THE REHABILITATION OF DISCHARGED MENTAL PATIENTS

An Analysis of the Rehabilitation Needs and Resources of a Sample Group of Male Patients Leaving Crease Clinic, 1952-53.

by

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Abstract

The return of the patient to the community is the goal of institutional treatment programs for mentally ill persons. The attention and effort made in recent years toward improved care of mental patients in hospital has also included consideration of the material and emotional needs of the patient at the point of leaving the hospital. This study examines the discharge situations of male patients treated at the Crease Clinic of Psychological Medicine at Essondale; and describes the role of social workers in patients' re-establishment in the community. The needs and problems revealed by the study are examined in the perspective of a comprehensive rehabilitation service for discharged mental patients.

The method used in the study was to compile pertinent information from the case records of 100 male patients discharged in a recent year. The information was extracted from the case records by means of a schedule. From this information was tabulated some of the common needs of patients leaving Crease Clinic. An analysis was then made of resources within the Clinic and in the community at large whereby the recorded needs might be met. A selection of case summaries was made to illustrate some typical problems.

The factual material illustrated the variety and frequency of rehabilitation needs. For the mental patient these included not only material needs for housing and a job, but also intangible needs for support and help with continuing emotional stress. The inter-relationship of outer material needs and inner emotional problems was noted. It was found that needs for housing and a job were a problem for approximately one patient in five; and that the proportion of patients who required help with inner stresses was approximately one in three. An examination of the resources available for meeting needs revealed significant gaps and limitations in the provision of subsidized boarding care and in the financing of vocational training. An over-all deficiency was apparent in the numbers of professionally trained social workers.

In the concluding chapter there is suggested an operational definition of rehabilitation: a process whereby needs are met which enable the patient to become re-established as a citizen. There is a discussion of ways and means of narrowing the gap between needs and resources, and of the role of the social worker in community action. The development of social welfare resources for discharged mental patients is related to a network of community facilities concerned both with civilian rehabilitation and with mental health maintenance.
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The Rehabilitation of Discharged Mental Patients
Chapter 1

Mental Illness and Rehabilitation

The maintenance of good physical and mental health, and the restoration of the ill to a state of well-being has long been an organized concern of society. Generally speaking, concern for the care and treatment of mentally ill persons has developed historically at a slower pace than concern with physical breakdowns in health. The reasons for this slower pace appear to be that the causes of physical illness are easier to detect, and also that fears and superstitions are generated by some of the more bizarre manifestations of so-called insanity. These fears and superstitions have been considerably but not totally resolved by the contributions of modern psychiatry, which provides a foundation for understanding and orderly classification of mental diseases. This basis of understanding liberated the dynamic in man's social consciousness so that social welfare philosophy and leadership could be positively directed and mobilized to meet the needs of the mentally sick. A resultant trend was the tendency to counteract any popular feeling of physical and emotional isolation of the mental institution from the community. The attitude was cultivated that the mental hospital was a community resource to which mentally disturbed citizens could come for treatment and afterward return
to their homes. A great deal of emphasis in recent decades has been directed to institutional treatment, and only more recently has specific attention become focused on comprehensive programs for post-hospital care and re-establishment. In this paper mental illness is seen within the philosophical framework of social welfare, wherein relief for the mentally distressed is dispensed by community agencies on a basis of self respect.

There are various ways of approaching the subject of mental illness, but in general the social worker views such illness as symptomatic of mental or emotional disturbance resulting in inability to participate normally in social relationships. Since the problem is not essentially one of unusual overt behavior but is concerned with basic personality functioning and social relationships, it follows that treatment and restorative programs for the mentally ill are seen in this context. Such programs take cognizance of the underlying factors contributing to the personality disturbance. We seek to understand the various underlying factors, physiological, psychological, sociological, etc. in terms of their dynamic inter-relationships, in order to aid the person who is mentally ill to achieve greater harmony within himself and in relationship to his fellows.

According to social welfare concepts, bringing aid to the mentally ill rests on the philosophical premise that every human being is of worth, to be accorded dignity, and having a right to aid in time of need. The needs of the mentally ill have always been difficult to comprehend fully, and society has not always acknowledged even basic dependency needs as worthy of humane
Historical Antecedents

The basis for the rational and scientific treatment of diseases, including the insane, was laid by Hippocrates (460-370 B.C.), known as "the father of medicine". The therapy built upon this basis by the humane Greek medical pioneers was succeeded for many centuries by a superstitious mixture of astrology, alchemy, magic rites, with the accompanying belief in demoniacal possession and the practice of burning "witches". The early colonists carried over with them from Europe to America these same superstitions regarding mental illness. Probably because of concern with the immediate problems of existence, public provision for handicapped persons in these early days was based not so much upon humane considerations as upon social expediency and economy, with a general attitude of coldness and contempt, rather than sympathy and understanding.

The introduction and development of welfare measures came in the latter part of the eighteenth century in the wake of progressive forces released by the political and social revolutions in America and France (1776 and 1789). In America, many of the early experiments in social welfare were initiated by the Quakers. In 1773, the first separate institution for the insane in America was established at Williamsburg, Virginia.

The reform measures of this revolutionary era were given added impetus by three pioneers in psychiatry: Rush in America,

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known as "the father of American psychiatry"; Pinel in France, who had the chains removed from the insane and started treatment based on kindness and sympathy; and Tuke in England, who provided a protected institution for patients who were treated as guests rather than inmates. At the beginning of the Nineteenth Century, profound social forces were in ferment: the repercussions of the Industrial Revolution; the Poor Law Reform movement in Great Britain; and reform studies in the United States.

Supplementing the "rational reform" measures of men like Pinel, Tuke, and Rush, there appeared in 1841 the unique personality of Dorothea Lynde Dix, with whom is associated "moral reform". As a retired school teacher nearing forty, her career as a reformer started with the instruction of a Sunday School class in a jail in Boston. Her protest against the treatment there, especially of the insane persons who were "locked up", started her on a crusade that eventually took her on inspection tours of the mental hospitals in the United States, Britain, Canada and Europe. In nearly every instance, her inspection and campaign led to the erection of a new hospital or the enlargement of an existing one.

It was the significant advances at the turn of the twentieth century which heralded the coming of age of psychiatry in America. Along with the rise of reform movements, political, economic, social: there was a striving for new goals in the field of social welfare. Relative to the care of the mentally sick there were developed new facilities and techniques in professional training for staff, and in research; the rise of out-patient departments and psychopathic hospitals, and the beginnings of the employment of social casework techniques in the care and treatment of the
mentally ill. Climaxing these progressive developments was the founding of the Mental Hygiene Movement in 1909 by Clifford Beers, a former mental patient who wrote a striking account of his own experiences in his book "A Mind That Found Itself". Forging as an instrument the National Committee for Mental Hygiene, Beers set himself to the task of directing public attention to the prevention of mental sickness and to setting up arrangements for a working partnership between the public and psychiatry. He succeeded in awakening the public conscience and in gearing the resultant emotional energy to a practical program of medical and social engineering which continues to the present time. This movement had far-reaching repercussions not only in raising standards of care for mentally ill persons, but also in the stimulation of public and professional education in mental hygiene, in the opening of doors for the integration of mental hygiene thought, philosophy, and practice into such disciplines and fields as medicine, social work, education, religion and industry.

Social Work in Mental Hospitals

The relationship of social work with psychiatry in the treatment of the mentally ill was a significant factor in the development of the profession of social work. The relationship had its formal beginning in 1906 with the employment of social workers in Manhattan State Hospital, New York City, where social workers visited patients' families to obtain information needed by the psychiatrists about their patients' lives. Later the function of

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preparing families for return of patients to their homes was added. Impetus to this trend was provided by the dynamic approach of Dr. A. Meyer, a psychiatrist who insisted it was not enough to study the individual as an isolated unit and that it was as important to study the environment from whence he came and to which he might return. As social workers became the established contact between the hospital and the community they were also involved in making provision for the indigent insane, and in looking after families of breadwinners incapacitated by mental illness.

During this period, one of the most serious questions confronting social workers was the readjustment of mental patients returning from hospitals to normal community life, and this concern has remained to the present day. It was the early experience of social workers that patients discharged as cured often were unable to readjust themselves to community living. Without auxiliary aid, patients might experience another mental breakdown and require readmittance to the hospital. The environmental conditions to be met upon return to society were never quite the same as when the patient was first hospitalized. Often he was hindered with new obstacles, one of the most difficult of which was the stigma of insanity with which the patient of an asylum was branded. Whereas the patient cured of pneumonia or typhoid or appendicitis might return to take up his affairs at the point where his temporary illness had interrupted his normal routine, the recovered mental patient was a marked man. He had been "crazy", and according to the popular legend, "once insane, always insane". Consequently his relations with acquaintances and even with his family were
likely to be strained. Under this strain some minds gave way again, resulting in the person becoming socially inadequate or having to be readmitted to a mental institution.

Another concern of the social worker was the fact that frequently when a patient has improved enough to be returned to the community, his discharge had to be delayed because of socio-economic difficulties. There might not be any home or family to whom he could go, or he might find it impossible to get employment at once so as to be self-supporting. "Often, in such instances there remained only one of two choices for the hospital superintendent, neither of which could be a satisfactory one: the patient could be retained in the hospital or be transferred to the poorhouse, where he might spend the rest of his life as an unhappy public dependent." This situation posed a problem in social welfare for the solution of which no medium or agency existed. There were no facilities whereby the recovered patient could be given comprehensive help and advice to enable him to start on the road to independence.

The earliest attempts at solution to the problem of the care of the discharged mental patient arose from "the after-care movement", which had its beginnings in Germany in 1829, and was introduced to America during the 1890s. "The principle behind this movement was to provide adequate financial, medical and moral assistance to patients discharged from mental hospitals, in order to aid their adjustment to the outer world and to check

1 Deutsch, op cit, p.289.
relapses due to social handicaps.

It is interesting to note that the initial assignment of what was probably the first psychiatric social worker in America consisted of aiding the Manhattan After-Care Committee. Other hospital district after-care committees were soon organized, their major purpose being to find suitable homes and employment for needy ex-patients, to render other social services as needed, and to exercise general supervision over them during the period immediately following their discharge. "Such were the beginnings of direct collaboration between social workers and psychiatrists in America."

The integration of social work with mental health services received added stimulation during and following World War I. The services of social workers were desired for the program of treatment and rehabilitation of returning soldiers suffering from war neuroses and psychoses. The need for trained psychiatric social workers was so acute that the National Committee for Mental Hygiene proposed the establishment of a training school for such social workers. In Canada the first course was inaugurated at the University of Toronto in 1919.

During these years the association of social work with psychiatry was one of the factors in bringing about a shift of emphasis on the part of social workers in their approach to social need. Their focus of concern shifted from the broader environmental factors underlying social ills to the developing of casework techniques arising from a deeper understanding of individual

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1 Ibid, p.289.
2 Ibid, p.290.
personality afforded by dynamic psychiatry. There was a gradual modification from an exclusive interest in external problems toward inclusion of treatment of personality difficulties. In dealing with the socio-economic problems precipitated by the Great Depression, social workers effected a comfortable balance of sociological and psychological factors in their approach to human needs. The learning gained by psychiatric social workers in the mental health field was utilized by other specialists in the general field of social work.

**British Columbia**

In colonial days the problem of caring for mentally ill persons was solved easily by sending the patients back to Britain. For a time, arrangements were made for the shipment of patients to California to be cared for in institutions there. Later, patients were kept in gaols or in the Royal Hospital in Victoria. British Columbia became a province in 1871 and in the following year the Royal Hospital became the first official mental hospital in the new province. Due to overcrowding, new quarters were first acquired on the present site of the Woodlands School in 1877-78; and a new institution was later established at Essondale in 1910.

The administration of the early hospitals laid emphasis on kind and humane treatment of patients. An attempt was made to

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2 Sources of the information in the following two sections are Master of Social Work Theses by Birch, Sophie (1953); Clark, Richard (1947); and Pepper, Gerald (1953). See bibliography for titles.
provide patients with comfortable living quarters and a plentiful supply of nourishing food. 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. 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 family affection was conducive to restoration of mental health".

The turn of the 20th 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. The principle of segregation and the use of hydrotherapy are illustrative of progressive measures which were gradually introduced.

In 1919 the Canadian National Committee for Mental Hygiene, following its survey of the mental institutions, suggested the employment of social workers in connection with the Mental Hospital, with a view to increasing the numbers 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. In 1930 the Committee installed in the position of social worker

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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.
at Essondale Miss Josephine Kilburn, Registered Nurse; and the following year she was retained by the Provincial Government to establish a social service department. 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 available. Another function of the department was a follow-up service to patients after discharge to assist in their re-establishment in the community.

Social Work at Essondale

The nature of the responsibility for treatment which is allocated to the psychiatric social worker is determined by several factors: the type of mental institution, its organization and auspices, its training or research emphasis, and the philosophy and skill of the staff. The Group for the Advancement of Psychiatry of the American Psychiatric Association considers that the treatment of the mentally ill is primarily a community responsibility and that the mental hospital is a treatment facility of the community, rather than its dump-pile for the disposal of human wreckage. The goal of treatment is seen as return to community living.

At the administrative level the treatment of patients in both the Provincial Mental Hospital and the Crease Clinic of Psychological Medicine is considered to be "a total push relationship situation" which is patient centered. It includes the whole of physical medicine as well as the more specific therapies pertaining to psychiatry. It is the treatment philosophy of Provincial

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Mental Health Services that the problems of mental disease will never be solved by any one group of professional workers, and the co-operation and coordination of all groups both professional and otherwise is essential. Patients need in their treatment the full co-operation of the physiotherapist, the occupational therapist, the recreational therapist, the psychotherapist, and the assistance of the social worker, both during and following hospitalization. "The function of the psychiatric social worker is to contribute his knowledge and casework skill in such a way that it is purposefully related to psychiatry, the total treatment program of the hospital, hospital organization and administration, and to the contributions of all other professions and departments in the hospital." A corollary is that the quality of the treatment afforded patients is wholly dependent upon how ably the various professions can work together.

In order to help mental patients, the social worker must know the sources of tension in their lives. He must understand what the person feels, how he deals with his feelings, how this way of responding serves him in the light of his present life pressures, past experience and future aspirations. It is this understanding of the individual and what the problem means to him that enables the social worker to modify either external or internal pressures, or both, so that the individual may be relieved of stresses and participate in the recovery of self-reliance. Part of the skill

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2 British Columbia, *Annual Report of the Mental Health Service*. Queen's Printers; Victoria, B.C.; 1951; p.44.
of the social worker is in estimating the patient's capacity for self-help, and in his ability to strengthen the healthy aspects of the patient's personality by helping him to adjust to the realities of a changed and limited situation. The social worker understands that the patient is a part of a dynamic social group involved at all times in a complicated system of interpersonal relationships and during the patient's treatment period in hospital the social worker is concerned with all aspects of the patient's relationship with medical and nursing staff, with other patients, family, friends and community.

To be fully effective in helping, the social worker should work closely with the patient from the moment he enters the hospital until he is finally re-established in the community. One of the initial services to patients and relatives is the intake study and evaluation of the patient and his illness. The intake and reception process also involves interpretation of hospital facilities to patients and their families, as well as assistance to families who have problems arising out of the patient's admission, such as feelings about having a mentally ill relative or fear of the hospitalization and the treatment. At Essondale at the present time caseworkers are assigned to the Admissions Sections of the Provincial Mental Hospital and the Crease Clinic, all workers being under the supervision of an Admissions Casework Supervisor.

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1. Annual Report of the Mental Health Services, op cit, p.46.
2. Pepper, op cit, chapter 2.
The social information obtained by the social worker when the patient is admitted is rapidly made available to other members of the treatment team, thus accelerating the formulation of provisional diagnosis, of initial treatment plans, and the mobilization of all services within the hospital for the treatment of the new patient. In the Social Service Department, the treatment period is considered in three phases or aspects: active therapy in hospital; pre-convalescent planning prior to discharge; and the convalescent or probationary period after the patient has left the hospital or clinic. The contact with the patient on the ward is directed towards building a supportive, understanding relationship, through which the patient is helped to hold onto whatever reality functioning he may possess. Interest in wife, children or parents is kept alive; and the patient is helped to do something about those problems of which he is most aware and concerned. Interviews with relatives are directed toward keeping up the family's interest in the patient. This is done by familiarizing the relatives with the nature of the illness, the treatment, the hospital and clinic routines; by helping relatives with their own feelings concerning mental illness, and finally through support and clarification the relative is encouraged to participate positively in plans for the patient's discharge. In assisting the patient's family, the social worker frequently contacts community resources such as family child and assistance-giving agencies.

Prior to discharge, the social worker starts to prepare the patient for leaving the hospital and clinic and he will discuss
with the patient his feeling about leaving, and returning to his family and to employment. The patient is encouraged to make week-end visits to his home so that the transition from hospitalization will be gradual, and problems that arise on these visits can be ironed out before final discharge.

The social worker's role in the final or post-discharge phase of the treatment process is to assist in the re-establishment of the patient in the community. The patient is helped to retain the gains made in hospital; to locate satisfactory employment and accommodation; to become reconciled to those changes in his own ability and in the circumstances of his life, which the illness may have brought about. As well, family, friends, employers and community agencies are prepared for the patient's return to routine living; and necessary interpretation of the patient's needs in his extra-mural treatment is provided.

From the point of view of organization, the various phases of treatment are the responsibility of the Continuing Services Sections of the Social Service Departments of the Provincial Mental Hospital and the Crease Clinic respectively. It should be noted that the public welfare agency of the city of Vancouver, and also the public welfare agency of the Province - Social Welfare Branch - provide social assistance as an aid in rehabilitation. Outside the Greater Vancouver area, the Social Welfare Branch also gives casework services throughout the patient's illness, including intake studies, family casework, and follow-up services after discharge.
Modern Concept of Rehabilitation

Public acceptance of social welfare goals has advanced to include the aims of rehabilitation of disabled citizens. Concern with the problem has been so great that the word rehabilitation itself has become hackneyed - almost beyond the point of practical specific meaning. Popular references are made to the "rehabilitation" of the blind, of paraplegics, of the tuberculous, of discharged prisoners, of injured workmen, of aged persons. Rehabilitation is a concern of the community because the disabled citizen, so handicapped that he cannot "pull his own weight", immediately becomes a problem of the community in which he has roots and will presumably seek re-adjustment. Rehabilitation and after-care is more intimately the concern of the hospital, gaol or treatment institution because the aim of the treatment programs of these agencies of the community is to see the patient through to maximum social integration into the community. A general definition of rehabilitation is the statement of the National Council on Rehabilitation, New York, to the effect that rehabilitation "is the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable."

Rehabilitation has to do with a person's re-establishment in the community after a period of disruption of normal living due to some disabling condition or dislocating circumstance. In the broad sense, rehabilitation includes the entire process of a patient's treatment in hospital and his return to routine civilian living. In this sense, for example, the rehabilitation of the mentally ill begins immediately upon admission to hospital,
and all subsequent examination, treatment, nursing care, psychotherapy and social casework are aimed at promoting a normal social integration and preparing the patient and the relatives to make an accepted adjustment. For the purposes of this study the term rehabilitation is used to refer to the latter portion of the treatment goals, which embraces plans and programs for the post-discharge period after the patient has left the hospital. Rehabilitation services are dispensed under various administrative auspices - some by the hospital and some by specialized rehabilitation agencies.

A survey of available literature shows that programs for the rehabilitation of physically and mentally handicapped persons vary widely both in the comprehensiveness of the services and in the administrative auspices by which the programs are implemented. Primary factors affecting comprehensiveness are first of all the breadth of vision; the acceptance, and the participation of the whole community; and secondly, the financial capacity of a community to provide services. Rehabilitation, like public health, is purchasable. There are programs utilizing the medical, social, psychological, economic, educational, and vocational aspects of rehabilitation. Such programs are available to the handicapped through the facilities of clinics, community services, foster and domiciliary homes, hospitals and rehabilitation centres, schools, and sheltered workshops. Initially the programs were

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1 Psychiatric Services Physicians Manual, op cit, Chapter 12.
developed by individual practitioners in various professional fields. Many were financed by private, philanthropic societies such as the American Red Cross Society, Blind Institutes, and so forth. As such private programs have become more widely recognized, it has become common for governmental support to be made available by financial grants. Some countries, such as Great Britain, New Zealand, and the United States, have set up governmental rehabilitation programs which have included medical treatment, vocational training, and employment placement of individuals on a national basis as a function of government.

Government sponsored rehabilitation programs were first developed to meet the needs of physically handicapped persons who had an employment problem. For example, in the United States, the Vocational Rehabilitation Act, 1920, was passed to provide services other than physical restoration services, with a view to filling the gaps between the results achieved by existing hospitals and clinics, and the return of the patient to self-support. The financing of the program was put on a permanent basis by the Social Security Act 1935. During World War 2 as a result of the revelations of Selective Service of the incidence of mental disorders in the civilian population, the scope of rehabilitation services was extended by the Barden-La Follette Act (1943) to include the psychiatrically disabled person. This meant that every psychiatrically disabled person could get help in job finding, vocational guidance, vocational training, and occupational counselling, whether he was a veteran or a civilian.

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At the present time, the federal government makes grants to the states for 100 percent of the necessary program costs of administration and vocational guidance and placement services, and for 50 percent of other case service costs such as medical and psychiatric examinations, medical treatment, training, and maintenance during the period of the rehabilitation process. The program is administered by the Office of Vocational Rehabilitation of the Federal Security Agency. It is observed that with respect to the dominant precipitating factor in disability (physical, mental), vocational rehabilitation programs were first developed for the physically disabled due to the ease of defining "disability" for this group as compared to the difficulty in measuring the handicap accompanying mental and emotional disorders.

Canada has had one comprehensive rehabilitation program, namely that for physically handicapped veterans, under the Department of Veterans Affairs. The Department has utilized private organizations for certain types of handicaps such as blindness, deafness and paraplegia, but there is not yet a comprehensive scheme for civilians. There are a number of organizations both public and private, working with various types of handicapped children and adults, for example the Workmen's Compensation Board, T.B. after-care; National Society for the Deaf and Hard of Hearing; the Canadian Paraplegic Association; the Canadian National Institute for the Blind; the Canadian Arthritis and Rheumatism Society; provincial societies for Crippled Children and Cerebral Palsy.

The National Advisory Committee on Rehabilitation of Disabled
Persons was set up by Order-in-Council in December 1951. This Canadian Committee aims to develop a national program to provide civilians the same services as are now available to veterans. A Federal Coordinator has been appointed and a system of federal Rehabilitation Grants to the provinces has been initiated.

To date, Saskatchewan is the only province which has developed civilian rehabilitation programs. British Columbia has enacted social welfare legislation which permits the development of such a program within its public assistance scheme. In practice, however, public welfare officials tend to utilize existing private agency resources rather than to develop new facilities to meet the needs of handicapped persons.

Specialized agencies or hospital departments for the rehabilitation of the mentally ill are a new development in Canada. The most ambitious undertaking at present is the After-Care Department of the Ontario Hospital, London. This department was organized in September 1949, with the financial support and encouragement of the Ontario Department of Health and with financial assistance from the Federal Department of Health. It is headed by a psychiatric social worker, and the team includes three additional social workers, four nurses, and two psychologists. The hospital psychiatrists serve as consultants. The Department utilizes a down-town building to serve as offices, consulting rooms, and as club rooms and recreation centre for former patients who may reside in the district.

1 Stevenson, Dr. G.H. "Rehabilitation of the Mentally Ill". Ontario Medical Review. Volume 19, Number 11; November 1952.
An agency interested in all aspects of mental health, including the rehabilitation of discharged mental patients is the Canadian Mental Health Association. The Association is a voluntary society of citizens dedicated to the task of preventing mental and emotional illness, helping children and adults to achieve better mental health, and improving treatment for those who are mentally disabled. There are five provincial Divisions of the Association. In 1953 the Saskatchewan Division enlisted the aid of a Junior Chamber of Commerce to assist in the rehabilitation of discharged mental patients in occupational settings.

Post-discharge Problems of Crease Clinic Patients

The Crease Clinic of Psychological Medicine, opened at Essendale, B.C. on January 1, 1951, was designed and equipped to serve as a diagnostic and active treatment centre for the early cases of mental illness: primarily early psychoses and psychoneuroses. By statutory provision, the duration of a patient's treatment period is limited to four calendar months. Admissions are therefore encouraged only of those patients who are considered to have a reasonable prospect for recovery and discharge in the four months period. Patients with a less favourable prognosis are referred to the Provincial Mental Hospital. A patient may be admitted to Crease Clinic either by voluntary application or by certification of two medical practitioners. The only patients who lose control of their affairs are those deemed unfit by their attending physicians to carry out this function; in which case the Inspector of Municipalities is notified and acts as committee. The general environment of the building is attractive, with tasteful furnishings, and varied and plentiful recreational
and occupational services. Every effort is made to render early hospitalization in the Clinic as similar to hospitalization for physical illness as possible.

What kinds of problems and situations are experienced by these patients when they leave the Clinic? How has their absence affected their families, their jobs, their acceptance in their neighbourhood? To whom may they be referred for assistance in meeting their needs in getting re-established in their homes and communities? How adequate are community facilities for aiding needy patients in their rehabilitation after discharge from the hospital? These are questions that are being given thoughtful consideration by the treatment team at Crease Clinic. They are questions of particular concern to the Social Service Department at the Clinic, which assumes major responsibility for the welfare of patients in the transitional period following discharge.

Some characteristic problems in rehabilitation from Crease Clinic are related to the short-term nature of hospitalization, and to the fact that voluntary admission can be terminated within five days notice given by the patient. It has been found in experience that the average length of stay of patients actually is approximately two months. These circumstances limit the time available whereby the Clinic staff can assess the patient's social situation, and formulate a post-discharge plan.

A majority of the patients are rehabilitated directly back to their families or friends with the assistance of adequate

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1 Pepper, op cit, Chap. 4.
social casework before and during the actual rehabilitation placement. The problems of this group may not be related directly to their illness but may be primarily associated with the physical disruption of routine family living resulting from the absence in hospital of the housewife, the mother or the breadwinner. The family member's absence from home may have added problems and responsibilities for a wife or husband, privation for the children; and supportive casework help is requested in facilitating the family's return to more stable equilibrium.

It is the experience of the staff, however, that there are many patients who do not possess family, friends or financial resources; or whose family and friends are disinterested or actually hostile or resentful. These patients require more extensive help and support from the Clinic in becoming securely established in an emotionally healthy environment. This group has a wide variety of needs. First of all there are a multitude of very basic dependency needs which must be met before they are re-established in the community: money, food, clothing, shelter, a job, a meaningful relationship with some interested person or persons. For a person who has been hospitalized for a mental or nervous disorder, the return to the community is often a threatening experience; and to lack the security of friends and adequate finances enhances this feeling of distress and uncertainty, and in turn increases the possibility of a relapse and a return to hospital. These patients may look to their discharge with all the insecurity of a person recovering from an illness, or they may prefer to regard themselves as never having been sick, but in
either event they are fearful of the rejecting attitudes of society.

There are also many patients who leave the hospital with a residuum of the mental disorder or upset which led to their hospitalization. These patients have received treatment and have made a certain recovery, enabling them to return to the community; but they have retained a certain mental handicap which adds to their problems of re-establishment. Of the total of 1172 patients discharged from Crease Clinic in 1952-53, for example, the psychiatric condition of those described as "improved" numbered 727, or more than one half; the remainder of those discharged being described as "recovered", "unimproved", or "without psychosis and unclassified". Such patients may retain feelings of undue submissiveness, or depression, or anxiety, or fear of people. Sometimes these feelings are related to an unresolved marital conflict, or an unsatisfactory work adjustment which precipitated the breakdown but remains unsolved. Sometimes the feelings are the end result of years of emotional deprivation or conflict with parents. The inner problems of these patients may be of such severity that they cannot be further reduced by known methods of psychiatric therapy; but they are persons whose life can be made more comfortable by a kinder environment or by the sympathetic understanding and interest of the social worker who continues to see him.

The discharged mental patient who is inwardly weakened or handicapped in his ability to make wise decisions or to get along well with family or fellow employees, needs help in meeting the
additional external stress of securing accommodation, a job, and of functioning independently in our complex society. For such a person with a severe mental handicap, the psychiatrist sometimes recommends sheltered accommodation, protective work placement or financial subsidization in maintenance. The patient thus would have a transitional experience or period of convalescence between the protective hospital setting and complete independent management of his affairs in the community. But if community resources are lacking to make possible the implementation of such recommendations, what is to be done and where is the patient to go? Frequently it is for the individual social worker to seek the best available compromise solution and to help the patient as well as he can to adjust to a limiting situation.

Theme of the Thesis

A trend in the manner of coping with the incidence of mental disease has been to accent the maintenance of good mental health and to bring closer to community awareness the treatment facilities set up to restore the health of the mentally sick. The master design for mental health care in British Columbia calls for attempts to prevent or to solve the problems while people live in their own homes and before hospitalization becomes necessary. When institutional treatment is indicated the Crease Clinic receives patients who will be absent from their homes for short-term hospitalization; and the Provincial Mental Hospital receives patients for whom long-term hospitalization (and consequently a long absence from home) is indicated. One of the next planned steps is the establishment of a Day Hospital where active treatment
for day patients would be available on an out-patient basis. This out-patient department would fill the gap between the general hospitals and the Crease Clinic. It would fulfill the need for further follow-up treatment and supervision of patients discharged from Crease Clinic.

At the present time, however, patients are discharged in full from Crease Clinic, and there is no administrative provision for probationary services, as is the case at the Provincial Mental Hospital. Consequently the follow-up services at present undertaken by social workers represent an extension of the clinical of the Crease Clinic into a necessarily limited out-patient department service. A recent study undertaken by the social service staff 1 indicated that the lack of a central office in the Clinic to mobilize all the rehabilitation resources of the community, together with the rapid turn-over and short stay of the patients, resulted in inadequate preparation for rehabilitation, with readmissions being one of the final results. An additional limiting factor in discharge planning is that the average length of stay of patients is approximately two months. Due partly to the pressure of work on the Clinic social workers and to the lack of a central rehabilitation office, it frequently happens that a careful evaluation of a patient's potentialities, abilities, aptitudes and special needs cannot be undertaken preceding discharge.

The present study considers the limited out-patient services now available within the perspective of a comprehensive rehabili-

1 Pepper, op cit.
tation service for discharged mental patients. It seeks to ascertain the prevalence of patient need in three areas of adjustment: housing, vocational skills and training, and problems of inner stress requiring casework services. It then makes a descriptive survey of available resources within the hospital and in the community at large, with respect to these three selected areas of need. Of the many kinds of problems and needs experienced by discharged patients, the three areas of adjustment have been arbitrarily chosen: housing and a job being basic needs; and problems of inner stress being a need indicated by the records of the Social Service Department and the writer's own experience. This selection is confirmed by much current reference material on rehabilitation.

In order to make the study more manageable, the scope of the thesis is limited to an examination of the case records of male patients only; also those who were discharged from Crease Clinic during a recent year, and only those who were referred to the Social Service Department during their hospitalization. Pertinent information relative to the three categories of need was extracted from case records by means of a schedule, an outline of which appears in the Appendix. A full year's sample was decided upon, so as to include employment needs at all seasons and levels of employment. "Needs" are those denoted either by the recommendations of the treatment team or arising from the patient's own request for service. Other needs, no matter how obvious, are not considered in the present study if no recommendation or request was made about them.
It may be noted that the case records or unit files of patients are a comprehensive compilation of the impressions and services of professional staff members who have contact with the patient. The file includes the ward notes of the doctors, the daily records of nursing and treatment staffs, the psychological reports, social service notes, and reports of the rehabilitation officer. The material for this study was obtained primarily from the reports of the psychiatrist, the social worker and the rehabilitation officer.
Chapter 2

Common needs in Rehabilitation

Human experience has been described as the interaction of the individual and his total environment; and living as "the process of accommodating our changed and unchanged selves to changed and unchanged surroundings." From this viewpoint a person's life will be successful or not, according as his power of accommodation is equal to or unequal to the strain of fusing and adjusting internal and external changes. It is assumed that human beings have certain needs and that the dynamic for the interaction of individual and environment is found in a person's striving to meet these needs. The striving is part of the urge for survival, of the will to grow and improve; and on this the whole idea of rehabilitation is based.

The fundamental needs of man have been variably stated by theologians, philosophers, scientists, and statesmen. They include - as well as the physical needs of food, clothing, and shelter - "an opportunity to grow up free to make choices which will make it possible for him to secure a living, establish a

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home, raise children, enjoy leisure, and feel at home in the universe." The need to be loved is part of the basic human psychological structure. The individual's behaviour represents his unique way of meeting his needs within the framework of his environment; it is a manifestation of his attempt to adjust so that he may be as comfortable as possible. Because some of his internal needs may conflict with others, because he may be frustrated in meeting his needs by the external world of reality, and because he does not live in isolation but in a social milieu, the attainment of a comfortable, personal adjustment not only is an achievement of considerable magnitude but is also a relative matter. The quality of human adjustment is relative when measured in terms of the psychological concept of maturity. Life may become qualitatively richer and more meaningful. The mature person has found a pattern of behaviour which permits him to live constructively in his social world, and which enables him to develop his unique potentialities.

When we speak of human experience as the interaction of the individual with his outer and inner environment, and of human behaviour as the end product of the process of achieving satisfaction of needs, we are presuming the operation within individual persons of a dynamic coordinator,-the "I",-a medium of adjustment between the individual and the outer world. In psychoanalytical terms this executive function is included in the concept of the ego. The ego represents the attempts of the person

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to keep harmonious the relationship between the primitive instinctual urges or drives (concept of the id), the conscience or critic (concept of the superego), and the reality world. The various methods used by the ego to keep a balance or to attain "wholeness" in the psychic structure are called mental mechanisms. This entire theoretical structure is a professional attempt to comprehend the functional unity of the various components of personality. It serves as a useful tool and means of communication for professional persons in defining personality problems and prescribing programs of treatment.

The outcome of the person's contact with his environment may be successful, in the sense that he achieves an adjustment satisfactory to himself and to others; or it may be unsuccessful, in the sense that he has failed to achieve an adjustment satisfactory to himself and to his fellows. The basis for success or failure rests in the variations and combinations of the factors noted: the individual's power of adjustment, and the pressures or strains to which the individual is exposed in his environment. When failures in adjustment become too great for the individual or too noticeable to his fellows, he comes or is sent to a person who can help him with his material needs or with problems of inner stress. Assistance is available from the professional groups concerned with helping people to a more satisfactory adjustment: doctors, clergymen, teachers, social workers. Persons whose adjustment has been unsatisfactory may be distinguished from the theoretical norm of adjustment by their unusual behaviour represented by two different types of reaction to
failure: One type of reaction to failure is seen in a person who finds himself incapable of fulfilling the requirements of his particular situation and attempts adjustment by resorting to "psychological flight" from the situation. A second type of reaction is that of attacking the situation directly. Both ways of reacting are disastrous: one resulting in damage to the personality, the latter in damage to the situation. The former type of behaviour is exemplified in the form of character traits such as seclusiveness, timidity, fears, suspicions, some forms of physical illness, excessive dependency, and other emotional symptoms included in the category of poor mental health. The latter reaction may represent a pattern of delinquency and crime. Both reaction patterns may be said to result from a failure in the adaptive capacity of the ego to resolve the environmental pressures impinging upon the personality. Crime or social misbehaviour may represent an attack upon the environment; mental ill health, a retreat from it.

A third reaction is that of neurotic adjustment. This is a complicated behaviour pattern wherein a person is neither able to express his drives and meet his needs by direct action, nor successfully to repress the wishes. So he expresses them in symptoms which partially or indirectly or symbolically gratify his need, and at the same time serve as a form of self-punishment for and denial of gratification. The development of such disadvantageous substitutions cause him suffering which counter-balances his secret pleasure.
The mature person does not resort to flight or attack or waste psychic energy in neurotic frustration, but rather learns to accept the limitations of the present situation and to live with them, at the same time joining with others in remedial social action programs.

The emotional problems presented by patients in a psychiatric treatment centre are apt to be extreme examples of the reaction patterns so far outlined. Delinquent persons frequently become inmates of gaols and penitentiaries and may be referred for psychiatric assessment. Persons classified as psychotic or psychoneurotic may become patients in mental hospitals. The psychoses are the most extreme of all emotional disorders, wherein the ego partially or totally has given up the function of estimating the external world and making adoptions to it. In psychoanalytic phrasing, the ego of the psychotic distorts reality and allows instinctual impulses to find expression either directly or symbolically. The psychoneurotic patient has become so frustrated by inner neurotic conflicts that normal routine living is not tolerable, and in some cases treatment by professionally trained people may be called for.

The Sample Group Studied

In order to ascertain the nature and approximate frequency with which post-discharge needs and problems are encountered, it was decided to review the discharge history of a sample of one hundred male patients admitted to the Crease Clinic in a recent year. The fiscal year April 1, 1952, to March 31, 1953, was chosen. A schedule was used to collect together all pertinent
information on individual patients, and to record what rehabilitation services were recommended by the psychiatrist, or carried out by the social worker. The sample group of one hundred patients was selected by considering every fifth case (male and female) referred to the Social Service Department during the period concerned. The number of male patients turned out to be 109, and the first nine selected by this means were disregarded, so as to arrive at a round figure of 100, for ease of tabulation. The maximum period of treatment of these patients was four months, the average being two months. The ages of the group ranged from boys in their teens to men in their seventy's. The educational level of the group was fairly high for those reporting this information; the larger proportion having completed at least Grade 8. The occupational experience of the men was widely representative, ranging from unskilled manual work to persons practicing a profession.

All cases in the sample had been referred to a social worker. This means that the worker is responsible for such social services as may be indicated during the period of hospitalization. It is also expected that in a joint assessment with the psychiatrist, patient needs relating to discharge will be provided for, and appropriate services offered to meet needs in the post-discharge period.

Some limitations in the method of study may be noted. Probably the biggest practical limitation was lack of detailed or standardized recording on the unit files. Data was secured from the ward notes of the psychiatrist, the summaries of the rehabilitation officer, and the social service notes. Only those
needs indicated in these records were tabulated, although it may be that some rehabilitation problems actually experienced were not recorded. Furthermore, it sometimes happened in a particular case record that whereas an expression of concern or an actual recommendation was made by the psychiatrist for a certain form of post-discharge care, no record was available as to whether or not the recommendation was carried out. As well, often no account was given as to the reasons for a particular recommendation, or in what instances a compromise plan was agreed upon because of lack of resources for carrying out an "ideal" plan for post-discharge care. Generally speaking, the pattern of recording observed in the sample group is that in a brief final statement by the psychiatrist or social worker there is mention of what plans were made for the patient when he was discharged. The brief statement may contain a general reference to the fact that the rehabilitation officer or social worker were helping the patient find a job or accommodation, or that the social worker would offer follow-up casework services to support the patient in a particular aspect of his adjustment. It sometimes happens that no comments can be found referring to the specific social circumstances at the point of discharge.

Other limitations are inherent in the categories chosen in the schedule. For example, information on education was obtained from the admission form, which includes no more than reference to the grade completed in school. As the major concern was not in this area of adjustment, further details as to specialization or to personal reaction to education were not drawn from social or medical histories. In the employment
categories, arbitrary divisions were made between skilled and unskilled manual labour. For example, a farmer was considered "skilled manual labour", whereas a farm hand was listed as "unskilled manual labour".

For people referred to Social Welfare Branch offices, the unit files did not always specify the post-discharge needs in the same categories chosen in the schedule. Most were referred for long-term casework service, the primary need in some cases being for financial assistance. Consequently in the tabulation all referrals to Social Welfare Branch are included in the one category, without sub-classification under job placement or housing.

Two groupings in the schedule are of those cases which did not contain a recommendation for, or otherwise did not require, post-discharge services from Crease Clinic. For example, one group is composed of those patients discharged to the community who returned directly to their homes without aid; and the second includes those who were discharged directly to an institution or hospital. Some patients are discharged to the Provincial Mental Hospital for further treatment; some to general hospitals for surgery or other therapy; some to T.B. sanitoria for specialized care; and some to correctional institutions such as the Boys' Industrial School. Approximately one male patient in seven is admitted to the Provincial Mental Hospital at the point of discharge from the Clinic. Also included in this category are patients who left the Clinic without permission, or patients

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1 Source: Annual Report of Mental Health Services, 1953; op cit, p.155.
admitted under voluntary papers who made their own plans and gave the prescribed five days notice requesting their discharge. A small number of patients were subject to deportation proceedings immediately at the time of discharge. As all cases in this sample had been referred to a social worker, in each instance social services would be available to facilitate the discharge. When the patient was being discharged to another hospital or institution he would be helped to anticipate the move, and if a social worker was available in the agency to which he was going, this worker would be alerted to the patient's arrival and probable need. In all instances the responsibility of Crease Clinic social workers terminated at the date of discharge.

The information thus gathered comprises a basic table for the present study (Table 1). It needs careful explanation. The results indicate that close to one-third of the men discharged from Crease Clinic, (31 per cent), have relatives or friends with whom they can live when they leave the hospital. It is assumed that these patients are able to turn to their relative or friend for any help they might require in a practical way, or in the form of encouragement and support. Although follow-up contact by a social worker was not provided, this does not mean that no social problems existed. The probable interpretation is that the patient was considered capable of self-help and of independent management of his affairs, without extra support from Clinic personnel.

Of the group of 100 patients, 8 had more than one need at the point of discharge, and these needs are indicated in Table 3.
Table 1. Rehabilitation Needs of 100 Male Patients Discharged from Crease Clinic

<table>
<thead>
<tr>
<th>Rehabilitation Needs</th>
<th>Persons</th>
<th>Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Post-discharge situations for which after-care was not indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>:discharged to third-party care</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>:miscellaneous</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>B. Relating to material needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requiring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>:housing</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>:job placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-from rehabilitation officer</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>-from social work staff</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>:vocational training</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>C. Relating to inner stresses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requiring casework services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>:from social work staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-short-term contact</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>-long-term contact</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>:from Social Welfare Branch staff</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>:from other social agency</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>D. No record of discharge situation</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>E. Other</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>52</td>
</tr>
</tbody>
</table>
Table 2. **Destination of Discharged Patients For Whom After-Care Was Not Indicated**

<table>
<thead>
<tr>
<th>Destination</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to third party care</td>
<td>31</td>
</tr>
<tr>
<td>Discharged to own care</td>
<td>8</td>
</tr>
<tr>
<td>Discharged and admitted to Prov'l Mental Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Discharged and admitted to general hospitals</td>
<td>3</td>
</tr>
<tr>
<td>Discharged and admitted to Boys' Industrial School</td>
<td>1</td>
</tr>
<tr>
<td>Deported</td>
<td>1</td>
</tr>
<tr>
<td>In care of Dep't of Indian Affairs</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>
Table 3. Patients With More Than One Need

<table>
<thead>
<tr>
<th>Needs</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job and housing</td>
<td>4</td>
</tr>
<tr>
<td>Job and help with inner stress</td>
<td>3</td>
</tr>
<tr>
<td>Housing and help with inner stress</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

That only 8 patients had more than one problem may at first seem surprising, for patients who have suffered a mental breakdown have multitudes of problems and experience many inner and outer stresses which have weakened their ego. In the records however, it is generally the case that the doctor or social worker singles out the primary obstacle confronting the patient. It can be assumed therefore, that this is the main problem, but not necessarily the only problem. It can be assumed also that the doctor and social worker have made an assessment of the patient's situation; and have reported that he lacks a particular basic need such as housing or a job; or that he will need some extra emotional support if the danger of a future
breakdown is to be lessened.

**Housing**

If the sample cases are representative, more than one-fifth (21 per cent) require environmental aid in getting a place to stay, finding a job, or obtaining training in some vocation. Five requests were made on behalf of patients who were destitute of housing resources and who were totally dependent on receiving aid from Clinic personnel before they could leave the hospital. Every person needs a place to stay, and adequate housing is therefore an obvious and immediate need of every patient when he leaves the Crease Clinic. For the patient who has his own home, or has money to rent a room, or who has understanding and accepting friends or relatives with whom to live, many of the problems of accommodation are eliminated. But patients are referred to the social worker for help in this area of adjustment when a deficiency of some sort is apparent. The referred patient may not have any money to rent a room; he may have no friends or family members in the vicinity; or the family may have nothing to do with the patient, leaving him to make his own arrangements as best he can. Frequently the patient's life situation is such that he must return to live with a wife or husband or parent, when strained relationship exists which may have been the precipitating or contributing factor in his illness. In such a situation the social worker will assume a helping role both with the patient and his relative, so that the living arrangement will provide as few stresses and strains for the patient as
possible. The present study did not undertake a qualitative investigation of the patient's housing, as to whether or not it was satisfactory. The five requests refer to patients who did not have even a room to which to go.

It is sometimes the case that a discharged patient's adjustment would be facilitated by some degree of care and supervision by relatives or boarding house operators. Occasionally a greater degree of supervision is required by patients who cannot manage their own affairs completely and are unable to support themselves fully in employment, and for these a foster home type of care is recommended by the psychiatrist.

Locating suitable housing is predominantly a practical service, although some form of counselling or modification of the attitudes of others is frequently called for as well. It was originally planned to subdivide this category according to the factors of financial need and need for supervision, However, on examination of the sample group of cases, recorded information was either lacking or was not sufficiently refined to make possible a sub-classification.

Needs in Vocational Adjustment

This study considered three components of vocational need: job placement, training or re-training, and sheltered employment. If the figures are representative 16 per cent of the discharged men have needs in this area. Only one of the 16 was for training. The need for job placement means that the patient's primary problem is finding a job, rather than indecision as to choice of vocation. Vocational services to meet this need include finding a job for the patient, seeing that he is placed in the job, and ideally
should include subsequent contact with the patient and his employer to ascertain if the placement is mutually satisfactory.

A need for vocational training or re-training may be indicated when the patient himself expresses a desire for it, or when such training is recommended by the treatment team. For example, a young patient may have made a choice in favor of a particular trade but lack training for it. A middle-aged patient may have some basic skills in a particular line of work but require re-training or "brush-up" courses to place him in a better position to compete in the employment market.

A need for protective work placement refers to a patient who is capable of living in the community and of doing a job of work, but whose mental and emotional state is such that he is incapable of withstanding the normal stresses and demands of competitive employment. Somewhat surprisingly, examination of the case records of the sample group of patients failed to reveal mention of this particular need. It would appear either that this problem occurs infrequently, or that such a recommendation is not considered (and therefore not recorded) by the treatment team due to their awareness that resources in the community to meet the need are limited or completely lacking. It may be that this type of placement is of more frequent significance for patients of a mental hospital with more serious and more incapacitating forms of mental illness than are usual in the Grease Clinic.

The nature and the extent of the help which patients may require in vocational adjustment varies widely, for many factors
are involved. For every person, a satisfying work experience is a major part of good mental health. Not only is work necessary for the support of oneself and one's family, but it is an important outlet for many natural impulses such as competitiveness and aggression. For some, success at work is a compensation for weakness in other areas. Work sometimes brings people into close and friendly relationships with others. It may also be a creative activity which satisfies basic emotional needs. To some people work brings recognition and prestige. Young people often look upon a job as a symbol of maturity. Older people who continue at work after the usual time for retirement feel that they are useful and contributing members of society and not a burden. In Canadian culture it is expected that a man should work, and inability to hold a job becomes a reflection upon his adequacy. Unemployment affects not only the man but also his wife and children; the results being not only financial hardship but also a wounding of pride, with feelings of guilt and shame. Satisfying work, then, is as important for most people as are food, sleep, and recreation; and few people who do not work are genuinely happy.

Despite its importance in good mental health, many people have difficulty in achieving a satisfying work experience. Many young people are uncertain about their choice of a vocation or lack knowledge of what preparation is needed to achieve their goal. Some never find a really satisfying work placement. In an industrial setting it is difficult for workers to have the feeling that they are more than anonymous "cogs in a great machine"; and management-labour relations need strengthening.
so that workers feel they are useful members of society. In times of depression or seasonal unemployment there are not enough jobs to go around. A man who is unable to find work is unable to support himself or his family. Unemployment therefore may have devastating effects upon a man's sense of worth and usefulness as an independent and contributing member of society.

The hazards and difficulties in achieving a good vocational adjustment are frequently accentuated for those who are discharged from a psychiatric clinic. Unsatisfactory work itself may have been a contributing factor in the onset of the mental illness, and when such a person returns to the community he will need to effect a more satisfactory resolution of this problem if the gains in psychiatric treatment are to be implemented and retained. Emotional problems may have reduced a patient's working efficiency, blocked the achievement of his maximum potentialities for work, caused a patient to overreach himself in vocational expectations, or prevented the full personal satisfaction which work might bring. Patients sometimes bring to the Crease Clinic their anxieties about employment, lack of work skills or status; their worries about personal relationships on jobs; their confusions about the kind of vocation to choose or the kind of job to look for; and their convictions that they had greater or lesser abilities than they required on their present jobs. These expressions of concern are related to their problems in social and interpersonal relationships.

Vocational adjustment is only a part, but an important part, of the patient's total adjustment to his environment.
In its broadest terms, psychiatric treatment is aimed to improve this total adjustment, and one of the tests of effective treatment is a patient's ability to cope with employment stresses. One of the practical difficulties is that hospitalization, even for a few weeks or months, may mean loss of a job and the necessity of locating a new one after discharge. If a patient returns to the same job he may be apprehensive of the response of his fellow employees to his mental illness, and, fearing that he will be stigmatized, he may even refuse to consider going back. Many patients retain a residuum of their mental illness, so that they are handicapped in their ability to manage their own affairs, look for work, or to get along with fellow-workers. These patients are fearful of, and are quick to sense any rejection by employers or anyone else. They may have grave doubts as to whether or not they can contribute anything in a job situation. Vocational counselling of such mentally handicapped persons requires patience, understanding and encouragement by the counsellor in helping each patient to reach his own best possibilities. We cannot discuss in further detail here the technical casework processes which may be utilized by the social worker in helping patients in their vocational adjustment, other than to note the unique vocational problems presented by discharged mental patients.

Reference material dealing with the vocational rehabilitation of psychiatric patients indicates that the largest number who will need and profit by vocational services are young people, largely schizophrenics, who have little or no previous work history. These young patients need plenty of time to find
their work goals. Accurate information should be given them about the satisfactions and dissatisfactions to be expected from different kinds of work. This group of patients are apt to be unrealistic and their first plans are often impracticable. In practice, discussing work plans is a fundamental means of testing on a reality basis the patient's readiness to return to the community. Much patience is called for in helping the patient to a final plan of his own. It has been found in some instances that the counselling process takes two-and-one-half times as long for the emotionally handicapped as for the physically handicapped.

The aim in vocational counselling is to help the patient to a work goal in which his maximal potential is reached in terms of intellectual capacities, skills and aptitudes, vocational interest or preference, physical condition, and psychiatric disability. To accomplish this aim, the counsellor, from the point of view of good professional social work practice, will work in close collaboration with people in other disciplines. For example, at the Crease Clinic, the social worker or rehabilitation officer ideally would have the assessment of the psychiatrist of the patient's capability to function under the stresses and strains of a particular work placement. He would also have the assessment of the psychologist as to the patient's intellectual capacities and work aptitudes, so as to indicate

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his capability for a particular job or his need for vocational training. The social worker's assessment of the psychosocial situation reveals some of the social, family and practical considerations in planning. Particular work settings must be understood and related to the patient's personality and social situation. Details to be considered in work settings are the physical set-up, the relationship with staff and supervisors, hours of employment, degree of responsibility, and the nature and level of work and production requirements. All told, the process of vocational counselling is a highly personalized one of matching the unique needs and capacities of a particular patient to a work goal. It is a professional undertaking which may require many hours of interviews, and which calls for much skill, good judgement, and adaptability on the part of the counsellor.

A satisfying work experience is such an important factor in mental health, that time and effort are justified to ensure the best possible vocational adjustment of the discharged mental patient. A good work adjustment will heighten his sense of worth and contribute to his over-all adjustment, thus assisting him to maintain the gains in treatment he has received in hospital. As already noted, the vocational needs of patients are not all the same, so that individual help is required. Vocational services may include help in finding a job, help in choosing a vocation and in getting training for it, help in settlement in a protective work placement, or follow-up contact and encouragement after a placement has been made. Planning for a
patient's vocational future should begin at the time of a patient's admission. Primary responsibility is with the psychiatrist, but the entire hospital staff should be alert to the patient's probable need for a job after his treatment is concluded.

Extra-mural Treatment Needs

There are a number of patients receiving casework services during their stay in the hospital whose mental and emotional equilibrium at the time of discharge is such that continued encouragement and support is required to strengthen them. Judging from the present study, this is true of nearly one in three of discharged patients already referred for casework. Thirty one requests for this type of after-care were recorded, as shown in Section C. of Table 1. As noted earlier in this study, post-discharge casework services are frequently recommended by the psychiatrist to assist patients in re-establishing themselves and in maintaining the treatment gains made in the Clinic. For the purposes of this thesis, extra-mural treatment by social workers includes efforts in the relief of internal stress, when predominant concern is the provision of emotional support rather than a practical service. In some instances these casework services are more or less brief and transitory in nature, contact being maintained for only a few weeks until the patient is settled comfortably in his home and job. Henceforth the patient is expected to be able to manage independently without casework support or help from the social worker. In other instances, when inner and outer stresses upon the patient
are anticipated and are expected to remain for several months, long-term casework services may be recommended by the psychiatrist. These services are in the nature of extra support from the Clinic, the aim being to alleviate the possibility of a relapse and subsequent re-admission to the Clinic. Because of the interrelatedness of factors in human experience, such casework support may touch upon a wide variety of human problems: marital conflict, unsatisfactory vocational adjustment, financial burdens, and so forth. Help may also be required by the patient whose emotional or mental disturbance continues to handicap him in making adjustments to civilian living. This kind of treatment represents an extension into the community of the treatment facilities of the Crease Clinic.

The structure and function of the Social Service Department at Crease Clinic is such that extra-mural services to patients residing in the Greater Vancouver area are given by the Clinic social workers. In the present sample there are 10 requests of this nature. Patients whose residence is outside Greater Vancouver are served by the district or amalgamated offices of Social Welfare Branch. In the latter instance, supervisory and consultative help with the psychiatric aspects of post-discharge care of patients is provided by the social workers at Crease Clinic, who have access to psychiatric consultation. The sample contained 13 requests for this service. This investigation distinguishes four categories of follow-up casework services. The first two categories refer to services given by Crease Clinic social workers. Of these, the phrase "short-term service"
designates contacts limited in duration to less than one month following discharge; "long-term service" will indicate contacts of longer duration than one month. We will also distinguish the referrals of cases for service to Social Welfare Branch offices, and referrals to other social agencies in Vancouver or elsewhere. "Other social agencies" includes the Provincial Probation Service, Vancouver City Social Service Department, and children's and family agencies. Eight requests in the sample fell into this category. Referrals are made to other social agencies when the predominant problem relates to the function of the particular agency. If service is required with the psychiatric aspects of after-care, the case is usually carried on a joint basis with the Crease Clinic Department.

The remainder of the sample reveals the proportion of patients who are discharged directly to another hospital or institution. The destination of these patients who did not receive post-discharge service from Crease Clinic staff is shown in Table 2. There were 8 patients who were discharged on an independent basis, who established themselves without reliance on friends or family or hospital personnel, and who carried out their own plans and living arrangements without follow-up contact from Crease Clinic. Of the remaining 10 patients, 4 were committed to the Provincial Mental Hospital; 3 were admitted to general hospitals for medical or surgical therapy; one was admitted to the Boy's Industrial School; one was deported; and one was discharged in care of the Department of Indian Affairs.

In 3 instances the unit files failed to indicate the
destination of the patient at the point of discharge, what plans were made, or whether or not a post-discharge service was required. Three patients left the Clinic against advice and one died in hospital.

Rehabilitation a Process of Meeting Needs

The figures which have now been reviewed provide a highly significant cross-section of the kinds of situations faced by the discharged mental patient, and the relative frequency with which certain types of problems are experienced. They give practical meaning to "rehabilitation", the process whereby the needs are met which enable the patient to become re-established as a citizen. For the mental patient it is not only a question of having a house and a job; it is a matter of attaining a comfortable equilibrium in the face of outer pressures and inner turmoil. If the sample of cases studied are representative, the proportion of discharged patients for whom the outer pressures of material needs are a significant problem is approximately one in five; and the proportion of patients who require help with inner stresses is approximately one in three. During a patient's stay in hospital, the role of helping persons is to help release the healing forces at work within the personality which are struggling to achieve harmony, wholeness and happiness. When the patient leaves the hospital doors the aid of helping persons is required to meet the material and emotional needs of the proportion of patients noted. How, and by whom these needs are met, will be considered in the following chapter.
Chapter 3

Resources For Meeting Needs

The variety and frequency of the rehabilitation needs of patients discharged from Crease Clinic is well illustrated by the factual material in the foregoing chapter. How far they can be met depends on, (a) the resources which the patient has when he comes to the Clinic, (b) any changes in his situation during his period of treatment, and, (c) what the social worker can mobilize for him, or help him use, on discharge. The social worker is the staff member who serves as a link between the Clinic and the community; and it is therefore largely through his efforts that comprehensive social services are mobilized to meet needs. Whereas it is not within the scope of this study to discuss in detail the technical casework processes which may be used in bringing social services to discharged mental patients, it is helpful to note some broad classifications of casework treatment methods which are generally accepted in the profession of social work. All of these methods may be utilized by the social worker in his overall effort in aiding patients; but to present a picture of some of the concrete discharge problems, the needs covered under the inclusive term "casework services to discharged
patients" are broken down into several categories.

In social work professional literature it is recognized that casework in any area of treatment is composed of clusters of basic techniques, depending on the problem, the aim, treatability, agency function and so forth. These factors include the building of a professional relationship; the establishment of confidence; the reduction of anxiety by acceptance and support; the maintenance of focus on specific goals desired by the client; the support of constructive defences and work with the relatively healthy part of the client's personality; and the use of practical resources. Interviewing and the use of relationship are basic common factors in all casework. Because personal and social combinations shift and overlap, all of the techniques noted may be used in one particular case, but weighted differently in another. A differential use of techniques is employed in individual cases on the basis of diagnosis of the social problem.

On this common basis, it is possible and helpful to make a simple classification of casework treatment methods into three divisions: one, administration of a practical service; two, environmental manipulation; three, direct treatment. In the first of these the primary focus in assisting the client is

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Hollis, Florence, Women in Marital Conflict; A Casework Study. Family Service Association of America; New York; 1949; Chapter XI.
the worker's choice and use (on the basis of social diagnosis and through the medium of the casework relationship) of a social resource afforded by the community. Examples of practical services are providing financial aid, locating housing, and procuring legal help or medical care. By means of such services the client is aided towards realizing independence, self-help, self-awareness, and responsibility, so that he can continue to contribute something to the solution of his problem; or, if he is not able to do so, to be sustained in appropriate ways.

The second method referred to is sometimes termed "social therapy" or "indirect treatment", wherein common casework techniques are employed to help the client, but with emphasis upon changes in the social situation. "In general, such environmental modification is undertaken by the caseworker only when environmental pressures upon the client are beyond the latter's control but can be modified by the caseworker, or when such pressures are much more likely to yield to change when handled directly by the worker rather than by the client himself." Examples of such arranged situations are homemaking services, group experiences, substitute family care, and vocational or educational adjustments. Also included in this method of treatment is the modification of attitudes toward the client of significant persons in his life: parent, teacher, spouse, or employer.

In direct treatment, the purpose of interviewing is to

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1 Hollis, op. cit, p.147.
induce or re-inforce attitudes favorable to maintenance of emotional equilibrium, to making constructive decisions, and to growth or change. This method of treatment comprises three closely related yet distinguishable treatment processes to which may be applied the terms "clarification", "psychological support", and "insight development". Direct treatment leading to psychotherapy, is intensive therapy. On a less intensive level, direct treatment is sometimes referred to as counselling, a form of treatment probably more frequently used in casework with discharged mental patients. "Counselling is intended to help a person in a rational way to sort out the issues in his situation, to clarify his problem and his conflicts with reality, to discuss the feasibility of the various courses of action, and to free the client realistically to assume the responsibility of making a choice."

If the 100 cases studied are representative, the main problem of approximately 21 per cent of the male patients discharged from Crease Clinic is material need of housing or a job. The chief need of approximately 31 per cent of the patients is help with inner problems of emotional stress. Patients with these needs receive help either in direct service from the social worker and rehabilitation officer, or as a result of community services mobilized on their behalf by these staff members. The social worker's body of knowledge and

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1 An enlargement of these terms may be found in Hollis, op cit, Chapter XI.
2 Hamilton, op cit, p.250.
acquired skill relates both to casework help available through a worker-patient relationship, and also to the skilled use of community resources for the benefit of the client. The social worker is active in both areas of internal and external stress, helping the patient by locating work and housing, and also helping the patient to hold to his treatment gains through individual and family casework services. There are many ways of helping in these two areas, one of the major ways being to put the patient in touch with the community agency which can best meet his particular need. Public welfare and social assistance agencies can be of great help in providing financial support, in securing accommodation; and in the case of the Social Welfare Branch, in the provision of casework services outside the Greater Vancouver area. Children's and family agencies can be of vital service when the patient's problem relates more specifically to child and family welfare. Thirteen per cent of the cases studied were referred to Social Welfare Branch, and 8 per cent to other social agencies in the community. In a discussion of available resources in meeting patient needs in rehabilitation, we require some indication of the adequacy of such resources from the two sources noted: hospital personnel and existing community facilities.

Job Placement

Job placement is a personalized service which involves finding a particular job for a particular patient, getting the person into the job, and following up by making contact with the patient and employer. In the Crease Clinic, men patients may get help of this kind from the social worker or from the
rehabilitation officer. In the year 1952 there were five caseworkers and one casework supervisor in the Continuing Casework Section of the Social Service Department, which is responsible for all rehabilitation services, of which job placement is one. (How these staff members compare in number with approved personnel standards will be discussed later.) The present rehabilitation officer is a trained social worker who was appointed to the Men's Division of the Rehabilitation Department in February 1950. His primary function is that of job placement and the location of temporary housing for a selection of male cases from both the Provincial Mental Hospital and the Crease Clinic.

The chief community resource available to social workers in job placement of patients is the National Employment Service, with offices located in Vancouver, New Westminster, and in some larger rural centres in the province. The Service is divided into various sections: farm placement, general labour, trades, and professional employment. There are also Special Placements Sections in the Vancouver and New Westminster offices, which receive referrals of those patients who present an employment handicap, including discharged mental patients with a continuing psychiatric disability. Some patients prefer to go the Employment Service office on their own. Some feel insecure about going alone and the social worker makes the preliminary contact, accompanies the patient for an interview with the Placement

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1 Source: Interview with Addison, Mr. D., Rehabilitation Officer, Crease Clinic.
Officer, and provides casework support during the placement process. When referral is made to the Special Placements Section, the social worker making the referral communicates to the Placement Officer a general picture of the kind of person the patient is, with as much information as to his vocational preferences and needs as is available. The Placement Officer needs to know whether the patient has fully recovered, if further treatment is planned, and how the residual of the patient's illness may affect his functioning in employment. The Placement Officer then endeavors to place the individual by personal contact with the prospective employers.

Personnel Officers and employers may be contacted directly by the social worker, although in general practice social workers act on the premise that the National Employment Service is the appropriate and specialized community agency to provide service in job location.

Patients who reside in rural parts of the province where no Employment Service office is located are referred to the field offices of the Social Welfare Branch for help in job placement in their home community. Approximately 35 per cent of patients come from outside the Greater Vancouver area.

A limited amount of money is available through the Business Office of the Clinic to assist patients at the time of discharge to maintain themselves until the first pay from their job is received. The maximum allowance per patient is $20. A stated

Pepper, op cit.
gratuity may be authorized for a particular patient by the attending psychiatrist. For those patients who are eligible, the Unemployment Insurance Commission may provide financial aid during the post-discharge period before employment is actually located.

It is generally agreed by the Grease Clinic staff that community resources for job placement are fairly adequate, and that little difficulty is experienced in placing patients except during periods of seasonal unemployment. However it is felt that there are too few social workers to serve the numbers of patients who need help in finding a job.

Vocational Training

The consideration of vocational training or re-training is particularly appropriate for patients in the younger age brackets who have no trade or acquired skill, for those in whom a poor vocational adjustment contributed to their illness, and for those whose personalities are appreciably altered by the mental illness. Two kinds of resources are required in vocational training: (a) the educational facilities; and (b) the necessary funds for tuition and for maintenance during the training period. Lack of community educational facilities is seldom a hindrance, and a wide variety of courses and training are available in Greater Vancouver at five different sources. These include the Vancouver Vocational Institute, operated by the Vancouver Board of School Trustees, and offering a wide selection of first class trade training. Part of the Institute's service is to help trainees into positions of employment. There
are several business colleges offering commercial training; and also privately operated matriculation schools. The Vancouver School Board sponsors night school classes during winter months. There are a wide variety of correspondence courses available under the auspices of the Department of Education, private engineering schools, and the University of British Columbia Department of Extension.

Patients who have adequate funds to finance their training need help only in arriving at a choice of vocation and in registering at the appropriate training school. But when funds are not available from the patient or his family, plans for vocational training must be deferred until the patient saves the necessary money. The Crease Clinic has no funds available for this purpose, nor at the present time are funds provided by governmental bodies.

Whereas certain government aid for vocational training is provided a limited number of persons with major physical handicaps, the terms of reference of the scheme are not as yet sufficiently broad to include persons with a psychiatric disability. In 1942, the Vocational Training Co-ordination Act was passed and administered by the Federal Department of Labour through its vocational training branch. Under the Act, various training projects are carried on by means of agreements between the Federal Government and the provinces. Schedule "M" of the

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Sources: 1. Interview with Miss R. Kickley, Secretary of Division for Guidance of Handicapped, Community Chest and Council of Greater Vancouver.
Act is an agreement between the Government of the Province of British Columbia and the Dominion Department of Labour and was originally voted for training of unemployed persons. It is now being used, in some degree, to provide vocational training for a limited number of persons with major handicaps. Authority has been granted from the Director of Technical and Vocational Training, Provincial Government, to the Division for Guidance of Handicapped of the Community Chest and Council of Greater Vancouver, to recommend such handicapped persons as they deem fit for vocational re-training. The Consultative Committee of this Division is comprised of physicians, social workers, placement officers, a psychologist, vocational counsellors and rehabilitation officers; and screens applicants for a programme of vocational training. Recently, another agreement was proposed under the Vocational Training Co-ordination Act, known as Schedule "R". Should this agreement become implemented by legislation, there will be a definite means by which handicapped persons can be given training in addition to many other benefits. Schedule "R" sets forth what are deemed to be the essential requirements and conditions of a special schedule for the training of disabled persons.

It would appear therefore that a very serious and fundamental gap in community resources exists in this area of vocational training. The facilities for training are available; but they are limited to those who have ready capital, and they exclude persons who are financially dependent or in marginal income groups. A high proportion of patients discharged from Crease
Clinic fall into the latter income bracket. It may be that in the future the terms of reference of schemes of governmental aid for vocational rehabilitation will be extended to include selected patients with mental or emotional handicaps. It will be recalled that in the United States, rehabilitation services to the physically disabled were first provided under the Vocational Rehabilitation Act of 1920. The scope of the Act was gradually enlarged until in 1943 the psychiatrically disabled were included in a joint state-federal program.

Housing

Patients who are well enough to manage their own affairs and who can afford to pay rent in advance, are usually quite able to find suitable housing on their own. Some patients need the helping hand of the social worker in getting established in a good boarding house. There are many good boarding homes in the community and they are a valuable resource to the person who can care for himself. All boarding homes, where there are more than two people, are licensed under the Welfare Institutions Licensing Act of the province.

Patients who require help in finding a place to stay are frequently those without funds. If these persons are employable they are not eligible for social assistance; and if they are simultaneously ineligible for unemployment insurance benefits, they are dependent on charity, and their plight is obvious. These patients need a place to stay while they locate a job and until they receive their first pay cheque. Some male patients are placed directly from the Clinic with mining and
logging firms, with arrangements worked out in advance for transportation directly to the camp, and for maintenance and clothing until the first cheque comes in. The small gratuity of up to twenty dollars which can be given to the patient on discharge on the authorization of the psychiatrist is sometimes not sufficient to get a person started in day-labouring jobs. The hospital maintains hotel accommodation with meals to the extent of two rooms (one in Vancouver and one in New Westminster), which are always available to the rehabilitation officer for temporary placement. Low cost housing is available at the Salvation Army Hostel in Vancouver for those patients who are able to pay their own way.

One solution of the housing problems for patients who are without funds is the provision of facilities for subsidized boarding care. An example of this type of care is a special institution called "The Vista", which is maintained by the provincial government as a mid-way home between hospital and community. This facility is limited to female patients and to a bed capacity of seven. No separate housing unit of this sort is available for men, although recommendations for its establishment appear in Annual Reports of recent years. Subsidized boarding care can be made available through public welfare agencies to patients medically certified as unemployable and who are otherwise eligible for social assistance benefits. This type of care is lacking for employable patients who need board

Birch, op cit.
and lodging until the first pay cheque is received.

If a patient's mental illness after he leaves the hospital is a source of disturbance to himself or to others, certain specialized facilities or housing arrangements are called for. For example, a moderate amount of sympathetic understanding and casual supervision by operators of boarding homes is all that is required for some patients to adjust satisfactorily in such a setting. These specialized arrangements do not exist at present, and such facilities can be found only through effort by the social worker in direct contact with an individual boarding home operator.

**Family Care**

At the present time, no special administrative arrangement or agency exists to carry on a program of family care for discharged mental patients in this province. Foster family care is defined as the placing of the mentally ill patient in a family other than his own for care. This type of placement may be used for a particular group of patients when the outlook for their recovery is not hopeful. They may be patients who have responded to hospital treatment to such an extent that it is felt they can adjust to living under close supervision in a home and benefit from the individual attention which comes from family life. Family care is also used for some patients who have responded so well to intensive hospital treatment that they are placed in

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1 Crutcher, Hester B., *Foster Home Care for Mental Patients*. The Commonwealth Fund; New York; 1944.
homes as a therapeutic measure with the purpose of hastening their recovery.

Requests made to Clinic social workers for this type of care are dealt with on an individual basis. The worker himself may seek out a home and arrange for the patient to live there; or the worker may request the co-operation and assistance of Social Welfare Branch offices or municipal public welfare agencies. The Social Welfare Branch offices do not maintain a roster of suitable homes, but they are acquainted with foster homes used for child placement, and they will make an effort to honour a specific request on behalf of a discharged patient from Crease Clinic.

Casework Services

Casework services to patients following their discharge are given by the staff of the Social Service Department at Crease Clinic, who may also refer patients to community social agencies for this type of service. As at present organized, the Department at Crease Clinic is divided into two sections: the Admissions Section, dealing with intake and brief services to patients; and the Continuing Service Section, responsible for services to patients on the ward, pre-convalescent planning, and follow-up casework services in the post-discharge period. The Admissions Section is composed of one casework supervisor and two social workers; and the Continuing Service Section is composed of one supervisor and five workers; making a total of seven workers.

The American Psychiatric Association has established certain
personnel standards for psychiatric hospitals and clinics. The personnel ratios call for at least one social worker to every 80 new admissions per year, and at least one social worker to each 60 patients on convalescent status or family care. Administrative and supervisory social workers should be provided in the ratio of one supervisor to every five caseworkers. Due to the fact that the Social Service Department at Crease Clinic does not distinguish in-patient and convalescent care in the assignments of social workers, an exact comparison with Association standards is not feasible. Neither is statistical data at hand on the number of patients on convalescent status.

However, the number of new admissions to Crease Clinic (male and female) during the fiscal year of 1952-53 was 1221, which, on the basis of the standard personnel ratios, would call for 15 social workers. This figure does not include social workers who would be assigned to patients on convalescent status and family care. On the basis of these figures, the present social service staff of seven would need to be more than doubled to fulfil the personnel standards of the American Psychiatric Association.

An assessment of the volume and the standards of service given by Social Welfare Branch offices would entail an independent research project of considerable magnitude and is beyond the scope of this thesis. The assessment would provide a pertinent

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topic for a future study and analysis.

Crease Clinic social workers may refer patients to community social agencies for a casework service of a specialized or particular nature, on a division of labour basis. These community agencies provide family, children's, and child-guidance types of service. Cases may be held jointly with the community agency, with the hospital social worker being responsible for the psychiatric supervision of the patient, and the community agency worker assuming responsibility for problems of child care, legal separation, and so forth. Some cases may be closed by the hospital social worker at the point of referral to a community agency if follow-up psychiatric supervision is not indicated.

For present purposes it is not necessary to undertake a comprehensive survey of the many community agencies available. An outline of the services which the community of Greater Vancouver has established to meet the needs and problems of its citizens is printed by the Community Chest and Council. It can be noted however that the public welfare agency of the City of Vancouver (City Social Service Department), and also the public welfare agency of the province (Social Welfare Branch), are providing the Provincial Mental Health Services valuable rehabilitation services. The City Social Service Department provides financial aid to individuals and families who are eligible. The

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2 Annual Report of Mental Health Services, 1952. op cit p.54.
Social Welfare Branch gives casework services as well as social assistance in helping patients to re-establish themselves.

Schedule A, which follows, contains short summaries of five typical cases, each illustrating a particular cluster of problems in rehabilitation. The meeting of the needs presented in the case summaries calls for the discriminating application of the resources so far discussed. The examination of the resources available in British Columbia indicates that gaps and limitations exist, especially in the provision of subsidized boarding care and financial aid, and also in the numbers of social workers employed at Crease Clinic. An extension of present resources and the creation of new ones is necessary if discharged patients in need are to have access to a comprehensive rehabilitation service. The development of this service will be discussed in the succeeding chapter.

Schedule A - Five Typical Cases

Case 1 - Sam S.

Case 1 is an illustration of ways in which hospitalization for mental illness, even for a short period, may be disruptive of routine family living. Sam S. was a 61 year old married man who was admitted as a certified patient to the Clinic in an extreme anxiety state. He was overtalkative, hyperactive and restless. The diagnosis was "manic depressive - manic". In a month's time he was discharged to his home as recovered from a

The summaries in this schedule were made from case records at Crease Clinic, with all identifying information removed or disguised in order to safeguard the confidentiality of the records.
psychotic episode. Mr. S. lived on the outskirts of a small city, where he and his wife operated an auto court. The children were married and living in their own homes. Mr. and Mrs. S. were financially dependent on the returns from the auto court, from which they made a modest living. At the time of discharge the psychiatrist advised that due to the patient's tendency to worry, he should be relieved of as much responsibility in the business management as possible; and also that due to a heart condition, Mr. S. needed to curtail his physical activity. A social worker interviewed Mrs. S. with a view to assessment of her ability to shoulder a larger measure of responsibility, and in order to learn more details about the operation of the business. It turned out that Mrs. S. was a strong, capable person, able to take over management of the court and to make arrangements whereby Mr. S. would be relieved of physical labour. Casework services were focussed on counselling Mrs. S. in planning for her husband's return home; and in helping Mr. S. to accept with as much equanimity as possible, the relinquishment of some responsibilities he ordinarily assumed as head of the household.

Case 2 - Tom T.

The case of Tom T. illustrates the extent of need of those patients who, at the time of discharge, lack financial resources and also the help of relatives in becoming established in the community. Tom was a 21 year old single man who was admitted to the Clinic under voluntary papers, and who remained for a four months period of treatment. His diagnosis was that of
"mixed schizophrenia". Background information indicated that he had been born and brought up in a rural community in Eastern Canada. He had lost the use of one eye when a boy. He had worked at numerous jobs, and it was reported that he had been unable to hold any steady employment. There was a history of petty theft. Tom had a reticent manner, and he found it difficult to talk about himself. During his hospitalization a report on the man's parents was received, to the effect that they appeared to have no real interest in the patient, and suggesting that he not return there. Tom's contacts in this province were limited to a religious group and a friend in Vancouver. He was without funds. Although it was expected that Tom would always have many problems in adjustment and that in his relationships with people he would probably remain withdrawn and unstable, he had become a little more sociable during his period of treatment and there were no complaints of petty thievery. On the basis of the information available it was decided that discharge planning should aim at Tom's re-establishment in or near Vancouver, where he would be close to his friend and religious group. The needs of this young man were therefore quite comprehensive. There were his immediate needs for a place to stay, a job with which to support himself, and sufficient cash to purchase meals until he got paid. Perhaps of more long-run importance in maintaining a state of good mental health, was his need to establish relationship with someone who would show interest and liking for him. At least in the transitional period of moving from the hospital to his new-found accommodation, he needed the support and
encouragement of the hospital social worker.

Case 3 - Don D.

Illustrative of those patients who leave the hospital with a residual of the mental disorder or upset which led to their hospitalization is the case of Don D. These patients have received treatment and have made a certain recovery, enabling them to return to the community; but they have retained a certain mental handicap which adds to their problems of re-establishment. Don D. was an 18 year old single man who was admitted to the Crease Clinic under voluntary papers, and who remained for three months treatment. The diagnosis was "pathological personality - schizoid personality". He was admitted in a tense and anxious state; and his complaints included those of nervousness, inability to concentrate on his work, and extreme irritability. During his stay in the Clinic it became apparent that his basic problem was his inability to get along with people. The problem appeared to be rooted in unsatisfactory boyhood relationships with his parents. There had been continual quarrelling between his parents for all of his living memory. He was the only child in the family. Don's mother tended to be overly-protective and solicitous of him; his father being a rigid person whose constant criticism and lack of praise was felt by the patient as severe rejection. Don was unhappy at home, but although he had made one or two attempts, he had been unable to emancipate himself from his parents, either physically or emotionally. During his hospitalization, Don's tension and anxiety subsided. There were some indications of modification
in the rejecting manner of the father; and after one or two week-end leaves at home, Don was discharged, on the understanding that the social worker would continue to see both Don and his parents. He returned to live with his parents, where it soon became evident that the modification in the attitude of the father was superficial and short-lived. Don's tension and anxiety began to mount, and this was shown by quarrelling at home and dissatisfaction at work. It was therefore apparent that a long-term contact with the social worker was called for. Don was not able to bring himself to leave home, nor was he able to live comfortably in such close relationship with his parents. Don needed help to resolve the long-standing conflicts in relationships with parents, which made it difficult for him to get along with friends, employers, and members of the opposite sex.

Case 4 — Carl C.

Carl C. is an example of a discharged patient who needed special consideration in job placement and living arrangements. Carl was a 22 year old single man who was found wandering about the countryside in a dazed condition, and who was admitted to Crease Clinic as a certified patient. He was a lonely, withdrawn, indecisive young man, with feelings of unhappiness and hostility toward his parents. The diagnosis was "simple schizophrenia"; and he was discharged as "unimproved" at the end of three months. Carl was the youngest of five children. His older siblings were well established, but indicated their unwillingness to have Carl stay with them, because he asked "foolish questions". The father was a brusque, professional man, who was impatient
with Carl's instability and flightiness in employment, and who expected more in the way of performance than Carl was able to produce. The mother was described as an eccentric person, with a mildly elated manner. Neither parent seemed able to accept their son's mental illness or to recognize his unusual behaviour as due to the illness. The parents recommended that Carl get established away from home, but although they offered some financial aid, they made no concrete plan for his re-establishment. Because of the father's harsh manner and the tenseness in the home generally, the psychiatrist considered that it would be therapeutic if Carl was rehabilitated away from home.

A supervised foster home situation was recommended. Carl was not considered a candidate for long-term treatment at the Provincial Mental Hospital; but neither was he well enough to earn a living steadily should he be discharged from the Clinic. He required some guidance in the management of money; and a work situation with few demands and stresses. Whereas remuneration from employment was considered important from the point of view of Carl's self-esteem, it was of secondary consideration to his personal feeling of comfort about any work undertaken. Carl therefore needed special consideration in becoming established in a foster home or boarding home with some supervision; and in obtaining employment where he could earn money but where competitive pressures and demands were at a minimum. Lacking a feeling of warmth and acceptance from parents or family, Carl needed the support of a relationship with a social worker over an extended period of time.
Case 5 - Lee L.

The special problems presented by Lee L., a 16 year old adolescent, illustrate some of the lacks in community facilities for residential treatment of emotionally disturbed children. Lee was a ward of a children's agency and was admitted to Crease Clinic as a certified patient with a diagnosis of "primary behaviour disorder in a teen-age boy". For several years he had presented symptoms of aggressive and delinquent behaviour, which brought about his admission to the Boys' Industrial School. He was admitted to the Crease Clinic "for assessment, evaluation and recommendations as to future planning". Initially his behaviour was no problem on the ward. He was restless and active but not to a degree considered beyond normal for an adolescent. Later he became a considerable problem, creating disturbances by annoying older patients, so that it was necessary to restrict his privileges on the ward. He was sullen, defiant, and rebellious in his manner. He had difficulty in forming relationships with people but did relate to staff members to some extent. Still later he became quieter and more co-operative, and seemed to modify somewhat his defiant behaviour.

It was the psychiatrist's judgement that Lee's behaviour was related to emotional deprivation in early years. The psychiatrist's report stated that the Clinic was not organized to deal with this type of problem, since it required a special environment suitable to the patient's age, and a much longer period of treatment than the four months available at the Crease Clinic. It was also stated that it was unlikely that the boy
at that time could adjust in any of the usual foster homes; and that he would require a special home where both parents were experienced and willing to accept a boy as seriously disturbed as Lee.

It would appear that this is the type of problem which has been met in some of the United States through residential treatment centres and specialized foster homes for emotionally disturbed children.
Chapter 4

The Development of a Comprehensive Rehabilitation Service

In recent decades the manifestation of intensive, widespread, and sustained public interest in mental hospitals has done much to break down the walls of isolation that tended to separate mental patients from the community. This public interest has been stimulated and nurtured through such media of mass communication as the press, radio and movies. As well, more direct contact of individuals with mental hospitals has resulted from the inauguration of "Open House" policies by hospital authorities, and from the development of hospital visiting plans in co-operation with the Canadian Mental Health Association. Within mental institutions themselves there has been a change in the approach to patients from one wherein custodial care in an "asylum" was predominant, to a public health approach wherein treatment and return to the community became the dominant concern. The focus of attention in this thesis has been in the problems, and programmes mobilized to meet them, of male patients returning to the community upon discharge from Crease Clinic.

The study shows that there are both common and distinctive aspects of the rehabilitation of mentally ill, as distinguished from physically ill, persons. The common aspects of the
rehabilitation process relate to the premises and concepts on which the programmes are based; and on the network of community resources upon which its successful accomplishment is dependent. Some of the philosophical and practical assumptions include recognition and acceptance of each individual as a self-respecting person no matter what his state of health; recognition of the right of every person to a "health and decency" standard of living and to opportunities to experience satisfying human relationships; recognition that the rights of the individual and of society are inter-related; recognition that progress in social welfare arises from broad community understanding as well as from creative contributions by individuals and professional groups. Community resources include agencies and groups contributing services to meet human needs in all their variety and complexity: medical, educational, social, vocational.

In this study, rehabilitation is considered to be more than the possession of vocational skills and needs, and to include all aspects of the patient's total adjustment to life. As a member of his own profession and as a responsible citizen, the social worker recognizes the relationship between the interests and needs of the mental patient and those of the community in which he lives; and he takes responsibility for participating in social action to obtain resources for the unmet needs.

Whereas in the case of physical ailments the rational resources and emotional strength of the individual can help him adjust and adapt to a changed self or a changed situation, the patient afflicted with a mental disturbance is limited in
his ability to utilize these adaptive resources and strengths. As well, in the case of mental illness it has been found that an emotionally unsatisfactory environment sometimes contributes to the onset of the illness. Consequently, rehabilitative efforts on behalf of the mentally sick are geared not only to strengthening the mental and emotional resources of the patient himself, but to modification of pathological aspects of the external environment as well. For this reason, an arm of treatment must extend beyond the walls of the Clinic into the homes and communities of its patients. This function is carried out by Clinic social workers, under the direction of psychiatrists.

Since admissions to Crease Clinic are encouraged only of the early cases of mental illness, it may be expected that mental illness is treated at an earlier, less debilitating stage, and that the residual effects of the illness are less limiting. Indications of this are seen in the fact that the sample failed to show any need for protective work placements or sheltered forms of accommodation such as family care. Whereas it is the writer's experience that such protective living arrangements are sometimes called for in the case of Crease Clinic patients, the incidence of such need is not nearly as great as might be expected at the Provincial Mental Hospital. One suggestion to develop this type of resource is to foster the establishment of homes for group living by religious, cultural, or ethnic groups in the community. The probable channels for such

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1 From an interview with Dr. F.E. McNair, Clinical Director.
community undertakings are the Canadian Mental Health Association, and the Health Division, Community Chest and Council of Greater Vancouver.

Again, in Crease Clinic the rapid turn-over of patients and the average stay of two months, call for rapid assessment of post-discharge needs of patients, and adaptability in fitting resources to needs. The brief time which staff have to help the patient is a limiting factor in mobilizing comprehensive help. What we might call a major rehabilitation effort, including personality and vocational assessment and the carrying through of a plan, requires more than two months of planning and working with a patient both during and following hospitalization. It may be that a well-staffed out-patient department to whom patients could be referred, would be the means of extending and carrying to fruition the blueprint for rehabilitation marked out by the treatment team at Crease Clinic. At the present time such major rehabilitation efforts are necessarily restricted to a very few individuals; and post-discharge help for the majority of patients is limited to minimal help in re-establishment.

Of the selected rehabilitation needs of patients studied, resources are fairly adequate for patients requiring help in finding a job. Major gaps in resources were apparent in the financing of vocational training, and in the provision of subsidized boarding home care. An over-all deficiency exists in the numbers of professionally trained social workers.

A limitation of the study is that in actual practice human
needs are not neatly separable and cannot be segmented. Rehabilitation is a highly individualized service, wherein many community services are mobilized and co-ordinated to meet the peculiar needs and capacities of an actual client. This kind of personalized service is "tailor made" for each individual discharged mental patient. It is not exclusively any one kind of professional service, such as medical service, social service or vocational service. In the Crease Clinic the team approach in planning under the direction of the doctor, is followed as closely as possible. In actual practice, the social worker and the rehabilitation officer are the professional team members who have contact in the community outside the hospital. Of these, the social worker is professionally trained to help patients cope with life stresses. From the social worker's point of view, any help given, whether practical or supportive in nature, is given on the basis of an integrated understanding of the factors operative in the patient's life situation. The focus is held to the patient who has a problem within a set of specific circumstances. On the basis of a dynamic understanding of the patient's life situation the worker is aware of the unique need of the patient for a particular kind of housing, or for a work placement of a certain nature, or for help in a particular social relationship. Consequently discrimination is a criterion for the professional administration of any service. Without an understanding of the dynamics, environmental treatment becomes merely symptomatic.
As at present organized the Men's Division of the Department of Rehabilitation functions specifically in the areas of job placement and temporary housing for patients about to be discharged. It would appear that the practice of providing jobs or housing as a service in itself is a limited manner of meeting the total needs of patients and is uncongenial to the casework principles above. This study gives primary consideration to the incidence of patient need for particular services. An evaluation of the services given is an area for further study.

Ways and Means of Developing Resources

From a consideration of the reference material in the fields of mental illness and rehabilitation, some general suggestions can be put forward as to ways and means of alleviating the present deficiencies in resources. It is also possible to point up the probable direction of movement in the development of a comprehensive rehabilitation program which includes the discharged mental patient. Effective future progress in this field will follow a road between two extremes. One extreme is the tendency to "do nothing" until all facts are gathered and more knowledge is at hand concerning mental illness. A second extreme is the tendency to regard euphorically the recent advances in psychiatric care as indicating that new horizons are easily attainable. Between the extremes, a realistic program leading to tangible progress is possible by breaking down the problems and needs into discernible well-defined areas of activity. These areas of activity include the adaptation of established services as well as the creation of new ones, in favour of more
comprehensive help for the mental patient returning to the community. Because the Grease Clinic is regarded as a treatment resource of the community, and because post-discharge care is partially dependent upon community facilities, suggestions for the future must pertain both to the hospital and to the community.

Within the hospital itself, one of the first aids to progressive development of rehabilitation services is the existence of smooth, workable and well-defined channels of communication between the various levels of hospital administration. At the present time workable channels of communication exist to deal with matters in the clinical treatment of patients. For example, the members of the treatment team come together at Ward Rounds for joint planning. The Clinical Director sends out memoranda to all concerned when there are matters in the clinical treatment to be considered. However it is axiomatic that over-all concern and responsibility for post-discharge care rests with the top levels of hospital administration. The implementation of the treatment philosophy and policies of administration is the concern and responsibility of professional staff members. Since social workers have the most direct contact with community agencies, and are most directly active in post-discharge care of patients, it follows that channels of communication must not only reach down from hospital administration to the Social Service Department, but also proceed up from the Department if administration is to be fully aware

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Pepper, op. cit., Chapter 2.
of this sector of patient need. It would appear that the appropriate lines of communication for this inter-change are through the Hospital Council to the Social Service Department. The Hospital Council is an advisory body established to discuss over-all policy, to deal with matters that transcend the fields of several services and that require the special co-operation and consultation of department heads.

Another means whereby present personnel resources may be adapted toward assisting patients on discharge is in the use of group methods in preparing patients for discharge. As all patients are not at present routinely referred to Social Service, by use of group methods a social worker could help prepare patients for leaving the hospital; help them to anticipate, and plan how to cope with, post-discharge experiences and problems; tell them where various kinds of help are available in the community and how to use this help to meet their own needs. As well, just prior to discharge, all patients might routinely be referred by the psychiatrist for an interview with a social worker, so that an assessment of their readiness for discharge, from a social as well as from a psychiatric point of view, might be made. This would be particularly important for those patients who had not previously been referred to the Continuing Casework Section of the Department. A suggestion has been made elsewhere that rehabilitation services in the Clinic be centralized and that one person be appointed to bring together information on community resources in rehabilitation.

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1 Ibid, Chapter 4.
Within the Social Service Department itself, it is suggested that a further investigation be made of the group of patients who leave the hospital without follow-up aid. The recording of a pre-discharge social study of these patients by a social worker would include an assessment of the environment to which the patient is returning, and determine the relative stability of the family constellation, as well as the positive and negative factors in the patient's social relationships and economic situation. In the case records studied in the sample, there was frequently insufficient evidence as to whether or not a thorough rehabilitation assessment was made, or as to the factors operative in the decision against follow-up service. More detailed and standardized recording of such information is called for in order to determine and classify deficiencies in personnel and resources. This information would be useful in interpreting to appropriate community and governmental sources the requirements of the Clinic if a positive approach to rehabilitation is to be implemented in action.

Development of Resources Within the Community

The development of rehabilitation resources is determined not only by what happens in the hospital, but also by the participation of hospital personnel in community planning. The social worker's responsibility to patients rests not alone in use of casework skills to bring help, but also embraces efforts in the sphere of social action. The social worker is in a position to bring into focus the lacks of community resources. As a professional person and citizen he is also obligated to
help the community plan wisely to meet these needs. To help effectively in this way the social worker requires a wide knowledge of federal, provincial and local planning, as well as vision as to how a needed project should develop, both now and in the future. As a result of the preliminary study in this thesis, a number of topics are indicated as requiring efforts in social action; further research being required to determine classification and priority of projects. The need for more financial aid is apparent in order to help patients whose lack of adjustment is accentuated by shortage of funds. An examination of rehabilitation resources shows that financial aid is especially required to secure vocational training, and for maintenance until a job and first pay-cheque are obtained. It has been found in experience that there are also needs for special forms of accommodation: subsidized boarding homes or a "vista" for males; at least a few foster homes for mental patients; specialized foster homes and/or a residential treatment institution for emotionally disturbed young people. Access to sheltered workshops and to protective work placements may be required for a limited number of patients discharged from Crease Clinic. The need for more trained social workers is well known: it is a problem still exercising the concern of hospitals, professional associations, Universities and Schools of Social Work, and the community generally.

The development of programs for the rehabilitation of mental patients is related to the development of wider community programs concerned both with civilian rehabilitation and with
mental health maintenance. For example, resources for accommodation and job placement helpful to discharged mental patients are required also in aiding the re-establishment of the arthritic, the discharged prisoner, the drug addict, the alcoholic, the tuberculous. As well, the battle for better mental health in the community is fought on many fronts, of which institutional psychiatric treatment is only one. From the point of view of sound professional practice, the social worker's concern with the rehabilitation segment of mental health maintenance should be realistically integrated with more inclusive social welfare measures. For example, specialized foster homes or residential treatment facilities for emotionally disturbed children are types of projected resources which are of interest not only for Crease Clinic personnel but also to members of social agencies, general hospitals, and child guidance clinics, who have experience in dealing with disturbed children.

Traditionally and constitutionally, the development of public health, welfare and social services in Canada has been regarded as a matter primarily for municipal and provincial action. Nevertheless, many of the earliest welfare undertakings in Canada have been initiated, not by provincial or municipal governments, but by voluntary organizations led by public-spirited citizens. As the worth of these programs was proven and as the financial burden of carrying them became too great for private philanthropy, municipal governments, first of all, responded to appeals for help by granting financial assistance without assuming administrative responsibility. Gradually the necessity
for taking over certain of the undertakings as a direct administrative responsibility of the municipal authorities became apparent. Financial, and subsequently, administrative responsibility for certain health and welfare services was imperceptibly shifted from voluntary to municipal auspices. This process repeated itself at the municipal-provincial level. Finally the federal government responded to the development of public opinion in favor of a larger measure of social security, and began to assume direct administrative as well as financial responsibility for special social service programmes. For example, federal grants to the provinces in the mental health field totalled $8,737,000 between May 1948 and March 1952.1

An example of this process of shifting responsibility for social services is seen in the development of the Vista as a rehabilitation home for women patients from the Provincial Mental Hospital and Crease Clinic. The Vista was first opened under private auspices in 1944 and was taken over by the Provincial Government in 1947.2

Voluntary community agencies may participate in the development of needed social services through the establishment of study committees and action groups. At the present time a special committee of the Community Chest and Council of Greater Vancouver is studying the question of treatment facilities for emotionally disturbed children. Another committee of the Council

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1 The Canada Year Book, 1952-53.
2 Sophie Birch, op cit.
is making a study of sheltered workshops. The Social Service Department at Crease Clinic has representation on these committees, which are both engaged in developing community resources. Some social services in the community come into being as an extension of present governmental programs. The Provincial Government has announced projected plans for the construction of a Day Hospital where active-treatment for mentally disturbed persons will be available on an out-patient basis. In addition, it is expected that the Day Hospital will act as a screen to the Crease Clinic, and be able to treat many patients without admission to hospital. It is also expected that social workers will be participating members of a treatment team on much the same basis as is now common at Crease Clinic.

In the sphere of rehabilitation specifically, recent developments at several levels of government indicate a growing interest and attention to problems of rehabilitation for handicapped persons. In December, 1951, the National Advisory Committee on Rehabilitation of Disabled Persons was set up by Order in Council to review existing rehabilitation facilities in Canada and to assess the possibility of co-ordinating existing facilities more fully. The Committee was established to provide central guidance to all provinces on matters pertaining to the development of an over-all network of services for all disabled persons in Canada. On May 1, 1953, the Federal Government made available to the provinces certain health grants to assist the provinces in the development of provincial rehabilitation programs. Under the appropriations funds were made available
for (1) training of professional rehabilitation workers, 
(2) medical rehabilitation equipment, (3) rehabilitation health services.

Spear-heading the development of a provincial rehabilitation program in British Columbia has been the Community Chest and Council of Greater Vancouver. In 1952 the Council for Guidance of Handicapped was incorporated into the Community Chest and Council, and became known as the Division for Guidance of Handicapped. The terms of reference of this Division pertain to physically handicapped persons only. Its functions are to coordinate the many agencies and the work of many professional people active in the task of helping to rehabilitate physically disabled persons. In December, 1953, the Division for Guidance of Handicapped compiled a brief of recommendations for a comprehensive rehabilitation program for the physically handicapped in the province of British Columbia. This brief was presented to the Provincial Government and contained the results of the Division's careful survey of the community resources presently available, the gaps and deficiencies in the present structure, and the needs for a comprehensive, all-inclusive, long-range rehabilitation program. Summarized in the brief are the resources of several organizations which are helping its clients to full physical, mental, psycho-social, vocational and economic rehabilitation, as well as an enumeration of the facilities, conditions and personnel deemed necessary to make the organization's program work effectively.

It may be that in due time the federal-provincial plan for
rehabilitation will make provision for persons with psychiatric disabilities. In the United States, governmental rehabilitation aid which was first provided for physically disabled, later included psychiatric disabilities; and this course of events may be repeated in this country.

The goal in the development of social welfare resources is to ensure in the community a network of facilities for meeting the needs which individuals are unable to meet themselves. The process of social action is the mobilization of group effort in the interests of social welfare. Some of the needs of patients discharged from Crease Clinic are distinctive and require specialized facilities; some of these needs are the common needs of other sick and disturbed persons. Our concern for mental patients is the development of facilities and the administrative and organizational techniques through which our knowledge and our skills can be applied.

Conclusion

The mentally sick were at one time the outcast and the wanderers of society, objects of fear, persecution or disinterest. In due time, when expediency was the apparent criterion of community attitudes, the insane were lodged privately, or in gaols, or in houses for the poor. A developing social welfare philosophy resulted in the assumption by the state of responsibility for the custody and care of the mentally handicapped in separate state-supported hospitals. The rise of modern psychiatry and the multi-discipline approach to treatment, with its goal of returning the mental patient to the community as a
participating member of it, brings to full circle the change in the way men and women think of mental illness. The change in attitude in some areas has been revolutionary. The present generation is involved in the development and implementation of practical programs to achieve the goal society has set for itself. Progress has been made in philosophy and concepts; much has been accomplished in hospital care which requires only expansion; but in the provision of a comprehensive plan for rehabilitation, much new ground has yet to be covered: in a developing philosophy and concept of practice, in building a body of knowledge and methodology, and in provision of a variety of community resources which may be integrated into the social fabric. Not until the discharged mental patient is able to make his way effectively in his home and community and has been restored to his optimal state of health, will the process of rehabilitation be complete.
### Appendix A

**Items of Information Compiled from Sample Cases**  
(One in five sample of all patients discharged from Crease Clinic, 1952-53.)

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**Discharge Situation**

A. Discharged to third party care

B. Needed housing

  Needed job placement

  Needed vocational training

C. Needs relating to inner stress

  (a) Greater Vancouver area
      : short-term contact
      : long-term contact

  (b) Outside Greater Vancouver

  (c) Referral to social agency

D. Discharged to their own care

E. Miscellaneous

F. No record of discharge situation

G. Other
Appendix B

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