A Federal Coordinator was appointed, and each province was empowered to establish provincial coordinators. On April 1st, 1955, the Government of British Columbia appointed Mr. C.E. Bradbury as Provincial Coordinator, who is directly responsible to the Deputy Minister of Health. Mr. Bradbury administers the provisions under Schedule R, a set of regulations governing the operation of individual and special class projects for the training or retraining of disabled persons under the provisions of the federal-provincial rehabilitation programme. This schedule is attached to and forms part of the Federal-Provincial Vocational Training Agreement under the provisions of the "Vocational Training Co-ordination Act, R.S.C. 1952, C 286, as amended by S.C. 1953-1954, C.45." The Vocational Training Agreement applies to seven schedules governing the operation of various types of training projects. The Disability Allowances Act, 1955, limits allowances to persons totally and permanently disabled. Under Schedule R, however, a disabled person may apply for rehabilitation aid. At present the Provincial Mental Health Services make limited use of the facilities under this scheme. In some cases the City Social Service Department has provided financial assistance while the patient receives vocational training. This service has recently been incorporated into the rehabilitation programme of British Columbia. The Provincial Coordinator,
however, has no way of providing medical treatment during the training period, and must request the Assistance Agency to carry on with medical coverage. This is not always granted and is subject to individual consideration.

Mentally Ill and Their Treatment, Principles and Problems

In order to identify the rehabilitative objectives of the Grease Clinic which uses the resource of the City Social Service Department, an examination of current literature on rehabilitation concepts is in order. One such concept discussed by Stanton and Schwartz is what they term "the unknown factor."¹ This is recognized by all medical practitioners. Specialized types of treatment are available in mental hospitals and clinics, yet it is known that many patients recover "spontaneously." A study undertaken in 1953² by the Social Service Staff of the Grease Clinic indicated the average length of patient hospitalization was six to eight weeks. To accept that these patients were discharged upon "improvement" suggests that this may have been due to several factors. We know that mechanical therapy alone cannot repair the dysfunction in relationships which has taken place. Psychotherapy using the concept of relationship between the psychiatrist and the patient would


enable improvement, but the time of stay for treatment is generally too short to make use of this method. The thesis of the long research project by Stanton and Schwartz\(^1\) maintains that many patients improve "spontaneously" due to the type of contacts which they make with other patients in the institution (staff and patients).

Caudill et al.\(^2\) using the technique of concealed participation, have described the way in which patients inducted new patients in the role of being a patient. Observation was made that pressure was exerted toward conformity with the values and standards of this informal group. Hospital personnel (staff, patients, volunteer workers), and visitors in their various contacts, become interwoven and incorporated into this intangible unknown factor, thereby forming a part of the "therapeutic community" which thus constitutes part of the social and cultural determinants of the patient's behaviour. Edward Stainbrook,\(^3\) has stated the concept that if the mental hospital or clinic is a "community organized for therapeutic living, we must rely upon the social sciences for enlightenment as well as upon the psychological and physiological systems of theory."

---

1 Stanton and Schwartz, *loc. cit.*


Walter E. Barton recalls that Dr. Abraham Myerson of the Boston State Hospital, who developed the "total push" treatment, was convinced that the regression of schizophrenia was the result of hospitalization, not because of the regression of the disease itself. He also accepted the theory that the regressive deterioration of schizophrenia could be prevented if the hospital environment offered the right kind of pressures and stimuli.\(^1\)

The Boston State Hospital is conducting a series of investigations which have relevance for better understanding of the ward as a "therapeutic community,"\(^2\) and which are also related to programmes of rehabilitation. To quote Dr. Barton:

> There is cumulative proof in the work of Maxwell Jones, Stanton, Schwartz, Redlich, Caudill and many others that a positive therapeutic effect arises from the interaction process between individuals and groups that form the hospital ward setting. The pattern of hospital organization is changing as a result of these new insights.\(^3\)

The forcefulness of this thinking, however, suggests the necessity of a close examination of community resources, to determine whether they are so designed, that the patient continues to receive the benefits promoted by this concept. Earlier detection of mental illness and new concepts of

---


\(^2\) Ibid., pp. 14-15.

\(^3\) Ibid., p. 16.
treatment creating increase in the numbers of patients requiring hospitalization, may necessitate hospital administrators to regard certain aspects of community resources, as part or a continuation of the "therapeutic community" concept. Community resources would thus in fact enable the patient to "bridge" more successfully his adaptation from the hospital community to the wider community in which he must participate and function. For the patient who has been mentally ill, there is generally a wide gulf between his life in the hospital and his subsequent life in the community. Some patients are able to bridge the gap between hospital and community; many are not. Careful assessment of the patients is necessary to ascertain this. This demands enough professional treatment personnel so that each patient can be known in a total-therapeutic way. Also needed is a close communication in an integrated, cooperative way of all community services, realigned to clients' needs, and the health of the community.

There are limitations as to numbers and professional personnel and in legislations which, in the case of the Crease Clinic, limits the treatment period to four months and makes no provision for screening patients in the community who need hospital care. These factors are motivating the present Mental Health Services Administration to plan with Community Agency Administrations and Citizen Leaders toward the extension and development of existing community resources for the use of the patient in his rehabilitation. For example; the
Mental Health Services Administration is actively planning with the Canadian Mental Health Association, the Community Chest and Council of Greater Vancouver, British Columbia.

Concepts of Public Welfare Philosophy

Many attempts have been made to define the philosophy of public welfare programmes. Sarah Riley offers the definition of a physically healthy standard for public assistance recipients as one including:

...adequate nutrition, shelter from the elements, warm and protective clothing, sufficient heat, water and light. Sufficient household supplies and equipment for eating and sleeping, and maintaining reasonable sanitation, and necessary medical and dental care.¹

As Jackson points out:

...physical standards alone may not be sufficient. Public Assistance recipients should also live on a mentally healthy level, which implies reasonable education for the children, community activities for adults, an opportunity to improve the ability and capacity for work and to carry out the duties of citizenship....If they do not get these they will become or raise second class citizens.²

It has been suggested that there are four basic concepts which, in effect constitute the philosophy of an effective public assistance rehabilitation programme. These are:

1. That recognition be made of the essential worth and dignity of each individual applicant.

2. That the client has within himself the potential ability to utilize these social services, with help if necessary, and become an asset to the community.


² Ibid., p. 86.
3. That everyone has the right to a satisfying and effective existence.

4. That as all persons are not created equal, the community must provide equal opportunity through medium of the social services to compensate for this variance of status.¹

The same writer, William Hooson, notes, however, that it would seem to be true that rehabilitation in the public assistance setting can only be effective and as far-sighted as the personnel who are employed to do the work.²

J.P. Kahn, M.D., responding with his observations noted on the twentieth anniversary of the passing of the Social Security Act, United States of America, states that:

...there are many individuals, including members of Social Welfare Departments, who find it necessary to believe that people are in need because of their own personal failure, and who find it disturbing to have someone point out that need is usually created by failures of Society and of the economic system, and that Society has a responsibility to provide decently for casualties.³

The writer concludes that "assistance should provide in a manner that preserves an individual's dignity, fosters his strengths, and places upon him the responsibility for the control of his affairs."⁴


² Ibid., p. 100.


⁴ Loc. cit.
Post Discharge Problems of Mental Patients

The Grease Clinic of Psychological Medicine, opened at Essendale, British Columbia, on January 1st, 1951, was designed and equipped to serve as a diagnostic and treatment centre for the early cases of mental illness; primarily early psychosis and psychoneuroses. By statutory provision, the duration of a patient's treatment period is limited to four calendar months. It was hoped that admissions would include only those patients who were considered to have a reasonable prospect of recovery to be discharged within the four month period.

A patient may be admitted to the Grease Clinic either by voluntary application or by certification of two medical practitioners. Any patient who loses control of his affairs is deemed unfit by his physician to carry out this function. In such a case the Inspector of Municipalities is notified and acts as "Official Committee." Some characteristic problems in rehabilitation from the Grease Clinic are related to the short-term nature of hospitalization and because voluntary admission can be terminated within five days' notice given by the patient. Mention has already been made that the average length of stay is generally of two months duration.

It is the experience of the Social Service Department social workers that many patients do not have family,
friends or financial resources available when they leave the clinic; or their family and friends are disinterested or hostile and resentful toward them, and will, therefore, be unwilling to aid in the rehabilitation process. These patients require either intensive or extensive help and support from the clinic in becoming securely established in an emotionally healthy environment.

There are many basic social and psychological dependency needs which must be met before these patients are re-established in the community: money, food, clothing, shelter, employment and a meaningful relationship with someone who will understand their deep basic needs. The return to the community for a person who has been hospitalized for a mental disorder is often a threatening experience. To lack adequate resources in finances, home, relatives or interested friends increases the patient's feeling of anxiety, and insecurity. The possibility of a relapse and return to hospital becomes very real. There are patients who leave the clinic with a residuum of the mental disorder which led to their hospitalization. The inner psychological problems of these patients may be of such severity that they cannot be resolved by known methods of psychiatric therapy. The stresses of these patients can be eased, although often not resolved, in making an adjustment to life, by manipulation of their environment to help them feel more comfortable in their adaptation and by the warm support, encouragement, and
active interest of a social worker. The discharged mental patient who is inwardly weakened or handicapped in his ability to meet the exigencies of his situation, needs and looks for help in meeting the inner and outer stresses involved in maintaining himself, as in securing accommodation, and obtaining financial assistance until he can become self-supporting and able to function independently in our complex society.

It would be reassuring to many of these patients if the community, for example, could provide a period of sheltered accommodation, sheltered work training and placement, or adequate financial subsidization in maintenance, while they are being helped toward rehabilitation. This need not be permanent. It is merely a humane rehabilitative step toward productivity, social usefulness and personal satisfaction.

Social Assistance and These Considerations

Patients referred to a public assistance agency to be eligible, must be without means of financial support. The very nature of this requirement may hinder the patient's rehabilitative chances. Poorly administered welfare services may also contribute to a remission of his condition. To receive assistance in British Columbia, an individual must fulfill the conditions of the 1936 "Residence and Responsibility Act," which in the case of patients to be discharged from the Grease Clinic must be determined by
the social workers in their pre-discharge assessment. For chronically ill patients who are not residents of British Columbia, plans for their repatriation to their former provinces are entered into before discharge becomes an issue. The passage of the Social Assistance Act in 1946 made legal provision for the:

...granting of aid to the individual whether adult or minor or to families who through mental or physical illness or other exigency are unable to provide in whole or in part by their efforts, through other security measures or from income and other resources, necessities essential to maintain or assist in maintaining a reasonable normal and healthy standard.\(^1\)

The concept, a reasonable normal and healthy standard, is unfortunately dependent upon the unpredictable fluxes in the standard of living. It has been said that public assistance relieves immediate stresses of individual financial need, of individual housing arrangements, and of physical stresses, all of which aggravate an individual's sense of psychological well-being. The present study questions whether the services provided by the City Social Service Department are extended beyond the above frame of reference to provide treatment services to assist the individual in his psychological adjustment.

Method and Approach of this Study

- The study is an outgrowth of a series of theses written about the Social Services provided with the Provincial

\(^1\) Hooson, *op. cit.*, p. 11.
Mental Health Services. Birch\(^1\) studied The Vista,\(^2\) as a resource in rehabilitation. Pepper\(^3\) studied social work participation in the treatment of the mentally ill. Sutherland\(^4\) discussed rehabilitation services for the mentally ill, and Schlesinger\(^5\) classified the social services provided to patients, and/or their relatives.

The present study will examine the particular problems presented in financial need, accommodation employment, and family difficulties of a group of discharged mental patients referred to a public assistance agency because of financial need. The study will examine the cases of the referred patients to assess whether public assistance services are adequate to effect continuing improvement in the psychological adjustment in the clinical sense of a discharged mental patient.

---


2 The Vista is 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.


The cases were selected in accordance with the following criteria:

a) All cases referred to the City Social Service Department between January 1st, 1954 and December 31st, 1954, for financial aid.

b) Cases referred for Nursing Home placement are not included in the study.

Schedules\(^1\) were used to obtain data from the patient's files. Other data were obtained through personal communication with the administration of the Social Service Department of the Crease Clinic, Essondale, British Columbia, and from the administration of the City Social Service Department, Vancouver, British Columbia.

To obtain clarity and to present the focus of the problems as seen by the two agencies, the cases numbered 1 to 15 will first be presented in Chapter 2 with the data obtained from the psychiatric hospital. In Chapter 3 the same cases will be presented with data obtained from the files of the Assistance Agency. The observations at the end of the presentation of each case are the personal opinions of the writer of this study. Chapter 4 will discuss the implications of certain of the findings and will make suggestions to provide better coordination of services between the two agencies for the discharged mental patient. The suggestion that the City Social Service Department

\(^1\) See Appendices A and B.
consider providing comprehensive casework services beyond financial aid to specially screened and selected clients, particularly families and clients where rehabilitation is possible, is considered as a preventative measure, and is in accordance with suggestions presented by the Report on An Administrative Survey of the City of Vancouver.¹

The study has concluded with a suggestion for a further research study at the City Social Service Department.

CHAPTER 2.

PSYCHIATRIC AND SOCIAL WORK CONSIDERATIONS
IN THE FIFTEEN CASES STUDIED

Introduction

In order to give adequate consideration to both the psychiatric and social work factors in the condition of patients discharged from a psychiatric hospital to the local community, it is necessary in this chapter to give brief consideration to the following points:

1. Social Casework Aspects.
2. Psychiatric classifications which influence the current practice of social work in the psychiatric hospital.
3. Pertinent regulations governing the admission and treatment of patients in the local psychiatric hospital.
4. Policies of the Social Service Department in the psychiatric hospital, with reference to referral policies.
5. A count of the disorders, length of stay and the social adjustment problems of the patients who are studied in this thesis.
6. Conclusions.

Social Casework Considerations

Social casework is a systematic process of social study, social diagnosis and social treatment. The process
embodied three basic principles, which are inherent in social
casework practice. As stated by Mary J. McCormick, they are
that:

...human personality is capable of modification and
change which can be self-determined and self-directed;
the professional nature of the client-caseworker
relationship is the primary medium of giving help;
the client's present must be observed in relation to
the past out of which it springs, and the future
toward which it strives.1

Social study seeks to understand what causes and
stresses are responsible for the problem, but also includes
the assessment of whatever positive resources, external
and internal, psychological and physical are at the client's
disposal. Thus the procedure of helping a person is positive,
for the productive use of the client's own inner and outer
resources is the pivot through which the helping process
evolves.

The definition of social casework as stated by
Mary J. McCormick traces this concept.

The entire process is directed toward the
human person, and is carried on for the purpose
of giving service that contributes to the well
being of that person....The character of the ser-
vice itself may vary according to the capacities
and limitations of the particular individual for
whom it is intended. This means that at all times
it will embrace the attempt to develop whatever
personal resources such an individual possesses for
meeting and solving his own problem. At other
times, service will be directed toward augmenting
those personal resources through the use of

1 McCormick, Mary J., "The Old and New in Casework,"
facilities which exist within the social order. In either event, the aim of casework is always the same, that is, to preserve human dignity through meeting human needs.¹

In finding himself at the centre of many psychosocial stresses, the client may be unaware of aspects in his personality which impair his functioning. If his ego is strong and supported by well structured defense mechanisms, he will be able to meet his problem with positive resources. On the other hand a weak ego, and crippling defense mechanisms will add to his stresses. In considering a psychosocial diagnosis, the caseworker must clearly understand the personality structure of the client, and what psychological factors and defense mechanisms are involved. The client's willingness and ability to use help will also influence the diagnosis. Albeit a client may express willingness to use help, the extent of the damage to his personality and functioning ability may seriously impede the treatment of his adjustment. Initial diagnostic impressions are reshaped and revised in the continuing treatment process, which itself is, in turn, continuously adapted to the technical knowledge gained about the client as this knowledge grows sharper and more defined.² Sound study of the problem and clear diagnosis is, however, entirely dependent upon a disciplined use of the professional interpersonal


relationship.

The casework relationship is the dynamic interaction of feelings and attitudes between the caseworker and the client, with the purpose of helping the client achieve a better adjustment between himself and his environment.\(^1\)

This unique "relationship" is the breath and essence of casework for it is a living process with a specific purpose, that of enabling a human being meet a problem which has created difficulties for him. "Relationship" takes life from the internal interaction of the back and forth movement of the attitudes and feelings which flow between the client and the professional worker.

In times of stress every human being wants the help and support that another human being can give. This natural desire for association in times of trouble leads to a peculiar form of relationship which caseworkers see as a medium through which a person is enabled to find new ways of looking at his problem and of handling himself. This relationship as it develops within the casework setting, is difficult to describe, and the specific factors that distinguish it from other human associations are not easily isolated. However, according to Hamilton, the handling of it is what characteristically gives the professional quality to any social service.\(^2\)

The translation of diagnosis into a working operational force—treatment, takes place in this working relationship. The treatment relationship itself is the vital integrative factor for the elements of diagnosis, and for the union of diagnosis and treatment.\(^3\)

---


Social Workers concentrate on the relationship and make use of the client's strength, but they never ignore the pathology which the individual presents.

Human needs may be met from the many resources provided by the social order. The psychiatric hospital is a particular type of agency provided to give care to the mentally ill. To the caseworker in this setting, the presenting problem is the patient's illness. In mental illness, many basic problems may underlie the presenting problem, and may be derived from unconscious conflicts within the individual. While the caseworker is aware of this process, it is not within the competence of casework to deal with it. The caseworker is concerned with the conscious reality problems which confront the patient in his day to day living, and which may be of tangible or intangible quality. Casework treatment may offer tangible services through agency or community resources. In using these resources, the client may also be helped to face his conscious emotional conflict, and be enabled to achieve a more satisfying adjustment.

Having presented a brief description of the dynamics of casework practice, it is in order to move to discuss the purpose of the present chapter, which is to examine the psychosocial problems which underlie and are related to the problems of mental illness, and the social services provided for them during their treatment in the Crease Clinic, and through referral to the City Social
Service Department. It is first necessary to offer comments about psychiatric classifications within which the framework of treatment in all aspects is offered to patients in psychiatric hospitals; and to mention briefly the function of the Crease Clinic.

**Psychiatric Classifications which Influence Treatment**

Diagnostic classification according to the British Columbia Mental Health Services Annual Report, lists forty-two categories with psychosis under four definitions, and forty categories without psychosis under four definitions.

Henderson and Gillespie, quoting the American classification, list seventy-two classifications of mental illness with psychosis under eleven definitions, and eighteen classifications without psychosis under two definitions.¹

The British classification is considerably smaller. In the classification or naming of mental illness, Strecker notes that "psychiatry strives to classify diseases and disorders of the invisible mind and personality functioning."² This obviously presents one of the most complex and intricate tasks to psychiatry. Yet as Strecker points out psychiatric classification does not always adequately describe a given mental illness. It is not within the competence of social work to discuss the frame of reference of a psychiatric

---


diagnosis, or to raise questions about psychiatric classifications, except to note that the gamut of human problems, the result of inner and outer stresses, which often result in some form of mental illness, are often marked by nebulous and indeterminate characteristics. It is therefore not always possible to impose upon these nebulous characteristics some standardized classification.

The rehabilitation of a discharged mental patient to the community is the major responsibility of the social worker. To achieve this the worker must have knowledge about the complexity of the precipitating problems of the illness, resulting in hospital care, and must also be aware of the point where the variation of the psychosocial problem differs from the classification of a psychiatric diagnosis. It therefore follows that the precipitating cause of a referral to a mental institution is influenced by many factors which cannot be contained in any one clinical generalization.

The Function of the Team at the Crease Clinic

The function of the team at the Crease Clinic is to provide treatment and care to those individuals who suffer from early mental illness. Treatment and care of the mentally ill is the combined effort of a number of disciplines, medicine, nursing, psychiatry, psychology, education, theology, occupational and recreational therapy and social work. According to statutory provision the duration of a patient's treatment period is limited to
four months. In special situations the Clinical Director may extend treatment for a further period. Should the patient not respond to treatment within this period, statutory provision permits certification to the Provincial Mental Hospital in accordance with the provisions of the Mental Hospitals Act, should relatives concur.

The Social Service Department at the Crease Clinic

The Social Service Department at the time of the study was staffed by seven social workers, three serving in the admission and brief service section, and four in the continuing section. Owing to limited staff available no section deals primarily with rehabilitation. Schlesinger has described the specific services which the caseworker provides to the patient and his family. His definitions of (i) direct services to patients; (ii) direct services to patients' relatives; and (iii) indirect services to patients and their relatives, have been accepted by the Crease Clinic Social Service Department as an adequate definition of the services given.

In 1954, 60% of the patients admitted were assessed and were given brief casework or social service help; some 40% of the patients admitted were screened into the continuing section for more intensive casework help.

1 Revised States of British Columbia, Chapter 207.
The criteria for selection of this 40 per cent were:
1. All children and adolescents.
2. Expectant mothers.
3. Situations involving the protection and care of children.
4. Family situations in which there were marital difficulties.
5. Rehabilitation problems, including single and unattached men and women, having no resources in family and friends, or interested community agencies.

Cases screened out for other than brief services of a liaison with community resources are the following cases:
1. Patients with whom community agencies were active.¹
2. Older patients with organic illness, or who were very psychotic, whose social and psychiatric problems were of long standing. These patients were usually active with community agencies. In all these instances service of a liaison nature is extended. In the cases of those not known to community agencies, relatives, friends, or the patient himself were seen and were referred to community resources.
3. Re-admissions to the Clinic where Social Service had been active during previous admission(s), and where the patient had not responded to any degree to the service offered.
4. Grossly psychotic patients who are unable to respond to any known, or available psychiatric treatment.²

The policy of offering services to patients most likely to profit from them has been adopted, but in practice

¹ "In these instances the agency knowing that their client had entered hospital would communicate with the Social Service Department. Available to these agencies upon written request would be the report of the Medical Superintendent regarding the illness and treatment of their client. Also available upon their request would be a conference during the treatment period. Although this policy has not been written down, it has been discussed between the administrations of the Crease Clinic Social Service Department and the City Social Service Department."*  

² Personal communication with the Provincial Supervisor of Psychiatric Social Work, Miss A.K. Carroll.
such a policy is often difficult to follow. A careful screening process may not always prove effective. The factor of urgency or emergency is often evident in human problems, and cause considerable difficulty in providing services to meet them.

Referral Policies between Agencies

It is relevant here to mention referral policies between agencies generally, for referral is an essential part of casework practice. The evolution of the policy of inter-agency referral is part of the historical process of social work. The development of referral policies between agencies is the outcome not only of administrative consultation, but also incorporates the lively participation of the social work staff through staff development. Gordon Hamilton has stated that one of the basic concepts to be mastered by social workers "is that of the generic aspects of various agency and institutional settings."\(^1\) Miss Hamilton continues that the "division of labour becomes possible only when there is a clear sense of the total needs and the related parts of the necessary service, with each separate agency accepting responsibility for distinctive line of practice."\(^2\) It is not possible to create a design for any permanent agency structure in a shifting cultural scene. "Agency functions must be altered to meet the pres-


\(^2\) Ibid., p. 117.
sure of new problems, new needs, new resources and new technical and specialized knowledge." Social problems are so complexed and social treatment is so varied that rigid psychosocial classifications cannot be formed to contain the gamut of human problems with which social casework practice is confronted. The basic services and resources for social work, however, must be conveniently grouped and arranged for maximum availability and benefit to clients. The unifying principle is the characteristic professional process, not the good natured or grudging cooperation of unselected department heads.  

The present referral policies between the Crease Clinic Social Service Department, and the City Social Service Department, reflect the principles and concepts mentioned above.

The administration of the Crease Clinic Social Service Department has striven constantly to arrive at clearly formulated referral policies with the community agencies. A manual of policy is presently in the process of compilation and will contain principles of this policy.

With respect to inter-agency policies between the Clinic Social Service Department and the City Social Service Department, since 1951 case conferences have been held between the two agencies, the purpose of which has

---

1 Hamilton, Theory and Practice of Social Casework, p.122.

2 Loc. cit.
been clarification of some of the characteristics of mental illness, and the social problems involved in referrals to the Social Assistance Agency. In 1953 City Social Service workers visited the mental health services at the Woodlands school, the Provincial Mental Hospital, and the Crease Clinic. The orientation of these workers reviewed the purpose and function of the Clinic, the social services available to patients and their relatives, and the kind of illnesses which would determine eligibility for admission to the Clinic. This discussion of policy was discontinued while the Director of Welfare was away on educational leave, and was not re-commenced again because of staff shortages. However, most of the City Social Service Department cases are screened out because Crease Clinic Social Service Department is responsible for 80 per cent of all patients admitted, therefore service is given where a positive response is most likely.\footnote{Personal communication with the Provincial Supervisor of Psychiatric Social Work, Miss A.R. Carroll.} The participation of the Crease Clinic Social Service staff in regular staff development programmes has also contributed to clarification of the referral policy.

Administrative representatives from community agencies have attended Crease Clinic staff meetings to discuss the policies of their respective agencies. With the present policy, the Admissions Social Worker of the
Crease Clinic, after diagnostic screening of the needs of the patient, determines eligibility for referral to the City Social Service Department. The clinical assessment at Ward Rounds held within ten days to two weeks after admission is designed to focus the treatment and rehabilitative resources. During the past year the participation of the Intake Worker and the Supervisor has increased considerably at Ward Rounds. At any given Ward Rounds the rehabilitation plans may be discussed of any patient in the Clinic, regardless of whether his or her name is on the list of patients scheduled for discussion at the particular time. The doctors also use this medium to discuss plans and problems inherent in the rehabilitation of any patient. In pre-Ward Round and Ward Round screening the Clinic attempts to provide a long term service for those patients whose psychosocial prognosis is somewhat optimistic. The criteria of selection now places more emphasis upon the younger group of patients, with less emphasis on the fifty and over age groups. Although this may appear to be discrimination because of age, the possibility of effecting any adequate rehabilitation plan for the older person with a long history of contact with social agencies is limited.

1 Personal communication with the Provincial Supervisor of Psychiatric Social Work, Miss A. K. Carroll.
Referral to the City Social Service departments may provide a vital step in the "total push" procedure. The treatment responsibilities of the social worker will lead him to seek to enable the patient and his relative to accept referral to a public assistance agency. To facilitate the referral or to clarify certain aspects of the problem, a telephone discussion between the Clinic and agency social workers may take place as a first step. The completed referral in writing must contain the relevant psychosocial information, including a medical statement from the doctor with a description of the medical symptoms, expected length of hospitalization and prognosis. Upon leaving the clinic the referred patient is often given financial assistance which will maintain him until his claim with the social assistance agency is established. Certain patients, whose separation from the clinic may produce fear and insecurity for them, are accompanied to the City Social Service Department. Post discharge consultation may also be indicated, but is not common procedure, except in those cases where the patient may show symptoms of regression. With this discussion we are now ready to examine the psychiatric disorders, the social factors, and the social casework services in the cases of fifteen patients who are studied in this thesis. The information used in this study has been taken from the patients' file in accordance with a schedule, which has provided the data
used in the short summary of the psychosocial factors in the illness; the social services provided, and the casework techniques employed in each of the fifteen cases. The observations noted are those of the author of this study. The cases are numbered 1 to 15.

Presentation of the Fifteen Cases Studied

Case 1. Psychiatric Statement: A voluntary male patient, who has suffered from rheumatoid arthritis made a suicidal attempt following depression. Discharged at nineteen weeks, diagnosed, "Reactive Depression—Rheumatoid Arthritis." Condition: "Improved."

Social Work Statement: This fifty-three year old single labourer, irregularly employed, a periodic alcoholic, had severed all connections with his family since the age of fifteen. He had bright normal intelligence, graduated from school with grade eight.

Individual social problems were related to his financial situation, unemployment insurance, employment, housing and alcoholic addiction. The patient was referred to Social Service Department five days before discharge. Attempts to find employment for him by the Rehabilitation Officer were unsuccessful. He was escorted to the City Social Service Department by a social worker and given fifteen dollars. The opportunity in interviews to discuss his fear of dependency enabled him to face more realistically his need to accept help.

Casework Techniques Employed: a) Five face to face interviews; b) psychological support enabled him to accept referral to a public assistance agency; c) environmental help also included two contacts with the Unemployment Insurance Commission, two contacts with the Vancouver General Out-Patient-Arthritis Clinic, the obtaining of a medical certificate stating the patient's unemployability, which was forwarded to the City Social Service Department with the Letter of Referral.

Observations: Patient who was thought to be severely maladjusted, although frustrated by his dependent condition, was helped to accept realistically his need for temporary relief and was supported to apply to the Assistance Agency.
Case 2. Psychiatric Statement: A "voluntary" male patient suffered for fifteen years from functional pains and vomiting, described as anxious and tense. Discharged at seven and a half weeks, diagnosed, "Psychoneurosis with somatic symptoms--Gastric neurosis." Condition: "Improved."

Social Work Statement: This fifty-four year old painter, with a history of tuberculosis, was in receipt of social assistance prior to admission to the Crease Clinic. Patient stated that he had education to grade ten at the age of fourteen, but had "missed several grades because of poor eyesight." Patient was married in 1928, there were three children of the marriage, ages twenty-five, twenty-two, and a fifteen year old boy living with patient's wife (from whom he had been legally separated since 1950). A long history of marital tensions, with separations and re-unions, resulted in exacerbation of patient's functional symptoms. Case was screened by social worker during the first week of admission. Individual social problems were related to his financial situation, employment, and a disturbed family situation. Upon discharge he was declared capable of full time employment.

Casework Techniques Employed: a) Communication by letter containing information of patient's illness and social condition was forwarded to the City Social Service Department.

Observations: This is a case of a long involved marital situation when for periods the "legal separation," was not observed by patient and his wife. During his stay in the Clinic, patient appears to have withdrawn himself from his family. The case was known to the Assistance Agency at the time of patient's admission to the Clinic.

Case 3. Psychiatric Statement: A "certified" male patient, suffered from migraine headaches, and was depressed about his wife's pregnancies. For six months prior to admission he was reported to give evidence of paranoidal trends, believing people were talking about him. Discharged at seventeen weeks, diagnosed, "Manic-Depressive-Depressed." Condition: "Improved."

Social Work Statement: This forty-nine year old garage attendant was married with four small children, ages 4, 3, eighteen months, and one month. Patient was born in Russia, had a very deprived childhood, with grade six education, and had been working since he was eleven. At the age of forty-four, patient married a woman twenty years his junior. With little or no training he had been
steadily employed. Individual social problems were related to the financial and marital situations. Social Service recorded notes dated one week after his admission indicated that patient expressed feelings of personal inadequacy, and was thought to show inability to relate to people. Consequently no individual casework was extended to him or to his wife. Patient's wife was seen and the referral to the Assistance Agency was discussed with her.¹

Casework Techniques Employed: a) Face to face interview with patient's wife (was not recorded on the file); b) Environmental help through letter of referral to the Assistance Agency.

Observations: The information indicates a deep family disorder. Both marriage partners experienced early deprivation. This family was not previously known to the Assistance Agency, and although they were alerted about the situation involving the care of four young children, an inter-agency consultation would have been in order.

Case 4. Psychiatric Statement: A "voluntary" male patient suffered from severe asthmatic attacks, was said to have difficulties in his inter-personal relationships. Discharged at seventeen weeks, diagnosed "Pathological personality." Condition: "Improved."

Social Work Statement: This fifty-one year old single unemployed fisherman of average intelligence, and grade eight education at fourteen, could not adequately discuss his condition with a social worker. He had no relative or friends, the result of gradual deterioration in his emotional condition. His individual social problems were financial, housing, and he was in need of leisure time activities. Social Service activity was at the fifteenth week of hospitalization, at the conclusion of a period of psychotherapy.²

¹ The discussion with the patient or his relative of the referral to the Assistance Agency was not clear from the recordings in certain cases. Personal communication with the Provincial Supervisor of Psychiatric Social Work, Miss A.K. Carroll, indicates that although it is not always specifically recorded in the file, all patients who are referred to a community agency are interviewed at least once, and the referral discussed with them.

² Personal communication from the Provincial Supervisor of Psychiatric Social Work, Miss A.K. Carroll. This information was not evident to the writer of this study.
Casework Techniques Employed: a) Consultation with the medical profession; b) Referral to the Assistance Agency and information to the Social Service Department, Vancouver General Hospital.  

Observations: This patient received psychotherapy and was not seen by a social worker until this was concluded when he was referred for help through the Assistance Agency.  

Case 5. Psychiatric Statement: A "voluntary" female patient, said to suffer from insomnia, confusion, and to be worried about an "extremely difficult financial situation." Discharged at seventeen weeks, diagnosed "Anxiety State." Condition: "Improved."  

Social Work Statement: This fifty-seven year old widow, having no children or relatives, was considered to be a chronic medical and social problem for the past twenty years. Patient has lived on a float house most of her life, and was well known to City Social Service Department prior to her admission. Her individual social problems were financial and poor physical condition. She was seen by a social worker one day before discharge, to clarify with her date of discharge and transportation facilities to Vancouver. Patient had a poor psychosocial prognosis, and was considered unsuitable for admission to the Crease Clinic.  

Casework Techniques Employed: a) One face to face interview; b) Environmental help (transportation arrangements) and referral to the Assistance Agency.  


Social Work Statement: A forty year old medical secretary, whose record indicated deep psychosocial conflict. Patient who had grade eleven education and one year at university, appeared to have been involved in several illicit relationships, resulting in the birth of three illegitimate children, the oldest aged eighteen. Patient was married during the war at the age of twenty-eight and was divorced after three years, seeing her husband on few occasions. Patient had poor relationships with her family, being closest to her father who died of a brain tumour when  

1 Personal communication from the Provincial Supervisor of Psychiatric Social Work, Miss A.K. Carroll. This information was not evident to the writer of this study.  

2 Loc. cit.
patient was twenty-two. She quarrelled frequently with her mother and brother, a minister of religion, who was close to the mother. Individual social problems were financial, employment, housing, and alcoholism. Social service became active at the third week of patient's hospitalization.

**Casework Techniques Employed:**
a) Face to face interviews to consider discharge plans. Exploration of brother's interest to help patient, which, because of his own family situation, he was unable to give; b) Social service report to The Vista and referral to City Social Service Department, who agreed to give follow up services upon patient's transfer to The Vista.

**Observations:** Early screening in this case focused discharge planning effectively. Patient was known to the Assistance Agency at the time of admission.

**Case 7. Psychiatric Statement:** A "certified" male patient suffering from asthma and malnutrition, whose poor physical condition was thought to contribute to his mental deterioration. Paranoid ideas led to fights and police intervention. Discharged at eight weeks, diagnosed, "Paranoid State." Condition: "Improved."

**Social Work Statement:** This fifty-eight year old single labourer of Polish origin, had grade six education at fourteen years. Patient had a fairly good work record until three years before admission, when he suffered from asthmatic attacks. He was known to the Assistance Agency during this period. He had no known family or friends and had moved from numerous boarding houses, because his erratic behavior involved him in fights with other boarders. His individual social problems were financial, employment, and housing.

**Casework Techniques:** a) Admission screening; b) Environmental help (letter to the Assistance Agency).

**Observations:** This patient was in receipt of assistance when admitted to the Clinic. The contact from the City Social Service was through their medical section to a medical contact at the Crease Clinic. This patient appears to be suffering from a chronic condition which indicates long term care.

**Case 8. Psychiatric Statement:** A "certified" female patient, was depressed about her husband's suicide three years prior to admission, and said to be "hallucinating." Discharged at nine weeks, diagnosed, "Paranoid Schizophrenia Chronic." Condition: "Improved."
Social Work Statement: This sixty year old widow of Finnish origin, attempted to support herself as a mas­sage since her husband's suicide three years prior to her admission. Patient owned her own home, and was now inca­pable of continuing her own support. Her married daughter, age thirty-five, wanted patient placed in a nursing home. Patient was very upset by her daughter's attitude, and was considered medically to be capable of accepting responsibil­ity for her own care. Her individual social problems were, financial, housing, and fear that the community would not accept a discharged mental patient.

Casework Techniques Employed: a) Face to face interviews enabled patient to accept referral to the City Social Service Department, and the fact that social assistance would help her remain in her own home, appeared to modify her fear of return to the community; b) Letter of referral to City Social Service Department.

Observations: Casework helped this patient main­tain independence, and facilitated her return to the community.


Social Work Statement: This fifty-seven year old widow who experienced childhood deprivation, and spent most of her early life in orphanages. Patient had been most promiscuous, and had entered into several common-law relationships. She was well-known to the Assistance Agency, and at the time of her admission was in receipt of assis­tance. She had no known family or relatives, and had irregular employment as a domestic. Her individual social problems were financial, and housing. Social service became active at the third week of patient's stay in hospital.

Casework Techniques Employed: a) Face to face interview; b) Letter of referral to the Assistance Agency.

Observation: This is another case of chronic psychological and social problems where the patient has

1 "This illustrates the Service given to a patient in a class which ordinarily would be screened out. In this instance the need for supervision, a place to live would necessitate opening the case for casework services to the daughter and services to the mother." Ibid.
been known to the Assistance Agency for a long period.

Case 10. Psychiatric Statement: A "certified" male patient admitted from Oakalla, where he was said to be exhibiting bizarre behaviour. He was poorly adjusted. Discharged at two weeks, diagnosed "Pathological Personality, Anti-Social." Condition: "Unimproved."

Social Work Statement: This thirty-four year old married prisoner was admitted from Oakalla, where he was serving sentence for assaulting his wife. Patient who had a below average intelligence with grade six education, had a poor work record as an unskilled labourer. He was married for thirteen years with three children, ages thirteen, ten, and five. Patient did not adjust well to treatment in the Clinic. His individual social problems were financial, and marital difficulties. Although the couple frequently stated their intention to separate permanently, they were ambivalent about this.

Casework Techniques Employed: Face to face interview with patient's wife; b) Environmental (referral to the Assistance Agency and contact with the Juvenile and Family Court).

Observation: Social service contact was upon the day of patient's discharge. Although a two page letter was forwarded to the Assistance Agency and the psycho-social implications were well focussed, the situation in this family deteriorated rapidly after the patient's discharge from the Crease Clinic and the oldest boy was in need of protection from this patient. Although it is further noted that many social agencies had been involved in helping this family prior to the patient's committal to Oakalla Prison and his admission to the Crease Clinic, this writer observes that the responsibility for joint agency planning in this case, appears to have been missed by all agencies concerned.

Case 11. Psychiatric Statement: A "voluntary" female patient who made a suicidal attempt, and said to have been promiscuous for some years. Discharged at seven weeks, diagnosed, "Pathological Personality - Inadequate." Condition: "Unimproved."

Social Work Statement: This thirty-one year old divorced woman, who had no friends or known relatives in Vancouver, and was unable to give a permanent city address.

1 For confirmation of these observations, please turn to the case presentation in Chapter 3.
Patient who had grade ten education had lived mainly by prostitution. Her eight year old child was placed for adoption shortly after birth. Patient had made several futile suicidal attempts. Social service became active at two weeks of patient's hospitalization. Patient's individual social problems were, financial, employment, and promiscuous behaviour.

Casework Techniques Employed: a) Brief face to face interview; b) Letter of referral to the Assistance Agency.

Observations: This patient's long history of difficulty prevents her use of psychiatric or casework services.

Case 12: Psychiatric Statement: A "certified" female patient, suffering from hypertension and gastro-intestinal disturbance, who was very hostile. Discharged at eight weeks. Condition: "Improved."

Social Work Statement: This fifty-nine year old widow, who was separated from her alcoholic husband, sixteen years prior to his death. There were no children of the marriage. Patient had grade twelve education, but a very poor work record as a domestic helper. Three years prior to hospitalization patient was a resident in a boarding home and in receipt of social assistance. She felt that the tensions in the boarding home contributed to her illness. Social service became active at two weeks of her hospitalization. Her improvement in the clinic was such as to suggest her transfer to The Vista for rehabilitation. Her individual social problems were financial, employment, and housing.

Casework Techniques Employed: a) Face to face interviews; b) Environmental (Letter of referral to the Assistance Agency).

Observations: Casework was well focussed toward rehabilitation planning, and clarified that a worker from the City Agency would give follow-up service when patient was transferred to The Vista.

Social Work Statement: This fifty year old single unemployed fitter, had grade twelve education at fifteen. Patient had no friends or relatives in British Columbia. He gave little information about himself beyond facts about his status and eligibility for social assistance. He indicated an early unhappy family life and a lonely existence. His memory failure and clinical symptoms indicate a chronic brain syndrome. His individual social problems were financial, and housing. He was seen by a social worker at the third week of his hospitalization.

Casework Techniques Employed: a) Face to face interviews; b) Letter of referral to the Assistance Agency.

Observations: This patient appears to have a long history of poor adjustment and poor physical condition which would prevent his use of psychiatric or casework services.

Case 14. Psychiatric Statement: A "voluntary" male patient who was described as restless, anxious, had frequent crying spells about a head injury. He had been unable to work because of illness. Discharged at three weeks, diagnosed, "Reactive Depression." Condition: "Unimproved."

Social Work Statement: This patient is a forty year old married man with two children, ages seven and three. He had been in receipt of social assistance from time to time. Individual social problems were, financial, employment, and a severe marital disturbance.

Casework Techniques Employed: a) Face to face interview; b) Letter of referral to the Assistance Agency.

Observations: This patient and his family were known to the Assistance Agency prior to his admission to the Clinic. The writer observed that an inter-agency conference would have more clearly focussed the difficulties in this severe marital situation in which the case of two small children was involved. As noted elsewhere in this chapter, this could have been requested by the Assistance Agency.

Case 15. Psychiatric Statement: A "certified" male patient, who was described as restless and aggressive for the past year. Discharged at twelve weeks, diagnosis, "Schizophrenic Reaction." Condition: "Improved."

Social Work Statement: This married thirty-one year old qualified plumber, had three children, ages seven, three and two years. Patient changed his jobs frequently
which aggravated a severe marital disturbance and affected the case of three small children. In the admission screening it was felt that patient and his wife were not amenable to casework. Later the case was transferred to a continuing service worker when patient's wife was seen for four interviews.

**Casework Techniques Employed:** a) Casework interviews with patient’s wife; b) Phone call to the Assistance Agency.

**Observations:** Inter-agency consultation would have clarified aspects of this severe marital disturbance in which the case of three young children was involved.

**Conclusions and Findings**

The records of a group of fifteen patients have been examined with reference to personal and social stresses, diagnosed psychiatric classifications and social rehabilitation in terms of what was available in 1954 considering staff shortages and public resources.

**The findings noted in the study of these cases are:**

Of the fifteen patients studied, 9 were male and 6 female. Their ages ranged from 5 patients between the ages of 31 to 40; 2 patients between the ages of 41 to 50 years; and 8 patients between the ages of 51 to 60 years. Their marital status was; 4 were married, 4 were single and 7 were separated either by death or divorce. The 4 married patients had dependent families.

1. **Psychiatric classifications:** Reactive-Depression, 3 patients; Schizophrenic Reaction, 2 patients; Psycho-neurosis, 3 patients; Pathological Personality, 4 patients;
2. **Precipitating Causes of Admission**: The records of the patients show that more than one condition contributed to the cause of admission. Thus while a patient may have attempted suicide, he may also have been upset and depressed because of a disturbing physical condition. Other patients may have shown evidence of depression, yet have been involved in severe family disturbances. Classification of the most common variable revealed that Depression appeared to be the precipitating cause in the admission of 6 patients; physical complaints which created psychological difficulties were noted in the admission statement of 5 patients; suicidal attempt, 1 patient; personality difficulties, 1 patient; confused behaviour, 1 patient; and bizarre behaviour, 1 patient.

3. **Admission Classifications**: 8 patients were admitted by "certification," and 7 patients by "voluntary" admission.

4. **Length of Time in Hospital**: 2 patients were in hospital under 5 weeks; 8 patients remained in hospital from 6 to 10 weeks; 2 patients stayed in hospital 11 to 15 weeks; and 3 patients were in hospital 16 to 20 weeks.

5. **Social Service Activity at the Point of Time in Hospital**: 12 patients received social service under 5 weeks of their hospitalization; 1 patient at 6 to 10 weeks; 1 patient at 11 to 15 weeks; and 1 patient at 16 to 20 weeks.
6. **Individual Social Problems:** The 15 patients all had financial difficulties. Six of the patients had, in addition, employment problems. Eight patients were also concerned with housing difficulties. Seven patients also had marital and family disorders. Two patients were also concerned about alcohol addiction, and one patient had no friends or relatives. Thus it is seen that of the group one patient only was concerned primarily with financial difficulties.

**Casework Techniques Employed:** Fifteen patients received face to face interviews with a social worker, and were given indirect environmental help through referral to the City Social Service Department. **Direct environmental help** was given to two patients in the form of financial help until his eligibility was established, and by escorting him to the Assistance Agency; transportation was arranged from the hospital for another patient. **Contact was maintained with other agencies in three cases.**

**Direct Services** were given to fifteen patients. **Direct Services** were given to patients' relatives in four cases.

**Observations:** Ten cases of the group studied were known to the Assistance Agency prior to the patient's admission to the Clinic. In these cases the Intake Social Worker would assume that a psycho-social assessment had been completed by the City Social Service Department. Unless any
of these patients were to be carried on a long term basis by the doctor and social workers at the Clinic, a full history would not be obtained. Frequently, because the City Social Service Department is unaware of their client's admission to the Crease Clinic, no psycho-social statement was received from them in these ten cases, although, in some instances, this had been requested.¹

Recording: In 6 of the fifteen cases studied, the recording on the files did not indicate the process of the service that was given. In other cases it was also difficult to assess the services. For example, it was not clear that each patient had been seen directly with regard to the referral to the Assistance Agency. The Provincial Supervisor of Psychiatric Social Work, Miss A.K. Carroll, advises that all patients were interviewed at least once and the referral to the Assistance Agency was discussed with them.² In several cases, the main files did not contain a completed copy of the social service notes. The filing system at the Crease Clinic does not contain correspondence in the main file which also adds to the difficulty of obtaining data. Much information which is implicit in the brevity of recording to the workers, creates a different interpretation for someone who is reading the file.

Inter-Agency Conferences: In four of the fifteen cases studied there appeared evidence of severe family

¹ Personal communication from the Provincial Supervisor of Psychiatric Social Work, Miss A.K. Carroll.

² Loc. cit.
disturbance. These are Cases 3, 10, 14, and 15. Cases 10 and 14 were known to the Assistance Agency prior to the patient's admission. Cases 3 and 15 were not known. Case 10 presented severe difficulties in the care of the children. It is not within the purpose of this study to suggest which agency should have accepted responsibility for further consultation in these cases, except to note that inter-agency consultation may have indicated which community resource could give service where such chronic family situations existed, or have shown the need for closer liaison in such cases.

The fifteen cases studied show evidence of chronic psycho-social disturbances, and poor psychological and social adjustment. Many were unable to use psychiatric or casework help. Social service help was given to them by the Crease Clinic Social Service Department which attempted to improve their adjustment situations. The records of these fifteen patients have been examined with reference to personal and social stresses, diagnosed psychiatric classifications, and social rehabilitation in terms of what was available in 1954 considering staff shortages and public resources. The chapter has dealt more specifically with the patient in the clinical setting of the psychiatric hospital. Since psychosocial rehabilitation must continue for a period after discharge from hospital, it is necessary to give further consideration to this aspect, in addition to what has
already been mentioned in this chapter. Chapter 3 will, therefore, consider the services given to the fifteen patients while under the care of the City Social Service Department.
CHAPTER 3.

PUBLIC ASSISTANCE CONSIDERATIONS IN SOCIAL SERVICES TO FIFTEEN DISCHARGED PSYCHIATRIC PATIENTS

Government Responsibility to Provide Welfare Services

The highest ideals of a forward looking philosophy has respect for the rights of the individual to self-determination. Such a philosophy considers that all human resources must be conserved and strengthened; that in times of stress and lack of livelihood, provision be made for social, emotional, and economic security. Western democratic government has a responsibility to provide for the welfare of the people. Gross need and economic insecurity is often related to personality maladjustment as well as to the economic system. Unmet needs, personal insecurity, and inability to make adjustment in relationships, not only often leads to mental illness, but to severe economic distress for all concerned in the problem. The relationship between mental health and public assistance is therefore recognizable.

The present chapter will consider the services which provide for a group of fifteen patients, who, because of economic need (lack of financial support), which determined eligibility, were referred upon discharge from the Crease Clinic to the City Social Service Department.
Development of City Social Service Department

Almsgiving and some form of organized charity can be traced to early recorded history. Investigation of living standards reflected a gradual change in attitudes toward poverty and the poor. The widespread poverty in the depression of 1930 onwards, again refuted the attitude that poverty was due to personal fault weakness of character, and individual laziness.

It is relevant to mention that the investigations of Charles Booth, 1840-1916, reported in his work "Life and Labour of the People of London," attempted to show the numerical relation which poverty and misery bear to regular earnings, and to describe the general conditions under which each class lived.1

The findings of the investigations of Booth, Rowntree, Beatrice and Sydney Webb, and many others who examined the conditions of the poor, have exerted influences upon the philosophy and conditions which have developed to meet the exigencies of people in financial and other needs.

The early beginnings of Vancouver's City Social Service Department in 1906 attempted to meet conditions which resulted from the depression. Food and lodgings to the indigent poor were provided under the direction of the

---

1 In his study Booth divided the population of London into light groups. Four groups he defined as living above the poverty line and four below. He described the poor as living under a struggle to obtain the necessities of life and to make both ends meet, while the very poor lived in a state of chronic want.
Health Department,

The following year, volunteer investigators, members of the Friendly Help Society, were active on behalf of the Health Department. In 1909 the Friendly Help Society merged with the Associated Charities, which was financed by public subscription. A relief officer was appointed in 1912 under the Health Department but it was not until the 1930's that assistance was administered to unemployed and unemployables under a department of the Council of the City of Vancouver. ¹ Eligibility for relief was determined by a means test administered by investigators. Assistance was granted in the form of groceries, scrip for goods, and some cash benefits. The establishment of a General Relief Section in 1935 reflects a fleeting awareness of the concepts later to be stated in Article 25:1 of the declaration of human rights approved by the United Nations General Assembly, December 10, 1948:

Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing, and medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.

¹ "In 1930, when Unemployment Relief became effective and costs of such relief were shared by Federal and Provincial governments, the department was divided into two sections—Unemployment Relief section and General Relief section. The latter cared for unemployables and the cost was 100% charge on the city. The changes to 'Family Section'; then to 'Welfare Section' were more in name than nature." Personal communication through Mr. J.A. Chambers.
Mother's Allowance, Social Allowance, and Old Age Pensions were amalgamated in 1942.\(^1\)

The present Social Assistance Act, passed in 1948, made legal provision for the granting of aid:

...to the individual, whether adult or minor, or to families, who through mental or physical illness or other exigency are unable to provide in whole or in part by their own efforts, through other security measures, or from income, and other resources, necessities essential to maintain or assist in maintaining a reasonable normal and healthy existence.

The Act defines assistance as meaning: a) financial aid; b) assistance in kind; c) institution nursing, boarding, or foster home care.

Other provisions are: counselling and health services, occupational training, retraining or therapy for indigent persons and mentally or physically handicapped persons, and "generally any form of aid necessary to relieve destitution and suffering."

The regulations of the Act provide the limit of personal property allowable to claimants for assistance, and state the duties of municipalities to provide and maintain social assistance at a reasonable level consistent with the cost of living as related to standards of assistance.

Legislation thus places responsibility upon the City of Vancouver to provide social assistance services to

---

\(^1\) Actually only the visiting staffs were amalgamated. Mother's Allowance continued to be administered by the Provincial Mothers Allowance Board in Victoria, and Old Age Pensions by the Provincial O.A.P. Board. This is still in effect.
citizens who through exigency are unable to provide for themselves.

The authority which allows the provision for the poor, indigent, and destitute is stated in Section 183 of the By-Laws of the Charter of the City of Vancouver.

It is relevant here to show the trends in public assistance cases and costs by including the statistics of social assistance cases and the cost to the City of Vancouver for February, 1944, compared with the figures for February, 1954 and 1955. In February, 1944, there were 1722 social assistance cases of 2088 individuals. Assistance in that year cost the City of Vancouver $17,771.87. The Provincial Government bore the remaining 80 per cent of the cost.

In February, 1954, 3015 social assistance cases of 4146 individuals with a total cost to the City of $29,904.43, and in February, 1955, 3053 social assistance cases of 4185 individuals, was a total cost to the city of $38,319.00. These figures give indication not only of the extension of services, greater recognition of need and the obligation of the City of Vancouver to meet need, but of the increasing pressures and larger case loads of the Social Work Staff.

Staff Organizational Structure

The establishment of a Social Service Committee of the City Council under the chairmanship of an elected
alderman, is the agency which recommended the necessary organization of a social service department to serve the City of Vancouver in respect to responsibility for giving assistance to meet need.

Authority has been delegated by the council to a single executive, the Administrator, whose decision is binding in most cases. In special cases a bylaw of the council may be passed to enable assistance to be given to persons in rare emergency situations. For example, if a person applied for assistance having no money, but had property which might yield an income if administered efficiently, a bylaw might be passed providing that the person receive assistance until assets could be gained from the property.

An assistant Administrator and a Welfare Director are directly responsible to the Administrator and meet regularly twice weekly with him on policies of the department and related cases. Three senior members of the agency compose the staff committee which meets to consider the appeal of an applicant for social assistance, and/or to consider some additional allowance to an applicant for special reasons. In each instance the case is studied beforehand, which is presented by the district Visitor. Following this procedure the committee makes a decision on the merits of the case. Any caseworker may present a case for consultation
or may ask for clarification, and further consideration of an appeal for assistance. Every effort is made to consider fully intricate factors causing hardship and to meet the special circumstances creating need.

The agency administration is represented by "line and staff structure." The Administrator formulates policy; staff operations and the efforts of a research department combine to suggest new measures which makes for more effective executing of modified policy.

The structure lines are from the Administrator, through the assistant Administrator to the unit directors and the directors of the different administrative departments. The unit directors are totally responsible for the work of their units. They divide some of their responsibility with the unit supervisors of casework, but are directly responsible for the unit, which includes clerical administration and the direct services to clients. The unit supervisors are responsible for casework supervision, and for aspects of administration such as eligibility and policy. Each unit supervisor consults monthly with the Director of Welfare.

Special staff meetings of the total department have been held from time to time. It is hoped by the Department that a regular general staff meeting scheduled to take place beginning in the spring of 1956, will be continued.

1 Some unit directors are graduate Social Workers.

2 The area served is within the boundaries of the City of Vancouver. For purposes of administration, the City is divided into four units.
The department is divided into geographical units. Most referred mental patients are seen at intake and referred to the unit serving their geographical area. In a special situation such as boarding home placements, a public health nurse of the medical section becomes involved. The public health nurse is a consultant and in this capacity is able to achieve direct and quick consultation with the patient's physician at the Psychiatric Hospital. Medical services are available for social assistance clients at the Vancouver General Hospital and St. Paul's Hospital. Medical cards are issued to all clients which permits them to choose their own private physician and to receive free drugs. Psychiatric consultation and specialist's services are available. It must be recognized, however, that financial destitution determines eligibility for assistance, and for any of the services available through the agency. Unless a referred mental patient qualifies in this respect, he would be ineligible for any other service, even though his border line or inadequate financial income created hardship and contributed to his precarious mental state. To qualify for assistance, he must be destitute and without means of subsistence. Should, however, a person have an income from another source which is below the social assistance rate, the agency would supply financial aid up to the stated assistance rate, and would extend with this any other services necessary. In cases where the recipient or his family are unable to provide recommended
appliances, such as glasses, dentures, et cetera, these would be supplied through the agency if the client qualified in respect to financial eligibility. In cases where it is advisable for an ill person to remain in his home, or where children of a client require temporary care during the illness, housekeeper or home maker service may be provided. In addition to these services, a Metropolitan Health Committee Nutritionist serves as a consultant, and assists in the question of budgeting, nutrition and special diets.

Social workers on the staff in addition to establishing and reviewing eligibility of persons in need of financial aid, provide a continuing counseling service, and by understanding and individualized service, enable the client to use resources within themselves and the community to achieve the greatest possible measure of self dependence.¹

Referral Policies which Affect Assistance Concepts

The referral of a client to another agency for service often demands a high degree of casework skill, affecting smooth transference and an adequate preparation of the client. A Department of Social Assistance has the primary responsibility for providing financial aid, and other services which are an adjunct to this primary service, to a large group of individuals who may be temporarily or even permanently unable to provide for themselves.

The City Social Service Department is so organized that clients may apply individually to the agency for assistance.

¹ City Social Service Department, unpublished statement provided by the Director of Welfare.
Some are referred by community agencies, the vast majority of applicants make personal application without reference from the agencies. The referral of a client from one agency to another is an important part of casework practice. There are two aspects to this problem, namely, to secure the service which will meet the client's specific need, and the professional relationship between the workers involved. Reference is here made to the report of a Committee designed to "Study Referrals from Hospital to Social Service Departments to Community Social Agencies," under the auspices of the Council of Social Work in Medical Care, United Community Services of Metropolitan Boston.\(^1\) The committee examined case material which dealt with the referral of cases by medical social workers to community agencies.

As a result of this analysis the committee arrived at two major conclusions a) referral of a patient to a community agency for service is part of casework process and should never be a routine procedure; b) clearly defined administrative policies and procedures relating to inter-agency referral are essential for good social work practice.

The committee concluded that all referral procedures, even those that are chiefly administrative in nature, should be based on sound casework practice.

Fifteen discharged mental patients were referred to the City Social Service Department for social assistance during 1954. The services which were provided to them by

\(^1\) The section of the article discussing referral policy will be more specifically dealt with in Chapter 4 of this study.
the Assistance Agency can now be discussed.

Discussion of the Social Services Provided to Fifteen Referred Mental Patients

To obtain data from the files of these patients, a (simple) schedule was used. The method of presentation used in Chapter 2 to describe the illness and social problems of the fifteen patients will be followed in the present chapter to describe the social services provided to the same group of patients by the City Social Service Department.

Case 1. Client was assessed eligible for "Support and Shelter Group 1." Referral to Vancouver General Hospital, Arthritis Clinic, was discussed with him. He became accepting of treatment there. An understanding, supportive relationship with the worker created feelings of trust toward other people, and a more confident attitude toward life. He was not previously known to the Assistance Agency.

Casework Techniques Employed: a) Face to face interviews which employed the use of a supportive relationship; b) Environmental help and use of community resources.

The case was closed upon client receiving employment benefit.

Observations: Noted improvement in the client's motivation, a better attitude toward his situation, and treatment for his arthritis was obtained.

Case 2. Client was eligible for "Support and Shelter Group 1, plus $7.50 extra T.B. dietary allowance." There is evidence in this case of good contacts and conferences with the Social Service Department of T.B. Control. Conference recommended that client be given assistance as a rehabilitative measure because his recovery was hampered by the stresses and strains created by marital disharmony. Information on this file regarding client's wife's mental state would have been valuable to the Crease Clinic. Case

1 Group 1, 2, 3, etc. refers to the number of individual included in the case.
was previously known to the agency prior to client's stay in Crease Clinic, when casework services with the family attempted to improve the family situation.

Casework Techniques Employed: a) Face to face interviews; b) Environmental help, and conference with a community agency focussed the plan for patient to live apart from his family until his physical health improved.

Case was closed upon patient obtaining employment.

Observations: Continued family services to patient and his wife might have maintained patient's improvement. He returned to live with his wife and family. Prognosis would indicate that his physical and mental symptoms would be re-activated.

Case 3. Client's family assessed eligible for "Support" only, while client still in hospital. Client's wife was very anxious about pressing debts and loss of income. Financial aid appeared to stabilize her. There was no referral or consultation with any community resource. Case was not previously known to the agency.

Casework Techniques Employed: a) Face to face interviews with the client's wife, and casework support enabled her to interpret the assistance service to her husband who resisted accepting help.

Case was closed: Client obtained employment.

Observations: Stabilization of the economic situation helped this family. In this case, however, there appears to be the genesis of a severe family disorder, and the psychological adjustment of four young children is involved. The case was not referred to the Family Agency for continued service. This is a case where preventative help would seem in order.

Case 4. Client assessed eligible for "Boarding Home-placement" and comforts allowances $7.00 per month. This client was known to the agency previously when he was considered incapable of handling money, because of gambling habits. Following recommendations from the Crease Clinic psychiatrist, client refused the service. The agency attempted to discuss client's referral to a neighbourhood house. He settled into a good boarding home-placement where he shared a room with three other men where some of his needs for social life were partly met. He seemed much more settled and happier, although his asthma did not improve. Transfer to Taylor Manor
was contemplated, but was not accomplished, because it was considered detrimental to his adjustment. Client was referred for treatment to Vancouver General Hospital Out-Patient Department, and was given new clothes.

Casework Techniques Employed: a) Face to face interviews; b) environmental help; c) Referral to community resource.

This case is still active.

Observations: There appears to be improvement in patient's adjustment, and he is more outgoing.

Case 5. Client was assessed eligible for "Support and Shelter" and was previously known to the agency. Because she had poor motivation, and was losing weight because she missed meals when not well, close supervision was given. Consultation with the agency nutritionist resulted in supplementary diet allowance of $5.00 being granted. She was enabled to establish a good relationship with the worker, who recorded a clear assessment of this case.

Casework Techniques Employed: a) Face to face interviews; b) Environmental help, which included consultation with and referral to a community resource regarding eligibility for the Widow's Pension.

Case was closed upon client becoming eligible for Disabled Veteran's Allowance, Widow's Pension.

Observations: Stabilization of this client's economic situation. The recording did not indicate that client's tendency to disregard personal care required close supervision. This may have been discussed in telephone conversation between the agency workers and not recorded.

Case 6. This client was known to the agency prior to admission to Grease Clinic. Upon referral she was assessed for "Support" only. Later, because of her poor motivation and alcohol addiction, which caused physical deterioration, she was placed in a boarding home, and was given $7.00 comforts allowance. In selecting the boarding home, care was taken to choose one where the owner was known to be a warm, understanding person. Although she appeared to accept the client, when difficulties arose, she requested her removal. Through the special Placement Section, National Employment Service, an

1 Taylor Manor is a Boarding Home for men and women, operated by the City Social Service Department, financed on shared basis between the Provincial Government and the City of Vancouver.

2 Supplemental diet is given only on medical recommendation, and for specific medical conditions.
attempt was made to place client in occupation. She worked for three weeks, and lived in a rooming house. Another Boarding Home was found, but because of her drinking she had to be moved. "Support and Shelter" was then given and she was helped to find a housekeeping room. A second job was found, which she kept under one month.

Other services provided in this case: Special shoes were supplied, dentures repaired, referrals to Alcoholic Foundation, and St. Paul's Hospital. Recording notes indicate that the patient continues to see the psychiatrist from the Crease Clinic.

Casework Techniques Employed: a) Regular face to face interviews, for this client required close supervision; b) Environmental help, which included referrals to community agencies.

This case is still active.

Observations: Chronic psychosocial difficulties indicate poor prognosis, and that the client will be a long term subject for care.

Case 7. Client was assessed for "Support and Shelter." He has been known to the agency since 1951, and was considered to require long term medical and financial assistance because of his poor physical and mental state. Regular supervision of his condition was maintained, and eyeglasses were obtained for him. A statement on this record indicates that it is thought that insecurity may precipitate similar mental symptoms which were present upon his admission to the Crease Clinic.

Casework Techniques Employed: a) Face to face interviews; b) Environmental help.

Case is still active.

Observations: Although this client's prognosis is poor, a good attempt is being made to maintain him in the community.

Case 8. Client was assessed for "Support and Shelter." She was not previously known to the agency. In this case "Shelter" was given, because, although client owned her own home, she had to pay taxes of $126.00 annually. When applying for assistance she owed $46.00 of the previous year's assessment, a total of $172.00 owing. During the Pacific National Exhibition, she rented her garden for parking purposes, for which she was paid $150.00, with which she paid the tax debt. She reported this to the worker and the case
was closed for two months, because the client having received
an income, was assessed as not being financially in need.
During this two month period the client had $40.00 for main-
tenance. Her family could not help. Client lost weight and
became concerned about her situation. There was evidence of
a good relationship with the worker who spent considerable
time explaining the policy of the agency to the client. The
client's resourcefulness was recognized and the assurance
that closure would be temporary seemed to stabilize her, and
attempted to maintain the plan of rehabilitation for her.

Casework Techniques Employed: a) Face to face
interviews which included psychological support and clari-
fication of her problem; b) Environmental help.

Case is still active.

Observations: Client appeared more stabilized
and her independence maintained. Although the two months'
closure appeared to cause some hardship, the client main-
tained a good relationship with the worker, and the improve-
ment in her mental health was good.

Case 9. This case of a difficult and involved marital
conflict was known to the agency since 1936. Case was
reopened in 1938, 1939, 1941, 1950 and 1951. The client was
assessed as eligible for "Support and Shelter Group I and
for casework." Contacts and referrals were maintained with
the Family Court, Vancouver General Hospital, and psychiatric
consultation with a private physician. The social information
is long and involved, starting in 1936, describing desertion
by a "cruel husband, non-support, frequent beatings, and
quarrels," and several common-law relationships with inadequate
shiftless partners. Family Court attempts to obtain support
were not effective. Occasional support to client from husband
was always reported to agency. Client's personality dif-
culties precluded Boarding Home-placement, and her frequent
ill-health created a precarious psychosocial situation. Since
discharge from Grease Clinic, client has been encouraged to
find baby sitting work up to the allowed sum of $10.00,1
which appears to have given some personal satisfaction and
stabilized her mental state. She also received care from a
private physician which helped her.

Casework Techniques Employed: a) Face to face
interviews; b) Environmental support, including use of
community resources.

1 This would be counted as an exemption before the adjust-
ment made in normal allowance. Personal communication with
Mr. J. Chambers.
The case is still active.

Observations: Evidence of stabilization of the situation is noted. The worker appears to have the confidence of the client and a good relationship between them seems to stem from the worker's non-judgmental attitude regarding client's common-law relationships.

Case 10. This is another very involved case of severe marital disorder involving the care and adjustment of three children, ages thirteen, ten, and five. The case was known to the agency prior to the client's committal to Oakalla and the Crease Clinic. There is a long list of contacts with community resources, including The First United Church Social Service Committee, The Catholic Charities, The First Baptist Church, The Mental Health Committee, The Family Service Association, The Catholic Children's Aid Society, and The Family Court. The contact with the agency began when the family lost their home and household effects by fire. The client was in a very confused state, and both he and his wife were emotionally disturbed. Their light was being disconnected; they had many debts and client was stated to be unfit to work. The case was presented to the Agency Staff Conference, but no assistance was given and the family was referred back to The Catholic Charities. On the occasion of the present contact, client's wife appealed for support for herself and three children. She gave a history of many early difficulties; of a controlling mother who forced her to marry client although she was pregnant by another man. Client also had a poor upbringing. His bitterness and rejection of the oldest boy has caused severe difficulties for the child. Because client had $60.00 back wages which he refused to sign over to his wife, assistance was withheld. His wife, desperate and harrassed by pressing heavy debts, threatened suicide. The money was finally obtained from the man, but two months' back rent absorbed it. Prior to client's discharge from the Crease Clinic, the agency worker recorded that it would be helpful to hold a planning conference with The Family Court, and The Crease Clinic. This was not held. One week following client's discharge, his wife deserted and the situation deteriorated rapidly. The twelve year old boy was not attending school; he "cried easily and was tense." He stated his father beat him, which client denied. Following examination by The Health Committee, the boy was taken into ward-care by The Catholic Children's Aid. It was thought that the other children were safe with client. Following an accident at work, assistance was given to him until Workman's Compensation was received. Client appeared seriously disturbed, and the other two children were then taken into care.

Casework Techniques Employed: a) Face to face interviews; b) Environmental help and use of community resources.
Case was closed. Workman's Compensation was obtained by client.

**Observations:**
This is a very seriously disturbed family situation which deteriorated rapidly after the client's discharge from the Crease Clinic. Clarification and assessment of this problem was not clearly defined in the early stages of contact, although there is adequate psychosocial data to establish diagnosis of the difficulties. Early inter-agency consultation in this case would have focused planned help to safeguard the care of the children and to have prevented the trauma which was experienced by them after patient's discharge from the Clinic. Serious consequences could have resulted to them because of the lack of agency responsibility. Information of this situation should have been forwarded to the Crease Clinic and an inter-agency conference held. Psychiatric participation would also have been most helpful in planning.

**Case 11.**
This client was assessed eligible for "Support and Shelter Group 1," and had been known to the agency on occasions since 1947. She has a history of inadequate adjustment, severe personality difficulties, and mental illness. Client was known to five community agencies and made several attempts to maintain herself. She was anxious to participate in vocational training. The Staff Committee of the agency, after reviewing her history and medical reports, did not recommend her for rehabilitation. Patient made plans with the National Employment Service to provide the vocational course which she completed. Following a period when she seemed better motivated, patient again developed somatic symptoms. She underwent surgery and was considered unemployable for one month. The City Social Service paid Boarding Home cost for this period. Client received Comforts' Allowance.

**Casework Techniques Employed:**
a) Face to face interviews; b) environmental help and referral to community agencies.

**Case closed:** The client assessed capable of employment.

**Observations:**
The recording in this case was not adequate, due to the assignment of different workers. This is a case of an inadequate single woman whose basic personality needs were not met through casework relationship. She seemed to wander from agency to agency, with no one agency assuming responsibility for coordination of services.

**Case 12**
This client was assessed eligible for Boarding Home care and $7.00 Comforts Allowance, which was first given in 1950. Contact was made with The Vancouver General
Hospital Women's Auxiliary, to investigate the possibility of the client finding volunteer occupation, as suggested by the Crease Clinic, Clinical Director. The agency medical section found a good Boarding Home for patient, which was later sold. Following this, her client's mental symptoms became more evident, and consultations with the clinical director established that every effort should be made to maintain her in the community. Good accommodation was found. The client became stabilized, and was useful in the home.

Casework Techniques Employed: a) Face to face interviews; b) Environmental help, and consultation with community resources.

The case is still active.

Observations: The client is more settled. Continuing psychiatric care through Crease Clinic is maintained.

Case 13. Client assessed eligible for "Support and Shelter." He was not previously known to the agency. Psychiatric consultation through Vancouver General Hospital, Out-Patient Department, was sought because client was showing signs of regression. This client gave a history of a very poor family background. Since coming to Canada at the age of 23, he had very good employment with an average wage of $400.00, when working. Ill-health and loss of work used his savings. Following an operation for mastoids, his mental condition deteriorated, and he evidenced severe symptoms of mental illness. He appears to be a candidate for long term psychiatric care.

Casework Techniques Employed: a) Face to face interviews; b) Environmental help and psychiatric consultation.

The case is still active.

Observations: The client's mental health is deteriorating and he may require committal to the Provincial Mental Hospital.

Case 14. This client was assessed eligible for "Support and Shelter Group 4." There was an earlier brief contact with the agency, though no help was given. Information on this record indicates a severe family disorder. The client, an inadequate, maladjusted person, appeared to be poorly motivated, and lacked ability to handle money. He changed jobs frequently and was a source of anxiety to his parents and family. After closure of the case a letter was received from his sister stating that client was causing trouble to
his aged parents who are in receipt of Old Age Assistance, and requested service to them. An agency worker phoned the sister, but received no reply. There was no referral for service to any other agency.

**Casework Techniques Employed:** a) Face to face interviews; b) Environmental help.

**Case was closed:** Client obtained employment.

**Observations:** Emergency benefit met economic need. The basic problem, however, was not modified. This appears to be another case of severe family disorder, aggravated by client's personality difficulties, and his established pattern of behaviour to work for a short while, after which he becomes a source of anxiety to his family by attempting to borrow money from them to maintain his family.

**Case 15.** This client was assessed eligible for "Support only, Group 5." He was not previously known to the agency and was employed steadily until September, 1954, when he lost his occupation through alcohol addiction. Client's wife seemed resourceful and attempted book-keeping work to meet mortgage payments on home. Referral was made to National Employment Service.

**Casework Technique Employed:** a) Face to face interviews; b) Environmental help and referral to a community resource.

**Case was closed:** Client received unemployment benefits.

**Observations:** Emergency help stabilized the economic situation. The basic problem of family disorder aggravated by client's difficulties, did not appear to be modified. This is another case in which the care of small children is involved.

**Conclusions and Findings**

The present chapter has studied the social situations of fifteen discharged mental patients who were referred to the Assistance Agency. The services given and the casework techniques employed to meet the individual and social stresses of the patients have been examined. All the
cases studied presented severe personal or family disorders. Financial assistance relieved elements of economic distress, but did not and indeed cannot alone modify the depth of disturbance in most of the cases studied. Other services offered by the Assistance Agency contributed to a more comfortable environment for the patients. When a patient was no longer in need of financial assistance, the City Social Service Department could not continue service.

The findings noted in the study of these patients are: Fifteen patients were referred for service and all became active cases. Of these ten were previously known to the agency, five were not.

Fifteen patients received financial assistance. Four of the patients received Boarding Home care (they were not referred for this service), but were assessed as being unable to make adequate arrangements for their own care. These patients received Comforts Allowance.\(^1\) Two patients were given Extra Dietary Allowance, and one patient was allowed an allowance of Extra Rent. One patient received new clothes, and the dentures of one patient were repaired. One patient was permitted to consult a private physician,\(^2\) and one patient was provided with new eyeglasses.

---

\(^1\) Boarding Home care costs $65.00 per month. Residents in Boarding Homes under the care of the City Social Service Department receive $7.00 personal allowance which is in addition to the $65.00.

\(^2\) This is available to all recipients of Social Assistance without cost to themselves.
In considering the Casework Techniques Employed, it is noted that fourteen patients received face to face interviews. One patient received indirect help through the interviews with his wife. Fifteen patients received direct environmental help through the contact with a community resource. Two patients were noted to have been given "psychological support."1

Of the fifteen patients who received assistance benefits, eight patients showed improvement in their psychological condition, and seven did not. Four of the cases presented severe family disturbances in which the care of young children was involved. Although in three of these cases service was terminated, the psychological condition of these patients was not thought to show improvement.

Under the section Observations, note is made that in most cases recording was up-to-date and contained an assessment of social data and recommendations. Data were thus easily obtained. Diagnosis of the basic psychological problems in most cases was overlooked. Treatment in the main was in meeting economic need and physical distress. Certain cases showed some attempt by the agency to improve the patient's psychological condition. At closure, no case was referred to a community agency for continued casework help.

1 The theory could be maintained that all the patients received psychological support by meeting their economic need. Certainly new eyeglasses and repair of dentures would help. Classification of casework services helps to demonstrate systematically the kind of casework help employed, and the service given to the client.
although emotional need was still evident. This was again very clear in those cases showing evidence of severe family disturbance, and involving the care of young children.

At the time of the study in January, 1955, seven patients were still receiving help and eight were not.

In concluding the present chapter, it must be stated again, that although social service help was given, the function and policy of the agency limited the help to relief of environmental pressures.

A forward-looking philosophy considers that all human resources must be conserved and strengthened; that in times of stress and lack of livelihood, provision must be made for emotional social and economic security. Every effort was made by the staff of the City Social Service Department to meet economic need; in many cases, however, the social and emotional stresses remained unmodified. The clients were not referred for help with these problems to relevant agencies.
CHAPTER 4.

DISCHARGED MENTAL PATIENTS AND PLANS FOR THEIR CARE

Purpose of the Present Study

Between January 1, 1954 and December 31, 1954, 1,256 residents of British Columbia were hospitalized at the Crease Clinic of Psychological Medicine. Of this total group, 480 lived in Vancouver. According to the records of the Crease Clinic, only fifteen, or slightly more than 3.01 per cent, who lived in Vancouver, required financial assistance from a public assistance agency. This figure includes only those who were legally eligible for public assistance, and would not include those patients whose financial stress was not severe enough to meet legal eligibility. Schlesinger also noted a low percentage of financial indigence in the group of patients he studied. Nevertheless, financial assistance still constitutes one of several major functions in social work practice, and should, therefore, be studied in relation to severe social adjustment problems of Canadian citizens, including those who have been hospitalized for mental illness.

The present study has attempted to examine the casework services given to fifteen discharged mental patients

---

1 Mental Health Services Report, op. cit., p. R 84.

by two social service departments within the Greater Van-
couver area of British Columbia.

The focus of the study has been to examine the
psychosocial problems of the discharged mental patient
referred to a Public Assistance Agency. The problems were
classified according to financial need, accommodation,
employment and emotional stresses.

The study has further asked how adequately the
public assistance agency is able to meet these needs. An
attempt has been made to examine the nature of the casework
services involved in the helping process in the psychosocial
adjustment of the patients studied.

Social Work Practice and the Need for Research

Social Welfare programmes are now firmly entrenched
within the framework of free democratic society. A recog­
nized responsibility of a government is provision for the
welfare of the people, that in times of stress and lack of
livelihood, provision be made for social, economic and emot­
ional security. The responsibilities of governments and the
evolution of social welfare services must always be closely
allied in respect of the needs of people and the provision
of services to meet need.

According to the thinking of a prominent social
worker,¹ social work has a great contribution to make in

¹ Altmeyer, Arthur J., Training for International Respon­
convincing the common people that democratic governments are making every effort to improve their lot, and that they are significant participants in that effort.

"Social work has been recognized as big business in two respects; it costs a great deal of money and it affects a great number of people."¹ Social work holds a significant place in both voluntary community enterprise and in government. Social work must, therefore, render an account of the way it attempts to meet the needs of people. This does not suggest that social work and social workers should be singularly preoccupied with either good social work practice or with bad social work practice. The implication of Mr. Altmeyer's statement referred to earlier, as to the relevancy of this study is clear; however, insofar as social work practice in all areas is designed to meet need, social workers themselves should be willing to make a critical examination of their own practice. Some agencies have employed experts in research to study their casework practices. In the interest of the growing social work profession it would seem that caseworkers themselves must see the value of such research and be willing to participate in it.

Human Aspect of Social Welfare Programmes

Human needs have been recognized in some form in all societies since the dawn of civilization. Social work, while

a comparatively "young" profession, is, nevertheless, the modern version of the democratic attempt to meet human needs. The performance of social work must therefore be judged in relation to the stage of development it has reached. Consideration must also be given to the fact that the structure of the services which brought social work into being is, in the main, sound—the result of long experience. The growth of the welfare structure of this era represents some of mankind's most promising advances in the solution of many human problems, echoing the concept spoken many years ago, Man shall not live by bread only. In attempting to meet individual need, social work services must deal with the effect the need has created—not only in the realm of economics, but what has happened in the individual's cultural and psychological adjustment. The profession of social work has accumulated some knowledge about the needs of individuals, and experience of how individuals react to situations which produce inner and outer stresses. The record of this must be contained in every case file of those individuals who, because of their varying needs, seek the help of social workers. The assessment and implications of this knowledge and experience should not only be available to the social work profession, but should provide the basis for research programmes designed to improve or modify welfare projects. Knowledge must be used and must be shared. Complacency which derives satisfaction from high costs of a welfare programme
either in the case of the mentally ill or in public assistance is sterile unless the programmes are designed and operated to meet the basic physiological and psychological needs of people. The services will be interpreted and used by the people accordingly. Social welfare services must be living processes. The highest ideals of a progressive thinking must infuse the realism of scientific considerations in the provision of budgets and administration of social services. Social welfare services, while concerned with individual need, should, through research effort, offer constructive methods of dealing with social problems. To do this more effectively, Welfare Administrators must be more concerned with human welfare in the broad sense and with human need wherever it arises. Through agency research, the study of man as an individual and as a social being, would not only provide enlightened services, but would also aid in the formulation of preventive measures to meet emergency needs and situations, beyond the control of the indigent and socially marginal individual. Such study would also consider daring and courageous measures to provide rehabilitation services for many chronic physical and psychological cripples, who, with consistent help, could lead more useful and satisfying lives.

These comments are offered as corollary to the findings of this study, with recognition of the fact that theory must be tested by practice, and practice refined by tested theories; that growth and development might occur,
this must always be so.

Effective planning and sound structuring of broad social welfare programmes have, therefore, to consider how the human element can enliven the services designed to meet the stresses and strains of individuals. This concept also applies to the services provided in psychiatric hospitals. Albeit, institutions for the care and treatment of the mentally ill do not always provide environments in which health can be restored. This has been succinctly demonstrated by Stanton and Swartz through research studies, showing that patients can be adversely affected by such situations as disagreement about their care by staff members, reacting to the disturbed atmosphere with increased agitation and tension.

The Patient and His Return to the Community

To be valid and effective, therapeutic effort must be related to the needs of the patient and to the specific conditions surrounding his illness. It is often difficult to separate the part of the problem which belongs to the patient and the part that is related to his being a member of a family unit. The factors that influence him toward illness and the factors that influence him toward health are intertwined. While these factors are known to be psychological social, economic and medical, in actuality it is difficult to make clear cut distinctions between them and other elements which contribute to stress and breakdown.
in mental health. The review of the cases under study demonstrated that each patient had many difficulties and concerns which were contributing elements in their illness. Treatment in hospital may have improved his psychiatric syndrome, but this very improvement may have created further difficulties for him in his normal social environment outside the hospital. An example of this consideration is noted in Case 4. A fifty-one year old unemployed fisherman, who had suffered from severe asthma, had no relatives or friends, which was possibly the result of gradual deterioration in his emotional condition. During seventeen weeks in hospital, helped by psychotherapy, his psychiatric syndrome improved and he began to relate better to the hospital staff and to other patients. He became one of a group, therefore he was less lonely and solitary. Having no friends or relatives interested in him, his return to the community would be a fearful experience for him. One of the disturbing elements contributing to his breakdown would be lack of means of communication with people in the group. Such a weak personality would require support in making the attempt to re-join the group. While it might be presumed that this is an isolated case, with the shortage of social work staff, a trend might be indicated. For most patients, the transition from the hospital to the community is a serious and difficult one. Should the patient be discharged prematurely or if he is not given adequate help during the transition period, the possibility of his re-admission to hospital is greatly
increased.

Many patients may improve in hospital only to return to a sick environment. Not all environmental situations are correctable or amenable to modification, and it may be destructive or even harmful to have the patient return to the environment where he became ill.

Case 2 gives an example of such a situation. The patient who had a long history of somatic complaints was unhappily married and legally separated from his wife. The tensions in the marital situation produced exacerbation of his functional symptoms. A poor work history, with inadequate provision and recourse to assistance aggravated the stresses in this family. The patient gave a history of frequent re-unions with his wife and it was noted that his recovery was hampered while he lived in the midst of the turmoil of marital disharmony.

Before this patient was admitted to the Crease Clinic, much time, effort and skill had been expended to plan support for this man to keep him away from an environment in which he became ill. Could this have been carried a step further by referral to the Family Agency, both patient and his wife may have been helped to resolve their feelings, and the pattern of illness and instability dealt with more effectively.

Again it is recognized that had more social workers been available in both agencies, a better coordinated service
could have been given to this family. Mention is also made of the short length of many patient's stay in hospital, often being discharged precipitously which causes strain on the existing hospital services. Should the discharge of a patient interrupt or preclude the beginning of adequate discharge planning, a considerable problem for the social worker often follows.

In the first chapter of this study, discussion was made of the "unknown factor" which often influences the therapeutic process. The extensiveness of this concept pervades the therapeutic process which goes beyond the operation of the institution. The inference of change in the patient's environment may prevent or impede his return, causing him to seek other resources in his effort to find a place for himself. In the period when his breakdown in functioning was taking place, his behaviour may have caused a serious rift in his relationships with his family. The feelings of guilt which such situations produce may so overwhelm the patient, that he feels he cannot return to the intensive relationships within the family structure. Frequently, too, the family has resistance to taking him back; all of which adds to his strain and to the problem of his rehabilitation. Case 14 illustrates this point. From the information on the City Social Service record given by the patient's relatives, it was evident that his poorly motivated personality functioning, seen in his inability to handle money, his frequent change
of jobs, and his indiscriminate borrowing of money had caused severe difficulties for his aged parents, his wife, and children. The patient was discharged at three weeks, his condition, "Unimproved." After a brief period on Social Assistance, he found unsuitable employment which soon folded up. He again disturbed his relatives whose resources were strained as they attempted to help. After closure of the case, the City Social Service Department received communication from the patient's sister, stating that the situation had deteriorated. This case appears to illustrate the lack of planned resources to help with the problems of what appears to be the beginning of a hard core problem family. Prevention of psychological difficulties in the development of two small children would seem to be a consideration in such cases.

Need for After Care Services for Patients

There is evident need for more adequate After-Care Service for all patients. Currently committees throughout North America and elsewhere are undertaking responsibility for organizing and maintaining After-Care Services. Hospital staffs, staffs and Boards of Community Agencies, and citizen leaders in social planning are banding together to tackle this problem. Because these programmes are so recently instituted, and, indeed, with many of them still in the planning phase, the gaps in community resources as shown in the cases studied here are evident.
The report of the Institute on Social Work in psychiatric hospitals emphasizes this concept:

Increasingly it is recognized that the patient's illness started in the community, that he may need hospitalization during a phase of his illness, and when hospitalization is no longer necessary he returns to his community, which has responsibility for him. There needs to be better integration and use of community health and welfare resources, so that there is less need to extend the hospital unwisely into the community. The individual should be returned to his community as a citizen and not as a patient. To do this the hospital administration has responsibility for making known the needs of the hospital to the community, and for helping social and health agencies to understand in what way their services can be helpful to the continued rehabilitation of the mentally ill person in his community.¹

As the hospital is part of the community, it should always be considered part of community planning.

The present practice in Vancouver of providing After-Care Service tends to be a mixture between the psychiatric social worker providing service, and referral to a community agency for a specific service such as financial assistance. The study has shown that when financial assistance is no longer needed by the patient, the City Social Service Department closes the case. In Cases 3, 14, and 15, there appeared to be need for continued After-Care Services to the discharged patient because the major psychological difficulties remained unmodified by the services already given to them. In cases 14 and 15, the discharged patient appeared to continue to create difficulties for his

¹ Knee, Ruth I., Editor, Better Social Services for Mentally Ill Patients, American Association of Psychiatric Social Workers, Inc., New York, 1953, p. 73.
In urban communities, complicated questions of agency function and responsibility for chronic cases, often result in the patient receiving inadequate services. Rigid agency policies tend to defeat integration of community resources. In the cases of discharged mental patients, the responsibility for clarification must be shared by the psychiatric hospital and agency administrations. To add to the difficulty of the individual social worker; agencies do not have clearly defined statements of cooperative policy and function. Until such statements are clearly formulated, contained in an agency policy manual, and available to other community agencies, inadequate social services will continue to defeat the purpose of providing services to clients.¹

This discussion prepares for comments about referral policies between agencies. Clear, efficient, meaningful referrals are related to sound casework practice, and involve the use of the systematic process of social study, social diagnosis and social treatment. The implication is clear that patients be referred to a community agency, only, if his needs are for support and casework help. The agency should not be expected to provide psychiatric After-Care. The medical and psychiatric controls are not to be found in a community agency. The cases under review indicate the

¹ It is the writer's opinion that these impressions have been verbalized by a large number of social worker practitioners.
urgent need for services provided in a psychiatric out-patients clinic. This service would, however, demand even more available staff. At the present rate of recruitment and the length of time, high expense of training, will this staff ever be available?

Examples of Referral Policy

The referrals of the cases under review appear to indicate the lack of clearly defined policies of referral between agencies.

One referral study has shown that:

A. 1. Hospital Social Service Departments should have a written statement of policy on: a) types of problems that are suitable for referral to community agencies; b) specific methods and procedure of referral.

2. Consultation and casework supervision is advisable in complex situations or in situations involving the question of suitability of referral to a particular agency or as to choice of agency.

B. Referral Procedures would involve:

1. Helping the patient accept referral.

2. Preparing the referral agency to be receptive to the patient.

3. Seeing that the patient actually gets to the referral agency.

---

C. Suggested Procedures to be followed would include:

1. When complex problems are under consideration a face to face conference between the two agencies would be necessary.

2. All referrals should be confirmed in writing. Letters of referral should state clearly the medical and psychiatric problem, the social implications, and clarification of the responsibility for each agency.

3. Cases in which responsibility is to be shared, division of responsibility should be clarified as early as possible, and at frequent intervals as situations change.

4. Joint conferences held regularly might be necessary to review cases receiving service.

D. Application of Casework Principles.

1. The caseworker in the hospital should have a clear understanding of the patient's problem if the referral is to be successful.

2. The patient should understand and accept the reason for referral and participate in the process.

3. The reason for the referral should be clear to the referral agency. While this requires accurate social diagnosis by the referring agency, it implies that the referral agency also has responsibility in determining the service to be provided. (This should not be done when the patient is on the doorstep.)
4. Both agencies should have a clear understanding of their responsibility at the point of referral.

The above considerations also suggest that serious reflection should be given to selection methods used by agencies in giving service. This particularly applies to some of the cases of the study. For example, a very specific set of priorities for selection would establish criteria for giving service. Investigation regarding the care of children, and the consideration of preventative measures on their behalf would suggest major priority. Where severe family disturbance is the major difficulty, aggravated by financial need, the consideration of joint community service in such cases poses serious consideration for the Assistance Agency, particularly in cases which are known to them before the mental breakdown of one of the parents. Not all public assistance agencies are able to accept work with families. When financial need was met in the cases studied, the case was closed and there was no record of a referral to a family or children's agency even where family problems are indicated. As long as it is necessary for the public assistance agency to close the case when the patient is no longer in need of financial aid, even though other social adjustment problems are evident, serious gaps in community services to clients will continue to jeopardize the patient's rehabilitation. At the point when closure seemed imminent consultation with related agencies may have made much needed service available.
Suggestions Recommended by the Study

In all cases studied the City Social Service Department carried through most adequately its responsibility for meeting financial need within the provisions of the law. It gave adequate medical services as defined by present policy. The recording of the services given, as formulated in their policy, was clear and the data easily obtained.

Because adjustment problems shown in the case records point out the need for more extensive social work coverage in order to meet all adjustment needs, the following points are suggested.

1. That regular consultation between the Grease Clinic Social Service Department and the City Social Service Department be re-commenced, that clearer definitions of policy and related responsibility for services may be formulated.

2. The establishment of a small specialized department, staffed by experienced professional social workers to be responsible for a smaller, more selective caseload to give comprehensive casework services to eligible families (including the eligible families of discharged mental patients, and eligible discharged mental patients where rehabilitation is a possibility).

3. An alternative to this plan would be granting of financial aid while specialized community agencies give services to meet other major problems. The element of prevention would be recognized and ultimate economy to the
agency would result.

3. Consideration of adapting the rural policy of an all round service to meet urban needs. This would involve continuation of service beyond financial eligibility.

4. Each of the above considerations would involve the agency in establishing a very efficient screening and referral service.

5. The establishment of and regular consultation with a selected community agency committee to consider the involved problems in many of these cases, and to suggest methods of service.

Conclusion

The study has examined the cases of fifteen discharged mental patients who, in 1954, were referred to the City Social Service Department. Examination of the psychological and social problems involved in the patient's hospitalization and eventual discharge to the community, has revealed the necessity for the re-commencement of regular consultations between the administration of the Crease Clinic Social Service Department, and the administration of the City Social Service Department.

Because of the special difficulties of the discharged mental patient which involves After-Care Services, the study has suggested the value of a Community Resource Planning Conference between The Psychiatric Hospital
administration and the representatives of Selected Community Agencies.

The study has made suggestions whereby the City Social Service Department could more adequately meet the total welfare needs of selected clients, including the eligible discharged mental patient. Recognition has been made of the fact that the City Social Service Department is meeting specific economic and physical needs, but because of present policy the psychological problems of most of the patients studied were unmodified at the closure of the case. In cases where severe major family difficulties were evident, the patients were not referred to other agencies for continued service. It is recognized that the policies of other community agencies may impede this, and may give rise to the need for clearer statements of policy from agencies. Ideally the written statements of policy of all community agencies should be freely exchanged and used in the interest of better services to clients.

A further research study might be undertaken at the City Social Service Department to examine the use made of community resources upon closure of a case where further problems are involved in the psychological difficulties of the individual or family concerned.

In the rehabilitation of the discharged mental patient, the community has a large stake. Psychiatric treatment is a means to an end. The objective is rehabilitation,
the return of the patient to the community and his functioning in that environment in a reasonably adequate and satisfying way, for it is within the patient's world of human and social relationships that rehabilitation is finally achieved.

In progressive thinking public assistance programmes the objective must be the prevention of dependency and psychological malfunctioning that the rehabilitation of the client to usefulness and functioning in his environment in a reasonably adequate and satisfying way might be achieved.

---


This report was not available in time to be used in this study. The recommendations dealt with on pp. 112 to 121 indicate that the suggestions made in the present study in some measure are substantiated by the findings of the larger research project.
Appendix A.

Schedule Used at the Grease Clinic

1. a) name and b) Number.

2. a) Sex. b) Age.

3. a) Marital Status. b) Number and ages of children.

4. Employment Record.

5. Education.

6. a) Date of Admission. b) Date of Discharge.
   c) Date of Social Service Activity.

7. Condition upon Discharge.
   a) Improved. b) Unimproved.


10. Social Problems:
    a) Employment. b) Financial.
    c) Housing. d) Family. e) Other.

11. Recording Notes.

Appendix B.

Schedule Used at the City Social Service Department

1. Number.

2. Known previously to the Agency.

3. Classification of Problem.

4. Other Services Given.
   a) Referral to Other Agencies.

5. Closed or Active at Present Time.

6. Condition upon Closure.

7. Reasons for Closure.

8. Recording Notes.

Appendix C.

Brochure of City of Vancouver Social Service Department

Under authority of the City Charter and the Social Assistance Act, the Social Service Department provides cash allowances and a variety of supplemental services to citizens in need of and eligible for financial assistance.

The department is provided for in the budget of the City of Vancouver and is responsible to the City Social Services Committee.

Social Assistance

As the Municipal Public Welfare Department, services are provided to residents of the city of Vancouver who qualify for assistance in the following categories:

Social Allowance

Under the Social Assistance Act, provision is made for cash allowances, on a means test basis, to those who are destitute and unemployable, and who have resided in the Province of British Columbia for one year continuously.

Allowances are paid monthly by cheque at the following maximum rates:

Grp. 1  Grp. 2  Grp. 3  Grp. 4
$45 + $5  $69.50 + $5  $83.50 + $5  $97.50 + $5

Grp. 5  Grp. 6
$111.50 + $5  $125.50  $5 + $2.00
extra for each dependent.

The cost of providing this assistance is shared by the Municipalities and the Provincial Government.

Mothers' Allowance

Under the Mothers' Allowance Act, cash allowances are available, on a means test basis, to certain mothers who have one or more dependent children under the age of sixteen, and where the husband is unable to provide because of death, desertion, illness, etc.

Allowances are paid monthly through the Social Welfare Branch, Department of Health and Welfare, Victoria, B.C. at the same maximum rates as social allowances.
Three years' residence immediately preceding the application is required. The cost of providing this assistance is borne by the Provincial Government.

Applications may be made through the City Social Service Department.

**Old Age Assistance**

Under the Old Age Assistance Act, provision is made for cash allowances, subject to a means test, for those citizens between the ages of 65 and 69, who have resided in Canada for twenty years.

Old Age Assistance is paid at the rate of $40.00 per month by the Provincial and Federal Governments, to which the Provincial Government adds a bonus up to $15 per month to B.C. residents.

Application may be made at the Old Age Assistance Board, 411 Dunsmuir Street, Vancouver.

**Old Age Security Bonus**

Under the Old Age Security Act, provision is made for a cash allowance of $40.00 per month without a means test, to persons 70 years of age and over who have resided in Canada for twenty years. The cost of Old Age Security is borne entirely by the Federal Government, and all applications are submitted to the Director of Old Age Security, Victoria, B.C. Forms are available at any Post Office.

To supplement Old Age Security, the Province provides a cost of living bonus up to $15.00 per month, on a means test basis, to those who have resided in B.C. for three years immediately preceding the date of application.

Application for bonus is made at the Old Age Assistance Board, 411 Dunsmuir Street, Vancouver.

**Disability Pension**

Under the Disabled Persons Act, provision is made for the payment of cash allowances, on a means test basis, to any person over the age of 18 years, who has resided in Canada for 10 years immediately preceding the date of application. The applicant must be totally and permanently disabled as outlined in the Act.

Disability Pension is paid at the rate of $40.00 per month by the Provincial and Federal Governments, to which
the Provincial Government adds a bonus up to $15 per month to B.C. residents.

Blind Pension

Under the Blind Persons Allowance Act, an allowance of $55.00 per month, including bonus, may be paid, on a means test basis, to any person over twenty-one years of age who is blind and who has resided in Canada for ten years immediately preceding the application.

Application is made at the Old Age Assistance Board, 411 Dunsmuir Street, Vancouver.

Services

The following services are available to those in receipt of Social Allowance, Mothers' Allowance, Old Age Assistance, Old Age Security Bonus, Blind or Disabled Persons Pension:

Casework Services

Social workers on the staff, in addition to establishing and reviewing eligibility of persons in need of financial aid, provide a continuing counselling service to individuals in receipt of public assistance. It is the goal of the City Social Service Department to assist needy citizens, by understanding and individualized service, to use resources within themselves and community to achieve the greatest possible measure of self-dependence.

Medical Services

All recipients of allowances, on a means test basis, in the categories outlined, are provided with a Medical card, which entitles them to the services of their own doctor.

Drugs, hospitalization and specialist services, as prescribed by the attending physician, may also be provided. In cases where the recipient or his family are unable to provide recommended appliances, such as glasses, dentures, etc., these may be supplied through this department.

Boarding and nursing home care may be arranged according to the need and the accommodation available.

Dental services are also available to dependents (of less than 11 years of age) of persons in receipt of social assistance.
Housekeepers

In cases where it is advisable for an ill person to remain in his own home, or where children require temporary care during illness of a parent, housekeeper or homemaker services may be provided.

Nutritionist

A Metropolitan Health Committee nutritionist serves as a consultant to the Department to assist in questions of budgeting, nutrition, and special diets.

Area Served

The area served is within the boundaries of the City of Vancouver. For purposes of administration, the City is divided into four units, located as follows:

- Centre Unit
- West Unit
- East Unit
- South Unit
- Intake Section.
Appendix D. Bibliography


Garland, Ruth, "The Psychiatric Social Worker in a Mental Hospital," Mental Hygiene, April, 1947, National Committee on Mental Hygiene (U.S.A.).


