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The Care of An Ageing and Disabled Group  
in a Veterans' Hospital

An Appraisal of the Domiciliary Care Programme Provided by  
the Department of Veterans' Affairs in Vancouver.

by

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Thesis Submitted in Partial Fulfilment of the  
Requirements for the Degree of  
MASTER OF SOCIAL WORK  
in the Department of Social Work

1950

The University of British Columbia

## Abstract

### The Care of An Ageing and Disabled Group in a Veterans' Hospital

This study makes an appraisal of a special example of institutional care for aged and disabled persons, namely, the specific group of veterans in Vancouver who, under present D.V.A. regulations, are regarded as being "totally disabled" and in need of domiciliary care. Chronic illness of long duration is one of the principal characteristics, though not the only one, of this group, and of their various disablements. The appraisal of this group, in relation to the domiciliary care programme, is made in the light of modern concepts of treatment and rehabilitation, but gives special attention to the contributions in understanding and relationship which can be made by the social worker.

In the welfare field, veterans are a special group because of their liability to disablement and to other possible causes of "premature ageing" which may have resulted from war service. They are a special group also because of the unusual number of facilities and opportunities for recovery and re-adjustment which have been provided for them. Domiciliary care is one of these special services, exclusively designed for veterans who require total care on a more or less permanent basis. Re-establishment of veterans with lesser handicaps already has been demonstrated on a vast scale since the end of the last war. But problems evidently remain for the type of veteran who is aged, whose disablements are of an extreme nature, and who, in spite of a superior treatment service, has not changed his total disability status. Lessons for other aged and disabled groups in the civilian population can be drawn from the present type of study.

The material of the investigation includes, first, a review of the general provisions of domiciliary care for Class-Six patients, based on over one hundred district files and a similar number of medial social service files. Detailed personal information was also obtained in interviews with many of the patients. Discussions were held with doctors and departmental administrators, and needs and services were discussed with staff members acquainted with the Class-Six patient. The basic method of using this material was to review psycho-social aspects of the status and attitudes of individual cases, to delineate basic social and emotional problems, and to appraise the domiciliary care programme in terms of its ability to meet these problems.

Social work practice and rehabilitation possibilities both reveal many gaps in the present programme, which is primarily designed to provide physical care. Case studies indicate that many of the critical factors in the older patient's adjustment are psycho-social as well as physical; yet little or no definitive treatment is given for psycho-social disorders. Recommendations, on the basis of these findings, include a method of classification and segregation of Class-six patients in groups, and the creation of rehabilitation-treatment services on an individualized basis. The role of the social worker is outlined in relation to the broader functions of the clinical team.

### ACKNOWLEDGEMENTS

Special thanks are extended to the many staff members of the Department of Veterans' Affairs who gave so freely of their time and knowledge in providing information for this study. While it is impossible to mention everyone to whom indebtedness should be acknowledged, my special appreciation is conveyed to Dr. G.H. Hutton and Dr. K.S. Ritchie of Shaughnessy Hospital; Miss Isabel Rutter, Senior Medical Social Worker; and Mr. Blair Clerk, Mr. R. Hodson, and Mr. W. McKenzie of the Veterans' Welfare Services Branch, for their generosity in devoting a great deal of time to the discussion of material in this text.

Special gratitude is also owing to Dr. L.C. Marsh, Miss Helen Wolfe, and Mr. T.L. Exner of the Department of Social Work, University of British Columbia, for the excellent guidance which they were able to give.

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# THE CARE OF AN AGEING AND DISABLED GROUP

## IN A VETERANS' HOSPITAL

### Chapter I

#### Background of the Study

The ability of the Canadian people to care for the ill and the disabled has advanced remarkably in recent years. Along with the steady development of new methods has come improved facilities and increasingly effective treatment. The prospects of recovery from a serious illness or injury have been greatly enhanced by technological advancements and improved medical skill. However, the recent "discovery" which, perhaps, is of greatest significance to the future well-being of disabled persons lies in the widening concept of disease and of society's responsibility to the ailing individual. Formerly, science focussed its attention on the specific ailment and sought to render a specific "cure". Later, this interest was extended to include prevention. In turn, the studies of prevention of illness wrought basic changes in the attitude towards cure. Greater understanding of causation led to a broadened approach which now seeks to understand the patient as a whole, and his welfare in relation to the society in which he lives.

Jonathan C. Meakins, M.D., Acting Chairman of the Montreal Rehabilitation Survey Committee, brings out the aim of a modernized treatment programme in the following statement.

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"In order that the entire needs of the disabled may be met and the different phases of care placed in their proper perspective, the programme

for re-establishment is viewed as falling into three stages or estates. The first is the prevention of sickness and injury; the second is the diagnosis and cure of such; and the third estate is that of convalescence, rehabilitation and re-socialization."

The emphasis in such a treatment programme is on the individual, rather than on his disability, and the aim is not "cure" in the restricted sense, but re-establishment in society. Treatment should include the patient's rehabilitation. However, rehabilitation is a relatively undeveloped field. In many respects it is still "in its infancy", and in other respects it is still "unborn". Nevertheless, rehabilitation has already opened up a vast field of constructive possibilities. Unexplored though many of these possibilities may be, the experience to date has justified the view that present accomplishments have merely "scratched the surface", and a great deal of the work has yet to be attempted. Doctor Meakins expresses this view in a promising vein when he writes:

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"It must not be thought that it [rehabilitation] has efficacy only when applied to those who are curable. because it is equally necessary for those who are born with physical handicaps which might be considered as irremediable and also to such as have acquired, through sickness or injury, a disability which to the uninitiated might appear to render the victim incapable of further, or at best greatly reduced, economic usefulness. It is surprising how comparatively seldom this pessimistic attitude is justified when knowledgeable "rehabilitation" is used."

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1. "Re-establishment of Disabled Persons", Report by the Montreal Rehabilitation Survey Committee, 265 Craig Street West, Montreal, Quebec, Canada, December 1949, p. 5.

2. Ibid., p. 5.

The studies of the Montreal Rehabilitation Survey Committee are concerned with needs and services pertaining to disabled persons in all categories. The principles adopted are applicable whether the handicapped person is young or old. "Knowledgeable rehabilitation" is defined by the committee to include medical rehabilitation, as well as employment and vocational rehabilitation. The total process is closely integrated, and aims "to develop and restore the handicapped individual to the fullest physical, mental, psycho-social, vocational, and economic usefulness of which he is capable, within the restrictions inherent in his environment." <sup>1</sup> Since the ultimate goal is social and vocational adjustment, the programme should include a variety of elements to be utilized to contribute to the individual's rehabilitation. These elements are: medical care, including psychiatry, as well as physical, occupational and speech therapy; social service; guidance and testing; educational, vocational and employment training; recreation; financial assistance; selective placement and careful follow-up.

These principles of modern rehabilitation form the essential background of the present study, which deals with a group of disabled veterans receiving institutional care in Vancouver. The problems which this group presents, however, are not the ordinary problems of rehabilitation because the group is predominantly composed of older men. Added to the problems of disablement, these patients are also suffering from the destructive effects of senescence. The study, therefore, has a double significance in that it attempts to deal with the re-establishment of disabled persons in relation to the rapidly-growing field of geriatrics and gerontology.

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1. Ibid., p. 19.

As a segment of the older aged population in Canada, however, it should be emphasized that the group selected for this study is by no means representative of the whole. It represents, if anything, an extreme type of residual group within the group of older persons who are disabled. In the first place, the group is composed entirely of veterans. From a welfare point of view, veterans are not an ordinary group in society because of unusual circumstances which surround their lives. The period during which they were engaged in active warfare was a period of maximum hazard - one in which the possibilities of disablement, or of afflictions tending to cause disablement, were exceedingly strong. On the other hand, as veterans, they have been entitled to unusual opportunities for recovery and re-adjustment, owing to the variety of special services available to them through the Federal Government. Domiciliary care is one of these special services, exclusively designed for the veteran who requires total care on a more or less permanent basis. On the whole, therefore, the domiciliary care patient is not only aged; his disablements are of a relatively extreme nature, and he has been given a relatively superior type of treatment service which has not changed his total disability status. Aside from the fact that this patient belongs to a residual group of disabled persons, the fact that he represents an older age-group in society is also of significance within the broad field of rehabilitation.

The general development of an active interest in the problems of the older person is a recent phenomenon which roughly parallels the growth in the field of rehabilitation. Indeed, the two fields are closely related in the sense that they are both a direct outgrowth of an expanding knowledge and understanding of people, made possible by the con-

contributions of medical and social sciences. Accordingly, the modern concept of ageing forms an important segment of the background against which the findings of the present study have been appraised.

#### Old Age or Disablement

A basic tenet of social work philosophy is the assumption that life is for growth. Life is not a static condition that sets in when adulthood is reached and ends abruptly in death. Rather, it is a dynamic process of adjustment to a life situation which is constantly changing. Old age is simply the last of a long series of adaptive changes in the life of the individual. Senescence (the process of growing old) is the individual's response to a life situation in which some of his functional capacities are increasing, and others are diminishing.

However, the rate and extend of this diminution of powers may depend on factors other than age. Many forces operate together to condition the response which the individual will make to internal and external changes occurring throughout his life. Generally speaking, the adjustment which the old person finally makes will be influenced by such things as, the extent and suddenness of changes in his situation, the nature of his established relationships - social, domestic and employment, and the way in which he met the crises of earlier life, such as puberty, marriage, parenthood, and menopause. The veteran was subjected to an additional crisis during Active Service. Physical and emotional hardship occasioned by the war, and the general dislocation of his affairs during wartime, may have had far-reaching effects on his adjustment in later years.

Irrespective of earlier experiences, however, the later years are normally a period of diminishing powers, in which the inner re-

sources of the individual decline and his external world narrows. It is not surprising, in view of this rather negative prospect, that many older people lose heart and look upon the future with fear and despair. They lose hope because they are unable to see the positive aspects of their particular situation. Actually, old age offers certain important compensations, and these should not go unrecognized. The accumulated wisdom of the older person, the wealth of experience upon which to draw, the ability to balance new against old, and to contribute a mature perspective to community affairs, should all be regarded as highly valuable assets.

Essentially, the problem of old age is one of balancing assets against liabilities. As at any other time of life, the key to wellbeing lies in a balanced adjustment. Under favourable circumstances, it is quite possible for assets to outweigh liabilities, and for old age to become a very satisfying life period. It can, and should be, a period of continued fulfilment, a reflective, peaceful era in which the older person gains respite from the toils and conflicts of the striving years. Nevertheless, certain disablements tend to multiply with age to upset the balance, and to destroy contentment.

#### Physical and Environmental Changes

Unfortunately, modern competitive society tends to make old age difficult. The emphasis which is placed on individual achievement in this type of society makes it difficult for the individual to retain a sense of security and personal worth when his physical powers of achievement begin to decline. Marked physical changes usually take place in the individual with advancing years. He experiences a decline in the speed and precision of motor performance, of perception, of learn-



ing, and immediate recall of memories. There is a general lessening of capacity for sustained work, and increased liability to fatigue, and a general slowing up which is often accompanied by chronic illness of a progressively disabling nature. <sup>1</sup>

In addition to these internal changes, the advancing years may bring various external changes such as the loss of family and friends through death, the loss of children who marry, or otherwise leave home to cultivate separate primary relationships, and the loss of gratification in work and active social life in the community. All these internal and external changes may combine to give the ageing person an increased sense of loneliness, inadequacy, or even deep helplessness. The psychological impact of accumulated events often destroys contentment, and brings forth a host of perversities and petty irritations in old age.

These readily observable aspects are a part of the common knowledge regarding old age. They are generally well-recognized and for that reason, they have largely governed the arrangements which have been made for the aged in the past. The common tendency has been to provide for the care of the aged in terms of their apparent physical needs, and to overlook the less-tangible elements of human life which are equally essential to emotional and physical well-being. This

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1. This statement is validated by the work of H.T. Karsner, M.D., of Cleveland, Ohio. In a study of the medical records of 19,000 persons, whose bodies had been thoroughly examined after death, it was shown that none of them had died of "old age". Regardless of chronological age, all of them had died of diseases well known to science, or from the effects of disease or injury in earlier life.

tendency has strongly influenced the care of veterans, as well as ~~other~~ other groups. The profession of social work, however, in attempting to broaden and deepen the approach to human problems, recognizes the necessity of looking beneath the surface to seek an underlying cause. To permanently change the surface manifestations, it is usually necessary to strike at the roots.

#### Basic Psycho-Social Needs

From earliest infancy until the moment when death finally relaxes the tensions of life, there are probably only two basic needs which human behaviour strives to satisfy.<sup>1</sup> These needs, or instinctual drives, may be described as (1) the need to love and to be loved (i.e. to feel wanted, useful to others, belonging, etc.), and (2) the need to act in an aggressive manner (i.e. to respond outwardly against anything which causes pain or discomfort). Hunger, fear, anger, and so on, to the extent that they produce a feeling of discomfort, will always evoke some expression of this so-called "aggressive drive". It can be shown that out of these two instinctual needs, and the desire to satisfy them, arise the complicated behaviour patterns of the individual.

Many of the problems of adaptation in "civilized" life result from the fact that these two drives are basically antagonistic. At the root of the human habit of social living is the desire in every person to love and to be loved. This desire can only be satisfied through close relationships with other people. The aggressive drive, however, operating at the same time whenever an unpleasant situation

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1. Josselyn, Irene M., Psychosocial Development of Children Family Services Association of America, New York, N.Y., 1948, p. 16.

arises, can easily cause great damage to the love relationships upon which the individual must depend. This conflict of impulses, which is most apparent in childhood, is gradually resolved as the child grows up and learns to adapt his gross expressions of impulse to the needs of the people around him. The growing-up process is largely a matter of discovering that maximum gratification can be obtained from life when there is some sort of integration or balance between these opposing forces. Until the personality is able to balance the one against the other, one of them will be destructive of the other, and the personality will be distorted. The individual whose personality is warped in this fashion cannot function constructively in society. He cannot adequately satisfy his own needs and is, therefore, incapable of consistently satisfying the needs of others.

Throughout life there are constantly occurring changes in the internal forces of the individual, or in the external demands of the environment, which continually call for some re-adjustment of the individual's habitual controls. The balance of life must be maintained in order to ensure continued gratifications. Depending on whether the individual has achieved a sound emotional balance, that is to say, a fusion of his basic drives which operates constructively for himself and for others, or whether he is functioning on a precarious basis which may, or may not, be neurotic in nature, his adjustment in any of the critical stages of life will be relatively easy, or extremely painful and distressing.

#### Physiological and Psychological Inseparability

Physical and psychological factors influencing human well-being are always closely inter-related and cannot, in effect, be separated,

except for purposes of theoretic study. The interaction of many active forces is a basic characteristic of the human personality, irrespective of age. Like most basic traits, it can be best observed in children.

A fundamental concept of infancy lies in understanding the lack of differentiation between the emotional and physical life of the child. Just as the human embryo, at a certain stage, is a mass of undifferentiated cells which later become specifically different organs and tissues, so the child at birth is an undifferentiated mass of physical and emotional life. He responds physically and emotionally at the same time to almost any stimulus whatever. As he develops towards maturity a separation of these responses gradually takes place, but the separation is never complete. Psychosomatic illness may occur at any age; physiological stresses may produce observable changes in mood at any age. <sup>1</sup>

An understanding of the way in which attitudes and feelings may effect the over-all ability of the individual to function adequately is a cardinal point in dealing with the problems of the aged. A person's declining physical powers may produce social and economic difficulties, and emotional conflicts; the ensuing emotional tension will produce a corresponding physical tension, which further upsets the delicate chemical balance of the body, thus aggravating the physical breakdown. A vicious cycle is established, and unless it is stopped by some adequate method, will cause a progressive physical breakdown, resulting in death or serious disablement. A common example of this type of physical deterioration is seen in the man who is apparently "hale and hearty" when he retires at the age of 65; a few

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1. Ibid., p. 33.

months later he is dead. The emotional shock of suddenly finding himself "on the shelf", apparently useless and forgotten, undoubtedly sets up an inner tension and anxiety about himself which is incompatible with physical health. Unless he finds substitute gratifications to sustain him, the cycle of decline may run a rapid course.

#### Disablement and Dependency Needs

The concept of physiological and psychological inseparability gives rise to a broadened concept of disease and disablements which are disease-produced. It was formerly believed that disease was purely and simply the work of some foreign entity in the human body, and that this entity had to be purged, cut, or otherwise removed from the system before the ailing individual could be cured. It is now recognized by a growing number of medical authorities, and by the social work profession at large, that disease is a condition of the total personality. The origin of certain diseases can be explained only in terms of the emotions (i.e. the psychogenic diseases).<sup>1</sup> All diseases have a strong emotional component which significantly affects the patient's recovery in one way or another. One patient's eagerness to recover, and another patient's reluctance to do so, cannot be explained in terms of the nature of the disease itself. Doctors are often at a loss to find sufficient evidence of disease to account for the patient's

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1. Two notable works in this field are: Dunbar, Flanders, M.D., Ph.D., Emotions and Bodily Changes, Columbia University Press, New York, N.Y. 1946; and, Weiss, Edward, and English, O.S., Psychosomatic Medicine, W.B. Saunders and Co., Philadelphia, 1943.

symptoms. In other cases, the disease is so plainly evident that the doctor is at a loss to account for the patient's recovery. The difference in the normal treatability of patients, then, is not in the quantity of physical disease which they possess, but seems to lie in the extent to which the total personality is "diseased".

The diseased personality is one which is in a state of emotional imbalance. The basic energies of the individual, for various reasons, are not operating in a natural, healthful pattern. Because of habitual frustrations, some of which may be life-long, the person finds it necessary to sacrifice one side of his personality in his attempt to satisfy an inordinate need at the other side. For instance, the person who has never been fully satisfied in his need to feel loved will always display a strong need for love and acceptance in his relationships with other people. He may satisfy this need by repressing his aggressive drives and behaving submissively. He may continue to live with his parents after he is grown up; he may marry a strong, dominant woman who "mothers" him, he may remain in the armed forces or work in some other paternalistic organization which looks after his welfare, or in some other way find a similar form of satisfaction during most of his life. He seeks this gratification through a pattern of inhibition and submission, and when circumstances change he tries to adjust himself according to this pattern. If he loses his parents or his family, or his job, or whatever he has had to lean upon, his anxiety may be very great, but, instead of acting aggressively to find new sources of satisfaction, he retreats and turns his aggressive energies inward. This process soon destroys his health and, if he finds love gratifications through ill-health, he will naturally want to continue

them. He has always found his greatest satisfactions in a dependency situation of some kind, so, whenever he encounters dissatisfactions in life, he responds by increasing his dependency. In other words, the person adjusts himself to life through his invalidism or his chronic disablement.

Conversely, a person may sacrifice his need to love and be loved. If the deprivations and frustrations of this need are very severe, or occur too early in life, the person may attempt to deny this need altogether. His behaviour may then be dominated by his aggressive drives. He may be abnormally hostile or fearful, or attempt to withdraw from people and from close relationships in general. Carried further, this type of behaviour characterizes the well-known forms of mental illness.

Without going into an exhaustive discussion of the dynamics of the human personality,<sup>1</sup> it is possible to say that chronic disablements, resulting from disease, are just as much a social and psychological problem as they are a physical problem. The essential problem is the patient, who must be studied and understood in terms of his adjustment to a total life-situation. Adequate treatment can be given only on the basis of such understanding.

#### Dependency And Institutions

Many older people, unable to find new forms of gratifications in their declining years, regress to a lower, more childish level of

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1. An extensive body of literature now exists in this field. A number of prominent works are listed in the bibliography of this study.

emotional life. Childish emotionalism is characterized by its dependency; it is concerned with receiving, rather than with giving. This emotional need to be given to, readily extends itself into the physical sphere. It also tends to produce physical breakdown which, to the individual, justifies his need for physical care. Depending on the extent of his need for this type of gratification, he will demand more, or less, attention from the people about him. The people about him may be quite unable, or unwilling, to satisfy this inordinate need, and would therefore be willing to turn the older person over to the care of someone else.

Many sociological and environmental factors in Canadian society contribute to the prevailing attitude towards old age, and the tendency to arrange for the care of older people in other than family homes. In urban areas, houses are usually small and incomes are usually insufficient to provide for the needs of older and younger generations at the same time. There is a tendency for women to work, and otherwise to occupy themselves away from the home, so that usually there is no one available to look after the older person who needs care and supervision. At the same time, there are still strong remnants of a traditional attitude which tends to relegate the old person to the position of a non-participating onlooker. The tendency is to place him "on the shelf", where he is expected to remain thoroughly passive and thoroughly impotent - industrially, socially and personally. The result of this attitude, which has been emphasized by the retirement practices of industry, is that the ageing person tends to look upon himself as being in the way, and no longer of any use to the community or to his family. If he has no family, the older person with a dis-



ability may have no recourse other than to enter an institution. Many older veterans are without close relatives, and it may be that the veteran is more prone to loss of family than other persons who have not been severed from home and community through exigencies such as war. These and other inimical conditions and attitudes seem to cause the older person to become severely frustrated in his former surroundings, and, therefore, to welcome the opportunity to go to an institution.

For many reasons such as those given above, a steady increase has occurred in the number of admissions of aged people to various institutions during the past twenty-five years. In this period most mental hospitals have doubled and trebled the number of first admissions of patients suffering diseases of the senium.<sup>1</sup> The number of aged veterans receiving institutional care in Shaughnessy Hospital, Vancouver, has increased approximately ten times since 1939.<sup>2</sup> General hospitals, nursing homes, and other care-giving agencies can testify to the growing numbers of aged people who are seeking care in institutions. They are accepting permanent care in institutions because life has failed to offer them anything better. In the light of current knowledge of the psycho-social factors influencing disablement and dependency, this tendency towards institutional living is a sad commentary on the emotional health of the nation. The person who goes to live in an institution is sacrificing the last shreds of his indep-

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1. "Patients in Hospitals for Mental Disease", Bureau of the Census, United States Department of Commerce, 1923 - 1939.

2. Unpublished admission records, Shaughnessy Hospital, 1939 - 49.

endence, and is minimizing his opportunities of living constructively or productively. He is accepting a state of total dependency in return for the dubious gratifications he expects to gain from his passive existence in the institution. In permitting the over-all situation, in which increasing numbers of old people tend to live in institutions, the nation is creating for itself a heavy burden. The cost of such a burden, in humanitarian as well as monetary values, will be too much to be borne on an increasing scale.

The responsibility of social work in helping to meet this growing problem is to sharpen the general realization of the dangers of "institutionalization", and prevent it from being accepted as a widespread method of care for the aged. In carrying out this responsibility, social work can attempt to demonstrate methods by which present institutions may become the vehicles for more effective living. As treatment centres for the aged, institutions can foster independence, rather than dependency, and, thereby, provide a nucleus for the programme of rehabilitation which will be needed to meet the disablements of old age throughout the community.

#### Purposes and Methods of the Present Study

Accordingly, the chief purpose of this study is to examine the provisions for the institutional care of a group of totally disabled, older veterans in Shaughnessy Hospital,<sup>1</sup> and to use this special group as a means of illustrating this broad welfare problem. The adequacy of

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1. The term "Shaughnessy Hospital", as used in this study, includes the ancilliary units at Hycroft and the George Derby Health and Occupational Centre.

facilities and the effectiveness of treatment is assessed in terms of the general considerations already brought out in this chapter. Two broad objectives have been set forth. The first concerns the rehabilitation of the older veteran into suitable employment and community life. Where rehabilitation is not possible, the second aim is to make institutional life a gratifying experience - one that will promote happiness through the constructive expression of individual desires. The thesis of this study has been previously cited in the quotation of Dr. J.C. Meakins when it was pointed out that rehabilitation has efficacy, not only for those who are curable, but is equally necessary for those who might be considered as irremediable. In addition it should be stressed that because institutional care is applicable in the extreme case, it does not mean that it is applicable in general cases.

The material in succeeding chapters helps to bring this theme more clearly into focus. The method followed in the investigation was, first of all, to survey the domiciliary care programme of the Department of Veterans' Affairs, and to examine the regulations and policies governing Class-Six treatment. Over one hundred district files of Class-Six patients in Shaughnessy Hospital were reviewed, as well as a similar number of medical social service files. Detailed personal information was obtained in interviews and in casual conversations with many of the patients. Discussions were later held with doctors, hospital personnel, and departmental administrators to obtain their opinions of the major difficulties regarding this older group. The work in the various welfare and therapy departments was observed, and conversations held with workers in each department to learn their views of existing needs and services pertaining to these patients. Problems of rehabilitation

were discussed with various members of the staff, and, although the writer found general agreement with the principles of treatment and rehabilitation, there was little agreement as to the extent to which they could be applied to this group. In the present study, therefore, the application of principles is not necessarily confined to areas within which agreement was found during the investigation.

## Chapter II

### Domiciliary Care for the Aged Veteran

The veteran who becomes totally disabled and who requires domiciliary care may obtain it in Canada through the Department of Veterans' Affairs. In British Columbia there are two centres in which this type of care is available: Shaughnessy Hospital in Vancouver; and The Veterans' Hospital in Victoria. At these centres the Veteran can be admitted as a patient, under the provisions of what is known as Class Six treatment, and there be given physical care and maintenance for as long as he requires it or desires it. Briefly stated, the patient in this category is given room and board, plus a monthly cash allowance for clothing and comforts. Whenever he needs it, he also receives medical treatment and hospital nursing care. At all times he is entitled to the use of existing institutional facilities and services. In addition to receiving an all-round type of physical maintenance while in the institution, most patients have some sort of trust fund set up for them during their stay and made available at the time of discharge.<sup>1</sup> This fund accumulates month by month and provides a sort of re-establishment grant for the patient who wished to go out into the world again. In event of the patient's demise, this fund is credited to his estate.

The above provisions form the principal elements of treatment which, at the present time, are the basis of veterans' domiciliary care.

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1. Eligibility for payment from the trust fund may not be established in some cases until after three months from date of admission under Class Six. Other factors governing trust funds are discussed in later chapters.

"Domiciliary care" is an interesting term, often used synonymously with "institutional care". At Shaughnessy Hospital the two terms seem to have gained equal currency, although the latter term may be preferred somewhat for its realism. The words, "institutional care" realistically convey the professional atmosphere of the hospital setting. On the other hand, "domiciliary care" contains a hint of idealism and may embody a suggestion of closer, warmer relationships in home-like surroundings. It suggests that the institution should be able to provide some substitute for the basic emotional gratifications which normally are fulfilled in family living. Perhaps the former term describes Class Six treatment as it really is, while the latter term indicates what it may be trying to do.

In practice, however, the Department of Veterans' Affairs, in providing domiciliary care for veterans, is chiefly concerned with the individual's economic and physical condition. A medical problem of some kind is often the most apparent reason for the old person's decision to enter an institution; the veteran is given "institutional care" only when he is totally disabled. However, a sound medical programme is the fundamental basis of modern rehabilitation. Without this prerequisite form of care, the patient would rarely be alive to participate in his rehabilitation. Accordingly, the veterans' domiciliary care programme deals first with this most basic problem, and includes wide provisions for medical treatment.

#### Treatment Regulations

Special Services to Canadian veterans are all authorized by legislation of the federal government. Administrative regulations,

defining the services in detail, were then established by order-in-council under each act. The twenty-four separate acts dealing with the affairs of veterans, plus the administrative regulations, comprise an extensive and rather complex body of law. In order to simplify the administration as much as possible, these laws were incorporated, in 1945, in a single volume known as "The Veterans' Charter".<sup>1</sup> The regulations governing the eligibility of veterans for treatment are to be found in this charter, along with all other matters pertaining to the rights of the veteran.

Medical treatment regulations, authorized and amended under the Department of Veterans' Affairs Act, June 1944, recognize twelve separate classes of treatment at the present time. Each class embraces special eligibility terms and prescribes the scale of allowances, special privileges, and limitations affecting the patient in his particular class. No differentiation, however, is made in the class of medical treatment except in the case of a pensioner who is entitled to treatment for his pensionable disability only. In certain other cases there is a limit to the length of time for which treatment will be provided free, but, otherwise, the scale of medical treatment, qualitative and quantitative, is limited only by the availability of medical skill and equipment.

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1. The Veterans' Charter, amended 1949, provided the chief source of regulations governing the domiciliary care of aged veterans studied.

Treatment is defined under treatment regulations. It includes medical, surgical and dental treatment, and the supply and maintenance of prosthetic appliances.<sup>2</sup> Briefly, treatment of this type is available to all veterans who served meritoriously in a theatre of actual war and who, according to a means test, are unable to provide the treatment for themselves. War disability pensioners are entitled to treatment for their pensioned disability at any time, and for any other condition if they are unable to pay for treatment elsewhere. In addition to these categories, certain merchant seamen and salt water fishermen in receipt of disability pensions under the Civilian War Pensions and Allowances Act, and all recipients of War Veterans' Allowance are eligible for treatment. The regulations stipulate that treatment is provided only through the centres, hospitals and facilities owned by the Department of Veterans' Affairs, or arranged by contract in civilian hospitals. Certain provisions are made for reimbursement to the veteran for medical expenses incurred outside the Department, but only special cases which are due to emergency or other extenuating circumstances are considered.

On the whole, provisions for treatment for the veteran are very broad. By including necessitous circumstances, the regulations bring treatment within the reach of virtually all former members of the armed forces who can demonstrate need. The few types of needy cases that would be disqualified are those that did not obtain honourable discharge or did not serve in a theatre of actual war, plus a small number of Canadian residents who served with other than Canadian forces and are not veterans

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2. Prosthetic appliances includes all such things as artificial limbs, dentures, eye glasses, special boots, braces, et cetera.



of World War II.

The means test could be a delimiting factor, but it also is fairly generous, taking into account both income and savings. For example, a single veteran is allowed an annual income of \$1200. If he has dependents he is allowed an additional \$400 for the first and \$150 each for all others. A married man with two children, for instance, could earn \$1900 a year and yet be considered in necessitous circumstances for purposes of treatment. If the veteran has savings, the test of eligibility is based on the amount to which his savings would be reduced if the treatment had to be secured from a private doctor. The veteran with one dependent could retain \$400 in savings, a higher amount being allowed for additional dependents.

Of the twelve treatment classifications, the only one providing domiciliary care is Class Six.<sup>1</sup> The veteran in this category is commonly described as "the Class Six patient". His eligibility for treatment under this class corresponds to the basic requirements set forth above, but it also requires that he be totally disabled, either permanently or temporarily. He must actually require domiciliary care. In return for quarters and maintenance and other services available to the Class Six patient, he agrees to pay the Department, out of income or assets, a sum not to exceed \$120 per month. Dependents' pension benefits are excluded in the calculation of income, and the first \$1000 is excluded in the calculation of assets. From the balance remaining, a fixed rate of monthly deductions is established in accordance with the patient's

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1. See Appendix A for transcript of treatment regulations pertaining to the Class-Six patient.

ability to pay. Great variations are possible under such a system of deductions and each case has to be settled individually.<sup>1</sup>

The most important clause in the regulations under Class-Six, and one that distinguishes it from all other classes of treatment, states that the veteran must require domiciliary care, and must be totally disabled. The general nature of the circumstances which would cause an aged person to require domiciliary care were discussed in chapter I, but it should be reiterated that old age itself is not necessarily a dominant factor in such a situation. Physical conditions ordinarily increase in old age, but they also occur in young people. Depending on personal and domestic circumstances, rather than the disability, the need of a young person for domiciliary care may be just as great as that of the old person. In that respect the younger veteran who meets these requirements is eligible for Class-Six treatment.<sup>2</sup> The presence of total disability is not, in itself, the raison d'etre of Class-Six treatment irrespective of other circumstances. Yet it is an essential condition of eligibility for such treatment.

#### The Concept of Disability:

The question arises as to how such an abstract thing as disability can be adequately assessed. For the purpose of granting pensions, a disability is defined as "the loss or lessening of the power to will or to do any normal mental or physical act".<sup>3</sup> The difficulties involved in

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1. Since "blanket" statements at this point might be misleading, this subject is treated in detail and illustrated in chapter III.

2. At the present time there are two Class-six patients in age-group 30 - 40 in Shaughnessy Hospital.

3. The Pensions Act, 2 (g), Chapter 157, Revised Statutes of Canada, 1927, amended in Chapter 23, Statutes of 1941.

applying this definition are evident. In order to demonstrate loss or lessening it must first be necessary to show that certain abilities were originally present and to what degree they were present. Some human abilities are impossible to measure by present methods. To arrive at a conclusive diagnosis of total disability on the basis of the above concept would be an arduous, if not impossible task. It is significant, therefore, that the Pensions Act does not attempt to define total disability.

A working concept of disability must always be relative to some established norm. In practice, therefore, the Canadian Pension Commission interprets disability in relation to employability, and makes a clear distinction between disability and helplessness. The veteran is regarded as being totally disabled when he is unable to engage in any remunerative employment in the unskilled labour market. According to a survey of industry, the Pension Commission listed a total of 850 unskilled jobs at which it was possible to obtain paid employment. The percentage of these jobs which the disabled veteran is unable to do is the percentage of his disability, and his pension is assessed accordingly. The veteran, for example, who is unable to do 85 of the listed jobs, would be assessed at ten per cent disability. The veteran who is unable to do any of the listed jobs is regarded as being totally disabled, and, therefore, eligible for domiciliary care if he requires it.

#### Class-Six Treatment Centres in Vancouver

Shaughnessy Hospital is the chief centre for Class-Six treatment in British Columbia. In January, 1950, a total of 485 patients were receiving domiciliary care at this Hospital. At the same time there

were 48 Class-Six patients at the Victoria Veterans' Hospital, Victoria, B.C. Of the total of 533 Class-Six patients in British Columbia, slightly more than 90 per cent were receiving care in Shaughnessy Hospital, and its two subsidiary units at Hycroft and the George Derby health and Occupational Centre, Burnaby. At that time the Class-Six population of the hospital was distributed as follows: Shaughnessy - 280, Hycroft - 116, Health and Occupational Centre - 89.

The background of Shaughnessy Hospital, itself, follows the common pattern of development in the Veterans' services between the two world wars. After about twenty years of very gradual development, there was a sudden, "mushroom " growth during World War II and the immediate post-war era.

Shaughnessy Hospital originated on its present site in 1917 for the treatment of war casualties, occupying what had been a residential school. Following World War I, the operation of the hospital was continued by the Department of Pensions and National Health. Between the two wars there was little expansion of facilities. Various alterations in the buildings, however, made them increasingly suitable for operation as a small general hospital. Plans for the erection of a modern hospital building were well advanced when the Second World War broke out in 1939. Construction began in 1940 and patients were all transferred to the new building by the summer of 1941. Accommodation at that time was 280 beds.

As the war continued, demands on the hospital increased and other buildings had to be adapted for temporary treatment purposes. The previous administration building was converted into an infectious disease



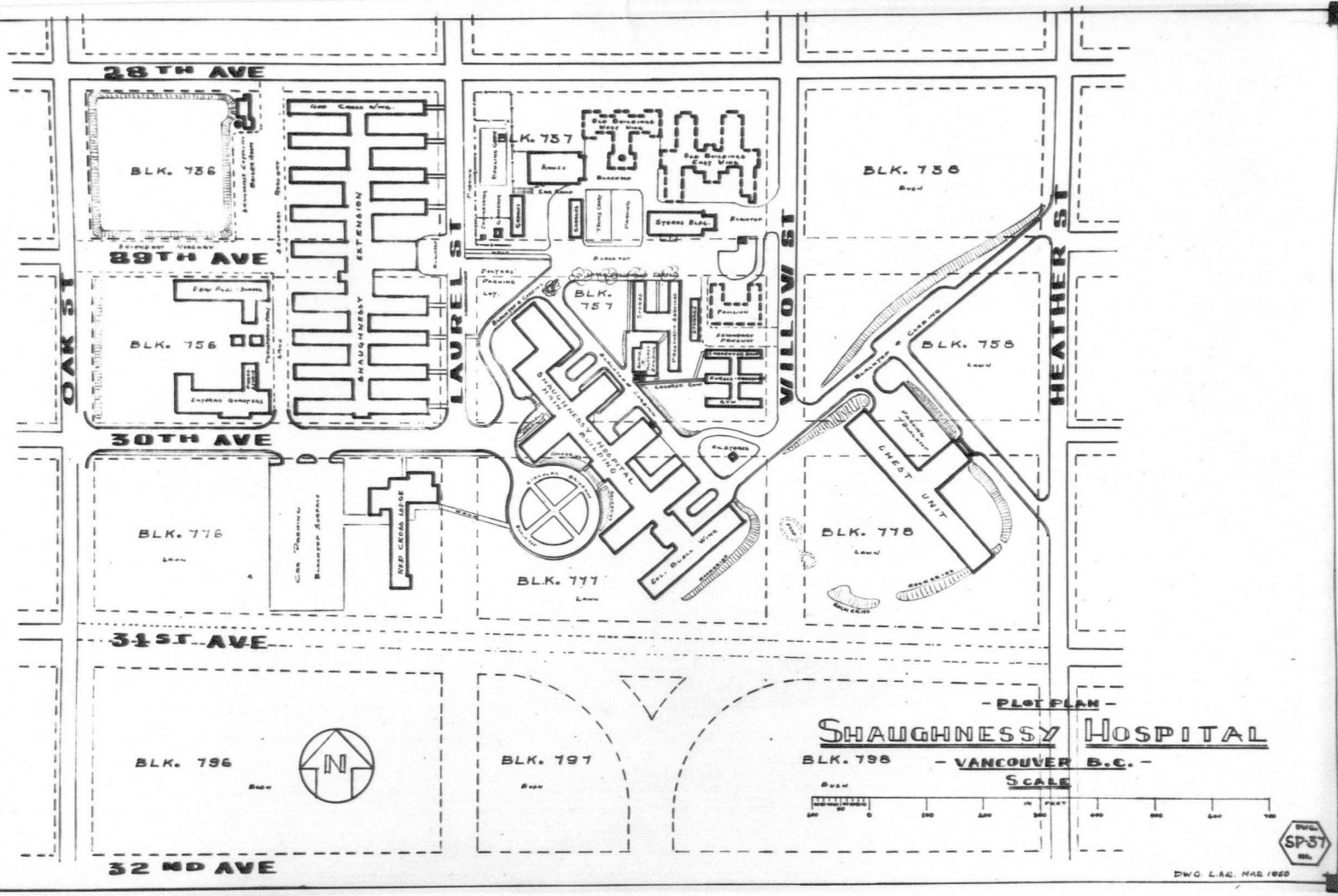
Shaughnessy Hospital - Front view of  
main building

unit; huts were erected in 1943, and "Hycroft", a large, private home, was taken over to provide overflow accommodation for patients receiving institutional care. In 1946, the Buell wing of four floors was constructed at the south-east end of the main building. Earlier in the war, a military hospital of 400 beds was erected on the grounds and commenced operation in conjunction with the main hospital. This military hospital was housed in a series of one-story buildings, now known as the "Extension". After the war, these buildings were taken over by the Department of Veterans' Affairs, and, presently, are being used to accommodate the majority of Class-Six patients living at the hospital.

A separate chest unit was constructed and occupied in 1946. This unit, which embodies the most modern planning and equipment, contains 125 beds and is separately equipped to care for its own radiography, occupational therapy and chest surgery. Total accommodation of the hospital, in 1946, reached approximately 1350 beds. Since hostilities ceased, however, various temporary accommodation has been evacuated and the present rated capacity is 1000 beds.

An adequate verbal description of Shaughnessy Hospital would involve a great deal of additional detail which would not be strictly relevant to the study. The photograph, given on page 27, is included, therefore, to give some idea of the modern type of building construction, the pleasant setting and the ample grounds which contribute in an important way to the well-being and contentment of older patients.

The plot plan of the hospital, given on page 29, clearly illustrates the growth and the present extent of the physical structure, Original



Plot Plan of Shaughnessy Hospital showing  
layout of buildings

buildings, shown by means of dotted lines, now represent a very minor part of the establishment. The vastness of the property, which covers forty acres, indicates something of the possibilities for future expansion.

The next major addition to the hospital is a proposed seven-story building to be used mainly for the treatment of Class-Six patients. Plans are still being drawn, but it is fairly certain that the structure will be situated in the north-east corner of the property, adjoining the chest unit. Every practical device will be included in this modern structure to ensure the physical comfort and convenience of the patients. Each ward is to be a self-contained unit, designed to include four solariums, a reading and writing room, and a room in which to entertain visitors.

The steady increase in services to the patient has been comparable to the increase in facilities. Hospital administration is superintended by a medical doctor. The superintendent is directly under the Vancouver District Medical Officer in matters relating to treatment, and is also responsible to the District Administrator of the Department of Veterans' Affairs in matters relating to general administration. All hospital departments, business and professional, are highly organized, and the professional work is carried on in each department under a separate director. Together, these medical directors constitute the medical advisory board. All branches of medicine are covered with the exception of obstetrics and pediatrics. Generally high professional skills, together with the most modern equipment and facilities, have produced outstanding treatment results. Full treatment records are maintained and an extensive educational programme is followed for the attending and interne staff.



From the standpoint of medical treatment, Shaughnessy Hospital is undoubtedly performing an excellent service to veteran patients in all categories. In its operation generally, the hospital is also known to be one of the most efficient in western Canada. Its average costs per patient per day are below the average shown for other veterans' hospitals across the country,<sup>1</sup> and they compare favourably with those of civilian general hospitals of similar size. This economy obviously is not obtained at the expense of treatment, but rather accrues from the unified activity of all departments, which is in accordance with the increasing standards of practice of scientific medicine. Despite the sound economies of the hospital management, however, it cost \$8.31 per day for every patient given treatment during 1949.

In addition to medical care, the hospital offers a variety of adjunct services to the patient. These services have the objective of furthering the patient's happiness under treatment, and, as far as possible, has physical and mental rehabilitation. Occupational therapy and physio-therapy are very active and highly organized departments. At present, medical social service is a relatively undeveloped part of the treatment programme. Two social caseworkers are attempting to carry the total burden of social work among the hundreds of patients within this busy institution. This lack, however, is compensated to a great extent by the work of the Veterans' Welfare Services which involve three full-time Veterans' Welfare Officers, and four others who give part-time services of a more specialized nature, such as, job placement and super-

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1. Unpublished Departmental statistics comparing the average costs per patient per day in all Canadian veterans' hospitals during 1949.

vision of institutional training. Both in theory and in practice, the social service and the veterans' welfare programmes tend to overlap at many points. Small staff and numerous referrals make it necessary to limit social casework services to emergency and superficial treatment. The workers are largely confined to work within the hospital. The Welfare Officers face the same sort of problem, but, because of their numbers, they have additional scope.

The recognized aim of Veterans' Welfare Services is the satisfactory re-establishment of the patient in civilian life. Welfare Officers do not employ social casework methods other than those that come under the heading of "counselling", but caseloads are carried on a fairly intensive basis over a long term. Follow-up procedures are continued after the patient leaves hospital, until such time as he is satisfactorily employed and re-established. It is largely owing to the work of the welfare officers, formerly known as Casualty Rehabilitation Officers, that the high standards of success in the rehabilitation of war casualties was accomplished after World War II.

Hycroft:

Hycroft, once the home of the late Senator A.D. McRae, has been described by the late Honourable Ian MacKenzie, Minister of Veterans' Affairs, as the loveliest military hospital annex on the continent. Commonly regarded as one of Vancouver's most magnificent homes, this stately residence was turned over by Senator McRae to the Department of Veterans' Affairs, and, in 1943, was converted for use as an Older Veterans' Home.



The Circular Driveway at Hycroft  
(main building not shown)

Centrally located off Granville Street at 16th Avenue, Hycroft occupies its own beautiful grounds with their stretches of lawn, secluded gardens, orchard trees, ornamental shrubs, and prize flower beds. From the wide terraces and sheltered verandahs the patients can enjoy a panoramic view of the harbour area. Included in the many fine facilities of this home are the badminton and squash courts, the indoor bowling alleys, the spacious indoor swimming pool, the billiard room, and the well-stocked library. In addition to these facilities for the relaxation and recreation of the patient, there are large greenhouses and an extensive gardening programme in which a limited number of patients can assist. An Arts and Crafts programme is provided by the Red Cross, and about twenty patients are usually engaged in weaving, leather work, and other similar handicrafts which require slight physical exertion.

The 116 patients at Hycroft are nearly all ambulatory since it is necessary to climb stairs. During the day they are free to come and go, to visit friends, go to the beach or park. Restrictions are placed on the time at which they must return each night, but periodic leaves are given to those who wish to visit relatives or friends away from Vancouver. Numerous amusements and entertainments are available to the patients. Two picture shows a week are given right at Hycroft and occasionally stage performances are given. Passes to all the local theatre, sports events and concerts are always available, and local organizations often take groups of patients on excursions, picnics and other outings. Transportation is provided by the Department of Veterans' Affairs whenever necessary.

According to the regulations governing Class-Six treatment, the patient is not allowed to work and earn wages (his total disability virtually precludes any unskilled labour on his part). However, certain patients can be given the privilege of employment within the institution in the library, kitchen, gardens, et cetera, and for this work they are allowed an additional five dollars per month. The extra money seems to mean a great deal to them. As a rule these patients are very faithful and zealous in their work, showing that these activities and responsibilities contribute to a sense of usefulness and well-being. Despite the regulation which debars a Class-Six patient from working, it is fairly well accepted by the administration that, even in Class-Six, a man may need to feel capable of some earning power. In practice, therefore, the Superintendent of the Home tends to overlook any knowledge he may have of patients who go out and earn a casual dollar by doing odd jobs. Similarly, patients are permitted to sell the products of their handicraft activities.

On the whole patients at Hycroft seem to be quite well satisfied with their lot. Relationships with staff seem to be exceptionally good, and a spirit of camaraderie among fellow-patients could be observed. Patients' quarters are large, airy rooms containing about twenty beds, but not being designed to accommodate beds, the rooms tend to be overcrowded. There is no privacy for the individual patient, but in general his surroundings are not cramped. Lounges and sitting rooms are large and comfortable. Most of the patients eat in the central dining room, though tray service is given to the few who are unable to get downstairs. Nursing and orderlie service is available for patients as they need it and the house physician is on call at all times. Whenever illness becomes acute

or seriously disabling the patient is always transferred to Shaughnessy Hospital for treatment.

George Derby Health and Occupational Centre

The George Derby Health and Occupational Centre was opened officially to physically disabled patients of Shaughnessy Hospital in 1947. One of seven similar institutions now operated by the Department of Veterans' Affairs, the Health and Occupational Centre is designed to serve as a sort of combined hospital and convalescent home. It is a place where treatment and training are brought together and closely integrated in order to bridge the gap between hospitalization and re-entry to civilian life. This new approach to convalescence, pioneered during World War II, is still under development, but it has already proved itself to be an effective means of promoting the physical and psychological rehabilitation of the disabled veteran.

Situated on the south-east shore of Burnaby Lake, the Health and Occupational Centre lies about three miles north of New Westminster. The property, comprising 250 acres adjoining Burnaby Park, occupies the slope from a height of land overlooking the lake to the lake shore. Beyond the lake a view of the snow-capped North Shore Mountains provides a distant background. Aside from the 22 acres which are cleared for the building site, the area is heavily covered with second-growth timber. The site itself and the surrounding bush are both being developed, and many projects are under way which will make constructive use of this natural playground. Woodland trails are being mapped out and portions of the dense undergrowth removed. Among the interesting pursuits already organized are swimming parties, horseback riding, and trips to outside points.





Aerial View - The George Derby Health  
and Occupational Centre

Areas around the buildings have been converted to playing fields, and immediate plans are under way for tennis, shuffle board, archery, outdoor checkers, and lawn bowling. Trap shooting equipment is on hand, and an outdoor rifle range is also projected for patients interested in this type of diversion. A small natural area close to the lake shore has been set aside for the miniature golf course.

The general lay-out of the buildings is shown in the aerial photograph, page 36, which also conveys a general idea of the secluded setting and natural surroundings. Burnaby Lake is just outside the picture in the lower foreground. Dispersal of the buildings offers privacy and also encourages the patient to be active. The buildings shown include the Central Administration Unit, the Treatment Building and Auditorium, the Occupational Therapy and Vocational Training Workshops, and eight Pavilions. The administration building contains the offices, dining room, kitchen, storage rooms, class-rooms, billiard room, library, bowling alleys, and canteen. Pavilions are all similarly arranged but differently decorated. Each accommodates 24 patients in dormitory rooms which vary in size from two beds to six beds. A comfortable lounge with open fireplace and a large screened verandah add to the homey atmosphere of the patients' quarters. In the basement, storage lockers, laundry facilities, and ironing boards are provided so that patients can care for their own personal needs. A supervisor occupies separate quarters in each pavilion.

The Treatment Building houses medical examining rooms, the Physiotherapy Department, a swimming pool, a technical library, and an excellent auditorium with complete stage accommodations. The auditorium serves as a gymnasium and is also used for games, concerts, dances, and other enter-



tainment.

Staff employed at the Health and Occupational Centre number over ninety. Over-all responsibility for the programme rests with the Superintendent who is a physician of wide experience in the treatment of war casualties. Specialist staff includes those in charge of Institutional Training, Physio-therapy, Occupational Therapy, Dietetics, and Recreation. Auxiliary Services have also been organized and operate in co-operation with the Recreational Officer.

This 200-bed institution presently contains a capacity number of patients, falling largely into three categories. The largest group is made up of Class-Six patients who were transferred from Shaughnessy Hospital mainly because there happened to be surplus accommodation at the Health and Occupational Centre. This group numbers 89. A second group of patients is composed of arrested tuberculosis cases, and the third group includes all other medical, surgical and orthopaedic patients. All patients are fully ambulatory and do not require nursing care. Therefore, there are no nurses on the staff. However, nursing orderlies give limited service to patients as they require it, especially to Class-Six patients who are infirm. When patients are taken ill, they may be transferred to Shaughnessy Hospital for treatment.

The Class-Six patients at the Health and Occupational Centre are eligible for available treatment, and, to a limited extent, for vocational training. As at Shaughnessy Hospital and Hycroft, however, the primary objective of treatment is the provision of continued domiciliary care. Class-Six patients have access to all institutional facilities and engage in light handicrafts, woodwork, and recreational activities according to

their individual ability. In addition to the greater emphasis which is placed upon satisfying activities in this centre, many older patients prefer to be there because of its rural isolation and natural beauties. More privacy and comfort can be obtained in the Club-like surroundings of the pavilion than would be normally possible in the open wards of the hospital or the vast rooms of Hycroft. Other patients complain that they are bored because they are too remote from the community and have too few contacts with people outside.

The remoteness, tranquility, and therapeutic activities of a health and occupational centre, undoubtedly, have a strong healing effect on the patient who is convalescing and gathering his strength for a return to active life in society. It is doubtful, however, if the Class-six patient should go to such a centre with no further goal than to eke out the remainder of his days. In the present situation at the Health and Occupational Centre, it seems anomalous to see two divergent aims in treatment in which a younger group receives rehabilitation services, and an older group receives quarters and maintenance.

Summary:

In this summary of existing provisions for veterans' domiciliary care it is apparent that Class-Six treatment is a widely-inclusive service, available, to the bulk of Canadian veterans whose circumstances have reduced them to the point at which they seem to need this type of care. It is also apparent that the Department of Veterans' Affairs has very extensive facilities and modern treatment centres for the physical care of disabled veterans. As a care-giving agency, the Department of Veterans' Affairs is rendering a service in Vancouver which is both ample and

admirable. Among the vast network of its available services many specialized types of treatment are employed to overcome specific disabilities. Tuberculous patients, for instance, have a separately designed chest unit and a highly specialized programme during treatment and convalescence. The Health and Occupational Centre, itself, is especially designed and equipped to advance a special phase of the rehabilitation process. In fact the whole institutional set-up is a network of specializations. The lack of truly specialized facilities for Class-Six treatment is notable.

Three widely differing types of institution are being employed in Vancouver for the domiciliary care of older veterans. Class-Six patients are being accommodated in these centres, not because the centres are specifically suited to the needs of older patients, but primarily because Class-Six is a numerous group and requires extensive living accommodation. None of the centres, estimable though they may be in many ways, have been specially designed or adapted to the Class-Six patient. Shaughnessy Hospital is an active treatment unit, properly equipped and operated to restore the health of a patient who is acutely ill. Hycroft is a palatial residence, primarily designed for luxurious living and the excessive leisure of an extremely wealthy family. The Health and Occupational Centre is primarily a reinforcement station where the patient musters his personal resources for a return to community life.

Undoubtedly, the specialized functions of these institutions succeed in meeting many of the requirements of the Class-Six patient. Some of the patients may need exactly the type of care they are receiving. That situation, however, is largely coincidental due to the patient's need for medical treatment, or to his phase of convalescence, both of which may be

temporary. It is an expensive procedure to use specialized facilities and complicated services if they do not actively further the programme in which they are employed. The outstanding fact remains that although the present facilities and services can meet some of the needs of all of the patients, and most of the needs of certain Class-Six patients, nothing has been specially designed to meet the total requirements of these patients, and no attempt has been made to provide domiciliary care facilities on a modern gerontological basis.

## Chapter III

### The Aged Veteran Receiving Domiciliary Care

Taken as a whole, the 485 patients receiving domiciliary care at Shaughnessy Hospital, Hycroft, and the Health and Occupational Centre present a picture of a badly deteriorated, almost derelict group of old men. This picture is in keeping with the basic philosophy of Class-Six treatment which is to provide a form of custodial care for disabled veterans whose circumstances have made it impossible for them to take care of their own needs. They are admitted to this type of care only after medical science has done its utmost, yet failed to overcome the patients' state of being totally disabled.

Many of the difficulties and incapacities of this Class-Six group seem to be of the type which ordinarily accompany old age, but which, for various reasons have afflicted these particular patients in extraordinary intensity and numbers. That old age, itself, is a predominant feature of this group is demonstrated in Table A below. From the hospital index of Class-Six patients, 216 names were selected in alphabetical order. Age distribution figures were compiled and enumerated along with the proportion of patients in each group who claimed any close relative or friend within a five hundred mile radius of Vancouver.

Table A

Age Distribution of Class-Six Patients giving proportion  
of Patients having Relatives

Age-Group	Patients	Per Cent	Relatives	Per Cent
40 - 49	1	.5%	-	-
50 - 59	22	10.1%	11	50.0%
60 - 69	60	27.8%	26	43.3%
70 - 79	106	49.0%	48	45.2%
80 - 89	26	12.1%	15	57.6%
90 & Over	1	.5%	1	100 %
Total	216	100%	101	46.7%

Source: Shaughnessy Hospital Index. Special Count.

It is shown that nearly one half of this representative group of patients are aged 70 to 80 years. Over three quarters of the total group are aged 60 to 80 years, the remaining 23 per cent being distributed fairly evenly within the twenty-year ranges above and below this predominant group. Only about 10 per cent are younger than 60. From this evidence it can be seen that, although Class-Six treatment is available to disabled veterans of any age, it is mainly the veteran whose disability is characterized by old age that seems to require this type of care. The prevalence of patients over the age of 60 may be explained by a number of reasons. It is generally recognized that the disabilities of the older person are always relatively difficult and resistant to treatment. It is also a special fact that at Shaughnessy Hospital an extensive programme of rehabilitation is provided for veterans of World War II, under the Veterans' Rehabilitation Act. The younger veteran, therefore, is helped to re-

establish himself in the community. No such programme has yet been applied to the older patient because the concept of rehabilitation is not a basic tenet of Class-Six treatment. This obvious discrepancy in the treatment of older and younger veterans is raised at this point, not as a critical issue, but primarily to explain the absence of the young disabled veteran from the Class-Six group.

The proportion of Class-Six patients who claim relatives or friends as next-of-kin is also significant. Less than half (46.7%) are able to name anyone at all within the reasonable travelling distance of five hundred miles. A few others listed people living in the United Kingdom. Presumably those patients who lack close relatives and friends would have no one with whom they could live if they were not in hospital. As for the patients who did claim some person as their next-of-kin, there would be a considerable number who, for various reasons, would not be willing or able to live with them. Most of these patients, when they take sick outside the hospital, have no one to look after them. Old age and the vicissitudes of life have left them virtually bereft of family and friends. This condition is just as evident among the younger patients (age 50 - 59) as it is among the older patients (age 80 - 89). It is, undoubtedly, a major reason why these patients elect to remain in hospital.

Because of their age and the nature of their disabilities, most Class-Six patients come within the field of geriatrics. Medical problems which confront the specialist in this field are invariably more complex and rigid than those commonly found among younger people. The human personality tends to acquire a certain fixity with age. The rapidity of many of the responses of the individual is diminished and

his general power of readjustment is consequently impaired. As a result, many of the disabling diseases of old age are degenerative in nature and follow a chronic course. This general fact is amply borne out in a distribution of the physical ailments of an unselected group of Class-Six patients (see Table B.) This distribution was compiled from the medical records of sixty patients, selected in alphabetical order from the District files of the Department of Veterans' Affairs.

As before, the great majority of the sample group are over the age of sixty, but slightly larger per centages appear in the groups aged 60 to 69 and 80 to 89. Altogether these 60 patients exhibit a total of 132 separate disease types, an average of 2.2 types of disease for each patient. While many patients had a clear diagnosis of one type only, others were suffering from three or four different types. For example, the diagnosis of one patient included arteriosclerotic heart disease, chronic dyspepsia, prostatism, and anaemia. Another patient, age 61 and confined to wheelchair, suffered from portal cirrhosis, emphysema, osteo-arthritis, and chronic alcoholism. These conditions are extreme but some type of chronic degenerative illness was found in every case.

Increasing age seems to have little effect on the numbers of diseases per patient. The group aged 50 to 59, in fact, shows the highest incidence of all i.e. 3 diseases per patient. This incidence may be affected somewhat by the size of the group which is very small. However, the fact will serve to illustrate an earlier point to the effect that the younger the patient, the higher his degree of disability must be before he or the Department of Veterans' Affairs is satisfied



to employ Class-Six treatment. Analysis on a larger scale would undoubtedly corroborate the view that the younger patient must demonstrate excessive disability before he will be considered for domiciliary care. In other words, since disability characterizes old age, the younger Class-Six patient may be described as "prematurely aged".

Table B

Distribution of Physical Ailments by Type of Disease and Ages  
of Patients

Type of Ailment	AGE - GROUP					
	50 - 59	60 - 69	70 - 79	80 - 89	Others <sup>(b)</sup>	All Ages
General Diseases	1	5	2	2	-	10
Musculo-Skeletal	1	5	7	6	1	20
Respiratory	1	5	9	8	-	23
Cardio-Vascular	1	7	15	3	2	28
Blood Stream	1	1	-	-	-	2
Digestive	1	-	1	1	-	3
Genito-Urinary	1	2	2	7	-	12
Endocrine	-	2	1	-	-	3
Nervous Diseases	-	-	5	-	-	5
Psychiatric	1	2	1	1	-	5
Senility	1	1	8	6	-	16
Unclassified (a)	-	1	4	-	-	5
Total Diseases	9	31	55	34	3	132
Number of patients	3	15	23	16	3	60

(a) Unclassified diseases included three cases of blindness and two carcinoma of rectum with removal.

(b) Two patients were aged under 50, one aged over 90.

Source: Vancouver District Files, D.V.A. Special Count.

The next largest incidence of disease appears among the men in the seventies who have 2.4 diseases per patient. This group happens to be the largest numerically, comprising over one third of the total. From the point of view of geriatrics, therefore, this older group would seem to present the most challenging problems with reference to rehabilitation as well as medical treatment.

It will be noted (see Table B) that the three most prevalent types of disease are those listed as musculo-skeletal (found mainly as arthritis), respiratory (mainly asthma and bronchial infections), and cardio-vascular (mainly arterio-sclerotic heart disease). These three types alone account for more than half of the ailments found in the group studied. By nature these diseases are acutely disabling and progressively limiting to the individual's mode of life. In severe cases the patient will often be reduced to a state of complete dependency. In most cases the patient with this type of disease will exhibit a relatively high need for dependency.

Considerable evidence has been brought forward in recent years, notably by Flanders Dunbar <sup>1</sup> and by Weiss and English <sup>2</sup>, to support the view that disease is not entirely a basic entity that invades the body from without, but is a reaction of the total personality towards satisfying some basic lack or imperfection in the emotional life of the individual. This lack frequently involves some form of dependency conflict (the need to feel loved), which may be satisfied by the healthy individual in a healthy way, or by the diseased individual - one in

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1. Dunbar, F, 10c. cit.

2. Weiss and English, 10c. cit.

whom the conflict is too strong - in a variety of neurotic ways. Heart disease, arthritis, and respiratory disorders are usually associated with excessive emotional tension. The disease often serves a very useful purpose for such an individual for it eliminates his neurotic tension by allowing him to satisfy certain dependency cravings. His anxiety disappears as soon as he gets sick because he enjoys the ministrations of the nurses and other hospital staff. Once these needs are gratified, the patient can relax his internal struggle, his symptoms disappear and he regains his health. The conflict, however, has not been resolved; it has simply been ameliorated by loving care and an improved state of health. If the dependency satisfactions of hospital care are not substituted, his symptoms will return after the patient is discharged, and another physical breakdown will allow him to re-enter the hospital. The damage which is done by repeated breakdowns leads gradually from a need for emotional dependency to a need for complete dependency and domiciliary care. These theories, which are being increasingly substantiated in psychiatry and medicine, shed additional light on the high incidence of certain diseases associated with patients whose high dependency needs can be readily demonstrated.

The length of time which patients spend in Class-Six treatment may also be pertinent to this discussion of the dependency problem, since they are problems which a programme of domiciliary care may be expected to solve. A distribution of the duration of treatment for the same sixty patients is set forth in Table C. It is noted that one of these patients has been in care for more than fifteen years. His physical disability is not a prominent handicap, yet he seems to find

it necessary to make the hospital his home.

Table C

Distribution of Patients according to Treatment Period and  
Age - Group

Duration of Treatment	Age - Group					
	50 - 59	60 - 69	70 - 79	80 - 89	Others	All Ages
1 - 6 Mos.	-	4	6	2	1	13
6 - 12 "	-	2	4	1	-	7
12 - 18 "	2	4	6	4	-	16
18 - 24 "	1	2	2	4	1	10
2 - 5 Yrs.	-	3	3	5	1	12
More than 10 yrs.	-	-	1	-	-	1
Total	3	15	23	16	3	60

Source: Vancouver District Files, D.V.A., Special Count.

The greatest number of patients in the sample group have been in Class-Six for a treatment period of 12 to 18 months, the next largest group appears in the period 1 to 6 months. Nearly half of the total group have been in care from 1 to 2 years. Various explanations are possible to account for this concentration of patients at intervals. In the first place, there is no adequate screening process when older patients are admitted to hospital. A considerable number of the older patients appear to be in need of long-term treatment when they come in. Some of them are placed in Class-Six on the assumption that they will want domiciliary care, and also for the reason that financial arrangements are possible under Class-Six treatment which enable the Department of Veterans' Affairs to recover some portion of the costs.

Pension, War Veterans' Allowance, or other income may be pro rated among the patient, his dependents, and the Department. However, the patient may recuperate and, if he is not satisfied to live in the institution, or is resentful of the Department administering his income, he may request his discharge. Anomalous though it may seem, the dependency needs of some patients also seem to operate towards an early discharge from Class-Six. While the patient is receiving active treatment, in the form of nursing care and medical attention in bed, he remains relatively contented. But when he is transferred to the Extension for domiciliary care, he receives supervision only and is expected to do certain things for himself, such as making his bed. At this point some patients become very disgruntled over the lack of service and decide to leave the hospital, presumably in the hope that they will receive more attention elsewhere. For reasons such as these, a considerable number of patients are discharged from Class-Six during the first twelve months.

Other factors which tend to account for the sudden shrinkage in numbers during the 6 to 12 month period would include the death rate, and the influence of the seasons on Class-Six admissions, discharges, and deaths.<sup>1</sup> Some correlation can be shown between the increase in admissions and deaths during cold weather, and the increase in discharges during warmer weather. On a seasonal basis alone, it is possible to account for much of the drop in numbers during the first year. The

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1. Chart B, Appendix B, graphs the monthly rate of admission, discharge and death during the period January 1949 to June 1950.

records for Table C refer to January 1950. Patients falling in the 6 to 12 month period at that time would have been admitted mostly during the spring of 1949 when admission rates were at a relatively low point.

The heaviest concentration of patients occurs in the 12 to 24 month period. After that the numbers decrease steadily owing to death, discharge, and occasional committal to Provincial Mental Hospital. Relatively few patients remain in Class-Six continuously for more than five years, (though recently a patient died after 22 years of domiciliary care.) Most patients come and go at intervals so that they are neither out nor in for any long continuous period.

Taking the sixty patients studied as being representative of the entire Class-Six group in Shaughnessy Hospital, it is possible to estimate roughly the number of patient-days which are taken up in the form of domiciliary care. This small group, representing about one eighth of the total of 485, had been given, in January 1950, an aggregate care equivalent to 102 patient-years, or 37,230 patient-days. The total group, which is eight times as large, would, therefore, have required 297,840 patient days. Breaking down this total according to the proportion of Class-Six patients in each of the three institutions, the following ratio is established: Shaughnessy Hospital - 173,740 patient-days, Hycroft - 71,978 patient-days, Health and Occupational Centre - 55,224 patient-days. Average patient-day costs <sup>1</sup> for the nine month

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1. Precise patient-day costs for domiciliary care are not available so the figures quoted include all patients. Cost accounting was instituted in May 1950 to determine the exact cost of Class-Six treatment.

period April 1949 to December 1949 were: Shaughnessy Hospital - \$8.31, Hycroft - \$3.23, Health and Occupational Centre - \$4.27.<sup>1</sup>

Computing costs from these figures, the estimated expenditure for the group of Class-Six patients at Shaughnessy Hospital (i.e., 280 patients) is \$1,443,780. Costs for the group at Hycroft (i.e., 116 patients) is \$232,490, and for the group at the Health and Occupational Centre (i.e., 89 patients), \$235,810. Total cost of domiciliary care for this group equals \$1,912,075, an average of \$3,081.51 per day.

The above figures are cited to illustrate the financial nature of the undertaking to provide domiciliary care for aged veterans in Vancouver. The figures are only rough approximations, but it may now be said that it would probably cost two million dollars to give domiciliary care to five hundred disabled veterans for as long as they wanted it. Supposing the error in these estimates turned out to be as high as one hundred percent, the figures would still provide ample evidence that Class-Six treatment, as it is presently constituted in Vancouver, is a very costly undertaking.

Recalling statements in chapter I with respect to the increasing number of aged people in Canada, and the increasing tendency for old people to require some form of institutional care, it becomes apparent that there is a limit to the extent to which institutional living can be supported on a national scale. Large-scale domiciliary

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1. Figures represent average per patient costs of all institutional services during that period, excluding medical officers' salaries.

care programmes for the aged are financially impractical on the present basis. At the same time, it is recognized that large numbers of older persons will inevitably fall into the condition of total disability, and a humanitarian society will insist that they be given care. All possible measures, therefore, must be employed to reduce this group to a minimal number. Such a reduction can best be accomplished by assisting the older person to retain his independence.

#### Practices and Policies Relating to Class-Six

On the surface, the physical disabilities of the Class-Six patient are the chief manifestation of his dependency problem. Most patients are acutely ill on admission to hospital. General debility and a multiplicity of chronic ailments lead the doctor to a diagnosis of total disability apparently requiring long-term treatment of the patient. Under those conditions domiciliary care may be prescribed. The recommendation is based primarily on the physical condition of the patient. Little, if any, attempt is made to evaluate the patient's social or emotional condition, though there is always a routine investigation of his financial situation. If information of a social or psychological nature comes out incidentally during the physical or financial investigation, it would probably be taken into account by the doctor, but no machinery has been set up whereby a differential diagnosis can be obtained and used as the basis for a recommendation for Class-Six treatment.

The patient usually recovers from his acute illness in a few weeks when he either asks to be discharged, or agrees to accept domiciliary care. If he remains, a financial agreement is arranged accord-



ing to the individual circumstances of the patient. Two illustrations will serve to indicate the wide range of possibilities in this area.

The patient is married and supporting his wife, has a full pension for war disability and total savings amounting to \$5,000. His sole income is from his pension which amounts to \$125.00 per month. When he comes into Class-Six his income and resources, in his own name, in excess of \$1,750.00, are turned over to be administered by the Department of Veterans' Affairs. In return for care and maintenance, and treatment when required, the Department can deduct a sum not to exceed \$120.00 per month. However, certain portions of the income cannot be taken, but would be administered as follows: His wife is permitted an income of \$75.00 per month from all sources. If she has no other income, she would be paid the full \$75.00 out of her husband's pension. A trust fund is also set up on behalf of the patient and is calculated on the basis of 10 percent of the pension he would be receiving as a single man. Full pension for a single man is \$94.00, so this patient would have \$9.40 set aside each month in his trust account. For his hospital needs he is allowed \$5.00 per month for comforts and \$8.00 per month for clothing. The remainder of his income, amounting to \$27.60, is deducted towards his maintenance. Since the patient also has assets amounting to \$5,000, he can afford to pay the full cost of his maintenance. An additional \$92.40 is taken each month from his assets to make up the \$120.00 until such time as his assets are reduced to \$1750.00. Thereafter, he would only pay \$27.60 per month for Class-Six treatment, and his wife's allowance would continue as long as she required it.

In other cases, the man's pension may be much lower and he may, or may not, have additional income from other sources. It is apparent, however, that the possession of material assets does not prevent the veteran from receiving domiciliary care. In the past, the regulations did not permit the Department to deduct more than \$30.00 per month for maintenance, and it was found that some patients, on their death, were leaving large estates to relatives who failed or refused to care for them. As executor of these estates, the Department was not entitled to any reimbursement, even though the patient had received costly hospital care for a period of several years. As they now stand, the regulations are quite liberal, but many patients strongly resent having to make payments at all. Some of them will give away their surplus assets before coming in for treatment, rather than pay for their treatment.

At the other end of the financial scale, the disabled veteran coming into Class-Six may be single and destitute, living on his war veterans' allowance of \$40.41 per month. He has no pension and no dependents. As a point of information, war veterans' allowance is a form of social assistance, amounting to \$485.00 per year, available to the veteran who is over the age of sixty, totally disabled and destitute. He is allowed to earn an additional sum of \$125.00 per year from all sources, including the War Veterans' Allowances Board Assistance Fund to which he can apply when in distress. He is eligible for hospitalization under treatment Class 5B. During active treatment under Class 5B his war veterans' allowance is continued, but deductions not exceeding fifty cents per day may be

made. A great many of these patients, known colloquially as "5B's", show poor prognosis and may be recommended for Class-Six. If he accepts Class-Six, his war veterans' allowance is suspended, the Department pays the cost of maintenance and grants him the regular allowance for clothing and comforts. No trust fund is set up in this case.

The patient who comes from Class 5B to Class-Six has no assets or income of his own. Unlike the pensioner who derives a certain income from the Canadian Pension Commission, the recipient of war veterans' allowance receives everything from the Department of Veterans' Affairs. He, therefore, has no independent resources from which the Department would be obliged to establish a trust fund. When he enters Class-Six he becomes, in effect, a ward of the Department, and the arrangements which are made seem to be based on the assumption that he will never want to, or be able to leave. On the contrary, however, these patients frequently regain their health and request to be discharged. They have no financial resources so they must apply to be re-instated on war Veterans' Allowance. This application goes through the normal channels for final approval in Ottawa before the patient can obtain any money whatever. A considerable delay is inevitable, during which time the patient waits restlessly for the day when he can leave the hospital. Thirty days delay is about the minimum that can be expected. A Veterans' Welfare Officer cited a recent example in which the patient urgently wished to be discharged, but, despite all efforts to expedite the matter, fifty-two days elapsed before his re-instatement came through and funds were made available.

Many patients in this category obtain a strong impression that Class-Six is very easy to get into, but difficult to get out of. Such evidence further emphasizes the point that the concept of rehabilitation has not been integrated in the Class-Six programme. Not only does this concept seem to be absent, but there seems to be an active tendency in some cases to discourage the patient trying to go back into the community.<sup>1</sup>

When active treatment has ceased, the patient who has been accepted for Class-Six, and has elected to remain, has the option of three institutions in which to live. In the first place, he will likely be transferred from the main hospital wards to a ward in the Extension. There is no policy of careful segregation for the ordinary patient so he will be allotted his bed in a large ward which he will share with about thirty heterogeneous patients in the same category. It is in these wards that he will see the greatest extremes in the state of being which characterizes this ageing group. The helpless and hapless, the helpful and happy, the active and the torpid, the alert and the listless, the hopeful and the hopeless - all types are mingled together in the Class-Six wards; but the mingling is not an equalizing force, and the predominant feeling is one of inertia and despair. Away from the wards there are many things near at hand for the patient's diversion and healthful activity. The woodwork shop, the arts and crafts,

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1. In fairness to the Department of Veterans' Affairs it should be mentioned that there are recent indications that the authority of the local war veterans' allowance committee will be increased to enable final authorization of allowances to be made in each District.

the library, the typing room, the Red Cross Lodge, and the ample grounds are all attractive places, but few of these patients take much advantage of them. They no longer seem to regard such activities as worthy goals. They are contented to face backwards into the past and drift towards the future. The poverty of sustaining human relationships is striking in the majority of these patients. Nobody cares because nobody seems to care.

The patient living in the Class-Six wards of the Extension may, for personal reasons, request a transfer to Hycroft or to the Health and Occupational Centre. If he is fairly active, fully ambulatory, and temperamentally able to get along with his fellow-patients, his request may be granted. Both these centres have limited accommodation and an attempt is made to maintain a capacity number of patients, so it may be necessary to wait for a vacancy.

#### Relative Costs of Class-Six Accommodation

The difference in costs between the three centres is an important reason why it is desirable to accommodate as many patients as possible outside the hospital. When a patient is transferred from Shaughnessy Hospital to Hycroft, the cost of his care drops from \$8.31 to \$3.23 per day, a reduction of \$5.08. If he goes to the Health and Occupational Centre the daily cost is \$4.27, a reduction of \$4.04. This striking reduction in costs is accomplished simply by utilizing a non-hospital type of accommodation. From the point of view of the ordinary needs of the Class-Six patient, the two non-hospital centres are rendering as high a standard of domiciliary care as is the hospital itself. No elaborate evaluation of personal needs is necessary to show that the

bulk of Class-Six patients do not need the expensive accommodation of the hospital. Apart from the occasional need for medical treatment, Hycroft and the Health and Occupational Centre serve these patients just as well at less than half the cost. At the same time the question arises, since there has been no accommodation specifically designed to meet the needs of domiciliary care, how much more economical would it be to implement a programme that would be designed to focus on the specific needs of this older group, and in so doing help them to help themselves. The first step towards the accomplishment of this end is to separate the miscellaneous group into its most obvious classifications, decide what basic differences exist in each, and plan towards making the most effective use of these differences.

## Chapter IV

### Categories of Class-Six Patients

It should be reiterated that Class-Six treatment, at the present time, is based chiefly on the physical condition of the patient. His total disability is the decisive factor. Although the regulations state that the patient must require domiciliary care, this is usually interpreted to mean that he requires it because of his disability. In other words, if the patient's eligibility is established, he can have domiciliary care if he wants it. In a similar manner patients are selected for Hycroft and for the Health and Occupational Centre. If they are physically active and not too senile or grossly disturbed, they are regarded as having equal advantages in any of the three centres. In a programme which aims to provide physical care only, it is to be expected that physical considerations will be uppermost. Psycho-social considerations are not emphasized because a domiciliary care programme, as such seems to be based on the assumption that psycho-social problems will disappear automatically once physical security is established. Segregation, therefore, if it can be so described in the present set-up, is simply a matter of physical limitations within the three types of institution, and from the point of view of the patient who does not need nursing care it scarcely can be said to exist.

The fact remains that three separate types of institutions are being used for domiciliary care. From this fact it can probably be said that the basic principle of classification and segregation has

been accepted by the Department of Veterans' Affairs. It is simply a matter of application to carry the principle a step further. Inadequate though it is to segregate patients on the basis of physical condition alone, it is probably necessary to start at that point. Careful diagnosis of the total problem of each patient would lead to more accurate classification, but for the moment three obvious categories of Class-Six patients can be recognized. These categories can be defined chiefly on the basis of the patients' physical ability to take part in a scheme of rehabilitation.

#### The Irremediable Patient

A patient in the irremediable group is one whose physical and/or psychological condition is considered by the doctors to be irremediable by any known treatment. Deterioration and loss of normal function has progressed to the point where the patient is seriously incapacitated and unlikely to make significant improvement. Such a patient may be grossly handicapped through damage to limbs or vital organs, suffer complete loss of mobility through some crippling disease, paralysis or arthritis, or be otherwise physically helpless, requiring constant attendance of orderlies and nurses. In the same group would be the patient who is psychotic, or whose emotional and intellectual capacities are seriously impaired. Alcohol, disease, arteriosclerosis, or other conditions have caused extensive, permanent damage to the nervous system and to the brain so that the patient requires psychiatric care in a locked ward, or, if in the open ward, requires close and constant supervision. Whether or not the condition of these patients can be ameliorated in the course of time, at the present time they are inaccessible and unresponsive to any ordinary therapeutic approach. In



their present condition these patients are virtually incapable of receiving help, other than bed-side care.

There is a sense of finality in the term "irremediable" which should not be taken to mean that the patient is permanently lost. His condition is irremediable only in the sense that it could not be significantly improved by any effort of the rehabilitation team. It is not an active medical problem because the condition is not amenable to medical treatment, but it is still the problem of the geriatrician to raise this patient's level of functioning to the point where other forms of treatment might profitably be attempted. If treatment methods are discovered and medical science succeeds in raising the individual patient's capacity for adjustment, then the patient would move out of the irremediable group into the treatable group.

Individual examples are not necessary to describe this type of patient who definitely requires a form of domiciliary care that can be given only in a hospital-type ward. At present all these patients are in Shaughnessy Hospital, many of them in the Extension. Those with pronounced psychiatric disorders are confined to a locked ward and are allowed outside only in the company of attendants. Such patients are segregated because of their unpredictable behaviour which, except under watchful supervision, may become a menace to themselves and to other patients. Other relatively helpless patients are to be found in every Class-Six ward in the Extension, and a few, who are still receiving active treatment, are patients in the main hospital.

Only those patients who still require some form of hospital care, and could not possibly be recommended for transfer to Hycroft or the Health and Occupational Centre at the present time, need be classi-

fied in this irremediable group. For them the full hospital treatment programme, including occupational therapy, physio-therapy, medical social services, vocational counselling, and institutional training, should be provided as required. Case conferences, attended by every member of this hospital team, should be held under the chairmanship of the doctor, and an individualized treatment programme devised which would aim to help the patient move forward into the intermediate group.

#### The Intermediate Patient

The patient in the intermediate group is fully ambulatory and displays a moderate residual capacity for self-sufficiency. He is totally disabled according to Canadian Pension Commission standards, but, unlike the patient in the irremediable group, he is not helpless. He may have one or two serious types of physical disability which prevent him from working in competitive employment and from living under conditions in which he has to take care of all his personal needs. In the institution, however, he looks after himself and his clothes, and makes his bed; he takes part in certain institutional activities, occasionally makes an effort at handicrafts or woodwork, takes occasional odd jobs in the community, such as gardening work at fair grounds or race tracks, travels about the city, visits the parks, and generally leads a moderately active life in a moderately independent way. Aside from the institutional rules, a few minor duties, and the shortage of spending money, this patient suffers few restrictions. His quarters are heated, his meals are provided; he rests frequently and continues to carry on fairly comfortably in this sheltered environment, living a life much the same as that of any ordinary aged individual.

The intermediate type of patient has all these advantages, but

he doesn't seem to be happy. He has hundreds of people around him but he frequently complains of loneliness. Instead of feeling fortunate in having so much, he often feels that he has come to "a sorry pass", that he was "unfortunate in having lived so long". He complains about his health, about his fellow-patients, about the staff and the poor service, and about the Department of Veterans' Affairs which he frequently believes to be "after his money". The variety of his other complaints is legion, with the weather topping the list as a universal source of annoyance. Despite the superficial independence which he enjoys, this patient seems to feel his dependent position in life very keenly. His inner hostility and rage over the frustration of being a grown-up adult in a child-like position of dependence on the parental figure of the Department, expresses itself in his interminable complaining. The more completely this patient reverts to a state of complete dependency, the more completely he will revert to a child-like level in his emotional reactions and in his relationships with other people. To be a child he needs a mother to look after him; but the Department is not a mother; it is an efficient, impersonal government organization. He, therefore, finds the Department very unsatisfactory as a mother because it does not give the warm affection and understanding that a mother ought to give. He is, therefore, frustrated in his relationship with the Department and with most of the staff, so he cannot be grateful for what he gets; he can only think about what he is missing, and feel frustrated in his dependency situation.

This frustration inevitably produces anger or a sour, complaining disposition. It is a common occurrence among Class-Six patients for outbursts of rage to occur in the wards, when patients and staff alike

are often the target of wild vituperation. In other cases the patient attempts to drown his angry feelings in alcohol. He exhibits controlled behaviour most of the time, but periodically, he has to go on an emotional spree by getting drunk. At such times, he may be absent without leave, or he may come in and disturb the entire ward. These episodes appear to be compulsive for, in spite of frequent reprimands, disciplinary action, and the threat of discharge, such a patient will continue to repeat his performance. The hospital superintendent has had to deal with so many charges of drunkenness that he is sometimes tempted to label the entire Class-Six group as "incurable alcoholics".

The Class-Six patient in the intermediate group handles his dependency problems in a variety of ways, but does not go to the length of leaving the institution. Unlike the child who experiences the same frustration, he cannot decide to grow up and become independent. Rather, he is more in the position of the over-protected child who is grown-up, but is still tied to his mother. He is torn between his need to be mothered and his desire to "stand on his own feet". However, his fear of being unable to stand alone in the world is the more powerful force so he remains where he is, his neurotic conflict unresolved.

The intermediate patient was not necessarily tied in this way to his boyhood home. His present sense of inadequacy and inferiority may not have dominated his early life. These feelings were, no doubt, always present, but did not assume control of his behaviour until after he had suffered the series of physical breakdowns and periods of hospitalization which led him gradually into Class-Six. His repeated failures as a normally functioning individual in the community, accompanied by the ordinary vicissitudes of old age, gradually broke down

his sense of security and personal worth. At first he was capable of remustering his resources after a breakdown. His personality was strong enough to enable him to take positive action in escaping from his dependent situation as a hospital patient. He would receive his discharge and return to his former life; but the pressures of loneliness and friendlessness, ill health and economic insecurity were too much for him to bear in his declining years. The strain continued, and the frequency of his illnesses increased. Finally he was forced to succumb, and he relinquished his cherished independence for a more sheltered environment in which he could still function and strive to retain what he had left of life. Consciously or unconsciously, he struggled against this final step, and, consciously or unconsciously, the patient is still struggling. The pain of this conflict is as much a part of his manifest dissatisfaction with Class-Six treatment as is the pain of his physical illness. But his physical condition, which is his most readily apparent problem, is the only thing for which he receives treatment, and the impact of the psycho-social forces on his life is largely overlooked.

A fairly typical example of the patient in this intermediate group of Class-Six patients is John S-, who has been in care for the past year. Mr. S is inclined to be reticent, but during frequent conversations he became increasingly frank in his opinions. He appears to be both intelligent and observant, and he often voiced thoughtful impressions with an air of realism.

#### The Case of Mr. S.

Mr. S was born in England seventy-six years ago. His parents were middle class people and he received a good education by

contemporary standards, attending high school and taking extensive military training. As a young man he served in the police force in India and various parts of the East. He always enjoyed the rugged, outdoor life and found great interest in hunting and in nature study. Completing his tour of service with the police force Mr S returned to England where he married at the age of 34. His only daughter was born in England, and shortly afterwards Mr S decided to come to Canada to make his home. He left his wife and child in England, but it was six years before he was able to send for them. Finally the family settled down on Vancouver Island, where they lived for three years before Mrs S died very suddenly. Mr S decided to send his daughter (age 9) back to England, where her relatives had offered to give her the advantages of family life and a proper education. He never saw her again until last year when she came to Canada for a short visit. Miss S (she remained a spinster) seemed to regard the visit to her father as a sort of duty. She and Mr. S were both very disappointed to find that they had so little in common. It was an anxious period for Mr S and he took sick during the visit, spending most of the time in Shaughnessy Hospital. Miss S tried to persuade him to go into Class-Six, but he refused. Finally she arranged with the Department to have him accepted, packed his belongings for him and went home while he was still in the hospital. After she had gone Mr S requested Class-Six treatment.

Mr S served in the Canadian forces during World War 1 and came back to live on his little farm on the Island after the war. Having been "gassed", he receives a small pension for bronchial condition. During the 1940's, his condition became more troublesome and he had to give up his farm and come to Vancouver for treatment. Periodically

it was necessary for him to enter the hospital, but in the intervals he did his best to support himself and carry on outside. His favourite motto is "Never let yourself slip", and he always hoped that he would not live to see his bronchial condition get the better of him.

As a patient Mr S still endeavours to keep himself from slipping. The morning is his worst period of the day, but he forces himself to get out of bed and shave before breakfast. During the day he seeks ways to keep active and spends considerable time trying to learn to type. Recently he was delighted when the librarian gave him a job typing out library cards and cataloguing books. Now he seldom misses a day in the typing room, and he thinks it is "a real pleasure to work for such a charming and considerate young lady as Miss X", (the librarian).

Mr. S brought out clearly his struggle to keep from slipping into a state of dependency. During the past eight years, his bronchial condition grew progressively worse and his general health deteriorated. Periodically, he was forced to go into the hospital for a month or two, but he strongly endeavoured to keep himself active, and always left the hospital as soon as the doctor would let him. Mr S did not make friends easily and always lived alone. He supported himself by working as caretaker in boarding homes where he usually had his own quarters in the basement. Last year he had a similar job in a private residence where he happened to take sick while the proprietor was away. With the help of neighbours, he managed to get to the hospital, but his condition was rather serious for several weeks. He was only back a short time when he fell ill again during his daughter's visit. Even after a long series of painful and frightening

episodes, this lonely old man of 75 was still reluctant to accept domiciliary care because to him it meant giving up his last shreds of independence.

Since the summer of 1949, Mr S has remained in Class-Six. He was sent to Hycroft, but after three weeks he asked to be transferred back to Shaughnessy Hospital. Not wishing to hurt the feelings of the management, he stated that he wished to leave because of purely personal reasons. He could not tell them that he "hated that old baronial castle, with its high-toned, fancy name, and its miles of marble corridors and steep stairways". He explained that Hycroft was all up and down hill, and he couldn't get around so well, being short of breath. "Besides, it takes more than ivy-covered walls, arbor paths, and pools filled with sodden leaves to make a home. The whole place is simply adaptable to nothing, as far as I can see. Whatever the purpose of building a layout like that was, it certainly wasn't to live in". Mr S. realized that his opinion was not shared by many of the other patients, and he would not wish to offend the management by expressing it to them, but he would certainly say the same thing to a board of higher officials, if they asked him.

Mr. S thought the Extension was far from perfect, but it suited him in some ways. It was on the level, and he was able to get around with less effort. He enjoyed walking about the grounds and frequently went to the Red Cross Lodge to read or chat over a cup of tea. Transportation was handier and he was able to visit his friends in Burnaby more easily. Then there was the typing which helped to keep his fingers limber, and the enjoyment of helping with the library work. He thought he would soon have gone crazy if he hadn't found some sort



of job away from the ward.

Mr. S stated that one of the main reasons he wanted to keep active was to be able to get away from the ward. To him the ward is a hateful place, "never free from the unpleasant sounds of coughing and flatulence". Many of the other patients are "abominable creatures", and he never dreamed that the human being could sink so low. For example some of the men have lost bowel control, and Mr. S finds it very distressing to have to continually watch where he steps. He also becomes very upset to see some patients lose their temper and blaspheme the sisters in the vilest way. It seems quite inexcusable for a man to speak to a woman that way, and makes him want to punch the man in the nose. It frustrates him continually to think that he is no longer physically able to do very much in a situation like that. Consequently, he tries to stay out of the ward as much as he can, and when he does go back, he either sleeps or buries himself in a book. Insufficient privacy and the lack of facilities and places to keep personal belongings, were other things that bothered Mr. S. His hat was all crushed because there was no decent place to keep it, and "a man has to go to the washroom to change his pants, if he doesn't want the nurses and a bunch of other people watching him". Mr. S thought it was very hard for a person to live all his life in conditions where there was normal privacy, and then in his old age to try to get used to doing everything in front of people.

Mr. S was asked what he thought the solution to these difficulties might be. He replied that he had given it considerable thought and had come to the conclusion that the patients should not all be mixed together the way they were. In his own case, he felt he would be much

happier living in a shack, except that he needed to be close to medical aid. He didn't need a doctor very often, but when he did, he usually needed him in a hurry. He thought it might be ideal to have his shack close to the hospital and be able to get medical aid just by pushing a button in his room. Mr. S went on to say that he had a trunkful of precious mementos and trophies which he had gathered from the far places of the world. They mean nothing to anyone but himself, and he can't enjoy them because they are locked away in the storeroom. He would like to have his things around him in a room where it wouldn't matter if he drove a few nails and hung things on the walls. He wouldn't mind sharing a cottage with another patient of his choice, providing they had separate bedrooms. As long as he had some place in the world where he could feel he really belonged, and maybe grow his favourite hollyhocks around the door, he would be content.

Asked if he had ever thought he would rather be living with a nice family, Mr. S said, "no". His reasons were somewhat vague, but they boiled down to the feeling that he would be too troublesome. At times he was inclined to be irritable. His coughing would be annoying to the rest of the household. His presence would tend to interfere with the activities of the younger people. Later he seemed to come closer to the truth when he admitted that he had little use for most of the people he had met in this world. The people that appealed to him to any extent were very few and far between. Very rarely did he find a fellow-patient with whom he could enjoy good conversation. It seemed as though Mr. S was afraid of family life because it would mean developing close relationships with people - a thing he had never been able to do successfully.

The case of Mr. S illustrates several social and psychological points that a purely physical type of domiciliary care fails to take into consideration. The first, and probably most basic point, is that physical care necessarily emphasizes the giving of things to people and the doing of things for people, rather than the giving of things in order that people will be able to do things for themselves. To give privileges without responsibilities is to depreciate the individual by forcing him to adjust to a situation which is consciously or unconsciously reminiscent of his early childhood. In re-creating that physical dependency-situation, the early emotional dependency-situation is also re-created automatically, unless something is done to counteract it. The domiciliary care patient reacts emotionally to this sort of situation. He reacts outwardly and inwardly;- outwardly by showing his dissatisfaction and, perhaps, by doing something about it; inwardly by tending to become more dependent and more passive. These conflicting forces are both present. The patient's adjustment and his immediate prognosis seem to depend largely on the relative strength of these two forces which are conditioned by the early life of the individual and are influenced by many factors as described in chapter I. The positive force, which is the tendency to react outwardly in the direction of greater independence, is the thing which domiciliary care may tend to destroy. It destroys because it fails to give responsibilities or to demand any growth of personality. The patient with the stronger personality tries to resist this destruction of his ego. This degree of resistance, which shows the relative ego-strength of the patient, should be evaluated more carefully than his physical con-

dition, for it is the estimate of his will to function, rather than of his mechanical ability to function. On the basis of such an estimate, the patient can be categorized for further treatment and rehabilitation.

The difference between Mr. A and a patient with the same type of disorder in the irremediable group is not a purely physical difference. All Class-Six patients are in the condition of being totally disabled physically, but Mr. S shows an ability to make positive personal adjustments, and a strength of personality which sets him apart from the helpless group. His active resistance to the prospect of coming into Class-Six, his insistence on getting out of bed and keeping himself active, his abhorrence of the hospital ward, all seem to show that Mr. S has a fairly strong drive to be independent. The psychological basis of this drive seems to be a fear of dependency. This fear is shown in his disappointment at not having died before his bronchial condition got the better of him, and in his life-long motto, "never let yourself slip". His poor relationships with his own family (he travelled widely and preferred to be on the opposite side of the world to that of his close relatives), his reaction to the idea of family living, his general dislike of people, his reticence and inability to make real friendships, all seem to show a fear of close relationships with people. Because he is afraid of close personal relationships, Mr. S is afraid to become too dependent. The two ideas are closely associated in the experience of every person because of the fact that first relationships are formed during a period of complete dependency in infancy.

Mr. S has a severe physical disability for which he is receiving domiciliary care. It is also apparent that he suffers from a

severe dependency problem for which he receives no professional treatment. Lacking treatment of this nature, the domiciliary care programme tends to aggravate, rather than alleviate his psycho-social disability.

Mr. S. shows a moderate ability to help himself, but because he does not show sufficient capacity to move immediately into rehabilitation, he should be classified in the intermediate group. Because he shows a positive ability to help himself, he would probably respond readily to an integrated programme of treatment which would cover the physical, psychological and social aspects of his problem. His response would be in the direction of greater self-sufficiency and independence which, if it did not lead to his rehabilitation in society, would enhance his general well-being. His productivity and usefulness would increase correspondingly, and the amount of actual care which he required would be decreased.

Patients in the intermediate group all show considerable ego-strength and capacity for positive adjustments within the institution, without much professional help. A separate analysis of every Class-Six patient would be required to determine the number of patients who would fall in the intermediate group, but it is estimated that this group would comprise a greater proportion of these patients than any other. Like Mr. S, there are numerous examples where the patient has found his own way of making constructive use of existing facilities. Mr. H, for example, with the help of the Department, managed to buy his own loom and have it set up in the ward. He had never done much weaving before, but now he is successfully turning out fine tablecloths, scarves, and other small articles for sale. He is much happier

now that his days are no longer idle; the small remuneration seems to increase his sense of independence and usefulness, and he is beginning to wonder if it might not be better for business if he could live outside. Another patient, Mr. F, decided to learn to play the piano. After a few lessons, provided through the Department of Institutional Training, his enthusiasm increased. He practised diligently on various pianos around the hospital, going from one building to another when his "music" began to create a disturbance. However, his skill improved fairly rapidly, and fewer people complained about his practising. Furthermore he is very pleased with the effect of the exercise in curing his hands of "arthritis". Mr. F loves to play for his own enjoyment. With encouragement, he might be helped to play for the enjoyment of others. If Mr. F and some others like him could get together, the social life of many older patients might be enhanced by the activities of a "Class-Six Orchestra". Other similar examples of the intermediate patient are to be found with reference to woodwork, handicrafts, literary pursuits, et cetera.

#### The Reclaimable Group

It may appear somewhat presumptuous at the present time to designate a group of Class-Six patients as reclaimable, for there has been no actual demonstration at Shaughnessy Hospital to show that such a patient is suitable for rehabilitation. On the contrary, the concept of total disability, and the present concept of domiciliary care is based largely on the assumption that the Class-Six patient will continue to be capable of very little in the way of self-help. Admittedly, the reclaimable group may be small; nevertheless there are a considerable number of Class-Six patients who seem to insist on trying to

get along by themselves. These are the patients who request to be discharged, often against medical advice, and return to live in the community. They do so because they feel capable of taking a job, or they have made living arrangements whereby they can get along on pension, war veterans' allowance, or some other means. As contrasted with the patient in the intermediate group, the reclaimable patient is one who has regained sufficient personality strength to enable him to leave the institution.

Many of the patients who take their discharge in this way do so in the spring and summer months.<sup>1</sup> In the warm weather their spirits rise and their self-confidence seems to return. This point is significant and, in some respects, exemplary of the reclaimable type of patient. In broad terms, the margin of his ability to function independently is so narrow as to be completely upset by such eventualities as the changes in season or climate. Winter conditions seem to impose an additional hardship on this patient which often overtakes his strength and results in physical breakdown. The exacerbation of his illness brings him back into the hospital where he may decide to spend the rest of the winter. In the spring, if his illness and prolonged dependency have not taken too great a toll of his ego-strength, he may decide to set forth on his own once again. Repetition of this performance, however, may lead the doctor to advise against the patient's discharge. Past experience has shown that such experiments with the patient's independence have often been short-lived and, from a purely physical point of view, are usually injurious. The doctors are also

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1. Table B, Appendix B.

aware that any planning for the patient's discharge has largely been done by the patient himself. They show a realistic skepticism of the disabled person's ability to make his own plans and necessary arrangements on a permanent or adequate basis. However, unless the plan is completely unrealistic, the doctors are obliged to allow him his freedom.

The group of Class-Six patients who show a marginal, or greater, ability to function outside of the institution, and who, at the same time, evince a strong determination to live in the community as much as possible, are the patients who would most obviously be classified in this reclaimable group. With a minimum of rehabilitatory effort, such patients could be helped to find the type of work and living arrangements which would be specially suitable to their needs. This small measure of additional support, plus follow-up services during winter months and in times of unusual stress, would be of immeasurable value in avoiding, or at least postponing, a further breakdown.

As in the case of the other two groups, a differential diagnosis of each patient is necessary before the reclaimable patients can be classified with any degree of surety. Mr. B, who recently left the hospital, seems to possess many of the qualities which would place him in the reclaimable group.

#### The Case of Mr. B.

Mr. B is a 74-year-old man who displays a keen intelligence and quickwit. He still retains a remarkable memory for dates and other factual material. In describing events during his life, for example, he was frequently able to use the history-book type of narrative, and to make unhesitating statements, such as, "On March the 24th, 1917, at 2.30 P.M., I was sent to headquarters and given special orders....."



Mr. B was very talkative during interviews and, although many of his statements about himself were apparent rationalizations, his testimony on the whole was quite convincing.

Born in Birmingham, England, in 186, Mr. B was the youngest in a family of three sons. His father was manager of a department in a large retail firm - a position which allowed him to wear the conventional tailed coat and striped trousers. During Mr. B's childhood his father managed the family with the same perfectionism as he managed his business. He cherished high ambitions for his three sons. The two brothers acceded to family demands and became very successful, - the older as a physician in London, the other as an engineer in New York. Mr. B's mother was apparently a home-loving woman who raised her own children when she might have hired a governess. However, she was proud, demanded strict conformity to class and family standards, and expected high standards of achievement in her sons.

Mr. B received good opportunities for education, and he attended the Church of England school until the age of 18. He states that he always wanted to be a civil engineer, but while studying for a university scholarship, he overworked and was suddenly stricken with the flu. He reacted so strongly to the illness, and was so slow in recuperating that the doctor forbade him to study for twelve months. Mr. B never attempted to pursue his studies any further. Instead, he joined the staff of a prominent wholesale draperies firm. This firm had a high reputation for sound dealings both with customers and with staff. Mr. B found considerable satisfaction in the work, in which he proved himself to be a capable salesman and a trusted employee. In 1899 he married, and in 1900 a wool famine reduced his firm's business

so that Mr. B was forced to seek another job. He joined a similar firm whose business standards were much lower. Although he seemed to be getting ahead, he never liked the firm, and in 1903, he decided to move to United States where Mrs. B had an uncle in Iowa.

In Iowa, Mr. B took up farming. He had managed alright for two years when Mrs. B, who had never been in good health, developed tuberculosis. A change of climate was prescribed, so they moved to Saskatchewan. Mr. B inherited money from his mother about that time so he bought a farm, settled down, and was fairly prosperous at the outbreak of World War I. In 1915, Mr. B joined the Canadian army. His wife was not strong enough to look after the farm so he sold out. Mrs. B and the two children went to live in town.

Mr. B had previous military experience in England, but he served as a corporal in the infantry during the war. On three occasions he was wounded, most seriously in 1917 when he suffered concussion and ruptured eardrums. He was granted a small pension for this disability, and was removed from the fighting line to a job in the head office of the Y.M.C.A. in France. After armistice he went with the army of occupation into Germany, returning to Canada in 1919.

Mr. B had never found much happiness in his marriage, nor had he been able to get along well with his wife. In his own words, she was a constant disappointment to him, and, if he had to live his life over again, he would never bother to get married. Mrs. B appears to be a weak, clinging type of woman, who complained a great deal about her physical ailments and demanded constant attention from her husband. Mr. B, however, had ailments of his own, and he made it very clear in his discussion of the subject that he had little sympathy for this woman

whom he regarded as an imposition on his life. Her demands were interpreted by him as "grasping" and "parasitic". She complained to other people about his behaviour, and Mr. B regarded this as a deliberate effort to disgrace him in the eyes of the community. When the children were grown up, he separated from her. Finally, in 1946, he felt that she was disgracing him so badly that they could no longer live in the same community, so he moved to Vancouver.

When Mr. B was repatriated after the war he settled in a little town in Saskatchewan and took a position in the office of a local department store. Following a series of complaints regarding the work of the Y.M.C.A. in occupied Germany, Mr. B was asked to go on a speaking tour of his federal constituency, and to attempt to clarify some of the issues. He spent the summer of 1921 in this task and returned home exhausted from overwork. He spent the next six years in military hospitals in Saskatchewan, suffering from what he described as "nervous debility due to shell shock". In 1927, he left the hospital, but has never taken employment. During the last twenty-eight years he has supported himself and his family on the proceeds of real estate investments, his war disability pension, and a total disability insurance policy which he took out in 1921. His insurance pays him \$50.00 per month, and his pension pays \$40.00, making a total monthly income of \$90.00 from these sources.

During his six-year period of hospitalization, Mr. B claimed there was only one doctor who was able to do him any good. This doctor prescribed a special medicine - a "special nerve food" - which Mr. B took by the bottle. He was not sure what the medicine contained, but it came in a large bottle, and there was something about it that seemed

to be just what he needed. This doctor also gave him advice about his social life, and, when Mr. B left the hospital in 1926, the doctor told him to go out and surround himself with young, lively people. Mr. B took this advice and proceeded to cultivate a large circle of young friends. Most of his time was devoted to these associations, and Mr. B remained in reasonably good health. He did not have to re-enter the hospital until 1946, after he had moved to Vancouver. Since then, he has been in Shaughnessy Hospital most of the time, usually as a Class-six patient. After six or eight months in the hospital, he would usually leave, to return in a few weeks by ambulance in a state of acute alcoholism or digestive disorder, and in a generally weakened, anxious, depressed condition.

While he is in the hospital, Mr. B shows no tendency towards excessive drinking. His alcoholism, therefore, is no problem as far as domiciliary care is concerned. Yet, in November 1949, when he was last admitted, he had been discharged less than three weeks when he was brought back to hospital with delirium tremens. As a patient Mr. B is very demanding and difficult to satisfy. He complains about the service a great deal, often unrealistically. For instance, he claimed that he lay in bed four days, last November, before a doctor or a nurse so much as came near him. The medical record for that period, however, describes in detail the medication and laboratory tests which he received, including comments on the patient's resistance to treatment. As a Class-Six patient in the Extension, he complains that the nurses never make his bed, so it goes unmade. He wants his breakfast in bed each morning, but he does not get it, so, rather than go down the hall to the dining room, he does without. He is supposed to get pills at nine o'clock,

but sometimes it is as late as ten thirty before the nurse gets around with them. "The pills are absolutely no good anyway", so Mr. B puts them in his pocket and later throws them away. He also complains about failing to get his hot milk at bed-time. "Twice in the last week that wretched nurse has been too busy to get my hot milk.... I think hot milk upsets my stomach and makes me worse.... I usually take it into the lavatory and pour it down the drain".

For the past twenty-eight years Mr. B has considered himself totally disabled and unfit for work. "All that has kept me going is an active mind and a strong will. I can laugh or cry with equal facility, but I prefer to laugh. It's doubtful if you will find another patient in this hospital who laughs as much as I do." Mr. B is very cultured and well-read, and has a flair for writing verses and reciting poetry. He states that he does not wish to work and has no need to do so, since he can get along very comfortably on \$90.00 per month. It makes him mad, though, to be paying out all that money to the Department and to get no service in return. If he were to take a job, Mr. B stated that he would prefer clerical work.

According to the medical record, Mr. B has occasionally become a source of annoyance to the doctors in the four years he has been around Shaughnessy Hospital. Most hospital staff have a tendency to become impatient with so-called malingerers, and, as a result, two or three rather scathing condemnations of Mr. B's life adjustment appear in his medical record. He is described as a person who gave up the struggle against his environment to take refuge in his health, a parasite on the body politic, a tiresome old man, and so on. These descriptive terms appear to be judgemental because the record offers no suggestion as to

the possible causes of this condition, and makes no recommendation as to its treatment. From the doctors' point of view, however, it is recognized that Mr. B does not show sufficient physical disability to justify the type of active treatment which he continually demands. The doctors' disapproval of continuing treatment expresses the futility of giving valuable time and materials to a patient simply because he keeps demanding attention. The implication, which underlies the disapproval is, of course, that, although a patient needs skilled help for physical disabilities, he should be quite capable of curing himself of any further abnormalities. However, it is not reasonable to suppose that Mr. B has any more control over his hostile attitudes than he has over his arteriosclerosis, so a further implication may be that the hospital does not propose to treat him for disabilities which are psycho-social in nature.

Mr. B has, undoubtedly, taken refuge in his health, but he has not done so in the deliberate attempt to become unworthy and tiresome. On the contrary, he has done so in the attempt to obtain certain basic gratifications from life, gratifications from which he has always been deprived, deprived to the extent that he must go on seeking them in an immature fashion. Many times he seeks them blindly, for he closes his eyes to certain other values in life and, thereby, arouses hostility and resentment in the very people from whom he hopes to receive kindness. There is little doubt that Mr. B's attention seeking is an infantile form of behaviour. It is the infantile quality of his behaviour that probably causes people to lose patience with him. He wants to be given to, to be waited on, much as if he were a small child. Never having received that sort of attention and been properly satisfied as an infant, he has continued to want it all his life. When his nurse fails

to bring him his pills or his hot milk, he is not concerned about the things he is missing, for he usually throws them away. What upsets him is the lack of interest and attention, the lack of "mothering" and "babying". This need to be "babied" is so strong that twenty-eight years of being totally disabled have failed to satisfy it. At the same time though, chronic ill health has proven itself to be the best device for Mr. B's purposes.

Mr. B's pattern of behaviour was probably established very early in life. Both his parents were stern, strict, and ambitious. His need to be loved, therefore, could not be fully satisfied because of parental demands for achievement. As a boy Mr. B was rarely ill, but when he was ill his mother always gave him a great deal of attention and sympathy. As he grew up, he received approval for his achievements at school and elsewhere, so he worked hard. Following the pattern of his brothers, he decided to enter a profession, although his basic inclinations seemed to lie in the fields of literature and salesmanship. The conflict between his basic inclinations and his need for mother's approval probably reached a peak about the time he was preparing to enter university, so Mr. B successfully capitalized on an attack of the flu to resolve this conflict. He remained physically unfit to study for so long that his opportunity to go to university was lost. Mr. B still rationalizes his actions in terms of frustrated ambition, but this rationalization is necessary in view of the outstanding success of his two brothers. In business life, the paternalistic attitude of Mr. B's "highly reputable firm" was very satisfying, but he could not adjust to the less restricted environment of the lower class firm. In marriage Mr. B was unhappy because his wife was weak and dependent in her ways.

She could not give him the "mothering" he wanted because she, herself, needed someone to cling to. Both were constantly dissatisfied, each blaming the other. When Mr. B was wounded during the war he demanded a great deal of attention until a way was found to grant him a pension for otitis media. At the end of the war, he had been in France three years, but apparently he had no burning desire to return home for he volunteered to occupy Germany. Finally he returned home, and attempted to settle down. Before he could do so he was called upon to tour his constituency and, in a psychological sense, to relive his war experiences over and over again on the public platform. This experience apparently had the effect of accentuating his need for dependency at a time when he had not fully readjusted himself to the relatively independent life of a civilian. He could not face the responsibilities of family life when he returned from his tour, and, having already taken out his total disability insurance, he entered the Veterans' Hospital where he stayed for six years.

Mr. B's prolonged hospitalization was terminated finally after he had been able to establish a warm relationship with one of the doctors. This relationship gave him satisfaction, and sufficient encouragement to enable him to go out and establish further relationships in the community. Within his wide circle of young friends, he was able to vary his companions so that he continually felt accepted and wanted. Alcoholic drinking was part of the social activity of the group, but excessive drinking was no problem to Mr. B during this period.

In 1946, Mr. B came to Vancouver to get further away from his wife. In the strange city, where he lacked the sustaining relation-



ships of friends, Mr. B once again found himself frustrated by a loveless life. He attempted to find satisfaction in heavier drinking, with the result that alcoholism contributed to his early breakdown and subsequent admission to Shaughnessy Hospital.

When Mr. B was last admitted in November 1949, he spoke as though he would not again attempt to live outside the hospital. He requested Class-Six treatment, turned over his income to be administered, and settled down to institutional life. He read extensively, wrote letters to his many friends, entertained himself in the Red Cross Lodge where he received visitors, played cards and so forth, and frequently went out to visit his young friends about the city. Sometime in February, 1950, Mr. B had occasion to consult one of the Veterans' Welfare Officers whose office is located in the Extension quite close to Mr. B's ward. The welfare officer, who is an elderly man himself, and one who has spent his life dealing with people and their personal problems, showed Mr. B a great deal of kindly understanding. Mr. B felt free to come back on a casual basis and, since the office was handy, he did so many times. Three or four times a week, he would drop in for a brief chat, and occasionally, as the relationship grew stronger, he would enter into deeper conversation, and discuss his more personal problems. The writer was also having conversations with Mr. B during this period, asking his opinion of the domiciliary care programme, and obtaining social history information. Mr. B quickly accepted the writer and kept coming back to tell something he just remembered. Numerous conversations came about in this "impromptu" fashion.

As time passed, Mr. B continued his relationship with the wel-

fare officer and with the writer. Eventually he began to mention the possibility of getting out of Class-Six, and he was given encouragement to make plans towards that end. It was not long before Mr. B announced that he was ready to leave. He had made arrangements to live with his "niece and nephew" (close friends) who had a comfortable little home and were very anxious to have him. Mr. B stated that he had been thinking it over and decided that it was ridiculous for him to be in hospital; he would be much healthier if his life were more independent. There was a moderate delay in arranging for Mr. B's money to be turned over to him, and his discharge certificate bore the usual appendage, "against medical advice", but Mr. B left the hospital in May 1950. No follow-up has been made to see how he is getting along, but two months have elapsed at the time of writing, and Mr. B has not returned. It is impossible to predict how long he will be able to remain living in the community, since there are a great many unknown factors in the situation. A major factor, however, will be the extent to which Mr. B can utilize his widening circle of young friends in the satisfaction of his emotional needs. Important though it obviously is, the hospital has made no evaluation of Mr. B's present situation, and it has no means of gauging what his future requirements for Class-Six treatment might be.

The case of Mr. B clearly demonstrates some of the lacks in the domiciliary care programme. It demonstrates that Class-Six patients are not all incapable of adjusting themselves outside the institution; that certain patients show a considerable capacity to help themselves, and they are actively seeking the type of social and emotional support that will enable them to do so. The presence of other Class-Six patients

similar to Mr. B, who are trying to find ways and means to leave the hospital, establishes the existence of a reclaimable group.

Mr. B further exemplifies the type of dependency problem with which an adequate programme of rehabilitation must be prepared to deal. It is apparent that physical treatment alone is not the answer to Mr. B's problem. He is looking for acceptance and warmth from other people, and he shows that he is able to grow emotionally when he receives this acceptance and warmth from relatively mature people. It is unfortunate that a relatively talented man has found it necessary to use physical disability, during the greater part of his life, as the means of obtaining emotional satisfactions, for it is apparent that he can give up his disabilities whenever he obtains these satisfactions from other sources. His social history and his recent experience at Shaughnessy Hospital show that, given the emotional support of a strong relationship with a helping person, he can move forward rapidly; given the more superficial relationship with his friends, and he can manage to sustain himself; but, deprived of positive relationships, he quickly goes to pieces. At the present time, Mr. B has little or no insight into this basic feature of his problem. He, therefore, is not capable of curing himself, or of building relationships in the community that will be really beneficial to himself. Instead of groping his way blindly through life, however, he could be helped to understand what it is that he is seeking. His hospital treatment could be designed to help him adopt a more constructive approach to life by showing him how to achieve his gratifications without destroying valuable portions of his personality in the process.

Other patients in the reclaimable group require a similar plan

of treatment, except that the basic programme should be flexible, and the services will have to be based on a careful assessment of the needs of each patient. Mr. P, for example, after several interviews with writer, became interested in studying mathematics and automotive engineering which was provided through the Department of Institutional Training. Soon he began to express dissatisfaction with Class-Six treatment and to say, "I'm too young a man to be cooped up in here". He was sixty-seven, but he decided he wanted to work in a little repair shop in a small town. He was sure he could support himself because he would have a garden and his other needs were few. During conversations with the writer, he was encouraged to look realistically at the difficulties he might encounter. Eventually he arrived at a satisfactory plan, received his discharge, and moved to a small town in the interior in April 1950. Over three months have elapsed and he has not returned, so all that can be said is that he is continuing to be successful in keeping out of Class-Six. Other patients have not been so successful, and, for various reasons, have had to come back to the hospital within a few weeks. They had been allowed to leave without adequate planning for their physical or emotional support. Without some support these marginal patients inevitably suffer a recurrence of their disabilities.

#### Summary

The evidence of the presence of three major groups of Class-Six patients is fairly conclusive. The chief distinction between these groups has been made on the basis of the level at which each group must make a more or less permanent adjustment. In other words, each group has a different capacity to accept and make use of therapeutic services

To simplify the programme, these groups should be segregated and given a broadly specialized type of treatment, aimed to produce a total adjustment in the patient which will be most useful to himself and to others. Within these broad categories, treatment of the patient should be given on a casework, or individualized, basis in order that the fullest use may be made of the patient's individual resources.

The helpless or irremediable group should be segregated on the basis of their need for a hospital-type of care. Hospital or semi-hospital care is necessarily expensive, so careful diagnosis and screening will have to be done to ensure that these beds will be occupied to maximum advantage. The intermediate group should be segregated because of their need for domiciliary-type care. Accommodation need not be expensive or luxurious, but should be suited to the patients need for freedom of action. Services and facilities should be provided to foster independence and self-reliance. The reclaimable group should be segregated because they demonstrate sufficient ego-capacity and general suitability for rehabilitation. Segregation of this strong group would tend to promote the growth of the individual patient in the group, and facilitate a broadly specialized treatment programme. At the same time, intensive casework will help the individual to move forward into rehabilitation.

## Chapter V

### A Treatment Programme.

In order to provide more specialized forms of treatment for each of the three groups of Class-Six patients, it has been seen that it will be necessary to devise means of segregating these groups. Separate treatment facilities, as well as separate treatment methods, will be needed because of the advantages of using the groups as units of treatment. Not only are there advantages from the administrative point of view in focussing the services of the rehabilitation team, but the group, itself, under trained leadership, offers several important therapeutic and growth-inducing advantages to the patient. The socializing effects of group activities play an important part in personality development and, therefore, should be consciously utilized in the treatment process. This subject is further discussed in later paragraphs, but it is introduced at this point to emphasize the need for physical segregation, as well as for categorization of older patients.

It has been previously noted that the Department of Veterans' Affairs has already provided many specialized treatment facilities. In providing specialized facilities for the treatment of older veterans, therefore, it is chiefly a matter of adapting and utilizing existing facilities, rather than a matter of creating new ones. It may be found necessary to design more economical types of accommodation for the long-term intermediate group of patients, but the other two groups, unless their numbers increase rapidly, can well be segregated within the existing centres.

From the point of view of present accommodation, the irremediable

group is the one that fits most naturally into the present set-up. Since these patients all require custodial care, or care in bed, they are all cared for in Shaughnessy Hospital, itself. Full provision is already made for their physical care, both in the main hospital while they are on active medical treatment, and in the Extension where they receive minimal treatment only.

It is commonly accepted that an active treatment centre is too expensive as a place for care of the chronically ill, and the Extension is presently employed as a cheaper type of accommodation to overcome that difficulty. No figures are available on the relative cost of maintenance in the Extension as compared with the main hospital, but the difference would seem on the surface to be considerable. The temporary, single-story buildings of the Extension are cheaply constructed. Maintenance is simplified for, although the Extension was originally intended as a self-contained hospital unit, it contains no costly medical equipment, elevators, air conditioners, et cetera, and, therefore, does not require the highly paid services of technicians and maintenance personnel. None of the patients require extensive treatment so that medical and nursing staff requirements are also minimized. Many economic advantages are, therefore, to be found in the use of the Extension for the Class-Six patient who is irremediable because of chronic illness.

There are several notable disadvantages to Class-Six patients in the Extension at the present time, but they apply mainly to those who are not helpless. The drab corridors, tiny solariums, crowded billiard room, and the absence of a recreation room, comfortable reading-writing room, or place to entertain visitors, are the type of inadequacies which apply

chiefly to the ambulatory patient. For the full-time bed-patient, however, the accommodation is probably quite adequate. Wards are airy and well-lighted. They are not over-crowded according to normal hospital standards, though the patient who is destined to spend many months in bed may prefer to see them less crowded. The thinning-out of beds in these wards might be considered in the future if the ambulatory, Class-Six patients are removed.

The intermediate group is the one for which an absence of special facilities is most apparent, and it is to this group that the most careful planning of additional facilities should apply. When Class-Six patients are finally broken down into groups for treatment purposes, the intermediate group will be the only one which requires domiciliary care in the strict sense of the term. The irremediable group will require a form of nursing-home care; the reclaimable group will require complete rehabilitation. The middle group will require a combination of care and treatment with specially created facilities for more or less permanent living, under conditions which are intermediate between life in an institution and life in the community.

The intermediate group does not need nursing or hospital care so it should not be included in the same category with hospital patients; nor should it come under hospital administration in expensive hospital quarters. This group is not ready for rehabilitation so it needs a different type of casework services. The type of programme which this group requires may best be described as "domiciliary care", which is roughly defined to include quarters and maintenance, or assisted maintenance, under conditions which will promote productive living through satisfying activities.



Facilities should be designed with this end in view.

The major problem in administering a large programme of domiciliary care is inevitably an economic problem. Costs are bound to be tremendous despite the most efficient economies, and the only solution which seems to be both practical and socially acceptable is to help the aged person to remain productive. This solution is adviseable not only from the point of view of reducing the burden to the nation, but from the point of view of raising the morale and general feeling of well-being of the aged individual. How this objective may best be accomplished is probably a controversial subject, but there are certain basic concepts upon which agreement can be founded.

In the first place, it is recognized that all giving comes out of some kind of abundance; giving cannot come out of emptiness. The willingness to give does not arise when a person feels that he has nothing to offer, that what he now has is barely enough to keep body and soul together. Productivity is simply a form of human giving and it is, therefore, based on a prior conviction that life is worthwhile, and that each individual plays an important part in making it that way.

A person has to actually experience a satisfaction before he can see any need to bend his efforts towards re-achieving it, either for himself or for others. The person who knows how to achieve real gratification of his desires can see the hope of future gratifications, and he will want to extend them. If he lacks the basic assurance that real gratifications are possible, he cannot then offer anything but pessimism and despair. In despair he often retreats from life, and tries to re-capture satisfactions which he had experienced in the past, in childhood, or,

perhaps, in infancy. These childhood satisfactions are invariably related to dependency and getting, rather than to those of independence and giving. Unable to face the frustrations of the present, he lives in the past, wants to be a child, wants someone to take care of him. He refuses to face the future because the present is too painful. It is, therefore, plain that the present has to be basically attractive before a person will actively seek to extend it and thereby become productive. It must be satisfying enough so that he will want to provide satisfactions for himself.

To make the present sufficiently attractive to make the aged veteran feel that life still holds an abundance, should be the proper aim of domiciliary care - one that will offer the most rewarding prospects to everyone concerned and to the community at large. Carefully considered facilities and services should be developed for this intermediate group to further this important aim. Facilities should be designed to counteract the destructive effects of "institutionalization". They should not hamper the individual in his attempts to achieve a feeling of belonging and a feeling of independence.

It is difficult to evaluate the existing facilities for domiciliary care at the three centres without bringing in an evaluation of services as well. Class-Six patients as a whole are seen to lack a sense of being worthwhile, but, on the whole, it cannot be said to what extent this is due to facilities, to services, or to personality defects that cannot be altered. However, it is safe to say that the hospital is unsuitable for the intermediate type of patient. To help him make a permanent adjustment in such an institution is to help him accept a perm-

anently high degree of dependency. If it is necessary for any reason to take this step, then the patient should be re-classified from the intermediate group to the irremediable group. Intermediate patients are capable of greater independence than it is possible for them to achieve within the hospital.

Hycroft, however, represents an important step away from the hospital environment. It offers a homier atmosphere and greater personal freedom, but it still retains all the important "earmarks" of an institution. Under the supervision of nurses, living in ward-like bedrooms, having a few privileges and no responsibilities, these patients are still in an institutional environment. They keenly feel their dependency in these surroundings. Compared with the other two centres, Hycroft, also, is relatively economical to run. This economy is a result of administrative efficiency and it is doubtful if practical methods of achieving further economies could only be made through a complete re-organization of Hycroft on a democratic basis. The patients would have to be placed in charge of most of their own affairs. However, the facilities do not lend themselves readily to that type of organization. Hycroft is built on a scale that is too inflexible, too elaborate, too alien to the ordinary Canadian way of life, for the average patient to feel that he has any deep personal share in its creation or function. The extent to which democratic organization can be fostered in Hycroft is seriously limited by the present physical set-up. Democratic procedures are always profitable, however, and despite the limitations of Hycroft they can be developed to useful purpose as described later under services for this intermediate group.

In view of the inadequacies of Hycroft, a new type of facility, which will be conducive to democratic living and productivity, will have to be provided for this intermediate group. Following the line of thought expressed by Mr. S (page 71) when he said he would prefer to live in a shack or some place where he could feel he really belonged, it would seem to be worthwhile to consider a cottage plan for this group. Mr. S is not able to live in his cherished shack because of the risk of becoming ill when he was isolated and alone. But he would be able to live in a community of shacks in which medical assistance was available if needed. He then could enjoy the privileges of his own abode, and have the surrounding piece of ground in which he could take pride. The shacks could be cheap cottages with two or three small bedrooms and one large, all-purpose living room. Furniture could be simple, sturdy and comfortable. Communal bathrooms and lavatories serving six to eight huts might simplify the plumbing system. There would be a central dining hall and kitchen in which the old people would do most of the work. Gardens and animals sufficient to supply many of the needs of the community would be maintained by the patients. Workshops of various kinds would guarantee the availability of full employment for everyone. A combined recreation hall and gymnasium would serve as a physio-therapy centre and a place for social events, business meetings, at cetera. In broad outline, this is the type of domiciliary care facility which would be very economical, if not self-supporting, and in which the most constructive purposes of institutional treatment could be realized.

The reclaimable group of Class-six patients will be continually augmented by patients who show a highly favourable response to treatment

in the intermediate group. At first, however, the reclaimable group will chiefly comprise patients who, on the basis of a full clinical assessment, show capacity, or potential capacity, for rehabilitation. As diagnostic services expand, these patients will be normally screened before they get as far as Class-Six.

The ideal facility for segregation of the reclaimable group and for conducting the rehabilitation programme already exists in the form of the Health and Occupational Centre at Burnaby. This centre is specially designed to bridge the gap between hospital and civilian life. Just as it serves the younger patient, this recuperation centre can be employed to help the older patient. In a growth-inducing environment of remedial activities, vocational re-training, social and recreational activities, and morale-building fellowship, the older patient will gradually prepare himself to return to the community. In using its valuable facilities in this manner, the Health and Occupational Centre is carrying out its proper function. It should be emphasized that unless the older patient is capable of using these facilities in accordance with their function, he should be placed in one of the other groups.

Existing facilities, with the exception of one major lack, seem to be highly suitable for the full-scale treatment of aged veterans. The lack of some sort of cottage plan, however, is crucial, for it involves the bulk of patients presently in Class-Six. Assuming that complete facilities were to be provided, then the success of the Department of Veterans' Affairs in achieving its aim would stand or fall on the quality of professional services and leadership within the programme. In the final analysis it inevitably rests with the staff to produce results.

### Treatment Services for the Irrremediable Group

Treatment of the helpless patient should follow the recognized standards of modern hospital practice. In other words, the patient, because he is sick, requires the services of a full clinical team.

Concepts regarding diseased and disabled persons have changed remarkably in the past quarter-century. With the progress in the understanding of human relations there has been a gradual recognition of the patient as a whole person with fundamental needs and rights to reasonable satisfactions. It is no longer considered reasonable to treat the patient's disease as a separate entity, or to regard it as something apart from the rest of his personality and his life situation. Rather, the disease is regarded as a symptom of the adjustment which the patient has made to an unsatisfactory life situation. The disease itself can be fully understood only in relation to the patient's total adjustment, and treatment can be scientific only when it recognizes and deals with all the factors in the individual situation. To deal with this total picture in a hospital setting requires the professional skill of more than one individual.

Differential diagnosis requires a skilled investigation of the three major areas of the patient's life - physical, psychological, and social. His present state of health is the sum total of what has happened to him in these three areas. The diagnostic team should, therefore, include a physician, a psychologist or psychiatrist, and a social worker. Since medical treatment is the primary need of the patient who is acutely ill, the doctor is the natural leader of the team. When the full medical report, psychological report, and social history have been prepared, a

case conference is held to consider the findings, to formulate a diagnosis, and to draw up a tentative plan of treatment. Ideally, the conference should be attended by the occupational therapist, physio-therapist, rehabilitation officer, and any other personnel handling specific phases of treatment, in order that their views can be included and their full co-operation ensured.

The full course of treatment which is agreed upon is then inaugurated while the patient is still in the acute stage of his illness. The social caseworker who is dealing with the patient's personal and domestic problems will work closely with him and with his family. The reaction and attitude of the patient to his illness, the reaction and attitude of the family, the general economic, social, and personal situation of these people, are some of the important psycho-social elements which determine the patient's adjustment and ultimate recovery. Close collaboration between the social worker and the doctor is obviously very necessary during this stage of treatment. If the patient shows deep-seated maladjustments which will not respond to medication and social casework, an appropriate form of psycho-therapy will be integrated with the other treatment. As time passes and the patient shows a readiness, additional treatment services will be brought in according to plan. Occupational therapy, physio-therapy, institutional training, vocational counselling, and other needed services will be fitted into the programme and directed towards the broad goal of treatment.

Social casework during this period continues actively in its task of building ego-strength and morale, using as its chief tool the strong professional relationship which by then will have developed between the

worker and the patient. Through this relationship the worker is able to give emotional support, and to help the patient move towards greater independence. An important part of the casework process is to ensure that the various adjunct services are geared to the progress of the case, and are integrated towards the recognized goal. Given sufficient inherent capacity for readjustment, the patient will readily respond to the work of the team and move towards re-establishing himself in the community as an independent and productive citizen.

Case conferences are held periodically to assess the patient's progress under treatment. Prognosis, which would be estimated at the original diagnostic conference, would be used as a partial guide in assessing progress. Each case would be appraised individually, and, if, after a significant period of treatment, the conference agreed that the patient was constitutionally unable to progress to the point where he could leave the hospital, the intensive treatment would be discontinued, and the patient would be placed in the irremediable group for chronic care.

As an irremediable patient, the veteran would then require extended bed-side care. Medical treatment would be minimal, administered in accordance with the nature of the chronic ailment. Social casework would continue on a fairly extensive basis until the patient had achieved a satisfactory adjustment to his unfamiliar state of total dependency. Recreational and occupational services would be continued in order to promote healthy relationships and satisfying activities.

The aim of treatment for the irremediable group recognizes the hopeless nature of certain ailments and attempts to provide a maximum of gratification and contentment for the individual during his remaining days.



The essence of this treatment process, as in all other treatment processes, lies, not in the lavish provision of material comforts, but in the warmth of helpful human relationships which form the roots of a sense of well-being. The social worker who is skilful in developing relationships of this nature should therefore play an integral part in the continuing treatment of this group.

In Shaughnessy Hospital, it should be noted that there is some tendency at the present time towards broadening the treatment approach to the irremediable type of patient. Particularly with reference to the Class-Six psychiatric ward, there has recently been an experimental programme of activities. This programme has been conducted largely by the occupational therapy department during the last five or six months. The occupational therapist who was assigned to this task is a vivacious young woman who previously showed a keen interest in older people. She arranged regular periods of manual and recreational activities, suitable to the type of patient with which she was dealing. Taking the patients in groups, she organized sing-songs, outings, and other forms of entertainment. Co-operative projects around the ward were also carried out by the patients.

The effect of this programme has been almost startling in some respects. The ward, which was formerly a sombre, uninviting place, occupied by extremely listless, apathetic patients, is now comparatively bright and active. The nursing and orderlie staff quickly captured the spirit of the programme, and responded with friendly co-operation. A cordial atmosphere was created in which the patients soon began to show a new interest in life. Some of the old men, who had not left their beds

in months, started to get up in the morning and dress themselves. Others showed interest in improving their personal appearance, and became more sociable. In general, the ward became neater and more pleasant. Attractive window boxes were constructed by the patients, and now exhibit their well-tended flowers. A patch of garden was dug up and planted outside the door. Various other signs of constructive activity are convincing proof that a kindly interest and a modicum of organized play will improve immeasurably the attitude of the irremediable patient. If a similar effort could be made by a team of therapists, the treatment results should prove to be even more startling.

#### Treatment Services for the Intermediate Group

An integrated hospital treatment programme, as outlined in foregoing paragraphs, is designed to meet the needs of every patient who enters the hospital. The intermediate group of patients is just an ordinary type of patient during the acute phase of his treatment. Like any other patient, because he is sick, he requires the intensive services of the clinical team which aims, not only to restore him to health, but to remove the causes of his breakdown. When the case conference agrees that hospital treatment is no longer profitable, and the assessment is made of the patient's capacity for further adjustment, it is found that he requires the type of support that has been made available to patients in the intermediate group. On the basis of a complete differential diagnosis and a full course of treatment, this patient is referred accordingly for domiciliary care.

There will inevitably be a range of patients within the intermediate group, and some patients will show a greater capacity for sound

adjustment than others. Also, the group probably will be very large, so it appears to be advisable to split it into two broad segments, suitable for Hycroft and for the Cottage Centre. The first segment will comprise those patients who are ambulatory, but who are relatively dependent and unsure of themselves. The second segment will comprise patients who, although they need a sheltered environment, display a sense of responsibility and a fairly high capacity for independence.

Hycroft will be organized to serve the needs of the weaker segment. Modification of the sleeping rooms and uniforms of the staff should be carried out to eliminate the hospital atmosphere and, insofar as possible, the institutional atmosphere. A nurse would be available at all times, but her services should be very much in the background, except when urgently needed. The patient will not then be faced with the constant reminder that he is ill. On the contrary, the emphasis of the treatment programme at Hycroft will be on creative activities. The professional staff will include personnel such as the occupational therapist, physiotherapist, vocational instructor, social caseworker, and social group worker. A specially selected couple might reside at Hycroft as house-mother and house-father.

The treatment programme should naturally continue on the same general basis as that which was begun in the hospital. Medical treatment will be diminished as rapidly as possible with the patient being taught to administer his own medication, or being encouraged to attend the out-patient clinic. Casework will be directed towards helping the patient prepare for the change and adjust to the new situation. During the transitionary period, the casework relationship will help to sustain the

patient until he is able to establish relationships with his new case-worker and with other staff and patients at Hycroft. A copy of the case record will be forwarded from the hospital so that the patient's progress in various activities can be noted, and the new programme commenced on a basis of his known strengths and weaknesses. Every encouragement will be given the patient to increase his desire to participate in constructive activities. Facilities should be provided in sufficient variety so that the patient will not lack the opportunity of using any important aptitude or ability which he may possess.

The aim of this type of treatment is to increase the patient's feeling of self-reliance and his interest in productive employment. A curative workshop should be established in conjunction with vocational training in order that the patient with special disabilities can be helped to acquire new skills in vocational fields. Inducement to make use of productive abilities should also be made in the form of a nominal wage for work in the shops, gardens, kitchens, and in the general maintenance of the institution for which paid employees are normally engaged. Wages are a vital incentive to work in this western society. The power of this incentive may be diminished in old age, but it is still a very active force among Class-Six patients.

Perhaps the most constructive aspect of this treatment programme is the conscious attitude of the professional staff towards helping the patient to help himself. It will be the major responsibility of the social workers on the staff to inculcate this basic principle of social work throughout the programme, and to offer guidance in its fulfilment. Democratic attitudes and practices should be promoted by group activities under

the leadership of a professionally trained group worker. The skilled leadership of such a worker is based on a practiced understanding of individual and group behaviour, made possible by modern scientific knowledge of community relations. Through the use of programme activities and an awareness of the interplay between personalities and between groups, the group worker can contribute to the growth of the individual and to the achievement of desirable social goals. Under his leadership the group process aims to encourage active participation so that group decisions come about as a result of knowledge and sharing of ideas, rather than as a result of domination. Participation in this type of group gives the individual a strong sense of belonging and increases his feeling of personal worth. The experience convinces him that, as a person, he can be socially effective. Within the group, he feels the forces of freedom, perhaps for the first time, when he realizes that the group, using a group process, actually determines its own destiny. It is exercising independence and the results are highly satisfying. The patient also develops a sense of responsibility towards other members and, because he has learned how to rely on others, he can begin to feel independent. Having developed this feeling of assurance, the patient can then carry it over into other aspects of the treatment programme, and he therefore becomes more ready to broaden the range of his activities.

Some patients in the Hycroft segment of the intermediate group will not be ready for a group experience but will continue to need the support of a casework relationship with its more individualized attention. Casework, however, will aim to develop the residual capacities of these patients, using the various treatment services, and to introduce the

patient to group experiences when he appears ready for broader socialization. Some patients may never make significant progress, but the aim of the whole programme will be towards moving the individual forward into constructive independence, moving him from Hycroft to the Cottage Centre or into the reclaimable group. The benefit to the patients who remain at Hycroft will be to increase their satisfactions under domiciliary care, and to decrease the cost of this care through their constructive participation.

The stronger segment of the intermediate group would be given domiciliary care in the newly-created Cottage Centre. Here the institutional atmosphere would be further minimized. The patients would live apart in their own simple quarters with their wives or a friend chosen from among the other patients. Patients would not be encouraged to live alone, but would be helped to find social satisfactions which would focus their thoughts and energies outward instead of inward.

The treatment programme would be organized on the same general basis as that at Hycroft, but, because of the relative independence of these patients, it would not have to be carried on so intensively. Patients would be more able to direct their own affairs, and would be somewhat accustomed to doing so. Group activities would play an exceedingly important part in the programme at this centre because of the aim to develop useful democratic procedures, and to motivate the individual towards improving the welfare of everyone within this tiny community. The general productivity of the group would then be the gauge upon which the success of treatment can be partially measured. This productivity will take the form of social action to correct unsatisfactory situations, and

will also be seen as productive labour. Facilities will have to be provided so that suitable sheltered employment of some kind will be available to every patient. Curative workshops and vocational training will be used to help the patient with special disabilities to find a satisfactory vocation. He would later be employed at a nominal wage, under conditions which approximate those of normal industry, and allowed to find his own work-capacity. Patients who develop fairly high work-capacity under these conditions would gradually become suitable for rehabilitation, and would be found normal or restricted employment at regular wages. If this could be done, the patient would probably be eligible for the reclaimable group and re-established in the community.

In the increased productivity and the generally improved personal adjustment of patients at the Cottage Centre, the rewards of the integrated programme of treatment will be seen. As an economic unit, the centre will be relatively self-supporting, providing domiciliary care on the cheapest possible basis. Products which cannot be consumed by the patients will be marketed at standard prices. The cost of the professional services will be high, but not considering other economies, this sum will be more than saved through the number of patients who are rehabilitated. Hycroft presently offers the cheapest form of domiciliary care, but, even at that low rate, a professional worker would only have to rehabilitate four patients per year to cover more than the cost of his salary. In fact, if the salary were as high as the saving on four patients, it would procure an exceedingly well-qualified worker; indeed, which would mean an even greater investment return in terms of sound treatment and rehabilitation. The productivity of the Cottage Centre is a strong dollars-and-cents argu-

ment for treatment on the broadest, highest level; the cultural, social, spiritual, and other intangible values cannot be estimated. However, the highest rewards of treatment accrue when the patient is able to leave the centre and take his place once more in the community.

The group of older patients who are fit to be re-established, personify the ultimate goal of the treatment programme. These patients have responded favourably to the over-all plan which was set out for them early in their acute phase of illness, and which was carried through under supervision of the clinical team. Based on careful diagnosis of individual needs and capacities - physical, psychological, and social - the combined therapeutic service was successful in restoring personality strength. The rate of recovery and growth for individual patients may have varied widely, but the final result is much the same when these patients are ready for rehabilitation. As a group the patients would range from those who had brief illness, short convalescence, and suitable home and employment to which they could return, to those who were totally disabled prior to admission, suffered prolonged illness, underwent chronic care in the irremediable group, gradually became ambulatory, were further motivated and re-trained at Hycroft, and progressively raised to independence in the Cottage Centre. The majority of cases would fall in between these two extremes, but regardless of the route followed in their treatment, the final phase of recovery is rehabilitation.

Rehabilitation, then, is not only a direct result of effective treatment, but is an exceedingly active phase of the whole process. In a well-established programme it will scarcely be possible to tell where treatment leaves off and rehabilitation begins. The patient will move



forward at his own pace. He will be given help according to plan, and his final re-establishment will simply be the fulfilment of a goal which was established earlier, and which he now recognizes as his own. Actual rehabilitation merely consists in using known information about the person, along with his acquired ability to relate to professional workers, and helping him to find employment in keeping with his abilities and living conditions befitting his psycho-social requirements. Through the medium of casework, the patient is given necessary support during his initial period of re-adjustment. A follow-up service is then provided in the hope of preventing the causes which would lead to another breakdown.

#### Treatment Services for the Reclaimable Group

The method of treatment, which has been presented somewhat idealistically in the preceding pages, does not yet exist at Shaughnessy Hospital. At the same time there is a considerable number of Class-Six patients who should be classified as a reclaimable group, and rehabilitated immediately. These patients have recovered from their acute illnesses and now need to be carefully assessed and screened by a clinical team. The type of plan for each case should be decided by the case conference, and the patient then transferred to the Health and Occupational Centre where the plan can be put into effect.

The rehabilitation team would include existing professions at the Health and Occupational Centre - medical, occupational therapy, physiotherapy, and vocational training - with the addition of a social caseworker, a job-placement officer, and a psychiatric consultant. Casework would commence on the basis of the case conference material, using occu-

pational therapy, physio-therapy, and stimulation of recreational and social interests as the background for selection of a suitable vocation. Once a strong working relationship has been established between the case-worker and the patient, the patient will be able to accept further guidance and arrangements for re-training, if necessary. Vocational training may be a new field for the patient, or it may be a sort of refresher course to re-build self-confidence and re-establish former skills. When this period of intensive treatment is nearing completion, and the patient is well-motivated towards employment, it will be possible to make an accurate assessment of his work-capacity as an additional aid to the welfare officer in obtaining employment.

The welfare, or placement, officer, in the meantime, will have followed the case closely, explored possible fields of employment, and made preliminary contacts with likely employers. When the patient is finally ready to take a job, he and the welfare officer can then go to an employer with something definite to offer. The man's employability can be demonstrated at a rated capacity, and the further assurance given that follow-up services will be maintained during employment. It seems to be in the best interests of the Department of Veterans' Affairs to accept the responsibility for maintaining the older veteran at his present level of functioning by means of careful follow-up. The proverbial "ounce of prevention" is much less expensive than "pound of cure".

An additional responsibility of the rehabilitation team, which especially concerns the welfare officer and the social worker, is to promote in the general community an attitude of co-operation and greater understanding of the older person's problems. They can do a great deal to

stimulate social action designed to remove the common, over-protective attitude towards old people, and the present tendency to embalm their personalities in lavender and old lace. Working through the National Employment Service, the Public Relations Officers of the Department of Veterans' Affairs, the service clubs, the social agencies, and other interested groups, this type of social action can be sponsored in much the same way as the public acceptance of other disability groups was sponsored in the past. Tax-payers, and especially industries, should be helped to realize that they are paying dearly for the care of the aged when they fail to keep them happily employed. The policy of individual firms, who regard it as more profitable to employ young people on an over-time basis than to employ older people on a part-time basis, is tragically short-sighted. The immediate gain is more than lost in the creation of a national burden of dependent old people. These employers must be helped to face their responsibility to the aged in the community, even if it is only on the basis of straight dollars and cents. The welfare officer should bear in mind this broader function of job-placement for the aged, and consciously seek to make the best use of his unique opportunities for interpretation and liaison in this field. Indeed, he must use this method if he is to be able to keep pace with the flow of rehabilitation, and to find suitable jobs in increasing numbers.

The role of the social worker in the rehabilitation programme is to employ the skills of social casework in bringing the basic problems of the patient into focus; to work with the team in assessing the things in his personality and social situation which can be changed, and the things which cannot be changed; and to use available resources in helping

the patient to live more adequately, by changing the things which are changeable and by accepting the things which are unchangeable. A primary change is the one that is wrought in the patient's own attitude towards himself. His own willingness to try to change his circumstances is brought about through the medium of a strong, supporting relationship with the worker, and it is this relationship that sustains the patient through the transitional period of his re-adjustment, and leads to the formation of positive relationships with other people. The skill of the worker is involved in maintaining control of this relationship so that it serves the patient constructively. This control is also exercised in reducing the intensity of the relationship as the patient finds new satisfactions and new relationships upon which he can rely. When his outside gratifications have been developed sufficiently so that the patient can carry on independent of professional help, he can be considered as rehabilitated.

Rehabilitation, as a phase of active treatment, always involves some kind of positive relationship, between the worker and the patient. The untrained worker may have sufficient intuitive understanding of people to make his helpfulness effective through a process of counselling. If the personality of the patient is too weak and he cannot respond to counselling, the worker, who lacks trained skill in relationship, can only close his case as "not feasible". The professional caseworker, however, has additional skills with which to build personality-strength, and, thereby, to enable the patient to change in ways which ordinarily would be impossible. The proportion of cases which the trained caseworker would recognize as being "not feasible" would, therefore, be

greatly reduced. Class-Six patients, by their very presence in that category, show a more-or-less serious personality breakdown which is usually related to their dependency needs. In the interests of successful rehabilitation, it is essential that the additional skills of social casework be employed in the solution of these underlying problems. Without the conscious employment of relationship-therapy, many of the potentialities of rehabilitation services can never be realized.

Helping the patient to modify his environment is the further method by which the caseworker endeavours to consolidate the gains of the rehabilitation team. Having helped the patient to recover his independence it is necessary to help him to preserve it by careful selection of the surroundings in which he will live. Living conditions and domestic relationships must be equal to his physical, psychological and social needs. In case conference with the doctor, the consulting psychiatrist, and the welfare officer, the patient's individual requirements should be discussed in relation to existing resources. The employment picture will be presented by the welfare officer. The advisability of accommodation with relatives, with friends, in a foster home, in a boarding home, and so forth, will be considered according to the over-all nature of the case. When a suitable plan is devised, the welfare officer will undertake to arrange employment, and the social worker to arrange accommodation. To ensure the success of these arrangements, the caseworker may have to enlist the co-operation of other social agencies, help the people with whom he will be living to accept and understand the old veteran, help the veteran to establish social contacts with older people's groups, and do whatever else is necessary to promote a rapid and effective adjustment to

the new environment. Added to this will be the necessity of periodic follow-up. The worker will continue to make brief contacts with the veteran at intervals to ensure that the situation has not deteriorated, and to reassure the veteran that he does not need to be sick before he can receive professional aid.

This follow-up service, since it is based on the principle of preventing minor difficulties from developing into serious difficulties, could readily extend itself into an out-patient department for the differential treatment of all aged veterans. There the veteran could come when he first recognized that life's problems were becoming too great, and he would be given expert medical, psychological, and social aid in overcoming his basic difficulties. Such a clinic could render invaluable service in preventing or postponing the final breakdown which often means hospitalization or domiciliary care for the aged veteran.

### Summary

Class-Six patients fall into three general categories of which only one requires domiciliary care in the strict sense of the term. Having been differentiated, these groups need to be segregated in facilities which will be suitable to their treatment needs. Existing facilities need not be greatly modified for this purpose, but the creation of a separate centre for the intermediate group is suggested. The essentials of the proposed centre could be adopted in a variety of ways. Ideally, the final plan should be based on preliminary experimentation.

Treatment services to each group would be broadly similar, but would be varied according to the needs of individual patients in the group. The aim of these services would be to develop and restore every

disabled veteran to the fullest physical, mental, psycho-social, vocational, and economic usefulness of which he is capable, within the limitations inherent in his environment. The Department of Veterans' Affairs already possesses many of the qualified staff needed in the operation of such a programme. It remains to provide additional staff which will complete the professional team, and then to integrate the available services in the interests of the patient.

### Appendices

- A - Transcript of Treatment Regulations - Class-Six.
- B - Rates of Admission, Discharge and Death of Class-Six Patients, January 1949 - June 1950.
- C - Bibliography



Appendix A

Treatment Regulations - - Class-Six

(Veterans' Care) A former member of the forces who is in receipt of payment of pension, or who is not in receipt of pension but had overseas service and received an honourable discharge therefrom, or

a person who served in World War I, or in World War II, in any of His Majesty's Forces other than those of Canada, or in any of the forces of His Majesty's allied or associated powers, and who was resident or domiciled in Canada or Newfoundland on the fourth day of August, 1914, if service was in World War I, or the first day of September, 1939, if service was in World War II, and who in either case is in receipt of payment of pension for a disability related to his said service, or is not in receipt of such pension but had overseas service and received an honourable discharge therefrom, or

a former member of the forces or other person who is a recipient of War Veterans' Allowance other than as a widow or an orphan:

and, in any case, who requires domiciliary care and is totally disabled, permanently or temporarily;

may, in the discretion of the Department having regard to his circumstances, be provided with quarters and maintenance and, when necessary, treatment, subject to the following conditions:

- (1) That he shall, if required, pay to the Department for administration, while receiving veterans' care, pension and any other income and resources to which he may be entitled; and that from any balance, after providing for trust fund and comforts and clothing, the Department may apply towards the cost of maintenance a sum not exceeding \$120.00 a month, provided that any pension paid to the Department in respect of dependents shall be utilized for the benefit of such dependents and that such other pension and any other income and resources be applied in accordance with a scale set by the Department and approved by the Treasury Board;
- (2) That should he, following admission, require treatment, for a disability attributable to service if he be a former member of the forces, or for a disability for which he is pensioned in other cases, he shall be granted such treatment, but shall not be transferred from this class:
- (3) That transportation on the first admission to this class may be furnished, if necessary; but shall not be furnished on discharge, unless he is discharged with the approval of the Department and is not in receipt of payment of pension and/or has no other funds from which transportation could be provided, in which case the Department may issue transportation consisting of rail, bus or boat fare, including meals, to the point from which he was brought in or a point equidistant thereto.

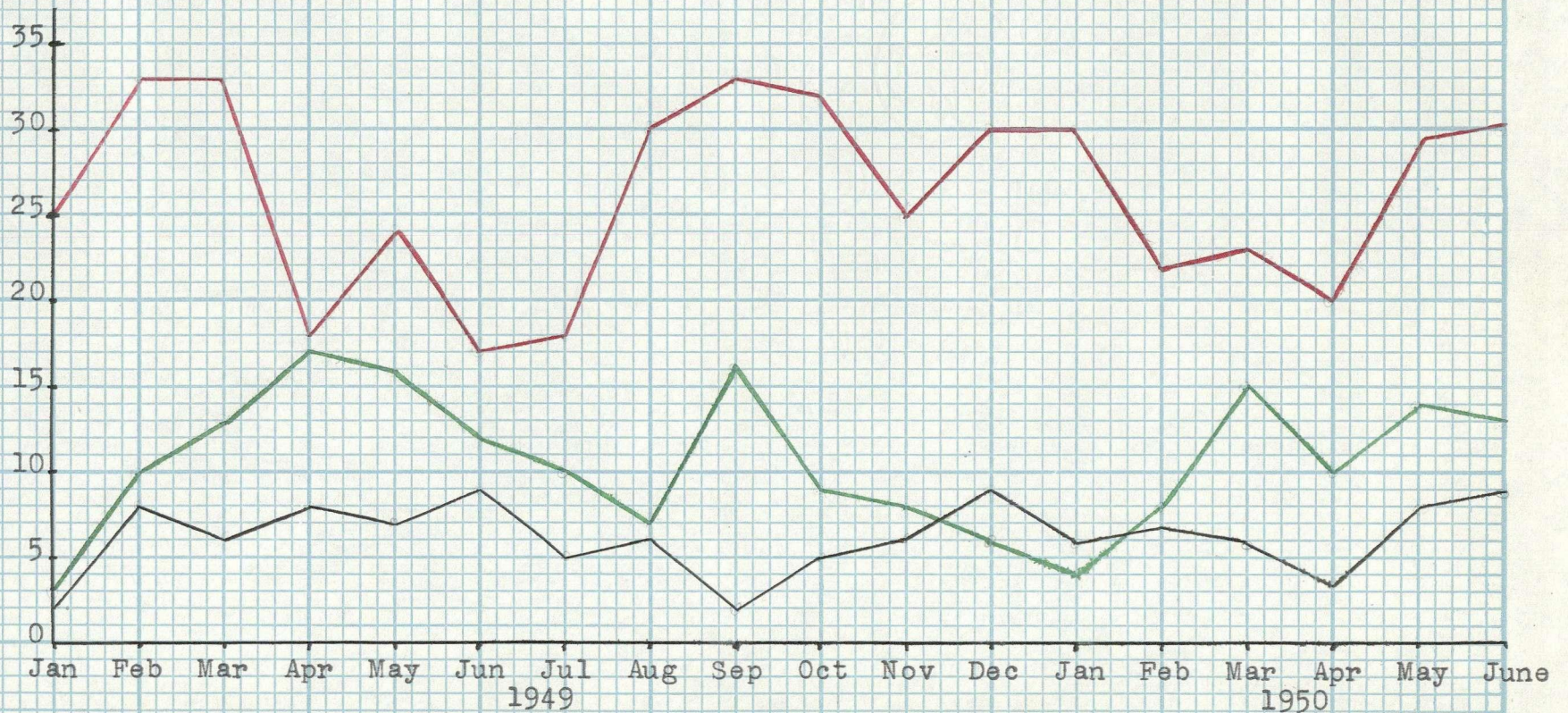
(Comforts and clothing may be furnished, subject to the provisions of Clause 16 or 17.)



# Appendix B

## Rates of Admission, Discharge and Death of Class-Six Patients, January 1949 - June 1950

Admissions - █  
Discharges - █  
Deaths - █



Source: Daily Admittance - Discharge Reports, Shaughnessy Hospital. Special Count.



## Appendix C

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