I must first express my pleasure at being asked to participate in this Seminar. The opportunity to associate with and learn from one’s professional colleagues in other countries and from other cultures is a priceless reward for one’s efforts to assist the mentally ill.

To meet again my friends in Mexico is also a warm and gratifying experience.

One attends many seminars and one often wonders just what we are accomplishing for our patients. The size of our problem, the shortage of personnel, the absence of adequate facilities and our inadequate knowledge of morbidity could easily immobilize us. On the other hand, we must find ways and means not only to expand our resources but to utilize those we have to maximum advantage.

During many discussions one hears the terms mental health and psychiatry used interchangeably. This has reached such a level that a misprint (or was it a misprint?) occurred in the report of The Joint Commission on Mental Health and Mental Illness in the United States—“Mental Health is our number one problem and we must stamp out mental health”. Surely mental illness may be one of our major health problems and it is mental illness that we wish to stamp out! In other fields of medicine there seems to be much less confusion between public health (i.e. primary prevention) and treatment—the cardiologist deals with treatment and when preventive measures of wide or universal application are available he assists public health personnel, health educators and other community services to apply these preventive measures to the population at risk. One wonders if those to whom we act as consultants, and even we ourselves, would not be less confused if we clearly separated these issues. The promotion of mental health and the prevention of mental illness is surely a cause to which we are all devoted and to which we must devote a major part of our efforts but there are also present in our society endemic mental illness for which we do not at this time have primary preventive measures available. We may, amongst ourselves, separate primary prevention from secondary and tertiary activities but our professional colleagues and the people we serve generally think only of primary activities as being prevention. Possibly it would be helpful if we would clearly define these issues.

We consultants at this seminar are unlikely to bring you any new knowledge or concepts but possibly we can bring points of view which may help you to clarify the issues you must resolve as you make efforts to meet the needs of your people. Being the first of the consultants to speak I have an advantage as I will not be repeating that which has been said by others. I am sure, however, that the field is big enough for all of us and that those who follow me will not, in any way, be restricted by the points I try to make.

Before continuing I want to emphasize again that I am not prepared to bring answers to any of your problems. I do bring a point of view which I hope will be helpful. I frankly expect to learn more from these discussions that I can contribute to them.

Everyone has stressed the unreliability of our statistics. However, no one can deny the existence of personal and social distress resulting from mental illness regardless of the true extent of these illnesses. We all know that we are unable to provide sufficient service to meet the needs of the people seeking help.

I have had the privilege of making sur-
veys in several countries and I have been impressed by the dedication of those working in our field, by the different ways in which different populations conceptualize mental illness, and by the fact that no one organizational pattern will meet all of these needs.

In countries with a high birth rate and a large proportion of children in their population it is obvious that a very large part of our efforts should be directed towards children. How I wish we really knew how to prevent these children from becoming mentally ill in adult life. In the absence of specific measures we must surely see that they have education in an understanding educational system which will provide special opportunities for those with special needs and early guidance and treatment for those unable to adjust to the opportunity provided. We must also hope that adequate nutrition, adequate housing, adequate recreation and work opportunities in later life will help to prevent some of the problems we now face. Are we asking for the millennium? I think we are. However, if we really value the individual and his health we cannot ask for less and we must look forward to the day when the promotion and preservation of individual health will be as important as any other consideration in our society.

What can we learn from the past? How did we reach our present position? Historically our patients were either left in the community or treated in such hospitals or other places of refuge as existed. Prior to the latter part of the 19th century our general hospitals were not as they are today. They were, in fact, places of refuge for the sick poor and provided more or less humane care. At that time the development of separate hospitals for the mentally ill would be well cared for, they and society would be protected and the moral treatment of the insane epitomized that which was best in the treatment of the mentally ill during the latter part of the 19th century. During the past seventy-five years our general hospitals have changed from places for the sick poor to become centers of diagnosis and treatment. Doctors have become, to a large extent, much more interested in diagnosis and treatment than in care and symptomatic relief. During recent decades we have also made progress in psychiatric treatment—treatments such as insulin, metrazole, electro-convulsive-therapy and more recently the neurotropic drugs have been introduced. As a result of these changes we are now able to move back into the centers of active treatment with our other medical colleagues. This is the dilemma we now face in North America. Ordinary illnesses are treated in the community by practicing physicians associated with general hospitals whereas too many of the mentally ill are treated in large centralized, isolated psychiatric hospitals. As I think of the problems you face I cannot help but wonder if they are greater or less than ours. You are short of beds, whereas we have many beds but most of them in the wrong place. We will have to resolve this problem. Either we move towards integration with the rest of medicine and our patients will receive treatment as others do or we will continue to develop separate services with all of the related problems of isolation, stigmatization and so on. Is your situation one full of opportunity for the development of new patterns of care or do you feel immobilized by the shortage of personnel, facilities and financial resources? I cannot help but feel that the former is the true situation. You have a wonderful opportunity to apply presently available knowledge regarding treatment of the mentally ill without being too heavily committed to what many of us now consider to be outmoded patterns of care.

Having mentioned the need to recognize the difference between mental health and psychiatric illnesses it might also be useful to separate into the appropriate groupings functional psychiatric illnesses, those of organic etiology, geriatric patients, the mentally retarded and epilepsy and to further recognize that we are involved in attempting to meet the situations created
by the psycho-social conditions such as delinquency, crime, alcoholism, drug addiction, suicide and so on. No longer should we speak of psychiatric illnesses as a conglomerate mass of pathology. The prognosis of depression is radically different from that of schizophrenia. Present treatment measures might justify public health case finding for depressions but these would hardly appear to be justified for cases of schizophrenia. Until there is added to the schizophrenic process evidence of disability it is doubtful that we can offer much in the way of treatment.

It is possible that we should not be talking about one mental health program but a variety of programs to meet specific needs. The program to meet the needs of the mentally retarded would seem, for example, to be quite different from that required for the treatment of the psychoneuroses. All medical treatment, and indeed etiology as well, would seem to fall under three headings—somatic, psychological and social. There seems to be little misunderstanding as to responsibility for diagnosis and treatment in the somatic field as everyone seems to agree that this is a medical responsibility. In the fields of psychological and social treatment and etiology there is disagreement and it may well be that we in psychiatry are not the best qualified to study the etiological importance of these factors or to propose preventive measures in these areas. If we recognize these areas clearly it does seem possible to communicate more effectively with other health workers in providing treatment and preventive services in our communities.

Psychiatry has apparently been characterized by a failure of communication. No other field of medicine has so quickly introduced new terms and discarded them in favor of others. These failures of communication and the too rapid introduction of new terminology probably account for the recurrent waves of enthusiasm in psychiatry and their subsequent abatement as those responsible for leadership in each successive period pass out of the picture. Many people have reviewed the history of mental hospital programs and it seems reasonable to conclude that the failure to pass on from one generation to the next those things that have proved useful is due to our unwillingness or inability to describe in readily understandable language and in an adequate theoretical framework the activities which have been beneficial in the treatment of psychiatrically ill patients. The two great status words of the present period would appear to be “rehabilitation” and “research”. The purpose of our present discussion is to clarify our thinking in the field of rehabilitation.

As a first step, I propose to give my own working definition of the word “rehabilitation.” This definition is not original but has been drawn from a number of sources. Some years ago, Dr. Howard Rusk stated that rehabilitation was the third phase of medicine, but this idea has been rapidly discarded as it has become apparent that rehabilitation is in fact the total treatment program for any particular patient. I have found it useful to think of rehabilitation as those processes which enable a patient to obtain the maximum social and personal function compatible with the personal, social, and community resources available to him. This definition consists essentially of three parts—the rehabilitation (treatment) processes, the maximum personal and social function, and the community and personal (deficits due to illness and total personal assets) resources available to the patient.

When does rehabilitation commence? This question is generally answered by the statement that rehabilitation should commence as soon as the patient becomes ill. A further inquiry as to what this means is usually greeted by a profound silence. It seems difficult to gain acceptance for the idea that rehabilitation commencing at the time a patient becomes ill is really a matter of an essential attitude which all of those responsible for treatment must have, and which the patient himself must assimilate.
from the total treatment team. The patient must feel from the beginning that the whole purpose of all the resources brought to bear on his illness is to see that he returns to the community with maximum personal and social function.

Traditionally, physicians have been concerned with medical diagnoses and with the treatment of the specific conditions diagnosed. A positive attitude toward rehabilitation requires the physician to be concerned with total assessment rather than purely medical diagnosis. That is to say, the physician at the time of his initial examination must make a complete medical, vocational, and social assessment of the patient. All treatment must be planned in terms of the initial and subsequent assessments. The physician must be concerned with the specific medical treatment indicated and with all of the general supportive measures which are designed to improve the patient's vocational and social function. It is helpful to keep in mind that a comprehensive rehabilitation program must include, at least as an available resource, academic and vocational training.

ORGANIZATION FOR REHABILITATION

While it is useful to think of rehabilitation activities on the basis of existing organizations, it should be borne in mind that the treatment of a patient should be a continuum, and that many aspects of our present organizations are not the most desirable, whether one is concerned with specific psychiatric treatment, rehabilitation, community care, or some other particular type of activity. In order to focus attention on rehabilitation, it is useful to consider the activities which take place in a hospital, in an outpatient department, in a community clinic, or in an after-care program. The ideal we should strive for is a community mental health center as described in the Third and Fifth Reports of the Expert Committee on Mental Health of the World Health Organization. In this concept of a community mental health service, each region or area would have its own mental health service based on inpatient beds but being as concerned with preadmission treatment, post-discharge follow-up, rehabilitation, and other aspects of the program as with inpatient care. Such a service would be readily available to all the people it is designed to serve and many of our present problems of communication, distance, and difficulty in assuring continuity of personnel and services would not exist. While we must continue to work with the services as we have them, and while we must do everything possible to see that our patients function at the maximum level as a result of our treatment, we should not fail to look forward to the time when our mental health service will be organized on a patient-care basis rather than on administrative lines devoted to inpatient care, outpatient care, and similar lines of authority and communication.

It is my impression that a rehabilitation program has the same characteristics and must function on the same basic principles whether it deals with inpatients of ambulatory patients, and that the services rendered differ quantitatively rather than qualitatively. In this respect, psychiatry is probably different from many other specialties as it is apparent that the type of treatment provided for a psychiatric patient is determined more by the patient's dependency needs than by his psychiatric diagnosis, whereas in specialties such as surgery it is more frequently the medical diagnosis and the need for specific hospital procedures which determine the type of treatment provided.

We are all well aware that many schizophrenics are functioning at some satisfactory level in the community, whereas others, who would be considered less sick on a straight psychiatric assessment, require hospital care. Schizophrenics are not usually admitted to the hospital because they are diagnosed as suffering from this condition but because along with this condition they are unable to function in a socially accept-
able manner. Our objective in treatment is not to make sure that a schizophrenic no longer has delusions or hallucinations, but rather to be sure that his behavior will be socially acceptable. Many of our so-called cured schizophrenics still have delusions but they have learned not to act on the basis of these and can function in an acceptable manner.

COMMUNITY ATTITUDES

If we are to provide programs designed to develop the maximum function attainable with the patients’ total resources, we must also consider the community’s attitude and the community’s assessment of maximum function. If one considers the mores of the average North American community, one quickly observes that a “normal” day consists of three eight-hour periods—eight hours of work, eight hours of recreation, and eight hours of rest. While many individuals vary from this community average, we can be sure that anyone who deviates substantially is all too often critically assessed by his friends and associates. I regularly ask groups of people, “Who in our community does not work?” The two answers I always receive are, “Those who are sick,” and “Those who are lazy.” It is strange that these two answers are almost always given, even though in the Montreal area there is continuing serious unemployment. Even after this matter of unemployment is raised, it is not uncommon to find a group replying, “They could work if they wanted to.” This community judgment seems to apply to the rich as well as to the poor, to housewives, to students, and to breadwinners. We have certainly found that patients will not do well on discharge unless they are capable of working according to the mores of their particular group. A school-child must study, a single girl, if not employed, must help with the household chores, a housewife must do her housework, and so on.

MOTIVATING FACTORS

The development of an inpatient program which can bring a person to maximum work or vocational function is handicapped by several community attitudes. Just as the community says the sick do not work, so it also says, “The sick are cared for in a hospital,” and “When I am sick and in a hospital I do not work.” It thus becomes essential in the development of a full rehabilitation program to consider those things which motivate a person in the community to work. It is interesting to discuss these motivating factors with different groups of people. I find that student nurses almost always answer in the following order: “I work to gain personal satisfaction,” “I work so that I can help others,” and “I work for money.” On the other hand, male attendants-in-training almost always reverse the order: they work for money, to help others, and for personal satisfaction.

A further breakdown of these motivating factors shows us that when people say “I work for personal satisfaction,” they really mean they would like to do something which they enjoy doing and which other people regard as important. When they say that they work to help others, we frequently find that their families or associates have been engaged in the service professions, and that, as a result, they are really looking for an activity where they will be associated with such individuals, who will give them recognition for the services they perform. The last factor, that of earning a living, is a highly variable one, which has become increasingly more difficult to assess in our North American society. As more and more work situations are developed in which it is not easy to find personal satisfaction and community recognition for the work performed, a greater emphasis has been placed on the material reward which can be obtained from higher wages. While all of the above are highly complex and difficult to evaluate, they are of the utmost importance in planning the rehabilitation of psychiatric patients.

It is quite apparent that the rehabilitation of a well educated individual with a good employment record and sound vocational
training is not difficult at all. Such a person, subsequent to an acute depression or other episode of illness, is generally quite capable of self-rehabilitation.

There are also women patients who are married and whose vocation in life is to be a housewife. Generally speaking, they do not require vocational training and, if their illness is controlled to the point where they can get along well with their family, can rest well, and can find satisfactory social contacts, they return to their normal activity and do reasonably well, at least between the episodes of illness.

There is an increasingly large number of geriatric patients who can get along well in the community if they are well oriented, able to rest properly, and capable of filling the "elder statesman" role. For example, we have found it possible to place some elderly women in the community by finding suitable homes in which they can assume the normal grandmother role.

Finally, there are those patients who constitute the hard core of our rehabilitation problem. These are patients with an incomplete education and a very poor vocational record. They fall into many diagnostic categories, but prominent amongst them are psychiatrically ill patients who are also mentally retarded; schizophrenics who had their first breakdown before they quite finished their schooling; and the psychopaths (or socio-paths) who did not succeed in applying themselves for a sufficient length of time to gain a basic education.

The psychiatrically ill person who is also mentally defective frequently requires training, assessment, and special placement to enable him to obtain a position in society compatible with his level of intelligence and in which he will not be either subject to too much demand or placed in a position so inferior that it fails to give him satisfaction.

The schizophrenic, on the other hand, has suffered basically from a failure of maturation, particularly in the area of interpersonal relationships. His rehabilitation is primarily a matter of conditioning or "treatment" so that he can at least function interpersonally at a socially acceptable level. At the same time he must be given sufficient academic and vocational training to enable him to establish a satisfactory place for himself in society.

The third group, namely the psychopaths, are a much more difficult problem. Intellectually they are seldom handicapped but the normal motivation for socially acceptable function seems to be lacking in them. By the time we see these patients in our adult services, they have generally learned that there are easier ways than working to obtain a certain standard of living, and that there are ways quite apart from making a useful social contribution, to gain a form of recognition. For these individuals, we find that time is of the essence. They must be placed in an environment where the causes of their illness will be understood, and where they will be treated fairly and consistently. Since they fluctuate between the ability to accept responsibility and the need to have it withdrawn, constant adaptation to this changeability is vital.

REHABILITATION OF MENTALLY ILL

Thus a comprehensive rehabilitation program must rest on the following principles:

1. A complete assessment of the medical, psychiatric, vocational, and social potentialities of each individual patient.

2. Adequate specific and general treatment for the psychiatric disability diagnosed.

3. Academic and vocational training which will enable the person to contribute in a socially acceptable way to the society in which he lives.
4. Vocational and social placement determined in accordance with the patient's medical, vocational, and social handicaps or potentialities.

To carry out such a program all of the diagnostic service must be conscious of the need for complete assessment rather than concerned only with the specific psychiatric disability which presents itself. Secondly, the treatment service must be supported by a program designed to enable a patient to function according to the mores of the community, with particular concern for work, recreation, and rest. Thirdly, for adequate placement in the community, a series of facilities must be developed ranging from residential rehabilitation centers through sheltered workshops and foster homes.

Drugs and Psychotherapy

I have carefully avoided a discussion of psychological and pharmacological support for the patient during rehabilitation. This is because of a fundamental belief that these are only a part of a comprehensive treatment program. If they are taken out of perspective, there is too much tendency to feel that drugs and psychotherapy alone can be sufficient in the treatment of all our patients. It is true that a considerable number of patients can function adequately on the basis of one or both of these methods of treatment, and that patients undergoing the process of rehabilitation must, of course, receive the appropriate drugs and the required psychotherapy. But such therapies alone do not constitute a comprehensive rehabilitation program. We must always remember that a very anxious woman can get along quite well at home provided she does not disturb her family's normal essential activities. On the other hand, an anxious woman who interferes with her husband's normal rest and prevents him from earning a living will very soon find herself in the hospital. Conversely, a man who can earn a living will be able to function in the community with much greater success than can the man who does not work to support his family. The judgment of the community regarding the state of health of our patients will always be based on their ability to fill a useful and contributory role in society, to use their leisure time profitably, and to rest during the expected periods. A person who can function on this basis is well in the eyes of the community. Regardless of how well we may say an 18 year old schizophrenic girl is, she will be sick in the eyes of her mother if she cannot be a mother's helper. And if we insist she is well, then her mother will say, as I have so often heard, "Doctor, if she is not sick then she must be lazy."

The following items appear to be all-important if our programs for the rehabilitation of patients are to be effective:

1. A change in the traditional attitude regarding the role of psychiatrist. As in other fields of medicine, the concept of "cure" seems to be detrimental rather than helpful. We must see psychiatric illnesses as part of the life history of the individual and we must see adequate treatment as being concerned, not only with signs and symptoms, but with the ability to function as a useful contributing member of society, selfsupporting and able to exist harmoniously with family and with society at large.

2. Psychiatric treatment per se is only one of the resources available to our patients whether they be treated as inpatients or outpatients. The improvement of communication between our services and other community services which can help people who are unable to function effectively is essential.

3. While the basic attitudes of the community are in need of change, more effective change may result from involvement in activities other than the traditional public education ones. The community should be involved in the further development and expansion of day-care centers, residential center, and sheltered workshops. As the community becomes involved in these programs, understanding of the needs of patients with psychiatric illnesses will
increase and attitudes toward such patients will undoubtedly change. Concurrent with this change one might reasonably anticipate improved attitudes in the matters of employment, rehabilitation allowances, and other community benefits which must be established if the patient is to feel secure and remain well.

4. It does appear that the psychiatric patient has one great need regardless of our team approach or the resources which we may develop to assist with his rehabilitation, namely, the need for a relationship with one person to whom he can turn with confidence and with the assurance of understanding and acceptance.

In conclusion, I hope that you can now realize why it would be so difficult for me to suggest the arrangements more likely to provide adequate services for your communities. We in Canada are at a crossroads—are we to perpetuate our present system of isolated psychiatric services or do we in psychiatry, along with our patients, return to the community. Many of us feel that the latter course is the only one which offers hope of a solution to our problems. In its full implications it means that we will be fully involved in the teaching of undergraduate and postgraduate medical students and other health workers and with other practitioners in the care of sick people. We will work with health and other authorities to apply preventive measures as these are identified. We believe that only in this way will we reduce the demand for hospital beds and bring about effective treatment. We do not know how many beds or personnel we will ultimately require. Certainly if the somatic, psychological and social needs of our population are to be met we will have to train more people and we will have to effectively use not only our valuable health resources but all other community resources as well. We feel that communities, made aware of their needs will be more successful in providing services to meet these needs than have been our past efforts with isolated services.

Perhaps we in mental health should recall that many public health measures were introduced on the basis of observations and not scientific fact. The first attempt to prevent the use of contaminated water and the introduction of vaccination were based on sound observations by practicing physicians. The problems of the mentally ill are such that the development or services and the training of personnel must not be deferred while we accumulate statistical information.