THE MARITIME SCHOOL OF SOCIAL WORK

MEDICAL-SOCIAL ASPECTS OF DISABILITY AND DEPENDENCY

A Study of the Medical Factors and their Social Implications in Families receiving Mothers' Allowance where the Husband is Disabled

A thesis submitted to the Maritime School of Social Work in Partial Fulfillment of the Requirements for the Master's Degree in Social Work

by

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PREFACE

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INTRODUCTION

At the present time, with political affairs at a crucial point in Canadian history, the social welfare programs across the country are under close study as are many other branches of governmental services. Of late many changes have been introduced into our Social Security system and the government has been taking more and more responsibility for the welfare of the people. Changes in attitude, and therefore in action can be traced from as far back as the early nineteenth century, in the field of welfare, particularly in respect of the care of dependent children.

In the nineteenth century, many children were institutionalized simply because their parents lacked the means to provide for them at home.[1] Almost from the beginning, private child-care institutions received financial aid from the government. The aid that was forthcoming was in the nature of a contribution to a worthy cause rather than payments to private agents for the discharge of a public responsibility. The failure of the state to provide adequate "outdoor" relief to parents who could not support their children, coupled with its willingness to subsidize institutions, naturally led up to their increase in size and number.[2]

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[1] H. Leyendecker, Problems and Policy in Public Assistance (New York: Harper and Bros., 1955), p.41

[2] ibid, p. 41

> The White House Conference on Dependent Children, called by President Roosevelt in 1909, had enunciated the principle that no child should be removed from its home by reason of poverty alone. One of the most tangible results of this conference was its influence on the establishment of programs of 'mother's aid' designed to enable widows, or women whose husbands were in hospitals or prisons, to remain at home to care for their children rather than to work, leaving their children unsupervised at home or on the streets or placing them in foster homes or institutions.[1]

This program of "mother's aid" along with the state's assumption of responsibility for institutions caring for the insane, and the feebleminded, marked the entry of the state into the field of social welfare. Prior to this time,

> The state's responsibility in the field of social welfare had been confined to the enactment of a poor law which defined certain obligations of local government. Now, however, the state government became involved in the administration of a direct service to certain dependent groups.[2]

In Canada, changes from "laissez-faire" to public responsibility were a little more difficult to achieve because of their peculiar constitutional division of responsibility. The British North America Act of 1867 assigned the responsibility of welfare exclusively to the provinces. However, with the problems which arose and were aggravated by the depression of the thirties and the inevitable unemployment and poverty of the post war years in Canada, the provincial powers have outstripped the provincial facilities to pay for their proper exercise of their duties, this being naturally felt most acutely in those provinces which are economically the weakest. Recognizing the need and realizing their responsibility, the federal government, being financially in a position to help and being in a position also to legislate

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[1] ibid, page 42

[2] ibid, page 42

on a nation-wide basis, gradually became involved in the provision for welfare needs. George F. Davidson, in his paper on Canadian Social Welfare observes that:

> The post war years have been marked by the strengthening and extension of public and welfare services across Canada; the establishment of the federal Department of National Health and Welfare and of provincial welfare departments in each province, in some cases in association with health departments; and, particularly since the war, the rapid development of public and voluntary prepaid health care plans.[1]

During these years, both the provincial and federal governments were becoming more involved in relieving need, and were extending their activity into new fields of social welfare legislation.

> It was during this period that the mother's allowances programs were established in a number of provinces. Manitoba enacted the first legislation in 1915, and this action was followed soon after by Saskatchewan, Alberta, British Columbia, and Ontario. Legislation was passed in three more provinces during the 1930's and in the remaining provinces in 1949.[2]

Nova Scotia passed its Mother's Allowance Act in 1930.

These allowances, which are designed to assist needy mothers and their dependent children are granted to widows and mothers with husbands in mental hospitals and, in nine provinces, to mothers who are deserted or whose husbands are disabled.

> Across Canada the nature, extent and duration of disability provided for show considerable variation. Thus, while the Acts and Regulations in three provinces make no specific reference to the nature of the disability, in five they specify that it may be physically incapacitated or else

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[1] George F. Davidson, "Canadian Social Welfare," Social Work Year Book (New York: National Association of Social Workers, 1957), p.115

[2] ibid, page 123

> committed to a mental hospital. With regard to extent of disability, in four provinces a mother may be eligible if her husband is totally disabled, while in five he must be unemployable or unable to support his family. With respect to duration of disability a mother may qualify for an allowance in five provinces if her husband is permanently disabled. Four provinces provide that the husband may be temporarily disabled but the disability must be expected to last a specific period of time.[1]

In Nova Scotia a mother whose husband by reason of permanent physical or mental disability is unable to support his family may be eligible. A mother may also be eligible under the Act as the wife of a permanently disabled husband if the latter is committed to a mental hospital or sanitorium.[2]

> The disability of the husband must be certified by the family physician...The departmental Medical Advisor examines the record to determine whether or not the father is unemployable within the meaning of the Act and the case is reviewed every six months or more often upon both social and medical evidence.[3]

As special services the Nova Scotia act provides that: "Casework and family counseling services are provided by visitors and investigators. Provincial field staff are required to visit each recipient at least twice a year."[4] Under an agreement between the Government of the Province and the Medical Society of Nova Scotia, recipients of Mothers' Allowances and their eligible dependents are provided with limited medical care at home or in the doctor's office including the drugs and dressings ordinarily used during such visits. This program does not include surgery except tonsils and adenoids and minor surgery in the doctor's

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[1] Mothers' Allowances Legislation in Canada, (Ottawa: Research Division, Department of National Health and Welfare, 1955), p.5

[2] ibid, page 32 [3] ibid, page 32 [4] ibid, page 35

office. Fractures and refractions (eye test) are included for children up to the age of fifteen years. Obstetrical benefits are also included. For these services the Department of Public Welfare pays the Society eighty-three cents per month for each person on whose behalf an allowance is paid. There is not special provision for the hospitalization of recipients of Mothers' Allowance or their dependents, but if they are unable to meet the account, the cost may be met by the municipality of residence in the same way as for others who cannot pay.[1]

Local policy in regard to casework services to recipients is to provide this service only in cases of observable and pressing need and on the request of the recipient.[2]

This thesis, concerning the families receiving Mothers' Allowance where the husband is disabled, is being written in co-operation with the other second-year students of the Maritime School of Social Work in partial fulfillment of the requirements for a Master's Degree in Social Work. Legislation, administration, and special services as they relate to the recipients directly will be studied and evaluated, jointly and individually from particular aspects. Since a study of the entire Mother's Allowance Act of Nova Scotia would be a much too comprehensive undertaking for this group in the time alloted, they have chosen to study only that part of the Act which deals with the mothers dependent on public assistance because their husbands are disabled. The study

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[1] ibid, page 35

[2] Lecture given by Miss Beatrice Crosby, January 27, 1958

will be based on the findings of a group project undertaken by the entire 1958 class of the Maritime School of Social Work. The project consisted of a study of the eighty families in the city and county of Halifax who are in receipt of Mother's Allowance under the section of the Act mentioned above. The cases studied were those who were in receipt of the allowance on December 1, 1957, and all statistical data collected is applicable to that date.

Since this was a group project all the cases were analyzed from as broad a viewpoint as possible. The writers were limited in their research by the focus of the records available to them which was necessarily the financial standing of the home as well as very brief medical notes on the father's condition.

For the collection of data the researchers have used both primary and secondary sources. The primary ones consisted of the files from the Department of Welfare, Halifax, district office and head office, and personal interviews with the thirty-three families in the metropolitan area of Halifax. To facilitate the group collection of this primary data, a set of ten schedules[1] was drawn up by means of which pertinent questions could be answered in reading the files of the Department of Welfare. For the personal interviews, seven questionnaires[2] were drawn up and focused on the more specific psycho-social conditions which were not included in the above files. The eighty cases under study were divided among the group for analysis, as were the families

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1 See Appendix A

2 See Appendix B

chosen for personal contacts.

As secondary sources of information the libraries at Dalhousie, the Maritime School of Social Work, and the Halifax Memorial Library were used. Other potential sources of information such as the Social Service Index, the Maritime Medical Care files, and other social and medical centers were not used by the group because of the limited access to these resources. Any other data which is pertinent to an individual focus of the thesis was the responsibility of the writer.

In this paper, data concerning living conditions and financial situations, as well as the roles of the mother and children will be used as background material, to set up the scene for the father, his disability, and the medical aspects of the family as a unit. Case studies will be used in particular reference to the father's acceptance of and attitude toward his dependency needs. A select group of cases which could benefit from services other than and in addition to the financial assistance already present will be analyzed on a case by case basis. Statistical data will be used to illustrate the number of fathers who attend out-patient clinics regularly, who are hospitalized or institutionalized at present, or have been in the past, those who are receiving regular and prescribed medications for their disability and who finance these medications. The degree of mobility of the fathers and prevalence of disabling diseases will also be indicated in statistical tables.

Disability which results in unemployability creates many complex problems both for the disabled and for members of his family.

> Handicapped persons have in common with all other persons certain basic needs, of which the most important is the need to be loved and wanted and to feel secure whether he is living with his own family or is living in a substitute family setting.[1]

The second basic need of the handicapped patient is to be viewed as a total human being. Also, fundamental to the handicapped is his need for complete evaluation of his condition as soon as it is discovered. To accomplish this aim, the evaluative study should include not only the physical aspects of his handicapping condition but also its social, psychological, educational, vocational, and recreational aspects.[2]

The increased time the man spends in the home, the way he used his new-found and often unlooked for leisure time as well as the physical and financial dependency which results from being disabled will take its toll in terms of personal relationships, physical and mental health, and happiness, if those directly involved do not come to grips with their situation and handle it successfully.

In the following chapters the study of these medical-social needs will be presented in the following order: the meaning of chronic illness will be explored and the meaning of disability under the Mother's Allowance Act. In general, this area will be examined by the entire group, but the writer will expand on this from a medical-social aspect. This will include the medical, social

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1 Helen M. Wallace, M.D., "The Role of the Social Worker in the Rehabilitation of the Handicapped," Social Casework, Volume 31 & 32, January, 1957, page 16

2 ibid, page 18

and psychological needs of the father; such as hospitalization and home-care, visits to clinics and doctor's offices and the doctor's visits to the home. Medicines and medical supplies, their need and sources as well as their financing will also be discussed. Some consideration will also be given to the social and psychological needs of the father as they involve his total well-being and the total approach in providing services.

The writer will also deal with the medical-social needs of the rest of the family, including illnesses and their causes, medical attention required and received, hospitalization, doctor's opinions and medications. This will again be discussed with the concept of the "total approach" in mind.

Medical expenses and how they are handled, what provision is made for them through public assistance and how the issue of medical expense effects the health of the disabled father and his family will be discussed.

The conclusions and recommendations will include the need for services to the father in accepting dependency and to the mother in dealing with disabled husbands, and illness in the home, and an evaluation of the adequacy of services presently being given. This section will also examine the trend in treating the total person, including his family, and the need for medical orientation in social work and social orientation in medicine. The methods of achieving this broadened concept will also be suggested.

CHAPTER 11

MEDICAL-SOCIAL NEEDS OF THE FATHER

This chapter will be devoted to an examination of the present-day meaning of chronic illness, the meaning of disability under the Mothers' Allowance Act, and the current trend in dealing with the needs of the disabled.

Minna Field in her book "Patients are People" says about chronic disability; "Prolonged illness should be viewed for all practical purposes as an extension of acute disease over a longer period of time."[1] For Miss Field to have said this in 1953 would indicate that prolonged illness has not always been seen in this perspective. Evidence to this fact are the multiple institutions of the nineteenth century, where people whose illness had passed through the acute stage without successful treatment were relegated to the background of the medical and social focus as hopeless cases, for whom nothing could be done. These people were considered mere"scraps of humanity", whose existence had ceased to be useful to anyone including themselves, and professional people consequently centered their efforts on those patients who showed evidence of improvement and were good rehabilitation prospects.

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1 Minna Field, Patients are People, (New York: Columbia University Press, 1953), page 7

However, a growing awareness and sensitivity to the dignity of the human person, has led medicine to the point of recognition that every patient has particular needs as a person, and because of his disability, these needs are aggravated, multiplied, complicated, and not unchanging or hopeless. The acceptance of this concept led also to the treatment of the whole man, to the treatment of not only the disease, but the patient as well. It is now accepted that the,

> Social implications of prolonged illness cannot be separated from their medical implications, and the problems which they jointly present seriously affect the patient, his family, the professional groups concerned with his care, and the community of which they are all a part.[1]

> This broadened concept of prolonged illness as both a medical and a social problem is a development of recent years and reflects the general tendency of modern medicine to consider the influence of social (including psychological) forces as contributory to pathological phenomena.[2]

A comparison between this broadened concept and the definition of disability under the meaning of the Mothers' Allowance Act shows some similarities and some striking differences.

Disability under the meaning of the Act refers to that state of a patient where he is (a) unable to support the family due to the illness, (b) "permanent" means disability of indefinite duration in which the illness or disability is of such a nature that the examining physician cannot with any degree of accuracy forecast the duration of the illness, and (c) the word "total" means that the husband must be completely or totally

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[1] ibid, page 9

[2] ibid, page 9

unable to support his family and not only partially so.[1]

In confirming a disability for the purpose of application for Mothers' Allowance, the medical examiner may make any of the following recommendations: (a) is permanently disabled to such an extent that he is unable to support his family, (b) has some degree of disability but before making any findings further medical evidence should be submitted (such as)....(c) is permanently disabled to such an extent that he is unable to support his family but he should be brought into the Victoria General Hospital for examination.[2]

The Regulations are quite flexible in this regard, however, and the final decision is made by the Director of Child Welfare[3] in view of not only the disability as such, but of the social evidence which, added to the disability, renders the man unable to support his family.

It is significant that the Act considers that a man's inability to support his family is an essential component of being disabled. Also that the term "permanent" as defined here, connotes the possibility of recovery by stating that a degree of uncertainty about prognosis is acceptable for eligibility.

The concept of the dynamic approach to this illness however, somehow fails short of what Miss Field would subscribe to as a 'total treatment of the total person'.

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[1] Policy Manual, Department of Public Welfare, Halifax, "Medical," page 2

[2] ibid, page 2

[3] Hereafter referred to as the Director

Consideration is nevertheless given to the medical-social picture to some degree in the provision in the Regulations that the

> Social worker must obtain a picture from the doctor as to what jobs are within the man's physical ability to perform. Having this, they then assess the man's capacity to accept such a job and only after both these evaluations have been made can they make a decision.[1]

The focus here is on the eligibility of the applicant to receive financial aid. But the philosophy which prompts the Department of Welfare to conduct a social and medical investigation, is one upon which can be built the team approach, to the total human being; his illness, his financial need, his other needs, and those of his family.

It may be well at this point to establish what these needs are, which present such a problem in the fields of medicine, social work, and public assistance.

The needs of the handicapped are many and varied as will be seen. They can perhaps be best grouped into three types; medical, social, and psychological.

When one thinks of an illness, be it acute or chronic, organic or functional, disabling or non-disabling, one thinks first of the medical implications. When a man breaks a leg, or contracts tuberculosis, or develops arteriosclerosis, the whole man is thereby affected. However, the problem is essentially a medical one, and the first service sought is that of the medical profession. It is appropriate then that the medical aspects of disability and resulting dependency be studied first.

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[1] Ibid, page 3

Hospitalization is perhaps the most prevalent and most threatening of issues in medical treatment of disability. This is indeed a significant factor in the eighty families being studied, in view of the fact that sixty-nine of these fathers have been in hospital for various periods of time.

TABLE 1

PAST HOSPITALIZATION OF EIGHTY FATHERS*

Length of Hospitalization	Number of fathers
Less than 6 months	33
7-12 months	12
13-24 months	--
Over 24 months	10
Not applicable (a)	11
Unavailable (b)	14
Total	80

*Source: files at the Department of Welfare, Halifax District Office

(a) Those not applicable have not been hospitalized because of their disability.

(b) Hospitalization not listed on record.

Table 1 indicates that thirty-three out of sixty-nine fathers spent six months or less in hospitals while twelve spent nine to twelve months, and ten have spent more than two years in hospitals. What it means for a father to be separated from his family by hospitalization has been the topic of many studies since the social

approach to illness has been integrated into the treatment program. Among the conclusions drawn from previous studies of this kind, Minna Field has stated that

> Hospitalization symbolizes an affirmation of his inability to deal with the demands of everyday living, an admission that his illness is not merely a temporary indisposition; and it may mean a confirmation of his fear that he is going to die.[1]

The records of these eighty families have shown a consistent resistance to hospitalization, particularly in the case of tubercular patients. The meaning of this resistance can perhaps be best explained by looking at the C-. family and their encounter with the problem.

Medical history: Mr. C-. is a 34-year old man who has been suffering from pulmonary tuberculosis since 1950. He spent one year in the provincial sanitorium and then left against medical advice. He went home and was urged by doctors to return to hospital. He returned to the Veterans Hospital where he remained for two years and again left against advice. In 1956 he again spent six months in the Municipal tuberculosis hospital. Despite pressure for him to return to hospital he persisted in staying at home. In June of 1957 Mr. C-. was forced to return to hospital for two months. The medical examiner's notes at this time were: Pulmonary tuberculosis, far advanced, active and open, thoroucoplasty and pneumonectomy in the right side. He now attends the out patient department of the municipal tuberculosis hospital every three months. His only medication is cough mixtures. He is in a very weakened condition and can walk only about one hundred yards because of respiratory difficulty.

Social history: Mr. C-. has four children. He lives in a small, four-room house in the slum area of the city. His house has been rated as unsuitable for habitation with a very low standard of housekeeping. Certainly, by anyone's standards, the physical surroundings of the home are not conducive to relaxation, or fruitful relationships. Before the onset of his illness in 1950 Mr. C-. was a coal hauler and earned $100 a month. His wife is now receiving $70 a month Mothers' Allowance and $24 a month from family allowance. This $94 is the extent of their monthly income. Mrs. C-., who is a small woman with a hunch back gathers coal from

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[1] Field, op.cit. p. 37

the railroad tracks for their fuel. Mr. C-. says that his nerves are bad and that the children bother him when they are noisy. He is very conscious of the contagious nature of his illness and leaves the room when visitors enter. He feels very inadequate in relation to his children because he feels he cannot give them fatherly love for fear they may develop tuberculosis. He would like to help them with their school work and attend Home and School Association meetings, but is unable to. Mr. C-. feels that the doctors are no longer interested in him, and is discouraged as for rehabilitation possibilities.

Here is seen a father who has experienced deep feelings of insecurity and inadequacy. His presence in the hospital has threatened his relationship with his family, and has presented to him the fact that he is completely dependent. His periodic refusal to stay in hospital is significant in the fact that separation from his family has been psychologically impossible for him to bear.

> Recognition that the individual (in hospital) came from the community and will return to it, for better or for worse, gives impetus to promotion of all services which will prepare him for his return as early as possible.[1]

This involves first of all the prevention of disabling attitudes. This is a responsibility which should be assumed by every person offering any service. Perhaps if Mr. C-'s doctor had shown more interest in him, not only in the progress of the tuberculosis but also in what Mr. C-. will be able to do while in hospital as well as on his return home, he would have been more resigned to stay in the hospital for the full course of his treatment. The services of a social worker while he was in hospital may have helped him to accept the reality of his disability.

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[1] Caroline H. Elledge, The Rehabilitation of the Patient (Philedelphia: J.B. Lippincott Co., 1948), page 83

Discharge from hospital can sometimes offer very little consolation, for in fact, at this stage many other problems are created. The problem of adjustment to staying at home, and of being unable to do anything constructive is indeed a real one.

After hospital the patient faces "one of the stages in a life which henceforth will be governed by the demands of an illness which threatens to change the whole pattern of living."[1]

Home can then become important in order to ensure that the person who is unable to leave the house may nevertheless receive the necessary medical and other services required. Among the medical needs of the disabled living at home are nurses' educational and service visits, drugs, supplies and facilities needed in the home, and doctor's visits to the patient at home.

It is essential, too, that a plan be made for the periodic re-evaluation of the handicapped person's status, since no person's conditions remain static. Thus one must be sure that it is known when a patient's condition changes and when therefore his needs change, so that the appropriate services may be offered him at the proper time.[2]

The case of the D-. family will illustrate the significance of the need for this periodic evaluation, and the type of help which can be given at these times.

Mr. D-. is 42 years old and has been suffering from pulmonary

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[1] Field, op. cit. p. 42

[2] Helen M. Wallace, "The Role of the Social Workers in the Rehabilitation of the Handicapped," Social Casework, Volume 31 & 32 (January 1957), page 17

tuberculosis since 1951, at which time they applied for and received Mothers' Allowance. Although Mr. D-. has spent a total of three and a half years in hospital, he has shown considerable resistance to demands for hospitalization from medical and welfare authorities. On occasion he has been threatened by a withholding of the allowance to force his returning to hospital. Mrs. D-. is forty-nine years old. At the time of application she was suffering severely from arthritis which became progressively more crippling. By 1954 she was completely disabled because of this. A daughter, now aged nineteen, contracted tuberculosis in 1955 and was hospitalized and in 1957 Mrs. D-. contracted tuberculosis and was hospitalized.

The social worker visited the D-. family every six months to re-assess the father's ability to work, and the general health of the family as well as their financial status. During these visits, the worker had an opportunity to observe the progress of Mrs. D-.'s arthritis to help her accept medical care and apply for Disabled Persons' Allowance, for which she was eligible but felt ashamed to apply. The opportunity also was hers to observe the need for the daughter's medical examination and care. The worker may also have dealt with Mr. D-'s lack of cooperation regarding hospitalization which was prompted chiefly by his need to be assured of financial adequacy at home. Regular evaluation by the medical examiner with a view to the health of the total family in this situation is also an obvious necessity, in order to prevent illness and to control progressive and disabling disease.

The Department of Welfare requires that the status of families in receipt of allowance be re-evaluated every six months by the social worker and the medical examiner. The prime purpose of this evaluation is, in practice, to establish the existence of continuing eligibility. Nevertheless, this is a most opportune arrangement for the regular assessment of the total situation and

enables the medical and social personnel to discover and handle the changing needs as they arise.

Table 11 shows that of the eighty families studied only sixteen were in hospital, while sixty-four were at home presently.

TABLE 11

FATHERS AT HOME OR IN HOSPITAL
as of December 1, 1957*

Location of fathers	In hospital temporarily	In hospital permanently	At home	Total
Number of fathers	8	8	64	80

*Source: Files at the Department of Welfare, Halifax District Office

Home nursing is then a requirement in many cases. It is not always possible or even practical for trained nurses to give regular attendance to most patients. It is nevertheless advisable that some provision be made by the nurses by which the mother of the family, another responsible person in the home, or a neighbour can be educated to understand the everyday needs of the patient and to know how to meet them.

The use of outpatient clinics is in a majority of cases an integral part of the medical treatment of the patient living at home. The many clinics available are unfortunately not of easy access to those living outside the city. For this reason, transportation service is a prerequisite to successful treatment of out-of-town patients needing out-patient attention. There are several organizations in the province which provide for the transportation of certain diagnostic groups. The Canadian Arthritis and Rheumatism Society, the Canadian Cancer Society and the

Canadian Paraplegic Association are examples of the services provided in this area. These organizations are financed through private funds and community chests, thereby including the community in the actual help given the disabled.

Table lll shows that thirty-one patients out of sixty-four fathers at home attend out-patient clinics. Of these, two attend on a weekly basis, two attend monthly, three go every three months and four go every six months. Sixteen seek treatment at the clinic as it is needed at irregular intervals. The frequency of the attendance of four patients was unavailable. The tubercular patients are required to have a check-up every six months while some go more frequently as their need indicates.

TABLE lll

ATTENDANCE OF THIRTY-ONE FATHERS AT OUTPATIENT CLINICS*

Place of Treatment	Frequency of attendance						
	weekly	monthly	3months	6 months	as needed	not given	total
Victoria General Hospital	1	1	1	2	10	1	16
Tuberculosis Hospital	-	1	2	2	4	3	12
Other	1	-	-	-	2	-	3
Totals	2	2	3	4	16	4	31

*Source: Files at the Department of Welfare, Halifax District Office

Of the twenty-five fathers who have tuberculosis, two are per-

manently hospitalized and six are in hospital temporarily. Of the remaining seventeen fathers with tuberculosis, twelve attend the outpatient department of the tuberculosis hospital, which leaves only five who do not receive regular attention.

A separation of the various diagnostic groups[1] to show the prevalence of disabling diseases is significant in that it indicates the proportion of conditions which require long hospitalization, and frequent attendance at out patient clinics. Records have indicated that twenty-five out of eighty or 31.25% of the fathers have tuberculosis. Hospitalization and outpatient treatment of this diagnostic group has already been discussed. It is not the writer's intention to develop the specific treatments for these various groups. Suffice it to say here that the predominance of tuberculosis in this group of dependent fathers leads one to wonder about the reasons for this disproportionate number. Damp housing, poor nutrition, and over-exertion as well as delayed diagnosis are some of the factors which have been proposed as an explanation of this situation.

The prevalence of heart conditions which is the second largest diagnostic group indicates a need also for slowed up activity and restricted diets.

An analysis of the caseload points out that in addition to the disability which qualifies the family for Mothers' Allowance, the fathers are suffering from various other diseases. These diseases are predominantly emotionally determined. There are,

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[1] See table IV, page 22

TABLE IV

PREVALENCE OF DISABLING DISEASES
AMONG EIGHTY FATHERS*

Diagnosis	Total number of fathers
Tuberculosis	25
Heart diseases	16
Brain disorders	8
Arthritis	7
Blindness	5
Schizophrenia	4
Ulcer	3
Paraplegia	3
Other diseases (a)	9

(a) includes asthma, syphilis, pneumonia, cancer, dermatitis, neuralgia, gastritis, neuroris, visual and hearing defects.

*Source: Files at the Department of Welfare, Halifax District Office

for example, tubercular patients suffering also from gastritis, ulcers, dermatitis, arthritis, psychoneurosis and high blood pressure. The presence of ulcers and asthma, among seven fathers would indicate that feelings of inadequacy, dependency, and hopeless disability present themselves not only in terms of the psychological but also in physical symptoms. While these secondary infirmities aggravate the problems of home-care, it is also possible that the problems of home-care have aggravated these conditions.

Observation of the emotional component of secondary illness

can be done in the case of Mr. H-.

In 1949 the H-. family applied for and received Mothers' Allowance. Mr. H-., in 1932, was diagnosed as having pulmonary tuberculosis. He was in poor physical condition and had trouble breathing as one lung was collapsed. In 1950, one year after receiving Mothers' Allowance he developed rheumatoid arthritis. Six years later his tuberculosis was noted closed but in the following year his medical record reveals "osteoarthritis of all extremities." He has become increasingly crippled and has lost the use of his hands. His shoulders and legs are also crippled.

His wife works outside the home every day. They have a twelve year old son. Mr. H-. has stated that he has found it very hard to stop working. He feels he has lost his freedom and is isolated because no one will employ a man with tuberculosis. He was an avid fisherman and prided himself on his skill in making casting-flies. He now misses the company of his friends and finds staying in bed or getting about on crutches very hard.

Mr. H-. illustrates quite clearly the psychological and physical processes of a man who is confined to bed and unable to work or form relationships because of a contagious disease. This, to him is a situation so severe and so hopeless that he has gradually become a total cripple. This process has many hidden and unconscious factors. The man was unable to fulfill his needs because of an illness, yet because of his failure to accomplish his goals he has become more crippled. One is cause and the other effect. Between the two it is difficult to determine any dividing line because feelings of inadequacy and progressive illness are so inter-related.

Rehabilitation should also be mentioned as a medical problem in this caseload. Caroline Elledge defines rehabilitation as "the restoration of the fullest physical, mental, social, vocational, and economic usefulness of which they are capable."[1]

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[1] Caroline H. Elledge, The Rehabilitation of the Patient (Philedelphia: J.B. Lippincott Co., 1948), page 3

It is an active process which must be built around the needs and abilities of each individual and one in which the patient has the primary role. This process demands the continuing involvement of many professionally trained persons including the doctor, physiotherapist, occupational therapist and social worker. Not the least of these persons is the social worker. The social worker from the Department of Welfare, or the hospital, or both can be helpful in working through with the individual the personal or family difficulties which may prevent him from using restorative service.

Prevention is a most vital branch of medicine concerned with the health of the families in question. Dr. Cabot of the New York School of Medicine states that "clearly the standard at which all concerned should aim is one of prevention, avoidance and the minimizing of the degenerative processes."[1] A program of preventing and minimizing these processes, involves the community, the professional groups, and the individual. The community has taken an active part in this. There are, for example, free innoculation and vaccination services for everyone, as well as mobile x-ray units for the early detection of tuberculosis. The families of tubercular patients are also required to have regular examinations in an effort to prevent the spread of this disease.

Publicity given to the various degenerative processes and their prevention is also a contribution on the part of the community and the professions.

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1 Hugh Cabot, The Patient's Dilemna (New York: Reynal and Hitchcock, 1940), p. 40

Individuals have not a little responsibility in this program of prevention. Sanitation, adequate diets, and housing play a significant role as do sufficient medications. These factors will be discussed in more detail in Chapter lll.

"Medical attention and supervision have to be provided on a team basis. The nurse, the social workers and the doctor must work together on all the problems that the patient and his family have."[1]

The social needs of the disabled are no less important than the medical in terms of the patient's adjustment to illness, and his endeavours, or lack thereof in gaining rehabilitation.

> Some persons will need services more than others. The fact that a person is in financial need, whatever the cause, does not in itself mean that he cannot take responsibility for his own affairs. It may mean, however, that he has also a need for various types of service. In his interests and those of the community, the administration must make available, either itself or through referal to other agencies, the services required.[2]

Perhaps the most obvious social need of the group under study, is the financial one. Doctor Helen Wallace of the New York College of Medicine lists financial assistance to help pay for medical rehabilitation care, for vocational training and for the expenses of daily living, as one of the basic needs of the disabled man.[3]

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1 George Silver, "Meeting the Needs of the Chronically Ill," Canadian Welfare, xxix, May 1953. p. 25.

2 ibid. p. 26.

3 Helen Wallace, "The Role of the Social Worker in the Rehabilitation of the Handicapped," Social Casework, Jan. '57, page 18

This need is being met at least in part by the Mothers' Allowance. However, this assistance is given to the mother for the care of her children, and the father's financial need is not considered in this program. The fact that it relieves him from the burden of maintaining his wife and family is of some small consolation to him in the fact that he is relieved of this economic stress.

The cases of Mr. D-. and Mr. H-. already cited[1] point out what it means to a father to be economically dependent. In the case of Mr. D-. was seen refusal to go to hospital because his family was living on a marginal income. His presence in the home at least indicated that although he was not contributing financially, he was not entirely useless to his family. In the case of Mr. H-. his wife was working every day and he was unemployable. His reaction was seen to be the development and progression of a crippling disease. It is not inconceivable that his dependence on his wife may have resulted in his becoming actually bedridden as a visable and acceptable explanation of his financial dependence.

Information and counselling service is of vital importance because it may make the difference between a patient's receiving good care on the one hand, and not knowing how to go about getting it on the other.[2] Vocational services such as vocational testing, guidance, training and placement, as well as evaluation of physical capacity for vocational rehabilitation is of great importance to the patient and to his family in terms of social rehabilitation in spite of his handicap.

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1 Supra pp. 17,18,23

2 Ibid, page 18

The Rehabilitation Center which recently began operation in this area will be of inestimable value to the fathers in this study. Because it is so new, and because at its inception it is necessary to be selective in its patient load, in order to use its facilities to best advantage, it may be a long time before its services can include many men in the category under study. However, the records have indicated that the social workers and/or the doctors have discussed the possibility of using this resource with some fathers. At the present time two of these fathers are attending the Rehabilitation Center for regular therapy and help toward rehabilitation.

A brief look at the progress of the disabilities in this study will reveal that regular assessment with a view to rehabilitation, additional care, or possibly hospitalization is advisable. The records noted that at the visitor's last report the condition of twenty-six disabled men had remained static, thirty had become worse and sixteen had improved. Recent evaluation of eight fathers was unavailable.

Mr. C-.[1] presents a typical situation with possibilities for some measure of vocational rehabilitation. It is conceivable that if Mr. C-. had some skill in handicrafts he would be able to occupy his time more fruitfully, and could contribute somewhat to their financial income. This type of project, although expensive and time consuming for the rehabilitation team at the beginning, would reap many benefits to the C-. family in terms of personal prestige

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[1] Supra pp. 15, 16

and self-satisfaction. Mr. C-. could then feel that he has some function in life. It is clear, however, that without help from some social agency, Mr. C-. could not possibly rehabilitate himself even to a marginal level of usefulness.

Recreational services, to enable the handicapped to lead a rich and not so isolated life, to learn to develop interests and hobbies and to participate in socializing experiences are an area in which much can be done to fill a void in the lives of many of the fathers in the group being studied.

In the thirty-three cases studied in the city it was found that twenty fathers stated that they had nothing to do with their time and consequently found it very hard to be home all day. Four were able to get out to walk around each day. Six fathers stated specifically that they spent their time reading or listening to the radio and watching television. Only two mentioned that they would like to have some training in a hobby. A great number of fathers at one time had hobbies such as making casting-flies, radio-repair, attending sports activities, among other things. The majority of them, however, have had to discontinue these recreations because of failing health, inability to leave home for any length of time, or because of arthritis and loss of sight. Transportation services to enable him to get to a clinic or hospital for medical treatment, and to educational, vocational, and recreation centers is another area which facilitates the "total treatment of the total person."

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1 Wallace, op. cit. p. 18

TABLE V

DEGREE OF MOBILITY OF EIGHTY FATHERS

Degree of Mobility	Percentage of fathers
ambulatory	55
periodically bedridden	18.8
confined to wheel chair	13.8
ambulatory with special aids	12.5
bedridden	1.3

An examination of the degree of mobility of the eighty fathers will serve to substantiate the need for these services. It has been found that 55% of the caseload were ambulatory, 18.8% were bedridden at times and could walk with difficulty, 13.8% were confined to wheelchairs, 12.5% used special aids for walking, such as crutches, canes, and special shoes, and 1.3% were bedridden. Thus it is seen that 45% of the caseload were in some way dependent for transportation to clinics, social activities, and rehabilitation and training centers.

The psychological needs of the handicapped father are of paramount importance, both as they affect his ability to recover from his illness and to adjust to it, in the event that complete recovery is impossible. As was seen earlier, the handicapped, like every other person, has a need to be loved and

wanted and to feel secure. Charlotte Towle, in her book "Common Human Needs," cites that it is vital that the disabled father be recognized as a person, one who is important in the family scheme. "Because of his handicap and also because of his dependency he needs this recognition all the more."[1] Fathers in such a position as to need not only medical attention, but financial help in order to maintain their families are likely to feel inadequate, hostile, or overly dependent to the point of regression. "More often than not we encounter disturbed feelings symptomatic of profound discomfort when major catastrophes of life drive them to others for help."[2] Mr. D-. and Mr. H-. bear out this theory as has already been seen.

Consider too, what it means to a father to be dependent and unemployed against his will. " A man out of a job is forced to live without routine or time-table--a frightening experience for any man."[3] The man who has filled his day with eight or ten hours of work must find new ways of living these eight or ten hours daily. He must learn to do without the things that his work has brought him; and his work has brought him more than weekly or monthly pay.[4] The values in work which must be compensated in forced retirement are many: social participation with groups, interesting experiences,

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1 Towle, op.cit.p. 78

2 Ibid, page 60

3 Robert Gomberg, "The Responsibilities and Contributions of Social Work in Strengthening Family Life," Social Casework, June, 1953.

4 Eugene Friedman and Robert Havinghurst, "The Meaning of Work and Retirement," (Chicago: The University of Chicago Press, 1954), page 187

creative self-expression, routinization of life activity, retaining self respect and gaining the respect of others.[1] All these feelings must be handled with the patient in order to help him make an adjustment to his new way of living, as a disabled person. All these are an integral part of being disabled.

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1 Ibid, page 191

CHAPTER III

MEDICAL-SOCIAL NEEDS OF THE FAMILY

> The psychosomatic movement which arose from an interest in the relation of the person to his illness, acquired more and more precision in the description of the personality of the patient, and at the same time brought in more and more of the family life. With this movement the idea of disease as an entity which is limited to one person, and can be transmitted or spread from one individual to another, fades into the background, and disease becomes an integral part of the continuous process of living.[1]

Family patterns are important, therefore, for an understanding of the illness of a father. A father's illness also has many repercussions on his family--affecting them physically in terms of health, financial security and physical comforts, and psychologically in terms of mutual acceptance or rejection, dependency and fear.

In this chapter the writer will elaborate on the family as a unit of illness, outlining the diseases prevalent in the eighty sample families. Their needs in relation to health will be discussed. Section two of this chapter will be concerned with the social problems of these families and provisions necessary for medical and social welfare. The last section will be concentrated on the way the various family and individual needs are met.

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[1] Henry Richardson, Patients Have Families (New York: The Commonwealth Fund, 1945), page 76

Medical Needs of the Family

Advancing medical science has as one of its objectives a better understanding of the family unit as one means of improving the prospects for readjustments necessitated by illness and as a part of treatment. It is necessary in this process that the patient be seen in relation to his family and that the family be viewed in relation to the patient, and the patient and his family in relation to illness.

A study of the M-. family will facilitate discussion of these problems.

Medical history: Mr. M-. is a thirty-four year old man who was diagnosed as having pulmonary tuberculosis, minimal, active, and open in 1947. The following year his medical record showed "minimal tuberculosis, quiescent and closed." In 1950 he began to have attacks of dizziness and blurring of vision and one year later, in 1951, he was diagnosed as disseminated sclerosis. The visitor's reports show that he is totally unemployable and has difficulty walking, as he has little control over his legs. He gets dizzy and faints if he walks very far. He now has multiple sclerosis which he describes as an "incurable nerve disease." He is almost totally blind and suffers from bowel and stomach trouble and picks up colds and flu very easily. He spent seven months in the tuberculosis hospital in 1947-48, and has been in the general hospital on three occasions. He now goes to the hospital every six months for a check-up. His family doctor visits him frequently. The doctor does not charge for his visits, and the Multiple Sclerosis Society helps out with medical expenses. He occasionally takes sedatives to help him sleep. These he gets from his doctor free of charge, or from the clinic. He feels that he is getting weaker all the time and has no hope for improvement. The doctor's prognosis was given as follows: "In my opinion this man will never be able to do much in the way of earning a living."

Mrs. M-. suffers from kidney infection and severe headaches. She also has a low blood count. She sees the family doctor who does not charge them and gets drugs from the clinic. She has not been in hospital since receiving Mothers' Allowance.

The oldest daughter, eleven-year old Laura, has tuberculosis of the bone and has broken her hand. Janet, aged eight, is

susceptible to colds and flu and has had pneumonia. The youngest girl, Marie, aged five, has abscesses on her chin and a cataract on her eye. All three of them have been in the Children's Hospital and have the doctor attend them at home on occasion. The doctor gives them medicines.

Social History: The family is composed of four children, a boy aged thirteen, and three girls, aged eleven, eight and five. They own a small four-room house in the working class residential area. The home is in "fair" condition. All six of them live in these four rooms. Their income consists of one hundred and thirteen dollars per month. Their sources of income include twenty-eight dollars Family Allowance, forty-five dollars Mothers' Allowance, and forty dollars Blind Persons' Allowance. The family received ten dollars weekly from local relief.

They used to use oil for heating their house but have had to change to wood. Mrs. M-. saws the wood herself. They have not been able to afford enough to eat, and the children find the food monotonous because they have the same dishes all the time.

Mr. M-. has a good head for figures and planning. With the help of the social worker he has planned a budget. He also has arranged to borrow money to have an addition built on the house. He has also designed cupboards for the house and is directing the building of them. His social worker has helped him obtain legal aid to settle a dispute over ownership of their land.

Bruce, the fifteen-year old son, has a paper route and earns five dollars a week from this. He keeps up the payments on his insurance and buys clothing. He has bought a television set for the family and is keeping up his payments on this.

Bruce was presenting a problem to his parents by getting into trouble at school because of his friends. He is slowly breaking away from them.

The social worker has given this family a great deal of help with their many problems. She helped them to work out plans for budgeting and enlarging their home, and to arrange for medical examination, counselling service on their problem with Bruce, and helped them plan a vacation.

A closing note on one of the visitor's reports says: "Even though there is a lot of arguing and bickering between the parents, the worker feels that closer supervision will help the family to overcome their difficulties."

Looking first at the medical status of this family one may see that health is a major factor in their lives. Mr. M-., with his long history of progressive disability, coupled with

advancing loss of vision, determines to a great extent the living pattern of his family.

The health of the rest of the family must also be considered in order to present the total picture. The survey has shown that there is a prevalence of disease among the mothers and children as well as the disability of the father. Pneumonia is perhaps the most common disease attacking these families, with an incidence of fourteen cases cited in the records. Fourteen families are also subject to frequent colds and six have suffered from flu. In addition to this there has been an overall picture of such ailments as gastric and kidney trouble, bronchitis, asthma, low blood count, high blood pressure and nervousness in children and mothers. It is interesting to note that the greater part of these disorders are to some extent emotionally determined, as in the cases of asthma, high blood pressure, and nervousness. The remainder would seem to have some relation to dietary deficiencies. There also appeared in the records a disproportionate number of defects of eyes, ears, teeth and throat among the children.

The M-. family, although possibly exaggerated in relation to the illness of the average family in this category, seems to illustrate the types of childhood ill health which confronts the family and the treatment team. The records did not indicate whether or not Marie has been given any attention for her abscesses and cataract. However, since treatment of the cataract would involve major surgery, and since there is as yet no public provision made for this form of treatment, Marie will unfortunately probably grow

up with this defect. Susceptibility to colds, pneumonia and flu have many contributory factors, not the least of which are damp or inadequate housing and overcrowding, as well as dietary deficiencies. In relation to this the M-. family has notably been lacking in proper food because of their financial stress.

Other families, the R-.'s, for instance, have had to eliminate cereals and fruit from their tables and the G-.'s have meat only once a week. Still other families have been seen to go without milk, and it is not too unusual to discover in this category that some families receive only one good meal a day. Attempts are being made to alleviate this situation by social workers, with the help of the Nutrition Division of the Department of Health, in providing help with menu planning and budget service.

Medical needs in relation to hospitalization of children is a significant factor in many of these homes. Of the thirty-three families interviewed in the city, twenty-two children from sixteen homes have been patients in the hospital.

The burden of childhood ill health is then a problem of large proportions and not one which is to be reckoned with lightly. The financial burden which these problems present is discussed in Chapter IV of this thesis.

These problems, although presenting themselves in physical symptoms with their causes and their necessary medical treatment are by no means simply medical problems affecting the individual stricken[1]

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[1] ibid, page 76

They are in perspective a part of living and a part of the family, because the family is the unit of living.[1]

Social Needs of the Family

"As with the patient, working with the family members implies a willingness to recognize and help with the problems they face rather than a denial that such problems exist."[2] They need sustained help, recognition of the burden they are called upon to carry, and an opportunity to voice their frustration and grievances.[3]

By virtue of the interaction existing between the members of the family group, feelings, ambitions, and plans are not separate distinct entities but are interrelated and interdependent. All of these may be and often are thwarted by the patient's illness.

> The shock of discovery of prolonged illness and its implications is as severe for family members as it is for the patient. The presence of a sick person in the home affects the life of the family, altering, both its major aspects and the minutiae of everyday living.[4]

In this section the writer will attempt to show what some of the social causes and effects of illness are, and how they are being dealt with.

It is difficult to separate cause and effect of illness in many cases because they are interrelated and interdependent, so that in the final analysis it becomes a vicious circle.

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1 Ibid, page 137

2 Ibid, page 137

3 Ibid, page 137

4 Ibid, page 137

"Belief in some sort of familial transmission is a tradition of the medical profession which is as old as the Christian era, and it persists with undiminished force to the present day." [1] Infections and low resistance levels contribute to the spread of disease within the family. Exposure to infection in the families with tuberculosis needs no explanation. Close and continuous contact with other family members suffering from infectious diseases plays an important part in the spread of disease.

It was noted for example,[2] that in the D-. family both Mrs. D-. and a daughter contracted tuberculosis which had already rendered the father disabled. Mr. D-. had spent a great length of time at home despite medical and social pressures. The consequence was a spreading of the tuberculosis to other members of the family.

Lack of money which often is a result of chronic illness, may cause deficiencies in diet and inadequate housing which in turn contribute to conditions conducive to the spread of disease. It has already been shown that dietary deficiencies are a significant factor in the cause of disease. This lack results in a lowering of body resistance to infections. The incidence of pneumonia, colds and flu among these families substantiates this observation. Neglecting congenital deformities and other expensive treatment of mothers and children is often attributed to the hesitation at using an already marginal income to fill these needs.

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1 Ibid, page 61

2 Supra pp. 17,18

Lack of money has also been shown to be a factor in the delay of early diagnosis because of the feeling of having to remain employed and independent for as long as possible.

It may be argued that the public assistance programs are not adequate for medical care. There is nevertheless a need for education and interpretation on the part of the medical and social work professions that there is a right inherent in our society, to the public aid of its dependent members. Handling of these feelings of dependency is also a vital part of the work with these families. There is a seeming paradox here because it is the aim of the professional group to use their skills toward the promotion of independence, and also their aim to encourage dependence on public resources in preference to physical and mental ill health. Charlotte Towle resolves this by seeing beyond the immediate goals. "We fail to comprehend," she says, "the interrelatedness of man's needs and the fact that frequently basic dependency needs must be met first in order that he may utilize opportunities for independence."[1]

Ambitions and plans for the family, as has been stated, are thwarted by the patient's illness. The parents of only seven of the thirty-three families have not had to change their plans for their children. Two have dropped their insurances on the children. Two children have had to leave school to help provide for their families while in five cases the parents had grave doubts as to the possibility of their children reaching or

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[1] Charlotte Towle, op.cit., page 5

completing high school.

A number of families have stated that they live from cheque to cheque and do not plan for the future of their children. This is indicative of the hopelessness of these parents. The S-. family presents an interesting example of hopeless attitude regarding the future of the children.

Mr. S-. is now in the county home after spending some years in the mental hospital for schizophrenia. Mrs. S-. has spent some time in hospital for tuberculosis. During the hospitalization of both parents, the children have gone from institutions to foster homes, and have had very unpleasant emotional experiences because of this separation. At present the mother and children are reunited and living in a middle-class home where the mother is a domestic. Mrs. S-.'s only ambition for her children at present is that they will be able to continue to live in their present neighborhood instead of returning to their former apartment in the slum area. The three children, boys ranging in age from eleven to eight, do not enter into any discussion of their future and Mrs. S-. does not approach the subject because she is afraid of failure in this respect.

Although this family may not be typical because of the absence of the father, it is nevertheless significant in that it illustrates the attitude of living from day to day, which was found to be widespread among many of these families.

Other family plans including moving to more comfortable living quarters, and provisions for the childrens' physical security have had to be forgotten. Eight families have had no plans at all, chiefly because the father's disability occured before the children were old enough to actually plan for. In the light of the absence of financial contribution, the need of the family to turn to the father for help in planning will assume added importance and will enhance and strengthen his feelings of worth and prestige.[1]

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[1] Ibid, page 137

The case of the M-. family[1] illustrates what it means to the father to be included in the planning for his children. Although Mr. M-. feels that through his illness he has become somewhat estranged from his children, he nevertheless takes pride in the fact that he can plan for them, in their school work, their social activities, and eventual careers. The loss of the insurance policies which he was carrying for his family was threatening to his status as provider. Still, he has been able to retain some degree of prestige in the family by entering into the planning for them.

Family relationships have been greatly influenced by illness. Of the twenty-eight fathers interviewed change in relationships have varied from almost complete rejection and resentment to an increased understanding between father and child. Mr. M-. for instance, finds that his "nerves" are getting worse and he cannot endure the noise of his children. The children in turn have grown farther away from their father, and spend less time in the home. They spend less time in their home and do not make any effort to help out with daily chores. Some fathers have commented that their children do not appreciate the fact of their illness while other children understand and show more respect for their father's wishes.

The father has lost his role as breadwinner for the family through illness. This has a profound effect on the child and his estimation of his father as well as the father's own feelings of

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[1] Supra pp. 33,34

selfworth.

> Anxiety, helplessness, and a sense of frustration that accompany the witnessing of another's suffering in the face of one's inability to alleviate the pain, the fear of contagion and inheritance, the threat of death frequently inherent in the diagnosis itself, presents in some measure a picture of the emotional plight in which family members find themselves.[1]

Meeting The Needs Of The Family

Having seen what the various needs of the families in this category are, it is time to turn to an examination of how these needs are dealt with. It is clear at this point that illness cannot be successfully treated unless all the factors contributing to the disease and affecting the recovery are reckoned with. This clearly calls for team work. The members of the treatment team will vary according to the case. Always the doctor will be the leader on the team and the patient, the focus.

At first sight the role of the doctor would appear to be simply that of medical diagnosis and treatment. However, the doctor is also interested in the patient's home conditions, his family relationships, his vocational and recreational activities. The observant doctor can learn much about the patient's life by encouraging conversation and listening not only to what the patient says but to how he says it. His behaviour and activities on the hospital ward are also meaningful in learning about the patient's personality and his ability to cope with his dependency.

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[1] Minna Field, op.cit., page 161

Treatment of the man and his family came naturally to the family physician of former years. However, today with growing specialization in medicine, additional emphasis must be placed on the philosophy of treating the person instead of only the diseased organ, so that the patient will not be lost sight of in the specialized treatment of disease.

The ways in which the doctor cooperates in the team approach to treatment, in addition to his specific function include an awareness of external factors affecting the patient's well-being, already outlined.

Quotations from some of the medical records submitted to the Department of Welfare would clarify the ways in which the doctor contributes to the "social treatment" of his patients. In the case of Mr. R-. who was diagnosed as having "dermatitis with superimposed secondary infection" and later a "chronic gastric ulcer," the physician's notes accompanying the examination form for application for allowance reads:

> In addition to the enclosed Medical Form I have also gone through his out-patient record at the general hospital as well as his inpatient record. I do not think this man is a malingerer. However, I do not feel that he has any organic disease sufficient to prevent him from working. He has got some low back pain which I feel would be best corrected by physiotherapy and graded exercises and a return to work possibly, at the beginning, of less strenuous nature than he has been able to do in the past. His complete lack of education makes this rehabilitation problem a considerable one. Nevertheless, should we not rehabilitate him within the next, say six months, I do not think this man will ever do another day's work.

This comprehensive note on the patient's illness in relation to his abilities to work or benefit from rehabilitative service, is a meaningful one for many reasons. Firstly, it shows that the examiner

has shown the interest to study the man's record for all its implications where a mere diagnosis and statement as to the patient's employability may have served the purpose of the Mothers' Allowance commission in determining eligibility. In addition, it has been taken into consideration that this patient is not a "malingerer," and that his education enters into the possibilities of total rehabilitation. This report also gives the social worker in the case some working knowledge of the medical possibilities for this man and a basis on which she can work with the father towards a maximum of independence. Where the doctor discovers such factors, his assessment as to their significance will ultimately lead him to refer the patient to other members of the team.

The social worker as a member of the treatment team has a vital role in helping the patient and his family achieve a maximum of independence.

For the social worker, an understanding of human behavior is even more indispensable than it is for the doctor. It is her responsibility to form a diagnosis of the social situation through a combination of the material obtained from the client, diagnosis from other professions, and observation of the home.

The medical social worker in reporting to the Department of Welfare on the F-. family states that "unless something definite in the way of assistance can be given to this handicapped man and his family, their social problem will continue to mount and will eventually cost the community much in terms of human wastage and money." In this way the medical and social needs are rated as parts contributing to the whole situation.

The social worker from the Department of Welfare, in her report on Mr. R-. shows some appreciation of the total situation in her report which reads: "Mr. R-.'s exzema has completely healed. He complains of dizzy and sick spells and loss of appetite. He feels all right for the first part of the day and then he develops these sick spells. Worker feels that it would be worthwhile to have this man examined at the hospital to have his condition assessed and to learn whether or not hospital treatment would render him employable."

In the public assistance field, the social worker's primary focus is naturally on the financial situation. This involves her in budgeting service, and allied fields of menu planning, and medical care. However, the public assistance worker becomes the family social worker and is faced with many other needs as well.

The medical social worker in the hospital helps the inpatient adjust to his illness as it threatens him at that time. On his discharge from hospital he will be referred to the public assistance worker for help in everyday living with his disability. The public assistance worker then, must work with the father in his home. She can be of real help to him by understanding his feelings about dependency and his new role in the family. Helping him to accept his situation and planning with him new ways to make his life a more endurable and in fact, happy one.

The social worker in helping the mother must be prepared to help her adjust to the fact of her husband's disability and his dependence on her. Because of the reversal of roles occasioned by the husband's disability strained relationships between spouses may

develop. In this area, the social worker features as a member of the treatment team by offering counselling service. Referring back to the M-. family[1] it may be seen that much relationship difficulties did arise and the social worker was able to help them work through their difficulties on a cooperative basis. "Sympathy, understanding, and supportive help may enable parents to carry their responsibilities more competently."[2]

It is obvious that if a social worker is to understand the problems inherent in disease, she must have not only an understanding of human behavior but also a working knowledge of the medical diagnosis and their processes and methods of treatment. More specific knowledge in relation to a particular illness is often necessary. Thus it becomes important for the social worker and the doctor to confer regularly for evaluation of progress and changing needs, both medical and social.

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1 Supra pp. 33,34

2 Charlotte Towle, op.cit. p 67

CHAPTER IV

MEDICAL EXPENSES

"Medical care for the sick poor has been a public responsibility as long as there has been a poor law."[1] Eveline Burns states that:

> The system of direct provision of benefits in the appropriate system where the full costs, with few exceptions is borne by the state, is more convenient for the patient, the professions involved, to the hospitals and other institutions and is simple administratively. It does not require the patient to have money available before seeking treatment and avoids any financial barrier between patient and treatment.[2]

This chapter will survey the public provisions for health matters on the federal, provincial, and municipal levels. Provisions for medical care under the Mothers' Allowance of Nova Scotia will be outlined, with a view to what provisions are supplied, and whether these are adequate. The medical expenses necessitated in the eighty families being studied will be examined and an attempt will be made to illustrate the bearing that expense has on securing medical attention.

The planning, supervising, and financing of public health and medical care services in Canada rest mainly with the provinces though the actual administration of services is conducted in most

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[1] Leyendecker, op.cit., page 129

[2] Eveline Burns, Social Security and Public Policy (New York: McGraw-Hill Book Co., 1956), page 132

provinces by municipal and other local authorities. The Federal Government provides consultative and specialist services, assists in the financing of provincial health activities through the National Health Program and also maintains services for special groups such as veterans and Indians.[1]

Federal activities in the field of health are largely centered in the Department of National Health and Welfare, with certain services for some special groups through various federal departments. The National Health Program, introduced in 1948, provides for the payment of federal grants to the provinces for the development of health and hospital services.

Health services in the provinces are administered in different ways but provincial functions commonly include central planning and administration. In Nova Scotia, among the principal Divisions of the Department of Public Health are Laboratories, N europsychiatry, Hospitals, Dental Services, Nursing Service, Child and Maternal Health and Communicable Disease Control. In addition, a provincial program of generalized public health services is administered through eight local health divisions, each staffed by public health nurses and sanitary inspectors under the supervision of a full time divisional medical health officer.[2]

The Department maintains two clinics for the free treatment of veneral disease. Seven of the families under study are known to have made use of this service. Mass tuberculosis x-ray surveys and

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[1] Canada Year Book, 1957, page 236

[2] Ibid, page 241

rehabilitation services in cooperation with the Nova Scotia Tuberculosis Association is provided. Free treatment for tuberculosis is provided in three provincial sanitoria and the municipal sanitorium at Halifax. The 31.25% of the caseload under study who were tubercular made use of these provisions for free treatment. Eighteen went to the Municipal Tuberculosis Hospital, five to the provincial hospital, and two to annexes of other general hospitals. At present five tubercular patients are in hospital, twelve fathers are attending the outpatient clinic at the municipal tuberculosis hospital for free treatment, and some receive free drugs from this hospital's dispensary. Their families were also given free check-ups at frequent intervals as a precautionary measure.

The Province of Nova Scotia pays eighty-five cents a month per person to the Medical Society for physician's services to recipients of Mothers' Allowance and Blind Persons' Allowance.[1] Thirteen families have made use of this scheme in the city.

The province also pays a per diem subsidy to all approved hospitals for all patients. The municipality pays for its indigent residents a maximum of six dollars a day and the province pays a similar sum for persons without municipal settlement. Table 1[2] indicates that thirty-seven of the eighty fathers being studied have spent some time in the general hospital under this scheme.

The Halifax Children's Hospital is also included under the

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[1] "Public Provisions for Medical Care in Canada" (Ottawa: Canadian Welfare Council, 1952), pp. 11-12

[2] Supra p.14

plan. Out of the thirty-three families interviewed in the city, sixteen of them had children who had been to the Children's Hospital. A total of twenty-two children were treated here under this plan.

Institutional facilities for mental patients include an active treatment mental hospital and a training school for mental defectives, both provincially operated, and seventeen county homes administered by local government authorities. Mental health clinics are operated in three centers and there are inpatient and outpatient psychiatric services provided at the provincial general hospital.[1]

Nine patients in this study have been treated in the provincial mental hospital, while five have spent some time in the county institutions and two are in the city hospital permanently. At present there are three of these patients in the county home permanently.

Of the total fifty-five fathers who at one time have been hospitalized the remaining six not otherwise accounted for were or are in other hospitals.

In Nova Scotia, the Mothers' Allowance Act provides for limited care of the patient at home and in the doctor's office including drugs and dressings ordinarily used during such visits. Minor surgery, eye tests for children, and obstetrical benefits are provided for.

Table VI shows that twenty-eight fathers, four mothers and thirteen children are receiving medications. This makes a total of forty-five persons needing medications. As mentioned above the Mothers' Allowance Act provides for drugs normally given in a doctor's

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[1] Canada Year Book, 1957, page 241

TABLE VI

SOURCES OF MEDICATIONS*

Members receiving medications		Sources of drugs			
Members of family	Total	Self-paid	Dispensaries	Other	Not Given
Father	28				
Mother	4				
Children	13	17	14	3	11
Total	45				

Note: Dispensaries include Halifax Visiting Dispensary, Victoria General Outpatient Department, and Halifax Tuberculosis Hospital.

Other includes sample drugs given by doctors gratis.

Not given indicates that drugs are used, but the source was not recorded.

*Source: Files at the Department of Welfare, Halifax District Office

office or on his visit to the home. Fourteen persons made use of the dispensaries available at the Victoria General Hospital, the Halifax tuberculosis hospital and at the Halifax Visiting dispensary. However, seventeen families paid for their own medications. These received drugs from other sources and the financing of drugs for eleven persons was unavailable.

The reasons for a majority of families financing their own drugs perhaps should be explained. Some of this group lived in areas outside the city, too remote to be of easy access to the dispensaries. Still others, while living in the city, are in need of expensive drugs not available at the clinic. The greater part of

this group, however, use patent medicines, not prescribed by physicians and purchase them at nearby drug stores.

Medical supplies such as canes, high boots, wheel chairs and crutches are supplied by the Red Cross. Fourteen percent of the fathers are using these special appliances, which have been provided by this society.

Dressings and supplies for the home-care of cancer patients are provided by the Canadian Cancer Society. This organization also provides for the transportation of their patients to hospitals and clinics. Transportation of paraplegics is provided through the Paraplegic's Association.

Clinic service is provided at the Victoria General outpatient department and the Dalhousie Public Health Clinic on a sliding fee scale. Recipients of public assistance receive free treatment. This survey has shown that a total of thirty-one fathers are attending outpatient clinics.

As has already been seen, eye tests are given to children under fifteen years of age free of charge. However, glasses are not provided for.

The greatest burden of medical expense, then, which falls on the family is for major surgery. Although this is only one area, it is nevertheless a major problem for many families. For instance in the case of the A-. family.

Mrs. A-. has four children, ranging in age from nine to two years. Her husband has been disabled for only eight months. He had been earning two hundred dollars per month as a labourer prior to the onset of his disability. They have a seven year-old daughter who has a club foot. Her parents have neglected to have this attended to on the basis that it would be beyond their means and the uncertainty of

the outcome was a risk they could not afford to face. In her present condition, this child requires special shoes which are expensive. She is therefore forced to do without even this much relief.

In this instance expense was the predominant factor preventing much needed medical attention. This child is facing a lifetime of deformity which could have been prevented had someone interpreted to her parents the meaning of such a condition. This clearly is the role of the social worker, to offer budgetary service so that the income can be utilized in such a way as to provide, at least in part, for the restoration of the child's foot.

The social worker should also be aware of other resources which Mrs. A-. could make use of to help her child. These resources would include special service club projects, Red Cross and other special services as they are made available. A great deal of interpretation is required both for the parents of this child and to the community concerning the need for services in this area.

> As workers confer with parents on problems presented by their handicapped children, it is important that they understand what the child and his disability mean to the parent. This can serve as a guide in the worker's efforts to help parents who turn to them not only in relation to their management of children but also in such vital decisions as to whether or not they place children, allow them to have special opportunities, or cooperate in medical care.[1]

The provincial-municipal programs providing for hospitalization is on the surface most desirable and seemingly benevolent on the part of the administrators. However, to leave the discussion at this point would not be telling the whole story. It is a policy in most municipalities to demand reimbursement for hospital debts paid on behalf of its patients. This accounts for the fact that six families were in debt

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[1] Charlotte Towle, op.cit., page 75

to the municipality or to the hospital at the time of the last visitor's report. These range from seventy-five dollars in one family to two hundred and fourteen dollars in another. Certainly procedures of this sort are a deterrent to seeking further hospital treatment.

The T-. family, for example were in debt $165.00 to hospitals. These bills had been contracted over the years since 1947. Several of the children have been to hospital as was Mr. T-.

In some cases where medications involve a large expenditure by the family, and where these cannot be obtained through public services, the cost of drugs is included in the budget for Mothers' Allowances. In the seventy-six budgets available in the survey, medications were included in ten. It is significant that seven of these ten families were living outside the city.

Chronic illness will, despite the many provisions for medical care, inevitably and all too soon exhaust the financial resources of a family. These patients are located in a vicious circle, for poverty aggravates chronic disease and chronic disease will pauperize a patient if it keeps up long enough which is often the case.

The writer would therefore conclude that Eveline Burns' statement at the beginning of this chapter[1] is sound, and merits consideration in the Mothers' Allowance program of Nova Scotia.

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1 Supra, page 47

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

It has been seen in the foregoing chapters that the Mothers' Allowance program in Nova Scotia has been instituted for the purpose of keeping the dependent mother in the home, caring for her children and preserving the unity of the family. In the beginning the provision of financial assistance was thought to be the answer to all the problems created by dependency. Indeed in some cases to attempt to do more than provide financial help would be threatening to the family in their desire to retain some measure of independence. The procedure for establishing eligibility for Mothers' Allowance necessarily involves clarification of the resources of the family, and their management of them. This in itself is considered by some persons as a threat to their integrity and ability to manage.

Further study into the matter has shown that particularly in the case of the disabled father, many complex problems also existed and threatened the unity of the family. Where this is the case, the trained public assistance worker will recognize the situation and allow the family the use of their right to self-determination in all aspects of family living.

On the other hand, George Silver has said that:

> Through several years of experience in giving economic aid, it became evident that while this appeared to be a pressing need for many individuals, the mere provision of material assistance was not enough. It did not always produce the result hoped for, that is, the re-establishment of the individual and/or family on an

independent basis.[1]

This study of the families who are receiving Mothers' Allowance because the husband is disabled has shown that financial stress was only one factor threatening the integrity of the home and of family life. Illness, almost invariably is accompanied by a multiplicity of complex problems which can only begin to be approached by the relief of economic stress.

Emotional adjustment to illness, presents a problem with all patients faced with the prospects of a prolonged illness. This problem is aggravated and intensified in the persons being studied here by the fact that they are fathers of families, fathers who have been unable to sustain their role as breadwinner. Thus when the Department of Welfare offers financial help to these people it is with concern for the total family. If this is so, then the total problem is assessed and dealt with accordingly.

Hence we come to the philosophy of social casework in public assistance. "It is discriminatory, unsound and failing in their obligations and objectives if they fail to extend casework services to all segments of the community where they can be used for the strengthening of family life."[2]

The Mothers' Allowance program may be seen as one of prevention and of treatment. It is a program of prevention for two reasons: The provision of financial aid helps to prevent the disintegration of the family unit and helps in some measure to prevent

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1 George Silver, op.cit. p. 26

2 Wallace, op.cit. p.21

the spread of disease in these families. The offering of casework services is a method of helping people to seek preventive services immediately on recognition of the potential problem without waiting for the infection to burst,- for the family situation to deteriorate. This applies to medical and social problems.

Mothers's Allowance as a treatment program is illustrated in the case studies in the previous chapters where it has been shown that casework and financial help have molified or solved problems which otherwise may have remained chronic.

The methods used in social treatment have been illustrated. It has also been made evident that the social worker is a member of a team in treating the patient and his family. The social worker approaches the patient through the family situation, while the doctor approaches the family situation through the patient. At some common level therefore it is essential that the social worker and the doctor meet and work together for common or complementary goals.

The common level at which the doctor and social worker meet implies that both these persons should have some working understanding of the other's profession, and what it entails. The social worker in Mothers' Allowance should be acquainted with the meaning of diagnoses and their implications. The doctor would need to know the types of problems which can best be handled by a social worker. A certain amount of this orientation is included in the professional training of these team members. However, in practical application, clarification as to dynamics in specific cases is essential.

This can best be achieved by means of the conference meeting

or on an individual personal consultation basis. In cases of special consideration for rehabilitation, the doctor and social worker would confer with each other regularly so that they may arrive at a medical-social diagnosis rather than two separate medical and social diagnoses. This way both members of the team could work together both knowing what the total situation is. This arrangement would seem to be the best for working toward the total rehabilitation of a man. This personal contact should be made with the man's private physician.

The doctor connected with the Department of Welfare also contributes to the treatment process by holding individual consultation with the supervisors of the social service department, with an effort to interpret the medical implications in special cases. Personal contact between these two team members would be preferred to the system of written memorandum because a fuller interpretation of all the medical and social factors would be necessary to effectively carry out plans for rehabilitation.

The conference meeting is an effective method for the two professions to interpret each's role in typical cases and facilitates team operation.

The professional person dealing with the patient and his family should consider not only the physical conditions but also the social, psychological, educational, vocational and recreational needs - sometimes simultaneously but always at a time appropriate for the patient.[1]

Timing of the various steps in treating the situation is important. It must be flexible for all cases for some will need

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[1] Helen Wallace, op.cit. p.6

services more than others and at different stages in the process of the disability and the development of family crises.

For this reason the Department of Welfare has included in its regulations a plan of re-evaluation and reassessment by both the social worker and the medical examiner every six months.

Except for those being helped on a regular basis, the question may arise about whether assessment on a six month basis is adequate. It would appear that biannual visits are sufficient since conditions are not likely to change so radically during the interim of these visits as to make prediction or effective handling impossible at these times.

This re-evaluation is for the purpose of establishing the status of the family in relation to the Mothers' Allowance. This for some people has a negative meaning, and is seen more as a "check-up" process in order to ensure the wisest use of the grant. It can however, be used very positively as an opportunity for helping these families adjust to their many problems, occasioned by illness and financial difficulty.

The modern trend in the total treatment of the total human person and the total family unit requires that socialwork in public assistance must become an affirmative institution in society, called upon, like medicine, education, and law for preventive as well as remedial services.

APPENDIX A

A. IDENTIFYING AND STATISTICAL INFORMATION CONCERNING FAMILY GROUP

(All information on this schedule applies to December 1st 1957)

1. Family Name:..... Street Address: City:

Father's Name: Age: Occupation until disabled:

Mother's Name: Age: Occupation:

2. Children under 16 years of age:

Name	Age	Grade & School or Occupation	Whether living in home	Eligibility under M.A. (reasons if not eligible)
(1)				
(2)				
(3) etc.				

3. Children over 16 years of age:

Name	Age	Occupation or School & Grade	Whether living in home	Marital Status	Eligibility under M.A. (reasons if not eligible)
(1)					
(2) etc.					

4. Other relatives living in home as members of family group:

Name	Age	Relationship
(1)		
(2) etc.		

(continued on next page)

A. (Continued)

5. re: Mothers' Allowance:

Date Allowance Granted:

Amount Received
(as of Dec. 1st 1957)

6. Date of Marriage

B. LIVING CONDITIONS

1. Present Accommodation: (as of December 1st, 1957)

   a. House - owned by family: assessed value; taxes; mortgages.
   b. House - rented: amount of rent.
   c. Apartment or flat rented: amount of rent.
   d. Rooms - rented: amount of rent.
   e. Living in home of relatives or friends - give details.

2. Adequacy of present accommodation:

   a. Number of rooms.
   b. Heated or unheated.
   c. Condition: good; fair; neglected; unsuitable for habitation.
   d. Number of persons living in this accommodation.

3. Location of present accommodation:

   a. Middle class residential district.
   b. Working class residential district.
   c. Mixed industrial - commercial - residential district.
   d. Slum district.
   e. Rural area.
   f. Farm.

4. Accommodation at time of application:

   a. House - owned by family: assessed value; taxes; mortgages.
   b. House - rented; amount of rent.
   c. Apartment or flat rented: amount of rent.
   d. Rooms - rented: amount of rent.
   e. Living in home of relatives or friends - give details.

(continued on next page)

B. (Continued)

5. Adequacy of accommodation at time of application:

a. Number of rooms.
b. Heated or unheated.
c. Condition: good; fair; neglected; unsuitable for habitation.
d. Number of persons living in this accommodation.

6. Location of accommodation at time of application.

a. Middle class residential district.
b. Working class residential district.
c. Mixed industrial - commercial - residential district.
d. Slum district.
e. Rural area.
f. Farm.

7. History of changes in living conditions since time of marriage.

a. Type of accommodation.
b. Ownership, renting, sharing accommodation.
c. Location of accommodation.

C. ANALYSIS OF THE FAMILY'S PRESENT ECONOMIC SITUATION

(All information on this schedule applies to December 1st 1957)

1. Present sources of income: (give exact amounts where possible)

   a. Mothers' Allowance
   b. Family Allowance
   c. Children's contributions
   d. Roomers and/or boarders
   e. Mother's earnings
   f. Father's earnings
   g. Educational bursaries, etc.
   h. Other cash income
   i. Other income in kind

2. Total amount of present monthly income.

3. Possible sources of income. (Specify)

4. Properties and assessed value: (omit house and farm buildings)

   a. machinery
   b. live-stock
   c. car
   d. boat
   e. other

5. Savings in bank. State amount.

6. Debts. List debts and amount as of time of last report.

(continued on next page)

C. (Continued)

7. Insurance:

	Type	Value	Premiums	Date when taken out.
a. On father.				
b. On mother.	"	"	"	"
c. On children.	"	"	"	"

8. Present monthly expenditures: (as of last report - give date)

Rent
Food
Clothing
Heat
Electricity
Taxes
Insurance
Mortgage
Medical Expenses
Extras

Total:

9. Handling of finances. State which member(s) of family handle(s) finances at present time.

D. ECONOMIC AND EMPLOYMENT HISTORY OF PARENTS

1. Father's employment history (List employment since time of leaving school)

Dates.	Type of Work.	Approximate salary.	Reason for leaving.

2. Mother's Employment.

	Type of work.	Approximate Salary.	Length of Employment.
a. Since award of allowance.			
b. At time of award of allowance	"	"	"
c. During marriage - prior to award of allowance.	"	"	"
d. Prior to marriage.	"	"	"

3. Pensions, compensation or insurance benefits - received by father.

Dates.	Name of Award.	Amount.

4. Relief. (City relief, other cash relief or relief in kind received by family)

Dates.	Source.	Amount.	Kind.

5. Insurance

a. List, with details, insurance policies carried by family before application.
b. List insurance policies dropped, with date of cancellation.

6. Outstanding bills and debts at time of application. list wi th amounts)

(continued on next page)

D. (Continued)

7. Budget at time of application.

   a. Total expenditures.
   b. Total income.

8. Home ownership.

   a. Length of time family owned home.
   b. Date at which own home was given up and reason.

9. Father's Education.

   a. To which grade did father go?
   b. Any additional special education or training. (give details)

10. Mother's Education.

   a. To which grade did mother go?
   b. Any additional special education or training. (give details)

11. Description of economic status of father's parents.

12. Description of economic status of mother's parents.

13. Description of living conditions of father before marriage.

14. Description of living conditions of mother before marriage.

E. FATHER'S DISABILITY

1. Nature of father's incapacitating disability:

   a. Mental, physical or both.
   b. Description on medical certificates. (verbatim reports with dates)
   c. Social worker's interpretation of disability.

2. Other present diseases of father. List.

3. Date of onset of disability.

4. Progress of disability. Static? Worse? Improved?

5. Hospitalization.

   a. Present hospitalization. Name of hospital. Date of admission.
   b. Past hospitalizations. Name of hospitals. Length of hospitalization.

6. Attendance at out-patient clinic.

   a. Name of hospital.
   b. Name of clinic.
   c. Frequency of attendance.

7. Transportation to clinic.

   a. Travels independently. Method of transportation.
   b. Dependent for transportation. Method of transportation. State who undertakes this responsibility.

(continued on next page)

E. (Continued)

8. Active Treatment.

   a. Describe active treatment received at present for disability.
   b. Describe past treatment.
   c. Describe results of treatment.

9. Prognosis. Describe prognosis in relation to handicap as given by doctor.

10. Nursing Care.

   a. Does father require nursing care?
   b. Does he receive regular nursing care?
   c. Who provides this care?

11. Cause of disability. (Industrial accident, infection, other physical condition, etc.)

12. Medication.

   a. Is father receiving medication?
   b. Who prescribed medication?
   c. Who finances these drugs?

13. Rehabilitation possibilities:

   a. Physical
   b. Emotional
   c. Educational
   d. Vocational

14. Degree of Mobility:

   a. Ambulatory
   b. Confined to wheelchair
   c. Confined to bed

F. PRESENT ROLE OF FATHER

1. Present residence of father:

   a. Home
   b. Institution: name; date of admission; permanent or temporary plan.
   c. Other

2. Position in family of father in home. State evidence of father's position in family as indicated by:

   a. The initiative he shows in family planning and work and in taking responsibility.
   b. The attitude of other members of the family towards him.

3. Visits to father in institution.

   a. Which members of family visit father?
   b. How often do they visit?

4. Inclusion of father in institution in family planning:

   a. Visits of father to home.
   b. Letters to father.
   c. Parcels to father.
   d. Spending allowance.
   e. Other.

5. Attempts of father in institution to retain active role in family.

   a. By correspondence.
   b. Retaining responsibility for family decisions.
   c. Other.

G. PHYSICAL EFFECTS OF FATHER'S DISABILITY AND RECEIVING ALLOWANCE UPON FAMILY

1. Sale or repossession of any of family's possessions. (Specify whether sold or repossessed)

   a. Car
   b. Television
   c. Furniture
   d. Other

2. Additional occupants in home - since award of M.A. in order to alleviate economic stress:

   a. Relatives
   b. Boarders
   c. Roomers

3. Children who have left school and begun to contribute financially:

Name	Age	Date of School Leaving	Amount of Monthly Contributions

4. Children who have left home:

   a. To be supported by relatives:

Name	Age	Date of leaving home	With whom living (state relationship)

   b. To become self-supporting:

Name	Age	Date of leaving home	Occupation

5. Added responsibilities in the care of the home assumed by the children.

(Continued on next page)

G. (Continued)

6. Changes in attention given to personal hygiene and health in the family.

   a. Regularity of meal hours.
   b. Adequacy of food budget and diet.
   c. Regularity of sleeping routines.
   d. Personal hygiene.
   e. Personal habits. (drinking, smoking, etc.)
   f. Physical health conditions. (Give details of medical care recommended and provided)

7. Changes in the family members' use of leisure time.

H. PSYCHOLOGICAL EFFECTS OF FATHER'S DISABILITY AND AWARD OF MOTHERS' ALLOWANCE UPON THE FAMILY

1. Psychological effects upon father:

   a. Expressed feelings.

   b. Changes in behavior.

2. Psychological effects upon mother:

   a. Expressed feelings.

   b. Changes in behavior.

3. Psychological effects upon children:

   a. Expressed feelings.

   b. Changes in behavior.

I. FAMILY'S RELATIONSHIP TO THE COMMUNITY

1. Marked changes in Church attendance and/or participation in Church activities since the granting of Mothers' Allowance:

   a. Parents
   b. Children

2. Changes in participation in school activities:

   a. Parents
   b. Children

3. Changes in other social activities:

   a. Parents (general community or personal activities)
   b. Children (general community or personal activities)

4. Community status of the family:

   a. In the opinion of the references.
   b. In the opinion of other community persons (from letters or from social worker's contacts)

J. ROLE OF THE SOCIAL WORKER

1. Frequency of contact with family:

   a. Total number of interviews with members of family (state in months the period of time within which these interviews were held).
   b. Number of home visits.
   c. Number of office interviews: state members of family with whom held.
   d. Number of letters to applicant and family.

2. Nature of contact:

   a. Number of routine interviews.
   b. Number of special interviews. (give details)

3. Services given by social worker (give details)

   a. Establishing eligibility for M.A.
   b. Budgeting service.
   c. Referrals for health care.
   d. Counselling in relation to employment of any member of family.
   e. Counselling in relation to education of any member of family.
   f. Explanation of rehabilitation resources for father.
   g. Casework service in relation to preserving father's role in family.
   h. Counselling or referrals in relation to behavior problems.
   i. Counselling or referrals with respect to relationship problems.

4. Relationship of family to social worker:

   a. Requests made by any member of family for services from social worker. (give details)
   b. Attempts made by any member of family to avoid contacts with social worker. (give details)
   c. Positive feelings expressed by any member of family towards social worker.
   d. Negative feelings expressed by any member of family towards social worker.

(continued on next page)

J. (Continued)

5. Social Worker's Evaluation of Family

a. In relation to use of allowance.

b. In relation to quality of family life.

APPENDIX B

QUESTIONNAIRE A

(Both Parents - Neighbourhood, social activities)

FAMILY NAME: .....

ADDRESS: .....

1. How long have you been living in this house (flat, room)?

2. How long have you lived in this district?

3. How do you like the neighbourhood?

4. Do you know many people here?

5. Do you visit back and forth with people here?

Questionnaire A (cont'd)

6. Do you belong to a Church here?

If yes:-
a) Are there many activities at the Church?

b) Do you and the children join in many of them?

7. What Schools do the children attend?

a) How are they getting along at school?

b) What activities are there at school, outside of class?

c) Do the children join in any?

d) Is there Home and School Association and are you able to attend meetings?

Questionnaire A (cont'd)

If no:-

e) Did you ever at any time attend Home and School Association Meetings?

8. Do any of you manage to get out to other activities?

9. On the whole, have you changed the kind of thing you do outside of the home since Mr. X became ill? Since receiving M.A.?

QUESTIONNAIRE B

(Both Parents - Finances)

Now I should like to ask you a few things about your financial situation.

1. How have you been managing on the Mothers' Allowance?

2. What expenditures have you had to cut down? (Note specifically children's Allowances)

3. Can you tell me a little about how you plan your spending?

4. Who, in particular, does the planning?

5. Who does the shopping?

6. Is there a store close by where it is convenient to do your shopping?

   a) Can you charge there?

Questionnaire B (cont'd)

7. Have you found that you had to borrow money? (Specify)

8. Have you been obliged to incur any debts to stores since you received the Allowance? (Specify)

9. Can any of your relatives help you with special needs?

QUESTIONNAIRE C

(Both Parents - Personal Hygiene and Health)

I have been wondering about your health since you have been living on Mothers' Allowance.

1. Have you found that you have been able to give the children the same kind of meal as you used to?

2. Have the children had much sickness?

   a) Doctor?

   b) Medicines?

   c) Hospital?

3. Have you had much sickness, Mr. X?

   a) Doctor?

   b) Medicines?

   c) Hospital?

Questionnaire C (cont'd)

4. Have you been ill much, Mrs. X?

a) Doctor?

b) Medicines?

c) Hospital?

QUESTIONNAIRE D

(To Mother - Reaction to Illness and Allowance)

Now I should like to ask you a few questions, Mrs. X. With the illness and trying to live on an allowance it must have been quite difficult for you to carry on in the home.

1. Have you had to work outside of the home?

2. With all this, have you had to train the children to take on extra responsibilities in the home?

3. Do you worry a good deal?

   a) (If husband away) About your husband being out of the home?

   b) About the children?

   c) About money?

   (If husband is out of home ask Question 4)

4. What was it like when your husband was home?

Questionnaire D (cont'd)

a) How did you manage the money then?

b) Did you take responsibility together for bringing up and disciplining the children?

c) Does it get discouraging to carry on alone?

d) Do you think your husband will ever get back on to his feet again? (If answer yes - specify)

e) Do the children talk about their father being away?

f) Are any of you able to visit him?

g) Do any of you write to him?

h) Is he able to write to you?

QUESTIONNAIRE E

Now Mr. X, may I ask you a few questions?

1. How long have you been sick?

   a) What do you think caused this? (If appropriate)

   b) At what point did it become so bad that you had to stop working?

   c) How did you feel about not being able to work?

   d) When did you think about applying for the Allowance?

2. What has been done about this illness?

   a) Does a doctor ever come to see you at home?

   b) (If "yes") How do you pay him?

   c) Did you have to go to hospital? (details)

   d) Does any nurse come in to see you? (specify)

Questionnaire E (cont'd)

e) Do you take any medicine or use any medical supplies?

f) (If "yes") How do you obtain them?

3. Do you feel that there has been any change in your condition?

4. (To Wife) Have you noticed any change, Mrs. X?

5. Has your illness changed the way you pass your time in the home?

6. Do you think your illness has made any difference between you and the children?

7. Have you had to change your plans for the family?

Questionnaire E (cont'd)

8. (If "yes") How do the children feel about the changes?

9. What chance do you think there is of things improving in the future?

a) Of your getting around more comfortably?

b) Of earning some more money in any way?

c) Of your learning anything which you think would help your situation?

10. Have you talked over any of these things with someone outside of the family?

a) Social Worker?

b) Doctor?

c) Rehabilitation Centre?

QUESTIONNAIRE F

(Older Children - Optional)

I have been wondering how you feel about some of these things - **A.**

1. What are you doing now?

   a) School - which grade?

   b) Work - what kind?

   c) After-school work?

   d) Helping around home?

2. Do you have many friends around here?

   a) What kind of things do you do together?

   b) Can you stretch your pocket-money to cover these things?

3. Do you and your friends have any way of making money around here?

4. Have you any idea what you want to do in the future?

QUESTIONNAIRE G

(Parents Together - Final)

1. Have you any relatives living near here?

2. (To Mother)
   a) Mrs. X, where did you grow up?

   b) Where have you lived?

   c) Do you see much of your family now?

3. (To Father)
   a) Mr. X, where did you grow up?

   b) Where have you lived?

   c) Do you see much of your family now?

4. Is there anything you would like to ask me now?

....

Date Interviewer

APPENDIX C

THE MARITIME SCHOOL OF SOCIAL WORK
Incorporated

HALIFAX, NOVA SCOTIA

150 Coburg Road,
February 5, 1958.

Dear Mrs.

Miss Robertson of the Department of Public Welfare has told me that you have kindly consented to see me in relation to the study of Mothers' Allowances, in which I am participating.

I should like to visit you on
If this time is not convenient would you please telephone 2-7341, Local 386, and leave a message for me. I will then try to arrange for another appointment.

I greatly appreciate your co-operation in this matter.

Yours very truly,

/bt

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