A "WHITE CROSS" SOCIAL CENTRE


by

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ABSTRACT

In 1956 plans were begun for the establishment of a Social Centre sponsored by the Canadian Mental Health Association in Vancouver, B.C. as a special resource for former patients of mental hospitals. It was opened in 1959. This thesis makes an appraisal of the Social Centre, the relevance of its initial planning, and the quality of its first year of operation.

Such a Social Centre is significant in social work because it demonstrates contributions from groupwork, casework and community organization while the setting is new enough to invite further experiment.

This survey employs the following techniques: the study of records; interviews with staff members, volunteers, and workers in related fields; and comprehensive interviews with a selected group of Social Centre members.

This study (a) confirms that careful preliminary planning, based on a study of needs, resources, and on evaluations of similar projects in other cities, substantially aided the experiment in achieving its aims. It is evident (b) that a professionally-trained social worker, with a knowledge of groupwork techniques and a knowledge of resources in the community was of value in setting up this service; and finally, (c) that the members themselves, given encouragement, can take much of the responsibility for the operation of the Centre. Continuing needs include (a) a broadening of membership to other categories than the present ones, (b) more centres to serve other districts, and (c) the co-operation of such allied agencies as neighborhood houses, "Y's", etc.
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A "WHITE CROSS" SOCIAL CENTRE

CHAPTER I

RESOURCES FOR THE MENTALLY ILL: THE CONTEMPORARY CHALLENGE

In August, 1959, the Vancouver Branch of the Canadian Mental Health Association, (C. M. H. A.) opened a "White Cross" Centre to meet the social rehabilitation needs of persons living in the community who had recently been discharged from mental hospital. This was prompted by various factors, some of which have been with us for many years, but some of which have been created only recently by a more enlightened attitude in medical treatment of the mentally ill. The White Cross Centre is only one of the services within the community which has made its appearance within the last five years or less, but it is unique in that it devotes itself particularly to the social rehabilitation of the patient. This paper is an evaluation of the first year of its operation, an examination of the casework-groupwork approach in social work employed there, and some of the community organization principles employed which made it a success. In order to see its place in the community and the reasons for its inception, it is necessary to look at the general picture of mental health services and attitudes in B. C. today.

Background

Since the beginning of this century, there seems to have been a steady rise in the incidence of mental illness in North America. In the Province of British Columbia, we have witnessed
the expansion of our Provincial Mental Hospital at Essondale, until now it has the aspect of a small city, complete unto itself with a population of over two thousand. Many factors have contributed towards this increase: the rise in the general population, improved medical skill in diagnosis, and particularly the stress of modern urban life. There are, in the hospital today, emotional casualties of frontier life, the great depression, two world wars and perhaps the tensions of the atomic age. When the population of the mental hospitals had reached alarming proportions, a combination of circumstances occurred which began to turn the tide. In 1958, the P. M. H. discharged more patients than it had admitted in any one year since it opened in 1911.¹

During this century, both at home and abroad, there have been developments in technique which have helped the psychiatrist to deal with these increasing problems. In the tradition of the great discoveries of Freud and his contemporaries and followers, psychotherapy has been explored and refined until now it can be used in the knowledge of its strengths and weaknesses. Electrotherapy, once a controversial issue within both professional and lay circles, now has a specific place in the care of the patient. Social work entered the picture in 1936 and can be proud of the contribution casework services have made towards more comprehensive care of the patient. Somatherapy, insulin therapy,

psychology, occupational therapy, recreational therapy, industrial therapy - these are some of the many contributions towards the treatment of this most baffling of human ailments.

During the past few years, a discovery was made which assisted all these therapies and changed, and enhanced, the results of treatment. This is the use of a group of drugs known as antaractics or tranquillizers. These drugs have the effect of controlling violent or other extreme symptoms and making the patient available for treatment of a specific nature, such as psychotherapy or casework. It has been found that early treatment is absolutely necessary for most types of mental illness. A patient who enters hospital in the early stages of psychosis is treated with antaractics for the first few days or weeks, then is available to the hospital team of experts: psychiatrist, social worker, psychologist and others, who concentrate on his treatment. It is usual now for many such patients to be discharged in less than four months, sometimes much less.

Although antaractics do not have any effect on some patients who have been in hospital for many years suffering from deeply entrenched schizophrenic reactions, they do bring about startling changes in many. This group reacts to the drugs in such a way that their most distressing symptoms disappear and they are enabled to move out of the hospital setting and take up a quiet life in a sheltered or supervised situation. With this group it is a matter of salvaging what is left of a badly damaged life, and making the most of what is left.
Thus we see that the skillful uses of drugs in combination with other therapies have reduced symptoms of mental illness and in some measure restored the use of mental faculties, but it is a mistake to think that all patients so treated and discharged are cured. Social inadequacies, always present in mental illness, are in many cases, the major obstacles to rehabilitation, once the symptoms of the disease have disappeared. Long years in hospital have severed contact with families and friends. Years of relative inactivity and institutional living have weakened skills and greatly reduced chances of employment. After a patient feels, upon discharge, like Rip Van Winkle, a stranger in a world he once knew so well. The more recently treated patient, although fortunate that he is likely to escape the long hospitalization, has still to make his way in the community in spite of the handicaps he might have sustained.

The community is, as it were, asked to share in the care and rehabilitation of the mentally ill. How is the community reacting to this demand? Is the hospital providing in the community services which will take the place of hospital care where it is needed? Do both community and hospital understand the nature and extent of this new role? As in most new things, there is likely to be a positive and negative side to the answer. Much yet remains to be done in reforming the public's attitude and sense of responsibility towards the mental ex-patient, but much has already been started and achieved as well. New and imaginative services have come to the fore which attempt to meet
the many needs posed by this change in focus.

Boarding homes, inspected, licensed, and supervised by the social service departments of the mental health services, provide a place to live in the community for those patients on probational discharge who are well enough to take advantage of such services, but who either have no homes of their own or who cannot, for one reason or another, return to their homes. At the time of writing, there are about one hundred persons living in such situations. There are others, discharged in full, living in these and similar homes who have completed a six months probationary period. The social service department has helped the ex-patients to move slowly from hospital to community, and helped the community, through the supervised boarding homes, to accept them.

Another interesting service originated by the mental health services in 1958 is the Sustaining Clinic in Burnaby, the first one of its kind in Canada. It performs the unique function of providing care for patients, similar to that which they would receive in hospital, but allowing them to live at home or elsewhere in the community. A team of doctors, social workers, nurses, psychologists, and occupational therapists meet the patients on a daily basis. This enables about sixty patients to

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live in the community with treatment. An additional service is an evening clinic which gives a minimal service twice monthly to a large group of patients who can function adequately but with less intensive attention. These patients often have regular employment or carry on their duties as housewives during this time.

Two "halfway" houses are operated by the mental health services in Vancouver: "The Vista" for women, and "The Venture" for men. These provide a home for the patient during the first few weeks after his discharge, before he moves back to his own home, or finds one for himself in the community. Here a warm understanding atmosphere prevails, psychiatric and social work consultation is available, and time for reorientation is provided.

There is now a noticeable tendency for Out Patient Departments to take a more active part in the care of mental patients. Many patients are treated at the Vancouver General, Shaughnessy, and Westbrook Hospitals and returned to daily life before hospitalization becomes necessary. In December, 1961, the Provincial Hospital itself opened an After Care and Rehabilitation Clinic in Vancouver for the care of the discharged patient. The psychiatrist and social worker who treated him in the hospital are available here for consultation, wherever the ex-patient happens to be living. The Ross Report\(^1\) called for

long-range plans for mental hospital facilities in the future to be dispersed throughout the province, attached to existing general hospitals or in small clinics more readily available, geographically, to the public. It is hoped that eventually the large, over-crowded mental hospitals, situated by themselves, far from the life of the city, will cease to be the focus of treatment and might in time disappear altogether.

Community services concentrate on assisting the patient to live outside the hospital, but the emphasis is on medical and casework treatment for the individual. It is only in isolated cases where a patient is actively assisted in his social rehabilitation with groups. Mental illness severs ties with friends and families. It also damages self-confidence, increases fears, and creates that most harrowing of human conditions, loneliness. Is life worth saving, worth struggling against odds to maintain, if it is to result in loneliness? Some patients, overwhelmed by the pressures which beset their rehabilitation, living alone, in reduced financial circumstances, unable to find suitable employment, have reason to doubt it.

It is to fulfill this need that the White Cross Social Centre of the C. M. H. A. came into being in the summer of 1959. Here the discharged mental patient could find friends who had had a similar background of experience; here he could test and reclaim his impaired or lost social skills, here he could talk to a social worker about the day-to-day problems of getting along with fellow human beings.
The time is now ripe for an evaluation of the effectiveness of the White Cross Centre. Since it was a response to a need which arose in the community, and was made possible by the community itself through the leadership of certain informed and energetic persons, its planning and development is exciting as a case history in the newest branch of social work, "Community Organization". The initial stages of the venture are particularly interesting because considerable efforts were made to set goals and standards and to foresee difficulties in advance. All too often an account of this important aspect is lost by the time an organization is recognizably successful. It is fortunate that such an account is available for the White Cross Social Centre.

Review and Evaluation

This paper will be an attempt to describe the White Cross Social Centre using all available sources and date. This will include the excellent annual report, published in 1960 by the director, extracts of which are in the Appendix. It will include material gathered from interviews with board members who were involved in the planning of the Centre, and community persons who contributed support. It will concentrate on material gathered in interviews with White Cross Centre members themselves, social workers who referred them and carried their cases,

doctors active in their treatment, and C. M. H. A. staff members. Much will also be based on the personal observations of the writer who spent the 1959 - 1960 academic term there as a first year student at the School of Social Work, University of British Columbia. This evaluation will be guided by social work theory of casework, groupwork and community organization, interpreted without any attempt to test the concepts per se.
CHAPTER II

PLANNING A SOCIAL CENTRE: THE VANCOUVER EXPERIMENT

The Canadian Mental Health Association has its roots in the Mental Hygiene Movement in the United States. This was founded in 1908 by Clifford W. Beers who himself had been a mental patient for a period of three years. During this time, he experienced, in three different hospitals, the kind of treatment afforded to patients as permissible and justified at that time. He had been beaten, humiliated, and disgraced, then discharged to find himself a victim of the prevailing public attitude towards mental patients. This was that the condition had been visited upon him because of some sin in his past and that "once mad, always mad," he could not be trusted to live a normal life again.

Clifford Beers, endowed with great natural gifts as a writer, speaker, and organizer, determined to devote his life to changing the lot of his fellow patients. Five years after leaving hospital he published his autobiography, A Mind That Found Itself.¹ In this remarkable book he described his experiences, his discoveries, and his beliefs. It was not only as expose of the shocking conditions found in the hospitals (there had been

these before) but also a plan for prevention of mental breakdown and rehabilitation of patients as well. This book appeared at a time when reform was on the march in other fields of social welfare as well.\(^1\) In England, a long series of reforms by eminent individuals and by the Charity Organization Society and the Fabian Society were culminating at this time in the repeal of the Poor Law and all the changes that that entailed. In America, similar changes were taking place in factory conditions, living conditions, rights of women, health and sanitation, and child labour laws. Prosperity had come to America and shone a bright light on many of its less worthy accomplishments. The time was ripe for Clifford Beers who was to wage a ceaseless battle against the whole problem of mental illness. He had gained the respect of the medical profession by his scholarly approach, and he had inspired the public with his sincerity, his sense of justice and his determination. Three years after the publication of his book, he founded the Connecticut Society for Mental Hygiene, and the next year, this became a national organization. Its aims were threefold: to raise standards of care in mental hospitals, to prevent, and to cure mental illness. Until his death in 1943, Beers fought to fulfill his hopes and succeeded to a remarkable degree, matched only by his convictions, his energy, and his dedication.

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Ten years after the Connecticut project, the movement began to find support in Canada. Since 1918, the Mental Hygiene Movement, now called the Canadian Mental Health Association, (C. M. H. A.), has contributed towards mental health by support of investigation and reform in hospitals; education of psychiatric nurses and social workers; pioneering research into new fields of service for children and the aged; and in prevention and cure in treatment. Much has also been done towards making the mental patient more accepted in the community by a combination of public education and personal contact in the form of volunteer visitors in the mental hospitals and help to patients after discharge. The movement gained momentum in the years following the first world war and, in time, had branches in all the major centres across Canada.

C. M. H. A. (Vancouver Branch)

The first headquarters of the C. M. H. A. in Vancouver was a one-room office on Pender Street. Under the guidance of Mr. James Ward, the Executive Director, membership grew rapidly from the beginning. This first enthusiastic group began the task of influencing the public attitude towards mental illness by organizing discussion groups, giving talks to service clubs, church and professional groups, and in every way possible making their voices heard. This enormous task, undertaken by a group with such small beginnings, was only possible because of the painstaking attention to small details and by building one success on another.
Volunteers

One important step which was to lead to many projects and open up new fields was the formation of a group of volunteers to work in the Provincial Mental Hospital at Essondale. The members of this group began to study the needs of the hospital patients by talking with them and the nurses and other staff members of the wards. They instituted a programme of visiting the patients, some of whom had had no contact with the world outside the hospital for many years. They cooperated with the Recreational Therapy and Occupational Therapy Departments in such activities as tea parties, picnics and car drives. Whatever the kind of activity in which they engaged, it was the warm personal concern and interest which was so appreciated by the patients who began to feel that, for the first time, someone from outside the hospital cared what became of them. The better the volunteers became acquainted with the problems of the patients and staff, the more they were able to contribute.

One significant contribution which grew into a well developed part of the programme was the interest taken in the patients' clothing. The volunteers noticed that the clothing worn by many of the patients was shabby and ill-fitting. The effect was depressing. It had been the custom of the hospital to allow patients to wear their own clothing, but when they had none of their own, hospital clothing was supplied. This was all too often drab, shapeless and utterly cheerless. The volunteers launched a city-wide campaign assisted by the press, radio and
television to collect good used clothing, including accessories, jewelry and underclothing. This was given prominence in the campaign by several of the city's most fashionably dressed women making a substantial contribution. The volunteers were given several rooms by the hospital administration, conveniently located on the ground floor of the East Lawn Hospital. Here they opened an Apparel Shop. With a referral from a head nurse, patients, men as well as women, can now have a new outfit of clothing. Of course, a volunteer agency could not undertake to clothe all the patients in such a large hospital, but they do make a colourful difference. There is enough clothing for patients to have some new things while in hospital, and a complete new outfit upon discharge. This single contribution has changed not only the appearance of the patients, but has raised their morale as well. From contacts like these, the volunteers were beginning to gain a new understanding of the patient as a person.

Open Door Service

One characteristic of C. M. H. A. programmes, wherever they are found, is an Open Door Service. This is an opportunity for members of the public to come in to the office and seek help in problems related to mental health in its broadest sense. The Marriage Counseling Service is one result of specialization of service, based on inquiries which were presented here. The staff was also concerned about the number of problems related to the rehabilitation of the patient released from mental hospital. These
were present in persons from all classes of society and seemingly in all stages of mental health or ill health. It was the volume and urgency of these questions, and the concern and growing awareness of the volunteers who had gone into the hospital, that pointed the need for services designed specifically to assist the patient returning to the community.

Early Plans

At the 1956 National Conference of the C. M. H. A., the executive director from here became interested in the plans and operation of a Social Centre for ex-patients from mental hospital which had recently been opened in Regina. This was a social club, held in several rooms on the premises of the C. M. H. A. office. The purpose of the club was to provide these people with an opportunity to test their social skills, make friends, and enjoy the benefit of mutual support during the time of stress upon leaving the hospital. Although this club was in little more than a beginning phase, the executive director could see its potential strength. A similar club had been started in New York, but evaluation material was not yet available.

Convinced that such a Centre should be opened in Vancouver, and that it would be within the capabilities of the C. M. H. A. to do so, in June of that year the Executive Director submitted the first of three briefs to the Board of Directors, suggesting such a move. These briefs outlined the needs of the ex-patient in the community as they had been seen by the Open
Door workers and the volunteers. The main problems were: (a) finding suitable living accommodation, (b) finding suitable employment, and (c) making friends. The brief suggested that the expanding programs of the C. M. H. A. should focus on the field of social relations and leave the other two areas to other agencies specializing in them. In particular, it recommended the operation of a Social Centre on the same premises as the offices which would provide room for a clubroom, a recreation room, kitchen and quiet library. The Board of Directors was interested from the beginning, but decided before going ahead to make a careful study of existing services in the community.

**Mental Health Centre**

In January of that year, 1956, the Mental Health Centre (M. H. C.) at Burnaby had been started, with the purpose of operating the Sustaining Clinic. The staff there had noticed from the beginning that social contacts of these people outside the hospital was seriously lacking. They had appealed to the C. M. H. A. for volunteers to work with the staff and provide a social occasion on the evenings when the Clinic was in operation. In fact, the social evening preceded the opening of the Clinic by several weeks. Was this not already fulfilling the social needs of the patients? After discussions with the staff at the Clinic, the Board of Directors decided that the service they proposed was different in scope, that it would neither interfere with nor duplicate the social evening at the M. H. C. Also, the
The proposed Social Centre would be available to a much larger group of people than the Clinic. While one service would be primarily a hospital setting, with a medical team in attendance, the other would be community-focused. As events proved, this was to become one of the most valuable aspects of the Centre, helping the patient to feel more independent and free from the hospital.

The Planning Committee

As soon as the Board of Directors had accepted the proposals, it appointed a Planning Committee, composed of some Board members and some interested persons from the community. It is to this Planning Committee that much of the credit for founding the Social Centre must go. By this time, a report was available from Regina, a one-year study from San Francisco, and a newsletter from another social centre called Fountain House in New York. These reports, plus a knowledge of the needs of the persons to be served, formed the basis for planning.

The first task was to launch a vigorous and far-reaching campaign of community organizations in order to gain public acceptance of such a venture within the community and also to raise the required funds. This was done in many ways. The press gave it

\[1\] Progress Report on Fellowship Club of San Francisco, May, 1956 through April, 1957.
much constructive and helpful publicity with pictures, articles and stories. Radio, in particular private stations, was outstanding in its contribution. Interviews of Board members, feature stories, direct appeals for funds and a variety of other broadcasts made their appearance in quick succession. Some contacts were made at this time with generous and creative people who joined the organization and stayed with it after the need for funds was over. These contacts led to others. For instance, a popular newspaper column called "About Town" was edited at this time by Miss Barbara Strong, whose family was closely involved with the founding of the G. F. Strong Rehabilitation Centre. Miss Strong organized a fashion show, featuring popular Vancouver singers and actors as models, which raised twenty-three hundred dollars for the campaign. This was the largest single contribution and was used to make small renovations to the building and provide the unusually attractive furnishings.

As the organization in the community began to attract attention, not only new services came into being such as the one mentioned, but established service clubs took part as well. The Kitsilano Kiwanis Club made a generous offer to underwrite the rent of the building for the first three years. They too, became involved in volunteer services and have done, among other things, any necessary carpentry work during the whole time of the operation of the Centre. Other smaller groups contributed funds, recreation equipment, a piano, volunteer service, a library of well chosen books, and much moral support.
If the Planning Committee had tried to do all this on its own, it is doubtful if so much would have been achieved in so short a time. But appealing to the community, involving the community in so many aspects of organization and delegating responsibility and decisions to responsible parties under the direction of the Planning Committee helped to launch the venture. These community contacts were to prove valuable during the years ahead when a sustained community interest was necessary to ensure its continued operation.

**Community Chest**

Only the salaries of the staff members and the operational costs of the office had not been met by the donated funds. With the approval of the Board of Directors, the executive director presented the case to the Community Chest. The Chest committee decided to take on these costs as a pilot project to last for one year, and if the project proved successful, to consider taking this responsibility on permanently. It now remained for the Planning Committee to find a director who would be capable of fulfilling these hopes and plans.

**Director**

In looking for someone to fill the position of director of the Social Centre, the Committee laid down general, rather than stereotyped requirements. They wanted someone who, "by education, experience, maturity and philosophy", would qualify as a
helping person; someone who had demonstrated a sensitivity to people and an understanding of the problems of the mentally ill. It would also, of course, be important at this state of the Centre's development to have a director who would be able to cooperate with the hospitals and agencies and set up a system of referrals. The choice fell to a recent master's graduate from the U. B. C. School of Social Work (Mr. B. Chud). Once appointed, the new director participated in all further planning and operation of the Centre.

Operational Details

It was decided at the beginning that the primary contact with the referring agencies would be with the heads of the social service departments, since the Centre proposed to be a resource effecting the social rehabilitation of the patients. The new director, in these initial stages, visited Crease Clinic, the Provincial Mental Hospital, the Mental Health Centre, Shaughnessy Hospital, the Vancouver General Hospital, as well as the Family Service Agency and neighborhood houses. After consultation with several selected social workers from the various agencies who would be directly involved with making referrals, these three main criteria for membership were established:

(a) All referrals from hospital settings were to be processed through the Social Service Department of the Hospital. The reasoning behind this was that many discharged patients would be asking for and would be in need of help other than that which could be provided at the Centre. The proper source for such aid was the Social Service Department. This procedure would enable them to refer back to
Social Service members who raised such problems.

(b) The discharged patient best able to benefit from the Social Centre would be the one who was confronted with social isolation upon discharge. A display of some motivation in surmounting social isolation was considered to be a necessary prerequisite for referral.

(c) The age group served at the Centre was to be in the adult category (about 25 to 55 years of age). Teenagers and senior citizens would be excluded for the present at least.

The requirements went on to outline details of procedure and to give the director the power to make final decisions concerning eligibility.

Since the operation of the Social Centre was a pilot project as far as the Community Chest was concerned, it was necessary to plan for evaluation from the beginning. The director drew up statistical forms, referral forms, evaluation report sheets, invitations to join, and so on. Because of their importance in evaluation and research, these have been assembled in Appendix "B".

Advisory Committee

Shortly after the Centre opened, but as part of its concept of planning, an Advisory Committee was formed. This was composed of a psychiatrist, a general practitioner, the assistant professor (groupwork), School of Social Work at U. B. C., and the director of the Recreation and Groupwork division.

Community Chest and Council. This group, together with the executive director of the C.M. H.A. and the director of the Social Centre, met several times during the year to discuss aspects of policy and operation which affected both the Centre and its place in the community.

Social Work Methods

No special plans were made for counselling at the Social Centre, except that each member would be interviewed before or shortly after joining the group. It had been decided by the Planning Committee that the director would provide: supportive casework services when these were sought; diagnostic casework services in cases where patients might be deteriorating or in need of referral back to their social worker; or helpful guiding of individuals towards agencies appropriate to their needs. Lengthy, on-going casework was to be avoided as incompatible with the aims of the Centre. Social groupwork, as taught in Schools of Social Work in Canada, would be the dominant focus, with casework added as a supplementary service where indicated. The director was a man of sufficient professional training and competence to handle both aspects.

On the day of the opening of the Centre, in July, 1959, "Open House" was held by the Board of Directors, to which were invited the many people in the community and in the professions who had contributed to its organization, thus handing back to this group some evidence of their efforts and support. These then,
were the principle preparations which went into the Social Centre before the ex-patients were invited to join.

The Fellowship Club, San Francisco

In 1956, a club with aims similar to the proposed Vancouver club, had been started in San Francisco. Although a brief progress report had been available in 1957,\(^1\) it was not until May, 1959, that a comprehensive evaluation of the project was published.\(^2\) Since these two clubs had much in common, and since the evaluation study was used as a resource in some of the planning which followed in Vancouver, it might be of value to examine its aims and conclusions at this time.

The Fellowship Club was a pilot project set up and financed by the San Francisco Association for Mental Health, an organization comparable to the Canadian Mental Health Association. This project was to be evaluated after a two year period by an evaluation committee, and a decision made at that time about its continued sponsorship. A Social Club Planning Committee, under the Board of Directors, was made responsible for the supervision and administration of the project, and was expected to make suggestions on matters of policy as the need arose.

The aims of this Social Club Committee were "to set up

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\(^1\) Progress Report on Fellowship Club of San Francisco, May, 1956 through April, 1957.

an experimental demonstration of a transitional therapeutic social club for convalescent patients released from psychiatric hospitals and to test the effectiveness of such a club as part of a multidiscipline community supported programme of treatment for the mentally ill." Its specific function was to aid the members of the club in their social rehabilitation through membership in a club composed of individuals facing common problems of resuming community life outside a hospital, and a common difficulty in making social relationships. The club was organized with professional direction, although it used the services of two volunteers as specialists in programme skills. A special unit of volunteers was established within the framework of the association's regular volunteer service programme.

The members were referred by community psychiatric facilities or private psychiatrists. It was assumed that the members were to have sufficient motivation for attending the club on their own initiative, and were to subscribe to certain overall policies such as to refrain from raising funds. The decision for suitability of memberships rested ultimately with the director. There were plans for membership of no more than fifty, and a limit of two years was placed upon the length of membership. This was imposed because, since the club was a step towards integration with the community, it was felt that some limit should be placed upon that step in order to avoid dependency, and encourage exploration of other facilities.

A Special Advisory Committee was set up to act as a
guide to the director. This group was not to interfere with the operation of the club, but to make studies, pass on suggestions, and help in the selection of staff.

The evaluation at the end of the first two years found the planning to have been sound and the results gratifying. Despite many staff changes, the only change made in the policy was the one which limited the time of attendance to two years. It was found that different persons had differing periods of time for adjusting to the community and that an arbitrary time was neither helpful nor feasible. The time limit was extended indefinitely.

They found many advantages to having two staff members, particularly a man and a woman at the same time. They felt that this gave a balance to the programme, a broader basis for diagnosis, a "parental" feeling to the relationship and a continuity to the programme when one staff member left. They stressed the fact that the leaders must have a common goal for the club and must accept each other in order to give security to the "family" of members.

The Special Advisory Committee had been abandoned during the first year and its function assumed by a Professional Advisory Committee composed of persons from related fields in the community. The Evaluation Committee favoured the use of the social groupwork method, rather than group psychotherapy, as being more directly related to the socialization process.

There are many factors in common between the White Cross
Social Centre and the San Francisco Fellowship Club. Comparisons will be drawn in Chapter IV, after an evaluation of the operation of the Social Centre has been made.

Community Organization

The Social Centre was a gesture of the community in accepting the ex-patient from mental hospital. As such, it is an interesting example of that newest branch of social work, community organization. Murray Ross, in his book, *Community Organization Theory and Principles*¹ has reformulated the basic principles of social work as they apply to this new and growing science. It might be of value here to examine the planning and operation of the White Cross Social Centre in relation to his main principles and use them as a guide in evaluating the planning of the Centre. These are concepts which apply to any community organization project, not necessarily one which is under the guidance of a social worker trained in this field.

Ross' first and perhaps most important principle is that "discontent with the existing conditions in the community must initiate and/or nourish the development of the Association." We have seen that, in the case of the Social Centre, requests for such a service come from the public through the Open Door inquiries, families directly concerned with discharged patients, social

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service staffs of the hospitals and from the C. M. H. A. volun-
teers who worked in the wards of the hospitals. The Mental Health
Centre in Burnaby had seen indications of social deprivation which
it was not able to meet on a large enough scale. Also, and this
cannot be underestimated, there was, at that time, a quickening
of interest in mental health on a national scale. Radio, tele-
vision, documentary movies, magazine articles, had taken up the
cause. Also, the evils and benefits of tranquillizing drugs had
just reached the public by some of these media and had heightened
awareness of the problems. The staff of the C. M. H. A. itself
had been encouraged by the beginnings of a Social Centre reported
from Regina and San Francisco. Other communities were seeing
similar problems and making attempts to meet them. This then,
was not an idea imposed on the community from without, but one
which had arisen from widespread discontent in the community it-
self. The concern about problems of mental health had not reached
the proportions it had over cancer, poliomyelitis or heart di-
sease, but it had reached a point where it was sufficient to mo-
tivate the public to "initiate and nourish" the development of
the Social Centre.

A second principle of community organization is that
this discontent which initiates and sustains an organization must
be widely shared in the community. Again, relatively speaking,
it is not widely shared in a general way such as the concern for
education of children, but was widely shown by those concerned
personally with the problems; i.e. friends and families of
patients, volunteers in hospital and so on. The Kiwanis Club has long been identified with service to the community and the local branch was quick to take up this immediate need. The newspaper, radio and television coverage was short-lived, but seems to have been effective. The professional interest, both at the university and in the hospitals seems to have been widespread within these fields. The interest was enough to initiate the opening of one Social Centre, but in view of the great needs of the growing numbers of patients released from mental hospitals, it was relatively small.

"Discontent, if it is to be constructive, must be focused and channelled into organization, planning, and action in respect to specific problems." The C. M. H. A. became the channel for the discontent and was the means of satisfying the needs of the community with respect to the released patients. Through the C. M. H. A., other groups such as the Kiwanis were able to act as well.

"The Association must make leaders (both formal and informal) identified with and accepted by major subgroups in the community." Doctors, social workers, and university teachers were quick to become interested and involved with this movement. It could not be said to have reached the top of the priorities in the city "charity" drives, but had acceptable and respectable backing. The radio and press representatives who helped to make it known were personally convinced of its value and gave more time than they were required to by their employers. One C. B. C. freelance writer and broadcaster in particular kept the campaign
in the public notice on a very high level of acceptability.

"The Association must have goals and methods of procedure of high acceptability." The movement was identified with professional standards from the beginning. Indeed, the whole C. M. H. A., has from its inception, been identified in this way. Government departments, hospital authorities and the clergy have usually subscribed to the goals of this organization because of its ideals and professional level of operation. Also, as pointed out earlier in this paper, mental health had been taken up on a national scale by the mass communication media. Unlike poverty, desertion, or mistreatment of children, which have long been associated with the lower classes or the irresponsible elements in our society, mental breakdowns, it appeared, could happen in any level of society. This tends to raise the level of interest in this disease and its problems.

"The programme of the Association should include some activities with emotional content." It is necessarily a concern to those working directly with mental patients to maintain a professional standard of confidentiality. With good screening of visitors, and interpretation to volunteers, the public has been helped to enter the mental hospital without fear of violating this trust. It was the personal contact of the volunteers which initiated the idea of a Social Centre. The emotional content in this campaign has been particularly well handled in order to draw enthusiasm from it as well as to protect the patients and ex-patients from being overwhelmed by it. The Kiwanis Club had
some personal contact with members during the renovation of the premises and, of course, the volunteers have always had contact with the patients themselves. Beyond this, though, was the interpretation to the public of the needs of these people, the possibility of finding such needs in one's own family, and the appeal to help someone who could not very well help himself.

"The association should seek to utilize the manifest and latent good will which exists in the community." Much of this became evident during the collecting of clothing for the Apparel Shop and for soliciting for memberships, but it is this writer's conviction that a great deal more good will existed than was used. In future, as mental illness becomes more and more widely known, this desire to help might again be called upon, and channelled into new organizations.

Lines of communication were established, talks were given, and bulletins were issued. This was not sustained long after the initial campaign, however, and would have to be reactivated if interest were to continue at a high level. The association developed good leadership among the volunteers, proceeded at a pace acceptable to the community, and has become accepted as a part of the community. It has in these many ways followed, consciously or unconsciously, many of Ross's principles of community organization.

From this planning, it can be seen that the Social Centre was directed and focused. It had its roots in deep emotional material, but was guided by professional knowledge
and experience so that this emotional basis was tempered with objectivity. Much of its success was due to the observation of sound community organization principles. The concepts of working with community discontent, channelling it through an acceptable organization, involving the community in the planning, and operation of a solution, and so on, were observed with gratifying results. Other Centres were examined and their examples followed. Advisory committees were appointed and a professional staff was employed. Much of the best work had been done before the Centre opened its doors to the first member.
CHAPTER III

PROGRAMME AND SERVICES: THE VIEWS OF THE MEMBERS

The primary purpose of the Social Centre is to provide an opportunity for the patient recently discharged from mental hospital (a) to test himself in a social situation, (b) relearn social skills which might be impaired by his illness, and (c) regain confidence in himself as a member of society. This is attempted through the provision of a suitable setting, and through the help which can be given by a professional worker and volunteers.

The Social Centre is not a hospital – no doctors or nurses are in attendance – yet here there are trained people who have the knowledge and understanding of the difficulties facing the patient in the community and who will help him to assume a place in society.

This chapter will attempt to describe the actual operation of the Social Centre. This will include the various physical parts of the facilities: clubroom, kitchen, etc.; the organized and unorganized parts of the programme; the place of the volunteer in its operation; and the counselling or brief casework services offered to the members. There will also be statistical details of the members themselves. In order to have a means of evaluating the work of the Social Centre by means of personal views, the writer conducted, in February, 1961, a qualitative survey among members who had attended the Social Centre for varying lengths of time and for various reasons. It was felt that a dozen views from the people themselves would be valuable in assessing the Social
Centre from different angles. The members who took part in this survey will be described in some detail and material from the interviews used freely throughout the description of the various parts of the programme.

The Members of the Social Centre

During the year, 125 persons were referred to the Social Centre from various sources. All but 13 of these found their way there. No follow-up study was done in this latter group to determine why they had not attended. The following Tables will give some information about the members.

Table A. Distribution of Referrals of Members to the White Cross Social Centre

<table>
<thead>
<tr>
<th>Types of Referrals</th>
<th>Sources</th>
<th>Numbers of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals from Psychiatric Hospitals</td>
<td>Crease Clinic</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Provincial Mental Hospital</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Mental Health Centre</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>V. G. H.</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Shaughnessy Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Non-Psychiatric Professional Referrals</td>
<td>Family Doctor</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Family Service Agency</td>
<td>1</td>
</tr>
<tr>
<td>Non-Professional Referrals</td>
<td>Self</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Relatives or Friends</td>
<td>6</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>125</td>
</tr>
</tbody>
</table>

Table B. (Part I) Composition of the Membership
Marital Status, Age Range

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>married</td>
<td>14</td>
</tr>
<tr>
<td>single</td>
<td>73</td>
</tr>
<tr>
<td>separated</td>
<td>9</td>
</tr>
<tr>
<td>widowed</td>
<td>14</td>
</tr>
<tr>
<td>divorced</td>
<td>11</td>
</tr>
<tr>
<td>Age range</td>
<td></td>
</tr>
<tr>
<td>20 – 30</td>
<td>37</td>
</tr>
<tr>
<td>31 – 40</td>
<td>23</td>
</tr>
<tr>
<td>41 – 50</td>
<td>29</td>
</tr>
<tr>
<td>51 – 60</td>
<td>11</td>
</tr>
<tr>
<td>over 60</td>
<td>1</td>
</tr>
<tr>
<td>unknown</td>
<td>23*</td>
</tr>
<tr>
<td>Total</td>
<td>125**</td>
</tr>
</tbody>
</table>

* approximately between ages 30 – 40.
** 57 men; 68 women.

Table B. (Part II) Composition of Membership
Education, Employment, Financial Situation

<table>
<thead>
<tr>
<th>Status</th>
<th>Number of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Education</td>
<td></td>
</tr>
<tr>
<td>Grade 7 - 9</td>
<td>26</td>
</tr>
<tr>
<td>Grade 10 - 12</td>
<td>34</td>
</tr>
<tr>
<td>Grade 13 to B.A.</td>
<td>11</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>33</td>
</tr>
<tr>
<td>Housewives</td>
<td>12</td>
</tr>
<tr>
<td>Unemployed</td>
<td>36</td>
</tr>
<tr>
<td>Unknown</td>
<td>44</td>
</tr>
<tr>
<td>Financial Situation</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>9</td>
</tr>
<tr>
<td>Fair</td>
<td>41</td>
</tr>
<tr>
<td>Poor</td>
<td>6</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>35</td>
</tr>
<tr>
<td>Unemployment Ins.</td>
<td>2</td>
</tr>
<tr>
<td>Disabled Person's Al.</td>
<td>1</td>
</tr>
<tr>
<td>Old Age Security</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>30</td>
</tr>
<tr>
<td>Totals</td>
<td>125</td>
</tr>
</tbody>
</table>
Table C. **Details of Hospitalization**

<table>
<thead>
<tr>
<th>Number of Admissions</th>
<th>Number of Members</th>
<th>Length of Hospitalization</th>
<th>Number of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 only</td>
<td>39</td>
<td>Less than 1 year</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>1 - 2 years</td>
<td>13</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>2 - 3 years</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>3 - 4 years</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>4 - 5 years</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 - 10 years</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 years and over</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-Patients</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unknown</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>80</strong></td>
<td><strong>Total</strong></td>
<td><strong>80</strong></td>
</tr>
</tbody>
</table>

**The Survey Group**

Twelve members were chosen for study, six of whom were still attending the Social Centre at the time, and six of whom were not. Of the six who were not attending the Social Centre, three had returned to mental hospital and three had moved to other resources or arrangements in the community for reasons which were to be determined. Some of these members had been known personally to the writer from work at the Social Centre the previous year during a field work assignment. Some had joined later and were unknown to the writer. This survey was conducted by personal interviews at the Centre, in private homes, or in the mental hospital, following the lines of a questionnaire designed
for the purpose. This questionnaire is included in Appendix "A".

Eight of the persons in the survey were in the caseloads of social workers at Crease Clinic, Provincial Mental Hospital, the Mental Health Centre, or the Family Service Agency. One was being seen privately by a psychiatrist. With the permission of the members, each of these workers and the psychiatrist were interviewed in order to gain an added dimension to the members' impressions.

The members in the group were equally distributed between male and female, six of each. The age range was between 24 and 64. The median age was 34\(\frac{1}{2}\) years and the average 40. Two were married and living with a spouse, eight were single, one widowed and one separated.

Two had full-time jobs, one of whom was in his own small business; one was working part-time; two were housewives. The three who were back in hospital were classed as unemployed. Employment was related closely to education which ranged from a few years in elementary school to a Bachelor of Arts degree. The median was 9.5 years of schooling, and the average was 9.04 years.

The medical diagnoses of these persons fell into these widely ranging groups: schizophrenia, chronic brain syndrome (the result of epilepsy), personality pattern disturbance, psychoneurosis, hysterical reaction, anxiety reaction, depressive reaction, and hypothyroidism.

Seven had been in hospital for less than one year, three for from one to four years, and one for sixteen years. The median length of stay was 1.5 years.
The picture which emerges from this data is of a person in his late thirties, single, and living alone. He would have spent the last several years in mental hospital. Although he might have spent about nine years in school, he has not now the requirements for easy employment or has lost the skills he once had, so he is probably unemployed at this time. He would be deprived in his social relationships and in poor financial condition. This is the person the White Cross Centre is trying to help.

The Setting: Facilities of the White Cross Social Centre

The Social Centre is in the C. M. H. A. building which also houses the regional and provincial offices, the office of the marriage counselor, the co-ordinator of hospital volunteers, the director of the Social Centre and the clerical staff. The Open Door service is handled here too, with various members of the professional staff sharing the interviewing. Rooms adjoining these busy offices, all on ground level, comprise the Social Centre.

Here there is a lounge, about the size of a living room in a larger than average house. The main entrance is through the office area, but there is also a French door directly into the lounge which is unlocked during the day. Furnished in modern Danish style, it is informal, colourful and bright. There is a small library off the main room containing a desk, reading lamps, and a good collection of books. The recreation room is just
large enough to accommodate a ping-pong table, or to be used as a room for dancing. The kitchen is small, but fully equipped. Much has been done for these rooms by volunteers and members, by the addition of curtains, paintings, and plants. A start has been made at clearing a very small piece of ground at the side of the building for a patio or garden.

**The Drop-In Programme**

The Centre is open from Monday to Friday during office hours, 9:00 A. M. to 5:00 P. M., for the unorganized or "Drop-In" programme. There is little structured organization during this time, but opportunities for many kinds of activities. There are books, the daily papers, current magazines, a record player, a typewriter, and a television set which is on surprisingly little of the time. Table games such as scrabble, playing cards, jigsaw puzzles, as well as ping-pong, are available. The kitchen always has a supply of tea, coffee, sugar, milk and cookies. When occasions arise for planning and sharing such as special social evenings, Christmas, or a party, lunches or dinner can be prepared. An occasion comes to mind when, one spring day, a few of the boys went down to the harbour and caught (or bought?) fresh fish, and returning, prepared a fish-fry for some of the other members. This is the sort of spontaneous activity to be found during this part of the programme.

There is a minimum of pressure to take part, to communicate, to come, or to leave. This programme is designed to
encourage the gradual growth of friendship through shared tasks and activities. It offers an opportunity to be among other people without having to participate with them. It exposes the members to new interests without requiring that they pursue them. Sometimes there are only a few members in during the day, and sometimes there are ten or fifteen.

In the survey, those who enjoyed this part of the programme emphasized the security of having a place where they felt welcome at any time, and the comfort of knowing that there was a place where they would not be lonely. In answer to a question on this part of the programme, one said, "I wouldn't know what to do without it. I feel at home there," and another said, "Just being there is a good thing. It is better to be with people than to stay on your own all day." One made this very practical observation: "It is friendly and it is free - that's a big thing when you are out of work."

They mentioned liking to talk to people, serve coffee, play whist and scrabble and play the piano. Although the television is on part of every day, no-one in the sample group mentioned it.

Three of the members interviewed found that it did not meet their particular needs, but thought it should be continued for the others. One said this was "because the patients seemed sicker than I was, and that worried me. I felt I should be doing something for them instead of relaxing myself." The other had a different reason; she said, "I felt confused and did not know
what to do. The larger a crowd, the happier I am. At the Social Evening now, I do know what to do."

The Social Evening

Invitations for the first Social Evening were sent out as soon as enough persons had been referred and had come to the Drop-In programme. This was late in September. About twenty responded on the first evening, and after that, the attendance varied between twelve and twenty-five all year. At first the director assumed responsibility for programme and arranged for non-threatening activities like bingo, pencil and paper games, music and dancing, and for the provision of food.

After about a month, there was some group expression of a need to have an elected head. A discussion was organized and eventually the members decided to have a chairman, a secretary-treasurer, a librarian, a house committee chairman, and a refreshment chairman. This committee functioned for the first six months, bringing ideas to the group for approval and accepting and implementing ideas from the group. A variety of activities developed: music, dancing, bingo, "twenty-questions", "hat-box" discussions, three mystery tours outside the Centre, and two beach parties. After this first length of time, a new executive was elected because some of the members had returned to hospital or had left town. A new executive accepted the responsibility of arranging programmes for a few months and then began to falter towards the end of the year. Nevertheless, the
performance of these groups showed throughout the year a measure of responsibility and a growth in social functioning which surpassed the expectations of the director and the Planning Committee.

Now that the White Cross Centre is in full stride, the Social Evening provides a bright spot in the week, a time to dress up and go somewhere. Theatre tickets, donated by the Theatre Under The Stars, the Vancouver Symphony Society, Famous Artists Ltd., and others, added to this feeling from time to time. It is also, of course, a testing ground for participation with others, for planning, and for acceptable social behaviour. The members expect a relatively high standard of behaviour and appearance from each other. Men and women, fairly equally balanced in numbers, mix well together. The fact that the director was a man, and the assistant, a School of Social Work student, was a woman, tended to assist this balancing. There is a high degree of acceptance of each other's shortcomings among the members. There is a feeling shared in common, of having come through the experience of mental illness and of being, in most cases, in reduced social and economic circumstances. There is a great common need for social contact. These factors create bonds which transcend the differences in social and educational background and make a social group out of these otherwise isolated individuals.

One member in the survey said, "No matter what you do, even if you cry, no-one bothers. It is not regarded as out of place. The others have had their troubles, too." Another said,
"I like parties. They are less intimate. I feel less as if I have to take part."

Members are encouraged to participate in the planning and to take responsibility for the programme. A reflection of the effect of this was evident in some of the responses. One said, "I am in charge of the food. That's my job and I love it." Another proudly said, "It is my music they dance to. I wired all the speakers myself." One very sick patient who had been on the first executive recalled, while in hospital, "I hope I'll be able to go to the parties again sometime." No-one in the survey did not like going to the social evening or would offer criticism of it.

The Art Group

One of the members who had had some experience in teaching art offered to give art lessons. This was not suitable for programmes on Thursday evenings because of its limited appeal, so he was encouraged by the director to ask other members if they would like a second evening. There was sufficient response to warrant the formation of an art group. This member led it for several months, then had to give it up because of other pressures. A volunteer with art training was found to take over the group and has given consistent leadership ever since. This is a smaller, quieter group with a different focus. The instruction is simple and not demanding and no emphasis is placed on competition. Some of the members of the Centre prefer this evening to the social
evening, but no-one in the survey group preferred it. Seven of
the survey group enjoyed going to the art group and had attended
with fair regularity. One admitted, "I am no good at art myself.
I get the coffee ready. I like to see the things they do." Two
others found it to be more particularly what they wanted. One
said, "My old interest in art came back." Another said, "It re-
minded me of my old interests in drawing when I saw the young
people doing things." Only one expressed a feeling of dissatis-
faction because she wanted more direct teaching, "like a real art
school."

Volunteers

It was the concern of the volunteers in the mental hos-
pitals which initiated the opening of the White Cross Centre; it
is natural that they should play an important part in its opera-
tion now. They represent the community offering to meet the pa-
tient half way in his return from illness.

Direct contact with the Social Centre involves the volun-
teers in the Drop-In programme on specific afternoons as hostesses
or housemothers. Each one has a different contribution to make
because they are all different and interesting individuals. They
bring a fresh, real contact with the world of children, households,
new interests and service to others. They have become part of the
community aspect of the programme by driving members in cars down-
town for shopping, to the Art Gallery, and on mystery tours. They
have invited members home for dinner singly or in small groups.
Recently they provided a wedding reception for two members who had met at the Social Centre and married. It would be impossible to list all the intangible things they do, unobtrusively and generously.

Several of the members in the sample group said that it had been a volunteer who had met them when they had first gone to the Centre. Comments such as, "She made me feel that she was an old friend;" and "A volunteer met me, she made me feel right at home - introduced me to others," and, "I liked the art group, the volunteer took a real interest in me and made me feel better." A patient in hospital said, "Mrs. ...... even came out here to visit me." This was particularly significant to this patient.

The volunteers come under the direct guidance of the director. He is in a position to maintain continuity because he is at the Centre every day, while they come one day a week. Also, through his professional knowledge of the individual members, though not communicated to the volunteers directly, he is able to help them to understand behaviour among the members which otherwise might be puzzling.

**Brief Casework Services**

When a new member joins the Social Centre and is interviewed by the director, he is invited to discuss his personal problems at any time with the director. From the opening of the Centre, this has been a well-used service. In other Centres across Canada, there has been much discussion about the validity
of such a service, whether it requires a qualified social worker, or whether it could be handled by a volunteer.¹ In order to clarify the position of the service in the Vancouver Social Centre, the director formulated the following aims in the First Annual Report, Vancouver, 1960:

(1) Whether the staff person in charge of the Centre is professional or non-professional, awareness of community resources is imperative;
(2) Where community resources are available, they should be used;
(3) Even where a professional is directing the Centre, it is important to steer clear of ongoing casework services;
(4) Wherever possible, the referral procedure should be so organized as to leave a door open to the Social Service Department at the hospitals so that, when problems are raised, they can be referred back;
(5) Where there is a professional, short-term problem-solving assistance may be undertaken either alone or in co-operation with the referring person.

Three of the members in the sample group had not talked to the director individually, one because she was too threatened by face-to-face interviews, and two because interviews with their psychiatrists filled their need at this time.

The others went to him with a great variety of problems: medical, emotional, employment, housing, interpersonal relations, and financial difficulties. Referrals have been made to hospitals, social agencies, family doctors, neighborhood houses, and so on. Help has been given on night school courses, contacting employers,

finding boarding houses, marital problems, and many other day-to-day difficulties.

The members all said it was good to have such a service whether they used it or not. One member, very threatened by a face-to-face interview, said, "Sometimes I think I would like to talk to him, but my mind is so mixed up. I am soon going to talk to him. It is good to know he is there." Other comments were: "It is nice to know he is always there," and, "It is wonderful to have him there. I do not feel alone," and again, "You know there is somebody you can go to." One particularly revealing comment was: "When I am worried or down, I can talk to him. I can say things that don't matter to anyone else."

The members stressed the value of having someone close at hand, who was interested in their welfare, who had time for small things, and above all, was available. Many of these people had met with the rebuffs society reserves for its most vulnerable members. Even being patients in the overwhelmingly large and understaffed hospital is enough to make a person feel insignificant. Here, there was "someone interested."

**Conclusion**

The outstanding features of the Social Centre, as seen by the staff and the members, are that it provides a place where ex-patients who otherwise would be lonely and friendless, are accepted and given the opportunity to belong somewhere. It is a
place where lost social skills can be relearned, retested, and regained. There is enough variety in the programme and in the opportunities for expression for almost any level of participation, and different kinds of help for different kinds of problems, both through professional and lay persons. Perhaps it can in some cases take the place, temporarily at least, of the family or home circle which is lost, or which never functioned satisfactorily. It is a stepping-stone back to the community.
CHAPTER IV
A THREEFOLD SERVICE

This review of the White Cross Social Centre reveals that it has a threefold aim: first, to provide a service to the member in his social rehabilitation after treatment for mental illness; second, to assist the hospital in its treatment plan; and third, to serve the community by offering a medium by which it can receive and learn to understand the ex-patient. An evaluation of a programme such as this is only possible in qualitative terms. Some of the services rendered might not be fully demonstrated for years, and might never be known for certain. Feelings, attitudes, personality growth and understanding do not lend themselves to tabulation. The material gathered from the survey of members, however, from the experiences of social workers, volunteers and others who are concerned with the ex-patient, can give us an indication of the effectiveness of the Social Centre during its first year of operation.

Introduction of Members

The members in the survey group were asked how they had heard about the Centre and what their feelings had been when they had first come. Five had been referred by a social worker; one by a doctor; three had heard about it in hospital and had inquired about it from their social workers; two had heard about it on the
radio during the fund-raising campaign; and one had "seen the sign near the door". All had visited the Centre shortly after hearing about it and indicated that they had come without apprehension. Predominantly, the members had been introduced through the social service department. The Planning Committee had chosen this means of referral because it was more closely related to the social needs of the patient upon discharge, and the wisdom of this choice has been borne out. One worker said, "It gave him something to look forward to when he left," and another, "I drove her to the White Cross Centre and introduced her to the worker. She had learned to trust me, so she was not too apprehensive about the Centre."

The staff and volunteers have consistently tried to make a member's first visit pleasant and welcoming, realizing that he is probably anxious, lacking in confidence or even afraid. According to the sample of members studied, this has been effective. A typical remark was, "Mr. C. was nice to me when I first arrived. You need it, you know;" another said, "Mr. C. met me. He came in to the living room and sat down with me;" and another, "The other worker (student) met me. It was a nice surprise."

Two of the persons in the survey group had heard about the Centre "over the radio" and had called in to investigate. When they became members, they gave their permission for the worker to contact the social workers they had had in hospital before discharge. Since both have been members since the very
beginning, their views are particularly interesting. One said, "I couldn't believe anyone was going to all this trouble for us (ex-patients). It made me feel like starting right in and helping to make it go." She went on to describe her gratification at having participated in the activities from the start. The other said, "I was a bit doubtful at first. I had tried several places - Gordon House, for instance - but I just couldn't get into the feel of it somehow. But I liked this place right from the beginning. It is easy to make friends here - they take you as you are."

A comment of one of the social workers is of interest here. She had come to the Centre one evening to speak to the director or person in charge on an evening when a beach party had returned for refreshments. All the members and the volunteers were in the recreation room at the back, having a happy and noisy time. The worker felt that, had she been a new member seeking the Centre for the first time, she might not have ventured in by herself. This would make one wonder if some prospective members might have been lost in this way. As far as is reasonably possible, a watch is kept for new members, and social workers are encouraged to accompany anyone who might be worried or shy. On the other hand, participation in a programme such as this demands a certain amount of readiness and initiative on the part of the member, and supposes him to be well enough to attend. It would be no kindness to expose a sick person to the demands of a group in which most of the members are nearing good mental health.
Programme

In examining the programme of the Social Centre, one is impressed with the wide variety of services offered and the many ways in which the members use them. There is the Drop-In daily programme, the organized Social Evening, the Art Group, and the Counselling Service. The members in the sample group, all remarkably aware of their individual difficulties in making social contacts, had consciously chosen the part of the programme which would assist them in their rehabilitation and had moved forward from one area to another as they had gained in confidence. One is impressed by the effort put forward on behalf of their own rehabilitation. This effort is assisted by the sense of security they feel in the setting. This has been expressed over and over again in the interviews. Perhaps this conscious effort is partly due to the fact that many have recently received psychotherapy and casework services in one form or another and have gained insight into their problems. Surely too, much of the feeling must derive from the high level of therapeutic groupwork which has characterized the direction of the programme from the beginning.

The atmosphere did not just "happen" naturally; it is the result of planning based on study, and flexibility based on experience. An effort was made to find games and activities which would produce the results required. Participation by members is one of the main sources of development and enjoyment for the members, and yet care was taken to provide for the ones
who were not yet ready to participate. The members more and more took over the job of providing food, especially for the Social Evenings, but at least the tea and coffee were always in the kitchen. The provision of food has been found to be a valuable therapeutic technique and is always present. It seems to represent warmth, acceptance and love.

Spontaneity has been treasured by the staff and encouraged whenever possible. When the U. S. Aircraft Carrier Coral Sea was entering the harbour, a group left the Centre and was downtown in time to see it dock. Again, one of the members was moving from one point to another and a group of men from the Centre hired a truck and moved her furniture. Another set himself up in business in a shoe repair shop. Members painted and decorated the premises, then flocked in large numbers to the opening. These are small things perhaps, but indicative of an attitude towards programme which is integrated with life.

A fairly well balanced group composition has been maintained, partly by working closely with the referring agencies, towards having a more or less compatible group of people. The C. M. H. A. staff has helped members who are able to participate in the broader aspects of community life to find a place elsewhere. This is possible because of the close contact the director keeps with both the hospital and the community. There has been a conscious use of leadership within the group, and an encouragement to share responsibilities wherever possible. Activities have been structured to enable growth through participation
on levels suited to the member moving at his own pace. And yet, one also gets the impression that the members are not overprotected by the workers. There is a realistic acceptance of the responsibility each owes to the Centre, each other, and the community. There is enough genuine integration with the everyday activities of the community to make this a real testing ground for new-found strength which is of lasting value to the members.

One very fortunate outcome of planning is the decor of the Centre. The well kept, modern, bright entrance and rooms of the whole C. M. H. A. premises, as well as the Social Centre, cannot help but lift the spirits. The first impression is of something interesting and new, surely the right note to strike for those who are facing unadjustment to living. Much has been done with a little by imaginative use of colour, furniture groupings and decorations. In the lounge, there are large reproductions of modern paintings and in the recreation room, French posters and paintings from the Art Group. The small garden, tended voluntarily by a senior citizen who lives close by, is part of the whole effect. Compare this with the appearance of Welfare Offices, Out Patient Clinics and even some Neighborhood Houses, and the difference is obvious. This is an aspect of planning all too often neglected, and so more noticeable when it is found.

The comments made by the different members of the sample group reflect the high degree of diversity of uses which the
program serves. Some participated in almost everything; some were almost spectators. One mentioned liking speakers, movies, bingo, food preparation and planning, and indicated that there were other things as well. She suggested that the group could go for more exploration trips. She stressed the fact that she could not afford much on her social assistance income, and appreciated the drives and concert tickets. No-one else was quite so enthusiastic; they mentioned one or two things they liked, such as music and dancing, or whist and cribbage. A typical comment was: "Just coming here - it's better to be with people." Another said, "I like most things; I like to watch." This casual but important function was again expressed in, "I like to come and talk to people. Mrs. ...... and I are real friends."

All of the members interviewed indicated that they had been able to find something for themselves in one aspect or another of the programme. They indicated that there was room for personal change, both forward and backwards. One of the members, who was back in hospital, anticipated returning, although his social contacts would be much less effective on his return than they had been previously. As one of the other members expressed it, "They take you as you are."

One of the most significant areas of discussion with the members in the sample was on the effect of the Centre on their own lives. As was to be expected, use of the Centre would depend on the relative illness of the member, the home situation, employment opportunities and his personality. Six of the sample
group had been attending the Centre for varying lengths of time, and were still there. They stressed as their main reason for attending the special understanding and acceptance of their status as ex-patients. One said, "I could come here because they understood. No-one else could have understood what it is like being out of hospital - you're nervous and don't always say what you mean. I'm alright here." Another said, "It's easier to make friends here." One particularly active member said that six months ago she "had nowhere else to go and this was so friendly."

The three who were in hospital all looked forward to visiting the Centre on their return to the community. The social worker of one of these members said, "He knows there is somewhere he can go when he leaves. He knows Mr. C., his only link, is interested in him. The Centre gives him status. He has said, 'I belong to the Centre.' Somewhere, he is important." Another social worker said, "It provides an anchor for him. He knows the Centre will be there when he needs it."

One had not found the Social Centre, especially in the unorganized Drop-In program, of any value to her. She explained, "You see, I am not really suited to the Centre, because I get confused about how to behave in a crowd. But it is wonderful for some people." Another had consciously attended the Centre on his doctor's advice until he had been able to re-enter his own group of friends and to make new friends. His doctor said, "He used the Centre only when he did not have satisfactory social contacts
elsewhere. It helped him to regain his confidence during this time."

One member who had attended the Centre on the advice of her social worker explained her reactions so well that she is quoted here at length: "I was shocked at some of the people -- they were so much sicker than I. I realized that other people had been really sick and I had only had a touch. It frightened me to feel that I might slip back and become like them. Then I realized that they felt the same way too .... I was not ready to go back to my own group. I was too shaky and did not want them to know I had had a breakdown. I felt better as I kept going. I went for about three months .... I renewed old friendships as I regained my confidence .... It is like wanting to go in swimming but being afraid to get your feet wet. The Social Centre was my first toe in the water. Mr. C. asked me to be interviewed on the C. B. C. He must have thought I could do it or he wouldn't have asked me. I felt proud of myself when I heard it on the radio. I thought, 'I must be well'. It all happened to me nearly two years ago. It seems as if it happened longer ago than that. I feel that it is all over now. Thank everyone for me, very much."

This then, is the essence of the service to the members: to provide the first step back into the stream of life again, to assist growth, to be aware of individual needs and differences, to enable realization of potential strengths and to help make the most of them. Some members will always be impaired. Some will
return to the community strong and effective, with a deeper insight into their own lives and lives of others than they had before their illnesses. The Social Centre can be a service to many different kinds of people, with many different kinds of problems.

Service to Hospitals

Social workers who had been in their agencies since the opening of the Centre were knowledgeable about it and had used it freely. They were aware of the limitations of the service and the qualification for membership. Some specific expectations were that it would be a stabilizing influence in the life of the patient, help him improve the quality of his interpersonal relationships and gain self confidence. Among those workers more recently employed in the hospitals and agencies, fewer were informed about the Centre and its resources. This would indicate that continuous publicity about the service is now necessary, even though the initial publicity was good.

Most of the workers reported that the Centre had assumed an important place in the patient's life, that he mentioned it frequently, and with pride. The referred patients reflected to the worker that they saw it as a help in returning to the community, not as a club where they could spend the rest of their lives. One worker said that the groupwork part of the program was not enough to hold her patient, but that the counselling service had proved valuable.
In a general way, all the workers and the doctors interviewed looked upon the work at the Social Centre as helpful. All the workers had found the contact with the director at the Centre to be helpful, but in varying degrees. Some had not needed to keep a very close check on their patient; with others, it had been imperative. One worker said that he had been grateful for the observations of the director in helping to diagnose one patient and assist him to return to the hospital. Another said that the director's observations had strengthened his diagnosis. One worker described a unique division of roles in dealing with the problems of one patient. This man was in business for himself, and doing well. The worker said, "He looks to me as a woman. He tells me only the good things that happen – does not want to let me see him fail. To Mr. C. he can be more realistic. This is real teamwork and is showing positive results."

Several workers stressed the degree of individual understanding which the members received. For instance, one said, "It gave her realistic support without catering to her unreasonable demands." Another worker said, "The reason the Centre was so successful with this patient was that they recognized her abilities and her strengths and gave them a chance to find expression."

Two workers had not found the Centre to be helpful: one, because the social needs of his patient were being met elsewhere; and another, that it would have been impossible for such an agency to meet the social needs of his particular patient, so unsettled was this patient's outlook at this time.
All the workers and the doctor interviewed felt that it was beneficial to have a professional contact with the director at the Centre. It enabled them, they said, to refer cases which could not have been referred to a recreational agency. Professional confidence and exchange of information had been necessary on both sides.

Comparison of the Social Centre and the Fellowship Club in San Francisco

The Vancouver and San Francisco centres have much in common which contributed to the success of each. Both had been demanded from the community for several years before they had been organized. Both set up research methods from the beginning with a view to evaluation and both were professionally staffed and guided. There was also the limited membership in the beginning, referrals from hospitals, a man and a woman on the staff, sponsorship from larger organizations (in San Francisco, the San Francisco Foundation, and in Vancouver, the Community Chest). Both projects found that it was beneficial to avoid a hospital setting.

The dissimilarities were in the setting itself and in some of the attitudes of the members. The Fellowship Club met once a week in a community centre. The Social Club had its own building, was open every day for the Drop-In programme, and two nights a week. This gave the staff the opportunity to have a broader view of the members in a variety of situations and perhaps
accounts for the greater responsibility which the members seem to have been able to take in planning and carrying out programme. The Fellowship Club evaluation spoke of a certain reticence in several patients in attending the Club for the first time. At least in the sample survey, this was not found in the Social Centre. Perhaps this was due to the types of patients who went to both places, and perhaps to the larger variety of settings and programmes.

It is of particular interest that the only part of the policy in the Fellowship Club which was changed after the two year period was in the time-limit for membership. The original limit of two years was found to be too unrealistic. Some members required longer in order to adjust to life on their own. They extended the time indefinitely. The time has come in the Social Centre, too, to evaluate this part of the policy. Perhaps we will have to recognize the fact that some members will need such a support indefinitely in order to stay out of mental hospital. It is here suggested that this sustaining support will become an issue to be considered in the future.

Service to the Community

An attempt was made to find a reflection of the Social Centre in the community at large. The director of the Centre for one was asked his impressions as seen through attitudes of families, friends, and associates of patients whom he had met through contacts with members of the Centre itself, and in other
community organizations. Unstructured interviews with individuals and groups conducted by the writer in connection with this thesis, and also during the course of a field work placement, add to this information. It has been found that, on the whole, there is a low level of awareness in the community about the nature and extent of the difficulties facing the mental patient. Upon acquaintance and understanding, however, it does appear that individuals and groups have changed their attitudes.

The C. M. H. A. is aware of the need for education and has included in its service a roster of speakers who can be called upon for talks of this kind on a variety of subjects related to mental health. The subject of rehabilitation was requested over and over again. The director was invited to speak to more than twenty service clubs and professional organizations throughout the city. He felt a growing awareness of mental health problems, but found it expressed as yet in only a generalized way. The community is not, for example, thinking very seriously about how it can be involved in the problems of rehabilitation. Wherever we have reached out with news about the Social Centre, we have reason to hope that we have heightened awareness of the rehabilitation needs of the ex-patient. The Centre represents only one aspect of rehabilitation. It will not be possible to consider the picture at all complete until the community learns to accept the ex-patient, in social situations, in housing and in employment, with a fuller understanding of what is involved.
What can be said in conclusion? The Social Centre has been an aid to certain types of ex-patients and to the hospitals. It also seems that whenever community groups and individuals have come into contact with ex-patients themselves and a professional interpretation of their needs, there has been an increase in understanding and acceptance. Cannot these two situations be brought together? More Centres are needed - not just in Canada, but in Vancouver alone - to handle the ever-increasing numbers of mental patients leaving our hospitals in need of some such help. Several times during the year, the Social Centre has had to suspend intake of new members, when overcrowding threatened to limit the development of the programme. This brings up the whole subject of limitation of membership for other reasons as well. It is in the stated purpose of the White Cross Social Centre to limit membership to those who can best benefit from the service, but it also excludes alcoholics, drug addicts, the aged and teen-agers. Are there enough facilities in Vancouver for these other groups to be cared for on the same level as the Social Centre? Indications are that there are not. Ex-patients who have an alcoholic problem would like to be given the chance to become more integrated with those who have not, but under the present limitation, this is not possible. The C. M. H. A. cannot tackle all the problems which arise in this field. It has been one of their strengths that they have recognized these limitations and done a good job within them, but it is here suggested that when future expansion is possible, this other group should be
considered. This soon would apply to the drug addict, the aged and the very young. Each group would have its special problem, very different from the ones now encountered, but as new things have been studied and planned in the past, they might also be tackled in the future.

In San Francisco, the Fellowship Club met in an existing community agency, with good results. In our city, we might combine the needs of the ex-patients with existing resources with the help of trained volunteers and professional workers. There is the possibility of Social Clubs in such places as Community Centres, Neighbourhood Houses, Young Men's and Young Women's Christian Associations. Experienced staff members might participate actively in the organization of such clubs, and in the training of volunteers; then they might act as resource people after the clubs had become established. When professional contact is needed with hospitals or doctors, professional workers might fulfill this role and interpret any special problems to the volunteers and agency staffs. They might also be helpful in keeping channels open between the hospitals and the community by interpreting the various functions of the different clubs.

This system would also have the advantage of bringing the ex-patient into contact with community resources even before he might be ready to use them, and of showing him the

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1 The idea that anybody can work with the mentally ill, provided he is interested enough, holds some dangers. Professional workers should be somewhere available for interpretation of danger signals in behaviour. There should also be a very clear statement of goals of the volunteers in working with ex-patients.
possibilities which awaited him when he became more fully recovered. There is now the difficulty, amounting sometimes to a barrier, of some members travelling great distances to attend the White Cross Social Centre. If more clubs were located in more local community agencies, this difficulty would be lessened or might disappear altogether. In places where there were only a few persons qualified as ex-patients to attend a social club, such as in smaller cities and towns throughout B. C., perhaps a visiting worker could encourage a more conscious effort to include them in existing social groups.

It is the aim of the C. M. H. A., in all its branches, to stimulate a wider knowledge and interest in the whole field of mental health, and to initiate study and action in particular parts. Is it possible in such a specialized area to be effective? The Social Centre in Vancouver has shown that, with study, planning, and organization, at least the area of social rehabilitation can be met with imaginative and meaningful services.
APPENDIX "A"


1. How did you first hear about the Social Centre?
   - from a worker? - a friend? - the newspaper?

2. After you heard about the Centre, how long was it before you first went there?
   - a few days? - a few weeks? - longer?

3. When you first went to the Centre, was your impression favourable or unfavourable?
   - can you describe it?

4. What was your reception like when you first attended?
   - did someone speak to you? - a member? - a worker? - did no-one speak to you?

5. Has the Centre helped you in your rehabilitation?
   - did you use it often? - a great deal? - some?
   - why did you use it? - had nowhere else to go? - liked it better than other groups?
   - have you made friends whom you see apart from the Centre?
   - have you made new friends elsewhere than at the Centre?
   - have you developed new interests which started at the Centre? - listening to music? - dancing - art?

6. What activities do you enjoy most at the Centre?
   - are there activities you would like to suggest?


8. Do friends know that you attend the Centre?
   - what do they think it is like?
   - what does your family think it is like?

9. Have you ever had problems to talk over with the director?
   - do you consider it a good thing or unnecessary to have someone at the Centre who can see individuals?

10. What do you think the Centre is here for?
    - do you think it is achieving what it is trying to do?
    - have you any suggestions?
APPENDIX "A"


1. What part of the rehabilitation of the ex-patient do you expect will be effected by the Social Centre.

2. What contact do you have with the Social Centre regarding your patient?

3. Was this contact helpful? If so, how? If not, what other information would you have liked?

4. Does your patient talk about the Centre? If so, what does he say? (general).

5. Have you ever been to the Centre yourself? Have you any opinions of it? Have you any suggestions to offer?

6. Do you think it is fulfilling its function?
## APPENDIX "B"

### Part I

**Social Centre File Card**

| C.M.H.A. WHITE CROSS CENTRE  
(Hospitalization data in reference report) | Current Address | Phone |
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THE CANADIAN MENTAL HEALTH
BRITISH COLUMBIA DIVISION
ASSOCIATION
FOUNDED 1918
FIVE EAST BROADWAY
VANCOUVER 10, B.C.

New Address: 3355 W. Broadway

SOCIAL CENTRE MEMBERSHIP APPLICATION.

PLEASE PRINT

DATE________________________

NAME__________________________________________________________

ADDRESS________________________________________________________

PHONE NO.________________________AGE__________________________

MARRIED________SINGLE________

APPROXIMATE DISCHARGE DATE____________________HOSPITAL____________________

I can attend Social Center: DURING THE DAY____EVENING______BOTH______

I have special interests in:________________, __________________, _____________

NO SPECIAL INTERESTS__________________________

SIGNATURE________________________________________
APPENDIX "B"

Part III

Social Centre Referral Report

C.M.H.A. SOCIAL CENTER

REFERRAL REPORT

Date __________________________

Referring Agency __________________________ Referring Person __________________________

Emergency Contact (Person from referring agency) __________________________

Name __________________________ Telephone No. __________________________

IDENTIFYING INFORMATION:

Name __________________________ Age _______ Sex _______ Race __________________________

Address __________________________ Occupation __________________________

Tel. No. __________________________ Education __________________________

Marital Status __________________________ No. of Children __________________________

Emergency Contact (Relative, friend, etc.) __________________________

Name __________________________ Telephone No. __________________________

Diagnosis __________________________ Discharge Date __________________________

Previous Hospitalization (Psychiatric) Yes _______ No _______ No. of times __________________________

Total time in Hospital(s) (Approximate) __________________________

CURRENT STATUS

Working? _______ Economic Situation? Good _______ Fair _______ Poor _______

Living Arrangements? With Family _______ Alone _______ Other _______

Referring Person's Opinion of Present Condition (With Special Attention to Social Relationships) __________________________

________________________________________________________________________

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PERSONAL INTERVIEWS - C.M.H.A. SOCIAL CENTER

APPENDIX A

PART I
APPENDIX "C"

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