AN AID IN THE REHABILITATION OF MENTAL HOSPITAL PATIENTS

A Study of Women Discharged on Leave to the "Vista" Rehabilitation Centre in Vancouver, British Columbia.

by

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TABLE OF CONTENTS

TABLES

TABLE OF CONTENTS (continued)

Sophie Birch: An Aid in Rehabilitation of Mental Hospital Patients.

Abstract

This study is concerned with the contribution of "Vista" rehabilitation centre toward the re-establishment of women mental patients. "Vista" centre is an auxiliary service of the Provincial Mental Hospital and Crease Clinic of Psychological Medicine at Essondale, B.C., and was originated to meet the need of particular women patients who are ready to leave the hospital but who have no resources of family, friends, or finances to see them through the initial period after discharge when employment is sought and accommodation secured.

Material used was secured from the unit files of women patients at the Provincial Mental Hospital and the Crease Clinic, one year [fiscal 1950-51] being chosen for case reading. By means of a schedule composite indications were derived from entries by the psychiatrists, social workers, nurses, psychologists, laboratory technicians and the supervisor.

The patients studied were divided into groups according to the reasons for which they were admitted to the centre: Group I, lack of family resources; Group II, patient rejected by family; Group III, return to family inadvisable; Group IV, a bridge between hospital and home required; Group V, referral for visit and observation. Samples from each group are examined to illustrate the services of "Vista" and the capacity of the patients to benefit from the assistance offered.

"Vista" is able to accommodate only limited numbers and for a limited period, and is not equipped to offer varied degrees, or varied lengths, of supervision that the many patients who are ready for discharge may require. "Vista" served very successfully as a bridge between the hospital and the community those patients who were ready to take employment, to become settled in living quarters by themselves, or return to their families after a brief sojourn at "Vista." But the sample cases show that other aids such as foster homes for mental patients need to be considered for the individuals for whom further hospitalization is not necessary, but for whom an indefinite placement in a protected environment under supervision appropriate to the particular stage of their recovery is indicated.

Acknowledgements

This study was made possible through the use of the unit files at the Provincial Mental Hospital and Crease Clinic. The writer is indebted to Dr. A. M. Gee, Medical Superintendent, for making these records available.

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CHAPTER 1

DEVELOPMENT IN TREATMENT AND SERVICE

Rehabilitation of the mentally ill has been the underlying philosophy of all the individuals who have been responsible for the care of the mentally ill from the earliest history of British Columbia to the present day. The objective has been the "restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable."[1] While many new methods of treatment have been discovered or applied over the years, there has been a lack in the preparation of the patient for his return to his family and to the community, a vital stage for many patients.

The "Vista" rehabilitation centre is an auxiliary service of the mental hospital and was opened to meet the need of women patients who were ready for discharge from the hospital but "who had no resources of family, friends, accommodation, or finances to see them through the initial period after discharge when job hunting is done and living quarters are found."[2] The

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1 This definition was adopted by the National Council on Rehabilitation, August, 1943.

2 Annual report on "Vista" for the fiscal year 1950-51 submitted by Dr. F. McNair, Assistant Clinical Director, Provincial Mental Hospital, Essondale, B.C.

"Vista" centre, on which this study is focused, became a part of the hospital treatment and rehabilitation programme long after the mental hospital was first established. However, before proceeding with a discussion of "Vista" and its place in the organization of the Mental Hospital, it might be worthwhile to take a quick look at the history of the development of the Mental Hospital in British Columbia.

It is interesting to note that it was not until the appearance of women mental patients that any action was taken by the Provincial Government authorities to provide a hospital for the mentally ill. The problem of caring for mentally ill persons in the early years was solved easily by sending the patients back to Britain. Obviously this method was not practical in all cases, and subsequently the mentally ill were shipped to California to be cared for in mental institutions there. As was to be expected, the California authorities soon objected to this practice; but they did offer to continue to accept the mental patients from British Columbia in their institutions if provision was made for their maintenance. This suggestion was not acted upon by the British Columbia government; therefore the new patients, as they appeared, were kept in gaols or the Royal Hospital in Victoria, depending upon the severity of the disturbance. However, when a woman patient appeared, it became necessary to make some new and different arrangements, as both the gaols and the Royal Hospital were restricted to the male sex. As a result, a hospital for women was opened. In time, this plan

was discarded. The women's unit became the general hospital, and the old Royal Hospital was converted into an "insane asylum" for both men and women. The first mental hospital in British Columbia was thus set up. It was opened in 1872, and continued to serve this function for five and a half years. The Provincial Secretary's department took charge of the new institution, and its management has been under his department ever since.

By 1873, an "Insane Asylums" Act was passed, placing the administration of the hospital in the hands of the Medical Superintendent and a supervisor of the Asylum; the former was non-resident, and the latter a resident layman whose duty it was to look after the internal economy and discipline. The Act provided that a "lunatic" should be committed to the "asylum" upon certification of two medical practitioners who were obliged to examine the patient together rather than independently as is the practice today. Little was known about the patient's background as no provision was made for statistical forms or for relatives to submit information. As yet, there were no social workers to contact relatives for social histories, to help the patients deal with problems in their social situations and to help the relatives to gain a greater understanding and acceptance of the patient.

Early Treatment Facilities

But even at this early date, consideration was being given to restoring the patient's capacity for interpersonal

relationships and his relationship in the group as a whole, as well as to help him acquire some confidence in his ability to adapt himself to social situations outside the hospital. The emphasis was on kind and humane treatment of patients. An attempt was made to provide patients with comfortable living quarters and a plentiful supply of good nourishing food which was considered as being of paramount importance in the treatment of the mentally ill. This is as true today as it was in these early days. The need for segregation of the acutely ill and the convalescent was also recognized at this time. The hospital personnel kept in mind that patients would be returning to their homes; every effort was put forth to keep alive their interest in activities in which they would normally participate outside the hospital. Patients were permitted to go for walks on the grounds, to use the reading room, and to attend the Divine Services and to enjoy the games and the dancing. There were no specially trained occupational therapists and recreational directors in those days, their duties being performed by the nurses and interested lay people. To help the patients keep abreast of current events, a local newspaper gave a free subscription to the hospital for several years.

Change of Location and Increase of Accommodation

Since this institution could only accommodate thirty-seven patients, overcrowding ensued and it soon became necessary to provide a larger institution and in a more suitable location.

The Royal Hospital was situated on an Indian Reserve and had originally been built for a pest house. The new location of the institution was the present site of the Woodlands School in New Westminster, the first building being opened during the fiscal year of 1877-78. Unfortunately, the new quarters left much to be desired insofar as comfort of the patient was concerned. There was no indoor plumbing and the supply of water for the institution was inadequate. The wards were sparsely furnished, heated by stoves and fireplaces and lighted with coal oil lamps.

During the next few years, many changes occurred insofar as the institution itself was concerned. Overcrowding had been a problem ever since the erection of the first building on the new site as a result of the increase of population in British Columbia, and of the habit of the British doctors of recommending the "shipping off of persons of incipient or borderline insanity or of moral depravity to the colony."[1] Therefore in 1889, an admitting building was erected and the old quarters changed to conform with new ideas. Recreation and entertainment were considered to be important contributing factors toward the improvement of mental health so were encouraged as much as possible. Therefore, in addition to provision of physical comforts, an amusement hall was acquired complete with a stage

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1 Report of the Medical Superintendent of the Provincial Asylum for the Insane, New Westminster, B.C., for the year ending December 31, 1897.

and piano, and volunteer lay persons were invited to assist with these activities.

By 1895, the medical superintendent's former residence was converted into a convalescent home for the women patients. Although this building was located on the hospital grounds, it was separate and apart from the other buildings. The home was the first to have electric lights, setting the precedent for the other buildings of the institution. There were many other changes, notably the provision of a proper day room, ample light and isolation for noisy patients.

As patients improved in health, their discharge was given much consideration. It was recognized that the family played an important part in the rehabilitation of the patient as it was felt that the "attention and care arising from the family affection was conducive to restoration of mental health."[1] In view of this, many patients were sent back to their families in Eastern Canada to ensure a more successful convalescence.

The year 1897 saw the passing of a new "Hospitals for the Insane Act" which changed the name of the institution from the "British Columbia Asylum" or "Provincial Asylum" to "The Public Hospital for the Insane". At that time, 310 patients were housed in ten wards and a cottage.

Of particular interest during this year was the discontinuation of concerts and other entertainment by lay persons

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1 Ibid.

for the patients as a result of complaints from patients' relatives. Subsequently, socials, group singing, dancing, and dramatics were introduced and patients were encouraged to participate. Lay individuals were permitted to attend by invitation only and usually only the genuinely interested persons and the relatives of the staff were invited. The patients seemed more at ease at such informal gatherings where there were fewer outsiders and since then, little, if any, use has been made of lay volunteers in the treatment programme.

The plan of removing chronic and incurable patients to their own homes and into the community was also introduced at this time. It is presumed that these would include the easily managed and not the severely disturbed persons.

New Developments in Treatment Approach

The turn of the twentieth century saw a more organized approach to the treatment of the mentally ill as well as a more progressive philosophy in the care of patients. "Restraint", which had characterized the early plan of treatment was dying away as there was gradually less need of it. Cure was not considered to be effected by one measure alone but rather by every means that would tend to build up the physical health and "to divert the mind from its morbid action."[1] The importance of good feeding, regularity of living habits and long hours of rest in the treatment of the mentally ill were stressed in the

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1 Report, 1901.

Medical Superintendent's annual report for the fiscal year 1900-01.

The first decade of the twentieth century marked the beginning of segregation of the chronic, feeble minded, and the infirm. Hydrotherapy, a new method of treatment, was accepted as an important innovation. Warm and cold baths, and a glass of warm milk were considered to be better than restraint, sedation, or locked doors.

By 1930, physical examinations were being done routinely at introductory examinations and a start had been made in family and personal history taking. Also laboratory tests in the new pathological laboratory had been added to the general examination. Overcrowding continued to be a problem, and subsequently the institution was moved to its present site at Essondale in 1913. The old buildings in New Westminster were converted into a Home for the Feeble Minded, presently known as the Woodlands School. The new institution was now being regarded more as a hospital than an asylum or an institution rendering only custodial care.

Introduction of Discharge on Probation

A recommendation for a social service department at the hospital was made as early as 1919 by the Canadian National Committee for Mental Hygiene. The Committee suggested the employment of one or two social workers in connection with the Mental Hospital, with a view to increasing the number of patients

to be placed on probation. As early as 1901, patients had been allowed to leave the hospital on a six month trial basis and if their adjustment proved satisfactory during that period, they were discharged in full. The Committee felt that the recovery would be more lasting if the patients could be assisted in their rehabilitation by social workers, thus obviating a possible return to the hospital. They believed re-admission was frequently the result of lack of sympathetic understanding on the part of the relatives in addition to absence of adequate supervision, both so essential to probationers. However, the social service department was not inaugurated until 1930, although Dr. F. Crease, Medical Superintendent of the Provincial Mental Hospital, recommended its establishment in his annual reports to the Provincial Secretary.

Establishment of Social Service Department

The social service department was organized by Miss J. Kilburn, a public health nurse with psychiatric social work training. The chief aim and purpose of the new department was to secure more detailed information regarding the home life and conditions of the patients which heretofore had not been obtainable. Such information was of value because any contributing factors to a patient's breakdown could be dealt with prior to his return home; otherwise, his improvement might not be as lasting. A follow-up of a patient after discharge and assistance in re-establishment in the community was another function of the Social Service Department.

This development was soon followed by the opening of a Child Guidance Clinic in Vancouver in 1932, again at the recommendation of the Canadian National Committee for Mental Hygiene. Thus the trend was moving from custodial care and rehabilitation alone to include prevention. The underlying philosophy of this new service was to prevent possible breakdowns in adulthood by means of casework service through environmental change, vocational guidance and correction of poor habit formation for those children who were experiencing difficulties at home, at school, and in the community.

In 1935, a Child Guidance Clinic was opened in Victoria, and cooperative work with the Welfare Field Service was established, thus providing a coverage of the entire province insofar as social services to the patients and families were concerned.

More Recent Developments in the Treatment and Care of the Mentally Ill

The ensuing fifteen years produced many new developments in the areas of treatment, rehabilitation and segregation. Dr. Crease, who had succeeded Dr. Doherty as Medical Superintendent, later becoming Provincial Psychiatrist, worked unceasingly for many years towards a programme of active treatment and prevention. Division of function and segregation brought about the Woodlands School for the training of the feeble minded, the Homes for the Aged for custodial care of aged individuals, whose symptoms are predominantly mental, the Essondale Hospital for treatment of

mental illness, the Child Guidance Clinics in Vancouver and in Victoria, and one travelling clinic and Delinquency Unit. The most recent development has been the establishment in 1951 of the Crease Clinic of Psychological Medicine, the purpose of which is to treat patients suffering from early symptoms of mental illness in which recovery may be expected within four months.

The treatment of the mentally ill includes the whole physical medicine as well as the more specific therapies pertaining to psychiatry. The treatment and the rehabilitation of the patient embrace the services of a group consisting of the psychiatrist, nurse, psychologist, social worker, teacher, occupational, and recreational therapists together with all others who contribute to the well being and comfort of the patients.

"Vista" Under Private Sponsorship

The social worker with her understanding of the individual, the nature of human relationships, and knowledge of community resources, had been able to help strengthen the healthy aspects of the patient's personality by assisting him to adjust to reality problems with increasing emotional satisfaction. However, there were a group of patients who could not be helped to re-establish themselves because of lack of adequate resources in their community. These were women patients who, although they did not require further hospital care, did not have any resources of family, friends, or finances

to see them through their convalescence. There were no resources outside the hospital to meet their particular need.

Mr. E. E. Winch, M.L.A., while visiting some patients on the ward, was approached by one such patient and his assistance was requested in this regard. He consulted with the Medical Superintendent and subsequently took this patient into his own home. He proceeded to interest the public in the plight of such patients and, in time, an organization was formed under his sponsorship which did not have a name but which consisted of four members, two men and two women. These people recognized that some patients were not capable of accepting employment and of living alone immediately after leaving the hospital but that they required a period of convalescence in a sheltered home of interested persons not related to them. The purpose of the organization was to help to rehabilitate from the Provincial Mental Hospital at Essondale patients who had no families and whom the medical superintendent was willing to discharge if someone would accept responsibility for them.

In time, the organization decided that a rehabilitation or convalescent home would better meet the need of such patients. Funds were raised and a large home with bed capacity for seven was located in a residential district at 3181 West Second Avenue in Vancouver. The organization, now known as the "New Vista Society," ran into many difficulties. Real estate men hesitated to rent or to sell a dwelling for such a purpose as

householders objected to having such a home in their neighbourhood and the city of Vancouver was reluctant to grant a license for the same reason. However, the home was opened without a license in January 1944 and became known as "The New Vista" with an ex-patient as the first supervisor. During the first year of its operation, twenty patients passed through this centre.

In February 1945, Mr. Walker, Deputy Provincial Secretary, commended the idea of "government institutions for patients who were ready for discharge on probation if only they had a place to go."[1] As a result, Dr. Crease recommended the purchase of the "Vista" from the "New Vista Society" emphasizing the fact that the home should have little or no hospital features, be well situated in the city geographically and have a "home feeling about it." The purpose of such a home was to aid the hospital in discharging female patients and to help the patients return to civilian life once again.

"Vista" under Government Administration

Thus in March 1947, Mr. Pearson, Provincial Secretary, speaking for the Executive Council agreed to take over "Vista". The staff as recommended was to consist of a supervisor, housekeeper and part-time janitor. The supervision was assigned

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1 Information obtained by Dr. F. McNair, Assistant Clinical Director at Provincial Mental Hospital, Essondale, from personal correspondence of Dr. Crease.

to the Provincial Supervisor of Psychiatric Social Work at the Hospital.[1]

Provincial Mental Hospital patients commenced going to "Vista" on May 15, 1947. During the fiscal year 1947-48, twenty-five patients were rehabilitated through "Vista". Miss Kilburn, Provincial Supervisor, in her annual report for this year, spoke favourably of the experiment since it gave the women patients an opportunity to take up life again, and had the added advantage of beginning their rehabilitation gradually and at the same time providing them with a home and counselling service. The patients were able to enjoy a homelike atmosphere while becoming accustomed to living in the community. Those cared for in the home were reported to show more security and consequently were more successfully rehabilitated than those who did not have this opportunity.

Thirty-four patients were rehabilitated through "Vista" during the fiscal year 1948-49 and thirty-two during the following year. The year 1950 marked the beginning of regular weekly visits by the assistant clinical director who passes on all admissions and discharges. All patients are considered "on leave" from the Provincial Mental Hospital while in "Vista". Prior to January 1952, the social workers did not continue their contacts with patients while the latter were in "Vista",

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1 Information obtained by Dr. F. McNair, Assistant Clinical Director at Provincial Mental Hospital, Essondale, from personal correspondence of Dr. Crease.

but resumed their supervision after the patients had left "Vista". At present, the contact is not interrupted by patients going "on leave" to "Vista", so that continued casework service is available to the patient throughout the whole period of treatment and rehabilitation.

Patients selected for "Vista" are prepared for placement there by the attending psychiatrist. They are advised that the management of "Vista" is cooperative and that each patient is expected to assist with some of the household duties under the direction of the supervisor, who is in reality a "house mother." The patients are requested to keep the supervisor posted on their activities while they are in her care.

Method of the Present Study

The purpose of the present study: to examine in detail the kind of work done in this particular type of rehabilitation centre, and to assess the role which such a unit can play among the facilities needed for the mentally ill. "Vista" was, and perhaps still is, a demonstration or an experimental project.

When this study was projected, "Vista" had been in operation for four years, and it is reasonable to believe that this can be considered a sufficiently long enough period to determine its contribution toward the re-establishment of the patients. One year, the fiscal year April 1, 1950-March 31, 1951, was selected for the case reading, and was appropriate measure. Regular weekly visits by the assistant clinical director to patients at "Vista" and closer supervision of the

patients on probation by the social workers were begun at this time.

The unit files at the Provincial Mental Hospital are unusually comprehensive and contain entries by the psychiatrists, social workers, nurses, psychologists, laboratory technicians and the supervisor at the "Vista". The psychiatrist's report generally includes the findings of the physical examination, a social history obtained from the patient, the psychiatrist's comments concerning the patient's general appearance and behaviour, her pre-occupations, mood, intellectual reactions and insight, as well as the diagnosis and prognosis. In addition to this, the psychiatrist's notes contain progress reports on the patient and other pertinent observations. The nurse's records consist mainly of daily reports on the patient's condition and progress in hospital. The social worker contributes social history information on the patient as obtained from relatives and other interested persons and a summarized account of subsequent contact with the patient, psychiatrist, members of the family and others on the hospital treatment team. The psychologist's reports include the results of the psychometric tests, which reveal the patient's intelligence rating, aptitude, degree of mental deterioration and an evaluation of the personality. Results of x-rays, basal metabolism tests and other laboratory tests are included in the reports of the various technicians. An evaluation of the patient's adjustment at the "Vista" prepared by the "Vista" supervisor, is also on

the patient's file. The material for this study was secured, therefore, from these unit records, and was collected according to a schedule.

CHAPTER 2

THE SELECTION OF PATIENTS

For some time the rehabilitation of women patients who had no resources of family and finances had been presenting a particularly difficult problem. Accommodation, so essential to a patient's adjustment to society is a primary problem of rehabilitation. It was also found that a Vancouver address is of utmost importance while a job is being sought. As rents are usually payable in advance, temporary shelter until the patient becomes financially independent, is paramount. In addition to the above needs, many patients also required a short period of convalescence in a protected environment. Thus "Vista" was established to meet a very real demand for an aid in rehabilitation.

In the course of the development of "Vista", the social worker's role in relation to the patients living there has changed somewhat. Prior to January 1952, the social worker did not visit the patient while the latter was in "Vista", but she resumed her contact after the patient's discharge from the centre. The responsibility for social work with the patient on leave at "Vista" was carried on by the Provincial Supervisor of Psychiatric Social Work in collaboration with the assistant

clinical director, and the latter made regular supervisory visits to the patients. The responsibility for job placements and procuring suitable accommodation rested with the "Vista" supervisor. At present, however, the social worker visits the patient at the "Vista" and it is she, rather than the supervisor at the "Vista" who helps the patient with plans for rehabilitation.

Selection of Patients

The patients referred to the "Vista" are carefully selected. In the main, the patients have recovered sufficiently from their illness for return to the community. In spite of their remission, these women still have a need for sympathetic understanding and encouragement during their period of convalescence. Some of the patients may not have families with whom they can stay while looking for employment; others might have families to whom it may be considered inadvisable for them to return. The latter need help to re-establish themselves apart from their families, whether or not they are wanted by their relatives. Such patients remain in the "Vista" for a relatively short time. The greater percentage of "Vista" patients require assistance in securing suitable accommodation and employment. Another group of patients, and these are relatively few in number, are transferred to the "Vista" for the purpose of obtaining further training in some vocation before they proceed to re-establish themselves in the community.

Some other patients are referred to the centre for observation prior to going to out of city homes. In all probability, such patients did not have the privilege of weekend leaves during their hospitalization to explore their ability to function outside the hospital, as could those who had relatives or friends near the hospital. These particular patients are thus given an opportunity to prove to themselves and to their psychiatrist that they can function satisfactorily away from the protective environment of the hospital. Patients who have been long term hospital residents usually require a proportionately longer time in "Vista" before discharge arrangements can be worked out. Still another group whom the "Vista" has served, are patients who require continuing permissive therapy and support during rehabilitation in order to expedite discharge. Such patients still need some supervision and contact with the doctor so that they may again gain sufficient self confidence to face people and return to their family or the community. In some instances, patients without financial resources and who secure employment may remain at "Vista" until they have received their first pay check. In short, patients who are referred to "Vista" are sufficiently recovered to be considered satisfactory candidates for eventual rehabilitation into the community.

Before the patient is placed in the "Vista," ". . . preliminary interviews and assessments are undertaken by . . . the Provincial Supervisor of Psychiatric Social Work and her

staff in cooperation with the patient's attending doctors."[1] The patient is advised that she will be on "leave" from the Provincial Mental Hospital or the Crease Clinic. She is told that she will be encouraged to participate in the management of the centre, which is operated on a cooperative basis insofar as the household duties are concerned, but under the direction of the supervisor. The patients are also informed that the supervisor should be treated as a housemother and that, although patients have considerable freedom to come and go as they please, they are required to report their activities to her while in her care.

Characteristics of Patients Studied

In the fiscal year 1950-51, approximately forty-three patients were discharged on leave to the "Vista" from the Provincial Mental Hospital and the Crease Clinic. According to the annual report, thirty-seven of these were satisfactorily rehabilitated; this represents ten per cent of the total number of 373 women patients who were discharged from the Provincial Mental Hospital and the Crease Clinic to the Community during this period. As three of the patients' files were not available, the records of only forty of the patients who were referred to "Vista" during the fiscal year 1950-51 have been read and analyzed.

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1 "Vista"--Physician's Manual, prepared for the Hospital Medical Staff.

This study is of necessity descriptive in character due to the limited amount of information to be found concerning patients following their discharge from "Vista." The material was incomplete on a number of files in regard to background information and patients' adjustment both at "Vista" and while on probation.

The information which was secured according to a schedule included statistical material; particulars regarding illness and hospitalization; social resources and rehabilitative adjustment.[1]

Of the forty files studied, twelve did not have any reports regarding the patient's adjustment at the "Vista" although limited information on some of the patients was secured from other sources such as the psychiatrist's notes and the social worker's recording on follow-up contacts. There was, also, no available information in seven files concerning the patients' adjustment following discharge on probation from "Vista." It is not known whether the social workers resumed their contacts with the patients after they left "Vista" and did not record their interviews, or whether the visits had not been renewed. As these patients have not returned to the hospital, however, it is assumed that they were able to re-establish themselves satisfactorily in the community.

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1 Appendix, p. 67.

Diagnostic Differentiation

The analysis of the diagnosis of the patients studied reveals that a variety of illnesses are represented, including schizophrenia, manic depressive psychosis, psychoneurosis, psychopathic personalities and alcoholism.

Table 1. Distribution of Patients According to Diagnostic Categories

Diagnosis	Number
Schizophrenics	19
Manic-Depressives	5
Psychoneurotics	9
Other (a)	7
Total	40

(a) Includes psychopathics, alcoholics, post-lobotomy patients and inadequate personality patients.

It would appear that the schizophrenics form the largest group. This is not unusual, insofar as the selection of patients for "Vista" is concerned, as schizophrenia is considered to be one of the most frequent major psychoses. One estimate indicates that fifteen to twenty per cent of the first admissions to public hospitals for mental diseases are schizophrenics.[1] According to one of the most acceptable authorities

1 Arthur Noyes, Modern Clinical Psychiatry, Philadelphia and London, W. B. Saunders Company, 1948, p. 358.

in the field, in the "normal," "average" or socially well-adjusted individual there is a "certain orderliness" and "harmony" in the mental life. "The various expressions of personality blend into a coherent composite picture. . . Thought is logical, feeling is congruous, action more or less expedient and fitting, and sentiments are characterized by a subtle blending of affect and idea."[1] In contrast to this, a schizophrenic breakdown is characterized by

> ...disturbances in the harmonious blending and coordination of the various elements and aspects of the personality. In this disorder of personality, functional mood tends to be inappropriate, thought disorderly and maladaptive. Some parts of the disorganized personality system continue to function in relation to reality while others do not. 2

> A large percentage of schizophrenic disturbances occur in persons who have been "shut in," have presented a barrier of remoteness and have withheld themselves from spontaneous emotional relationships with others. The resulting situation has been one of separateness, self concealment and psychological isolation within which the patient has maintained an autonomous inner emotional life... There is reason to believe that environmental factors are extremely important in the development of personality features that predispose to schizophrenic disorganization... Among these factors are early conditioning experiences, intrapsychic conflicts, insistent drives and urges, feelings of guilt or of insecurity, as well as various other long standing, troublesome problems and frustrated purposes. 3

This maladaptation or maladjustment shows itself in patient's inability to meet successfully the environmental

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1 Ibid., p. 351.

2 Ibid., p. 351.

3 Ibid., p. 356.

stresses and the internal difficulties. The goal of treatment, therefore, is to discover and modify the factors and problems which have acted as disorganizing forces on the personality and to relieve special symptoms, particularly those that are troublesome or dangerous to the patient or disturbing to others. In short, the patient is helped to correct his faulty habits and thinking, to redirect his interest to things outside himself by encouraging participation in socialized activities at first in the hospital and later in the community. Most patients who are referred to "Vista" are able to compete successfully, enjoy satisfying social skills, and are capable of meeting failure with renewed effort. However, some residual symptoms may continue to present handicaps to a degree where the patient may be unemployable or live in an unprotected environment.

Manic-depressive psychoses show wide variations in frequency, according to Noyes. He estimates that approximately ten per cent of the admissions to mental hospitals are patients suffering from this psychosis.[1] He goes on to say,

> ...there are two well-defined types or phases of manic-depressive psychosis: a manic or excited phase and a depressive phase. While the disorder assumes typically the form of psychotic episodes separated by intervals of mental health, it may happen that a person may never suffer from more than one episode, or again the disorder may become continuous. These episodes may be in the nature of a manic or of a depressive reaction, there is no constant

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1 Ibid., p. 329.

sequence or alternation of these reactions.[1]

Although no conclusive causes of the manic-depressive psychosis are known, there is the belief,

> ...that psychogenic factors play an important role, and that mentally dynamic factors are rarely, if ever, absent.... In many instances, for example, particularly among persons of middle life or later, one finds that difficulties in adjusting to changes in environment or threats to social, economic, or physical security may serve as precipitating factors in a depressive attack. 2

Noyes states that one important feature of manic-depressive psychosis is the fact that even repeated episodes as a rule do not affect the mind in its "intellectual," "affective," and "conative" aspects, and that a disorganization of the personality does not follow.[3] Of great importance, also, is the fact that

> ...the patient's pre-psychotic personality traits influence the prognosis both as to duration and outcome. If he has shown himself to be flexible, tolerant, conciliatory, without defensive, compensatory, or other signs of a deep sense of insecurity, and has had varied and wholesome interests the prognosis is more favourable than if his personality patterns have been of the opposite type. 4

Treatment is geared toward removing the symptoms and helping the patient to acquire a ". . . constructive understanding of himself, his assets, short-comings and handicaps, that a greater

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1 Ibid., p. 329.

2 Ibid., p. 329.

3 Ibid., p. 344.

4 Ibid., p. 344.

inner harmony and a less disturbing adjustment may follow."[1] An early sign of recovery is generally a return of self-confidence and initiative but a patient should be relieved of the necessity for making decisions until he is well on the road to recovery. A prolonged convalescence with a gradually increasing participation in occupational and recreational activities as well as the resumption of full duties is generally recommended.

"The psychoneuroses comprise a relatively benign group of personality disturbances that may be thought of as being intermediate or as forming a connecting link between various adjustmental devices unconsciously utilized by the average mind on the one hand and the extreme, often disorganizing methods observed in the psychotics on the other."[2]

> In the psychoses the distortion or disorganization of personality is often great, whereas in the psychoneuroses the personality remains socially organized. In the psychoneuroses inner experiences do not upset external behaviour to the extent or in the abnormal manner that occurs in psychoses. 3

Apparently, in the psychoneurotic there is no grave interference with the patient's ability to meet the realities of life. Psychoneurotics are described by Arthur Noyes as ". . . individuals who are unusually sensitive to tension and conflicts

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1 Ibid., p. 350.

2 Ibid., p. 270.

3 Ibid., p. 272.

of life, persons who have never really faced its problems and are especially prone to deal with tensions, wishes and conflicts by the faulty reactions we designate as neurotic symptoms."[1]

According to Noyes ". . . a psychopathic personality is a term applied to various inadequacies and deviations in the personality structure of individuals who are neither psychotic nor feeble minded yet are unable to participate in satisfactory social relations or conform to culturally acceptable usages."[2]

As has been illustrated, patients and their needs are different and, as a result, there is flexibility in the use of staff and treatment. The social worker has a particular contribution to make toward the patient's rehabilitation. With her understanding of the individual and human inter-relationships, she is able to strengthen the healthy aspects of the patient's personality by helping the patient to adjust to reality problems. The social worker helps the patient to use his capacity to meet the demands of everyday living as effectively as possible and in whatever social settings that patient may find himself. The social worker through her knowledge of the social situations, environmental factors and community resources contributes to the diagnostic study,

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1 Ibid., p. 281.

2 Ibid., p. 410.

determination of treatment and rehabilitative plan. Following discharge, the social worker in her frequent contact with the patient, particularly during the early months of rehabilitation, helps the patient to think through her feelings about problems and meet the demands of every day living.

If the patient has a family, the social worker performs an important service by helping the family to meet their feelings about their relative, problems related to hospitalization and rehabilitation of the patient. There is reason to believe that patients who have contact with a social worker following discharge adjust more satisfactorily in the community than those who do not have such supervision.[1]

Age and Diagnostic Distribution

Age distribution, when studied, revealed that approximately three quarters of the patients are under fifty years of age, the average being around forty-one years. Although the diagnostic distribution has already been discussed, it is of interest, however, to see the relation between age and diagnostic distribution.

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1 Personal interview with Dr. McNair, Assistant Clinical Director, Provincial Mental Hospital and Crease Clinic.

Table 2. Relation between Diagnosis and Age Distribution

Diagnosis	Age Groups						Total
	Under 20	20-29	30-39	40-49	50-59	60 and over	
Schizophrenics	-	5	6	4	2	2	19
Manic-Depressives	-	1	-	1	2	1	5
Psychoneurotics	1	1	2	2	1	2	9
Other	-	2	1	3	-	1	7
Total	1	9	9	10	5	6	40

Education and Employment Classification

The educational pattern seems to be more or less evenly distributed; the largest number having received grade twelve education as is illustrated by Table 3. It is noted that, in the main, the patients with high school education also have had additional training in specialized fields such as nursing, teaching or business. The average education of the group studied was grade nine but sixty per cent of the patients had partial high school or better.

Unfortunately there is insufficient information regarding the work histories of some patients to be able to secure an over-all picture of their employment adjustment as a group. However, it is noted that the patients who had a poor record prior to their admission, generally had some difficulties in adjusting satisfactorily in their employment following their discharge, whereas others who had enjoyed a good adjustment on their jobs seemed able to re-establish themselves more readily

and more effectively.

Table 3. Employment and Educational Classification

Employment	Educational Grades					Total
	1-7	8	9-11	12	13	
No employment	1	1	1	1	-	4
Domestic	5	4	2	2	1	14
Factory	1	1	2	-	-	4
Clerical	-	1	4	3	1	9
Trade	-	1	1	1	-	3
Professional	-	-	-	5	1	6
Total	7	8	10	12	3	40

By "domestic," in the table above, is included not only the housekeeping services but also hotel maid, cook, farm work, ward aid and waitress. "Clerical" includes stenographer, sales clerking, bookkeeping, etc. "Factory employment" is self-explanatory. "Trade" refers to such vocations as beauty parlour operators, telephone operators and dressmakers. The "professional" classification embraces the teaching and nursing professions. Some of the patients who had not been employed prior to their admission to the hospital were girls who married soon after they left school or who had been incapable of taking employment as a result of the onset of illness.

The results of a patient's referral to "Vista" can be

evaluated either in terms of the immediate outcome of the original placement or in terms of the status as of October 31, 1951. Of the total number studied, five patients were returned to the hospital, ten were discharged in full from "Vista" and twenty-five were discharged on six months probation being discharged in full at the end of that period if they maintained their level of improvement.

Table 4. Results of Patient's Referral to "Vista"
(Status as of October 31, 1951)

Status	Number	Per cent
Returned to hospital	5	12.5
Discharged on probation	25	62.5
Discharged in full	10	25.
Total	40	100

Of the five patients returned to the hospital, two showed recurring symptoms. One who had been in the hospital for over ten years and had been sent on a visit to the "Vista" for a holiday and to ascertain her readiness for rehabilitation found the sudden change of environment too threatening. However, after a further period of hospitalization, she was able to re-establish herself outside the hospital with the assistance of her relatives and the social workers, thereby illustrating that

"Vista" had served as a stepping stone toward her final discharge. The remaining two patients were found to be incapable of functioning satisfactorily away from the protective environment of the hospital and were subsequently returned.

Of the number who were discharged on probation, one was re-admitted to the hospital following the termination of the probation period while another was returned before the probation period had expired. Two other patients who were discharged in full have since been re-admitted for further treatment.

Marital Status

The marital status classification showed three groups, namely: single, married, and other. The married women comprised only ten per cent of the group. These were mostly patients who came from out of the city and were selected for "Vista" to bridge the gap between a protected environment of the hospital and the demands of every day living as a member of a family group. The remaining ninety per cent of the patients studied were divided evenly between the single and those who had been married at one time but who, for the purpose of this study are considered unattached, and included the patients who are widowed, divorced, separated, and deserted.

Selection Classification

Patients selected for "Vista" fall into five groups.

Choice is made on the basis of any information on patient's background and the wishes of the patient herself. The groups are therefore classified as follows:

I. Patients who have no families or whose relatives are interested but are not in a position to assist actively in the rehabilitation.

II. Patients whose families have rejected them completely.

III. Patients for whom it is felt inadvisable to return to their families because of unsatisfactory physical environment and poor family relationships.

IV. Others go on a visit prior to their returning to homes beyond the city or just for a holiday from the hospital.

V. The final group consists of patients who go to "Vista" for observation to ascertain if they can hold their improvement before proceeding with plans for their rehabilitation.

Table 5. Family Status and Psychiatric Diagnosis

Diagnosis	Group					Total
	I	II	III	IV	V	
Schizophrenic	10	-	6	1	2	19
Manic-Depressive	3	1	1	-	-	5
Psychoneurotic	3	-	2	1	3	9
Others	5	2	-	-	-	7
Total	21	3	9	2	5	40

Period of Hospitalization in Relation to Rehabilitation Potentialities

The period of hospitalization does not seem to have a very noticeable effect upon the success of final rehabilitation so far as the group studied was concerned. Of the five patients returned to the hospital, one had been in the hospital less than one year, two had been hospitalized for two years, one had been in the institution for less than three years and the remaining one less than ten years.

Table 6. Period of Hospitalization of the Patients

Period	Number
Under 1 year	25
1 to 2 years (a)	9
2 to 3 years	2
3 to 10 years	3
10 to 20 years	1
Total	40

(a) More than 1, les s than 2 years; and so on.

Conclusion

It would seem from the foregoing that patients are selected carefully for age, symptomology, and lack of family and economic resources; but there is doubt that rehabilitative potentialities within the individual are the chief criteria.

The patients are prepared for the transfer; and while at "Vista," are assisted in locating suitable accommodation and employment if they are ready for discharge. If they are only on visit basis, they are encouraged to enjoy their new experience with a view to interesting them in working toward discharge at some future date. It can now be asked what contribution "Vista" made toward the rehabilitation of the patients studied, and this question is to be examined in the following chapter.

CHAPTER 3

SOME SAMPLE STUDIES OF PATIENTS

The purpose of the present study is not to evaluate the services offered by "Vista," but to judge the effect on the patients on the basis of such factors as the length of contact, the focus of services given, and the progress reports.

In order to secure a fairly representative group of patients, samples were chosen from each of the five groups used in the selection of patients for "Vista" [Table 5, preceding chapter]. Of the total number of patients who went to "Vista" during the fiscal year 1950-51, six returned to the hospital, seventeen were helped to locate suitable accommodation only, and the remaining twenty were assisted in securing employment and accommodation.[1] A few of the patients were not able to take employment, but arrangements were made for this maintenance either by their relatives or public assistance. Others who had been referred to "Vista" for a visit, left to live with friends or relatives outside the province [Table 5, Group IV, preceding chapter].

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1 Provincial Mental Hospital Annual Report 1950-51. Assistant Clinical Director's Report on "Vista."

Lack of Family Resources

A sample has been chosen from Group I to illustrate how patients without family resources have been assisted through "Vista" in their rehabilitation. The case of Mrs. A is presented because it is a good example of how a patient who has no available relatives, was helped to re-establish herself in the community.

> Mrs. A came to the mental hospital when she was 30 years old. The committing doctors[1] reported Mrs. A to be in "a state of anxiety," "depression," and "subjective confusion." She was also said to be expressing "paranoid delusions." Reportedly, Mrs. A had become increasingly paranoid, fearing that her common-law husband, who had deserted her, would harm her. At the time of admission, she was quite "tense," "tremulous," "quiet," and "withdrawn," but "friendly" and "cooperative." She told the psychiatrist at the hospital that she was "nervous" and worried about this. The psychiatrist believed that although she was expressing delusional material, there was some reality basis for these ideas. Mrs. A was diagnosed as a "paranoid schizophrenic."
>
> Little is known about Mrs. A's early life and her relationship with her parents. She had received grade VIII education and prior to her admission to the hospital had been employed as a beauty parlour operator. She deserted her husband a few months after the marriage because he had tuberculosis and was unable to support her. Approximately a year later and when she was still in her early twenties, Mrs. A entered into common-law relationship, which lasted seven years when her common-law husband deserted her. There were two children of this union. No information is available concerning Mrs. A's legal and common-law husbands or her marital adjustment. Following desertion by her second husband, she was granted social assistance.

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1 Before patients can be committed to the Provincial Mental Hospital, they must be examined by two doctors in reference to the state of their mental health.

It would seem that Mrs. A had an unusual degree of emotional dependence. When her legal husband was unable to care and provide for her because of illness, she deserted him. The desertion by the common-law husband resulted in her becoming fearful, hostile and depressed, necessitating eventual hospitalization. The protected environment of the hospital, active treatment and considerable supportive and group therapy on the part of the psychiatrists, nurses and social worker, helped to meet Mrs. A's dependency needs and to relieve her anxiety and depression. However, Mrs. A continued to harbour her paranoid notions against various members of her community. The psychiatrist believed that if she was not placed in a position of stress and anxiety after leaving the hospital, she might be able to manage satisfactorily.

As Mrs. A had no relatives who could help her during her convalescence, she was sent to "Vista." She continued her level of improvement in response to the encouragement and support she received from the psychiatrist who visited her weekly, and from the supervisor at the "Vista." Mrs. A was helped to secure a suitable housekeeping position by the supervisor and subsequently she was discharged on six months probation. Upon leaving "Vista," Mrs. A was visited regularly by the social worker who gave her considerable psychological support and reassurance. At the end of the probation period, Mrs. A was reported to have remained at the same employment for six months and was said to be quite happy in her work. She had

also adjusted well socially, having resumed her contacts with friends and a nephew. From the foregoing, it could be said that Mrs. A had made a satisfactory adjustment in the three major areas, namely, personal, social, and economic.

Mrs. A would appear to have benefitted considerably from her hospitalization and experience at the "Vista" where her dependency needs were met so adequately. In the security of the hospital and with continued support and encouragement, she was able to develop more confidence in herself and to move on toward greater independence to the point where she was not only providing for herself but was also saving money toward the day when she would be able to set up a home again for her children. "Vista" gave Mrs. A an opportunity to become accustomed once more to living in a family home and to participate in its management preparatory to taking employment as a housekeeper. "Vista," therefore, would appear to have served as a stepping stone toward final rehabilitation for Mrs. A.

Family Rejection

Group II represents cases of patients who have been rejected by their relatives. Mrs. J is a good example of this group and also of the type of patient who failed to respond to "Vista."

> Mrs. J was forty-two years old when she first entered the mental hospital. She was diagnosed as a "psychopathic personality with psychosis." At the time of her admission to the hospital, she was reported to be anaemic and suffering from haemorrhoids and sphincter incompetence.

> Reportedly, Mrs. J was a "child of change of life who had exhibited behaviour difficulties from early childhood." Apart from this, no further information was available regarding her early life and family relationships. Mrs. J's first husband was killed accidentally while the second husband became separated from her as a result of her immoral behaviour. Subsequently, she also became quite anxious and fearful although there was no reality basis for such feelings. Her condition became such that hospitalization was recommended by the local doctors.
>
> Psychometric tests revealed that Mrs. J fell in the borderline group of general intelligence although there was a question of the accuracy of this result because of her apprehensiveness in the testing experience. While in the hospital, Mrs. J was described as being pleasant, seclusive and submissive. After seventeen months of hospitalization it was felt that her remission was such that an attempt should be made to rehabilitate her and she was accordingly transferred to "Vista."

Mrs. J proved to be a very unsatisfactory patient at "Vista." She was unable to accept any guidance or direction in reference to employment and general welfare. She finally obtained her own employment and was discharged on her own probation. Although she was reported by the social worker to be doing good work at first, the record shows she changed jobs frequently because of her inefficiency. She was incapable of handling money, and her poor judgement in her choice of companions culminated in immoral behaviour. Subsequently, a recurrence of her symptoms necessitated re-admission to the hospital. Mrs. J was unable to benefit from the service offered to her by the supervisor and the social worker.

This is a good illustration of how "Vista" was unable to effect a successful rehabilitation for Mrs. J because of the limitations of its service. This patient with her lowered

intelligence and seclusive and submissive behaviour was able to carry over the adjustment she had made at the hospital and "Vista" to her job, but not into her personal life. When faced with the problem of handling money and choice of companions, she showed poor judgement and seemed incapable of meeting the demands of every day living in a realistic manner.

It is thought that Mrs. J might have been able to adjust outside the hospital under close supervision such as she would receive in foster home or family care. The programme of foster home care as another aid in rehabilitation is discussed in more detail in the next chapter.

Return to Family Inadvisable

Group III is comprised of patients for whom it is inadvisable to return to their families for various reasons such as over-crowded living quarters, patient's poor relationship with various members of the family, etc. The case of Miss N is presented as a good example of "Vista's" service to this type of patient for whom it is inadvisable to re-establish herself with her family.

> Miss N came to the hospital at the age of twenty-eight years. Her mental illness was diagnosed as "paranoid schizophrenia." Her complaint, at the time of her admission was that people were offhand with her, unfriendly and disliked her. She was hospitalized for four months during which time she received considerable supportive psychoterapy in addition to active treatment. At the hospital, she was reported to be exceptionally pleasant and cooperative. She got along well both with the nurses and the other patients.
>
> Family history revealed that Miss N had always been submissive toward her parents, the father being a

> rather rigid person while the mother was over protective and somewhat dominating. She received high school and business training and was reported to have been a bright student. Her work record showed that she was highly successful in her vocation, and prior to the onset of her illness, had enjoyed a good relationship with her superiors and fellow employees. Miss N had varied interests and on the whole led a satisfactory social life.

She responded favourably to the treatment at the hospital and in view of her parents' tendency to dominate her, she was encouraged to rehabilitate herself apart from her family. Miss N derived considerable benefit from the help offered by "Vista" insofar as employment and accommodation were concerned. However, there seemed to be some difficulty in her relationship with the supervisor. The attending psychiatrist had been encouraging Miss N to become more independent of her mother and with this in view he had encouraged her to re-establish herself apart from her parents. Her rather aggressive behaviour toward the supervisor, therefore, may have been her attempt to be less dependent and more self-assertive in her relationship with persons in authority, particularly older women. However, in spite of this difficulty, she received effective assistance with employment, accommodation and contact with community groups. According to the social worker who maintained a regular contact with Miss N during the probationary period, Miss N has adjusted very satisfactorily.

"Vista" as a Bridge between Hospital and Home

Group IV consists of patients who go to "Vista" just

for a holiday from the hospital or for a short holiday prior to returning home to considerable responsibility. Miss B is a good illustration of the latter.

> Miss B was only twenty-two years of age when she was admitted to the mental hospital. Her illness was diagnosed as "simple schizophrenia." In addition to active treatment, she received considerable supportive psychotherapy.
>
> Miss B had not been planned for and her mother was ill during the pregnancy. She had a rather unhappy childhood, having had to live with a rigid, dominating grandmother until she was nine years of age.
>
> During Miss B's separation from her parents, a brother was born who was three years her junior and to whom she became greatly attached. She was greatly upset by his death at the age of ten years. Two other siblings were born a few years later. Her father was a dependent person, unable to accept the responsibility of his role as a father and husband; the mother was an undemonstrative individual who tried to control Miss B through illness. The mother burdened Miss B with adult responsibility but at the same time was reluctant to help Miss B to develop and grow up emotionally. As a result, Miss B would pay lip service to the mother's demands for conformity but would engage in delinquent behaviour without her mother's knowledge.

It would appear from the foregoing that Miss B had matured insofar as physical development and achievement was concerned but was infantile in regard to forming satisfying and normal relationships with others. Her seeking love and attention which her parents had not provided in her early years resulted in her becoming involved with older men.

In the hospital, Miss B was reported to be quiet and cooperative, however, showing considerable spontaneity and animation before discharge. She had made a good remission but

in view of the fact that she was going to be faced with a great deal of responsibility upon her return home, it was thought that Miss B should have further supportive treatment and a brief holiday before returning home. At this time, Miss B's father was also a patient in a mental hospital and her mother was in receipt of treatment for an emotional upset in a local hospital. She was accordingly sent to "Vista" where the supervisor and the psychiatrist continued to build up her confidence in herself and help her feel that she was a worthwhile person. Following the patient's discharge, this supportive help was continued by the local social worker.

It is believed that this patient's need for a holiday and an experience bridging the gap between life in a protected environment and one filled with demands and pressures were well met at "Vista."

Referral for Visit and Observation

Group V is made up of patients who are referred to "Vista" for a visit but more particularly for observation to ascertain whether they are ready for rehabilitation. Miss M's case is a good illustration of this group.

> Miss M first came to the hospital when she was in her middle thirties. She was diagnosed as a "simple schizophrenic" and was admitted to the mental hospital with the complaint of being overly emotional, tense, vague in her speech and exhibiting inappropriate emotions.
>
> A psychometric examination at the hospital revealed Miss M to be a dull, apathetic individual; she tested in the dull normal group of general intelligence and showed deficiency in judgement and inadequacy in

her generalizations. It was thought, however, that the estimate could be faulty owing to the effect of her illness.

According to the social history, Miss M had never been accepted by her father as his child, although there was no reason for him to believe otherwise. As a result of the father's rejection, the patient became quite antagonistic toward him, blaming him for her failure in life. The mother was more understanding and tried to make up for the father's attitude but was not particularly successful in this regard. There was also considerable sibling rivalry between Miss M and her younger and more successful sister. Upon completing Grade IX, Miss M had an endless variety of jobs, including factory, domestic and waitress work. Her work was unsatisfactory and she could not get along with the other employees.

Miss M exhibited behaviour difficulties while in the hospital but, interestingly enough, prior to her going to "Vista," she had been reported by the nurses to have been little trouble and to have proved herself to be a willing and hard worker on the ward.

Miss M was chosen for "Vista" with a view to determining what possibility there might be for her rehabilitation, as she did not require further active treatment, but was being rejected by her parents. Upon arrival at "Vista," Miss M became quite difficult. She was unable to take direction or to accept any helpful suggestions regarding employment or her general welfare. She found a housekeeping position which later proved to be unsatisfactory. Although her employer was reported to have been a fairly understanding person, she could not tolerate Miss M's inefficiency and subsequently discharged her. Miss M returned to "Vista" and finally was brought back to the hospital.

Miss M proved herself to be obviously unprepared for re-establishment in the community without supervision. On the other hand, she might have been able to get along satisfactorily in a foster home where she would have continued to remain in a protected environment and under supervision but would have the advantages of being able to enjoy life in a normal family group.

Family care in this instance would have been an extension of custodial care of the hospital, since patients in family care are still under the jurisdiction of the mental hospital.

Although Miss M's illness is deep-seated, it is thought that she may be able to respond to the individual care and attention which she would receive in a home. A simple, wholesome environment could meet her emotional needs, and close sympathetic supervision from the foster family would give the necessary protection. Miss M may not be able to become self-supporting for some time, if ever, but at least she would be able to leave the hospital and lead a more normal and satisfying life.

Conclusions

It would seem from the examples cited that "Vista" has been most effective in helping the patients who were, in the main, ready to take employment and live by themselves, and who did not require prolonged care of further therapeutic treatment outside the hospital. Their term in "Vista" is generally of

few weeks duration only. The supervisor with her knowledge of community resources has been able to assist patients in securing suitable employment and accommodation, and to acquaint them with the cultural and recreational facilities of the community. "Vista" also proved very helpful to those for whom a bridging of the gap between the protected environment of the hospital and the demands of family seemed indicated. However, some patients seem to have greater capacity for utilizing the services of the "Vista" than others who appear to require another kind of rehabilitative aid such as family care. This method of rehabilitation is discussed in detail in the next and final chapter.

CHAPTER 4

ADAPTATIONS TO FAMILY CARE

The treatment of the mentally ill includes the whole of physical medicine in addition to the more specific therapies pertaining to psychiatry. The treatment and rehabilitation of the patient must obviously be approached on a cooperative basis; and ideally the treatment team includes psychiatrist, nurse, psychologist, social worker, teacher, occupational and recreational therapists, together with others who may contribute in some way or another to the well-being and comfort of the patient.

In the British Columbia setting, "Vista" is considered part of a treatment plan, particularly suitable for patients whose needs are not being met as a result of the inadequacy of resources in the community. Although these particular patients did not require further hospitalization, they did not have any resources of family, friends or finances to assist them during their convalescence. In the protected environment of the hospital world where life is on a very simple level, the patient makes a beginning in social adjustment to her new surroundings while undergoing treatment. She learns gradually to tend to her own needs, to participate in ward and other

hospital activities, and finally to help others less capable than herself. The fact that a patient is needed by others and that her efforts are appreciated, gives her an experience of success and a feeling of personal worth. This is particularly true of patients who have been deprived and rejected by their families. The patient's recovery is measured through her ability to function in successive roles of increased responsibility.

However, upon leaving the hospital, disaster may result because the patient is suddenly faced with complications and responsibilities that healthy people take in their stride, but which are too threatening to her. The patient is not ready for the demands made upon her and, therefore, "Vista" offers an intermediate environment in which the patient can take her next step. "Vista" provides patients with a home, with counselling service, and the opportunity to begin rehabilitation gradually. Patients cared for in "Vista" are reported to show more security and consequently are more successfully rehabilitated.

There is evidence that the careful selection and preparation of the patients has contributed considerably to the success of "Vista" in their rehabilitation. On the other hand, it is clear, that some patients were not able to respond favourably to the services offered by "Vista." These were individuals who were not yet ready to leave the protective environment of the hospital and to face the complications and

responsibilities of every day living. For example, they showed poor judgement in choice of companions and jobs, handling of money and so on. Although such patients did not require active treatment, they were unable to function without some supervision. "Vista" is not geared to offer such service and, therefore, it is suggested that a family care programme would offer such patients more appropriate assistance.

Family Care--Another Aid in Rehabilitation

It has already been made clear that "Vista" is not equipped to assist patients who require prolonged care. However, it is believed that family care would meet the needs of such patients, and therefore, in this chapter, the family care programme will be outlined briefly, and examples will be given to illustrate that the patients who were returned to the hospital because they could not be assisted to re-establish themselves in the community, might have benefited from family care. Studies have shown that family care, in the majority of cases, meets the patient's needs for love and individual attention (which is fundamental in human relationships) more adequately than institutional care. The trend at present is ". . . away from institutions toward placement in the community and the utilization of facilities for living that are normal as possible, with the idea that the individual should have an opportunity to grow and develop in an environment in which

usual life experiences predominate."[1]

Family care is not a new idea and at present is accepted as a means of meeting an obvious need in many European countries as well as in a number of states in the United States of America and in the province of Ontario in Canada.[2] It is simply the boarding of mental patients in private homes.

The main advantages of this type of care for patients are the reduction of capital expenditures and provision of a more acceptable environment for those persons who require prolonged care.[3] It has also been stated ". . . that family care is a national benefit not only because it has resulted in the improvement of mental patients, but because it has given the public more understanding of the mentally ill than anything that has been done in the present generation."[4]

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1 Hester Crutcher, Foster Home Care for Mental Patients, New York, The Commonwealth, 1944, p. 9.

2 Crutcher states that the first family care programme to be established was reported to be at Gheel, Belgium toward the end of the sixth century. France, Germany, Switzerland, United States and Scotland introduced family care practice during the latter half of the nineteenth century. This method has also been used in Denmark for approximately thirty-five years. The first successful plan in the United States of America was initiated in the State of Massachusetts. By 1944, at least nine states were providing such a service with an ever-increasing interest throughout the whole country. The State Hospital in Ontario launched such an experiment and from January, 1933 to May 31, 1939, a total of 1,477 mental patients had been placed in family care.

3 Ibid., p. 31.

4 Ibid., p. 31.

Type of Patient Selected

The patients served by foster homes can be divided into two main groups, ". . . the chronic, non-recoverable who require little supervision and who can live in the community in controlled conditions,"[1] and ". . . the convalescent or recoverable patient who will eventually be able to resume his normal mode of living."[2] The larger group will be the chronic or continuous type of patient whose chief needs are a moderate degree of physical comfort, a sympathetic caretaker, some freedom to wander about the house and grounds, and simple recreation of various kinds according to the interests of the patient. With the great majority of these patients selected for family care, marked improvement is not expected. Although patients may respond somewhat to individual attention, it is not thought that they will improve to the point that they can become independent, social, and self-supporting people.

The second and smaller group for whom family care has been used by some hospitals are the convalescent or recoverable type of patient. Generally, family care has served as a therapeutic measure in such cases with a view to permanent and total rehabilitation of the patient.

The success of any family care programme is said to depend upon the supervision of the patient and the

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1 Leo Maletz, "Family Care: A Method of Rehabilitation," Mental Hygiene, Vol. XXVI: October 1942, No. 4, p. 594.

2 Ibid., p. 594.

> caretaker.... Foster families and patients may be carefully selected, but unless the patient's needs, both physical and emotional, have the necessary attention after placement, he will not be able to make the optimum adjustment. Through supervision, the caretaker develops skill in working with a patient, in recognizing progress, and in taking advantage of favourable responses, so that the patient can realize his potentialities for living in the community either in a foster family or as an independent member of society. 1

It would seem that ". . . even those who have shown no improvement in the hospital sometimes find in family life the therapeutic aids the hospital was not able to supply."[2]

Foster Home vs "Probation" or "Parole"

Crutcher points out that family care differs from "probation" or "visit" in that patients in these latter categories are usually much improved mentally. As a rule they return to their own homes or resume their former way of living. This would be true also of patients who have been rehabilitated through "Vista." Those placed in family care are generally not well enough to take their places in their former environment. Some patients placed in family care for therapeutic reasons may not be well enough to return to their own homes and to face the pressures which may actually exist there or which they may feel exist. Other patients who are not dangerous to themselves or others, are far removed from the realities of life and could

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1 Crutcher, Mental Patients, p. 95.

2 Ibid., p. 95.

not manage on their own. For such individuals, a ". . . simple, wholesome environment will meet his emotional needs, and close sympathetic supervision which can be found in homes chosen with this in mind will give him the necessary protection."[1]

Selection of Foster Homes

The foster home must be chosen very carefully to meet the psychological and emotional needs of the individual patient. The caretaker would of necessity be an especially tolerant, understanding and genuinely kind person. Ideally, the patient should be treated as a member of the family. Some responsibility and share in the duties of the home makes the patient feel more at home and helps develop the sense of belonging. Responsibilities can be increased gradually as the patient becomes more capable of accepting greater pressures; but at all times, the patient should have a clear idea of her duties and the demands that may be made upon her. For the convalescent patient, urban or suburban homes are suggested as there would be better socialization and more work opportunities. However, for those requiring prolonged care, rural homes are considered to be better because country living is less demanding and provides more privacy and greater freedom to the patients.

Role of Social Worker in Family Care Programme

The social worker makes an important contribution toward

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1 Ibid., p. 3.

the success of the family care programme. She locates and selects the foster homes for particular patients. The patients are prepared for the placement following which the social worker serves as a link between the hospital and the foster home for the patient. She interprets the patient to the foster family and helps the patient to adjust in her new environment. At the same time, the hospital is kept informed of the patient's adjustment and progress to ensure the best of care for the patient.

Two case histories are presented of patients who were returned to the hospital from "Vista" and who would appear to be suitable candidates for foster home or family care. One who was a voluntary patient and who had left the hospital at her own request and who was reported to be making only a very marginal adjustment on the outside, might have been helped toward a more permanent rehabilitation. The other patient, although she does not require active treatment, has shown that she is incapable of resuming a normal way of living without supervision which would be provided in family care.

The following illustration is presented to show how family care would be able to supplement the services of "Vista" in regard to rehabilitation of some of the women patients. Miss K's case is considered to be a good example of the type of patient who would have been able to benefit from family care.

> Miss K first came to the mental hospital on a voluntary basis[1] when she was 28 years old. Form F[2] which had been signed by Miss K and the committing doctor stated that she was "depressed." She was hospitalized for a period of three months during which time she received supportive therapy and was reported to have gained some insight into her condition. At the time of her first discharge, she was described as being unco-operative, petulant, refusing to participate in ward and hospital activities and demanding her release. In spite of her suicidal tendencies, her relatives were unwilling to commit her. 3
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> Miss K was re-admitted again on a voluntary basis approximately two and one-half months later, and remained in the hospital for 13 months. The doctors found Miss K to be immature emotionally, forming strong likes and dislikes. She was reported to exhibit childish behaviour, and therapy was therefore geared toward helping the patient develop a more adult outlook on life. The attending doctor believed that Miss K could manage to get along outside the hospital only if she were given tactful and competent direction.

Obviously, Miss K could not remain at the "Vista" indefinitely, and therefore, some other aid was required in her rehabilitation.

> The psychometric tests revealed Miss K to be in the average group of general intelligence with a "deterioration" loss of twenty-four per cent. The impairment is considered to be functional and would be restored with a lessening of her conflict. Miss K showed a goodly amount of planning, foresight and

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1 Voluntary patients require the certification of only one doctor and can leave the hospital at any time following five days' notice. S uch patients are always discharged in full when they leave the hospital.

2 Ibid.

3 If the patient is committed to Provincial Mental Hospital which involves the completion of committal forms by 2 doctors outside the hospital, a magistrate, and a relative, he is not able to leave the hospital at his own request as in the case of a voluntary patient.

> prudence in completing the tests. The results indicated Miss K to have inappropriate affect insofar as her social behaviour was concerned. A schizoid trend, ideas of reference, the belief that people do not accept her and withdrawal tendency was evident.

It would seem from the findings that she was experiencing difficulty in relationships with her mother and that she had an ambivalent attitude toward marriage--a desire for such a relationship and yet fearful of it. Apparently, Miss K was fearful of her mother and had strong feelings of resentment toward her mother, making it difficult for her to relate to others.

Her family history brings out the lack of affection for patient by her parents. She was said to be a "show off" and to have told many lies, much to the distress of the family. The relationship with the mother would appear to be particularly poor and as her step-father was said to be stern and cold in his attitude toward patient, she has never had an opportunity to form a satisfying relationship with either parent. She seems to be seeking a mother person as she has formed strong attachments to women older than herself. The history revealed that there was also some sibling rivalry with a step-sister, ten years her junior. The sister's greater acceptance by both parents and her greater social success only aggravated Miss K's feelings of rejection and self-depreciation. She was not informed that her birth was illegitimate until she was in her adolescence; this came as a terrific shock to her.

From the foregoing it would appear that in her early

childhood she was deprived by her parents, particularly by her mother, of any love and affection which is so necessary for stability and normal growth. Her feelings of rejection are shown to be strong as was illustrated by an expression of fear that others do not accept her, that "her mother didn't want her, and never has," etc. In view of her unsatisfying relationship with her parents, Miss K is ambivalent toward any object of hetero-sexual attraction. She apparently is afraid of any relationship for fear of rejection.

Obviously, Miss K's need for an experience of a satisfying relationship with parent figures cannot be met adequately in an institutional setting or even in "Vista." It is believed that placement in a foster home with kindly, understanding people who would give her acceptance, recognition, and affection and an opportunity to experience being an integral member of a normal family would meet this need.

> Since her parents refused to accept any responsibility for her, Miss K was sent to "Vista" with a view to helping her become established in the community. However, Miss K was unable to respond to the attempts of the supervisor to assist her, and refused to accept any employment or accommodation suggested to her. Her behaviour became such that it was necessary to have her returned to the hospital under sedation. She remained in the hospital for a few more months and then was discharged at her own request, as she was dissatisfied with the help that she was receiving at the hospital. She expressed the feeling that "everybody hated her" and she felt that to remain in the hospital would only cause her to regress. At the time of her discharge, at her own request, the social service department in the city to which she was planning to go was notified of her departure and her need for financial and rehabilitative help.

It has since been reported that Miss K has not adjusted well outside the hospital and has even attempted to return to the hospital.

Thus the history reveals that Miss K's early development has been lacking in love and affection which are vitally necessary for normal personality development. She has not experienced a satisfying relationship with others. This is borne out by her continual search for a mother person and her ambivalence toward the object of hetero-sexual attraction. The supportive treatment which she received in the hospital from her doctor has helped her in a better understanding of herself and even a better acceptance of herself. But it would seem that she requires a re-living experience of a satisfying relationship with a warm, accepting mother person over a period of time to help her to be able to form new relationships comfortably with those of her own sex and of the opposite sex. Obviously, "Vista" is not equipped to provide prolonged care as required by this patient and, therefore, family care would appear to be the most logical method of rehabilitation for Miss K.

Mrs. F is another example of a patient who had not adjusted satisfactorily in "Vista" and who may have benefited from family care.

> Mrs. F was 62 years of age when she was admitted to the mental hospital for the first time. She had been committed because she was expressing persecutory and delusional ideas, was hallucinating and was "nervous" and apprehensive. Her illness was diagnosed as "paranoid schizophrenia." She showed no interest

in ward activities but was quite content to sit just doing nothing.

Mrs. F was discharged on special probation[1] to the care of her sons after seven months hospitalization. At the time, she was still considered to be delusional and faulty in her judgement. Mrs. F was readmitted five years later with the same symptoms and two years following her readmission she was given a lobotomy[2] operation. She made a satisfactory adjustment to hospital life but continued to retain a few paranoid ideas around a circumscribed area.

Family history reveals Mrs. F received a strict upbringing in her childhood and had enjoyed few luxuries or pleasures as her father died when she was three months old leaving the family with little financial security. Mrs. F married at the age of 21 after a courtship of four years. Reportedly, her marital relationship was a happy one. She became a widow a few months before the onset of her illness.

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1 Patients who are discharged on special probation usually still require further hospitalization and are taken out by relatives against the advice of the attending doctor. The relatives are required to sign a special probation form which makes them responsible for patient's safety and welfare and also close supervision of patient on a 24 hour basis.

2 This operation involves primarily the "severance of brain tissues" according to Glenn V. Ramsey in his article on "A Short History of Psychosurgery." Olof Johnson and Ruth Ehrenberg, in their article entitled "A Correlation of Lobotomy Results with Basic Reaction Types" state that "the degree and rate of relief afforded by this operation depends directly on the severity of the mental illness and that prognosis is much poorer for cases that have entered upon a chronic schizophrenic disintegration." At the Provincial Mental Hospital, only those patients who have failed to respond to other treatment are recommended for a lobotomy operation. Usually such patients fall into two groups. The patients whose pre-psychotic adjustment had been fairly satisfactory are more likely to have a remission and in a large number of cases are able to leave the hospital following a period of convalescence. The other group is comprised of patients who had a poor adjustment prior to their breakdown and the operation is performed primarily to make them less of a nursing problem.

When Mrs. F's condition had shown to have been satisfactory for a considerable period and she seemed able to attend to her personal care as well as to relate reasonably well to the other patients and the members of the staff, it was decided to interest her in plans for discharge. In view of the fact that her sons were unable to provide her with a home, she was sent to the "Vista" as it was thought she might be able to manage herself and her affairs and that she should be given an opportunity for rehabilitation.

At "Vista," Mrs. F was reported to be cheerful enough but she was somewhat institutionalized in her habits. She seemingly showed little initiative and appeared to be interested almost solely in the personal lives of other patients. Mrs. F exhibited a tendency to be "watchful," "suspicious," and almost obsequious at times. The supervisor found her attitude rather trying, although she did think that in time Mrs. F would be able to handle some routine housework job.

Mrs. F was subsequently returned to the hospital and discharged on probation to her son shortly after, as he had been able to make satisfactory arrangements for her care in his home. Mrs. F has not returned to the hospital and it is possible that with understanding and acceptance of her as she is, she will be able to remain on the outside indefinitely.

It is obvious that "Vista" is not able to care for patients who require prolonged supervision in a protected environment although not necessarily in a hospital. It is

believed that Mrs. F would have been able to fit into a foster home where there would be a few demands made upon her and where she would be allowed to assume responsibility very gradually. With increased confidence in herself as a result of individual attention and affection, she would in time be able to care for herself and even to manage a fairly simple housekeeping job which she would be assisted in securing by the social worker who would have kept in regular contact with her throughout the whole period.

Assessment

"Vista" was established to help particular women patients whom the social service department found difficult to rehabilitate because of lack of community resources. It provides the patient with an opportunity for a more gradual exposure to the demands of everyday living. They become accustomed once again in living in a family home. Having a key to the house once more and the freedom to come and go without undue restrictions has an important beneficial effect on the patients. The patients in this way are encouraged toward independence, but at the same time they continue to have the security of a protected environment. In addition to this service, "Vista" has helped to meet the need for a Vancouver address which is such an important factor while employment is being sought. While at "Vista," patients can be reached more readily by the employment agencies when jobs

arise and can be interviewed by prospective employers without undue delay. The supervisor, or the "house mother" as she is known, through her knowledge of the community's resources has been invaluable in acquainting the patients with recreational and educational opportunities and has frequently been instrumental in arranging for a referral of the patients to various community groups and organizations. "Vista" has also assisted patients who upon discharge had no financial resources to draw on, by allowing them to remain at the home pending the receipt of their first cheque or the completion of their course. Thus "Vista" has served to bridge the gap between the hospital and the community, but it also meets some definite and personal needs of the person who has suffered so severely from shock or deprivation as to be subject to breakdown and a period of treatment in a mental institution. As expressed by Mr. E. Winch, "Vista" has given these patients ". . . a new outlook, hope and another chance."[1]

As has been stated previously, the idea of a rehabilitation centre for women mental patients was first conceived by a group of private citizens. The first supervisor of "Vista" was an ex-patient who was succeeded by Mrs. Roth when the centre came under the administration of the Provincial Mental Hospital. Mrs. Roth had not had any special training or experience in

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1 E. Winch, "Do Unto Others . . . ," New Horizons, December 1946, Vol. I, No. 1, p. 1. The New Vista Society, Inc., Vancouver, B.C.

working with mental patients but it was felt at the time that her experience in other fields would be helpful for this position. At the time of her taking over the position, she was regarded as being in much the same capacity as the charge nurse on the ward. The patients were expected to keep her posted on all their activities. The supervisor assisted the patients with their shopping, their becoming acquainted with the city if they were strangers and also in locating suitable accommodation and employment. In January 1952, Mrs. Roth resigned and the management of "Vista" was given to a graduate nurse with psychiatric training and experience. Her role is that of a "house mother" and a friend. At the present time, the social workers not only continue their contact with the patients when they are transferred to "Vista," but they also are now responsible for helping them to locate suitable accommodation, and to secure employment which previously had been the responsibility of the supervisor.

Unfortunately, "Vista" is able to accommodate only limited numbers and for a limited period. It meets the need mainly of those patients who are ready to establish themselves almost immediately in the community. But there are many other patients for whom boarding homes with varied degrees of supervision or varied lengths of supervision are required. Rehabilitation is not the end of treatment, but a concluding stage. For some patients, this final stage is of longer duration than for others and therefore some patients require

prolonged supervision which cannot be assumed by the "Vista" rehabilitation centre as it is at present. It would seem that other aids such as family care must be considered to supplement the services offered by "Vista" if such patients are to be given an opportunity to enjoy a more normal life than is possible in a large institution.

Appendix A

SCHEDULE

1. Name
2. Age
3. Education
4. Employment History
5. Marital Status
6. Health
7. Interests and Recreation
8. Diagnosis
9. Length of Hospitalization
10. Type of Treatment
11. Psychometric Test Results
12. Relationship with the Family
13. Why Chosen
14. Economic Resources
15. Family Resources
16. Pre-psychotic Personality
17. Adjustment in Hospital
18. Adjustment at "Vista"
19. Adjustment upon Discharge

Appendix B

BIBLIOGRAPHY

Crutcher, Hester, Foster Home Care for Mental Patients, New York, The Commonwealth, 1944.

Dwitt, H., "Family Care as a Focus for Social Casework in a State Mental Hospital," Mental Hygiene, 28, 4 October, 1944.

Glenn, Ramsey V., D.Ed., "A Short History of Psychosurgery," American Journal of Psychiatry, Vol. 108, No. 11, May 1952, p. 813.

Johnson, Olaf, M.A. and Ehrenberg, Ruth, M.D., "A Correlation of Lobotomy Results with Basic Reaction Types," American Journal of Psychiatry, Vol. 108, No. 11, May 1952, p. 817.

Maletz, L., "Family Care: A Method of Rehabilitation," Mental Hygiene, XXVI, 4 October, 1942.

Malholm, H. and Burton, W., "Family Care: A Community Resource in the Rehabilitation of Mental Patients," American Journal of Psychiatry, 98, 1, 1941.

Menninger, Karl A., M.D., The Human Mind, Alfred A. Knopf, New York, 1947.

Noyes, Arthur P., Modern Clinical Psychiatry, Philadelphia and London, W. B. Saunders Company, 1948.

Provincial Mental Hospital, Annual Reports, 1882-1950.

"Vista--Doorway to Freedom," Vancouver Sun, 3 December 1944.

"Vista", Physicians Manual, prepared for the Hospital Medical Staff at the Provincial Mental Hospital in British Columbia.