McGILL UNIVERSITY

THE OCCUPATIONAL THERAPY AND REHABILITATION CENTRE

A descriptive Study and Analysis of the Services of the Occupational Therapy and Rehabilitation Centre, and an Evaluation of the History of 63 Patients, known to the Agency within the Period from September, 1952 to September, 1953, in terms of the Factors influencing their Success or Failure in attaining prescribed Goals of Rehabilitation

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for

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by

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PREFACE

The research for this study was begun in 1953 at the Occupational Therapy and Rehabilitation Centre, when the building was located on University Street. At that time the Agency had been faced with the challenge of administering a greatly re-organized and expanded program of rehabilitation, which had been initiated a little over one year previously.

The writer, in undertaking the study at that time, had intended to hasten its completion so that the Agency's Staff might use it as the basis of its intended early evaluation of its program.

However, due to unavoidable circumstances, the writer was obliged to discontinue the study temporarily; and, in the mean while, the Centre shifted its location to its present address on Ottawa Street.

Some of the recommendations to which this study points have already taken place in modified form at the Centre; but there are other findings and recommendations made in the study, which might be of value, not only to the Staff of the Centre, in its new location, but also to all others to whom the study is addressed, namely, those who have a professional interest in discovering some of the practical aspects of planning and administering a successful program of rehabilitation.

In doing the research for this study, the Exec-

utive Director and Staff of the Agency were most co-operative in granting interviews when requested, and in volunteering information which they felt might be especially relevant to the study. The writer wishes to acknowledge a special debt of gratitude for this co-operation.

With reference to the planning and structuring of the study, the writer was given valuable assistance by Professor Marier and by Professor Tuck of the Staff of the McGill University School of Social Work. The writer wishes to express his warm appreciation of the above assistance rendered.

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CHAPTER 1

INTRODUCTION

The Montreal Occupational Therapy and Rehabilitation Centre represents, in its statement of function, the latest approach towards treatment of handicapped people, namely, that of providing a number of different services and utilizing a diversity of professional skills in an agency setting, to provide for the total possible rehabilitation of its clientelle of handicapped patients.

Before, however, undertaking the descriptive analysis of the programme and of the patients of this Centre, it is proposed to present a picture of the evolution of earlier approaches and attitudes towards those afflicted with illness, so that some perspective can be gained as to the extent of progress represented by present day attitudes and programme for the handicapped.

Disease and injury have, for as long as history, been the heritage of mankind. But what man has thought and felt and done about illness has progressively changed from era to era. Back in the 16th Century, a severe illness was thought to be God's invocation of a curse upon someone who had committed a grievous sin, and, accordingly, the severely ill became the objects of scorn and sometimes of open abuse.[1]

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[1] Montreal Rehabilitation Survey Committee, Re-establishment of Disabled Persons, Montreal, 1949, pp. 19-20.

However, as science progressed and man grew to understand better the cause-effect relationship which determined the phenomena, which he had hitherto misunderstood, he adopted a rational, humanitarian attitude towards those afflicted with illness. His treatment of the ill became kindlier and his interest in discovering the causes of illness became less that of mere curiosity and more a genuine attempt to forestall the occurrence of illness by controlling or preventing the conditions which caused it. Thus it was that anti-biotics and vaccines were developed which safeguarded man from incurring wasting diseases.

Not all attention was given towards the development of preventive medicine; some attempt was made to discover drugs and various other methods by which disease and injury, already incurred, might be treated to the point of the arresting of the acute phase of the illness and the alleviation of pain. This limited approach towards the treatment of illness would have sufficed if all diseases and injuries were so minor in severity or the damage resulting from them so reversible by means of strictly medical treatment prescription, that the patient could, with little inconvenience, resume his way of life as he did prior to his illness. But this was a fallacy. Many hospital beds continued for months to be occupied by patients who remained incapacitated long after the arresting of the acute

phases of their illnesses, and who, as the demand for hospital beds for the acutely ill increased, had to be transferred to homes for the chronically ill. Here they were treated as patients who would forever need to be looked after, and who could never be expected to assert any residual potentialities they might have had for self care, the performance of household activities or gainful employment.

Two significant points of departure from the above attitude towards and treatment of those patients, who will later be defined as handicapped people,[1] emerged and gained acceptance in the 20th Century. World War 1, with its urgent demand for man power on the battle front and in industry, prompted a renewed concern about the sick, who after treatment, would customarily have been considered unfit for the resumption of the normal activities of living. It came to be realized that illness did not obliterate all of man's potentialities for a successful personal, social and occupational life. And it was further realized that man's residual potentialities could, by the application of revolutionary treatment methods, be translated into actual abilities and skills, usable in employment situations, where the physical and emotional demands of the job had been evaluated and set

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[1] Infra., p. 8

forth.

Great Britain was the pioneer in World War 1 of techniques, particularly in orthopedic and plastic surgery, by which limbs and other parts of the body were restored to a reasonable degree of physical functioning. However, it was not until World War 11 that Great Britain, faced with the formidable total of 185,000 unemployed disabled men and women, saw the necessity of instituting treatment and vocational training measures by which 177,000 of the above 185,000 unemployed disabled again became occupationally productive. In addition to instituting treatment programmes by which large numbers of the unemployed disabled became employable again, Great Britain went further and, in 1944, passed the Disabled Persons Employment Act, which required employers to hire a certain percentage of handicapped people.[1] Not only Great Britain, but such other countries as the Union of South Africa, the U.S.S.R., Australia, Germany, Sweden, Denmark, Belgium, France, Chile, China, to name but a few, concerned themselves with the provision of specialized training services for disabled persons.[2]

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[1]Montreal Rehabilitation Survey Committee, op. cit., p.22

[2]International Labour Office, The Training and Employment of Disabled Persons, a preliminary report, Montreal, 1945 p,9.

The United Nations and its specialized agencies, too, have made the fostering of the rehabilitation of the handicapped one of their major concerns.

On the Canadian scene, the Federal Government has instituted special rehabilitation departments in which veterans suffering diversified disabilities are helped to attain as full a rehabilitation as possible. An example of this is the rehabilitation wing of the Montreal Queen Mary Veterans' Hospital. In addition to its veterans' programme the Government has set-up within the National Employment Service, special departments where disabled persons, whose residual handicaps do not interfere with their performances, are placed in jobs.

Not all the rehabilitation services in Montreal are under government auspices nor are their usage restricted to military personnel. The Handbook on Services to the Physically Handicapped in Montreal and its environs, lists numerous other private associations and societies - the Cerebral Palsy Association of Quebec, and the Canadian Arthritis and Rheumatic Society, for example, which provide for some phases of the rehabilitation of the civilian handicapped.

The multiplicity of private associations, societies, institutions and the like, which existed in Canada for the benefit of the handicapped, raised the question in Government circles and among private agencies as to the desirab-

ility of co-ordinating existing services for them and of instituting whatever new services seemed necessary. As a consequence of this, the Minister of Labour, in co-operation with the Minister of National Health and Welfare and the Minister of Veterans' Affairs, summoned a National Conference on the Rehabilitation of the Physically Handicapped, to which representatives of medical associations, universities and private agencies catering to the handicapped as well as representatives of the three above government departments on the provincial level, were invited. The Conference was held in Toronto in February, 1951. The principal recommendations of that conference were that a National Committee be formed to advise the Government on matters pertaining to the rehabilitation of handicapped persons and that a National Co-ordinator of Rehabilitation be appointed. These recommendations were carried out. The National Advisory Committee on the Rehabilitation of Disabled Persons was appointed by Order-in-Council in the closing days of 1951 and held its first meeting in February, 1952, at which time Mr. Ian Campbell was appointed National Co-ordinator of Rehabilitation. Upon the recommendation of the National Advisory Committee, the following measures were adopted by the Federal Government:

With reference to the co-ordination of rehabilitation services, the following provision was made:

> The Federal Government authorized the award of $15,000 per annum to each province, on a matching basis, to pay the salaries and expenses of a provincial rehabilitation co-ordinator and his staff and to supply certain services, necessary to the rehabilitation of individuals whose needs were not covered by other government provisions.
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> The co-ordinator was expected to co-ordinate, on a regional and local basis, the efforts of all agencies, public and private, working with the disabled, and to stimulate interest of the medical profession, management, labour and vocational counselling and placement officers in the potential worth of the disabled. He was further expected to establish a case-finding and case-referral system and endeavour to see that, as far as possible, the efforts of the disabled were guided to productive ends.[1]

With reference to vocational training, the following provision was made under the Canadian Vocational Co-ordination Act:

> With the approval of a Provincial Committee, including the Provincial Co-ordinator, training of any type desired could be obtained for a disabled person, provided that such training should result in his rehabilitation.[2]

Finally, with reference to the use of the National Health Grants Programme, the following expansion of its provisions was made, in the interest of handicapped persons.

The grant could be used for the following purposes:

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[1] Ian Campbell, "Co-ordinating Rehabilitation Services", Canadian Hospital, p.38

[2] Ibid., p.38

1. To meet the cost of training rehabilitation personnel.
2. To purchase equipment designed to reduce disability, for example: apparatus for electrotherapy, hydrotherapy, etc.
3. To expand existing rehabilitation services.[1]

All the above provisions, recommended by the National Advisory Committee, at a total cost of $1,000,000 annually, combined to represent a major step forward in co-operative planning, at Federal and Provincial Government levels, for the rehabilitation of the handicapped.

This last mentioned achievement of co-operative planning could not have been possible, had there not been a common understanding regarding what level of illness and injury would be termed a handicap and what level of treatment would be termed rehabilitation. The following definition of the handicapped, as set forth by the Canadian Welfare Council in its statement of policy in regard to a national programme for the rehabilitation of the disabled was accepted by the National Advisory Committee:

> The disabled are those persons who suffer from conditions which, regardless of their physical or mental origins, constitute, contribute to, or if not corrected, will result in an obstructed performance of the normal activities of daily living.

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[1] Ibid., p.39

In addition to the foregoing definition, the Canadian Welfare Council further set forth the following three classifications of the handicapped:

1. Those whose disabilities were such that they did not require special assistance in order to enable them to obtain permanent employment, or to live reasonably normal lives.

2. Those whose disabilities were such that, with special help in regard to medical and/or psychiatric treatment, vocational counselling, placement, and social case-work service, they could compete with the normal person in employment, and in every-day living.

3. Those whose disabilities were such that they could never be expected to compete in the open labour market and for whom the provision of sheltered workshops or special facilities for home work were, at best, the only form of employment, and for whom the desirable plan was that they might be helped to make a more satisfactory adjustment to the limited type of living possible for them.

The level of treatment or the rehabilitation goal had been stated by the Canadian Welfare Council as follows:

> Rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable.[1]

Further to the statement of the goal of rehabilitation, the Canadian Welfare Council had outlined the following services and facilities as necessary to be included in the programme of a rehabilitation centre:

1. Medical examination and rehabilitation of the patient.
2. Social case-work service.
3. Prosthetic department.

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[1] Ibid., p.122.

4. Vocational counselling and training.
5. Sheltered workshops wherein patients could develop work tolerances.
6. Employment placement.
7. Financial maintenance of patients, unable to afford cost of rehabilitation services.[1]

The Montreal Rehabilitation Survey Committee[2] also set forth certain recommendations regarding programme services, the following of which, were additional to those listed by the Canadian Welfare Council:

1. Physical therapy.
2. Occupational therapy.
3. Speech therapy.
4. Educational classes.
5. Recreational facilities.
6. Follow-up of the patient's adjustment after discharge from the Centre.[3]

The number and variety of the above services which have been found to be necessary for the rehabilitation of the handicapped, are an indication of how far informed thinking about rehabilitation has progressed since the abandonment of the strictly medical approach to treatment, which had concerned itself exclusively with the physical disability as though it were an entity in itself, without due recognition of the mental, emotional and social factors

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[1] Ibid., P.124.

[2] The function of this Committee and the recommendations made by it are elaborated upon in Chapter 11 p.31

[3] Montreal Rehabilitation Survey Committee, Re-establishment of Disabled Persons, Montreal, December, 1949, p.19.

in the patient's situation, which could obstruct or facilitate his rehabilitation.

This point of departure in the treatment and rehabilitation of the handicapped has recently been termed "comprehensive medicine". Dr. J. Howard Means, a leader in the field of medical education today, captures the essence of this new approach to treatment of the handicapped in the following statement about health and the way by which it is achieved:

> Health is that state in which the organism has achieved as successful an adjustment, intellectual and emotional, as well as physical, to its environment, as its constitution and the equipment available to it permit. Many forces are involved besides medicine. All the forces of our culture are involved.[1]

The many forces or services necessary for the rehabilitation of the handicapped can most effectively be utilized, if the majority of them are rendered concurrently in a single rehabilitation centre. Such a centre, or centres, should exist in every community where a rehabilitation programme is being undertaken, and its essential function would be the co-ordination of the rehabilitation programme in the locality. This was the recommendation made by Dr. W. P. Warner, Director General of

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[1]George S. Berry, "Medical Education in Transition", Journal of Medical Education, March , 1953.

Treatment Services of the Department of Veterans Affairs, in his keynote speech on Medical Rehabilitation of the Handicapped in Canada, at the first Conference on the Rehabilitation of the Physically Handicapped.

Examples in Canada of the above latest trend towards centralization of rehabilitation services are; the rehabilitation centre, operated in Vancouver by the Western Society for Rehabilitation,[1] and the two rehabilitation centres in Montreal, operated by the Rehabilitation Society for Cripples, and by the Occupational Therapy and Rehabilitation Centre, which latter agency has been chosen as the subject of analysis in this thesis project.

The writer's interest in undertaking the above project was first aroused when, as a student of the McGill University School of Social Work, the timely subject of rehabilitation of the handicapped was presented to the student body as a required area of investigation. This led to a visit to the Occupational Therapy and Rehabilitation Centre, which was having its first Annual Meeting after the commencement of its re-organized and expanded programme in May, 1951.[2]

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[1] A. C. Pinkerton et al, "Community Rehabilitation Centre", Canadian Hospital, September, 1954, Vol. 31, No. 9, p.40.

[2] Infra., p. 32

In listening to the Executive Director report on the great progress in rehabilitation achieved by one patient of the Centre, the following two questions suggested themselves as being important to be answered:

1. What percentage of the total patient caseload had been able to achieve full rehabilitation?

2. What resources or lack of resources in the patient, on the one hand, and in the Centre's programme, on the other hand, were responsible for the success or failure of patients in achieving full rehabilitation?

The answering of the above two questions seemed important because it would provide the Centre staff with a basis of evaluation of the effectiveness of its programme. This evaluation of programme had been one of the recommendations[1] made by a special committee of the Montreal Council of Social Agencies, which had made a survey of the Occupational Therapy Centre, before its re-organization and expansion into the Occupational Therapy and Rehabilitation Centre.

The importance of the study was seen also to lie in the probability that it would indicate generally what kinds of problems might be anticipated in the setting-up and carrying-out of a programme of total rehabilitation for

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[1] Infra., p. 30

all categories of handicapped people, and that it would indicate specifically to the National Advisory Committee on Rehabilitation the kinds of supplementary rehabilitation services which Government might make available.

As preparation for the carrying out of the study progressed, it became necessary to revise and re-state the earlier-mentioned major areas of enquiry as follows:

1. What services and facilities was the Occupational Therapy and Rehabilitation Centre equipped to provide,

2. How successful were the patients of the Centre in attaining the optimum rehabilitation goals set for them, and how much did their attainment or non-attainment of these goals appear to relate to factors within the patients themselves, and how much to factors inherent in the Centre's programme and the procedures used for carrying it out?

In further reference to the above questions, it is necessary to state certain limitations of the study.

Question one does not attempt to discover specifically what services were actually administered to the patients, since, as will be pointed out later, there were many omissions in the amount of recording done, of what

service had taken place.[1] But, it is intended, as stated, to set forth what treatment resources were available at the Centre.

Another delimitation of the scope of the study is that no consideration will be given to such aspects of the Centre's programme as its public relations activities, aimed at educating the public as to the possibilities of the patient's rehabilitation and as to the part they, especially prospective employers, could play in making rehabilitation a continuing success. The study is concerned with those activities which have a more direct bearing upon the success of the patient's rehabilitation.

With reference to question two, it is to be emphasized that it is not intended to prove conclusively that some particular factor or factors was responsible for the patient's successful or unsuccessful rehabilitation, but, instead, to point-up factors about which there was some indication that they might have operated in such a manner as to determine the successful or unsuccessful rehabilitation of the patient.

In the answering of question one,[2] information regarding the Centre's services and facilities was obtained partly from material contained in the Centre's booklet,

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[1] This lack of recording was possibly due to pressures of other more urgent staff responsibilities.

[2] Supra., p. 14

"Description of Services", partly from interview with members of the staff of the agency, and partly from the writer's own observation of the programme in operation.

Since it was proposed not only to state but also to do some evaluation of the Centre's programme facilities and its procedures for carrying out programme, it was necessary to have some criteria by which an evaluation might be made.

These criteria were gleaned from literature which described quantitatively and qualitatively the services necessary to be included in the programme of a rehabilitation centre. Such books, as "The Re-Establishment of Disabled Persons", and the "Proceedings of the national Conference on the Rehabilitation of the Handicapped", were sources of the above criteria.

In addition, the writer made visits to the Montreal Queen Mary Veterans Hospital Rehabilitation Department and to the Montreal Rehabilitation Society for Cripples, and observed their respective programmes in operation. Discussions were also held with the Staff of the two agencies with reference to procedures used for the carrying out of programme.

In the answering of question two,[1] which required

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[1] Supra., p. 14

an examination of the characteristics and circumstances of the patients of the Centre, the following were the line of thought and method used for the selection of the sample group to be studied:

Since the extent to which patients succeeded or failed in achieving optimum rehabilitation was information required for carrying out the study, the first step was to choose a sample from among those patients who were listed in the Centre's files as "closed cases". But since the study was attempting, not only to relate successful or unsuccessful rehabilitation, to certain factors in the patient, but also to certain characteristics of the Centre's programme, as they affected the patient, it became necessary to exclude from the "closed cases" all those patients whose treatment had commenced at the Occupational Therapy Centre - the agency which had later, in 1951 been re-organized into the Occupational Therapy and Rehabilitation Centre.

And, because it was anticipated that during the first year of operation, the Centre's programme, due to the recency of its re-organization, might have been greatly hampered by the commencement of treatment at the Centre at that time, it was decided to select from the "closed cases" only those patients whose treatment had commenced during September, 1952 and had terminated one year later, in September, 1953.

The number of patients selected by the above process numbered 74. However, it was later discovered that 11 of the 74 patients had never commenced treatment at the Centre.

Some of the reasons given why these patients had never commended treatment at the Centre were as follows:

A 10 year old girl had been transferred to the Children's Memorial Hospital, so as not to duplicate a service which the hospital was set-up to provide for children.

A 40 year old Jewish man had been transferred to the Jewish Vocational Services agency, so as not to duplicate a service provided for him by another agency.

A 50 year old man, whose disability was stated as "hypertensive cardio-vascular disease" was advised by his doctor that his condition had become too serious to permit the commencement of treatment at the Centre at that time.

With the 11 patients excluded from further consideration, the final revised sample group to be studied consisted of 63 patients. To facilitate the research plan, and in regard for the confidentiality of the case records, these patients were re-assigned case numbers

by the writer.

The next step was to discover how successful were the above patients in attaining the rehabilitation goals set for them by the Centre.

By inspection of the case records it was revealed that 21 patients had attained optimum rehabilitation,[1] and that 42 patients had attained little or no rehabilitation. Of the latter group, four patients had attained only a small identifiable degree of rehabilitation. The following two cases illustrate the nature of the limited degree of rehabilitation attained:

> Case 1: This patient was a 19 year old, unattached girl, whose disability was stated as "rheumatoid arthritis". Commenting upon her progress, the occupational therapist recorded that she had adjusted well to the programme and had shown improvement. However, before the patient was ready to begin her contact in the vocational counselling department, she terminated her contact at the Centre.
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> Case 60: This patient was a 47 year old, married man, whose disability was stated as "Parkinson's disease". Commenting upon his progress, the physical therapist recorded that he had improved physically, in that his muscles were functioning much better; but, according to the comment of the vocational counsellor, he had shown no positive change in his attitude towards work, and discontinued contact at the Centre, before the ultimate goal of rehabilitation - job placement, had been attained.

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[1] Optimum rehabilitation is here defined as the goal of rehabilitation which had been set for the patient by the doctor making the initial examination, and by the other members of the staff of the Centre.

Because the degree of rehabilitation attained by the above two patients had been so minimal, it was decided not to examine these and the two other patients as a separate group, but to combine them with the other 58 patients for whom there was no record of the attainment of any level of rehabilitation.

With the classification of the 63 patients into the two groups - those who had attained optimum rehabilitation, and those who had attained little or no rehabilitation, it was next proposed to examine and classify the patients in terms of the following characteristics and circumstances[1]: age, type of disability, duration of disability, medical prognosis, educational status, employment status and personality.[2]

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[1] These were the characteristics and circumstances which the writer felt would most likely prove to be factors, determining the patient's ability to attain optimum rehabilitation, or little or no rehabilitation

[2] Such was the dearth of information upon which the assessment of personality could be based, in terms of set criteria, that it was found expedient to set-up special tables, (see appendices E, F, G, H), in which were stated the kinds of information which had provided some insight into the personality of the patient.

The foregoing data were obtained from the case records and from staff members[1], and entered upon documentary schedules.[2]

For the purpose of analysis, all collected data, with the exception of that which related to the Centre programme itself, was classified on tables.

The following is the manner of presentation of the study:

In Chapter I, a general orientation has been given with reference to the modern concept of rehabilitation, as it relates to handicapped people, and some of the methods employed in helping the latter achieve it.

The chapter also states the purpose and importance of the thesis study undertaken, and outlines the steps taken in organizing it. In addition, such matters as the scope and limitations of the study, the sources of data, and the methods of collecting and analysing them, have been discussed.

In Chapter II, the historical background of the

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[1] Because of the incompleteness of the recording by staff members of their contacts with the patients, it was necessary to interview those members who could still recall unrecorded details about the patients and the outcomes of their treatment programmes at the Centre. It was realized, however, that such recalled information was subject to some slight margin of error.

[2] Infra. Appendix A.

Occupational Therapy and Rehabilitation Centre has been stated, and mention made of the two surveys done on the Occupational Therapy Centre,[1] and of the recommendations for improvement submitted by the survey committees.

The Centre has been described in terms of its physical structure, its objectives, its admission policies, its staff resources, staff responsibilities, and equipment facilities, its time-table, and its operational methods and procedures. The chapter closes with an evaluation of the organization, programme, and procedures of the Centre, in terms of how they might have affected the rehabilitation of patients.

In Chapter III, the term, "optimum rehabilitation", is defined and examples given to illustrate how it has been applied, in categorizing the patients.

The rehabilitation goals of the 21 patients who attained optimum rehabilitation are tabulated, and brief descriptions given of patients who had achieved the various categories of optimum rehabilitation.

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[1] The Occupational Therapy Centre had conducted a limited programme of rehabilitation prior to its reorganization and change of name to the Occupational Therapy and Rehabilitation Centre in May, 1951.

Following this, the characteristics[1] of the 21 patients are presented in tabular form, and analysed to discover which of them might have been factors which contributed to the patients' ability to attain optimum rehabilitation.

The presentation of each table is prefaced by a few remarks explaining its purpose.

The chapter closes with a summary and evaluation of the significant findings contained in the chapter.

In Chapter IV, the same general pattern of Chapter III is followed:

The varied rehabilitation goals set for the 42 patients who attained little or no rehabilitation are presented in tabular form, followed by a few brief descriptions of selected patients.

The tabular presentation of the characteristics[2] of the 42 patients is next undertaken, and this is followed by an analysis of the classified data to see which of the above characteristics might have been factors contributing to the patients' failure to attain optimum rehabilitation. These apparent factors are then compared

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[1] These characteristics are stated on page 20

[2] These characteristics are stated on page 20

with those which were indicated in Chapter III to have had a possible bearing upon the successful attainment of optimum rehabilitation by 21 patients.

In addition to the above, a few patients have been cited, whose circumstances indicated that their failure to attain optimum rehabilitation was not attributable to poor personality, as the preliminary analysis seemed to suggest, but rather to factors, independent of personality. These factors have been tabulated, and cases discussed with a view to evaluating the role of the staff in dealing with them.

In the concluding Chapter V, a recapitulation is made of the objectives of the study, the main questions asked, and the methods employed for collecting and analysing data.

Following the above, the major findings of the study are set forth, and the conclusions and recommendations stated.

Because this study is concerned not only with programme, but with the procedures by which programme is carried out, it was seen fitting to include in the appendix sample copies of standard forms used at the Centre.

Other items included in the appendix are the documentary schedule used by the writer in extracting

data from the case records of the 63 patients, and four tables which show the criteria used for establishing the personality levels of the patients.

CHAPTER II

HISTORY, ORGANIZATION, STAFF AND PROGRAMME SERVICES OF THE OCCUPATIONAL THERAPY AND REHABILITATION CENTRE

The main purpose of this chapter is to attempt to answer one of the principal questions to which this study is addressed, namely, to what extent were the success and the failure of patients in achieving optimum rehabilitation related to factors inherent in the Centre and its programme, as contrasted with those factors which were to be found in certain characteristics and circumstances of the patients?

It is therefore intended in this chapter to describe as fully as possible all the pertinent details about the Centre, which will make evaluation of it possible. Because the criteria of evaluation will be partly based upon certain standards and recommendations set forth in two surveys made of the Occupational Therapy Centre from which the Occupational Therapy and Rehabilitation Centre was the outgrowth, it is proposed briefly also to describe this earlier agency and to record some of the most important recommendations and observations made by the two survey committees which examined its programme in 1945 and again in 1949.

The Occupational Therapy Centre

The Occupational Therapy Centre was the agency which resulted from the amalgamation in March 1957 of

the programmes of three agencies, namely, the Occupational Therapy Department of the Victorian Order of Nurses, the Montreal Industrial Institute for Epileptics and the Handicapped Workers Section of the Protestant Employment Bureau. The agency had been located first at an address on St. Antoine Street, then at an address near the corner of Guy and St. Antoine Streets, and finally, from October 1st, 1948 to May, 1951, at the address on University Street, at which the present thesis study was undertaken.

Objectives

The objectives of this agency were to assist in the rehabilitation of the handicapped by the following measures:

1. The practice of occupational therapy in homes, hospitals, mental institutions, tuberculosis sanitoria and other establishments.
2. The operation at the agency of a remedial workshop, which provided gymnastics, physical reeducation and occupational therapy activities for the handicapped.
3. The operation of a vocational guidance, training and employment placement department.[1]

The above measures were carried out, first by a staff of four, which included an occupational therapist, a workshop supervisor, a home service supervisor, and a

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[1] Montreal Council of Social Agencies, Occupational Therapy Centre Survey, January, 1945, p. 2.

part-time social worker, and later by a staff of four which included the Director, who was an occupational therapist, two assistant therapists and an office secretary. [1]

Surveys and Recommendations

The Executive Committee of the Occupational Therapy Centre in October, 1944 made a formal request to the Montreal Council of Social Agencies to undertake a survey of the agency, which was then located at the corner of Guy and St. Antoine Streets. The Council accepted the carrying out of this survey, stating its two major objectives in so doing as:

1. The review of the programme of the Occupational Therapy Centre.
2. The preparation of a plan of action for the provision of a more adequate rehabilitation programme for the civilian section of the community.

Some of the main recommendations regarding organization and administration were as follows:

1. That the Centre should have as its major objective the rehabilitation of those physically handicapped who were susceptible of returning to industry, and that its programme should be developed as part of, and geared to the rehabilitation programme of the community.

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[1] Ibid., p.3.

In enlarging upon the foregoing recommendation, the following statement was made:

> The fundamental weakness in the present picture is that the Centre is something of a "dead-end". It does not have and, until now, the community has not provided a training or re-training programme to enable the graduate of the Centre to get another job and to become self-supporting.

2. That there should be a realistic re-statement of the purposes and objectives of the Centre, bearing in mind changes in conceptions and functions which may have occurred since the organization of the Centre in 1937 or which might occur as a result of the present review of the programme.

As an example of needed revision of the Centre's stated objectives, the following observation was made:

> The new statement of purposes and objectives should omit reference to employment placement and vocational guidance if it was no longer the intention of the Centre to engage in this work.

3. That the Centre should look for more spacious quarters, permitting the setting-up of rooms for private patients, for rest or relaxation purposes, recreation, and other possible expansion of programme.

4. That the present office of the Executive Director be made as sound proof as possible, since all conversations taking place in this room were easily overheard, making for difficulty in staff and case discussions.

5. That when feasible, consideration should be given to the provision of car service for home visiting and other purposes.[1]

Some of the main recommendations regarding programme were as follows:

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[1] Ibid., p. 15-16.

1. That the services of a part-time medical director be obtained in order to ensure adherence to medical standards in the operation of the agency.

2. That the services of a part-time medical social worker be obtained to participate in the well rounded planning with the patient which was needed early in his treatment, and to assist in discovering the social and emotional reasons which often prevented the patient from taking advantage of the treatments offered at the Centre.

3. That the possibility of securing the assistance of a part-time psychologist be explored, since an early objective measurement of the potentialities of the patient was most necessary, if his treatment was to be related to industrial rehabilitation.

4. That the caseload of the Centre be evaluated at periodical intervals of perhaps six months in order to assess the value of the services being rendered.

5. That periodic review of other community rehabilitation programmes be undertaken in order to keep the Centre programme abreast of and in adjustment with other services in this field.[1]

The above survey of the Occupational Therapy Centre was followed four years later in 1949 by another more extensive survey, which examined the extent of the needs of the handicapped in Montreal and the scope of the programme of existing services for their rehabilitation.

Because the Occupational Therapy Centre was included in the above survey and the recommendations of the survey held importance for whatever revisions in the future programme of the agency might be contemplated, it

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[1] Ibid., p. 19.

is proposed to describe briefly the survey and state some of its more important recommendations.

The survey was initiated by the Council of Social Agencies and its French counterpart, the Conseil des Oeuvres, and was carried out by a survey committee which comprised professional representatives from hospitals, social agencies, universities, departments of labour, of employment placement and of education.

The findings of the survey were published in December, 1949, in a pamphlet titled, "Re-establishment of Disabled Persons." The following are some of the more important recommendations made by the Survey Committee:

1. That a Physical Medicine and Rehabilitation Centre should be set-up in Montreal for the purpose of meeting the rehabilitation needs of the severely handicapped. This Centre, it was suggested, might undertake to provide in-patient services for the most severely handicapped. However, it was pointed out that such services would be costly and would not meet the employment and vocational rehabilitation needs, which the study indicated were of immediate and paramount importance in Montreal.

2. That a recreational programme should be included as a necessary rehabilitation service, and that the groupings of patients for such recreational activity should be determined by cultural interests and recreational preferences rather than by the type of disability.

The following activities were set forth as examples of the possible content of a recreational programme:

A choral group, orchestra, dancing class, card parties, drama group, craft classes and games requiring different grades of activity and skill.

3. That rehabilitation and employment services should be provided for the home-bound and the chronically ill, in spite of the time involved and the individual attention required by the therapist.[1]

The Occupational Therapy and Rehabilitation Centre

As a result of the recommendations of the two above-mentioned surveys, the decision was made to re-organize and expand the programme of the Occupational Therapy Centre so that the services rendered would provide more effectively for the total rehabilitation of the civilian handicapped client. This expansion of the scope of the programme of the Occupational Centre was initiated in May, 1951, at which time the name of the agency was changed to the Occupational Therapy and Re-habilitation Centre. The agency, however, was to remain in the same premises on University Street, until such time as a more commodious and better equipped building could be secured.[2]

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[1] Montreal Rehabilitation Survey Committee, Re-establishment of Disabled Persons, December 1949, p. 133-134.

[2] The University Street building was subsequently vacated on February 4th, 1954, and the Centre re-located in a very large building at 1030 Ottawa Street.

Physical Lay-out of Building

In appearance, the Centre was a hall, 75 feet long and 39 feet wide, in which all programme was carried out. This hall was located in the rear of the Montreal Diocesan Theological College, and entrance was gained to it by a steep flight of stairs.[1] With special permission from the College administrator, however, entrance could be gained to the Centre through the main hallway of the College. This entrance was used when patients were too crippled or otherwise handicapped to enter by the steep flight of stairs.

In the physical lay-out of offices and departments, there was very little partitioning. The area used for floor checkers and for gymnasum activity was an open space on the floor. The typing, weaving and sewing section was likewise unpartitioned.

The social casework department was partitioned off, but had no ceiling and was situated next to the carpenter's shop. The occupational therapy department likewise did not have a ceiling.

Objectives

In its statement of function, the re-organized Centre set forth three main objectives:

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[1] Infra., Appendix E

1. The provision of a service for the evaluation of the potentialities of handicapped people referred there.

2. The provision of rehabilitation treatment services aimed at assisting the handicapped to achieve the maximum physical, social and economic independence of which they were capable.

3. The establishment of a clinical facility for University students, for professional personnel and for research.[1]

The sheltered workshop and the home-bound service which were features of the previous agency, the Occupational Therapy Centre, were not included as such in the stated objectives of the new Centre, the Occupational Therapy and Rehabilitation Centre.

Admission Policies

In its statement of admission policies, the agency declared that patients might be referred for treatment or evaluation by private physicians, hospitals and social agencies, or directly by the applicant or some relative of his.

Such applications for treatment would have to be accompanied by a signed "Physician's Referral Form",[2] in which would be indicated the nature of the disability, the medical prognosis, the types of services required and whatever precautions during treatment would be neces-

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[1] Occupational Therapy and Rehabilitation Centre, Description of Services, Montreal, p.3.

[2] See Appendix, B. for copy of form.

sary to be observed, in view of the patient's condition.

It was further stipulated that agencies referring clients would be required to provide a transcript of all such pertinent information regarding the personal, social and economic history of the patient as might be useful in planning and carrying out an effective treatment programme.[1]

Three conditions under which a patient might be denied admission or continuation of treatment at the Centre were set forth:

1. If the case-load was too heavy to allow for effective service.
2. If, after an evaluation was made at the Centre, or at any other reliable centre, it was decided that the patient would not receive sufficient benefit to justify further treatment at the Centre.
3. If there was no current opening for the particular type of case, in which instance, the patient would be put on a waiting list.
4. If the disability of the patient was such as to unduly disturb the other patients.

Staff Resources and Equipment Facilities

The year following the establishment of the Occupational Therapy and Rehibilation Centre, t he treatment programme staff of the Centre was increased to include a full time social caseworker, a full time physical

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[1] See Appendix C for copy of referral guide form.

therapist, an additional full time occupational therapist, a part-time speech therapist and a vocational counsellor. There was no medical doctor on the staff. However, the many doctors who examined the patients at hospitals and in clinics, and prescribed the treatment programme, were considered as belonging temporarily to the Staff of the Centre.

Social Caseworker: The function of the social caseworker was to explore the feelings and attitudes of the patient concerning his handicap and help him alter them, where necessary, so that they might help rather than hinder rehabilitation. The social caseworker also concerned herself with helping to ease financial, family and other environmental pressures which might have so worried the patient that he could not apply himself, to the best of his ability, towards the treatment programme prescribed for him. In dealing with the above pressures, the social caseworker, where indicated, worked with relatives or friends of the patient in helping them to maintain a positive attitude towards the patient. In financial matters, where social agencies had made the referrals, the Centre's social caseworker clarified with the referring social caseworker what roles each would play regarding the finan-

cial problems of the patient.

Some of the other specific duties of the social caseworker were as follows: to be in charge of intake and see that all the necessary forms from the physician, who examined the patient and from the referring social agency, met with the requirements of the Centre; to compile or record all related information, including medical reports, social, educational and employment histories, evaluation and progress reports; to send regular progress reports to referring social agencies and physicians; and to assist in making future plans for the client, in co-operation with the rehabilitation team, and to handle the closing interview and follow-up[1] the progress of the patient after discharge.

Physical Therapist: The function of the physical therapist was the testing of the range of movement of impaired muscles, tendons and joints, by such physical means as massage and the strengthening and retraining of them, and remedial exercises.

The physical therapist was required, where indicated, to instruct the patient in the use of prostheses, particularly those needed for disabilities of the leg and foot.

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[1] This function of follow-up of the discharged patient was not eventually carried out.

The only electrical equipment available for the use of the physical therapist was a muscle stimulator. All other equipment used was to promote active remedial exercise.

Occupational Therapist: The function of the occupational therapist was to help the patient strengthen and extend the range of movement of impaired muscles and joints, and help develop the desired skills of mental and muscular co-ordination which would enable the patient to perform household activities at the greatest potential of efficiency or perform such activities of self care as attending to one's toilet, using transportation services, using the telephone, and caring for children.

The occupational therapist also selected for the patient such activities as would condition him physically and mentally for the sort of work he was expected to do upon termination of his contact at the Centre. In this connection, the occupational therapist worked closely with the vocational counsellor, who helped the patient determine the type of work he was best suited for.

In addition to the above, the occupational therapist sought, through recreational activities, to provide a socializing experience for the patient by encouraging him to participate in group activities, such as singing or informal discussions. In instances where

the patient was a foreigner and had difficulty in relating to others because of language, the occupational therapist helped facilitate socialization by teaching him to speak English.

Some of the various activity media used by the occupational therapist were: weaving, needle work, dressmaking, leatherwork, art work and gardening. A dummy pay phone and bus entrance were used to help train patients to perform activities of self care. Also, a doll was used to help a mother learn to perform motions required in the care of the baby she would later have to care for.

In order to evaluate the patient's ability to perform activities of daily living and self care, the occupational therapist used a standard form upon which the patient's abilities and his limitations were charted at the outset of training and thereafter throughout his period of treatment.

The following are examples of the use of this chart:

Under the heading, Dressing, the patient was checked in regard to his ability to perform such actions as putting on and removing under-clothing, putting on and removing a buttoned shirt, and putting on and removing a tie or buckled shoe.

Under the heading, Hygiene, the patient was checked for his ability to perform such actions as combing and

brushing the hair, using make-up, or shaving, brushing the teeth, taking a bath or shower.

Under the heading, Eating, the patient was checked in regard to his ability to perform such actions as eating with the fingers, eating with a spoon, stirring coffee, drinking from a glass, drinking from a cup, and pouring from a pitcher.

Under the heading, Daily Routine, the patient was checked in regard to his ability to perform such actions as shaking hands, turning a door knob, writing his name and address, sharpening a pencil, filling a pen, ringing a door bell, locking and unlocking a door, and lighting a cigarette with a match or with a lighter.

Finally, under the heading, Locomotion, the patient was checked in regard to his ability to perform such actions as getting out of bed to a standing position and getting into bed from a standing position, getting into a wheel chair from a standing position and vice versa, walking forward 30 feet and stopping quickly, walking sidewards through an aisle of seats, walking backwards, stepping up and down a curb and placing money in a turnstile.[1]

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[1] Occupational Therapy and Rehabilitation Centre, Description of Services, pp.15.

In order to evaluate the patient's ability to perform household activities, the occupational therapist used another standard form upon which to chart the patient's abilities and her limitations. The following are examples of the use of this form:

Under the heading, Meal Preparation and Service, the following were checked: the patient's ability to shop in the market, her ability to turn on a gas or electric stove, her ability to stretch and reach high cupboards or stoop to low cupboards and her ability to open a can.

Under the heading, Cleaning Activities, the following were some of the abilities checked: the ability to make a bed, the ability to tidy a room by picking-up objects from the floor, emptying ash trays and wastebaskets, dusting high and low surfaces, sweeping and mopping a floor, using a vacuum cleaner and washing windows.

Under the heading, Laundry, some of the following were checked: the ability to sort clothes, to carry wet clothes in a basket and to put clothes through a wringer and hang them on a line.

Under the heading, Sewing, the following were checked: the ability to use scissors, to use a needle and thread and to operate a sewing machine.

Finally, under the heading, Child Care, the fol-

lowing were checked: the ability to lift a child, to bathe it, dress it and feed it.[1]

Speech Therapist: The function of the speech therapist was to provide language training and speech retraining for patients whose handicaps stemmed from such conditions as aphasia, cleft palate, cerebral palsy, poliomyelitis, stuttering, impaired hearing and articulatory defects.

The physical and the functional etiology of the handicap was recognized and, where indicated, close team work with the social casework, physical therapy and occupational therapy departments was carried out to facilitate the r ehabilitation of the patient.

The equipment used by the speech therapist was a tape recorder for the recording of the patient's voice, and a mirror with which the patient could view himself as he practised the exercises prescribed for him.

Vocational Counsellor and Psychologist: The function of the vocational counsellor was to evaluate, by means of interviewing and the interpretation of psychological tests, the vocational potentialities of the patient and to help him choose an occupational pursuit which was in keeping with his capabilities. She was also required to

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[1] Ibid., pp. 18.

follow-up the patient's progress after his placement in employment.

A library containing literature on job opportunities and employment trends was one of the facilities of the vocational counselling department. The patient was encouraged to use this library on his own iniative, but, in addition to this, active help was given him in securing employment, either by his referral to specific jobs or by his referral to the Special Placement Section of National Employment Service.

The history of the Occupational Therapy and Rehabilitation Centre, a general description of the organization and of its physical structure, an enumeration of its staff resources, with a summary of staff functions and equipment used by staff, have been some of the matters so far discussed. It is now proposed to describe the treatment programme time-table and to mention some of the operational procedures by which treatment was carried out.

Time-table

The patient's treatment programme at the Centre commenced at 10.00 a.m. From this hour until 10.30 a.m., patients resumed work on activities and projects, both of an individual and group nature, which they had been doing the previous day.

From 10.30 a.m. to 11.00 a.m. a class was conducted by the assistant occupational therapist, for patients

who had disabilities of the hand.

From 11.00 a.m. to 12.00 noon a walking class was conducted by the assistant physical therapist, with the chief occupational therapist occasionally providing musical accompaniment on the piano. During this period, instruction was also given by the occupational therapist in self help and household activities. The period was also used by other members of the treatment staff for interviewing of individual patients.

From 12.00 noon to 1.00 p.m. the patients had lunch, seated around a long table. During this period, there was no direct supervision of patients by the staff, but they did nonetheless observe from a distance how the individual patients were adjusting to this unstructured social situation.

From 1.00 p.m. to 1.30 p.m. patients resumed the individual or group projects from which they had been interrupted for lunch.

From 1.30 p.m. to 2.00 p.m. remedial games and exercises were conducted for the strengthening and development of the arm.

From 2.00 p.m. to 3.00 p.m. the patients engaged in work on group projects.

From 3.00 p.m. to 3.30 p.m. a general class in gymnasium activities was conducted by the physical therapist.

From 3.30 p.m. to 4.00 p.m., under the direction of the occupational therapist, group recreational activities, such as music, games and specific projects were carried out.

It has been shown above that there was a definite plan at the Centre regarding the time interview sessions and testing and training periods for the patients were to be conducted. It is now proposed to examine the methods and procedures by which the patient was admitted to the Centre and his rehabilitation programme charted, guided and evaluated to the point of the termination of contact at the Centre.

Operational Methods and Procedures

Upon the receipt of application for a patient's admission to the Centre programme, such reports as the medical and social history of the patient,[1] and the Doctor's prescription of a treatment programme, were circulated by the caseworker to the other staff members who discussed informally the patient's situation. Upon the basis of this review, the caseworker made the decision as to whether the patient's application would be approved. In case of approval, the patient was asked to report to the Centre for his orientation interview.

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[1] Information on the social history of the patient was frequently lacking especially when the referrals were from other than social agencies.

During this interview, the patient was encouraged to express his feelings about the rehabilitation programme, and then clarification was given him regarding the nature of the treatment regime proposed for him.

Upon the completion of the patient's introductory interviews with all the other staff members, scheduled to work with him, the patient was placed upon a three weeks probationary period, during which an evaluation was made of his ability to avail himself successfully of the services of the Centre, failing which, he would be requested to discontinue treatment.

During the course of treatment, progress reviews of the patient were held periodically so that the treatment staff might all be informed how the patient was responding to the combined treatment programme and whether any modifications of a particular phase of the treatment programme were indicated. These progress reviews were usually held impromptu.

Progress reports[1] giving the evaluations of patients by each staff member, and a summation of these evaluations were circulated to the referring social agencies for their general information and to the doctor who had made the initial pre-admission examination of the

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[1] See Appendix D

patient, especially in cases where advice was sought regarding any proposed change in the treatment plan or in the intensity of the programme for the patient.

When the patient was nearing the successful completion of his treatment programme or when it was felt that a patient, because of continued absence, or for some other reason, should terminate his active contact at the Centre, a discharge conference, involving the members of the treatment programme staff was called by the social caseworker.

The decision of this Conference was then conveyed to the person who had referred the patient to the Centre and, where possible,[1] to the doctor who had made the initial medical examination and had prescribed the treatment programme.

Continued contact with the patient after the termination of his active treatment programme at the Centre was a responsibility accepted by the Centre and delegated to the social caseworker to carry out. No evidence was found by the writer, however, that this follow-up of patients' adjustment to the work or domestic situation, which was the goal of treatment, was ever carried out. The discharge of too many other responsibilities might have been the factor which precluded the caseworker's carrying

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[1] The Centre could not always be kept posted on the latest address of the doctor who had made the initial examination of the patient.

out this additional but vital function.

Summary and Evaluation .

The findings of this chapter will be summarized and evaluated with reference to the organizational features of the Centre, its physical structure and equipment, its treatment staff and the programme of services rendered at the agency.

The criteria of evaluation of the Centre will be the recommendations made by the Special Committee of the Montreal Council of Social Agencies which made a survey of the Occupational Therapy Centre in 1945, and also the later recommendations made by the Montreal Rehabilitation Survey Committee in 1949, regarding the content of a treatment programme in a rehabilitation Centre.

Other criteria will be the recommendations regarding programme made by the Canadian Welfare Council,[1] and the number and type of rehabilitation services rendered in such other rehabilitation Centres as the Rehabilitation Department of the Queen Mary Veterans Hospital, which the writer visited by appointment, and in the rehabilitation

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[1] Supra., p. 9 - 10

centre operated in Vancouver by the Western Society for Rehabilitation.[1]

The writer will also state, from his own point of view, any details about the Centre which appeared to him to have been very appropriately included in the programme, or any services or procedures which, in his estimation, were lacking, or, if present, could have been improved.

Objectives: In its statement of objectives, the Occupational Therapy and Rehabilitation Centre did not include the provision of vocational training in the Centre. This omission was in keeping with a recommendation made in the 1945 survey of the Centre, in which it was advised that, in view of the impracticality of successfully rendering the services of vocational training, such a service should be excluded from the statement of objectives of the Centre.

Another service which was excluded from the statement of objectives was the provision of an occupational therapy service in hospitals, mental institutions, and sanatoria outside the Centre. The continuation of such a service would have duplicated a service which was already available in many hospitals and in some institutions.

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[1]A. D. Pinkerton and N. J. Desjardins, "Step-by Step Story of a Community Rehabilitation Centre", Canadian Hospital, September, 1954, pp. 40-45.

The Centre did, however, increase the scope of its objectives by offering an evaluative service to the handicapped, by providing for the total rehabilitation of unrestricted categories of the handicapped, and by establishing a clinical facility for University students and professional personnel to obtain field work training and do research.

Organization: In its organization for programme and its drafting of procedures for carrying out programme, the Centre set forth clearly its admission policies and drew-up standard physician's referral forms and referral guides, by means of which some standardization of information required, regarding patients' disabilities and circumstances could be obtained.

The progress report form was a device by means of which the observations of the various staff people working with the patient could be pooled and a better appreciation gained of how the patient was responding to the overall rehabilitation process, and what modifications in treatment programme might be indicated.

The time-table was so arranged that patients had a balance between periods of activity and periods of rest.

Physical Resources and Equipment: The lay-out of the Centre was such that there could be little feeling of privacy while the programme was in process. The gymnasium was not partitioned-off, and patients were in full view of passersby. The social caseworker's office, though partitioned-off, had no ceiling and, being situated next to the carpenter's shop, the noise of tools in use in the shop was a source of disturbance when interviews with patients were in process.

In addition to the above, there was no room available which could be used for relaxation purposes.[1]

The deficiencies in equipment were most acute in the physical therapy department, where the only piece of electrical apparatus was an electrical muscle stimulator. It was not possible, therefore, for a patient to receive hydro-therapy[2] and other heat therapies available at the Montreal Queen Mary Veterans Hospital Rehabilitation Department and at the Western Society for Rehabilitation in Vancouver.

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[1] The provision of facilities whereby a patient could relax in seclusion was one of the recommendations of the Occupational Therapy Centre Survey committee.

[2] This service is now provided at the new Centre building on Ottawa Street.

Staff: When the Occupational Therapy and Rehabilitation Centre came into operation, its staff was increased to include a social caseworker, a psychologist, vocational counsellor, an additional occupational therapist, a physical therapist, and a speech therapist.

A medical doctor, the other staff person recommended as a necessity in the survey of the Occupational Therapy Centre, was not present on the staff of the Centre.

With reference to this omission, it was noted by the writer that of the 63 patients selected for study, 47 of them had been examined and referred by as many different doctors. Of these some were private practitioners, some were staff members of hospitals, and others were doctors serving their periods of internship. Since, as the writer was informed by a Montreal physician, there were only a few doctors in Montreal who had taken specialized training in physical medicine as it related to the rehabilitation of patients suffering diverse types of disabilities, it is questionable whether it was the best arrangement to have so many doctors with their different approaches to rehabilitation of the handicapped examine and prescribe treatment for the patients.

Instead of the above, it would seem a better

practice to have a single doctor, qualified in physical medicine, resident at the Centre, who would examine all patients and prescribe their treatment programme. In case of a medical emergency, this doctor would be available to handle the situation. He would also act as a liaison with the referring doctor, or hospital, in those cases where continuing medical supervision was indicated.

In view of the above, therefore, it would appear that the lack of a staff doctor was a serious omission at the time this study was undertaken.[1]

Apart from the absence of a resident medical doctor on the treatment programme staff of the Centre, the number of staff members and the diversity of professional skills they represented was a considerable improvement over the skeleton staff which had served the earlier Occupational Therapy Centre.

Services: The services provided at the Centre were not in every instance restricted to those services which it would normally be expected that the staff personnel, mentioned above, could provide and supervise. For instance, it was to be expected that the physical therapist would provide physical therapy in the Centre and that the occupational therapist would see that

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[1] The inclusion of a medical doctor on the staff of a rehabilitation centre was one of the recommendations made by the Occupational Therapy Centre Survey committee.

occupational therapy was employed in the rehabilitation of patients. But such services as educational classes and recreational services which had been recommended by the Montreal Rehabilitation Survey Committee, were provided under the supervision of the occupational therapist. This staff member taught English to patients from foreign countries and she conducted sing-songs and helped the patients plan parties which provided some form of recreation.

The above raises the question as to whether planned recreational activities should not be the responsibilities of a staff group worker, whose exclusive duties would be conducting a group work programme. The introduction of such a programme would have to be very carefully thought through, however, for since the group worker and the occupational therapist have certain common areas of skill, some confusion might be caused as to which staff person should shoulder a particular responsibility.

It would appear, however, that there was a definite area of treatment of the handicapped, which the group worker, as a specialist, was uniquely qualified to deal with. This area is the socialization of the deeply withdrawn, self pre-occupied patient.

The theory was advanced in an unpublished article[1] that although such media as art and craft work are successful in diverting the patient from his tendency towards extreme introversion, yet, there was the possibility that a patient might become so familiar with the technique of performing a particular activity, that he could do it mechanically and revert to his habit of self absorption.

In order to correct the above situation, however, the group worker, assuming the role of a group leader, could so guide or give impetus to interaction between members of a group, that, faced with the ever-changing challenge of adjustment to what was said or done by the other members of the group, the withdrawn patient would not find it possible to recoil into his shell of introversion.

However, the above use of the group worker as a therapist, would require a high degree of skill and competence in an area of group work which is still a specialization.

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[1] Janina Adamczyk, "The Relationship of Occupational and Recreational Therapy in the Institutional Treatment of Mental Patients". Unpublished, undated article by the Head of the Department of Sociology, Toledo University, Ohio., p.5.

The service to home-bound patients, which had been a recommendation of the Montreal Rehabilitation Survey Committee, was successfully provided, in one instance, to a 65 year old patient, whose disability was a double amputation. He was able to return, after treatment, to his former job.

The Centre, however, was not organized to provide,on a large scale, a service to home-bound patients.

The provision of a sheltered workshop[1] was one of the services of a rehabilitation centre, which was recommended by the Canadian Welfare Council. This was not provided, as a separate service, at the Centre. However, a somewhat comparable service was provided, on a limited scale, in the occupational therapy department and in the carpenter's shop, which operated under the supervision of the occupational therapist.

For example, when a patient was approaching the time when he would be returning to work or having his first employment experience, his activities in the occupational therapy department were so increased that he was able to develop the work tolerance he needed,

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[1] It is the writer's understanding that the type of sheltered workshop referred to here, is the one which provides a pre-work experience for patients who will ultimately return to full scale employment.

so that his transition from treatment at the Centre, to the assumption of the full responsibilities of a job, would be as easy as possible.

The provision of a car service was a recommendation of the Occupational Therapy Centre Survey Committee, for those patients who were so handicapped, that they could not use the regular transportation facilities of the street car, bus, or taxi. Such a service was provided at the Occupational Therapy and Rehabilitation Centre, in the form of a special taxi service, operated by a man who was trained in the handling of patients, who had disabilities of such severity, that they needed special assistance with their transportation to the Centre.

The follow-up of patients' adjustment, after discharge from the Centre, was a service recommended by the Montreal Rehabilitation Survey Committee,[1] and a responsibility delegated by the Centre, to the case-worker. The writer did not discover, however, any instance where this responsibility had been carried out. It is possible that contact with the patients had been continued after their discharge from the Centre, but

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[1] Supra., p.10.

that, due to other pressures, such contacts were not recorded.

In reviewing the scope of the responsibilities of the caseworker, it would appear that more than one caseworker would be required if follow-up contact with patients was to be effectively carried out.[1]

In summary, it has been shown that the Occupational Therapy and Rehabilitation Centre undertook to provide a complete programme of rehabilitation for unrestricted categories of handicapped patients. In attempting to achieve its objectives, the Centre employed the services of a qualified staff, which represented a diversity of professional skills, which were far in excess of those which were available at the earlier agency, the Occupational Therapy Centre.

In its re-organization, the Centre set forth clearly the conditions under which patients might be admitted or required to discontinue treatment at the agency. It drafted "physician's referral forms", and "referral guides", which gave to those concerned with

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[1] When the Centre moved to its most recent location on Ottawa Street, another caseworker was added to the staff.

the referral of patients, an indication of the amount and type of required information concerning the patient, which would be most meaningful to the Centre's programme staff. In addition, the Centre drew-up progress report forms and instituted other procedures whereby the entire treatment staff could function as a team, both in planning and in carrying out the individualized treatment programme of the patient.

But, in contrast to the many positive elements in the Centre's programme of rehabilitation as briefly outlined or suggested above, there were some minor and some major limitations[1] in its programme of services, which might have posed some difficulties to patients. These limitations were in reference to the physical structure of the building, its programme equipment facilities, the number of its staff and certain of its procedures for the referral of patients.

The building did not provide a ramp, whereby severely handicapped patients could gain easy entry to the Centre.[2] Many offices and departments were unpartitioned, thereby inviting the distraction of patients, when in process of carrying out prescribed treatment

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[1] It would appear that most of these limitations were unavoidable.

[2] The main hall way of the Diocesan Theological College, which had been used in cases of emergency, could not take the place of the convenience of a ramp.

activities. The caseworker's office, which ideally should help promote the patient's feeling that undivided attention was being given to him and that his problem was being treated confidentially, had no ceiling, and was situated next to the carpenter's shop, from which the sound of electric saws in operation was almost deafening.

In reference to the programme equipment, the physical therapy department, which ideally should have had facilities for hydrotherapy and other therapies, administered with the aid of electrically operated machines, had a mechanical muscle stimulator as its only piece of electrical equipment.

With reference to staff, the responsibilities delegated to or otherwise assumed by the occupational therapist and caseworker were so expansive, that the services of additional assistant staff were clearly indicated. The inability of the caseworker to follow-up the progress of the patient after discharge was a case in point.

Regarding certain referral procedure, the practice of having so many doctors, with as many different approaches to rehabilitation, examine and prescribe the treatment programme of the patient, would most likely not permit the rendering of an optimum service to the Centre's clientelle.

In conclusion, therefore, although the programme of the Centre had many positive elements by means of which the rehabilitation of the patient was possible, yet it also had characteristics which, for certain patients, might have proven to be a handicap, which, added to the ones they brought to the Centre, might have been too great for them to overcome.

CHAPTER III

PATIENTS WHO ATTAINED OPTIMUM REHABILITATION

In this chapter it is proposed to discover what were the diverse characteristics and circumstances of the 21 patients who had attained optimum rehabilitation and to ascertain whether any of the above characteristics and circumstances of the patients might have been factors contributing to their ability to attain optimum goals of rehabilitation.

The following factors will be examined: age, type of disability, duration of disability prior to referral to the Centre, medical prognosis, educational status, employment status, and personality.

The patients listed as having attained optimum rehabilitation are those who had reportedly attained the goals towards which treatment was directed, whether such goals were employment placement, recovery of optimum speaking function, or improved ability to perform household activities and to care for one's self generally. The following three cases illustrate patients, whom the writer had placed in the optimum category of rehabilitation:

In case 31 the patient's disability was stated as a back injury. The statement in the case record regarding the disposition of the case was that the patient "had received maximum treatment" in the

casework, physiotherapy and occupational therapy departments and that he had been tested, trained and placed in employment by the vocational counselling department. Thus it was inferred that the maximum goal of rehabilitation, namely employment placement, had been attained.

In case 5 the patient's disability was stated as left hemi-plegia, which affected his gait. It was indicated that he had attended the casework, physiotherapy and occupational therapy departments and the closing statement was that "his gait had improved and that he had returned home". Thus, again it was concluded that the maximum intended goal of rehabilitation, namely the correction of an impediment in the gait, had been achieved.

In case 62 the patient's disability was listed as hemi-plegia, which affected the proper functioning of one hand. The patient received treatment in the casework, physical therapy and occupational therapy departments, and in the closing summary he was described as "having a good motivation to be self-sufficient and as being able to perform household activities well". Thus it was inferred that the maximum goal of rehabilitation towards which treatment was directed, which in this case was the ability to perform household activities, had been achieved.

It is now proposed in Table 1 to classify the rehabilitation goals of the 21 patients who had attained optimum rehabilitation.

TABLE I

Rehabilitation Goals of 21 Patients[a] attaining optimum Rehabilitation

Goals attained	No. of Patients
Total:	21
A, The Employed Rehabilitated:	11
a) placed in a new job	6
b) returned to former job	4
c) secured job himself	1
B. The Non-employed Rehabilitated:	10
a) improved ambulation	6
b) ability to perform household activities and care for self	3
c) improved speech	1

[a] Henceforth all mention of patients refers to those of the Occupational Therapy and Rehabilitation Centre.

An examination of Table I reveals that 11 of the patients attaining optimum rehabilitation had secured employment at the time of leaving the Centre.

Six of the 11 patients had been placed in new employment situations as a result of testing and counselling in the vocational counselling department of the Centre. A general description is given below of four of the above six patients:-

Case 31: This patient was a 48 year old, unattached woman with a high school education, who had worked as a packer and later as a teacher prior to her admission to the Centre. Her disability, sustained since birth, was "spondilythesis", which required the support of a Taylor Brace. Her medical prognosis at point of referral to the Centre was good. She received treatment in the casework, physiotherapy, occupational therapy and vocational counselling departments and was reported as having attended regularly and related well to the staff of the Centre. In response to her suggestion that it might be possible for her to attend a business machine training school concurrently with her attendance at the Centre, this arrangement was effected, and, upon the conclusion of her treatment at the Centre and her training at the school, she was placed in a clerical position.

Case 44: This patient was a 27 year old unattached man with a Grade 5 education, whose employment prior to admission to the Centre was that of hospital orderly, which job entailed waiting on tables, washing dishes and general help around the hospital. He was described as irritable, depressed, impatient, overly religious, and wishing for death. His disability was "epilepsy and defective gait". His medical prognosis was fair. He received several sessions in the casework, occupational therapy, speech therapy and vocational counselling departments. His attendance at the Centre was reportedly regular and he co-operated well with staff and other patients. He was placed in a job situation requiring the cleaning of tables, washing of floors, and other general cleaning chores.

Case 41: This patient was a 19 year old, unattached girl who had attended a school for crippled children, where she took a business course. She worked as a stenographer prior to admission to the Centre. She was described as an attractive, friendly, fairly independent girl. Her disability was "anterior poliomelitis", which resulted in a hip-knee fusion. She received treatments in the casework, physiotherapy, occupational therapy and vocational counselling departments. During treatment, her attitude to her handicap was good and her relationship to the staff and to other patients harmonious. Upon the conclusion of her treatment she was placed in a new job situation.

Case 30: This patient was a 15 year old, unattached girl whose education was obtained in the special class of an elementary school. She was described as a friendless girl who had a poor attitude towards her parents and who exhibited feelings of inferiority. Her disability, sustained one year previously, was stated as"hysterical conversion symptoms", with no specification as to what form the disability took. Her prognosis was fair. She received treatment in the casework, occupational therapy and vocational counselling departments. Her attendance was regular and she related well to staff and to other patients. She made pronounced progress in overcoming her former anxiety and achieved an 11 point raise in I.Q. rating. She was placed in a factory and did general factory work for four months. She did not like this work and on her own initiative she secured a job drilling holes in bracelets and inserting decorative stones.

Continuing the examination of Table I, it is indicated that four of the 11 patients in the employed rehabilitated category had returned to their former jobs. A general description is given below of three of the above four patients:-

Case 11: This patient was a 20 year old unattached man, who had a grade 7 education. He was employed as an office boy and later as a coach cleaner prior

to admission to the Centre. He was described as a man of dull, normal intelligence, who was habitually tense and unable to concentrate. His disability was stated as "general weakness resulting from the Guillain Barre syndrome". The disability had been incurred two months previously and the prognosis at point of referral was good. He received treatments in the casework, physiotherapy and occupational therapy departments. He related well to staff and other patients and on the whole was self-directing. He completed treatment and returned to his former job as a coach cleaner.

Case 47: This patient was a 32 year old, unattached woman whose education reached college level. She was employed as a librarian prior to her admission to the Centre. She was described as being very withdrawn and having few friends. Her disability was "schizophrenia", first diagnosed eight years previously, and her medical prognosis at point of referral to the Centre was good. She had treatment in the occupational therapy department only. Her attendance was regular and she related well to patients and staff.

Case 54: This patient was a 29 year old, unattached man, who had a grade 10 education. His employment prior to referral to the Centre was an apprentice machine operator. He was described as having a very pleasant manner and being co-operative. His disability was "severed tendons of the index fingers of the right hand". The injury was incurred six months previously. No medical prognosis was given at point of referral. He received treatment in the casework and physical therapy departments. There was no mention of how he reacted generally to the treatment programme, but his situation was described as having improved and he was able to return to his former job as an apprentice machine operator.

Case 33: This patient was a 46 year old, married man, who had worked at an electrical shop prior to admission to the Centre. His disability was an "amputation of both legs, as a result of diabetes mellitus", incurred four years previously. No medical prognosis was stated at point of referral. This patient received treatment at home by the physical therapist. He had a strong motivation to return to work and resumed his job in the electrical shop.

Continuing the examination of Table I, it is indicated that one patient had found a job on his own volition.. This patient is described below:

> Case 22: This patient was a 34 year old, unattached woman, who had a high school education, which included commercial training. Prior to her admission to the Centre she did general office work. She was described as a pleasant, timid and somewhat lethargic individual of dull, normal intelligence. Her disability was the "severed tendon of a finger", incurred two months previously. No medical prognosis was indicated. She received treatments in the casework, physical therapy, occupational therapy and vocational counselling departments and was conscientious in working towards her rehabilitation. On her own volition she sought out and secured a job.

Continuing the examination of Table I, it is indicated that of the 10 patients, whose optimum rehabilitation had not included employment placement, six had attained the Centre's optimum goal for them of improved ambulation. Four of these six patients are described below:-

> Case 3: This patient was a 48 year old, unattached man, who had a high school education, which included some techincal training, His pre-referral employment was not stated. His disability was impaired gait, resulting from hemiplegia which followed a head injury. The disability had been incurred three months previously, and his medical prognosis was stated as good. He received treatments in the casework, and physical therapy departments. No details were given regarding his performance during treatment, but it was indicated that his gait had improved and that he had returned to his home in the Maritimes.
>
> Case 4: This patient was a 23 year old, unattached Italian woman who had a grade school education and was unemployed prior to admission to the Centre. Her disability, incurred since birth, was "cerebral palsy", which made her so weak and tired that for

many years she was unable to walk. Her condition was at one time considered by a physician to be hopeless. Her medical prognosis at point of referral was, however, declared fair. She received treatment in the occupational therapy department only, where she was taught to use orthopedic braces which improved her gait.

Case 20: This patient was a 31 year old married woman whose 30 year old disability was "poliomyelitis with arthodasis of the left foot". She received treatment in the physical therapy department only, and at point of terminating treatment had attained the desired co-ordination of muscular activity which resulted in improved ambulation.

Case 39: This patient was a 53 year old unattached woman whose occupation prior to referral was receptionist. She was described as an extremely depressed woman who wept easily and was very dependent upon her sister-in-law and nephew. Her disability was "very poor ambulation" occasioned by her affliction one year previously with Parkinson's Disease. She received treatments in the casework and occupational therapy departments and at point of termination of treatment was described as having improved in ambulation.

Returning to the examination of Table I, it is indicated that of the 10 patients whose optimum rehabilitation had not included employment placement, three had attained the Centre's optimum goal of rehabilitation, namely, the performance of household activities and activities of self care. The following is a description of the above-mentioned three patients:

Case 18: This patient was a 48 year old unattached woman who had a good position in employment prior to her admission to the Centre. This woman whose estranged husband had been in a mental hospital for 19 years, was described as a constant worrier. Her disability was an "injured hand and foot", which resulted from hemiparesis, sustained two years previously. Her prognosis was fair. Her programme

at the Centre consisted of treatments in the casework, physical therapy, occupational therapy and speech therapy departments. She remained on the active file of the Centre for 10 months and was declared as having achieved the level of functioning of her hand which permitted the performance of household activities.

Case 52: This patient was a 62 year old married woman who was reported as having been very discouraged about her disability, which was "left-sided hemiplegia". Her treatment programme included sessions in the casework physical therapy and occupational therapy departments. At point of termination of contact she was reported as having acquired facility in dressing herself.

Case 62: This patient was a 26 year old married mother of two children, who had a high school education and worked as an office secretary prior to her admission to the Centre. She was described as being attractive and optimistic. Her three months old disability was an "injured right hand and right foot", which resulted from hemi-plegia. Her prognosis was fair. Her treatment programme comprised sessions in the casework, physical therapy and occupational therapy departments. During her programme of treatment, she related well to other patients and to staff, but at times was very demanding of attention. Upon termination of her treatment at the Centre, she was declared as being able to perform household activities well.

Once again, examining Table I, it is indicated that one patient had achieved the optimum goal of improved speech. This patient is described below:

Case 5: This patient was a 36 year old unattached woman, with a high school education, who had worked as a school teacher prior to her admission to the Centre. She was described as having had perfectionist drives. Her disability, sustained three years previously, was "aphasia", which resulted from a hemiparesis. Her treatment programme consisted of sessions in the casework, physical therapy, occupational therapy and speech therapy departments. She

attended the programme regularly, had a good attention span and related well to both staff and patients. At point of termination of contact, she was declared as having achieved an improvement in her speech.

With the classification of the 21 patients, attaining optimum rehabilitation, in terms of the various rehabilitation goals attained by them, and a general description of the patients in these various classifications, it is now proposed to consider the diverse characteristics and circumstances of the patients, to see which of these factors may have promoted the attainment of optimum rehabilitation. The factors which will be examined are the patient's age, the type of his disability, the length of his disability prior to referral to the Centre, his medical prognosis, employment status, educational status, and personality.[1]

The first factor to be considered is the patient's age. This is presented below in Table II, which shows the distribution of patients in age intervals of 10 years.

It is the purpose of this table to try to establish whether a correlation existed between the patient's age and his successful attainment of optimum rehabilitation. If such a correlation existed, then it would seem reasonable to assume that the younger patients, that is, those

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[1] Personality is here defined as the level of the patient's emotional and social adjustment prior to referral.

40[1] years old and less, would be the ones who, by virtue of their youth and assumed greater adaptability, would be able to attain optimum rehabilitation more readily than the older patients, over 40 years.

TABLE II

Ages of 21 Patients attaining Optimum Rehabilitation

Age (in years)	No. of Patients
Total:	21
20 and under	3
21 - 30	5
31 - 40	4
41 - 50	5
51 - 60	1
61 - 70	3

In examining Table II, it is indicated that 12 of the total 21 patients were 40 years old or less and that only 9 were over 40 years. On the basis of this small numerical difference in the two groups under 40 years and over 40 years, it is concluded that, in

[1] The age of forty has been chosen because the "change of life" usually takes place at this time and is characterized by internal changes which demand a decelerated pace of living.

the case of the 21 patients of the Centre who had attained optimum rehabilitation, age was not a significant factor in determining the ability of the patient to attain optimum rehabilitation.

The second factor to be examined in Table 111 is the type of disability suffered by the patient. By the classification of the patients' disabilities, it is proposed to discover what were the sorts of disabilities which were successfully responsive to the treatment programme of the Centre.

In examining Table 111, which classifies the disabilities of 21 patients who attained optimum rehabilitation, it is indicated that these patients had disabilities stemming from diseases or injuries which fell into three broad classifications: neurological conditions, fractures and amputations and mental and emotional disturbances.

Although a large number and diversity of disabilities had been incurred by the 21 patients, yet one notes that neither heart nor arthritic conditions appeared in the disability classifications. This raises the question as to whether the absence of such disabilities indicated that none of the patients attending the Centre had had these disabilities or whether patients having these disabilities were to be found only among those 42 patients who had attained little or no rehabilitation.

Table III

Disability Classifications of 21 Patients attaining Optimum Rehabilitation

Classification of Disability	No: of Cases.
Total:	21
Neurological Conditions:	13
a) Hemiplegia	5
b) Aphasia	1
c) Epilepsy	2
d) Poliomyelitis	2
e) Miscellaneous	3
-Cerebral Palsy	
-Parkinsonism	
-Guillain Barre Syndrome	
Fractures and Amputations:	5
a) Spondylithesis	1
b) Amputations	2
c) Severed tendons	2
Mental and Emotional Conditions:	3
a) Schizophrenia	1
b) Hysterical Conversion Symptons	1
c) Mental retardation ...	1

The third factor to be considered is the duration of the patient's disability. It was felt that there might be a correlation between the length of the disability and the degree of difficulty involved in rehabilitating the patient. This feeling was expressed by the Executive Dir-

ector of the Centre in her report at the first Annual Meeting of the Centre[1] as follows:

> It has long been the feeling of experts in the field of rehabilitation that the patients' dependency needs are intensified the longer they remain in a hospital setting, and that total rehabilitation is more easily accomplished the earlier the patient is encouraged to get service in a setting that duplicates the normal insofar as possible.

In the light of the above remarks, it was assumed that Table IV, which examines the duration of the disabilities of the 21 patients who attained optimum rehabilitation, might reveal that the majority of the patients had had disabilities of short duration, that is, for 12 months or less.

Table IV

Duration of Disability of 21 Patients Attaining Optimum Rehabilitation

Duration of Disability (months)	No: of Patients
Total:	21
1 - 3	5
4 - 6	1
7 - 12	2
13 - 24	2
Over 24	8
No data	3

[1]Occupational Therapy and Rehabilitation Centre, Annual Meeting, Montreal, March, 1953, p.3.

In analysing Table IV, it is noted that 8 of the total 21 patients had had disabilities extending over a period greater than 24 months.[1] The remaining 10 patients, with the exception of the 5 patients, listed as having had disabilities over a period of one to three months, were fairly evenly distributed among the other categories. Thus the assumption was not borne out that the majority of the patients who had attained optimum rehabilitation might have been those whose disabilities were of short duration only.

The fourth factor to be considered is the medical prognosis given the patient at point of referral by the examining physician. The various categories of prognosis used by the physicians were as follows: excellent, very good, good, fair, poor, uncertain and guarded. These categories were not defined.

For the purpose of simplification, the above categories have been reduced to three.

The category, good, denotes those patients whose medical prognoses were listed as excellent, very good, or good. The category, fair, denotes those patients whose medical prognoses were listed as fair, and the category, poor, denotes those patients whose medical prognoses were

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[1]To be more specific, the lengths of the disabilities of these 8 patients varied from 3 years to 49 years with an average length of disability of 16 years.

listed as poor or uncertain or guarded. The "no data" category denotes those patients whose medical prognoses had not been stated in the case records. There were as many as 9 such cases, which left a mere 12 cases upon which to test the writer's hypothesis that the majority of the patients who had attained optimum rehabilitation were those whose pre-referral medical prognoses were in the good or fair categories. These 12 cases are examined in Table V.

Table V

Pre-Referral Medical Prognoses of 21 Patients, attaining Optimum Rehabilitation

Pre-Referral Medical Prognoses	No: of Patients
	Total: 21
Good	6
Fair	6
Poor	0
No data	9

In examining the above table we find that there was an even distribution of 6 patients in the good and in the fair categories of medical prognosis and that there were no patients rated in the poor category. Excluding the unlikely possibility that some of the 9 uncategorized

patients might have belonged rightfully in the category of poor prognosis, the above findings would suggest that the ability of the 21 patients to attain optimum rehabilitation might have been related to the fact that their medical conditions had been such, at point of referral, that they had been awarded favourable medical prognoses.

The fifth factor to be considered is the educational status[1] of the patient, prior to his referral to the Centre.

Because of the prevalence of good, inexpensive facilities in Canada[2] for the attainment of formal education, it was assumed that the level of formal education attained by a patient might be some indication of his general level of adjustment, and that the latter might determine the success with which he could apply himself to the treatment regime of the Centre.

In the light of the above, it was further assumed that the patients who attained optimum rehabilitation at the Centre might have been those whose formal education had reached the level of at least grade 7 of Public School.

It is now proposed in Table VI to test the above

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[1]Educational status is defined as level of formal education attained by the patient.

[2]Three of the 21 patients who attained optimum rehabilitation had been listed as having been of Danish, German and Italian origins. In the absence of any information to the contrary, it is assumed that these 3 patients had been born in Canada.

assumption.

Table VI

Educational Status of 21 Patients Attaining Optimum Rehabilitation

Educational Status	No: of Patients
Total:	21
Attended Public School ...	12
Attended High School ...	8
Attended College	1

In examining Table VI, which classifies the 21 patients attaining optimum rehabilitation in terms of their educational statuses, it is indicated that 8 of the 21 patients had had at least High School Education, Twelve other patients, had had Public School Education, but no information was available regarding how many of these 12 patients had at least grade 7 Public School education. In view, therefore, of the above lack of information, no conclusions can be made regarding the validity of the assumption that, in the case of the 21 patients attending the Centre, their attainment of optimum rehabilitation was related to their having attained a grade 7 or higher level of formal education.

The sixth factor to be considered is the employment status[1] of the patient prior to his referral to the Centre. It was felt that the successful holding of a job required that the employee be so well adjusted socially and emotionally, that he could accept the inevitable demands and frustrations of the work experience and continue to function competently.

Therefore, it was assumed that if a patient had had a work experience, prior to his referral to the Centre, his adaptability to his former job might also mean that he could adapt to the regime of treatment at the Centre. Thus, it was further assumed that the majority of the 21 patients who had attained optimum rehabilitation would have had a successful working experience prior to referral to the Centre. This assumption will be tested in Table VII, which classifies the employment status of the 21 patients who attained optimum rehabilitation.

In examining Table VII, it is noted that 14 of the 21 patients attaining optimum rehabilitation, had been employed prior to referral to the Centre. This majority of previously employed patients tends to bear out the assumption that previous work experience was conducive to the

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[1]By employment status is meant whether the patient had worked or not. In the absence from the case records of any evaluation of the work experience of the 21 patients, it was assumed that they had all had satisfactory working experiences.

patient's ability to adjust successfully to the regime of treatment at the Centre.

Table VII

Employment Status of 21 Patients attaining Optimum Rehabilitation

Employment Status	No: of Patients
Total:	21
Employed ...	14
Not employed ...	2
No data ...	5

With reference to the 5 patients concerning whom no data was available regarding working experience, they were all married women who had made satisfactory marital adjustments, and on the basis of the adjustment made in this area, it might be assumed that they were, alike the 14 patients who had had previous work experience, adaptable to the treatment programme of the Centre.

The seventh factor to be considered is the patient's personality.[1] This has been stated in Table VIII under the two categories: well adjusted, and fairly well adjusted personality.

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[1] Supra., p,70.

The well adjusted category denotes those patients who had manifested only positive characteristics, such as good co-operation and strong motivation to get better.[1]

The fairly well adjusted category denotes those patients who had manifested some positive characteristics, such as self direction and regular attendance, but also some negative characteristics, such as, shyness and frequent worrying.[2]

It is assumed that the patients who had well adjusted personalities would have been able to adapt themselves to the treatment programme of the Centre and continue treatment towards the successful attainment of optimum rehabilitation. Conversely, it was assumed that the 21 patients who had attained optimum rehabilitation at the Centre would have had well adjusted personalities. This assumption will be tested in Table VIII.

In examining Table VIII, it is indicated that 18 of the 21 patients had had well adjusted or fairly well adjusted personalities. Thus the assumption that the personality of the patient had a direct relationship to his ability to attain optimum rehabilitation was borne out in the history of the 21 patients who had attained optimum rehabilitation at the Centre.

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[1] Infra., Appendix E.
[2] Infra., Appendix F.

Table VIII

Personality of 21 Patients attaining Optimum Rehabilitation

Personality	No: of Patients
Total:	21
Well adjusted	11
Fairly well adjusted	7
No data	3

Summary and Evaluation

In this chapter it was proposed to examine the 21 patients who attained optimum rehabilitation to see what rehabilitation goals had been achieved by them and to discover what kind of a group they were in terms of such characteristics as the following: age, type of disability, duration of disability, medical prognosis, educational status, employment status and personality adjustment.

The findings were that 11 of the 21 patients had been rehabilitated to the point where they resumed their former employment or undertook new jobs.

Among the remaining 10 patients, some had been rehabilitated to the point where their gait and ability to walk had considerably improved, and others were able to perform household activities and care for themselves gen-

erally. One of the 10 patients, who had suffered from aphasia, was able to speak much better.

With reference to the kind of a patient group which was represented by the 21 patients who attained optimum rehabilitation, the following were the findings:

There was a wide diversity in the ages of the patients, some being younger than 20 years, others, between 20 and 50 years, and still others between 51 years and 70 years of age.

The disabilities of the patients fell into three main classifications: nuerological conditions, which accounted for more than half the total number of patients, fractures and amputations, and mental and emotional conditions. None of the patients had had disabilities of a cardiac or arthritic origin.

The time lapse[1] between the occurence of a disabling condition and the patient's referral to the Centre varied from one month to 49 years. Ten patients had incurred their disabilities within a two-year period.

The medical prognoses awarded the patients in their initial medical examinations were either good or fair. No data was available regarding the medical prognoses of nine patients.

The levels of education[2] of the patients were as follows: attendance at public school, at high school and at College - the majority having attended public school.

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[1]This term is synonymous with the term, duration of disability, which has been employed in Table IV., p. 74.

[2]Also termed, educational status.

Experience in employment[1] was had by the majority of the patients, with two patients only, being known not to have worked.

The personalities of the patients were well adjusted or fairly well adjusted.[2] No data was available regarding the personalities of three patients.

In addition to discovering what kind of patients were those who had attained optimum rehabilitation, it was also the purpose of this chapter to go further and see whether the fact that the patients had attained optimum rehabilitation might have been related to some specific factor or factors in their characteristics and circumstances.

According to the findings, the following three factors stood out as possibly contributing to or justifying the patient's ability to attain optimum rehabilitation: the medical prognosis awarded the patient in his initial examination; his employment experience; and his personality.

In the above connection, it was found that the medical prognoses of 12 of the 21 patients had been either good or fair. Thus the assumption was in this case validated that a fair or good medical prognosis pre-disposed the patient to attain optimum rehabilitation.

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[1] Also termed, employment status.

[2] Examples of the type of criteria used to establish personality levels are given in Appendices E and F.

It was found also that the majority of patients who had attained optimum rehabilitation had had a work experience, prior to attending the Centre. Thus the assumption was borne out that, a work experience in the history of these 21 patients, prior to referral to the Centre seemed to have pre-disposed them to the attainment of optimum rehabilitation.

Another finding was that the majority of patients who had obtained optimum rehabilitation had had well adjusted or fairly well adjusted personalities. Thus the assumption that a well adjusted personality would pre-dispose the patient towards the attainment of optimum rehabilitation seemed to have been borne out in the experience of 21 patients who received treatment from the Occupational Therapy and Rehabilitation Centre.

The question arises as to why only one-third of the total 63 patients had attained optimum rehabilitation.

It is proposed in the following chapter to establish what were the characteristics and circumstances of the remaining 42 patients, who had attained little or no rehabilitation, and to discover which of them might have been factors which pre-disposed the patients to failure to attain optimum rehabilitation.

CHAPTER IV

PATIENTS WHO ATTAINED LITTLE OR NO REHABILITATION

In Chapter III, the characteristics and circumstances of the 21 patients who had attained optimum rehabilitation were tabulated and an attempt was made to discover how these characteristics and circumstances might bave been factors responsible for the successful attainment, by 21 patients, of optimum rehabilitation, in terms of certain treatment goals which the Centre had set for them.

In Chapter IV, it is likewise planned to ascertain the nature of the characteristics and circumstances of the 42 patients who attained little or no[1] rehabilitation, and to discover to what extent the above might have been the factors, attributable to the patient himself,[2] which had a bearing upon his failure to attain optimum rehabilitation, in terms of the Centre's treatment goals, as cited later in Table IX.

In examining Table IX, it is noted that a large diversity of rehabilitation goals had been set for the 42 patients who attained little or no rehabilitation.

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[1] The term, no rehabilitation, is not to be taken literally, since it is to be anticipated that some movement towards rehabilitation does take place when a patient is exposed, for more than a month, to a programme, such as that provided at the Centre. However, reference is made here specifically to the non-attainment of goals of rehabilitation as set by the Centre. The term, little rehabilitation, has been discussed in Chapter I, p.19.

[2] As contrasted with the factors within the Centre programme itself, as discussed in Chapter II.

TABLE IX

Rehabilitation Goals set for 42 Patients Attaining little or no Rehabilitation

Goals set for Patients	No. of Patients
Total:	42
Vocational Counselling and Job Placement	12
Evaluation of Potentialities	10
Improvement of Ambulation	5
Improvement of Ability to speak ...	5
General emotional and Social Adjustment	5
Psycho-social Adjustment to Handicap	3
Cultivation of Ability to Lip-read	2

Vocational counselling and job placement was the rehabilitation goal towards which treatment was directed for most of the patients.

The goal which ranked next in order of frequency was that of evaluation of the potentialities of those patients whose conditions were such that it could not be prognosticated what total level of rehabilitation they were capable of attaining.

There was a fairly even distribution of patients in terms of the remaining rehabilitation goals.

It is proposed to describe below, for each goal of rehabilitation category stated in Table IX, a few of the patients included in that category.

Under the category, vocational counselling and job placement, the following three patients are described:

> Case 8: This patient was a 22 year old, unattached woman, with a high school education, who had done clerical work prior to referral to the Centre. Her disability was stated as "epilepsy", for which the medical prognosis was poor. She received treatment in the casework, physical therapy, occupational therapy and vocational counselling departments.
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> Case 10: This patient was a 53 year old, married man, with public school education, who had operated a news stand prior to referral to the Centre. His disability was stated as "reactive depression", for which the medical prognosis was fair. He received treatment in the casework, occupational therapy and vocational counselling departments.
>
> Case 60: This patient was a 47 year old, married man, with a public school education, who had worked as a watchman, prior to referral to the Centre. His disability was stated as "Parkinson's Disease". No medical prognosis was stated. He received treatment in the casework, physical therapy, occupational therapy and vocational counselling departments.

Under the category, evaluation of potentialities, the following three patients are described:

> Case 13: This patient was a 51 year old, unattached man, with a public school education, who had worked for 15 years in a liquor bar, prior to referral to the Centre. His disability was stated as, "rheumatoid arthritis", for which the medical prognosis was fair. He received treatment in the casework, physical therapy, occupational therapy and vocational counselling departments.

Case 25: This patient was a 47 year old, unattached French speaking man, with a public school education, whose disability was stated as "anterior myocardial infarction". No medical prognosis was stated. He received treatment in the casework, physical therapy and occupational therapy departments.

Case 28: This patient was a 47 year old, unattached woman, with a public school education, who had never worked before, except in performance of chores in the home. Her disability was stated as "epilepsy", for which the medical prognosis was good. She received treatment in the casework and occupational therapy departments.

Under the category, improvement of ambulation, the following two patients are described:

Case 23: This patient was a 48 year old, married woman, with high school education, who had practised as a nurse for nine years, prior to referral to the Centre. Her disability was stated as "diffuse arachnosis of the spinal cord". No medical prognosis was stated. She received treatment in the physical therapy and occupational therapy departments.[1]

Case 32: This patient was a 48 year old, married man, with a public school education, who had done construction work, prior to his referral to the Centre. His disability was stated as "multiple sclerosis", for which the medical prognosis was fair. He received treatment in the casework, physical therapy and occupational therapy departments.

Under the category, improvement of ability to speak, the following two patients are described:

Case 12: This patient was a 35 year old, married woman, with public school and business school

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[1] It was contrary to general procedure for a patient not to be seen in the casework department. Perhaps the caseworker was ill at that time, or so busily occupied with a heavy schedule of work that she had not the time to do the necessary recording of her contact with the patient.

education, who had done office work prior to referral to the Centre. Her disability was stated as "right hemi-paresis, with aphasia". No medical prognosis was stated. She received treatment in the casework, physical therapy, and occupational therapy departments.

Case 55: This patient was a 47 year old, unattached man, with a public school education, who had operated a grocery store, prior to referral to the Centre. His disability was stated as "left hemi-paresis, with aphasia". No medical prognosis was stated. He received treatment in the casework, physical therapy, occupational therapy and speech therapy departments.

Under the category, general emotional and social adjustment, the following two patients are described:

Case 43: This patient was a 22 year old, unattached woman, with public school education, who had had no work experience prior to referral to the Centre. Her disability was stated as "Schizophrenia". She received treatment in the physical therapy and occupational therapy departments.

Case 48: This patient was an 18 year old, unattached girl, with a high school education, who had worked as a switchboard operator, prior to referral to the Centre. Her disability was stated as "active rheumatoid arthritis", for which the prognosis was poor. She received treatment in the casework and occupational therapy departments.

Under the category, psycho-social adjustment to handicap, the following two patients are described:

Case 9: This patient was a 67 year old, married man, with public school education, who had worked as a book-binder, prior to referral to the Centre. His disability was stated as an "amputated left leg", for which the medical prognosis was good. He received treatment in the casework, physical therapy and occupational therapy departments.

Case 51: This patient was a 16 year old boy, with public school education, whose disability was stated as "rheumatic heart disease", with a poor medical prognosis. He was seen once by the caseworker in an orientation interview, and died shortly afterwards. His disability had been considered very severe.

Under the category, cultivation of ability to lip-read, the following two patients are described:

> Case 6: This patient was a 19 year old, unattached young man, with college education, who had had no previous work experience, prior to referral to the Centre. His disability was stated as "deafness", resulting from drugs taken in treatment of tubercular meningitis. His medical prognosis was good. He received treatment in the casework and occupational therapy departments.
>
> Case 36: This patient was a 35 year old, unattached woman, with College education, who had worked as a dietician, prior to referral to the Centre. Her disability was stated as "nerve deafness, with bilateral gradual tone loss". She was seen once in the vocational counselling department.

The rehabilitation goals set by the Centre for the 42 patients who attained little or no rehabilitation, have been stated, and general descriptions given of the patients for whom the goals were set.

It is now proposed to tabulate the 42 patients with reference to the same specific characteristics and circumstances[1] which were used as the basis of tabulation of the 21 patients who had attained optimum rehabilitation.

Following this, it is proposed to discover whether these factors might have been in any way responsible for the failure of the 42 patients to attain optimum rehabilitation. The findings in this regard will be compared with

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[1] Age, type of disability, duration of disability, medical prognosis, educational status, employment status, and personality adjustment.

those made with respect to the 21 patients who attained optimum rehabilitation.

The first factor to be considered is the patient's age. It is assumed that if age of itself had any great significance with reference to the rehabilitation of the patient, that the older patients, those over 40 years old,[1] would be the ones who would fail to attain optimum rehabilitation. This assumption will be tested in Table X.

TABLE X.

Ages of 42 Patients attaining little or no Rehabilitation

Age (years)	No. of Patients
Total:	42
20 and under	6
21 - 30	7
31 - 40	8
41 - 50	10
51 - 60	7
61 - 70	4

[1] The reason for the choice of 40 years as the dividing line between the two groups is stated in Chapter III, p. 71.

In examining the above Table, it is noted that the largest number of patients, namely 10, occurred in the age category, 41 years to 50 years, and that there was no significant difference in the numbers of the other patients distributed in the remaining age categories.

By grouping together the patients in the first three age categories and comparing them numerically with the groupings of the last three age categories, it is indicated that there was an even distribution of 21 patients in each of the two combined groupings. This is contrary to the assumption upon which the analysis of this table was based, namely that the majority of patients attaining little or no rehabilitation would be those whose ages were over 40 years. This finding is in keeping with that made regarding the 21 patients attaining optimum rehabilitation,[1] namely, that age of itself was not a significant factor in the rehabilitation of the handicapped.

The second factor to be considered in Table XI is the disability of the patient. It is proposed to discover what kinds of disabilities had been suffered by the patients who had failed to attain optimum rehabilitation, and whether they were any different from those suffered by the 21 patients who had attained optimum rehabilitation.

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[1] Supra., p.

TABLE XI

Disabilities of 42 Patients attaining little or no Rehabilitation

Type of Disability	No. of Patients
Total:	42
a) Neurological	20
epilepsy	4
aphasia	5
hemi-plegia	4
miscellaneous [a]	7
b) Mental and Emotional[b] ...	7
c) Heart	6
mitral stenosis ...	3
rheumatoid heart disease	2
anterior myocardial ... infarction	1
d) Arthritic	3
e) Fractures and Amputations..	2
f) Unclassified[c]	4

[a] The seven miscellaneous disabilities were: bilateral spastic paresis, phyrmidal tract degeneration, diffuse arachnosis of the spinal cord, multiple sclerosis, nerve deafness, Parkinson's disease and poliomyelitis.

[b] The mental and emotional disabilities were: depression - (2 cases), schizophrenia - (2 cases), neuroses - (3 cases).

[c] The unclassified disabilities were: severe burns, deafness from drugs taken in treatment of tubercular meningtis, pernicious anemia, and phlebitis in the left leg.

In examining Table XI, it is indicated that 20 patients out of the total 42 patients had disabilities stemming from neurological conditions.

Comparing this with the findings, with respect to the group of patients attaining optimum rehabilitation,[1] it will be noted that neurological conditions also predominated among this group. However, upon closer inspection of the specific types of neurological conditions listed in the two tables, it will be noted, in the case of the patients listed in Table XI, that aphasia was the disability suffered by 5 patients, compared with the single case of aphasia suffered by a patient who had attained optimum rehabilitation. This raises the question whether aphasia might have been a very difficult disability to rehabilitate, for which reason the patients attained little or no rehabilitation.

Continuing the examination of Table XI, it is indicated that of the 42 patients attaining little or no rehabilitation, 7 had suffered mental and emotional disturbances.

Comparing the above finding with the incidence of mental and emotional disturbances among the patients attaining optimum rehabilitation, it is indicated that

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[1] Reference is made to Table III, p.73., which lists the disabilities of the patients who attained optimum rehabilitation.

only 3 of the latter had suffered such disturbances. On the basis of this numerical disparity, therefore, it would appear that mental and emotional disabilities presented more than ordinary difficulties, in terms of rehabilitation, for the patients of the Centre.

With reference to such disabilities as heart and arthritic conditions, Table XI shows a distribution of 6 patients and 3 patients respectively, who suffered the above disabilities. Regarding the patients who had attained optimum rehabilitation, none of them had suffered these disabilities. On the basis of this, therefore, it is assumed that disabilities stemming from heart and arthritic conditions are very difficult to rehabilitate and that, for this reason, none of the patients suffering these disabilities were able to attain optimum rehabilitation.

With reference to fractures and amputations, there were 2 patients who had these disabilities, and attained little or no rehabilitation. Among the group who attained optimum rehabilitation, there were 3 patients. It would appear, therefore, that fractures and amputations were not disabilities which, by their very nature, posed difficult problems of rehabilitation, and that the patients, who attained little or no rehabilitation, had failed for some reason other than problems inherent in the

disability itself.

With reference to the 4 unclassified disabilities listed in Table XI, it will be noted, upon examining and comparing the disabilities of the other patients who attained optimum rehabilitation, that none of the above-mentioned 4 unclassified disabilities was duplicated. On the basis of this, therefore, the question is raised whether these disabilities were such as to present a problem of rehabilitation with which the patient could not cope.

The third factor to be considered in Table XII is the duration of the patient's disability. It is proposed to ascertain whether the patients who did not attain optimum rehabilitation[1] were those who, for the most part, had disabilities of long standing, that is, disabilities lasting over one year.

In examining Table XII, it is indicated that 17 patients had had disabilities lasting between 13 months and 24 months. Comparing this with the combined total of patients having disabilities of 12 months duration or less, it is noted that the latter patients out-numbered the former ones by the statistically insignificant difference of 4 patients. On the basis of this, therefore, the assumption cannot be validated

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[1]The term, "patients who did not attain optimum rehabilitation" and the term, "patients attaining little or no rehabilitation", are used synonymously.

that the patients who attained little or no rehabilitation were those who, for the most part, had disabilities of long duration, namely over 12 months. It would appear, thus, that length of disability was not a significant factor in pre-disposing the 42 patients to the attainment of little or no rehabilitation. This finding coincided with that made in reference to the 21 patients who attained little or no rehabilitation.

TABLE XII

Duration of Disabilities of 42 Patients attaining little or no Rehabilitation

Duration of Disability (Months)	No. of Patients
Total:	42
1 - 3	4
4 - 6	7
7 - 12	10
13 - 24	17
No data	4

The fourth factor to be considered in Table XIII is the medical prognosis ascribed the patient by the doctor at point of referral to the Centre.

It is assumed that if medical prognosis had any great significance in terms of the level of rehabilitation the patient might be expected to attain, that the majority of patients attaining little or no rehabilitation would have had poor medical prognoses. This assumption will be tested in Table XIII.

TABLE XIII

Medical Prognoses of 42 Patients attaining little or no Rehabilitation

Medical Prognosis	No. of Patients
Total:	42
Good	10
Fair	9
Poor	9
No data	14

In examining the above table, it is indicated that the highest number of patients attaining negligible rehabilitation, namely 10, had had good medical prognoses, while there was an even distribution of 9 patients in both the fair and in the poor categories.

Excluding the unlikely possibility that all

the 14 patients for whom no data regarding medical prognosis was available, might have belonged in the poor medical prognosis category, thus making a total of 23 patients who had poor medical prognoses, it is concluded that the distributions of patients in terms of their medical prognoses did not bear out the assumption that the predominance of patients failing to attain optimum rehabilitation would have had poor medical prognoses at point of referral.

The above conclusion did not coincide with that made in reference to the 21 patients attaining optimum rehabilitation.[1]

In the latter instance the majority of the patients had fair or good medical prognoses, and it had been thus assumed that the patients, who had attained optimum rehabilitation, might have been a special group who, because of their favourable medical prognoses, were easy to rehabilitate.

The fifth factor to be considered in Table XIV is the educational status of the patients who attained little or no rehabilitation. It is proposed to discover whether there seemed to be a relationship between the patient's level of education and his inability to attain

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[1] Supra., Chapter III, Table V., p. 76.

optimum rehabilitation. If such a relationship existed, it is assumed that the patients who attained little or no rehabilitation would be those whose formal education was less than Grade 7.

TABLE XIV

Educational Status of 42 Patients attaining little or no Rehabilitation

Educational Status	No. of Patients
Total:	42
Attended public shcool	30
Attended high school	8
Attended College	3
No formal education	1

In examining the above table, it is indicated that all of the patients, with one exception, an illiterate 44 year old man, had had some formal education prior to attending the Centre. However, 30 patients of the total 42 patients had attained public school level of education. Because the actual grades completed at this level were not generally stated in the case records, it remains an open question whether

the level of education attained in the public schools might have been so low as to have posed a handicap to the patients in their ability to make optimum use of the treatment facilities at the Centre. If this were the case, then it may be concluded that there was some validity in the assumption that the patients who had attained little or no rehabilitation had done so partly because of the handicap posed by their low level of formal education.

With reference to the 21 patients who attained optimum rehabilitation the lack of information regarding what level of public school education had been achieved by the patient, likewise precluded any general conclusion regarding whether a direct relationship existed between the patient's educational status and his ability to attain optimum rehabilitation.

The sixth factor to be considered in Table XV is the employment status of the 42 patients who attained little or no rehabilitation.

It is assumed that patients who had had employment experience prior to attending the Centre would have developed such patterns of work tolerance and social adjustment as might have carry-over value, enabling the patient to adjust more readily to the routine of the

Centre.

TABLE XV

Employment Status of 42 Patients attaining little or no Rehabilitation

Employment Status	No. of Patients
Total:	42
Employed	32
Not employed	7
No data	3

In examining the above table, it is indicated that 32 of the total 42 patients had had employment experience prior to referral to the Centre. Only 7 patients had not had this experience.

On the basis, therefore, of the large majority of patients not attaining optimum rehabilitation, who had had employment experience, it is concluded that the assumption is not borne out that patients who had worked prior to referral to the Centre might, by virtue of this experience be expected to have the capacity to attain optimum rehabilitation.

In the case of the 21 patients who attained optimum rehabilitation, however, the assumption was borne out that pre-referral employment experience might have been a factor in their attainment of optimum rehabilitation.[1]

The seventh factor to be considered in Table XVI is the personality[2] of the patient.

It is assumed that a direct relationship might exist between the nature of the patient's personality, and his ability to attain optimum rehabilitation. On the basis of this assumption, it is proposed to discover whether the majority of the patients attaining little or no rehabilitation had had poor personalities.

TABLE XVI

Personality of 42 Patients attaining little or no rehabilitation

Personality	No. of Patients
Total:	42
Well adjusted	3
Poorly adjusted	33
No data	6

[1] Supra., Chapter III, p. 82.

[2] Personality is discussed in Chapter I, p.20, and the factors employed in determining personality levels are stated in Appendices, G & H.

In examining Table XVI, it is indicated that 33 of the 42 patients had poorly adjusted personalities. This large majority suggested that the assumption might have been correct that the 42 patients had failed to attain optimum rehabilitation, because of their poorly adjusted personalities.

Comparing the above finding with that, in regard to the 21 patients who attained optimum rehabilitation, it is noted that, with the latter, a similar assumption appeared to be validated, namely that the attainment of optimum rehabilitation was related to the patient's having a good or fair level of personality adjustment.

In the examination of the patients who attained little or no rehabilitation, with reference to their ages, types of disability, and other characteristics, the "poorly adjusted personality" of the patient has, more than any other characteristic, appeared to be a factor in his failure to attain optimum rehabilitation.

It is now proposed to indicate in Table XVII some of the specific ways in which the patient's poorly adjusted personality operated to require or otherwise to cause his premature termination of treatment at the Centre.

Following the presentation of Table XVII, brief

descriptions will be given of the patients, categorized in the above table, in terms of the specific reasons for their discontinuance of treatment at the Centre.

TABLE XVII

Ways in which "Poorly adjusted Personality" accounted for premature Termination of Treatment of 15 Patients attaining little or no Rehabilitation

Ways in which "Poorly Adjusted Personality" accounted for premature Termination of Treatment	Number of Patients
Total:	15
Patient exhibited active psychiatric problems, untreatable at Centre ...	9
a) Patient's behavior was upsetting to other patients	5
b) Patient's behavior was not upsetting to other patients	4
Patient too disturbed at sight of other handicapped undergoing treatment	3
Patient lacked confidence in ability to be rehabilitated	2
Patient too fearful of having recommended operation on hand, prior to continuation of treatment at Centre	1

Of the 9 patients, mentioned in the foregoing table, who had exhibited active psychiatric problems which could not be treated at the Centre, two patients

will be described, whose behavior was so upsetting to other patients, that the Centre, in the latter's interests, had to require the temporary discontinuation of their attendance:

> Case 43: This patient was a 22 year old, unattached girl, whose disability was stated as "Schizophrenia". No medical prognosis had been given. It was reported in one of her progress reports that she had been unkempt and had assumed peculiar postures during treatment, which had been a disturbing influence upon the other patients. It was concluded that her behavior was such that it was doubted that she could fit into a sheltered workshop programme, if such a service had been available at the Centre. It appeared to the staff that commitment to a mental institution was the only realistic plan for her.
>
> Case 53: This patient was a 44 year old married man, whose disability was stated as "mild Parkinsonism". His most recent progress report stated that a considerable amount of intensive work had been done with him, but that, in view of his constant demands and his adverse effect on the rest of the patients, it was felt that he would be required to terminate treatment at the Centre, until such time as his condition had improved to the point where he was treatable at the Centre.

With continuing reference to the 9 patients who had exhibited psychiatric problems during treatment at the Centre, the following two patients will be described, whose behavior, though disturbed, was not upsetting to the other patients:

> Case 25: This patient was a 47 year old, unattached man, whose disability had been stated as "Anterior myocardial infarction". No medical prognosis had been given. In the report on his progress, it was stated that the patient was confused and that his attendance at the Centre had been poor. It was felt by the staff that he

required further medical and psychiatric evaluation before he could benefit from the Centre's programme.

Case 16: This patient was a 31 year old, unattached man, whose disability had been stated as "asthma". After evaluation, however, it was discovered that his major disability was "psychoneurosis", and treatment was directed towards rehabilitation in this area. In the report on his progress, it was stated that he had appeared to be in conflict between his dependency needs and his innate resourcefulness. He had exhibited a low level of maturity, and had had utterly unrealistic ideas as to his capabilities. The staff recommended to him that he might benefit from psychiatric treatment outside the Centre, but he was not receptive to this suggestion, and the staff could see no value in his continuing treatment at the Centre until his deeper personality problems had been dealt with elsewhere.

In evaluating the situations of the four patients described above, it might be wondered why patients who had such deep seated personality problems should have been admitted to the Centre for treatment, when the facilities were not available for treating such disturbed conditions.

Perhaps the answer to the above lies in the fact that the stated disabilities of the patients, at point of referral, had only in one instance, (Case 43), given any indication that the patient had a severe emotional disability.

It is in the above situation that the Centre's function of evaluating the rehabilitation potential of the patient comes into focus. For, it is evident that,

no matter how good the patient's medical prognosis might be at point of referral, his involvement in the recommended programme of rehabilitation will be dependent upon personality factors, and these, it would appear, cannot always be accurately assessed until the patient is exposed to the setting of the rehabilitation centre.

Continuing the examination of Table XVII, it is noted that 5 patients had discontinued treatment because they had been too disturbed at the sight of other handicapped patients undergoing treatment. Two of these patients are described below:

> Case 6: This patient was a 19 year old, unattached man, whose disability was stated as "deafness" as a result of drugs taken for tubercular meningitis. His medical prognosis was good. In the case-worker's record, it was stated that the patient had attended the Centre twice only and that he had appeared to have been shocked at seeing himself grouped with others whose handicaps were more apparent than his was.
>
> Case 50: This patient was a 42 year old married woman, whose disability was stated as "phlebitis in the left leg and cancer of the left breast". Her medical prognosis was good. From the case-worker's record, it was revealed that the patient had phoned to say that she had not planned upon returning, because she had found the other handicapped patients too upsetting to her, and that she felt she belonged with healthy, normal people.

In evaluating the situations of the two patients described above, it is evident that if they had had strong personalities, they would have adjusted to the presence of other more severely handicapped. However, it is wondered how successfully the patients' attitude

towards the situation might have been altered if it had been anticipated and discussed with them by the caseworker. The records do not indicate whether this had been attempted.

It is wondered, too, whether the above situation was provoked by the fact that there was little partitioning of rooms at the Centre and so, a number of patients could be seen simultaneously as they received their various treatments.

Continuing the examination of Table XVII, it is indicated that 2 patients had discontinued attendance at the Centre because of a lack of confidence in their ability to be rehabilitated, and that one other patient had discontinued because he had been fearful of having the recommended operation on his hand, without which, treatment at the Centre would have been ineffective. These cases will not be described, but, in evaluating the reasons for their failing to continue with treatment, it seems clear that they were not yet ready to avail themselves of the Centre's services, and that there was little that the caseworker could do to hasten the process.

It has been noted earlier in the chapter that the majority of the patients who attained little or no rehabilitation had had "poorly adjusted personalities". From this it was assumed that personality was predominantly the factor which was responsible for the patients' failure

to attain optimum rehabilitation. However, in the cases of 12 patients, there were factors, independent of personality, which were responsible for their discontinuation of treatment. These factors have been tabulated in Table XVIII. Following the presentation of the table, brief descriptions will be given of some of the patients referred to in the table.

TABLE XVIII

Factors overriding "Poorly Adjusted Personality" as Cause of premature Termination of Treatment of 12 Patients attaining little or no rehabilitation

Factors overriding "Poorly Adjusted Personality"	No. of Patients
Total:	12
Patient's acute medical condition required treatment outside Centre ...	7
Patient misconceived Function of Centre	3
Patient's financial situation precluded attendance at Centre	2

Of the 7 patients, mentioned in the foregoing table, whose treatment at the Centre had been terminated for medical reasons, the following two patients will be

described:

> Case 12: This patient was a 35 year old, unattached woman, whose disability was stated as "right hemiparesis with seizures". No medical prognosis had been given. In the case records of the caseworker and of the occupational therapist, it was stated that the patient had had neurological seizures and that it had become necessary for him to discontinue treatment in order to undergo an operation at the Montreal Neurological Institute.
>
> Case 34: This patient was a 63 year old married man, whose disability was stated as "pernicious anemia, affecting his gait". No medical prognosis had been given. It was revealed by the occupational therapist, that this patient had phoned to say that he would be discontinuing treatment temporarily because the swelling in his foot had increased, and that he was currently having the condition treated by his private doctor.

In evaluating the situations of the two above-mentioned patients, it is noted that it was a normal development in a rehabilitation centre for a patient to be referred to a specialist, outside the centre, for treatment of an acute illness or injury, and thereafter to have the patient resume his programme at the Centre. In this instance, however, the two cases were closed, and there was no indication of what activity had taken place between the patient and the Centre, subsequent to the patients' temporary discontinuance of treatment for medical reasons. This was an occasion where follow-up by a staff person, presumably the caseworker, was indicated.

Continuing the examination of Table XVIII, it

is indicated that 3 patients had discontinued contact at the Centre, because of a misconception of the function of the agency. One of the 3 patients is described below:

> Case 7: This patient, who was referred by a private doctor, was a 24 year old, unattached woman, whose disability was stated as "hemi-plegia". Her medical prognosis was good. In the caseworker's record, it was explained that the patient had discontinued treatment because she had misunderstood the function of the Centre, having got the impression that it was a placement bureau. She said that she was not interested in participating in any recommended treatment programme.

In evaluating the situation of the above patient, it is clearly indicated that the patient needed to have been orientated as to the function of the Centre. This patient, alike the two others who had had an inaccurate understanding of the agency's function, had been referred by a private doctor, who, perhaps was not fully aware of the scope of the Centre's programme, and the need for fuller interpretation of its function, as the social worker at a referring agency might have done routinely.

Continuing the examination of Table XVIII, it is indicated that two patients had discontinued contact at the Centre because of financial pressures. One such patient will be described below:

> Case 36: This self-referred patient was a 35 year old, unattached woman, whose disability was stated as "nerve deafness". No medical prognosis was stated. The occupational therapist recorded that this patient had considered the Centre only as a place to help her find employment. Accordingly, she did not accept

> the training in lip reading prescribed for her at the Centre, but secured a clerical job, depending upon her residual hearing ability as a means of retaining this job.

In evaluating the situation of the above patient, it is to be noted that this was another referral which was not initiated by a social agency, where the social worker would have been able to inform on the function of the Centre.

It is to be noted, also, that in situations such as this, where the need for money was so pressing that the patient would forego taking essential treatment at a centre, in order to obtain employment; there was a need to have some financial resource, presumably some Government provision, which could be made available to the patient, so that he could take advantage of a prescribed treatment programme at a rehabilitation centre.

Summary and Evaluation

In this chapter it was proposed to examine the 42 patients who attained little or no rehabilitation, to see what rehabilitation goals had been set for them, which they failed to attain; to discover what kind of a group they were in terms of such characheristics as age, type of disability, duration of disability, medical prognosis, educational status, employment status and personality adjustment; and to ascertain which of the above characteristics might have been factors in the patients' failure

to attain optimum rehabilitation.

The findings were that the rehabilitations goals set for the patients who attained little or no rehabilitation were more expansive than those set for the group who attained optimum rehabilitation. In addition to the goals of vocational counselling and job placement, improvement of ambulation, and improvement of ability to speak, which had been the goals set for the latter group; such additional goals as evaluation of potentialities for rehabilitation, general emotional and social adjustment, psycho-social adjustment to the handicap, and cultivation of the ability to lip-read, were set for the former group. Thus it would appear, that the group of patients who attained little or no rehabilitation had had greater demands placed upon them in terms of adjustment to a regime of treatment.

With reference to the general characteristics and circumstances of the patients, the following were the findings:

As was the case with the patients who attained optimum rehabilitation, there was a wide diversity in the ages of the patients, some being less than 20 years old, and others 70 years of age. The majority of the patients were between 21 and 50 years of age.

The disabilities of the patients fell into six main classifications. Three of these were the same as those of the patients who attained optimum rehabilitation.

The three additional classifications were heart, arthritic and miscellaneous conditions.

The duration of the disabilities prior to attending the Centre had ranged from one month to 24 months, with the greatest concentration of patients having illnesses or injuries, which had lasted between one and two years. This compared with the findings made regarding the patients who attained optimum rehabilitation.

The medical prognoses awarded the patients at time of their referral to the Centre, were mostly good or fair. This was also the case with the group who had attained optimum rehabilitation.

With regard to the levels of education attained by the patients, only one patient had had no formal education. Of the remaining ones, three had attended college and the others had attended high school or public school. This compares fairly evenly with the findings made in reference to the patients attaining optimum rehabilitation.

The personalities of the patients were predominantly poor as contrasted with the well adjusted personalities of the group which attained optimum rehabilitation.

With this general description of the patients who had attained little or no rehabilitation, it is now proposed to mention those of their characteristics which had seemed significant enough to have been regarded

as factors in their failure to attain optimum rehabilitation.

The personality of the patient, more so than any other characteristic appeared to account for his inability to attain optimum rehabilitation. Other possible factors were, the types of disabilities suffered by the patients. For example, aphasia, mental and emotional disabilities, heart, and arthritic conditions were found to have occurred exclusively or predominantly with the group who attained little or no rehabilitation, and were therefore assumed to have been possible factors in their failure to attain optimum rehabilitation.

In addition to establishing that personality maladjustment was a possible determinant of the patients' attainment of little or no rehabilitation, it was further attempted to identify specific ways in which this maladjustment may have operated to account for the unsuccessful outcome of the prescribed treatment programme. In this connection, the following findings were made, based upon the experiences of 15 patients[1].

The personality problems of nine patients were so deep-seated, that the Centre was left with no other recourse, than to recommend them f or psychiatric treatment

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[1] These 15 patients were not a sample group. Of the total 42 patients who had attained little or no rehabilitation, these were the only ones whose case histories indicated the specific ways in which their discontinuation of treatment was attributable to personality factors.

elsewhere and require their discontinuation of attendance at the Centre until they had attained a level of functioning which would permit them to benefit from the agency's programme. The above action taken by the Centre seemed to have been fully justifiable, because the behavior of five patients was so disturbed, and so disturbing to other patients, that the latter had indicated their intentions of withdrawing from treatment, if the offending patients were not removed.

The personalities of six other patients were not so severely maladjusted but, as a result of them, the patients failed to attend the Centre and utilize its resources. Some of the reasons why treatment was discontinued were as follows: Patients were too disturbed at the sight of numbers of other handicapped undergoing treatment; they lacked confidence in their ability to be rehabilitated; and, in one instance, a patient was too fearful of having a recommended operation, which was necessary before he could participate in the Centre's programme.

The question may be raised as to what action the Centre's staff might have taken to influence patients who were reluctant, for personality reasons, to avail themselves of the agency's services. The answer to this question may be found in one of the guiding principles

of the social casework process: "you must start where the patient is. You cannot force him against his will". It would seem that the only action staff could take would be to adopt a warm attitude towards the patient and acquaint him with the fact that rehabilitation had been possible for other patients.

Another question may be raised as to why patients who manifested such deep seated personality problems were accepted at the Centre, when the level of treatment which they required was beyond the scope of the agency's programme. The answer to this question may relate to the fact that one of the Centre's important functions is the provision of an evaluative service for patients, whose levels of potential rehabilitation could not be prognosticated, without exposing them to an actual experience in a rehabilitation programme and process. Should it be indicated, after this experience, that the patient was too severely handicapped, either physically or emotionally, to benefit from the Centre's programme, then appropriate referral elsewhere could be made. With reference to the nine patients, who during the course of treatment, had manifested psychiatric problems, the caseworker either made the arrangements for the patient's referral elsewhere, or suggested to him where he might obtain the kind of treatment which seemed indicated for him.

In addition to the identification of certain specific ways in which the patient's discontinuation of treatment was attributable to personality factors, there were other factors, unrelated to personality, which were discovered to have accounted for his termination of contact at the Centre. These factors were: the patient's development of an acute medical condition which required treatment elsewhere; the patient's misconception of the function of the Centre; and the urgency of his financial situation, which required that he obtain employment and forego attendance at the agency.

With reference to the above, it is to be noted that in a rehabilitation centre, patients are accepted for treatment, who have chronic disabilities, which are apt periodically to become acute again, thereby requiring temporary treatment outside the centre. In the cases of the seven patients who had required such treatment, there was no record indicating why they had not returned to the Centre after treatment, and it is therefore wondered whether, such was the pressure of staff duties, that no follow-up of the patient could have been undertaken, or whether the follow-up had been made, but not recorded.

With reference to the patients whose financial situations were so poor that they were forced to undertake employment and forego attending the Centre, it is clear that the agency's waiver of the regular fee for treatment

would not have sufficed to permit their continued attendance. It appears that, in order to meet situations such as this, Government might make special funds available, upon the recommendation of the Centre.

In conclusion, it has been the main purpose of this chapter to try to establish what characteristics and circumstances the patients who attained little or no rehabilitation had brought with them to the Centre, so that a differentiation might be made between what factors within the patients themselves, as opposed to factors inherent in the Centre's programme, had been responsible for their non attainment of optimum rehabilitation, as the 21 patients, examined in Chapter III, had done.

In the following chapter, which concludes the study, it is proposed to re-capitulate the purpose and objectives of the study, and to state its most significant findings and the conclusions made upon the basis of these findings.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The descriptive study and analysis of the Occupational Therapy and Rehabilitation Centre has been an attempt to evaluate the importance of the role played by the Agency in terms of the breadth and quality of rehabilitation services and facilities provided, the types of clientelle served, and the degree of success with which the clientelle attained the goals of rehabilitation prescribed for them by the Centre.

The study was seen as a timely and important one for the Staff of the Centre, which had one year previously commenced its re-organized and expanded programme of total rehabilitation for all categories of the handicapped.

The study was also seen to be important, in a general way, to those who contemplated setting-up or expanding rehabilitation services, and who needed to know some of the practical problems involved in administering a full scale programme of rehabilitation of the handicapped.

The study was further seen as being important, in a specific way, to the National Advisory Committee on the Rehabilitation of Disabled Persons, which, on the basis of its findings, might exercise its function of interpreting to Government the special un-met needs of the handicapped, so that Government might legislate for the provision of services or financial resources necessary to meet these needs.

Sources of Information and Main Questions

Before undertaking the study, visits were made to other rehabilitation agencies and a perusal was made of current relevant literature, so as to help furnish some criteria for the evaluation of the Centre.

In carrying out the study, the programme of the Centre was observed periodically and discussed with the Agency's Staff, when some point of clarification was needed. Since the effectiveness of the Centre's programme could only be evaluated on the basis of the success or failure of its clientelle in achieving the rehabilitation goals prescribed for them, it was resolved to select 63 patients who had commenced and terminated treatment within the period September, 1952 to September, 1953, which was a little over one year subsequent to the inauguration of the Centre's re-organized and expanded programme.

Because the case records of the 63 patients were not compiled for research purposes, and possibly because of problems associated with the relative recency of organization of the Centre's revamped programme, they did not yield the type and amount of information about the patient, which would have permitted a more detailed and therefore a more conclusive study.

The Staff were able to supply from memory a few

details missing from the case records, but such information was insufficient, and, moreover, could not be accepted as being entirely accurate, owing to the normal imperfections of the memory. The study had therefore to take the above limitations into consideration.

The main questions posed in the study were the following:

1. What services and facilities did the Occupational Therapy and Rehabilitation Centre provide?

2. What were the disabilities and general characteristics of the Centre's clientelle?

3. What goals of rehabilitation had been set for the patients?

4. How successful were the patients in achieving these goals?

5. What factors in the patients' situations, and what factors inherent in the Centre's programme and its procedures seemed to account for the outcome of their contact?

Findings

In regard to the above questions, the following were the findings:

The Occupational Therapy and Rehabilitation Centre provided for the rehabilitation of its clientelle in many

areas of possible rehabilitation.

Provision was made for patients to be tested and counselled in reference to their employment potentialities; they were trained to overcome impediments of gait and speech; they were instructed in the performance of household activities and of general activities related to self care. In addition to the foregoing, patients were helped to make a more positive emotional adjustment to life.

In the provision of the above services, the Centre employed a qualified staff, comprising such diversified professional skills as: casework, physical therapy, occupational therapy, speech therapy, psychological testing and vocational counselling. This Staff met periodically in conferences where the patients' progress was discussed, and staff members were able to function ideally as a team.

The programme was carried out in a building which was a single large hall. One outstanding feature of the building was the lack of partitioning of rooms in the various therapy departments. As a result of this, patients could easily be distracted from their prescribed activity, either by passersby, or by the noise of tools at work in the carpenter's shop.

The disabilities of the patients were predominantly of neurological origin. The other handicaps related to mental

and emotional conditions, fractures and amputations, heart conditions, and arthritic conditions.

None of the patients suffering heart or arthritic disabilities attained the rehabilitation goals set by the Centre, and only a few of those who had mental and emotional handicaps were likewise rehabilitated.

The following are the general characteristics of the patient group:

In age, they ranged from under twenty years old to seventy years of age -- the predominance of patients being between twenty-one years old and fifty years old.

In education, the majority of them had attended at least public school. Some had attended high school, and a few had gone as far as college.

Regarding employment prior to referral to the Centre, only nine patients had been known not to have had a work experience.

In reference to personality, more than half the patients appeared to have had poorly adjusted personalities. It was noted that, with but three exceptions, all those who had well adjusted or fairly well adjusted personalities had attained the optimum goal of rehabilitation prescribed for them.

The rehabilitation goals as set by the Centre were as follows: vocational counselling and job placement;

improved ambulation; adequate performance of household activities and re-development of the ability to speak. Some success had been met by the patients in attaining the above goals.

However, in pursuance of the following goals, no patient was able to attain rehabilitation: general emotional and social adaptation; psycho-social adjustment to the handicap, and development of the ability to lip-read, in cases of deafness.

Regarding the general outcome of the Centre's treatment programme, twenty-one patients had attained optimum rehabilitation, while forty-two patients had attained little or no rehabilitation.

The success of the twenty-one patients was attributed to positive personality factors, characterized by their regular attendance at the Centre, their optimistic attitude towards treatment, and their willing co-operation with staff and other patients.

The failure of the forty-two patients was attributed in part to negative personality factors, which hindered them from involving themselves in the Centre's programme, and at times made them so confused or destructive that psychiatric referral was indicated and their continued attendance at the Centre had to be disallowed until they had

improved to the point where they could benefit from the Centre's programme.

Other factors responsible for the discontinuation of treatment and consequently the non-rehabilitation of the remaining patients were: the need for medical referral because of an acute condition which had developed; the inability of the patient to attend the Centre because of his very poor financial situation which required that he remain in employment, even though he might thereby be jeopardizing his future health; and the patient's misconception of the function of the Centre.

With reference to the factors inherent in the agency and its programme, which might have influenced the premature discontinuation of patients' attendance at the Centre, there were indications that the noise emanating from the workshop and the distractibility of patients, which was heightened by the absence of partitions in certain departments, had in some measure contributed to the patients' withdrawal from treatment. It was noted, however, that patients whose personalities were the least adjusted were the ones who discontinued for such stated reasons as being upset by the appearance of so many other handicapped patients.

There were other features about the Centre , its Staff and its services, which might conceivably have been limiting factors to the overall effectiveness of its programme.

The specific way in which patients would be affected, however, could not be identified in the experiences of the forty-two patients who attained little or no rehabilitation. However, these apparently limiting features about the Centre will be stated in the recommendations which follow.

Recommendations

On the basis of all the findings made in this study, the following recommendations are made:

It is recommended (1),that the Occupational Therapy and Rehabilitation Centre acquire the facilities of a larger, better laid out building, which provides partitioning between the various departments and offices, (2), that the physical therapy department be equipped with electrical equipment, additional to the muscle stimulator which was its only piece of electrical equipment. Such facilities as hydrotherapy and wax therapy have been stated by a specialist in rehabilitation as having a unique importance in the treatment of specific types of disability.

It is recommended (3), that the Staff be augmented by an assistant social caseworker, in the absence of whom, it would appear that a single caseworker's responsibilities would be too broad to permit the rendering of the important service of follow-up of the patient after discharge.

It is recommended (4), that because of the scope of the responsibilities assumed by the occupational therapist, with reference to planning of recreational programmes and other activities, an assistant occupational therapist be also employed.

The area of programme in which a group worker might function in a rehabilitation centre was discussed earlier in the study, and it is recommended (5), that consideration be given to the possibility of employing the skills of such a staff person.

It is also recommended (6), that the services of a part-time medical consultant be obtained, who could make the initial medical examinations of applicants to the Centre, prescribe and follow closely their treatment programmes, and work in close liaison with specialists outside the Centre, to whom patients might be referred.

The fact that two patients were forced to forego treatment at the Centre, owing to the urgency of their financial situation, suggests that this is one area where some Government or other resource might be made available, upon the recommendation of the Director of the Agency.

Evaluation

In final evaluation of the Occupational Therapy and Rehabilitation Centre, it is noted that, at the time

this study was undertaken, the agency had only recently re-organized and expanded its programme; that the agency appeared to have been under-staffed; that it operated under the physical limitations posed by absence of partitioning of departments and lack of adequate equipment, especially in the physical therapy department.

In spite of the above and other handicaps, twenty-one of the sixty-three patients studied had attained optimum rehabilitation; fifteen of the remaining forty-two had discontinued treatment because of personality problems; and twelve patients had discontinued because of the need for medical referral, or because of financial problems.

Under the above circumstances, therefore, it would appear that the programme of the Occupational Therapy and Rehabilitation Centre was an effective one.

The fact that some of the recommendations made in this study are now in operation in the Centre's new building and that many other facilities have been added to the overall programme is an indication that the Staff, when operating in the previous building on University Street were aware of the gaps and limitations in the programme offered, but that such limitations could not have been effectively corrected in that particular building.

APPENDICES

DOCUMENTARY SCHEDULE

Code Number:_____ Name of Doctor:_____

Referral Source:_____

Age:_____ Sex: _____ Marital Status: _____

Level of Education attained: _____

Nature of last Employment: _____

Nature of Disability: _____

Medical Prognosis: _____

Length of Disability: _____

Goal of Rehabilitation: _____

Services prescribed: _____

Services rendered: _____

Closing Summary:[1] _____

_____

_____

_____

[1]This summary indicated whether the goal of Rehabilitation had been attained, and if not, the circumstances under which the patient's treatment at the Centre was discontinued.

P H Y S I C I A N ' S R E F E R R A L F O R M

OCCUPATIONAL THERAPY & REHABILITATION CENTRE

3477 University Street - Montreal, Quebec

Lancaster 6184

Name----------Date of Birth----------

Address----------Telephone----------

Diagnosis----------

Date of Onset----------Hospital No----------Prognosis------

Physical History, Operation and X-Ray Report----------

Wasserman----------T. B.-------Blood Pressure----

Cardiac Condition----------

Contra-indications----------

COMBINED REHABILITATION SERVICES:

Treatment Emphasis

____General Evaluation

____Muscle Re-education

____General Strengthening Exercises

____Heavy Resistance Exercises

____Gait Training:
____without full weight bearing
____with full weight bearing

____Self-Care

____Household Activities

____Increased Work Tolerance

____Heavy Work

____Casework Services

____Psycho-social Adjustment to Handicap

____Vocational Counseling

____Job Placement

Suggestions----------

Attendance at Centre-------Hours per day-----Days per week---------

When do you wish to see patient again?----------

Patient's Clinic Day----------

Date----------Physician's Signature----------

OCCUPATIONAL THERAPY & REHABILITATION CENTRE

3477 University Street Lancaster 6184

GUIDE FOR REFERRAL

Name Birthplace Birthdate

Address Telephone Religion

Disability:
Date of onset Doctor

Family:
Wife or Parents Children or Siblings

Cooperating Agencies or Persons and Addresses

Educational or Vocational Training:

Psychological Test Results
(indicate if any tests have been administered;
(if so, where?)

Employment History

Financial Circumstances:

Who has financial responsibility for patient
while he is at the Centre?
Can he pay full or modified fee?

Family Relationships:

What appears to be attitude toward marriage or parents.
Attitude of family towards patient.

Attitudes toward handicap:
Acceptance
Cooperation with treatment recommended
Reaction to social life - family
Reaction to employment

Other significant information:
Pertinent data from background or present circumstances.

Do you consider patient has good potentialities for rehabilitation?

Patient's plans?

Referring Agency Date Worker

PROGRESS REPORT

OCCUPATIONAL THERAPY & REHABILITATION CENTRE

TO: (Physician or Agency) DATE:

NAME: O.P.D.# DIAGNOSIS: Simple Schizophrenia

ADDRESS: REFERRED BY:

DATE TREATMENT STARTED: AIM OF TREATMENT:

PHYSIOTHERAPY REPORT:
Not seen in this department.

Physiotherapist

OCCUPATIONAL THERAPY REPORT:
Patient attending three full days weekly, and programme has included needlework, typing practice, recreation, etc. Work quality and attention span have been fairly good and patient seems to learn quite readily. However, iniative and ability to carry a project through to completion are very poor, and patient tends to sit, remote and withdrawn, until a specific suggestion is made by the therapist, and then frequently rejects the suggestion for no apparent reason. She requires constant supervision and direction, and for the most part is unable to relate to the others in the group. This patient tends to express bizarre and unrelated ideas, and it does not seem, for the present, that she is employable.

Occupational Therapist.

CASE WORK REPORT:

Case Worker

PROGRESS REPORT
(Continued)

VOCATIONAL COUNSELLING REPORT:

In an Interview conducted to determine patient's readiness for job planning, observations made in the Occupational Therapy department were corroborated. Many of the responses were illogical and unrelated to the subject under discussion; she indicated that she does not want to work but if she must work, would take a job only as a sales clerk and this only in a department store. She has unreal conceptions of the requirements of such a job, and, because of her present level of functioning, her limited knowledge of French, inability to complete sales slips and her lack of experience, she would not be accepted for department store sales work. On the basis of these observations, as well as her need for constant supervision and direction, she is unlikely to be able to fit into any job at the present time, and it is doubtful whether she would be able to meet even the standards of a sheltered workshop if this were available.

Vocational Counselor

We would be glad to discuss this type of case further with you, if you wish. At the present time the type of service_____requires is not available here.

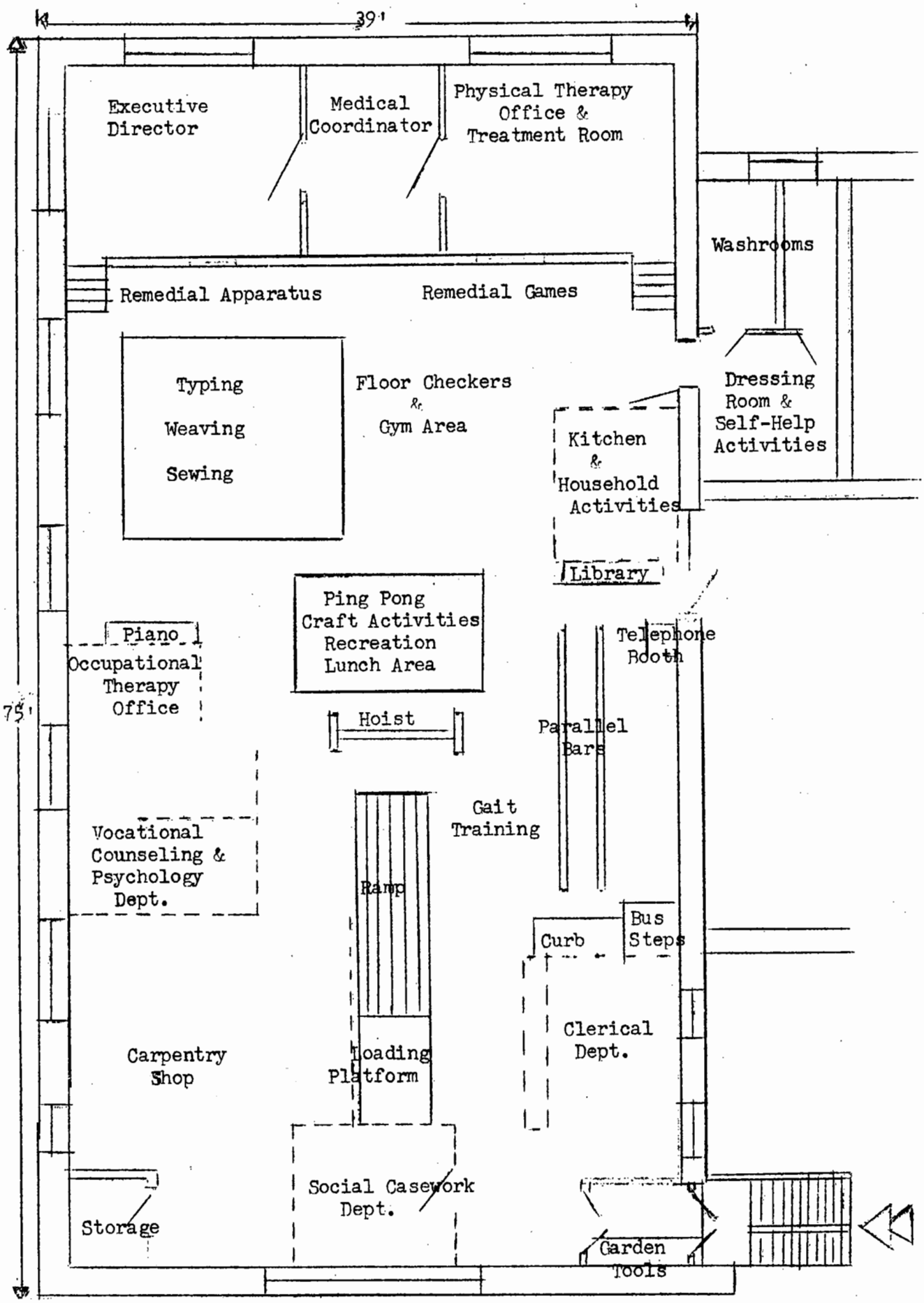
Executive Director

COMMENTS OF PHYSICIAN OR AGENCY: (Duplicate sheet to be returned to O.T. & R. C.)

Thank you for your evaluation of this patient. She appears to be presenting active psychiatric problems, rather than rehabilitation problems at this time and we have referred her back to her former therapist.

Director of Social Services

_____hospital


39'
75'
Executive Director
Medical Coordinator
Physical Therapy Office & Treatment Room
Washrooms
Remedial Apparatus
Remedial Games
Typing
Weaving
Sewing
Floor Checkers & Gym Area
Dressing Room & Self-Help Activities
Kitchen & Household Activities
Library
Ping Pong
Craft Activities
Recreation
Lunch Area
Piano
Occupational Therapy Office
Telephone Booth
Hoist
Parallel Bars
Gait Training
Vocational Counseling & Psychology Dept.
Ramp
Bus Steps
Curb
Clerical Dept.
Carpentry Shop
Loading Platform
Social Casework Dept.
Storage
Garden Tools

APPENDIX E

Positive Characteristics of 11 Patients,[a] attaining optimum rehabilitation, who had "well adjusted" Personalities

Case No.	Positive Characteristics	Total No. of Patients
	Total:	11
4	Attended regularly ... ... co-operated with staff and other patients.	1
5	Attended regularly and had good motivation to get better ... co-operated with staff and other patients.	1
22	Was conscientious and eager to work	1
31	Attended regularly ... co-operated with staff and other patients	1
41	Accepted handicap ... co-operated well	1
49	Attended regularly ... Had strong motivation to work again	1
54	Co-operated well	1
59	Co-operated well	1
62	Co-operated well ... had optimistic attitude	1
63	Attended regularly ... co-operated well, was cheerful, and had optimistic attitude	1
74	Co-operated well	1

[a]These 11 patients have been previously mentioned on page 82 in Table VIII, which categorizes 21 patients who attained optimum rehabilitation, in terms of their personalities, prior to referral to the Centre.

APPENDIX F

Positive and Negative Characteristics of 7 Patients,[a] attaining optimum rehabilitation, who had "fairly well adjusted" Personalities.

Case No.	Positive and Negative Characteristics	Total No. of Patients
	Total:	7
11	Co-operated well, was self-directing ... had very tense personality.	1
18	Attended regularly ... but worried frequently	1
39	Co-operated with staff ... was extremely depressed over financial dependency on a relative	1
44	Attended regularly ... was irritable and depressed	1
47	Attended regularly and co-operated with staff and other patients ... was shy and withdrawn, and had few friends.	1
52	Co-operated with staff and adjusted well to the programme ... was very discouraged about her illness	1
71	Attended regularly and adjusted well to staff and other patients ... had a poor relationship with her family and exhibited feelings of inferiority.	1

[a] These 7 patients have been previously mentioned on page 82 in Table VIII, which categorizes 21 patients who attained optimum rehabilitation, in terms of their personalities, prior to referral to the Centre. The three patients mentioned in Table VIII, concerning whom no data were available are not mentioned in this Table.

APPENDIX G

Positive Characteristics of 3 Patients,[a] attaining little or no rehabilitation, who had "well adjusted" Personalities

Case No.	Positive Characteristics	Total No. of Patients
	Total:	3
1	Adjusted well to programme	1
36	Appeared to have many strengths ... was very resourceful in seeking out jobs	1
58	Was co-operative and got on well with other patients	1

[a] These 3 patients have been previously mentioned on page 104 in Table XVI, which categorizes 42 patients who had attained little or no rehabilitation, in terms of their personalities, prior to referral to the Centre.

APPENDIX H

Negative Characteristics of 10 Patients,[a] attaining little or no rehabilitation, who had "poorly adjusted" Personalities

Case No.	Negative Characteristics	Total No. of Patients
	Total:	10
2	Adjusted well to programme	1
10	Had very limited personality, showed no initiative and was untidy	1
26	Had poor relationship with her husband	1
32	Was very quiet and appeared to have been lost and unhappy	1
42	Lived alone and had few friends	1
43	Felt neglected by her father ... had an illegitimate child prior to referral to the Centre	1
48	Was bitter about her unhappy home life	1
51	Had friction with every family with whom he had been placed	1
53	Was shiftless, very argumentative and demanding of attention	1
70	Was withdrawn and uncommunicative ... lacked hobbies	1

[a] These 10 patients are a sample of the 33 patients previously mentioned on page 104 in Table XVI, which categorizes 42 patients who attained little or no rehabilitation, in terms of their personalities, prior to referral to the Centre.

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