FROM CUSTODIAL CARE TO REHABILITATION:
THE CHANGING PHILOSOPHY AT VALLEYVIEW HOSPITAL

A Study of
Treatment Facilities
Discharge Planning and
Community Resources Available for
the Psychiatric Geriatric Patient

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ABSTRACT

In 1960, the Home for the Aged, an institution of the Province of British Columbia, underwent an official name change to Valleyview Hospital. The change in name indicated a change in the philosophy toward the treatment of the aged mentally ill person. This change can be equated with new knowledge about the physical, psychological and social aspects of aging. Formerly the program and the goal were related to custodial care; now, the program and the goal are related to treatment which will result in the aged mentally ill patient returning to a living arrangement in the community that is most appropriate to his needs.

This study, cites the problems of aged people in this province, with particular reference to problems of mental illness. The process of admission to hospital, treatment programs and discharge procedures, particularly as they relate to the work of the Social Service Department, are described. Against this background of procedures, the particular criteria for discharge and rehabilitation planning, as related to the hospital and to the resources available in the community are examined. Particular patient groups are noted in relationship to the particular resource required to receive them back into community.

The study reveals that, although, using hospital criteria for discharge, a large number of patients could be appropriately rehabilitated, but sufficient community resources, including family care, boarding and nursing homes, are lacking for such patients. Furthermore, community attitudes towards the aged mentally ill person have not changed to meet the new philosophy about their treatment in Valleyview Hospital.

Since correspondence revealed that Valleyview Hospital is unique amongst mental hospitals for the aged on this continent, the study was of necessity a pilot one, and is primarily descriptive. However, the questionnaire method was used to gather data about existing living accommodation available to discharged patients.

Finally, the study offers some suggestions for improvement and expansion of community resources, and of legislation concerning them which, if carried out, would ensure, to a greater extent, that the philosophy of treatment and rehabilitation, rather than custodial care, could be translated into practice.
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CHAPTER I

PROBLEMS AND POTENTIALS OF AGING

Introduction

Aging is a universal process. It is a process both slow and gradual. It is a process which cannot be halted except by the death of the individual.

Even with this inevitability, aging has different meanings within various human societies, and the way in which the individual prepares for his aged period is partially decided by the culture in which he has developed. The classical Greek considered old age as an "unmitigated misfortune" since "many are the ills that invade the heart" ¹ in old age. On the other hand, the peasants, in the high valleys of the Andean regions of Ecuador, Peru, and Bolivia, after a life of hard toil to gain a subsistence living, looked to old age as a time when the aged one assumed a respect and honour not accorded during the earlier part of life. ² This respect and honour is also given to the aged members of the St. Lawrence Island Eskimo whose

¹ Slater, Philip E. "Cultural Attitudes Toward the Aged." Geriatrics, vol. 18, number 4, (April, 1963), p.308
island home is in the Bearing Sea, one hundred miles from Alaska and within sight of Siberia. These Eskimos, however, expect the aged one to carry out tasks which are within his capacities for their philosophy of life, "work is life and life is work", applies to all members of that culture.¹ While the Eskimos work as long as possible, the Japanese and Burmese aged assume new roles of contemplation and leisure. In the Japanese case, the aged individual receives marked respect from other age groups inside and outside the family.² The same respect holds true for the Burmese aged individual, although one group receives special deference as "those who eat in tranquility". This group is in receipt of pensions.³

Basically, therefore, the attitudes toward aging in the five cultures cited, with the possible exception of the Ancient Greeks, are in direct contrast to the attitudes which are directed toward the aged in Canadian society. Charlotte Buhler suggests that the "culture of the modern western world is one of action....Action (is our) means of mastery over our environment (and) our means of self expression as well as self fulfillment." One of the results of this attitude is a lack of time for contemplation.⁴ It is, then, no surprise to learn that the aged have little wish for contemplation since "people

¹ Hughes, Charles C. "The Concept of Time in the Middle Years: The St. Lawrence Island Eskimos." Aging and Leisure, p.91-95
² Smith, Robert J. "Japan: The Later Years of Life and the Concept of Time." Aging and Leisure, p.95-100
³ Ruston, Colleen. "The Later Years of Life and the Use of Time Among the Burmanese." Aging and Leisure, p.100-103
⁴ "Meaningful Living in the Mature Years." Aging and Leisure, p.349
who are not active are made to feel useless and even worthless."¹ From this attitude, springs many of the difficulties which the aged experience in Canada.

Now a question arises. What is aging? Perhaps, Leonard Z. Breen has given the best answer when he declares that:

"For this writer aging is a process of change; it is not a state of being. It is dynamic. Aging is not adjustment, physical structure, or social dissatisfaction. It is itself a process without inherent qualities of goodness and badness. This continuous change, is what we in general may understand as 'aging'.²

Aging and the individual have a unity. From this idea, aging becomes part of the lifelong processes of development, change and evolution. All these processes are known to happen simultaneously with respect to a single individual and at different rates within and among individuals. These points suggest that work with the aged should include understanding of the past experience and maturation of the individual. To leave this important aspect out of the total consideration would create a distortion which would result in faulty reasoning when attempting to explain the actions of a given aged individual at a given point in time.

Perhaps this is where the difficulty lies in the general Canadian attitude. So often it is easier to ignore the

¹ Ibid, p.350
individual sufferings of the aged person while understanding the general problems of the aged group. As a result, fewer services are supplied to the aged group even though the aged people have thoughts, feelings and impressions which have been sharpened by the struggles of life. It might even be suggested that the aged individual is open to a greater number of problems as a direct result of the cultural demands of Canadian Society. In any case, the aged group must either receive equal treatment in the supplying of services, or be considered as a minority group with all of the lack of understanding, stereotyping and prejudice that such a term implies.

As more aged individuals swell the Canadian population, there will grow a stronger demand for services in all aspects of living from increased pensions to more, and more adequate housing and living arrangements. A projection of the aged population numbers is suggested by Dr. Schevenger. He declares there will be more than two million Canadians over the age of sixty-five by 1980.¹ This does not seem to indicate any change in the life span of the individual, only a greater number of "people...living...out their expected life span".² Thus, it can be expected, as the aged population increases, the demands from this group for more services will become more insistent.

On the one hand, the aged population increases while, on the other hand, Canadians, in general, seem to maintain a somewhat

² Towards Better Understanding of the Aged, Seminar at Aspen, Colorado, September, 1958, p.10
negative view of old age. Why should such a negative view be held? Might the answer lie in the way our society is geared to action? Sustained action requires the vitality of youth, and so it is assumed that the old person cannot offer much to society because he lacks the vitality and quickness of youth.

Such an attitude is an unfortunately narrow one. Although the aged may lack a sustained vitality, they are able to offer many other useful contributions to Canadian society. Accumulated life experience and the reasoned decisions which can accompany such life experience, hint at the usefulness, the productivity, of older people which remain untapped by Canadian communities.

Perhaps the negative view can be traced to another general difficulty for the aged. In the past fifty years, at least, great changes have advanced Canada in many different ways, for example, industrialization. So great are the changes that a visitor from fifty years ago would scarcely recognize his country. These changes were hastened by the Great Depression of the 1930's and by two World Wars. As a result, the present aged group has passed through a period of rapid changes which has forced them to make a transition from the life of their past experience, that is, farms, small towns, a more leisured pace of life, to a life which is chiefly spent in urban areas with the crowds, traffic and a fast pace of life. The transition seems to have left the present aged population ill-prepared to meet the new demands of modern Canadian society.
In this sense, the present negative view of the aged may be justified.

Nevertheless, whether condemnation or pity is given to the aged group, there remain many problems which the aged individual faces when he must make this transition. In light of this difficulty, it seems wise to discuss briefly a few of these problems, always bearing in mind that, although these problems are evident, there remains another side: the potentials of aging. This balanced view is essential because aging is not a total problem area. It also retains a promise which this society has not yet considered of value to any great degree. There follows, then, a brief discussion of these problems; absence of clearly defined roles, isolation, economic insufficiency, retirement, and health.

General Problems of Aging

(1) Absence of Clearly Defined Roles.

In general, the aged individual has no guide lines to indicate the roles to be assumed after the age of sixty-five. Cavan (et al) outlines this difficulty:

"The societal pattern fails to define clearly what the role of the old person is with reference to other age groups or within the old groups. This failure is especially marked in the case of the old man, whose role was previously closely related to his

\[1\] For purpose of this thesis, the age of sixty-five has been selected as the beginning of that time in life known as the aged period.
employment and his position as chief wage earner in the family. For the old married woman, the shift of role is less marked. In fact, such a shift may never be necessary if she is able to maintain her position as manager of her house."

This absence of clearly defined roles for the aged reinforces the fact that Canadian society expects very little in the way of a contribution from the aged individual. On the other hand, action is stressed as an essential ingredient to contentment and success. It is not surprising, therefore, that the aged individual gains the strong impression that he is useless and worthless and cannot contribute any skill to his country. It might be speculated that this basic conflict causes many of the emotional problems in old age.

(2) Isolation

Each individual needs interaction with other individuals for both support and mental stimulation. Mental health can only be maintained if satisfying interpersonal relationships are available for everyone.

This is especially true for the aged who face inevitable readjustment difficulties as loved ones die, or move away or retire and as loss of health threatens. To make new friends under these conditions, might prove to be an overwhelming strain which the elderly person is unable to tolerate. Then again, there might be resentment toward younger age groups.

These issues could drive the aged individual into a sense of isolation heightened by loneliness.

(3) Economic Insufficiency

An adequate income is essential to meet the daily maintenance needs of each individual. From income the individual is able to provide adequate food, housing, clothing, medical attention and recreation.

If these ideas regarding income are applied to the aged, it can be readily seen how anxiety and stress are created in the individual aged person who must exist on an inadequate income. Coupled with the fact that physical and psychological reserves may be low, such stress can be so overwhelming that breakdown of various types can result. Williams sums up the problem in this way:

"Thus, in general, older people seem to be notably disadvantaged in terms of wealth or in their command over scarce means. This, in turn, placed restrictions on the type of social systems in which they can participate. However, it must be remembered that this problem tends to be cumulative with others and to be acutely concentrated in certain groups. When it is combined with poor health, loss of power, prestige and recognition through loss of employment, and loss of emotional response through death of a spouse and friends, the problem can indeed become acute." 1

1 Williams, Richard H. "Changing Status, Roles and Relationships." Handbook on Social Gerontology, p.280
Retirement

The problem of retirement in Canadian society continues to receive a great deal of critical attention from many quarters. The reason for this can be found, perhaps, in the fact that retirement affects virtually every employed man and woman and, therefore, poses a threat to the individual's known way of life. As Dr. Tyhurst notes, retirement involves change or transition, bereavement or grief, loss of activity, degree of social isolation, loss of income and changes in social status. ¹

Since retirement may force an aged individual from an active to a leisurely way of life, a complication is added to an already threatening situation. How will the person use his leisure time? This question must be asked and answered, if possible, by the individual about to retire. If he is fortunate enough to retire to other work, it can be presumed that his adjustment will not be great, for his whole way of life, including training, is geared toward a life of work. Unfortunately, those who retire to a life of leisure without preparation are faced with great adjustments for which their life work and education gave them little preparation. This latter group may suffer emotional problems.

Because retirement poses such an emotional strain, there might be a need for retirement counselling to help the

individual to plan carefully for the day he leaves his work. How such a program would be prepared and whether professionally trained personnel would be needed is beyond the scope of this thesis. Nevertheless, the adoption of such a program might pay dividends through reduction of stress and anxiety associated with retirement. Some day, Canadians may have to consider and develop this idea.

(5) Health

There have been many advances and discoveries in the field of medicine. These have resulted in a good health standard for most people in Canada; they have resulted in lower death rates among babies; they have resulted in more elderly people living longer. But many of the areas in medicine which have not advanced are in those very areas of illness which plague individuals as they grow older. It is suggested, therefore, that:

"Medical advances by and large have been beneficial in the field of active bacterial ailment - such as Smallpox, Diptheria, and Cholera, Pneumonia and Meningitis - but chronic rheumatism, degenerative diseases of the heart and blood vessels and senile mental disorders have remained untouched by modern discoveries and with large numbers of old people in the community their total incidence is higher than ever." ¹

Health, therefore, can become a problem of considerable

concern to the aged person. It is at this period in life when he is more susceptible to the degenerative diseases, both physical and mental. To face the prospect of recovering from an illness which has affected the person adversely, can cause psychological disturbances of varying severity. How these can be combatted depends partly on the skill of the medical doctor and partly on the amount of physical reserves which the older individual can draw on at the time of his illness. Also, it has been suggested that "old people are more depressed and disturbed by illness than younger people because of their diminished body reserves and because of our society's emphasis on youth." ¹

Many other problems can face the aged individual, ranging from fear and uncertainty of the future to difficulties with relatives. Nevertheless, the aging process cannot be considered in total as a problem period. It is granted that problems can exist, as briefly discussed above, and as amply explored in the growing amount of literature on the subject. But there is a gradual increase in emphasis upon aging as a period of potentials. This more balanced view of aging suggests that a new philosophy is beginning to permeate the field of gerontology.²

¹ Bonner, Judy (ed) The Word is Hope. An Institute on Rehabilitation of the Aging, Austin, Texas, 1961, p.5
Potentials of Aging

As knowledge increases, there is an increasing awareness of the potentials of aging. This is, perhaps, best noted in the wealth of literature ranging from the "popular" writings to large compilations of present day knowledge about aging. Journals are devoted to the subject and cover every aspect of aging from medical studies to sociological and anthropological data. This accumulation of knowledge in the literature strongly suggests the waste in allowing the aged population to under-produce in a myriad of ways for themselves and hence for society.

Much of this knowledge is beginning to reach the general public who are beginning to respond through the development of clubs for elderly people in various communities, as a means of relieving the sense of isolation experienced by the aged as loved ones and close friends die. A better step in this direction might be seen in the functional community centres which offer multipurpose activities for most age groups. This type of development holds a promise of communication between the various age groups and later may be a means of welding the experience of age with the vitality of youth. A further benefit could be found in the development of new roles for the aged within these centres through the aged acting as leaders for some of the children's and young adults' groups.

Other signs of public interest are evidenced in the gradual increase in pensions, and with the pensions approp-
riately planned in relation to the cost-of-living index, income deficiencies may disappear to a large extent. This, of course, means better food, enough clothing and more adequate housing, all of which would result in a better level of good health and wellbeing.

These changed attitudes on the part of the public suggest a more positive philosophy of aging which the aged group senses. This encourages the elderly to begin wondering about the growing opportunities for leaving their mark on society. Kenneth Duncan emphasizes that the "aged seem increasingly to conclude that age means opportunity to undertake for themselves the creation of a new place in society."¹ He goes on to argue that people want to help, therefore, the aged must somehow "capitalize on this unprecedented interest and willingness to help, while it exists."²

In spite of this evident interest in the aging, society retains a fundamental ambivalence toward the aged. On the one hand, they are seen as figures of authority while on the other hand, they are viewed as dependent and childlike individuals. After pointing this out, Jerome Kaplan declares that there might be a swing toward the former view. "In the immediate years ahead, it is not inconceivable that the older person may be more fully equated with authority."³ What this means in

² Loc. cit.
terms of the Canadian culture is impossible to predict today.

The aged individual does have certain advantages when compared with the younger age groups. As an example, consider the fact that the aged have relatively free time following their retirement. One of the questions which the retiring person must consider is what he plans to do with his time following the final day of his work. It is suggested that aged individuals can capitalize on the free time and use it to their own constructive advantage, including the development of meaningful hobbies, the change to new work, or in any other constructive way which will satisfy the aged individual. Once this satisfying activity is found for the retirement years, the aged individual can remain a contented, satisfied citizen.

This aspect also has direct implications for better mental health. The aged individual who keeps active, as the culture demands, continues to have an interest in life. One survey even suggested that an active interest in community life aids the aged individual to remain healthier mentally than is usual for the population as a whole.¹

Still, in spite of these potentials, the aged must continue to face for some time the pervading community attitude that the aged, in general, have reached their declining years and are, therefore, of little use to society. Tibbitts takes issue with this idea when he argues that:

¹ Bonner, Judy (ed) The Word is Hope, p.5
"ideas abound that a person undergoes growth until middle age then gradually declines in all faculties until death. (This is) not necessarily true. (There are) different qualities of (the) human organism (which) have different rates of achieving the prime level, e.g. physical abilities may decline after middle age, yet intellectual functions may gradually increase until very old age."

The two sides of aging discussed so far, the problems and potentials, place the aged in a new light. There is a suggestion, also, of a three dimensional view, as society begins to consider how best to allow the aged to take part in active life which adds greatly to the resources of Canada. Perhaps Tibbitts concludes this idea as well as any writer when he suggests "that a population with a sizeable portion of the persons surviving beyond their 65th birthday preserves mental and physical abilities which add immeasurably to the intellectual and material wealth of the community." 

Now that brief consideration has been given to the problems and potentials of aging in general, the focus can be narrowed to consider the aged in the Province of British Columbia.

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2 Loc. cit.
General Problems of Aging in British Columbia

The Lower Mainland and Vancouver Island is blessed with a temperate climate which encourages the growing of flowers from February to November. It is this type of climate which seems to draw people, including the aged, to this area. Statistics seem to point up this assumption although the writers are not aware of any studies that provide conclusive evidence.

Vancouver Island has a population of 291,000 while the Lower Mainland has 866,200 people. The total is 1,157,200. By way of comparison, Canada's total population is 18,238,200 and British Columbia's is 1,629,000.

The aged population of sixty-five and up are considerably less in the total population but they nevertheless represent a significant group of people. Vancouver Island has 35,900 of them while the Lower Mainland has 99,900 which makes a total of 135,800 aged citizens. Again, as a means for comparison, Canada has 1,392,100 aged and British Columbia has 165,600.

1 The Lower Mainland includes the Fraser River Valley from Vancouver to Hope and from the United States Border to the mountains on the north side of the Fraser River. The Valley is approximately 100 miles long by 15 miles at the widest point. Vancouver Island is approximately 140 miles long by 60 wide.

2 All figures are approximate and have been rounded out to the nearest zeros for ease of calculation. The figures were obtained from the Government of Canada Census Tracts, 1961; B. C. Government's Department of Social Welfare Annual Report, 1964; and B. C. Government's Annual Budget, 1965.
When these figures are assessed and calculated into percentages,\(^1\) some interesting facts are revealed with reference to the population spread in British Columbia. For example, British Columbia's general population is eight percent of Canada's population. Yet, six percent of that eight percent reside in the Lower Mainland and on Vancouver Island. The figures are even more startling when it is known that this six percent represents seventy-one percent of the total population of British Columbia.

The aged population assumes similar characteristics. Twelve percent of Canada's aged population reside in British Columbia. Of that twelve percent, nine percent live within the Lower Mainland-Vancouver Island area. This nine percent represents eighty-two percent of British Columbia's total aged population. In other words only eighteen percent of the aged live outside of the Lower Mainland-Vancouver Island area and within the boundaries of British Columbia.

These figures prove interesting when a contrast is made between the aged population and the total population. For example, seven percent of the total Canadian population is sixty-five and up whereas British Columbia's aged population is ten percent of its total population. This comparison between the two figures, that is seven percent for Canada and the ten percent for British Columbia, indicates the greater proportion of aged in British Columbia when compared to the rest of Canada.

\(^1\) All percentages are approximate.
Comparing the figures further, reveals that the Lower Mainland-Vancouver Island area has eight percent of the aged population as compared with the ten percent for the whole province of British Columbia. Thus, as revealed, only two percent of the total aged population lives within the border of British Columbia and outside the Lower Mainland-Vancouver Island area.

What do these figures reveal? There is a larger proportion of the aged population in the Lower Mainland-Vancouver Island area of British Columbia than in the whole of Canada. It would follow, then, that this lower south-western corner of British Columbia has a larger proportion of the problems of the aged such as: isolation, economic insufficiency, retirement and health. It follows, too, that the demand for services for the aged would be greater than elsewhere. A further result would be an increased demand for monetary aid from local governments.

On the other hand, questions could be asked about the remaining eighteen percent of the total aged population in the remainder of British Columbia. Since there is a larger population of younger age groups in other centres in British Columbia, there may be a greater number of services for these age groups rather than including the aged groups in the overall service pattern. And again, the figures could suggest a scattering of the aged population with resultant increased problems in isolation.
Since British Columbia then has as residents a high proportion of Canada's elderly people, and since it is recognized that there are problems related to old age, it would follow that mental illness in this age group would be more prevalent in British Columbia than in other parts of Canada. This is difficult to document and, in fact, may be impossible to document in detail. However, whether the incidence of mental illness can be documented or not, the fact remains that many aged individuals do suffer from mental illnesses and are admitted to Valleyview Hospital for treatment.

Psychiatric Disorders Among the Aging in British Columbia

Psychiatric disorders among the aging, including the complex causes leading to these disorders, are not well known to or understood by the general public. In fact, there exists considerable fear of such illnesses which these writers have found prevalent during the tours conducted for the general public at Valleyview Hospital. Much of this fear might be rooted in a general ignorance about mental illness but there might be an added factor insofar as the mental illness of the aged is concerned.

Psychiatry has developed considerable knowledge about psychiatric illnesses of the aged. As this knowledge develops and progresses, the names of the illnesses change causing confusion. To the person unversed in psychiatric
terminology such terms as "senile dementia" and "arteriosclerotic brain disease" are incomprehensible and, hence frightening.

In view of this confusion in terminology another approach must be taken for the purposes of this thesis. Rather than describing in detail the various psychiatric disorders associated with the aging process, the aged person's illness will be considered from the Social Worker's point of view, that is, in terms of its social significance. What caused the aged person's breakdown? How did he react? What were the symptoms? What is the person like in personality? What in his background might have particular bearing on the present illness? These and a myriad of other social questions asked in the light of the aged patient's history offer data to the psychiatrist who diagnosis the illness. This diagnosis must not detract the Social Worker from the social aspects of the patient. These social aspects make the aged patient an individual among aged individuals within the hospital setting.

To understand a little about the psychiatric disorders among the aging, there must be a beginning somewhere. This beginning must be found in the causes. Such illnesses are "induced by a complex of chronic poor physical health, enforced idleness, reduced income, lack of social outlets (social obsolescence) and other emotional, psychological and environmental stresses peculiar to older people in our culture."¹

¹ Caufrey, Eugene A. and Goldstein, Marcus S. "The Health Status of Aging People." Handbook of Social Gerontology, p.184
Attached to the understanding of the causes of these disorders, there must be as much understanding of the personality as possible. This includes some knowledge of the background of the aged person who is mentally ill for should "an aged person become mentally ill, his behaviour will depend on his character throughout life. A person who has had emotional problems throughout life will evidence multiplications of them in advanced years." 1

It is within an understanding of these two aspects, that is, the causes of the breakdown and the aged individual's personality, that a diagnosis can be developed by the psychiatrist. From this diagnosis, treatment is suggested. Successful treatment means that the patient is returned to a former level of good health which is appropriate to the particular age of the patient. Treatment may be successful for "there is evidence to support the claim that, given appropriate treatment and relief from major environmental stress, many aged patients can be restored to a state of mental health normal for their age." 2

This is the hope at Valleyview Hospital. To offer this hope to the psychiatric geriatric patient, 3 a team comprised of Psychiatrist, Medical Staff, Social Workers, Occupational Therapists, and other staff all cooperate to give a service to this type of patient of whom there are a great many. For

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1 The Word is Hope, p.5
2 Ibid, p.184
3 Aged psychiatrically ill patient.
example, Valleyview Hospital had seven hundred and forty-one patients in residence at the end of March 31, 1964.¹

There is a growing belief that the aged psychiatric patient can respond to treatment if the treatment is given early enough. Coupled with this belief, is the belief that mental hospitals for the aged should have "open door" policies to allow the ambulatory aged patient to come and go at will about the grounds of the hospital. Also related, is the belief that custody is not necessary for the aged patient during the remainder of his natural life. As a result of these beliefs, fairly recent in origin, all the Valleyview staff considers that a patient should be discharged from the hospital as soon as he has made a satisfactory response to treatment appropriate to his age. No longer will this institution act as a total custody unit. All of these points suggest a new philosophy toward aging. This philosophy is reflected at Valleyview Hospital and will be enlarged upon in the succeeding chapters.

¹ 1964 Annual Report, Mental Health Services, Province of British Columbia, p.10
CHAPTER II

SCOPE AND METHOD OF STUDY

In Chapter I some of the problems and potentials of the aged person, generally, were examined; particular attention was then focused on the mentally ill aged in the Province of British Columbia. Reference was made to Valleyview Hospital, and since the study is concerned with patients' discharge from this hospital, a description of it will provide an appropriate background against which to present the scope and method of the study.

Valleyview Hospital

Valleyview Hospital is situated twenty miles east of Vancouver on the north side of the Fraser River about one mile beyond Crease Clinic and Essondale Mental Hospital. The grounds front on a busy highway which is an alternative route into the interior of British Columbia.

In general, Valleyview Hospital is organized into separate buildings linked together by spacious lawns and well
kept, parklike landscaping. The largest building, the admitting area, is flanked by seven other buildings. These buildings, placed as they are on the side of a hill to take advantage of the view looking east, actually pose many problems for the aged patients who must walk between buildings. For younger individuals, the hills would not hamper movement but to the elderly person they require a great deal of strain and effort beyond the capacities of many aged people.

Within the admitting building are the diagnostic services: Medical, Laboratory, X-Ray, and others. Rehabilitation services are provided also in this building and include Occupational and Recreational Therapy and Social Services. Six other buildings house the patients. The seventh has a small dinning room and "Tuck Shop".

There are two other hospitals situated at Vernon and Terrace which are part of the psychiatric geriatric unit for the elderly mentally ill. Dellview at Vernon and Skeenaview at Terrace are only mentioned at this time to show the extent of the services provided to this elderly group. This study will not include these two hospitals since neither provides a discharge service which is our main area of focus.

The MacLean thesis¹ has outlined the history of Valleyview Hospital. Although there is no need to reiterate the

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history, it is worth noting that as the history of Valleyview has evolved, there has also evolved a philosophy toward the aging. Dr. John Walsh, the Medical Superintendent at Valleyview Hospital, explained his ideas with the authors in a personal interview about the philosophy at the institution. He noted that society, in general, wants to put the aged away. Previously, many elderly psychiatric patients were sent to the Home for the Aged but when this institution became known as Valleyview Hospital in January, 1960, the change of name reflected adequate experience and facilities to return the aged to their normal environment, that is, the community. Today, as Dr. Walsh suggests, Valleyview "receives (the mentally ill aged) in order to help them over their present difficulties or crisis or episode and let them carry on as before."

In his concluding remarks, Dr. Walsh strongly emphasized that "recognition of social and psychological factors contributing to psychiatric illness in the aged is probably the most important advance made in recent years. This recognition means that the patient is treated using medical, social and scientific knowledge. Recovery is a good prospect. In other words, we are following through on what is known."

Such views imply a change of philosophy at Valleyview and suggest a justification for the many changes which have taken place. For example, there has been a change from custodial care to active treatment; from locked doors to the "open door" policy; from the almost total segregation of the sexes in
buildings to the mixed wards. In addition, the idea that most patients can be returned to the community, is, perhaps, the greatest change to be developed at Valleyview Hospital. In the following Table, the changed philosophy at Valleyview Hospital can be seen in concrete form.

**TABLE I**

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patients in Residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April 1, 1963</td>
<td>252</td>
<td>477</td>
<td>729</td>
</tr>
<tr>
<td>Total Admissions</td>
<td>188</td>
<td>141</td>
<td>329</td>
</tr>
<tr>
<td>Total Under Care</td>
<td>458</td>
<td>636</td>
<td>1,094</td>
</tr>
<tr>
<td>Total Separations*</td>
<td>181</td>
<td>172</td>
<td>353</td>
</tr>
<tr>
<td>(Discharged in Full)</td>
<td>(10)</td>
<td>(9)</td>
<td>(19)</td>
</tr>
<tr>
<td>(Died)</td>
<td>(123)</td>
<td>(125)</td>
<td>(248)</td>
</tr>
<tr>
<td>Net Increase or Decrease</td>
<td>+25</td>
<td>-13</td>
<td>+12</td>
</tr>
<tr>
<td>Total Patients in Residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 31, 1964</td>
<td>277</td>
<td>464</td>
<td>741</td>
</tr>
</tbody>
</table>

* Separation means discharges through deaths, transfers, probation, etc.

1964 Annual Report, Mental Health Services, Province of British Columbia, p.122

1 The mixed wards allow the mingling of sexes during the day although sleeping quarters are placed at opposite ends of the building and are separated from each other.
This chart also suggests that a beginning movement of patients to the community is taking place. Although the number of discharges are small during the Fiscal Year, April 1, 1963, to March 31, 1964, it suggests the growing importance of the Social Service Department in preparing the patient for discharge and in seeking the necessary resources to receive the patient in the community. With the expansion of this role of the Social Service Department, a study of the effectiveness of the Department in terms of discharge procedure and the problems the Department must face in its efforts to discharge patients seems important. The focus of this study, then, is on the role of the Social Worker within the hospital and, in particular, within the process of discharge of patients back to the community.

In order to learn whether other institutions shared the philosophy regarding the mentally ill aged as it is reflected at Valleyview Hospital, letters were sent to appropriate national department in Canada, Great Britain and the United States. The replies indicate that no similar institutions exist in these countries, with the possible exception of Villa Selicinia Geriatric Hospital, Jackson, Louisiana. The letter from Washington, D. C., declared that "the Villa is reported to have geriatric wards of good repute. Their main objective is to relieve the pressure upon psychiatric institutions throughout Louisiana, and improve the care of the geriatric patient who does not require extensive psychiatric hospitalization." (See Appendix B.) Whether this means that a
similar philosophy has been developed in Louisiana is difficult to determine.

The assumption, therefore, is that Valleyview Hospital is a unique institution and that any study of various aspects of the work of the institution would not only be helpful to the institution itself, but would, to some extent, provide further knowledge about the aged.

Certain points have been outlined above in order to emphasize the need of a study around the aspects of discharge from Valleyview Hospital. First, a positive philosophy, which emphasizes the many potentials of the aged group, has pervaded the hospital and enabled active treatment of the mentally ill aged patient with the thought that eventually the aged person can be discharged from the hospital. Secondly, Table I indicates a small number of discharges as a distinct sign of the increasing effectiveness of the new philosophy. Thirdly, Valleyview Hospital appears to be a unique institution with a special focus on the psychiatric geriatric patient, his treatment, and probable return to the community. These points indicate the reasons for a study such as this at this time.

The Scope of the Study

Primarily, this study must remain as a descriptive one. No previous studies have been completed in the area of discharge and the related resources with the result that an overview is
needed at this time to indicate some of the specific problems which the Social Worker must face each time a patient is discharged. To say that the hospital is oriented toward treatment and discharge answers one question but raises another; is the community ready to receive the patient? Our study will attempt to answer the latter question.

Although a theory of discharge may state that all patients are possible discharge prospects, in practice certain problems arise which are partly attributable to the types of resources or lack of resources in the community, and partly attributable to the stages of recovery to which a patient has advanced.

If the community is not ready to receive the patient, what other alternatives must the Social Worker seek to effect the discharge? By gaining such an overview, perhaps, other research studies might be indicated which might assist the hospital Social Worker toward an understanding of the community in its role as the receiver of the patient.

The study is limited to the study of Valleyview Hospital in the Lower Mainland of British Columbia in order to determine whether the resources for the psychiatric geriatric patient are adequate to receive these patients upon discharge. It is proposed to examine the present criteria of discharge as it is set against the available community resources. Is this criteria unrealistic? Does each patient actually reach the point of discharge? If a patient is deemed dischargeable, are there adequate resources to receive him? An attempt will be
made to answer such questions as these. In addition, there will be an attempt to view realistically some of the gaps in the existing criteria of discharge and the existing criteria for reception of these patients in the community. In this way, a demonstration of limitations in the criteria may pave the way toward an adequate discharge policy based on adequate resources.

The total patient group will be included in the study but will be divided into two groups, those who progress to the point of discharge and those who must remain in custodial care for various reasons. Further, for purposes of this study no age limitation is set because admission to Valleyview Hospital takes into account various factors associated with the aging process. There are at present, therefore, some patients in Valleyview Hospital who are below the age of sixty-five. To arbitrarily set age sixty-five as the admission age to Valleyview Hospital would prevent this small group from obtaining the treatment Valleyview offers.

The Method of Study

This study examines the criteria of discharge against the community resources. To understand these criteria, it is necessary to analyze the process of admission to hospital and also the treatment process. With this backdrop, an evaluation of the discharge criteria can be developed both in terms of the hospital and in terms of the community.
For this study, statistics have been analyzed for the past year terminating on March 31, 1965, the end of the just past Fiscal Year. Particular attention has been paid to the discharge statistics and the rate of patient return statistics to suggest the weaknesses in the discharge criteria.

A questionnaire was developed to assess certain randomly selected boarding and nursing homes in the Lower Mainland in the hope that this method might help in an understanding of the attitudes which those people managing these resources may have toward the aged psychiatrically ill patient.

Certain selected cases have been studied to illustrate both successful placements in the community and problems in discharge to the community.

Case histories have been selected to illustrate as much of the procedure in the hospital as possible.

The sources of data have been many and varied. The Valleyview Hospital Staff have provided much information of value which otherwise might have remained unknown for purposes of this study. The same help was extended by randomly selected boarding and nursing homes from Vancouver City through to Abbotsford. To obtain some information about other possible institutions similar to Valleyview Hospital in Canada, Great Britain and the United States, letters were sent asking for information. Other sources of information have been: Mental Health Reports, Mental Health Acts and Census Reports.
Within this chapter, changing philosophy has been noted as an important aspect in bringing about many of the changes within Valleyview Hospital. One change of utmost importance was suggested in the name change from the Home for the Aged to the present name. This change is suggested in the concept that Valleyview's prime focus is on treatment of the psychiatric geriatric patient, not on custodial care. With this focus in mind, Chapter III will discuss the admission procedures and treatment processes.
CHAPTER III

ADMISSION, TREATMENT, AND SELECTION
OF PATIENTS FOR DISCHARGE ¹

It is logical, before examining discharge criteria, to examine some of the ways in which the changing philosophy affects the treatment of the psychiatric geriatric patient in Valleyview Hospital. Transition from custodial care to rehabilitation and discharge to the community is the basis of the present "open door" philosophy in Valleyview. This "open door" philosophy: (1) eliminated the patient waiting list which neared the two hundred mark in 1962; ² (2) created heterosexual (mixed) wards which house male and female patients in the same quarters and engaging in common treatment activities; (3) provided an additional "short term" treatment service for patients who are able to stay at home, but occasionally require a short stay (no longer than three months) in Valleyview Hospital; and (4) provided more social work staff to provide better service in discharging patients from Valleyview Hospital.

This chapter is focused primarily on the psychiatric geriatric patient. His progress is examined from the time of admission to Valleyview Hospital to his eventual placement on

² Ibid p.20
one of the treatment wards. Finally, when the patient successfully responds to the specialized treatment in the hospital, he is prepared for discharge. The discharge criteria and the resources available in the community will be examined in the following chapter.

ADMISSION

As soon as the psychiatric geriatric patient is admitted to the Valleyview Hospital his rehabilitation treatment begins. In the examination room the physician meets the patient for the first time. As a standard procedure at admission to the hospital, the physician performs a complete physical and mental examination. In addition, he compiles a short medical and social history of the patient which he may obtain from one or several of the following sources:

1. The patient himself - if the mental condition is stable enough.
2. The relatives - if they have arrived with the patient to the hospital.
3. The police officers - if they have brought the patient to the hospital.
4. The ambulance attendants and nurse - if no one else accompanied the patient to the hospital.

If, in the opinion of the examining physician, there is a need for further background information on the patient, he may request the Valleyview Hospital Social Worker to obtain
a more detailed social history. The Social Worker may obtain it: (1) from other agencies in the community; (2) from various agencies throughout the province; (3) from other hospitals where the patient has had treatment at some other period of time.

At the end of the general examination by the Valleyview Hospital physician, the patient is placed for observation on the admission ward which is situated in the main Valleyview Building. The observation consists of assessing the patient's social behaviour on the ward, his mental condition, and his physical condition. All necessary laboratory tests are performed (blood, X-Ray, and others) and continued rehabilitation treatment is given. The patient remains on the admission ward for one week and is later introduced to the treatment team.

The treatment team convenes, as a rule, every Tuesday morning - this meeting is called "The Case Conference".

The Treatment Team

The Treatment Team consists of the principal staff members from the various specialized departments in Valleyview Hospital. It is headed by the Medical Superintendent and its role is to establish and put into effect the rehabilitation plan that is best suited to each patient.

The team members' functions are as follows:

(a) The Medical Superintendent - as mentioned above - is the chairman of the treatment team. He introduces the patient to the other members and
personally interviews him in order to re-evaluate his affective capacities. At this time the Medical Superintendent encourages the patient to express his personal concerns and problems.

(b) Staff physicians - all four physicians take part in the conference. Here the examining physician presents to the team the patient's medical history, the results from laboratory tests and reads the patient's social history. Finally, the physician proposes the diagnosis and makes recommendations regarding the treatment needed in order to rehabilitate and eventually discharge the patient. If the patient has made sufficient improvement in the past week, the team makes a decision for immediate discharge.

(c) Nursing Supervisors and Charge Nurses. The Charge Nurse at this point is requested to give a detailed description of the patient's every day condition from the time that he was first admitted on the ward. The nurse evaluates any significant changes of the past week and discusses the patient's adjustment to the hospital situation.

(d) Occupational Therapist and Recreational Therapist - the representatives of these departments examine and make recommendations concerning the patient's ability to take full advantage of the various Occupational Therapy and Recreational Therapy activities in the
hospital. They also indicate ways in which these activities may enhance the patient's rehabilitation and discharge possibilities.¹

(e) The Social Worker - the Social Worker's role at the Case Conference has many purposes:
1. He may be requested to provide detailed social assessment of the patient.
2. He may receive a direct referral from the team to discharge the patient.
3. He may make recommendations regarding the resources available in the community.
4. He may be assigned to the patient for provision of casework services during the patient's stay in Valleyview Hospital.

Purpose of the Case Conference

The purpose of the Case Conference is to decide on a cooperative rehabilitating goal of treatment for each patient admitted to Valleyview Hospital. Ultimately this goal is to enable the patient to be discharged to the community. The goal is established in three steps:

1. The patient is assessed individually.
2. He is introduced to each member of the Treatment Team.
3. The Treatment Team finalizes the patient's transfer

¹ Some of these activities are woodwork, painting, knitting, bingo, sing-songs, movies.
from the admission ward to the level of treatment best suited for his diagnosed mental and physical condition.

The patient's evaluation or assessment, therefore, is based on a detailed clinical examination and diagnosis of his somatic condition, determination of his functional potentialities and the degree of his intellectual deterioration. Since the entire team participates in this assessment, it is considered the first step in introducing the patient to the therapeutic activity. Therapy is planned after there is a complete understanding of the dynamics of the disorder and the affective and intellectual potential of the patient. Since the most important therapeutic efforts are directed towards the preparation of the patient for fulfillment of his future social role in the community, he is transferred to the appropriate treatment facility available in the hospital. It is there that he will be helped to develop his remaining affective and intellectual capabilities and social potentialities. Further treatment on each ward is directed at reorientation to the future environment in the community, by way of Environmental Therapy, Group Therapy,^1^ Physiotherapy, Podiatry, Recreational Therapy and Occupational Therapy. Occupational Therapy is aimed mainly at reactivation and improvement of manual skills. Since all work in Occupational Therapy is

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^1^ By group therapy we mean all activities performed in groups - in Valleyview Hospital social group therapy was done on a study basis in 1962 and was very successful.
performed in groups, it also aids resocialization* and communication among patients engaged in manual projects.

TREATMENT FACILITIES

In accordance with the Treatment Team's decision, the patient is transferred to one of the following treatment facilities of Valleyview Hospital.

1. **Infirmary Wards**

   The patients who are transferred here, in addition to their mental condition, need complete bed care and maximum nursing attention. The various physical disabilities encountered here, range from total paralysis to periodical incapacitating cerebro-vascular strokes. Patients from these wards are discharged to nursing homes, providing they respond successfully to treatment of their mental illness to the extent that they can be accepted for nursing home care in the community.

2. **Closed Wards**

   These wards are divided into separate male and female quarters. Patients who are transferred here are predominantly ambulant, but need close supervision because of extreme mental confusion, wandering and seemingly irreversible intellectual deterioration. Here there are also special facilities for those patients who are in need of closely controlled diets, and who have special somatic problems. Some patients here are

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* Definition of resocialization: A process by which the human being acquires the knowledge of his group and learns the social roles appropriate to his position in it.
suffering from circulatory and cardiac insufficiencies, endocrine disorders and respiratory malfunctions.

The Nurse's role in the rehabilitation of the patient on the closed wards is limited to reactivation of the patient's remaining physical and intellectual capacities, starting at the minimum level of his abilities. When the patient responds successfully to small tasks, for example, walking to the dining room, sitting at the table, and feeding himself, the Nurse progressively increases the patient's responsibilities. They will probably be always limited in nature, however.

In the closed wards are encountered the largest number of patients who can eventually be discharged but for whom there are presently no appropriate facilities available in the community. As a result, such patients stay in hospital longer than is necessary and constitute, theoretically, one group of patients. Another group of patients in the closed wards may never be discharged because of their extreme and progressive mental and physical deterioration. (This subject will be dealt with more fully in Chapter IV.)

3. Open Wards or "Mixed Wards"  

The open wards occupy three buildings and house both men and women patients. Some of the patients transferred here may be anticipating the final stages of their discharge (as recommended by the Treatment Team). Others may require a longer resocialization period before being ready for discharge.

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1 Mixed Ward - unofficial name given to the wards that house both male and female patient population engaging in common rehabilitation therapy. The wards are never locked by key and have unlimited visiting hours.
to the community. Here the patients are helped, encouraged and motivated to be self-sufficient in all aspects of everyday life.

TREATMENT TOWARDS REHABILITATION

The fundamental rehabilitation plan in Valleyview Hospital is to treat the individual patient according to his or her remaining capabilities, both intellectual and affective. The patient's assignment to one of the wards described above is carefully planned by the Treatment Team in order that a stabilizing environment may be provided in hospital to prevent the slow-down or further deterioration of the patient's mental and physical capacities. (See Factors Considered in Discharge Planning, p. 43.)

The problems of physical deterioration are dealt with by engaging the patient in routine daily activities of elementary nature which are aimed at retraining the patient in such routines as bedroom, dining room and toilet habits. This retraining in the elementary daily routine is introduced gradually to the patient by competent nursing staff at regular intervals.

The patient's intellectual (mental) capacities are maintained and, where possible, improved by the administration of psychogenic drugs which are prescribed by the hospital staff of physicians. Drug Therapy is not sufficient in itself to restore and maintain the patient's mental and intellectual potentialities. The patient requires, in addition, constant
motivation. Motivation is regarded by the Valleyview Hospital staff as the process of organization which gives self-direction and guides the activities of the person involved. There are essentially two components of motivation: one is some degree of discomfort about his present condition; the other is some degree of hope or some goal sought to be worth achieving by the patient. In Valleyview Hospital, the goal is discharge to the community. The patient, therefore, is motivated to achieve his goal by various activities on the ward that will prepare him, both physically and mentally, for his return to the community.

The patient is encouraged to establish friendships and relationships with members of both sexes; is engaged in all types of group activities on the ward and is encouraged to take the initiative for attending the various occupational and recreational activities and religious services. Such a patient has ground privileges; he may go in and out of the ward at any time, entertain visitors in the Valleyview "Tuck Shop" and go on week-end leaves with relatives and friends. Eventually this patient is able to return either to self-care, to family care or to any suitable rest home or boarding home in the community.

Motivation of the patient towards eventual discharge is also the function of the Social Worker. Throughout the patient's stay in Valleyview Hospital, the Social Worker provides casework services and acts as a liaison between the
patient, his family and the community. The Social Worker's major role, however, is in selection and discharge of the patient from Valleyview Hospital.

FACTORS CONSIDERED IN DISCHARGE

Although every patient in Valleyview Hospital is considered for discharge, providing that he or she responds successfully to treatment, there are certain distinct groups in the patient population. These fall into three categories, depending on the degree of care and supervision they may require at the time of discharge. Each category is illustrated by actual cases in Chapter V.

(a) The ambulant psychiatric geriatric patient who suffered a functional illness associated with the aging process, for example, a psychotic or psychoneurotic reaction with a social or psychological stress as a basis. This person, given proper treatment at Valleyview Hospital, requires minimal care or supervision, and is able to function successfully in any boarding home or rest home in which he may be placed. After his treatment in Valleyview Hospital, he is lucid (aware of his environment), well oriented to time, place and person, and often is able to care for himself. (See Case History I, Chapter V.)
(b) The "in-between" psychiatric geriatric patient: This patient does not require complete nursing care, but needs close supervision and special understanding from competent nursing staff. This patient's medication has to be supervised and the nurse must have an awareness of his changes of behaviour and his mental condition which may call for changes in medication or special diet. This patient is ambulatory but tends to be forgetful and disoriented. The "in-between" patient constitutes the major patient population in Valleyview Hospital. (See Case History II, Chapter V.)

(c) The psychiatric geriatric patient who needs full nursing care and supervision: This patient is either bedridden or in a wheel chair at all times. In addition to his severe degree of mental deterioration, he also suffers chronic physical deterioration due to the aging process. This patient may be discharged from Valleyview Hospital when his mental condition improves to the extent that he will not be disturbing to others. (See Case History III, Chapter V.)

In addition to the above three categories, there are patients who will not be discharged from Valleyview Hospital

1 This is an informal term used in Valleyview Hospital.
because of their chronic physical and mental status. If some respond successfully to treatment and are considered for discharge, their stay in Valleyview Hospital is often prolonged because of certain existing impediments that make all attempts to discharge such a patient time consuming and, usually, futile. Some of these impediments are:

1. The need of these patients for a selected and highly protective environment in the community because of their limited capacities. Resources to meet such needs are almost nonexistent. (See Chapter IV, Section II.)

2. Where suitable accommodation in the community is located, it is more expensive than other types of accommodation. The reason for this is found in the greater amount of services and facilities required to care for these patients.

3. In order to obtain the additional assistance required for the patient in this type of accommodation, it is necessary to seek the cooperation of community Social Welfare Departments. Unfortunately, some departments do not cooperate with Valleyview Social Service.

As a result of the above impediments, much effort and time is required from the Social Worker. More important, is the delay in discharge the patient faces as a result of the above impediments. This delay is reflected in the patient who has been prepared for discharge but is unable to leave hospital. (See Case History IV, Chapter V.)
The above impediments are a reflection of the broad social and psychological problems of today with which the aging population is faced in general. (See Chapter I.) Valleyview Hospital attempts to overcome these impediments. This is seen in the philosophy which pervades the process of treatment, selection and discharge of the patients.

PATIENT SELECTION FOR DISCHARGE

The Social Service Department of Valleyview Hospital has developed a liaison with community agencies and has located some suitable resources for the care of the discharged patient. However, this selection of boarding homes and nursing homes is done in a random way and at the present time there are no specific, well-formulated criteria against which to measure resources. Neither are there specific criteria within hospital which can be used in the selection and referral of patients for discharge planning.

The selection of patients for discharge planning is on a very informal basis. One procedure has been tentatively developed whereby three months from the date of admission, the patient's file is brought to the attention of the Social Service Supervisor. The names of those patients are brought forward, who appear to have responded to treatment, as indicated in the medical records. These names are assigned to the individual Social Worker. The Social Worker, in turn, consults the hospital physician for a final decision concern-
ing the patient's successful response to treatment which
would indicate his readiness for discharge planning.

Three months was selected by the Valleyview Hospital
staff as a suitable period of time at which the patient's
progress may be evaluated. However, there are many exceptional cases where patients responded to treatment in
Valleyview Hospital before the three month period. Such
patients are selected prior to the three months period and
referred by the attending physician to the Social Service
Department for discharge planning.

As the physician himself cannot constantly be aware of
all the patients all the time, it was, therefore, agreed by
the Treatment Team members that it is in order for any one of
them to bring to the attention of the physician any patient
who appears to be a possible candidate for discharge. This
procedure is actively carried out at all times during the
patient's stay in Valleyview Hospital in order that an early
response to treatment may not be overlooked.

The above methods of selection of patients has certain
advantages; for example, the informality of the referral of
patients eliminates the necessity for formal written
communication between departments within Valleyview Hospital.
Nevertheless, there are disadvantages in this informal
procedure; it creates duplication, confusion, overlapping of
services, disagreements and a lack of coordination between
the physician and the other Treatment Team members. It also.
allows for the occasional patient suitable for discharge to go unnoticed.

The physician in charge examines the referred patient and officially declares the patient no longer in need to remain in hospital. Then, with the consultation of the Social Worker, the physician decides whether the patient may be discharged to self-care, family care, nursing home care or boarding home care. From then on the remaining planning is the responsibility of the Social Worker.

The Social Worker informs the Valleyview Hospital Business Office that discharge is being considered and requests information concerning the patient's financial status and other assets that are available to support the patient in the community. The Social Worker also gathers, from the Head Nurse on the ward, by way of a written nursing assessment, information concerning the patient's everyday behaviour, his mental and physical needs (see nursing assessment form, Appendix C). In addition, the Social Worker obtains a one month supply of the required medications prescribed by the physician. Other pertinent information may be requested from the Occupational and Recreational Therapy Departments, or from any other person that is known to be in close contact with the patient. This person could be the Chaplain, Dentist, Beauty Parlor Operator and also interested friends or relatives. The Social Worker then contacts a selected community resource(s) to determine the suitability of placing the patient. Having
completed the preliminary work, the Social Worker consults the physician again to discuss the discharge plan and to reevaluate the patient's condition before discharge is finalized. After the completion of these plans at the hospital, the patient's family is contacted again and involved in the final details of the discharge planning. Some interpretation to the family regarding the patient's needs and capabilities is often necessary. Reassurance is given that the patient may return to the hospital without any formal certification, when and if his condition deteriorates to the extent that he will require further hospitalization and treatment in Valleyview Hospital.¹

The patient himself is made aware of the planning at all times. He is actively involved in the overall planning of his discharge by the Social Worker and the Nursing Staff on the ward. Sometimes the patient himself initiates a request for discharge. If his request is realistic, the patient is given all the support and assistance from the Social Worker to return wherever he wishes in the community.²

The following chapter will examine in detail the criteria for discharge from Valleyview Hospital in comparison with the resources available in the community.

¹ Comparatively few patients return to hospital - in the Fiscal Year of April 1, 1964, to March 31, 1965, out of 143 discharged, 12 returned - 8 from boarding homes, 3 from family care, and one from nursing home. (See Chapter IV.)

² Patients have been discharged to Italy, India, and Hong Kong.
CHAPTER IV

DISCHARGE CRITERIA AND COMMUNITY RESOURCES

Chapter I presented in general the "open door" philosophy of Valleyview Hospital; Chapter III demonstrated the effects of this philosophy on treatment and referral of patients for discharge planning. Since the success of the "open door" philosophy is in direct relationship to an effective discharge program, this chapter will examine the discharge program and process in effect at Valleyview Hospital at this time.

Discharge Related to Resources

Although the philosophy of Valleyview Hospital may regard all patients who have responded to treatment as dischargeable, discharge itself is directly linked to the resources available in community. The quality and quantity of the latter are major factors in determining the extent of a discharge program. There are two reasons for this. In the first place, hospital policy must be practical and workable at Valleyview Hospital as in all hospitals. A discharge program cannot exist in a theoretical vacuum. Consideration must be given not only to
decisions about the suitability of a patient for discharge but also, and perhaps even more importantly, to the type of patient the community is equipped and willing to receive from the hospital. Secondly, with reference to the situation in community, one must consider the differences between psychiatric geriatric patients and younger mentally ill patients. In planning discharge with and for younger patients the problems of resuming customary roles and responsibilities awaiting them in the community must be considered and carefully examined.

The problems of the aged have been presented in detail in Chapter I under the headings "Absence of Roles, Economic Insufficiency, Retirement and Health." These problems represent a lack of roles and responsibilities. For psychiatric geriatric patients the basic factor to be considered in discharge planning is the amount of care and supervision they require within the community. It is, therefore, necessary at this point in time, to assess what resources are available within the community in order to determine criteria for discharge from Valleyview Hospital.

The Resources

There are four types of resources available for Valleyview Hospital patients in the community. They are:

(1) Family (including relatives and friends) and self-care.

(2) Licensed Nursing Homes.

The Hospital Act defines these in the following way:
"Licensed hospital means a private hospital in respect of which a license has been issued pursuant to this act which has not been revoked. 'Private Hospital' or 'hospital' means a house in which two or more patients, other than the spouse, parent, or child of the owner or operator thereof, are living at the same time, and includes a nursing home or convalescent home...."  

(3) Licensed Boarding Homes.

The licensing Act refers to such a home (with specific reference to the aged) as:

"a building or part of a building...conducted or operated by a person which is used, in whole or in part...(c) as a boarding home or other institution wherein food or lodging together with care or attention are furnished, with or without charge, for two or more persons who, on account of age, infirmity, physical or mental defect, or other disability, require the attention or care, excepting a home maintained by a person to whom the inmates are related by marriage...."  

The latest figures available for the province indicated 4,843 licensed beds for adults (the infirm and the unemployed). Well over half of these are located in the Lower Mainland-Vancouver Island area.  

1 Hospital Act, Part II "Private Hospital", para. 7, (B. C.)  
2 Welfare Institutions Licensing Act (Province of British Columbia), R.S. 1948, C363, Section 1, para. 2  
3 Welfare Institutions Annual Report 1963-64 (telephone conversation with Welfare Institutes, 635 Burrard Street, Vancouver, B. C.)
Licensed "Boarding Homes Special" (of which two exist at this time with a total bed capacity of fifty-eight). These homes, while licensed under the same provisions as "(3) Licensed Boarding Homes", have been placed in a separate category in this presentation because of their special ability in providing care for the psychiatric geriatric patient. For clarity they shall be referred to as "Boarding Homes Special".

It is our intention to examine each of the resources separately and in detail in the next section. First, a brief examination will be made of statistics which reveal the resources used in the past year and the relationship of these to the care needs required by patients in hospital.

TABLE II  The number of discharges made to each of the resources during the Fiscal Year 1964-65 (April 1 to March 31).

<table>
<thead>
<tr>
<th>RESOURCES USED</th>
<th>TOTAL NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Homes</td>
<td>55</td>
<td>39%</td>
</tr>
<tr>
<td>Boarding Homes</td>
<td>42</td>
<td>29%</td>
</tr>
<tr>
<td>&quot;Boarding Homes Special&quot;</td>
<td>9</td>
<td>6%</td>
</tr>
<tr>
<td>Family</td>
<td>30</td>
<td>21%</td>
</tr>
<tr>
<td>Self-Care</td>
<td>7</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>143</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
TABLE III  
A breakdown of patient population by ward on March 31, 1965. Where possible, the comparable type of resource required in the community is given.

<table>
<thead>
<tr>
<th>HOSPITAL WARD</th>
<th>COMPARABLE COMMUNITY RESOURCE</th>
<th>TOTAL NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infirmary</td>
<td>Nursing Homes</td>
<td>186</td>
<td>25%</td>
</tr>
<tr>
<td>Open</td>
<td>Boarding Homes, Family, Self-Care</td>
<td>176</td>
<td>23%</td>
</tr>
<tr>
<td>Closed</td>
<td>&quot;Boarding Homes Special&quot;</td>
<td>176</td>
<td>23%</td>
</tr>
<tr>
<td>Admitting 2</td>
<td>-</td>
<td>81</td>
<td>11%</td>
</tr>
<tr>
<td>Closed &quot;A&quot;3</td>
<td>-</td>
<td>140</td>
<td>18%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>759</td>
<td>100%</td>
</tr>
</tbody>
</table>

The most obvious fact evident in Table III is the total number of patients requiring "Boarding Homes Special" care. This is a conservative figure but it is still more than double the present capacity in the community.

1 See Chapter III "Treatment Facilities" which describes the wards in detail.
2 For these patients the potential need for community resources have not yet been determined.
3 These patients have not responded to treatment. They require custodial care because of their extreme mental deterioration and even on the closed wards it is necessary to segregate them from the other patients. Therefore, any resource capable of accepting these patients could accommodate this category of patient only. Some patients, should they deteriorate physically, might be eligible for nursing home placements but the majority will remain in hospital.
1. **Family and Self-Care**

   While the provincial government sets standards for boarding and nursing homes there are no government standards for, or particular community interest in, family care or self-care. The criteria for discharge to this resource are set by the hospital.

   A. **Family**

      Although twenty-one percent of all discharges within the past Fiscal year were family placements, for the most part to a husband/wife or daughter, this is not considered a major resource by the hospital. Much has been written in current literature on the changing nature of family life under such topics as "urbanization vs. rural living" and "the nuclear vs. the extended family". However, interviews with many families both at the time of admission and at the time of discharge have indicated two primary areas which have curtailed the number of potential discharges to families. The first is the absence of space within the home or apartment for the aged member. The second and more decisive fact is that families, prior to the patient's admission to hospital, had been endeavouring to cope, for various reasons and often for a period of up to ten years or more, with a parent or relative who actually needed hospitalization for most of that time. This has often involved unsuccessful placements with
various family members, numerous emergencies at all hours of the day or night, and unsuccessful attempts at placement in various boarding or nursing homes. In all such instances, not only the amount of time, but the amount of money and emotional stress have been considerable. Finally, in sheer desperation, admission is sought to hospital. Often, in the past, this has been complicated by the hospital's long waiting list which often kept prospective patients waiting for periods of up to a year or more. Once the initial shock of admission with its certification of a parent is over, families are consoled by the care and treatment the patient is receiving. In many cases, and understandably so, no emotional or physical energy is left, only fear and concern about the possibility of having to cope with the parent once again in the home. Because of such experiences some family members strongly resist the discharge of an elderly family member. When reconciled to the discharge, they often prefer to "let the experts handle it". Whether or not the new "open door" philosophy with its increased admission and potential for taking younger, less deteriorated patients will ever change the circumstances surrounding this situation it is perhaps too early to ascertain. Nor can one predict what changes in attitude toward responsibility for care of elderly family members will accompany changes in society's view of the aged person.
The Criteria for discharge to the family are:

1. Both the patient and family member (or interested friends, relatives) must be motivated toward (desirous of) this type of placement.

2. Family members should be able to cope with the mental and physical needs of the patient by understanding what the care needs are and how best to meet them. (Patients who would normally require twenty-four hour care and supervision are not considered suitable for discharge to the family.)

3. The patient must be oriented to person and place. That is to say, the patient must be aware of and able to recognize the significance of meaningful people in his life. He must also have some general awareness of where he is and how far away other places are in relation to his own location at any one time. Not infrequently psychiatric geriatric patients live completely in the past, e.g. children are identified as siblings, children's home become the scene of their own childhood, with accompanying irritations and confusion. Such indications reflect a need for special care, understanding and supervision by trained persons.

4. The patient must have some awareness of his own physical and mental capabilities and limitations, that is, a realistic recognition of his or her capabilities as limited by age and health. Some examples would be: realization that his or her memory is not as good as it used to be; an awareness of the inability to perform the role of breadwinner. Failure to have this awareness or acceptance can result in
various manifestations of hostility, paranoid delusions and depressions.

5. Proper facilities must exist for the patient within the home. For example, the absence of stairs for the patient with a cardiac insufficiency.

B. Self-Care

This is a form of placement where the patient is discharged on his/her own devices, usually to the home vacated at the time of admission. The Table on page 5\(^4\) indicates the rarity with which this type of placement is made. Not only do few patients show such mental improvement that they can function without any supervision, but, because of the age factor alone, discharge candidates are discouraged from thinking in terms of self-care. Very careful consideration by both the Medical and Social Service Departments is given before a placement of this nature is made.

The criteria for discharge to self-care are:

1. Oriented in all spheres (time, place, person). In other words, mentally bright and alert.

2. Awareness and acceptance of their own mental and physical capabilities.

3. Memory - intact.

4. Ability to function without supervision.

5. Motivation - this type of placement must be requested by the patient.

6. Interested family member or friend in the area.
Someone who would normally be in touch with the patient by telephone or in person on a daily basis as a precaution in the event that the patient might suffer from an accident or illness within the home.

The study of each of the licensed resources in community will begin with a simplified chart based upon the licensing Acts\(^1\) and twenty-four questionnaires (Appendix D) completed by both boarding and nursing home staff.

The hospital-set criteria for discharge will follow an examination of each resource.

2. **Licensed Nursing Homes**

   Nursing facilities - minimum-good bedside nursing care.

   Physical facilities - Private rooms, semi-private and four-bed wards. Lounges.

   Staff Training - Graduate nurse in charge.

   Supervision - Twenty-four hour care (three shifts).

   Cost of Care - Private $10.-16. per day and up.

   Welfare $205. per month (ward only).

   Patient's degree of physical deterioration - No limit.

Nursing Homes vary in the amount of nursing care facilities they are prepared to offer. The minimum requirement as outlined in the chart is "good bedside care".\(^2\) However, the majority of nursing homes built within the past few years are modern-

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2. The Office of the Inspector of Hospitals is currently preparing, for government acceptance and publication, definitions covering such terms.
styled, one-storey buildings offering complete nursing facilities (excluding surgery). They are usually known as Private Hospitals. It is to these resources that Valleyview patients who require nursing care are discharged as the services and facilities offered are comparable to those available on the infirmary wards within Valleyview itself.

Nursing home placements have been very successful to date. There was only one return to hospital in the past Fiscal Year and the demands of post discharge follow-up in this area have been minimal.\(^1\) One of the reasons for this has been the repeated use of those homes wherein successful discharges have already been made. One home has accepted over forty patients in the past two years with no returns to hospital.

The majority of nursing homes accept welfare patients, although this is not a licensing requirement. However, the number of welfare beds is limited and this presents a problem of delay in discharge. Welfare beds for Valleyview patients are extremely limited in number.

A second area of concern in nursing home placements is the fact that while supervision is given by Graduate Nurses, there is no assurance that these nurses are experienced in psychiatric nursing. The pre-admission histories and assessments made at intake conferences of patients who have been admitted from nursing homes give a fairly reliable picture of the calibre and nature of the services given by the homes involved.

\(^{1}\) Returns to hospital will be discussed under the section "Discharge Follow-up".
There is also a shortage of Occupational Therapy and Recreational Therapy in nursing homes, although recognition of the need for Physiotherapy is becoming more and more apparent. The criteria of the hospital for discharge to a nursing home are:

1. The patient must be physically in need for nursing care.
2. The patient must not be a disturbing influence for other patients.

3. **Licensed Boarding Homes**

   - Nursing facilities - none required.
   - Physical facilities - Private, semi-private, three to four-bed wards. Dining room or tray service. Lounges.
   - Staff Training - none required.
   - Supervision - Day care (operator and/or owner or staff member must be present in the home at all times.

   **Patient's degree of physical deterioration - ambulatory.**

   **Cost of Care** - Private $110.-250. per month (based on general accommodation and care needs.

   Welfare $95. per month (ward only).

   Boarding homes, rest homes, guest houses or comfort homes, whichever the owners prefer to call them, range individually from warm, comfortable "homes away from home" to little more than barren rooming houses.

   As indicated in the outline, no nursing facilities are
required. The patients have their individual doctors within the community and day care only is provided within the building at all times. Usually the operator and/or owner lives within the home.

All patients must be ambulatory. Regardless of how long they have lived in the home, when a patient's condition and care needs require chronic nursing care, the patient must be moved to a licensed nursing home. Those persons with temporary illnesses, of course, can remain in the boarding home under their physician's care.

Twenty-nine percent of patients discharged within the past Fiscal Year were discharged to boarding homes. Returns to hospital from these placements will be discussed later. It is noted, however, that boarding home placements tend to be the most difficult and unstable. Such placements tend to require the closest follow-up care and attention. Some of the reasons for this will be discussed in the following paragraphs.

One of the most difficult problems in using boarding homes as a resource is the lack of trained staff. It is unfortunate that the regulations which give such strict and detailed attention to the physical aspects of the building itself, do not go further to provide assurance that candidates for licenses have a working knowledge and understanding of the patients who are entrusted to their care. Many, although licensed to care for the aged, have no understanding of the needs and behaviour patterns of the patients who are senile. Others do try with good intentions, but, without training of
any kind, they must rely only on their own personalities and any clues they may learn, rightly or wrongly, from experience. This creates a range of operators from "the warden" who substitutes authority for knowledge to the "timid one" who fears the use of authority of any kind. Equally lacking in realistic understanding and controls, both types of operators fail.

Night courses have been offered from time to time to boarding home operators by the Health and Welfare Department but on a voluntary basis only.

Another problem in this area is the limited amount of supervision. The quality of care and supervision has been discussed in the preceding paragraph. Here the amount of supervision will be discussed. Many aged patients can manage quite well during the day with minimum supervision but their peak of confusion, and, if they are so inclined, tendency to wander, usually comes at night. Although the regulations require a staff member in the home at all times, this does not mean that they are on duty at night but only that they must be sleeping in the home.

A third problem is the physical layout of many of the homes. Converted older homes present a problem in the number of stairs between high-ceiling floors and at the entranceways to the building. With a lounge and kitchen facilities, little sleeping room is available on the main floor. Most patients, therefore, must be able to climb a flight of stairs, or at least, if they are on the main floor, handle the outside stairs.
Another problem is the lack of opportunities for Occupational and Recreational activities. Boarding homes in the country with acreage around them have less of a problem with the latter but many patients, accustomed to urban living, naturally wish to return to familiar surroundings.

As a natural result of these problems there are a number of vacant beds in boarding homes which are unsuitable for Valleyview patients because of shortcomings in the quality and quantity of supervision, stabilizing therapeutic limits, or just the physical layout of the home. On the other hand, there are patients ready for discharge to boarding home facilities who must await suitable vacancies.

Based upon the capabilities and limitations of boarding homes which have been cited, the hospital has set the following criteria for discharge to such homes:

1. Oriented to place, person. That is to say, sufficiently alert mentally to correctly recognize their surroundings and the people with whom they are living.

2. Ability to establish some degree of relationship, to communicate, verbally or otherwise, with their fellow patients and with staff.

3. Cooperative toward taking medication and observing the boarding home regulations.

4. Desirous of a placement in a boarding home as opposed to, for instance, self-care.

5. Memory satisfactory for recent and past events.

6. Good sleep habits. (i.e. no habits that would be
deemed peculiar or disturbing to other guests."

7. Ambulatory.

8. Able to care for personal needs with minimum degree of supervision.

9. If delusional, such delusions should not be interfering or pose a threat to safety of patient or to others with whom he will be associated.

The physical limitations of patient (e.g. a patient with a heart condition) are considered on an individual basis when selecting an appropriate home. The extent of the patient's activity in Occupational and Recreational Therapy is hospital is compared with what the individual home has to offer. For example, a patient who likes gardening is placed in a home which has gardening facilities.

4. "Boarding Homes Special"

Nursing facilities - Emergency equipment (e.g. oxygen).

Physical facilities - Private, semi-private and three and four-bed wards. Dining room or tray service. Lounges. (Same as standard boarding home.)

Staff Training - Trained psychiatric nurse in charge and providing supervision for all other staff.

Supervision - Twenty-four hour care (three shifts).

Patient's degree of physical deterioration - Ambulatory (same as standard boarding homes).
Cost of Care

- Private $125.-250. based on care needs.
- Welfare $95. per month - accepted on temporary, emergency basis only.

Although a conservative estimate of twenty-three percent of our patients presently qualify for this type of placement less than ten percent were placed in such homes in the last Fiscal Year. Yet the two homes involved are constantly faced with vacant beds. The reason is primarily financial. As outlined in the chart the Welfare rate is accepted on a temporary basis only. This financial problem lies in the fact that these homes are not prepared to offer the type of service they can give on a welfare rate for boarding homes of $95. per month. To the present time, any increase in the amount of boarding home rates for care needs has not been forthcoming from the Department of Welfare.

With a staff under the charge of a trained Psychiatric Nurse, patients are supervised by a person with suitable training and qualifications. With twenty-four hour care they have the amount of supervision needed as well.

The major role of such homes in relation to Valleyview Hospital had been in managing temporarily with difficult patients who were awaiting admission to the hospital. With the elimination of the waiting list, this role has virtually disappeared.

Because of the staff in these homes, their understanding,
training and special ability to manage, criteria of Valleyview Hospital for discharge to such homes are:

1. Patient must have ample private means of support.
2. Patient must be ambulatory. (Licensing regulation.)

To date, these homes have been able to cope with all psychiatric geriatric problems and with the close supervision provided by an interested community doctor, have been able to provide treatment and to stabilize the condition of many patients who would otherwise have required admission to Valleyview Hospital.

It is unfortunate, however, that a patient's financial position is a determining factor in whether he spends the remainder of his life in a mental hospital or returns to a boarding home in the community.

DISCHARGE

In order to introduce and maintain the "open door" philosophy of Valleyview Hospital it was necessary to have support from such resources in community as various Welfare Departments, Health Departments, Victorian Order of Nurses, Medical Doctors, and Police. It was, and is, necessary to alleviate any concern they may have regarding discharges of psychiatric geriatric patients back into community, some of whose social histories indicate long and frequent involvement of the time and effort of many, if not all, of the aforementioned agencies. At the same time, boarding home operators, nursing home owners, and families had to be assured that they
were not leaving themselves open to unwelcomed grief with a discharged patient they could not handle and could not have removed without overcoming almost insurmountable obstacles.

In short, the era of waiting lists at Valleyview Hospital had left its mark and these people, agencies and groups, were understandably cautious about again assuming the care of a patient this hospital considers ready for discharge.

In order to offer assurance and support to those in the community involved directly or indirectly with discharged patients, and to the patients themselves, an indefinite form of probation was created. It allows a patient to return to hospital, if necessary, at any time after discharge, quickly and without the need for recertification. By its very nature, this type of probation provides an easy flow back into hospital and, interestingly enough, has helped operators, owners, and families to cope with many more problems since they know that the hospital is ready and willing to be of assistance if called upon.

Unfortunately, there remain some local Departments of Welfare and nursing homes which are extremely reluctant to accept patients from Valleyview Hospital under any conditions. Usually these Welfare Departments regard committal of the aged to be permanent. With their own busy schedules, they resent applications for the return of former clients whom they feel are better cared for in hospital. At the same time they expect the hospital to be prepared for admissions indefinitely. The attitude of the nursing homes would appear, for the most part,
to reflect the age-old stigma of mental illness, as well as an outmoded philosophy regarding the care of the aged.

There are two other forms of discharge but these are seldom used at this time. These are:

1. Discharge in Full
   It must be used under the following conditions:
   a) for voluntary admissions
   b) for those discharged to addresses outside the province. (e.g. Italy and Alberta within the past Fiscal Year.)

2. Six-months Probation
   This is used in cases of self-care or family placement at the request of the patient or family members. Depending upon the adjustment the patient makes to his environment he or she will, at the end of the six-month period, be either discharged in full or transferred to the indefinite form of probation.

   Neither form of probation is meant to be restrictive in any way and, should the family wish it, this can be changed to a full discharge at any time.

   An important aspect of discharge planning is the role of the Public Trustee. Most persons admitted to Valleyview Hospital will, by the very nature of their condition, be considered "incapable of managing their own affairs". Where the appointment of a "Quasi Committee" has not been made by the Supreme Court prior to admission of such a patient, action is automatically taken to designate the Public Trustee as the
The function of the Public Trustee is (in a trust capacity) to receive and disburse all monies on behalf of the patient; to receive, hold, protect and, if necessary, sell such property or assets of a patient, and to invest monies in approved securities.

By the very nature of their condition, the majority of patients will be discharged as "incapable of managing their own affairs". This means that the Public Trustee must assume responsibility for more and more patients. (472 admissions in the Fiscal Year 1964-65 at Valleyview Hospital alone.)

Lack of staff and, therefore, insufficient time to deal adequately with the problems of individual patients has resulted in delays both in actual discharges from hospital and in initial payments to operators, owners, and patients after discharge. This has created undue stress and hardship on those affected. Such stress has often hampered a patient's adjustment in community and has complicated the post discharge follow-up service from hospital.

FOLLOW-UP SERVICES

Those patients discharged within the Lower Mainland receive follow-up services, assistance, and advice where needed, from the Social Workers at Valleyview Hospital. In the remainder of the province the Mental Health Centres have been

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1 Valleyview Hospital statistics as yet unpublished.
of tremendous assistance to the patients and have kept Valleyview Hospital in touch with the progress and adjustment of each patient in the community.

Most of the local Department of Social Welfare have cooperated with the hospital Social Service Department in placement and follow-up services. Many of these Departments welcome the hospital assistance; the Vancouver Department, however, prefers to provide these services from their own agency to welfare patients returned to that city. Although a large majority of patients are admitted from the Vancouver area, the number of discharges to the City are very small. Nursing homes in this area are reluctant to accept Valleyview Hospital patients, particularly those in receipt of government financial assistance and many delays are experienced in placing such patients in boarding homes because of the heavy demands for this type of placement.

Although the returns to hospital have been less than ten percent (sixty-one percent of this from boarding home placements), the demands for follow-up especially in boarding home placements have been extensive. The main reason for this has been the inexperience of operators. Their lack of understanding of the problems of their aged patients creates a constant need for assistance and advice from the hospital workers. Unfortunately the Social Workers are often unable, with the demands on their time, to give as much help to each operator as required.

There have been four family, one nursing home, and eight
boarding home returns to hospital of those discharged within the Fiscal Year 1964-65.\(^1\) This represents a total of thirteen or nine percent of discharges. One patient readmitted from a boarding home was discharged again two weeks later to another boarding home and has adjusted well in the second home. One readmission from a family placement was depressed over a daughter's illness but was able to return to the family eight days later. A second return from family was due to sudden physical deterioration. The patient has since expired. The remaining ten patients suffered relapses and were returned to hospital because they had become management problems. The stay out of hospital ranged from ten days (for an alcoholic) to seven months.

There is one area where valuable help has been forthcoming, and, in fact, has made discharge possible. This is the service offered by the Victorian Order of Nurses and Public Health Nurses. Diabetic patients have been discharged to their homes, and boarding homes, because of the willingness and cooperation of these agencies to provide daily insulin therapy. One patient has been out of hospital two years because of the availability of this service.

This chapter has presented some of the problems and limitations inherent in the resources presently available in community and the effects of these problems and limitations on the discharge criteria of Valleyview Hospital. The next, concluding chapter will present a summary, case histories, the findings and recommendations of this study.

\(^1\) Valleyview Hospital Statistics.
CHAPTER V

ANALYSIS OF STUDY AND CONCLUSIONS

There are ever increasing demands from the community for the services of Valleyview Hospital. The hospital has endeavoured to meet these demands by changing its role from that of custodial care of patients to treatment and discharge of patients: the "open door" philosophy. This study has attempted to assess the effectiveness of this "open door" philosophy which permeates the life of the hospital and the hospital's function in relation to the community.

We have presented a general view of the problems and potentials directly bearing on aging in British Columbia and, in turn, on psychiatric geriatric patients in Valleyview Hospital. Secondly, we have discussed the team approach to treatment and finally, discharge criteria in relation to community resources.

Discussion of such matters as a team approach, treatment plans, criteria for discharge is, in the long run, significant only in terms of human beings. In order to bring alive, to give added meaning to the study, we are citing, in this chapter, some case illustrations.
Case History I

Discharged to Boarding Home. Admitted to Valleyview Hospital July 20, 1964.

Mrs. A., 90 years of age, is a woman with gradual mental deterioration causing paranoidal thinking for the past two years. She has been known to the Social Service Department in Vancouver since 1958. Mrs. A. is a widow; she has one married son, but was living alone. Recently she became confused, stating that a "man was persecuting her and controlling her mind with a machine". The son took her into his home where, for a short while, she improved. But eventually she became suspicious of the family, accusing them of stealing her belongings and "poisoning" her food. She finally attacked her daughter-in-law and had to be taken as an emergency case to Vancouver General Hospital. Nothing could be done for her there and she was admitted to Valleyview Hospital.

In hospital her diagnosis was "Paranoidal Delusion State, with very little Chronic Brain Syndrome".

Remarkable progress has been noted since admission. By August 2, 1964, the patient improved to the extent that she was friendly, cooperative and not delusional. She attended Occupational Therapy and had ground privileges. In October, 1964, Mrs. A. was referred to Social Service Department for discharge planning. The discharge plan was discussed with Mrs. A. and her family and it was evident that the family would be unable to care for her successfully. Therefore, the Social Worker enlisted the cooperation of the Vancouver City
Social Service Department in providing financial assistance. Mrs. A. was subsequently discharged to a boarding home after she had visited the proposed boarding home and agreed to go there.

Mrs. A. is known to be doing well in the boarding home and is very happy. The family is very satisfied with this arrangement.

Case History II
"In-Between" Case.
Discharged to Boarding Home staffed with psychiatric nurses.

Mrs. B. is a seventy-two year old woman who has one son and two daughters, all of whom are married. This patient lived with one of her daughters and managed fairly well until October, 1962, when she had a cerebral vascular accident and as a result experienced mild memory loss and confusion. She developed unreasonable fear and apprehension; she was afraid to do anything or go anywhere, afraid of falling and of getting lost. She stated that she is "going completely to pieces mentally".

Mrs. B. was admitted to Valleyview Hospital in May, 1963, and diagnosed as "Chronic Brain Syndrome associated with Cerebral Arteriosclerosis with Behavioural Reaction".

The prognosis was good and she was referred to Social Service Department for discharge planning after the admission conference.
In hospital her whole mental outlook steadily improved. She became interested in Occupational Therapy work and in the various recreational activities.

The Social Worker had a series of interviews with Mrs. B. during which her discharge was discussed. Although Mrs. B. was willing to talk about discharge to community, she was reluctant to leave the hospital as she was very dependent upon her doctor and the nurses on her ward.

On September of the same year, Mrs. B.'s doctor considered that she was ready for discharge. The Social Worker spoke with the family about plans for discharge and by this time Mrs. B. herself was well able to accept discharge. A supervised boarding home was considered most appropriate for her because there she would receive the necessary support and attention of the staff. She is expected to become apprehensive and upset periodically and will become very attached to the boarding home staff as she was to the nursing staff in Valleyview Hospital. The family agreed to visit regularly and Occupational Therapy will be provided to help her to retain her interest in manual work. In addition, periodic follow-up from the Valleyview Hospital Social Service Worker will be necessary to give Mrs. B. additional support so that she may function well in the community.

Case History III
Discharge to a Nursing Home. Admitted to Valleyview Hospital June, 1962.

Mr. C., who is seventy-nine years old, was admitted from
St. Paul's Hospital where he had been admitted because of an acute episode of nausea, vomiting and distention. He had been manifesting signs of forgetfulness for seven years prior to admission to Valleyview Hospital. He progressively became suspicious, disturbing, selfish, and hostile to everyone. He was often described as having lost interest in life, but he never displayed suicidal tendencies.

Mr. C. had lived with his bed-ridden wife in a dilapidated house and cared for her until her death in 1961. Following her death his mental condition deteriorated. He drank alcoholic beverages excessively, was undernourished and had many physical problems. Eventually he was admitted to St. Paul's Hospital, and from there to Valleyview Hospital.

Diagnosis on admission to Valleyview Hospital was "Chronic Brain Syndrome associated with Senile Brain Disease aggravated with Alcoholism, Malnutrition and Anemia".

At Valleyview Hospital this patient was gradually brought back to a better physical and mental state. He became cooperative, pleasant and friendly. His condition was considered satisfactory despite some general physical deterioration. He was referred to Valleyview Hospital Social Service Department for discharge planning in February, 1964.

Because of his physical deterioration, it was considered that a nursing home was the most appropriate placement for Mr. C. His family, when consulted, were surprised that discharge was being considered and were disturbed about such a plan. Several interviews with the Social Worker resulted in
better understanding of the discharge plan and the family agreed to the plans.

The Social Worker made the necessary arrangements and Mr. C. was discharged to a nursing home where he is getting the required physical care. Although he remains somewhat confused and disoriented, his condition is not disturbing to patients or staff.

Case History IV
Discharge uncompleted.

Mr. D. was admitted to Valleyview Hospital in March, 1961. He was a seventy-eight year old retired labourer, who came to Canada from Scotland sixty years ago. He was admitted to Valleyview Hospital because of severe mental confusion. In addition to mental confusion, he was a known diabetic for many years, and had been taking insulin. Mr. D. denied having any serious problems in controlling his diabetic condition, although according to his family, he was in a state of diabetic coma not long before his admission to Valleyview Hospital.

Mr. D.'s diagnosis after admission to Valleyview Hospital was "Chronic Brain Syndrome associated with Senile Brain Disease with Behavioural Reaction".

In Valleyview Hospital, the patient's diabetes was brought under control and his mental condition improved to the extent that he was able to go out on weekend leaves to visit his family.
In June, 1964, Mr. D. was referred to the Social Service Department for discharge planning, by the attending physician. The Social Worker learned that the patient was pleasant and cooperative only if he had his own way regarding his diet. When Mr. D. was required to pay special attention to his diet in order to control his diabetes, he became stubborn and hostile. In view of his behaviour, extra care, understanding and attention on the part of the nursing staff was required.

Several boarding homes in the community were considered in planning Mr. D.'s discharge, but none of them had the trained staff or the facilities needed for the control of the patient's diabetes and the provision of close care and supervision. Without such services, the patient could not function adequately in the community.

Mr. D.'s discharge planning was, therefore, postponed indefinitely because no suitable accommodation in the community was available.

Case History V

Discharge to Family. Admitted to Valleyview Hospital July, 1963.

Mr. E., eighty-three years of age, is a retired farmer. Until recently he had no problems with either his physical or mental health. He was admitted to St. Paul's Hospital for treatment of diabetes and head injury. A few weeks prior to admission to St. Paul's Hospital Mr. E. had symptoms of confusion and lack of coordination. One day he fell down stairs, lost consciousness; subsequently he became more
confused, restless and drowsy.

In St. Paul's Hospital his diabetes was brought under control in twenty-four hours and his head injury investigated. He recovered from the accident well but continued to be very disoriented and confused. Periodically he displayed episodes of aggressiveness and hostility. As a result no nursing home would take him and he was admitted to Valleyview Hospital.

Mr. E.'s diagnosis on admission to Valleyview Hospital was "Chronic Brain Syndrome associated with Cerebral Arteriosclerosis with Psychosis and Diabetes".

In Valleyview Hospital the patient responded well to treatment and soon became pleasant, quiet, and cooperative in all respects. His movements were rather slow but he was quite talkative and his response generally reliable and coherent. He expressed a wish to go home to his wife and was, therefore, referred to the Social Service Department.

The Valleyview Hospital Social Worker interviewed the patient and later his eighty-one year old wife and it was learned that she was eager to have her husband home again. Only one problem needed to be solved; control of his diabetes. The Social Worker solved this problem. Accordingly, arrangements were made to have a nurse from the Victorian Order of Nurses call regularly to help Mr. & Mrs. E. with the control of Mr. E.'s diabetes.

Mr. E. was subsequently discharged to the care of his wife in October, 1963.

A recent follow-up visit by a Valleyview Hospital Social
Worker indicates that Mr. E. is doing well at home and the couple are very happy.

Case History VI
Discharged to Self-Care.

Mrs. F. is seventy-seven years of age. She was brought, by ambulance, to Valleyview Hospital on January 10, 1964, from her home in Vancouver. She had been in fairly good health and had been able to look after herself until January 7, 1964. Her friend, who accompanied her to Valleyview Hospital, said that he and his wife had called to see her on that date and found her in a state of mental confusion. She had a flight of ideas and believed that her husband had died the night before. He had, in fact, died in June, 1963. The friends managed to calm her, but early next morning the police were called because Mrs. F. was wandering in the street and shouting incoherently.

Mrs. F. was admitted to Valleyview Hospital and her mental diagnosis as "Minimal Degree of Chronic Brain Syndrome associated with Cerebral Arteriosclerosis" and "a History of Epilepsy".

After a short period of treatment, Mrs. F. was transferred from the main Valleyview Building to a "mixed ward". She had improved to a considerable extent, was participating in social groups on the ward and was subsequently referred to the Social Service Department for discharge planning.

Mrs. F. was interviewed by the Social Worker several times and the possibility of discharge to a boarding home was
discussed with her. She wished, however, to return to her own home and be near her friends. This was considered a realistic plan.

In March, 1964, Mrs. F. was discharged to her own home "on probation". A friend volunteered to visit her periodically to ensure that she was managing adequately. Follow-up visits to her home by the Valleyview Hospital Social Worker were made and up to this time she is known to be managing very well.

The cases cited outline some of the successful discharges from Valleyview Hospital to community resources. In addition, one case has been cited which illustrates the problems inherent in discharge from hospital.

CONCLUSIONS

By accepting and implementing the "open door" philosophy of treatment and discharge, Valleyview Hospital has at this time progressed in its thinking far in advance of community resources and community attitudes toward care of psychiatric geriatric patients. This study has pointed out some of the difficulties and problems inherent in the resources presently available in community.¹

THE RESOURCES

1. Family and Self-Care

As presented in Chapter IV, the family is not a major

¹ Despite the inherent problems the hospital in the last Fiscal Year (1964-65) discharged in numbers the equivalent of patients from three hospital wards and admitted for treatment a number equal to nine wards. There are fifty patients on each ward.
resource for the discharge of hospital patients. Self-Care, because of the nature and age of the geriatric patient, is rarely used.

2. **Licensed Nursing Homes**

These have been a reliable and satisfactory resource for hospital patients. Only one return to hospital came from a nursing home. The difficulty lies in the limited number of satisfactory homes available for Valleyview's discharged patients because of a reluctance, particularly in Vancouver where a large number of these homes are located, to accept hospital patients.

3. **Licensed Boarding Homes**

As indicated by the statistics of returns and by the demands for follow-up services, the greatest problems related to discharge lie in this area. The causes are lack of training of the staffs and the lack of a requirement that staff be trained, by licensing regulations. The problems of the patients are not understood and the psychological and social needs of the patients are not met.

4. **"Boarding Homes Special"**

These homes are very suitable for discharged patients, particularly for those patients who require twenty-four hour supervision by trained staff. These homes are, however, limited by their shortage in numbers and by the financial difficulties which deprive welfare recipients of this type of care outside of the hospital.

All the licensed facilities in the community are lacking
in programs of Occupational and Recreational Therapy. There is also a tremendous gap in the type of care and supervision offered between the present boarding and nursing homes. This gap can be filled only by an increase in the number of "boarding homes special" and training for boarding home operators.

VALLEYVIEW HOSPITAL DISCHARGE CRITERIA

An examination of admission and treatment facilities indicate that these aspects of the service are very satisfactory. However, the method of selection and referral of patients for discharge planning is less well structured. The problem lies in the lack of suitable resources in community to accept patients once they have responded to treatment. The criteria for discharge from hospital are restricted because of the necessity of considering what types of resources are actually available within the community.

DISCHARGE

There are difficulties inherent in the communities' attitudes toward discharging patients. Moreover, there remains in the community agencies, particularly in some local Departments of Welfare, the reactionary view that Valleyview Hospital should serve in the role of "home for custodial care".

The Office of the Public Trustee represents frustrating delays in the area of discharge because of the inability to cope with the increasing load which more and more discharges represent.
RECOMMENDATIONS

Based on our conclusions concerning community resources, hospital criteria for discharge and community attitudes toward discharge, the following recommendations are made:

I. Implementation of an organized public relations program is needed within the hospital. With such a program closer liaison with the community in general and with various government departments, particularly the local Department of Welfare, could be maintained. Such a program could interpret the needs of the aged person, generally, but more particularly, could interpret the philosophy, purpose and program of Valleyview Hospital to appropriate community health, welfare, and other agencies, as well as to the general public.

II. Creation of smaller psychiatric geriatric treatment units throughout the province. Some of the advantages of such units would be:

1) To permit the patient to receive treatment within familiar surroundings.
2) To enable community participation and involvement in providing resources such as the licensed homes and Occupational and Recreational facilities within the community itself.
3) To provide smaller units with more individual treatment as opposed to the large impersonal type hospitals.
4) To provide an available resource for day or night care when advisable and desirable thus enabling the patient
to remain with his family while receiving treatment.

III. The establishment of government subsidization for "in-between" care homes. This includes "boarding homes special" and those homes providing "in-between" care on a physical needs basis.

the need for this type of treatment has already been demonstrated in Chapter IV of this study. The present welfare rate for "licensed boarding homes" is insufficient to cover the cost of care provided in the homes already in existence. It is our belief that an increase in the present welfare rate of $50.-60. per month per patient would enable better use of the present homes and encourage the establishment of still more homes of this calibre.\(^1\)

IV. Government subsidization for an after-care program of Recreational Therapy and Occupational Therapy within the licensed homes in community. Until such time as this program can be implemented an increase in the number of occupational and recreational staff in hospital is recommended in order to carry out a weekly program with patients already in community.\(^2\)

V. Compulsory courses for operators of boarding homes catering

\(^1\) The present cost of care in Valleyview Hospital is $7.52 per day (this figure does not include building and equipment costs). The patient pays $1.50 per day of this amount.

\(^2\) The need for such a program has been demonstrated by a study of the Community Chest and Council "A Study of Unmet Needs in the Rehabilitation of the Adult Chronically Ill." A report of the Sub-Committee on Chronic Illness, Social Planning Section, Committee on the Welfare of the Aged, Community Chest and Councils of the Greater Vancouver area, September, 1964.
to the geriatric patient. The leadership for such a program should be provided by Valleyview Hospital. This could consist of an introduction to Valleyview Hospital, its services and discharge program; its changed philosophy toward the aged; and its function within the community. Such an introduction could include a series of evening lectures on selected subjects concerned with the aging process. Valleyview Hospital is presently being used as a teaching facility for student psychiatric nurses from the Provincial Mental Hospital. The assistance of the teaching staff of the Mental Hospital could be of aid in preparing such a course for boarding home operators.

VI. It is strongly recommended that a separate department be created within the Office of the Public Trustee with headquarters at Valleyview Hospital to deal with the legal and financial problems of Valleyview patients. It is felt that such a step, by simplifying the channels of communication between the hospital and the Office of the Public Trustee, could provide an efficient service and reduce the problems presently created by delays in the administration of patient accounts.

FUTURE RESEARCH

Because of the subject matter, this study has been primarily descriptive in nature. In essence it has been an examination of a philosophy concerning, in a broad sense, the acceptance and understanding of the elderly person in society; in the narrow sense, it has been an examination of some of the
problems posed for a progressive Geriatric Hospital, in which
the efforts of all staff members are directed towards appropri­
ate treatment of the mentally ill elderly person and his
return to the community when treatment has been concluded. In
the course of such a pioneer study many questions have been
raised. Such questions can only be posed here. Answers can
only be found by further research.

Translating our questions into concrete research possibil­i­
ities, the following areas of study seem to be important:

1. An assessment of discharged patients - their adjustment
   and social well being within the community.

2. A study of reasons for, and patterns of behaviour in,
   returns to hospital.

3. A qualitative and quantitative assessment of the present
criteria for discharge from Valleyview Hospital with the
use of controlled and experimental groups of patients
within hospital over a specific period of time.

4. A study of community attitudes and agency attitudes
toward Valleyview Hospital; its philosophy, its function,
its facilities. Such a study might reflect changing
community attitudes toward the aging person, particularly
the psychiatric geriatric patient.

5. An assessment of the effectiveness of the "mixed, open
wards" presently operating at Valleyview Hospital. This
is a new experiment introduced in 1963. The effect has
yet to be scientifically evaluated in terms of helping
patients toward rehabilitation and discharge.
6. A study of the possibility of implementing a discharge program at Skeenaview and Dellview Hospitals. These units could become extensions of the model of Valleyview serving some of the needs within the Interior of the Province.

In conclusion, we look optimistically to the future and the effects of the changing philosophy toward the aged in our affluent society. We have tried to indicate some of the limitations apparent in the present community resources and in the government legislation regulating them. Many psychiatric geriatric patients have been successfully discharged from Valleyview Hospital to resources in the community. Many obstacles remain but the ground-work has been laid and the future of Valleyview Hospital as a treatment facility appears to be a bright one.
APPENDIX A

Bibliography
(1) Articles


(2) Journal Reprints


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(5) Pamphlets and Monographs


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(6) Theses and Studies


APPENDIX B

Letters
December 23rd, 1964.

Dr. M. Martin, Chief,
Mental Health Division,
Dept. of National Health and Welfare,
Ottawa, Ontario

Dear Dr. Martin:

I write from Valleyview Hospital, Essondale, the largest of three units comprising the Geriatric Division of the Mental Health Services of British Columbia. The purpose of this letter is to determine whether comparable Institutions exist in other Provinces and if so, to determine their whereabouts so that we might communicate with them to share ideas and experiences with regard to programs.

I would like to state that this hospital has 791 beds and its purpose is to provide treatment and rehabilitation for elderly men and women suffering from psychiatric illness consequent to the aging process. Patients are admitted directly from the Community. Patients with psychiatric disorders of long standing, e.g. Chronic Schizophrenics, are not included. We have an active Rehabilitation and Discharge program.

It would be appreciated, therefore, if you would let me have the names of other hospitals with similar programs.

Yours truly,

J. Walsh, M.B.,
Medical Superintendent.
Dr. J. Walsh,
Medical Superintendent,
Valleyview Hospital,
Essondale, B.C.

Dear Doctor Walsh:

Re: Institutions for the Aged

I was interested in your enquiry as to whether there are comparable institutions to yours in other provinces. I have not been to Valleyview since 1961 but I recall the impressive program and facilities at that time.

The Dominion Bureau of Statistics recognizes nine types of mental institutions, one of which is the "Aged and Senile Home". Valleyview and Dellview are in that category as you will see from the attached Directory.

Some institutions with excellent programs for the aged may be classified in other categories. I do not find Rosehaven which is at Camrose, Alberta, in the 1962 directory. It has a fine program for the aged and you could get details from Dr. Randall Maclean or from Mrs. Olive Noonan, if she is still Superintendent.

You will note that there are five county hospitals listed for Nova Scotia. These hospitals are developing rapidly and there are many aged patients. Dr. Clyde Marshall could provide information.

Your question is an interesting one and I would like very much to hear from you if you make additional discoveries or if you have additional questions.

Yours sincerely,

Morgan Martin, M.D., M.Sc.,
Chief, Mental Health Division.

Encl.
## Directory of Psychiatric In-patient Facilities, 1960

Répertoire des hôpitaux de soins psychiatriques, 1960

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See footnotes and abbreviations at end of directory. — Voir renvois et abréviations à la fin du répertoire.
| Location | Name | Category | Type of Institution | Ownership | Average In-patient Population
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See footnotes and abbreviations at end of directory. - Voir renvois et abréviations à la fin du répertoire.
## Directory of Psychiatric In-Patient Facilities, 1960 — Concluded

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1 Based on period of operation. — D'après la période d'activité.


* Includes temporary transfers from the Provincial Mental Hospital, Ponoka. — Y compris les transferts temporaires de l'hôpital psychiatrique provincial de Ponoka.

### Category — Catégorie

- Pub. — Public
- Pte. — Private
- Fed. — Federal

### Type of Institution — Affection

- Alc. — Hospital for alcoholics — Hôpital pour alcooliques
- A.S.H. — Aged and senile home — Hospice pour vieillards
- Dist. Child. — Hospital for emotionally disturbed children — Hôpital pour enfants souffrant de troubles émotifs
- Ep. H. — Epilepsy hospital — Hôpital pour épileptiques
- Gen. — General hospital — Hôpital général
- H.M. Def. — Hospital for mentally defectives — Hôpital pour déficients mentaux
- Ment. — Mental hospital — Hôpital pour maladies mentales
- Pa. H. — Psychiatric hospital — Hôpital psychiatrique
- San. — Sanatorium

### Ownership — Appartenance

- D.V.A. — Department of Veterans Affairs — Affaires des anciens combattants
- L. — Lay
- Mun. — Municipal
- Prov. — Provincial
- Rel. — Religious

---

Alberta:
- Calgary General Hospital
- Colonel Belcher Hospital
- Rosehaven Home for the Aged
- Provincial Auxiliary Mental Hospital
- University of Alberta Hospital†
- Provincial Mental Hospital
- Provincial Training School
- Linden House

British Columbia:
- Provincial Mental Hospital
- Crease Clinic of Psychological Medicine
- Provincial Mental Hospital (T.B. Unit)
- Hollywood Hospital
- Woodlands School
- Skeenaview Hospital
- Tranquille School
- Shaughnessy Hospital
- Vancouver General Hospital
- Delview Hospital
- Royal Jubilee Hospital

Ownership:
- D.V.A.
- L.
- Mun.
- Prov.
- Rel.

---

1. Based on period of operation. — D'après la période d'activité.

* Includes temporary transfers from the Provincial Mental Hospital, Ponoka. — Y compris les transferts temporaires de l'hôpital psychiatrique provincial de Ponoka.
### Directory of Mental Health Clinics and Out-patient Departments, 1960

**Répertoire des dispensaires d'hygiène mentale, 1960**

<table>
<thead>
<tr>
<th>Location (Situation)</th>
<th>Name</th>
<th>Parent hospital (Institution mère)</th>
<th>Auspices (Responsabilité)</th>
<th>Sessions per week</th>
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See footnotes and abbreviations at end of directory. — Voir renvois et abréviations à la fin du répertoire.
### Directory of Mental Health Clinics and Out-patient Departments, 1960 — Continued

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Directory of Mental Health Clinics and Out-patient Departments, 1960 — Continued
Répertoire des dispensaires d'hygiène mentale, 1960 — suite

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Manitoba

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Saskatchewan

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See footnotes and abbreviations at end of directory. — Voir renvois et abréviations à la fin du répertoire.
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¹ Unless otherwise specified. — A moins d'avoir contraire.
² A — Adults; C — Children. — A — Adultes; C — Enfants.
Dear Sirs:

This letter comes to you from Valleyview Hospital, the largest of three units comprising the Geriatric Division of Mental Health Services for the Province of British Columbia, Canada. The purpose of this letter is to determine whether identical institutions exist in the United States and, if so, to determine their whereabouts so that we might communicate with them to share ideas, concerns and experiences, etc., with regard to respective programs.

First of all, I would like to state that the purpose of Valleyview Hospital (bed capacity of approximately 800) is to provide care and treatment for elderly men and women who are suffering from psychiatric illnesses "consequent to the aging process". Most patients are admitted as certified patients but it is also possible to gain admission on a voluntary basis.

Valleyview Hospital is an institution separated from the large Mental Hospital complex for the Province, at Essondale, B. C. In the performance of our functions and duties, the administration of this hospital is responsible directly to the Deputy Minister of Mental Health Services Branch of the Province of British Columbia.

We feel that we are different from most of the known psychiatric hospitals for the aged in that we are strictly a psychiatric geriatric hospital. An applicant for admission is not actually required to be a certain age such as sixty-five or seventy, but could come into hospital at any earlier age if his mental, emotional, or behavioural disorder were primarily associated with the aging process.

On the other hand, such patients for example as the chronic schizophrenic or the paranoid patient - even of seventy-five years of age - would not be admitted to this hospital if he were basically well oriented but with psychiatric disorders of long standing.
It has been rather encouraging to note the number of our patients whose response to care and treatment permits them to return to community. Such patients return to family or relatives, to Boarding and Rest Homes, and to Private Hospitals in community—depending on their respective circumstances and care needs. The number who return to hospital for further care has been almost negligible. For example—during the first eight months of this fiscal year, 1964-65, we have discharged from hospital one hundred and four patients. During this same period of time only eight patients have returned to hospital and some of these had been out of hospital for as long as two and a half years.

Because of the foregoing and because the field of geriatrics is relatively new, we would like to know about similar institutions so that we might communicate with them.

We would be grateful for any information you might be able to supply in regard to this matter.

Yours truly,

Dr. J. Walsh,
Medical Superintendent,
Valleyview Hospital,
Essondale,
British Columbia,
Canada.

JW:jda
Dear Dr. Walsh:

We wish to apologize for the long delay in replying to your letter, forwarded to the Office of Aging.

We have contacted the Public Health Service and its National Institute of Mental Health to obtain information about institutions in the United States that provide psychiatric geriatric treatment.

The National Institute of Mental Health has made a number of grants to support studies in several institutions. A few persons to whom you may address inquiries are:

(1) Mrs. Marjorie Fiske Lowenthal, Langley Porter Neuro-psychiatric Institute, 401 Parnassus Avenue, San Francisco, California. This institute, for the past six years, has engaged in a research study centering about mental health problems of aged patients admitted to and discharged from a city general hospital.

(2) The Director, Ypsilanti State Hospital Ypsilanti, Michigan; also Dr. Wilma Donahue, Chairman, Division of Gerontology, The University of Michigan, 1510 Rackham Building, Ann Arbor, Michigan. Dr. Donahue has conducted a number of comprehensive studies on the geriatric mentally ill at Ypsilanti.

(3) Superintendent of Boston State Hospital, 591 Morton Street, Boston 24, Massachusetts. They did a study of geriatric patients admitted to a state mental hospital; a multidisciplinary team investigated physical, social, economical, and emotional problems of such hospitalized patients.
(4) Superintendent of DeWitt State Hospital, Auburn, California. They conducted a study to evaluate the potentials for social rehabilitation of state mental hospital patients, 65 and over, including patients in a wide variety of diagnostic categories, and varying periods of hospitalization. The study centered about pre-placement services, follow up, and community services.

(5) Mr. Jack London, Administrator, Villa Selicinia Geriatric Hospital, Jackson, Louisiana. The Villa is reported to have geriatric wards of good repute. Their main objective is to relieve the pressure upon psychiatric institutions throughout Louisiana, and improve the care of the geriatric patient who does not require extensive psychiatric hospitalization.

I hope the foregoing information will still be timely and useful.

Please let us know if we can be of further assistance.

Sincerely,

Donald P. Kent
Director

Dr. J. Walsh
Medical Superintendent
Valleymount Hospital
Essondale, British Columbia
Canada

Ministry of Health,
Alexander Fleming House,
Elephant and Castle,
London S. E. 1, ENGLAND

Dear Sirs:

This letter comes to you from valleyview Hospital, the largest of three units comprising the Geriatric Division of the Mental Health Services for the Province of British Columbia, Canada. The purpose of this letter is to determine whether identical institutions exist in the United Kingdom, and if so to determine their whereabouts so that we might communicate with them to share ideas, concerns and experiences, etc., with regard to respective programs.

Valleyview Hospital (bed capacity approx. 800) is designed to provide care, treatment and rehabilitation for elderly men and women who are suffering from psychiatric illnesses (consequent to the aging process). Most patients are admitted as certified patients but it is also possible to gain admission on a voluntary or informal basis.

Acceptance for admission is based on clinical factors in accordance with illnesses restricted to aging rather than on a specific age. This would exclude chronic psychoses e.g. Schizophrenia or dementias due to other causes.

My experience in Mental Hospitals in England up to 1952 suggests that Geriatric Psychiatry may still be part of each Mental Hospital program. Under these circumstances our statistics would not be comparable.

I have reason to believe, however, that much progress in geriatrics has been made in recent years and would be grateful for any information you may be able to supply on this matter.

Yours truly,

J. Walsh, M.B.,
Medical Superintendent,
Valleyview Hospital,
Essondale, B. C., Canada

JW:pw
Dear Sir,

I am replying to your letter of 27th January.

The responsibility for the provision of services for the elderly mentally infirm in Great Britain is jointly held by the Local Authorities and Hospital Services.

Local Authorities care for the majority of such patients in welfare homes, but it is recognised that there is a need to separate the more difficult management problems into Homes for the Elderly Mentally Infirm.

If the Local Authority are unable to manage elderly infirm patients because they are in need of considerable nursing care, or other facilities of a hospital, the patients may be admitted to a geriatric unit. Here assessment of medical, psychiatric and social factors take place, and the disposal of the patient is decided.

The majority of such patients are sent to, and are looked after, in chronic annexes to geriatric units. The patients with more difficult behaviour problems (because of dementia or personality disorder) are looked after in psychiatric hospitals.

Another facility, of which increasing use is being made, is the Day Hospital. This may cater for the aged with physical handicaps, the elderly mentally infirm or both. There seems little doubt that this type of facility is useful in (1) facilitating early discharge of patients, (2) lightening the burden on relatives, and thus enabling patients to stay in the community, who would otherwise have been admitted to a long-stay bed. You may care to write to Dr. L. Z. Cozin, Clinical Director Cowley Road Day Hospital Oxford, for further information in this field.

You may also be interested in the study done by Dr. C. B. Kidd at Purdysburn Hospital Belfast, published in the British Medical Journal, Volume II page 1491, 1st December 1962; or in Professor Martin Roth's study carried out in the Newcastle-upon-Tyne area and published in the British Journal of Psychiatry, Volume 110, pages 146-158 and 668-682 in February and September 1964.

I should stress that I have used the term "elderly mentally infirm" to indicate aged individuals who have a mild degree of dementia, often accompanied by physical handicap. There are of course a group of patients whose main problem is a potentially recoverable psychiatric condition, (e.g. depression, paraphrenic); these are dealt with by psychiatric units and are frequently able to return to the community.

Yours faithfully,

J. Walsh Esq. M.B.
Medical Superintendent
Valleyview Hospital
ESSONDALE B.C. CANADA
APPENDIX C

Nursing Form
ASSESSMENT FOR PROSPECTIVE DISCHARGE PATIENTS - NURSING

Ward: ____________  Patients's Name: ____________________________

Physical care needs: Please note if patient requires help or supervision with any of the following activities:

1. Dressing neatly and appropriately
2. Washing hands, face and teeth, caring for hair and shaving
3. Bathing
4. Using the toilet
5. Getting up or going to bed
6. Walking (stairs or level)

Does patient eat well?

Any special problems?

Is special diet required?

Are table manners disturbing to others?

Sleep well?

Does patient snore, scream or wander at night?

Incontinent?

Constipation?

Could patient care for own room?

Help around house?

Attitude to medication: cooperative?

Requires supervision?

Resists?

Sight:

Hearing:
Nursing Form cont'd.

Social patterns: Interaction with other patients -
  friendly;
  shy or withdrawn;
  controlling;
  critical;
  sarcastic or quarrelsome?

Interaction with staff - What attention
does patient require from staff (other than physical care
needs)?

Does he/she make excessive demands on staff?

What means of control seem necessary or effective?

Interested and visiting relatives and friends:

Has leave been permitted?

Has he/she ground privileges?

Nurse's evaluation of patient's ability to function in
boarding home/nursing home placement:

Please add any comments that person caring for patient should
note.

Date: ___________________________ Charge Nurse: ___________________________
APPENDIX D

Boarding and Nursing Home Questionnaire
QUESTIONNAIRE FOR BOARDING HOME OPERATORS AND NURSING HOME MATRONS

A. 1. (a) Identifying Information

Name of Home -
Address -
Type of License - nursing home/boarding home
Owner -

(b) Finances

Number of private patients -
Number of welfare patients -
Sex: M - F -
Total ---

Is cost determined by:
a- physical facilities? (i.e. private room, ward)
b- the individual care needs?
c- by patient's ability to pay?

Range of Costs -

2. Measurement of the home "tolerance level" and ability to cope with the psychiatric geriatric patient.

(a) Are there patients who are:
- incontinent? (if yes, is cause physical or mental)
- not ambulatory? (include bed patients, deck chair, wheelchair and those who can walk only with assistance)
- delusional? (details)
- hallucinating? (visual? auditory? details)
Questionnaire cont'd.


- wandering? (if yes, means of control)
- restless at night?
- irritable, agitated:

(b) Any patient on discharge from Valleyview?
Any patient on waiting list at Valleyview? Why?
Admitted to Valleyview? Why?
Are there patients presently in home from P.M.H.? Crease? other boarding home? nursing home where patient evicted?

3. **Staff and Patient Responsibilities**

What is the ratio of staff to patients?
What is the time extent of care and supervision offered by staff on a daily basis? (maximum-24 hrs.)
What responsibilities are expected of patients? (i.e. caring for own room, own laundry, etc.)

4. **Medical**

Is there a house doctor or individual family doctors?
Are tranquilizing medications used? to what extent?

5. **Staff Training**

a. psychiatric nurses
b. registered nurses
c. trained practical nurses, aides and/or orderlies. where trained?
d. untrained but with previous experience in homes
e. none of the above

Worker's comments: ---