CENTRE HOSPITALIER DOUGLAS **DOUGLAS HOSPITAL CENTRE**

6875 BOUL. LASALLE BLVD.,
MONTREAL, QUE., CANADA H8H 1R3
Téléphone: 761-6131

Le 29 décembre 1980

MEMOIRE SOUMIS A LA COMMISSION D'ETUDE SUR LA FORMATION DES ADULTES

1. Au nom de l'hôpital Douglas à Verdun, Québec, nous sommes heureux de pouvoir présenter à cette Commission d'étude sur la formation des adultes, les besoins éducatifs des patients de notre centre hospitalier.

   Le Centre hospitalier Douglas est reconnu comme un hôpital psychiatrique au niveau de la province et offre des services psychiatriques de première ligne aux régions de Côte St-Paul, Ville Emard, Ville LaSalle, et Verdun, de même qu'un service de deuxième ligne en psychiatrie dans le Service aux adultes, aux enfants et aux personnes âgées.

2. Nous sommes intéressés parce que plusieurs de nos patients (approximativement 300) n'ont pas acquis une formation de base en lecture, écriture, simple mathématique, à cause de leur maladie.

..../

Projet Pilote

Il y a trois ans, l'hôpital Douglas a commencé un projet pilote sous les auspices du Service de l'éducation aux adultes du Protestant School Board of Greater Montreal (PSBGM). Ce service était un projet de réadaptation qui tentait de donner aux patients une base en lecture, écriture, connaissances telles que: changer la monnaie, lire les étiquettes, etc. Même si ce projet était de dimension limitée, il a été un outil efficace dans notre processus de réadaptation pour les patients psychiatriques à long terme.

La majorité des patients de notre hôpital sont des adultes dont l'éducation scolaire a été interrompue à cause de leur maladie et il en résulte qu'ils n'ont jamais eu l'avantage d'avoir une éducation complète. Nous avons présentement un nombre approximatif de 300 patients entre les âges de 25 à 40 ans qui pourraient bénéficier d'une base qui pourrait leur être donnée. Même si les services éducatifs offerts aux adultes sont intéressants et diversifiés, i.e. céramique, arts plastiques, etc. notre intérêt principal est d'offrir à nos patients une base éducative leur permettant de vivre à l'extérieur de l'hôpital.

Le Service de l'éducation aux adultes du PSBGM, nous a donné son support complet quant au projet mais ne peut plus fournir les fonds nécessaires pour continuer ou élargir le projet. Dans notre

poursuite vers la réadaptation, l'éducation a été choisie comme ayant une importance primordiale.

Dans les annexes incluses, vous trouverez l'histoire détaillée du projet, ainsi qu'une prévision pour les cinq prochaines années. Le deuxième annexe est une étude des recherches effectuées par le CEGEP Dawson sur les besoins éducatifs des patients psychiatriques. L'annexe trois comprend des lettres écrites par des patients exprimant leur appréciation. Nous demandons à la Commission dans leur étude du dossier de l'Education des adultes à travers la belle province de sérieusement considérer les besoins éducatifs des patients psychiatriques dont plusieurs vivent en institution.

Recommendation

. Donnant que l'hôpital Douglas a déjà un mandat par contrât de service avec la Commission scolaire (PSBGM) pour fournir les services d'éducation aux enfants handicapés et aux adultes jus'à l'âge de 21 ans.

. Sachant qu'il y a d'autres adultes qui ont besoin des mêmes facilités, même s'ils sont âgés de plus de 21 ans.

Nous proposons que l'éducation aux adultes pour cette population soit considérée comme un droit acquis et que notre hôpital puisse avoir un contrat de service avec une commission scolaire qui fournirait des services spécialisés sans prendre compte de l'âge de l'individu et que les fonds nécessaires, puissent être donnés à la Commission scolaire afin de fournir ces mêmes services spécialisés sans prendre compte de l'âge de l'individu.

pour Joyce Boillat, M.D.
Directeur du Programme de réadaptation
et de traitements spécialisés (PRTS)

/gl

THE PROTESTANT SCHOOL BOARD
OF GREATER MONTREAL

BUREAU DES ÉCOLES PROTESTANTES
DU GRAND MONTRÉAL

80 10 14

Dr. G. Harnois
Director General
Douglas Hospital
6875 LaSalle
Verdun, Québec

Dear Doctor Harnois:

Re: Report of a sub-committee of the Advisory Committee on Adult Special Education concerning recommendations for providing a permanent funding base for the education of adult psychiatric patients at the Douglas Hospital.

In the early fall of 1978 Mrs. Marion Kift, Coordinator - Psycho-Educational Services of the Douglas Hospital, and Mr. David Flanagan, Director, Adult Education Services of The Protestant School Board of Greater Montreal, met to consider the possibility of establishing some kind of educational services for the adult psychiatric patients at the Douglas Hospital. As a first step, an Advisory Committee on Adult Special Education was organized to act as a consultative body for an adult education program at the Douglas. The committee was established in October 1978 with representation from:

Adult Services, PSBGM
Student Services, PSBGM
Adult Services, CECM (English Sector)
Dawson College
Concordia University
McGill University
Psycho-Education, Douglas Hospital
Psychology Department, Douglas Hospital
Chaplain, Douglas Hospital
Psychiatry Department, Douglas Hospital

In October 1978 a six-month pilot project in Adult Education was begun in the hospital. The Douglas Hospital provided the facility (Newman Pavilion) and Adult Services, PSBGM, provided the services of a coordinator-teacher, and a teacher, both employed on a part-time basis

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for 15 hours a week each. These employees were required to have training in Special Education because it was recognized that many of the potential students would require this kind of expertise.

The hospital undertook the very difficult problem of identifying and selecting, on a priority basis, those patients capable of responding to special education stimulation. In order to gain as much knowledge as possible regarding this experimental project, a survey of 56 psychiatric hospitals across Canada was undertaken. Thirteen institutions indicated that adult education was already a recognized service. (See Annex I)

During the course of the six-month pilot project it became evident that better administrative and coordination systems would have to be worked out between the several hospital divisions and the school board services. It was also evident that better selection criteria of students would have to be developed.

At the end of the six-month pilot project an evaluation was undertaken by the Advisory Committee. The results of the evaluation are contained in Annex I. It was recommended that:

1. a permanent Adult Education Centre be established within the Douglas Hospital to provide and/or facilitate educational opportunities for adult psychiatric patients;
2. the PSBGM provide funding for teaching personnel, teaching materials, and teaching equipment.

Based on the evaluation by the Advisory Committee and based on the obvious need to continue to serve an educational need which had not been previously fulfilled prior to the launching of the experimental project, the PSBGM decided to continue to support the project. On September 24, 1979, a resolution was adopted to this effect. (See Annex II) The project was assigned three teachers for the 1979-80 session, but the commitment would terminate June 30, 1980. The commitment was made contingent upon the PSBGM and the Douglas Hospital making every effort to seek special funding from the Ministry of Education and/or the Ministry of Social Affairs in order to finance the educational needs of the psychiatric patients at the Douglas Hospital.

The PSBGM funding was developed through its Adult Services budget. The funding was drawn from the 'Global Envelope' for Social/Cultural Education granted by the Ministry of Education through its General Directorate of Adult Education. The 'Global Envelope' can be supplemented by fees paid by Adult Education students. The monies available in this budget envelope are used to serve the social/cultural educational needs of the adult population within the Board's territory. In order to fulfill this wide mandate the Board must establish priorities to service the public demand for adult courses. Some 22,000 clients avail themselves of these

cont.

offerings annually. Due to heavy demand in this social/cultural area, the Board cannot commit a guaranteed funding base for special projects serving a limited population. For these reasons a permanent funding base for this project must be established by the government.

Adult Services and Student Services (PSBGM) both undertook to seek special funding from their respective ministries. (See Annex III) In both cases appeals fell on stony ground. The PSBGM adopted a specific resolution seeking permanent funding based on a similar arrangement as had already been established in the Entente governing the education of patients at the Douglas Hospital, Children's Services. (See Annex IV)

During the second year of operation (i.e., 1979-80) the principal of the Douglas Hospital School, already provided by an MAS-MEQ agreement on behalf of the children in Children's Services of the Douglas Hospital, agreed to administer and offer educational support to the adult program. This proved invaluable inasmuch as the already 'in-place' system could provide many of the links between the several groups involved in the adult program. Also during the second year a systematic diagnostic-prescriptive educational model was introduced to select the students, to provide instruction and to evaluate progress.

A most important facet of the second year was the fact that Dawson College, in conjunction with the Advisory Committee, on a research grant from the General Directorate of Adult Education (MEQ), undertook an analysis of the needs, and recommended solutions, for the education of patients in psychiatric hospitals. (See Annex V) The findings of this report are very encouraging and support the work in progress in trying to serve the educational needs of this special group.

Based on the Year-End Report (See Annex VI) and in spite of the fact that no permanent or alternate funding had been found in 1979-80, the PSBGM undertook to finance a limited program at the Douglas Hospital Adult Education Centre during 1980-81. (See Annex VII) Once again the Board requested that every effort be made to obtain permanent funding. This resolution allowed the project to continue for 1980-81, but subject to review.

IT IS CRITICAL NOW TO SOLVE THE FUNDING PROBLEM.

CONCLUSIONS:

1. The Advisory Committee on Adult Special Education, the PSBGM, and the Administration of the Douglas Hospital view the program as successful.
2. Educational input has been demonstrated to provide an important portion of the hospital psychiatric rehabilitation program. The impact on the

cont.

patients has been positive and profound.

3. Education provides a focus to patient rehabilitation.
4. The Ministry of Social Affairs, the Ministry of Education, the PSBGM, and the Douglas Hospital must address themselves to the problem of establishing permanent funding for providing, and seeing to, the educational needs of this special group.

RECOMMENDATIONS:

1. The program should continue and expand to include all patients for whom an educational input is required for their rehabilitation.
2. The program must serve both francophone and anglophone students - the PSBGM to provide this service.
3. A permanent funding base must be established
   either by
   a. permitting the PSBGM and the Douglas Hospital to expand the Protocol of Agreement for Children's Services to include the adult population of the hospital,
   or
   b. by special funding through the General Directorate of Adult Education (MEQ) to the PSBGM Adult Education Services.
4. The Ministry of Social Affairs and the Ministry of Education must develop techniques to provide adult educational services to all psychiatrically disordered patients in all psychiatric hospitals in Québec.
5. It must be recognized by all that education is an integral part of the multi-disciplinary rehabilitation team; as such, the responsibility to provide funding for the required education must be recognized.

FIVE YEAR PLAN

Budget Forecast based on:

1. a patient population of 700 of whom 15% (105 patients) could benefit from an educational input as part of their rehabilitation program;
2. recognized Special Education ratios of 6:1;
3. gradual expansion through 1985 to reach optimum input.

1980-81	3 part-time teachers 27 weeks x 45 hours = $28,000.00 (includes some materials)	$28,000.00

cont.

1981-82	8 Full-Time Permanent Teachers	$180,000.00	
	1 Administrator	30,000.00	
	1 Secretary	15,000.00	
	Materials & Supplies	10,000.00	
	Equipment	16,000.00	
		251,000.00	$251,000.00
1982-83	12 Teachers	$360,000.00	
	1 Administrator	35,000.00	
	1 Secretary	18,000.00	
	Materials & Supplies	15,000.00	
	Equipment	10,000.00	
		438,000.00	438,000.00
1983-84	15 Teachers	$495,000.00	
	1 Administrator	40,000.00	
	1 Secretary	20,000.00	
	Materials & Supplies	20,000.00	
	Equipment	10,000.00	
		585,000.00	585,000.00
1984-85	17 Teachers	$595,000.00	
	1 Administrator	45,000.00	
	1 Secretary	22,000.00	
	Materials & Supplies	22,000.00	
	Equipment	10,000.00	
		694,000.00	694,000.00
			1,996,000.00
	+ 7% Fringe Benefits		132,000.00
			$2,128,000.00

This Forecast Budget does not include the cost to the Douglas Hospital of supplying the facility, i.e., the top floor of Newman Pavilion.

Respectfully submitted,

Mr. J.D. Flanagan, Author
Mr. S. Conrod
Mr. C. Tisshaw
Mr. N. McGregor
Dr. J. Biollat

jdf/ek
Enclosures (7)

J.D. Flanagan

REPORT ON ADULT EDUCATION IN DOUGLAS HOSPITAL

The Advisory Committee on Adult Special Education was organized to act as a consultative body on an Adult Education Program at Douglas Hospital Centre in Verdun, Québec.

The members of the Committee were: -

Ms. M. J. Kift: Co-Ordinator, Psycho-Educational Services,Douglas Hospital.

Dr. T. S. Callanan: Chief Resident in Psychiatry, Douglas Hospital.

Mr. B. Conrod: Director of Continued Education, Dawson College.

Mr. J. Fiset: Coordinator of Teacher Planning and Continuation, Concordia University.

Mr. D. Flanagan: Director, Adult Education - Protestant School Board of Greater Montreal.

Dr. G. Mager: Educational Psychologist, McGill Faculty of Education.

Mr. W. Martin: Principal; Region 93, Commission des Ecoles Catholiques de Montréal.

Mr. N. McGregor: Principal, Douglas Hospital School.

Mrs. S. Sirota: Psychology Department, Douglas Hospital.

Mr. C. Tishau: Special Education, Protestant School Board of Greater Montreal.

Reverand D. Wilson: Chaplain; Chairman, Patients' Rights and Ethics Committee, Douglas Hospital.

Mr. S. Courval: Teacher, John F. Kennedy High School.

Mrs. M. Yelin: Co-Ordinator; Protestant School Board of Greater Montreal - Pilot Project.

In October 1978, a six-month pilot project in Adult Education was begun in the hospital. Its purpose was to assess the needs and feasability of such a program and its findings are reported here. This report also proposes the esta-

blishment of permanent Adult Education facilities in Douglas Hospital Center and as such, is in line with the spirit of current Government policies. Specifically, Bill Number 9, under the auspices of the Minister of Social Affairs secures the handicapped in the exercise of their rights and this includes the right to education. Additionally, a recent White Paper from the Minister of Education outlines adult literacy as a high priority for the Ministry and in doing so, recognizes that certain individuals may have special needs.

A survey of 56 psychiatric hospitals across Canada indicated that adult education is already a recognized service with 13 institutions (see Appendix I). Further information on these services is being sought.

The Douglas Hospital Centre, founded in 1881, is Québec's largest English-speaking psychiatric center. The hospital is accredited by the Canadian Council on Hospital Accreditation and has approximately 1,050 beds, over 90% of which are designated for the treatment of adult patients.

The patient care facilities are distributed throughout more than twenty buildings on the hospital grounds and services are divided into programs. The hospital has a dual responsibility: to provide total services to the areas around the hospital (i.e., Verdun, LaSalle, Ville Emard, Côte St. Paul and Pointe St. Charles - a Francophone and Anglophone population of one quarter million); and, to function as a second-line hospital for Greater Montreal and the remainder of the Province of Québec. The treatment services of the hospital are organized into four main clinical Programs and people who are hospitalized receive these services according to their needs as provided by the individual Programs.

The Community Psychiatric Centre (C.P.C.) Program serves the geographically defined area in the immediate neighbourhood of the hospital. As well as out-patient services, in-patient therapy is offered in four 22-bed units (two for Anglophone and two for Francophone patients). The duration of stay for in-patients in this Program is relatively short and at discharge, follow-up care is provided by the same multi-disciplinary team as had provided in-patient care.

The Children's Services Program of Douglas Hospital accepts children up to the age of seventeen. This Program was instituted to provide special care for children that is not available in their own environment. It consists of six hospital units and a Day Care Center. To meet the highly specialized learning needs of these patients, there is a school specializing in psycho-education which is governed by the Protestant School Board of Greater Montreal.

Additionally, there is a Geriatric and Medical Services (G. & M.S.) Program that is aimed at solving, as effectively as possible, the psychiatric problems of the aged patient population and at offering them the possibility of rehabilitation. Again, treatment services are varied depending upon the specific patient needs.

For adult patients requiring medium and long-term treatment, a specific program has been developed - it is the Admissions and Continuing Treatment Services (A.C.T.S.) Program. This is the largest Treatment Program in Douglas Hospital providing both out-patient and in-patient services with approximately 500 beds available for in-patients. By virtue of its size and orientation, the majority of students in an Adult Education Program would come from the patient population of A.C.T.S. The orientation of this Program is based on patients' needs: these may be needs of a medico-psychiatric nature; or psycho-educational needs or psycho-social

needs. Individuals suffering from severe mental illnesses have medico-psychiatric needs necessitating medication and continued care, in order to help them resume contact with reality and to allow them to regain their state of health. Following a prolonged period of hospitalization, certain people have psycho-educational needs, in other words, these people require treatments oriented according to their level of education and their personality development. Many of these patients are low educationally with specific needs and for them basic education skills are crucial to their rehabilitation. A similar group consists of those people who are still in hospital but who are capable of reintegrating into society. They have life-skill needs. Help for these people consists of supplying them with resources (including basic education) enabling them to integrate into their milieu. Perhaps the following examples will best illustrate the actual educational needs of some of these groups of patients.

Among the first group of patients to be assessed during the Pilot Project was a young man, 28 years old, who, although he has basic learning skills, functions only at the low to mid-elementary school level. Now, after several years of hospitalization, his psychiatric condition is stable and improved. His return to the community however is in jeopardy as he lacks the necessary educational skills in order to function independently and productively in daily life. Although not quite illiterate, he will have difficulty filling in job applications, balancing a bank book or even reading instructions without academic up-grading.

Still other patients have not attained this level of functioning. One patient, in his mid-thirties, has never attended school. He has the necessary ability as shown by his initial assessment but, being illiterate, his opportunity

to return to the community without basic education is limited. He would be unable to read signs or count change making even the use of public transportation a difficult task. For these patients and many others who have needed lengthy hospitalization, a basic education is required to improve the quality of life with the hospital and to increase the possibility of a life outside the institution. The hospital has been able to provide many modalities of treatment but until now, one vital component has been missing - an opportunity to have access to education.

While we do not have an accurate survey of all of our patients' educational needs, we have enough information now that we know that education is needed at many different levels and in many different areas of specialization. We have therefore been making good use of the cooperation of the community educational resources to begin the development of a wide range of educational opportunities.

At this point, our Pilot Project of basic academic skills under P.S.B.G.M. is supplemented by assessments for training in sign language (for our mute patients), tutoring for individual patients (a McGill project), English as a second language instruction (a Concordia project), and we are about to embark on an assessment program for CGEP level educational needs (a Dawson project).

With the support and collaboration of both local and provincial Health and Educational authorities, it is our hope that we will gradually develop adequate responses to meet the widely varied educational needs of the adult psychaitric patients.

The following recommendations are therefore proposed to the Admissions and Continuing Treatment Services of Douglas Hospital and the Adult Services of the Protestant School Board of Greater Montreal: -

It is recommended: -

1. That a permanent Adult Education Centre be established within Douglas Hospital to provide and/or facilitate educational opportunities for adult psychiatric patients.

2. That Douglas Hospital allocate space for such a Centre and provide heat, light, housekeeping and maintenance services.

3. That the P.S.B.G.M. provide funding for personnel teaching materials and teaching equipment for:

   2,880 group hours of instruction to be organized into;

   4 classes - 5 days per week - 2½ hours per day - 48 weeks per year.

   The classes to be arranged as follows;

   Basic skills training (pre-academic)
   Literacy
   Academic Upgrading I
   Academic Upgrading II

PERSONNAL REQUIRED

4 - Teachers trained in Special Education	
15 hours each/week X 48 weeks at $20.00/hour	$ 60,000.00
1 - Co-Ordinator trained in Special Education with administrative and assessment skills	
20 hours/week X 48 weeks at $20.00/hour	20,000.00

The role of the Co-Ordinator would include the following:

Administration of the Adult Education Centre

Assessment of referred patients

Liaison with Hospital staff (interpretation, orientation)

Supervision/liaison with the Tutoring Program

Facilitation of referral to community adult education

Teaching Materials	2,500.00
Teaching Equipment	3,000.00
TOTAL:	$ 85,500.00

Respectfully submitted on behalf of the Adult Education Advisory Committee of Douglas Hospital.

Marion J. Kift, M.Ed.
Chairman

T. S. Callanan, M.D.
Chief Resident

/jc
April 2nd, 1979

SURVEY OF ADULT EDUCATION IN CANADIAN PSYCHIATRIC HOSPITALS

	B.C.	ALTA.	SASK.	MAN.	ONT.	QUE.	N.B.	N.S.	P.E.I.	NEWFLD.	TOTAL
Number of Enquiries sent	7	3	2	3	11	17	2	3	1	1	56
Total answers	4	3	2	2	11	13	2	2	1	1	41
YES	2	1	1	1	4	2	-	-	1	1	13
NO	2	2	1	-	6	10	2	1	-	-	24
Alternate Arrangements	-	-	-	1	1	1	-	1	-	-	4

Source used for the selection of Hospitals: CANADIAN HOSPITAL DIRECTORY

Criteria for selection: PSYCHIATRIC HOSPITALS SERVING ADULT PATIENTS

Date of initial inquiry: DECEMBER 20, 1978

ANNEX II

EXTRACT FROM THE MINUTES OF A MEETING OF THE PROTESTANT SCHOOL BOARD OF GREATER MONTREAL HELD IN THE CITY OF MONTREAL ON THE TWENTY-FOURTH DAY OF SEPTEMBER, ONE THOUSAND NINE HUNDRED AND SEVENTY-NINE

"On regular motion, it was carried unanimously -

WHEREAS the report of the Advisory Committee on Adult Special Education at the Douglas Hospital indicated that the 1978-79 six-month pilot project conducted by the Adult Education Division of The Protestant School Board of Greater Montreal was beneficial, and served to fill an educational need which had not been previously fulfilled,

BE IT THEREFORE RESOLVED THAT the Adult Education Division of The Protestant School Board of Greater Montreal continue the Douglas Hospital Project and that, during the first semester of the 1979-80 Session, three teachers be assigned to the Douglas Hospital Project with a maximum of 15 hours per week per teacher.

BE IT FURTHER RESOLVED THAT any commitments that the Adult Education Division of The Protestant School Board of Greater Montreal makes for the 1979-80 Session be terminated on June 30th, 1980.

BE IT STILL FURTHER RESOLVED THAT every effort be made by the Board of Directors of the Douglas Hospital and the PSBGM to seek a special subsidy from the Ministry of Education and/or the Ministry of Social Affairs in order to finance the educational needs of the patients at the Douglas Hospital.

VOTE: 15-0-0"

CERTIFIED that the foregoing is a true and correct Extract from the Minutes of a Meeting of THE PROTESTANT SCHOOL BOARD OF GREATER MONTREAL held on September 24th, 1979.

Olga Kowcz

(Mrs.) Olga Kowcz,
Secretary General,
The Protestant School Board of Greater Montreal.

September 25th, 1979.

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THE PROTESTANT SCHOOL BOARD
OF GREATER MONTREAL

BUREAU DES ÉCOLES PROTESTANTES
DU GRAND MONTRÉAL

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Monsieur Robert Diamant
Directeur général, D.G.E.A.
1035 rue de la Chevrotière
21e étage, Edifice G
Québec, Qué.
G1R 5A5

Objet: Projet pilote aux adultes
à l'Hôpital Douglas

Monsieur le directeur,

Depuis le mois de novembre 1978 et ce jusqu'au 30 juin 1980, les Services de l'Education aux Adultes du Bureau des Ecoles protestantes du grand Montréal se sont engagés dans le développement et le financement des aspects andragogiques d'un centre expérimental d'éducation aux adultes à l'Hôpital Douglas à Verdun. L'objectif et la raison de cette expérimentation sont de fournir, aux patients adultes du département psychiatrique, l'occasion de développer leurs habiletés académiques et de planifier un programme éducatif tel que les sujets puissent en tirer un impact thérapeutique positif et augmenter les possibilités de leur réhabilitation dans la communauté en général à l'extérieure de l'hôpital.

De novembre 1978 à mai 1979, un projet pilote de six mois a été parrainé par les Services de l'Education des Adultes du Bureau des Ecoles protestantes du grand Montréal afin de vérifier les possibilités d'offrir une éducation aux adultes internés à l'Hôpital Douglas. Cet hôpital a fourni l'espace physique (Pavillon Newman), le chauffage, la lumière, l'entretien, le ménage et les meubles. Le Service de l'Education des Adultes a offert les services d'un enseignant coordonnateur et d'un enseignant tous deux employés sur une base à temps partiel, ainsi que le matériel didactique.

Un comité consultatif sur l'éducation aux déficients adultes de l'Hôpital Douglas a été créé. Beaucoup de travail fut accompli afin de mettre sur pied un tel centre et d'établir des critères pour l'admission des patients adultes, de développer la qualité et le type de programme et les attentes que l'on peut espérer.

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As noted in the Board resolution of September 24, 1979, any commitment that the Adult Education Division of the PSBGM makes for the 1979-80 session at the Douglas Hospital shall be terminated on June 30, 1980. As explained in my letter to the Ministry on this subject, it is highly unlikely that the Adult Education Division will be able to subsidize the Douglas Hospital Project for another year; therefore, it becomes a matter of urgency that representations be made to both Ministries in order to get permanent funding for this Project.

Yours sincerely,

J.D. Flanagan

J.D. Flanagan
Director
Adult Education

jdf/ek
Enclosures (4)

ENDORSED:

Ian Trasler

Ian Trasler, Deputy Director General

BUREAU DES ECOLES PROTESTANTES
DU GRAND MONTREAL

Monsieur Robert Diamant
Directeur général, D.G.E.A.

Une évaluation de ce premier projet fut soumise aux membres de la clinique, aux patients eux-mêmes, aux enseignants, aux coordonnateurs et au personnel des Services de l'Education des adultes.

Les résultats de cette évaluation furent encourageants et nous sommes certains que l'expérience a été bénéfique et qu'elle a servi à combler un besoin éducatif jusque là ignoré. Le Bureau des Ecoles protestantes du grand Montréal a adopté le 24 septembre 1979 une résolution autorisant les Services de l'Education des Adultes à continuer le projet de l'Hôpital Douglas et à nommer trois enseignants en charge chacun d'un maximum de quinze heures d'enseignement par semaine. Plus tard il fut résolu que tout engagement pris par le Bureau des Ecoles protestantes du grand Montréal en regard dudit projet pour l'année 1979-1980 prendrait fin le 30 juin 1980. De plus il fut résolu que le Bureau des Ecoles protestantes du grand Montréal et l'Hôpital Douglas devraient joindre leurs efforts afin d'obtenir une subvention spéciale du Ministère de l'Education ou du Ministère des Affaires sociales et ce dans le but de financer des activités qui répondraient aux besoins éducatifs des patients de l'Hôpital Douglas (ci-jointe copie de la résolution).

Une fois encore l'Hôpital Douglas a fourni l'espace physique: un pavillon sur le terrain dudit Hôpital, le chauffage, la lumière, l'entretien, le ménage et les meubles.

Les ressources requises pour le financement des données de l'Education des Adultes dans ce projet ont été prises à même l'enveloppe globale pendant les deux dernières années. L'année en cours 1979-80, nous dépenserons pour ce projet approximativement $27 000. La section du temps partiel des Services de l'Education des Adultes s'est développée très rapidement cette année au point que toutes les ressources qui nous sont allouée dans l'enveloppe globale pour l'année 1979-80 ainsi que celles provenant des frais d'inscription et de scolarité sont épuisées. De ce fait nous serons obligés de nous retourner sur tous les surplus accumulés dans le passé afin de faire face à nos engagements cette année vis à vis de la section du temps partiel.

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BUREAU DES ECOLES PROTESTANTES
DU GRAND MONTREAL

Monsieur Robert Diamant
Directeur général, D.G.E.A.

Il semble bien clair que pour l'année 1980-1981 nous soyons dans l'impossibilité de financer le Projet de l'Hôpital Douglas à même notre revenu global.

Quoique pareille requête serait jugée un peu tardive, cette lettre est pour demander une aide financière pour mener à bout ce projet cette année.

Sachez que toute assistance financière que vous pourriez nous accorder sous forme d'allocation afin de couvrir certains des coûts apérationnels de cette année serait des plus appréciés.

J'aimerais formellement demander que la Direction générale de l'Education des Adultes accorde une subvention spéciale en addition à toutes allocations normales afin de supporter un centre d'éducation pour adultes à l'Hôpital Douglas pour l'année 1980-1981. Ceci permettrait aux Services de l'Education des Adultes de continuer à apporter son aide à ce projet.

Il n'est pas nécessaire de préciser que je suis à votre entière disposition pour fournir quelque rapport ou information statistique que ce soit afin d'appuyer cette requête et pour vous rencontrer, vous ou votre délégué afin d'examiner la situation.

Vous remerciant de votre coopération, veuillez agréer, Monsieur le directeur, l'expression de mes sincères salutations.

J.D. Flanagan.

J.D. Flanagan
Directeur
Services d'Education des Adultes

Pièces jointes:
1- Lettre de Mr Marion J. Kift
   Coordonnateur - Services Psycho-éducatifs
2- Résolution du B.E.P.G.M. du 24 septembre 1979
3- Liste des membres du Comité consultatif sur
   l'éducation aux handicapés adultes
   Hôpital Douglas.

cc: Mr. Robert Bertrand

THE PROTESTANT SCHOOL BOARD
OF GREATER MONTREAL

BUREAU DES ÉCOLES PROTESTANTES
DU GRAND MONTRÉAL

February 13, 1980

Mr. Cliff McCullough
Chairman
Comité interministériel
Ministère de l'éducation et des affaires sociales
Complexe G
1035 rue de la Chevrotière
Québec, Qué. G1R 5A5

Sujet: Programme pilote d'éducation pour les patients adultes à l'hôpital Douglas

Cher Cliff,

Je veux clarifier un problème qui existe maintenant concernant la procédure à suivre par le BEPGM pour cette clientèle.

Depuis l'année scolaire 1978-79, le service des adultes du BEPGM, les enseignants qui travaillent de près avec le personnel de notre département des services aux étudiants et avec l'équipe des enseignants et le directeur à l'hôpital Douglas, ont mis en place un projet pilote -qui évalue éducationnellement et développe un programme éducatif qui répond à leurs besoins.

Nos problèmes budgétaires nous forcent à faire face aux réalités financières. Le département des services aux adultes déclare qu'il existe quelques contraintes qui les empêchent d'engager les sommes adéquates pour ces services à long terme.

Afin que nous puissions résoudre ce problème, nous suggérons un plan d'action pour la considération du comité interministériel.

Option 1

1. Nous voulons organiser un continuum de services pour les patients de l'hôpital Douglas.
2. Ce continuum peut être organisé avec une extension de notre contrat de service nous permettant d'ajouter les adultes (ayant plus de 21 ans) à nos chiffres totaux pour l'hôpital Douglas.
3. Les mêmes normes et responsabilités de notre école déjà en place à cet hôpital s'appliqueront à notre programme éducatif pour les adultes.
4. Le directeur de cette école pourra fonctionner officiellement comme responsable pour le programme aux adultes, rôle qu'il joue maintenant informellement en collaboration avec le directeur des services aux adultes.

.../...

Option 2

Le département des services aux adultes peut continuer à prendre la responsabilité du programme et continuer à travailler en collaboration avec l'équipe qui est en place sous notre direction, au département des services aux étudiants.

Notre projet pilote se terminera en mai 1980 et le succès de cette initiative est bien reconnue par les professionnels, médecins et psychiatres de l'hôpital jusqu'à présent. Nous voulons donner un service semblable à ceux qui existent déjà à l'Institut Philippe Pinel et à l'hôpital Louis Hippolyte Lafontaine, qui opèrent des programmes de ce genre depuis quelques années.

J'espère que vous pourrez nous donner la direction à suivre et votre autorisation pour cette initiative.

Dans l'espoir d'un dénouement favorable quant à ce programme pilote, je vous prie de croire, cher Cliff, à mes sentiments les meilleurs.

C. Tisshaw
Directeur adjoint
Service aux étudiants

CT/rl

ANNEX IV

THE PROTESTANT SCHOOL BOARD
OF GREATER MONTREAL

BUREAU DES ÉCOLES PROTESTANTES
DU GRAND MONTRÉAL

February 29th, 1980.

Mr. J.D. Flanagan,
Director of Adult Services.

Re: Douglas Hospital Project

Dear Mr. Flanagan:

The accompanying Extract from the Minutes of a Meeting of the Board held on February 27th, 1980, relative to the above underlined subject, is forwarded to you for appropriate action.

Yours sincerely,

Olga Kowcz

(Mrs.) Olga Kowcz,
Secretary General.

K/ap
Encl.

c.c. Mr. M.R. Fox
Mr. I. Trasler

EXTRACT FROM THE MINUTES OF A MEETING OF THE PROTESTANT SCHOOL BOARD OF GREATER MONTREAL HELD IN THE CITY OF MONTREAL ON THE TWENTY-SEVENTH DAY OF FEBRUARY, ONE THOUSAND NINE HUNDRED AND EIGHTY

"Douglas Hospital Project

On regular motion, it was carried unanimously -

WHEREAS it is extremely difficult to function in the community without basic academic skills, and

WHEREAS it is too difficult for most psychiatric patients to take advantage of adult education opportunities in the community, and

WHEREAS academic failure contributes to a person's feeling of worthlessness and incompetence, and

WHEREAS a sensitive, special education approach needs to be developed to meet the needs of adult psychiatric patients:

- ratio of 1:4
- possibility of 5-day a week classes
- special adult oriented materials
- teaching methods which cater to individual learning problems and promote success
- interpersonal interaction which enhances dignity, independence, feelings of worth, self-confidence and responsibility
- teachers with appropriate training, experience and attitude, and

WHEREAS the number of teachers hired should be based on the number of patients needing education, and

WHEREAS the experience with the six-month Adult Education Pilot Project and the 1979-80 Adult Education Centre, both funded by The Protestant School Board of Greater Montreal, Adult Services, in cooperation with the Douglas Hospital, has demonstrated the significant, positive contribution that adult special education can make in the lives of psychiatric patients,

BE IT THEREFORE RESOLVED THAT, as recommended by the Adult Education Committee, the Douglas Hospital and The Protestant School Board of Greater Montreal make joint representation to the Ministries of Education and Social Affairs to obtain recognition of and permanent funding for special education for adult psychiatric patients on a per capita basis and on the same division of responsibility as has already been established in the present arrangements for the Adult Education Centre and in the Entente governing the education of patients in Douglas Hospital, Children's Services.

VOTE: 11-0-0 (Mrs. G. Freedman, Mrs. A. Oulton not present for vote; Mrs. B. Guard, Mr. C. Whittaker absent)"

CERTIFIED that the foregoing is a true and correct Extract from the Minutes of a Meeting of THE PROTESTANT SCHOOL BOARD OF GREATER MONTREAL held on February 27th, 1980.

Olga Kowcz

(Mrs.) Olga Kowcz,
Secretary General,
The Protestant School Board of Greater Montreal.

February 29th, 1980.

Annex V not included. It is assumed that you already have a copy. (Douglas Hospital Report.)

YEAR END REPORT
ADULT EDUCATION CENTRE
DOUGLAS HOSPITAL

SUBMITTED BY: KAREN FOLEY
HEAD TEACHER

JULY. 1980

YEAR END REPORT
ADULT EDUCATION CENTRE
DOUGLAS HOSPITAL

Friday June 13, marked the closing of the Adult Education Centre, Douglas Hospital, for the school year 1979-80.

Two major changes significantly affected the operation of the school during this past year. Firstly, there was an increase of two teachers which allowed for an extension of the programme. Secondly, a change of location to a bungalow, situated at the outer limits of the hospital property, provided the school with an atmosphere of normalcy not experienced last year on Newman 3B.

The first term began with two teachers working from 9:00 a.m. to 12 noon, Monday thru Friday. Ten students were accommodated during this time, with hours of attendance varying according to the patient's needs and ability to concentrate. Also taken into consideration was the availability of teaching time and the pupil's capacity to work in a group situation. The student population was almost evenly divided between community-based patients and full-time residents of the hospital.

With the addition of two teachers in January 1980, the programme was revised and the classes, which accommodated sixteen students, were set up as follows.

a. <u>Specialized Class</u>:

The teacher worked on an individual basis with pupils not able to work in a group situation. This class included two aphasics.

cont.

b. Literacy:

Students wishing to acquire very basic literacy skills were placed in this group.

c. Low Academic Upgrading:

This was a class designed to upgrade reading, writing, and mathematical skills for those working at a grade 2,3 level.

d. High Academic Upgrading:

In this group students working up to a level of grade 6,7 competency were encouraged to improve their skills as a prelude to further education if desired.

In total, twenty students were accommodated this year, nineteen in the regular classes, and one who was taught individually by a volunteer teacher. Those few who withdrew from the school did so because of personal turmoil within their own lives which made concentration in a structured situation impossible.

A most significant aspect of the programme was that the curriculum was designed to ensure success. This is vital if the student is to develop confidence in himself and in his ability to cope in a learning situation. Only then can he be encouraged to pursue his education outside the confines of the hospital.

At the present time there is a small waiting list for September 1980. This is misleading however, because some of the hospital staff, having been advised that the school was full, have failed to refer potential students. Therefore, the patient population presently accommodated at the Adult Education Centre is not representative of the need within the hospital.

As previously stated, a change of location this year favorably affected

cont.

the operation of the school. As the patients were required to transport themselves to a dwelling outside the hospital proper, the school situation more closely approximated a standard school set-up. It should be noted, however, that due to the extreme mental stresses that these students experience, a great deal of support would be necessary if integration into existing adult education facilities were to be considered. For some patients this could never be a reality.

The atmosphere within the school was also greatly affected by the change of location. As there were twenty to twenty-five adults functioning in such close quarters, it was necessary for the pupils to improve their social skills in order to get along with the other students. Also, negative behavior as often displayed on the ward was totally unacceptable in the school and, for the most part, this criteria was adhered to by the students. Thus the teachers, and the patients themselves, served as models of appropriate behavior.

There has been much success. Academic gains have been made but, more importantly, the students are exhibiting suitable social conduct at school and have improved feelings about themselves and their ability to learn.

The following excerpts, taken from the pupils' written work, demonstrate their attitude and positive feelings towards the school.

A thirty-seven year old student in the early stages of learning to read writes: I'm very smart to learn to read in school.

A young woman, being helped to learn to speak writes: I am very better than I was. I couldn't understand before, I couldn't speak. But now I'm speaking - I can talk now.

Another student writes: I have a new outlook on life. The school has inspired me very much.

Another young man, confined to institutions since the age of twelve writes: They are my only friends in school. I am able to get my opinions

cont.

across. People listen to me to hear what I want to say.

One of the other students sums it up with these words: I want to fit into this world and have a good job and close friends. I think this school is a start for someone who doesn't know about things and who will like to know it better. It is for someone who doesn't know what is going on outside because he has been in the hospital a long time. It helps them to get out really fast.

In accordance with the success of the Adult Education Centre to date, and to accommodate the needs of present and prospective students, the following recommendations are suggested for the school year 1980-81.

1. That the programme should be continued.

2. That staffing be at least the level it is now with a view to seeing it expand in order to adapt to the needs of the patient population.

3. That consideration be given to tying in with teacher training programmes (e.g., McGill) to increase the quality of instruction. Supervision time would then be necessary.

4. That consideration be given to providing liaison for those students able to begin integration into existing adult education facilities.

5. That, as the school has been accepted as a viable part of the hospital's operation, consideration be given to effecting a closer association with the hospital staff, with concomitant dovetailing of goals and objectives.

6. That the close relationship that has been developing between Chris McFadden, Director of Forward House, and the Adult Education Centre be fostered as ultimate aims and interests are similar.

EXTRACT FROM THE MINUTES OF A MEETING OF THE ADULT EDUCATION COMMITTEE HELD ON MAY 7th, 1980

"PILOT PROJECT - ADULT EDUCATION - DOUGLAS HOSPITAL

Document presented - Letter dated April 29th, 1980 from Mr. J.D. Flanagan, Director of Adult Education Services, with accompanying exchange of correspondence with DGEA

Mr. C.E. Tisshaw, Assistant Director of Student Services, advised that the Entente governing the education of patients in Douglas Hospital Children's Services terminates at age 21, but that some logical continuing special education was required. He spoke to the innovative project which, he stated, was providing meaningful education to in-patients and had proven to be very worthwhile.

The Director of Adult Education Services advised that Adult Services has pursued permanent funding for the pilot project at Douglas Hospital in accordance with the Board's resolution of February 27th, 1980, and DGEA has replied that the regular budget be used to cover costs for the current year, but that a policy for the education of the handicapped is being formulated to be effective June 30th, 1980, when it will be possible to reconsider the Board's request.

In the discussion that ensued, it was the consensus of the Members that the pilot project at Douglas Hospital be considered a priority within the Adult Education Services.

The Director of Adult Education Services agreed to pursue this matter further and submit an update to a subsequent meeting of the Adult Education Committee."

ANNEX VII

THE PROTESTANT SCHOOL BOARD
OF GREATER MONTREAL

BUREAU DES ÉCOLES PROTESTANTES
DU GRAND MONTRÉAL

September 29th, 1980.

Mr. J.D. Flanagan,
Director of Adult Services.

Re: Adult Education - Douglas Hospital Project

Dear Mr. Flanagan:

The accompanying Extract from the Minutes of Meeting of the Board held on September 22nd, 1980, relative to the above underlined subject, is forwarded to you for appropriate action which should also include initiating action re joint efforts with the Douglas Hospital to seek funds from other sources for permanent financing of this project.

Yours sincerely,

(Mrs.) Olga Kowcz,
Secretary General.

K/ap
Encl.

c.c. Mr. M.R. Fox
Mr. I. Trasler
Mr. M.J. McDonald
Mrs. G. Freedman

6000 AVENUE FIELDING AVENUE, MONTRÉAL H3X 1T4

EXTRACT FROM THE MINUTES OF A MEETING OF THE PROTESTANT SCHOOL BOARD OF GREATER MONTREAL HELD IN THE CITY OF MONTREAL ON THE TWENTY-SECOND DAY OF SEPTEMBER, ONE THOUSAND NINE HUNDRED AND EIGHTY

"ADULT EDUCATION - DOUGLAS HOSPITAL PROJECT

On regular motion, it was carried unanimously -

WHEREAS the Board's commitment to finance the Douglas Hospital Adult Education Pilot Project terminated on June 30th, 1980, and

WHEREAS it is proposed that the project be continued in a modified form for 1980-81 with the understanding that joint efforts will be made by the Douglas Hospital and the PSBGM to seek funds from other sources for permanent financing of this project,

BE IT THEREFORE RESOLVED THAT, as recommended by the Adult Education Committee, the Douglas Hospital Adult Education Project be continued in a modified form during 1980-81 for a limited period of time of approximately seven months with the understanding that -

(a) the expenditure for said period will not exceed $28,000 within the Adult Education Budget,

(b) joint efforts will be made by the Douglas Hospital and the PSBGM to continue to seek funds from other sources for permanent financing of this project,

(c) the whole matter will be subject of review in January 1981 or shortly thereafter.

VOTE: 14-0-0 (Dr. J.A. Simms absent)"

CERTIFIED that the foregoing is a true and correct Extract from the Minutes of a Meeting of THE PROTESTANT SCHOOL BOARD OF GREATER MONTREAL held on September 22nd, 1980.

Olga Kowcz

(Mrs.) Olga Kowcz,
Secretary General,
The Protestant School Board of Greater Montreal.

September 29th, 1980.

dawson college

EDUCATION FOR PATIENTS OF PSYCHIATRIC HOSPITALS

AN ANALYSIS OF THE NEED AND RECOMMENDED SOLUTIONS

FINAL REPORT

Presented to: Willaim A. Young, Responsable du Projet
Director – Community Services,
Dawson College, Montreal.

Presented by: Christopher MacFadden, Realisateur du Projet
Executive Director,
Forward House Inc., Montreal.

EDUCATION FOR PATIENTS OF PSYCHIATRIC HOSPITALS

An Analysis of the Need and Recommended Solutions

FINAL REPORT

Presented to: William A. Young, Responsable du Projet
Director - Community Services,
Dawson College, Montreal.

Presented by: Christopher MacFadden, Realisateur du Projet
Executive Director,
Forward House Inc., Montreal.

in collaboration with: Dr. Jonathan Davis,
Psychologist,
Douglas Hospital Center,
Montreal.

15/07/80

EDUCATION FOR PATIENTS OF PSYCHIATRIC HOSPITALS

An Analysis of the Need and Recommended Solutions

FINAL REPORT

Table of Contents

Foreward

A short time ago the Community Services Division of Dawson College became concerned about the educational opportunities being made available to adult patients associated with either psychiatric institutions or the psychiatric treatment services of general hospitals. The College consulted representatives of the Douglas Hospital Center and became convinced that the problem required in depth analysis prior to deciding upon a specific course of action. Consequently a project proposal was presented in the fall of 1979 to the Ministère de l'Education, Direction générale de l'éducation des adultes - service études et projets. In essence the project was designed to examine the question of inequality of access to education, as it pertained to those adults who have been handicapped by mental illness, to recommend ways in which the situation could be corrected, and to denote the style and approach of the adult education programs which would subsequently be required. The Project was approved and work began in early 1980.

Many individuals gave unselfishly of their time and energies towards the realization of this project. It would be inappropriate to attempt to name them all. Nevertheless, one individual in particular, Dr. F. Fenton, psychiatrist and researcher at the Montreal General Hospital, deserves special mention. Throughout the course of the project he made himself readily available for ongoing consultation and assistance. His professional expertise and personal insight were invaluable to this project.

Anyone wishing to acquire further information regarding this project and its results should direct their requests to: Christopher MacFadden, Executive Director, Forward House Inc., 2240 Girouard Ave., Montreal, P.Q.

Goal

The goal was to analyze and assess the educational needs of adult patients associated with either psychiatric hospitals or with the psychiatric treatment services of general hospitals.

Hypothesis

The following hypothesis were identified at the outset of the analysis:

- that a review of the literature would yield pertinent information regarding the role of education in the rehabilitative process for these patients, provide the background for further investigation as well as a suitable instrument for assessment of educational needs.

- that consultation with professional educators and mental health professionals in psychiatric institutions, general hospitals and community-based agencies would clarify some of the complexities of the problem as well as suggest solutions.

- that adult patients residing in psychiatric institutions would demonstrate diverse levels of functioning and capability and therefore different levels of educational needs.

- that the number of patients associated with psychiatric hospitals and the psychiatric treatment services of general hospitals who live in the community and experience periodic admissions would outnumber considerably those patients receiving long-term institutional care.

- that on practically all levels of psychiatric treatment and rehabilitation the educational needs of this population are not being attended to in an organized and systematic manner.

Conclusions and Recommendations

1.) All patients associated with either psychiatric hospitals or the psychiatric treatment services of general hospitals have a right to education. Such a position is clearly in accordance with the principle of universal accessibility to all levels of education for the handicapped recently recognized by the Quebec government and consistent with the positions and principles regarding adult education established by the United Nations Educational, Scientific and Cultural Organization (UNESCO) in its "Occasional Paper 34".

2.) Chronically disabled psychiatric patients whether they be in-patients of psychiatric institutions or out-patients residing in the community require Adult Basic Education programs.

For these populations, as for other handicapped persons, the educational needs may be conceptualized as deficits in living skills. In order to gain a greater mastery over their environment these people need tutoring in a variety of areas such as how to shop, budget, take public transportation, use the telephone, read street signs, write basic letters, talk to other people, and so on. In short, what is needed are skills for life management, community adjustment and individual autonomy.

The specific needs vary greatly from psychiatric in-patient to psychiatric out-patient populations. Indeed, the relative superiority of out-patients over in-patients with respect to level of adaptive functioning was found to be the major criteria distinguishing the two groups. There would appear to be a large group of psychiatric in-patients which cannot live in the community, not because of their level of psychopathology, but because of their shortage of survival skills.

Despite a moderately high level of problem behaviours, the out-patient group maintained itself in the community, albeit unsatisfactorily, apparently because of its possession of positive skills. It was apparent, however, that the out-patients lacked many other skills which would permit them fuller integration into the community. Some of those other missing skills, especially in the social and vocational areas of functioning, could account at least in part for the frequent rehospitalizations in this population.

Adult Basic Education programs for all psychiatric patients should be designed to respond to the clearly defined level of functiong of each patient, which is to say that the particular patient's level of functioning will reflect that person's educational needs and therefore determine the type of program required. The establishment of different levels of functioning according to a progressive hierarchical model will consequently lead to the development of different levels of educational program. Once the level of functioning for a particular patient had

been established and the required educational program had been implemented, it would be expected that the patient would move through progressively more advanced levels of education at a suitable pace until reaching an optimum level of functioning. For example, at initially low levels of functioning a patient may require instruction in personal hygiene and proper attire while at higher levels instruction in budgeting, travel, shopping, etc... The focus of the various programs of instruction themselves would emphasize living and coping skills, life management training, community adjustment and individual autonomy while substantially improving the patient's quality of life.

Whatever the established level of functioning, appropriate basic skills such as reading, writing and mathematics should be taught within the daily living context of these patients (eg. literacy for newspapers, job applications etc..., writing for letters, mathematics for budgeting and shopping).

3.) Both in-patients and out-patients associated with psychiatric institutions and the psychiatric treatment services of general hospitals should be guaranteed the right of access to education, irrespective of their particular level of functioning.

For in-patients, the implementation of such Adult Basic Education programs is especially problematic. Education within psychiatric institutions must be seen as distinct from, yet of equal importance to, traditional forms of psychiatric treatment and therapy. Modalities for close interaction between these two spheres must be established. Medical staff, social service staff and professional educators would have to consult regularly and cooperate closely in order to accurately assess a particular patient's educational needs and to subsequently provide the required educational program. Such collaboration would have to include community-based mental health agencies upon the patient's discharge from hospital so as to insure continuity in the educational programming being provided.

For out-patients, the implementation of such Adult Basic Education programs should become the responsibility of community-based mental health agencies and they should be mandated by the Quebec government to do so. Educational programs designed specifically to respond to the needs of out-patients simply do not exist in the province despite the fact that this population is considerably larger than the in-patient one. Therefore development and implementation of such programs is seen as an immediate priority. In-patients functioning at the higher levels could also participate in such programs thereby further advancing the goals of reintegration and normalization.

4.) Teacher/student ratios for the Adult Basic Education programs outlined above should range only from one-to-one to one-to-four. It is anticipated that individual instruction (one-to-one) would be more prevalent for in-patient populations (teachers at the Douglas Hospital's Center for Adult Education have strongly supported this indication) while group instruction (one-to-three, one-to-four) would probably be more appropriate and effective for out-patients.

5.) Whatever form the particular educational program takes it must address itself to the widespread apathy and amotivational status of a chronically disabled psychiatric population which has been conditioned by former experiences to expect failure in almost all areas of endeavour. Therefore, such educational programs must, while taking into account motivational difficulties, problems of concentration, inappropriate social behaviour,etc..., build guaranteed success and a clearly recognizable sense of accomplishment and achievement into all program levels. In some cases, implicit incentives would have to be included, for instance financial reimbursement for program attendance and completion of each level of instruction.

6.) An appropriate scale for the assessment of chronically disabled psychiatric patients in the areas of vocational capability, social skills and overall independent functioning must be developed. Widely used existing scales for the assessment of level of adaptive functioning were developed for use with the mentally retarded. They are not wholly adequate for use with psychiatric populations. Out-patients in particular have functioning and living skills deficits that are not measured by these tests. Generally speaking, their educational needs are in the vocational/social areas and in the higher levels of independent functioning.

7.) Appropriate teaching materials for the Adult Basic Education programs outlined above will have to be collected, developed, prepared, packaged, tested and evaluated. Such materials should clearly reflect the objectives of the programs themselves, especially with respect to providing life management training within the context of an adult's actual living experience and present situation.

8.) In conjunction with Conclusion and Recommendation No. 2, it is also understood that only a very small percentage of this psychiatrically handicapped population will be able to avail themselves of traditional Adult Education programs and structures unless these are significantly and substantially modified to meet the special needs of chronically disabled psychiatric patients. Consequently, Adult Basic Education programs designed specifically to meet their special needs must be

developed. Nonetheless, for those who can avail themselves of the traditional programs and structures, liaison officers are required to facilitate and coordinate the particular patient's entry and to provide continuing assistance during the course of the patient's participation in such programs.

9.) In conjunction with Conclusion and Recommendation No. 3, in order to insure appropriate and effective delivery of Adult Basic Education programs to both in- and out-patients through psychiatric institutions and community-based mental health agencies, an appropriate system of monitoring and accountability would have to be established.

An independent, non-partisan organization such as l'Office des personnes handicapées du Québec should be mandated by the Quebec government to provide the means and methods of initial and periodic independent assessments of the specific educational needs in direct relation to the level of functioning of each and every patient associated with psychiatric institutions and the psychiatric treatment services of general hospitals. The results of these assessments would then be made known to the particular party mandated by the Quebec government to provide Adult Basic Education programs for this population (psychiatric institutions, general hospitals, or community-based mental health agencies). They in turn would contract with an appropriate educational institution in order to develop and implement the required program.

Considerable time would have to be spent at the outset in program development and teacher training. After this initial phase, it is anticipated that a certain degree of standardization would occur among the various levels of educational programs and as a result the efficiency in service delivery would increase markedly.

Methodology

The analysis was conducted according to the four separate phases outlined below.

1.) Review of the Literature

McGill University, Library Division, was contracted to conduct three computerized searches (Medline, P.A., ERIC) for literature pertinent to the role of education in the rehabilitative process for patients associated with psychiatric institutions, the psychiatric treatment services of general hospitals and community-based mental health agencies. The literature thereby obtained was reviewed to provide background and focus for the present analysis.

2.) Consultation

Professional educators and mental health professionals in psychiatric institutions, general hospitals and community-based agencies were consulted in an effort to further delineate the problem, to establish directions for the present analysis and to identify potential solutions.

In addition, an initial or preliminary educational needs assessment was conducted with a group of nine Douglas Hospital Center's management/ administrative personnel; and a group of six members of the Douglas Hospital Center's psychiatric nursing staff.

3.) Data Collection and Analysis

A scale of measurement was chosen for its ability to tap adaptive behaviour functioning and was administered to adult in-patients and adult out-patients. Dawson College was then contracted to provide the necessary computer time to run the various computer programs which had by then been devised. The results were subsequently analyzed.

4.) Collogue

A number of the professional educators and mental health professionals previously contacted and consulted were invited to participate in a mini-seminar. At this mini-seminar the preliminary findings of the present analysis were presented and discussed.

Major Findings

1.) Review of the Literature

Since the early 1960's the advent of psychiatric pharmacotherapy and the development of new conceptual frameworks such as milieu therapy, the therapeutic community, and community psychiatry have represented a major shift in the treatment and care of the mentally ill.[1,2,3] In conjunction with this increased emphasis upon the role of the community as a therapeutic agent, the effects of psychiatric hospitalization have come under careful scrutiny. The social breakdown syndrome has been extensively described[4] and understood as a component of the institutionalization process. Institutionalized treatment contributes to a lack of self-confidence, loss of individuality, dependency, apathy and stigmatization among patients.[5,6] Further to this, it initiates a collapse in the social relationships so vital to the successful adjustment of the patient following discharge as well as a general improverishment in their daily living skills.[7]

Day or night hospitals, halfway houses, foster care homes, and vocational placement programs have been established in an effort to provide concrete solutions to this problem by diminishing the length of hospital stay and facilitating reintegration into the community. Though more ambitious projects have offered an alternative to immediate hospitalization,[8] the chronically ill have remained consumers of hospital-based services largely through the "revolving door" syndrome.[9,10] The

process of institutionalization has continued to take place as these patients tend to perceive the institution as their only harbour when, due to flare ups of their illness or to the poverty of their skills, they find themselves unable to cope with the stress and demands of daily living. They in fact spend the greater portion of their lives either as long-term in-patients or living marginally in the community and experiencing periodic hospital admissions.

The whole field of adult education is expanding rapidly and attracting widespread attention. It is the considered opinion of some that adult education will in fact be the educational priority in North America during the 1980's. There is considerable evidence supporting such a view. The General Conference of the United Nations Educational, Scientific and Cultural Organization (UNESCO), meeting in Nairobi in 1976 at its nineteenth session, stated that:

> "... the access of adults to education, in the context of life-long education, is a fundamental aspect of the right to education and facilitates the exercise of the right to participate in political, cultural, artistic and scientific life;" [11]

and further stated that adult education

> "... should be based on the needs of the participants and make use of their different experiences in the development of adult education; the most educationally underprivileged groups should be given the highest priority within a perspective of collective advancement; " [12]

and

> " it should be adapted to the actual conditions of everyday life and work and take into account the personal characteristics of adult learners, their age, family, social,occupational, residential background and the way in which these interrelate; " [13]

The Quebec government's recent White Paper on the Colleges clearly pointed to definite problems in this area.

> "Il existe également des groupes particulières, comme les adultes, les personnes handicappées, le troisième âge, et les economiquement faibles, qui, de manière généralement moins apparante, il est vrai, sont aux prises avec des contraintes qui limitent indûrement leur accès à l'enseignement collégial" [14]

With these observations in mind, the role adult education can play in the lives of the chronically mentally ill has been receiving considerable attention of late.[15] There is a growing awareness among those working in the field of mental health that the educational process can significantly improve the psychiatric patient's vocational and social adjustment in the community and, for those patients undergoing extended in-hospital care, can combat the negative effects of institutionalization while substantially improving the quality of their lives. Several educational programs have been established and all seem to indicate a significant degree of success with this population.[16,17,18] They all accept as their initial premise that:

> "Much of their (psychiatric patients) difficulty in adjusting to the community has to do with not knowing such things as the essentials of managing their money; how to use banking services; how to use the resources available to them in the community; how to use their leisure time; the fundamentals of nutrition, meal-planning, and shopping; how to use public transportation; the essentials of grooming,

> personal hygiene, and sex education; .....
> For many patients knowledge and skills in these areas make the difference between being able to live independently in the community and living in a hospital or existing at a very low level in a residential care home." [19]

It has also been noted that once these skills deficits have been identified and responded to with appropriate adult education programs,

> "... long-term patients realize that the basic skills of everyday living are learned skills and not abilities or talents magically bestowed on others but not on themselves. The students learn that others have also had to learn these skills, that no one is born with them. Much of the mystique of making it in the world is taken away." [20]

Those working with chronically disabled psychiatric patients in this relatively new field of endeavour also strongly agree on two other main points: - "Programs for this type of student must be personal, informed, and individualized." [21]

- "These people, especially, must be provided the opportunity to participate in the same educational experiences which are available to the mainstream of the adult population." [22]

Adult education programs designed for this population tend to target such areas as basic skills training, literacy, upgrading of academic and life management skills at various levels, and vocational/social assessment. Such a focus is in direct line with currenttrends and developments in the overall approach to the rehabilitation of psychiatric patients, especially with respect to levels of expectation. [23,24,25] Community-based mental health agencies are assuming a greater role in teaching patients the life skills they require in order to achieve

stability and independence in the community. This trend can only intensify as more and more patients receive acute treatment on a short-term basis at psychiatric institutions and general hospitals and are then discharged to the community. At the same time psychiatric institutions are becoming somewhat more attentive to the educational needs of their long-term populations, particularly with respect to improving the quality of life for these patients and also to increase the possibility of their discharge to the community.

In conclusion, it can be seen that the field of adult education is acquiring greater and greater recognition including the Quebec government. The scope and range of programs and services associated with adult education will, in the foreseeable future, expand and grow accordingly.

Education specifically designed to respond to the needs of handicapped persons has already been identified as a priority in this area. It would be expected, therefore, that adult education for chronically disabled psychiatric patients, as handicapped persons, would be in the forefront of this expansion and growth.

2.) Consultation

Interviews and consultations were conducted with mental health professionals and paraprofessionals directly involved in the process of providing services to in-patients and out-patients associated with psychiatric institutions, psychiatric treatment services of general hospitals, and community-based mental health agencies. Professional educators in the different educational institutions who are or would be implicated in a program of education designed for these patients were also

contacted and consulted. As a result the following description of the situation at present and perceptions of the overall problem were identified.

A cross-Canada survey conducted in late 1978 showed that adult education services were being provided in thirteen of fifty-six psychiatric institutions.

In Quebec, recent government legislation, most notably Bill No. 9, clearly established the rights of the handicapped, including the right to education, while recognizing its specialized nature.

In Montreal, the Douglas Hospital Center in October, 1978 undertook in conjunction with the Protestant School Board of Greater Montreal (PSBGM) a six month pilot project in Adult Education. Towards the end of this project a brief educational survey and assessment of the patients in Adult Services at the hospital was completed. After interviewing and testing selected chronic patients (35) with respect to academic aspirations, academic standing, and special interests, this report strongly urged the implementation of a tutorial system of education designed to respond to the highly individualized needs that had been identified.

In April, 1979 the Advisory Committee on Adult Special Education at the Douglas Hospital Center recommended that in collaboration with the PSBGM a permanent Adult Education Center be established which would operate four classes, five days a week, focusing on Basic Skills Training, Literacy, and Academic Upgrading. Such a center was subsequently established with four half-time teachers emphasizing diagnostic prescriptive teaching. Unfortunately the Center's continued existence seems to be in considerable jeopardy at the time of writing.

It appears that two other psychiatric institutions in the province (Hôpital Louis-Hippolyte LaFontaine - Montreal, and Hôpital Robert-Giffard - Quebec) are attempting to provide some forms of educational services to their adult in-patient populations.

There is no evidence that any general hospital in the province responsible for providing psychiatric treatment and therapy on an in-patient basis is attending to this field of endeavour.

It appears widely accepted that the number of patients associated with psychiatric hospitals, the psychiatric treatment services of general hospitals, who reside in the community and experience periodic admissions (out-patients) considerably outnumber those patients receiving long-term institutionalized care (in-patients). Nonetheless, there are extremely few community resources of any type available to out-patients and educational programs designed specifically to respond to their needs appear to be virtually non-existant.

An initial or preliminary educational needs assessment was then conducted. The instrument used was the CSE/Elementary School Evaluation Kit: needs assessment, which is designed to solicit ratings and rankings of importance of one hundred and six educational goals for all elementary school grade levels (See Appendices). The test was independently administered to one group of nine Douglas Hospital Center Management Personnel and one group comprised of six members of the Douglas Hospital Center's psychiatric nursing staff. The results (See Appendices - Table 1) were found to be sporadic, overly subjective and inconclusive. There was also serious doubt as to whether the instrument itself was appropriate given the objectives and type of population being considered by the present analysis.

As a result, a search was conducted in an effort to find a more suitable scale of measurement to be used in assessing the educational needs of the population in question. Eventually, it was decided that the Adaptive Behaviour Scale of the American Association on Mental Deficiency was the most appropriate scale of measurement available at the time the present analysis was undertaken.

3.) Data Collection and Analysis

In recent years the educational needs of handicapped populations have been increasingly evaluated in terms of adaptive functioning. The term "adaptive behaviour" refers to the effectiveness of an individual in coping with the demands of his environment. The Adaptive Behaviour Scale (ABS) of the American Association on Mental Deficiency (AAMD) was developed specifically to measure such personal and social effectiveness. A large literature has grown up supporting the educational relevance of the ABS for handicapped populations. For example, Wilson (1972) supported the view that many educators are now leaning toward a behavioural analysis of pupils' difficulties. He pointed out that although the ABS scale is behavioural it contains an element of subjectivity which allows the educator the freedom to design an individualized format for teaching. The ABS has proved to be a useful tool in individualized curriculum planning for the retarded. Schacter, Rice, Cormier, Christensen and James (1978) described in detail a system for basing teaching programs on the individual needs of retarded clients, using the ABS.

The ABS was chosen for the present study because of its widely documented use, and proven usefulness, with other handicapped populations.[++] Fortunately, data had already been gathered on a large sample of in-patients from the Douglas Hospital Center. A second set of data was collected and added to this first set from a sample of chronic psychiatric out-patients at Forward House Inc., a community-based mental health agency in Montreal.

It is possible to think of objections to the use of the ABS with psychiatric populations. For one thing, it could be argued that it (or any other instrument for that matter) cannot fairly appraise their educational needs because adaptive functioning may be suppressed by psychopathology. In other words, although the ABS may measure current level of functioning, it is impossible to know what the level would be if the given patient were not mentally ill. This objection was partly answered in the present study by evaluating only patients who were not floridly psychotic (and whose adaptive functioning was therefore stable enough to be reliably estimated).

[++] It is of some interest that the test has already been adopted for use with francophone populations in Quebec, although the present sample consisted of anglophones. The French version is on file in the office of the American Association on Mental Deficiency, 5201 Connecticut Ave. N.W., Washington, D.C. 20015.

Furthermore, recent published evidence, Sylph, Ross, and Keward (1977), suggests that adaptive functioning and maladaptive functioning, as measured by Parts I and II of the ABS respectively, (See Appendices - Tables 2 & 3), are factorially independent of one another. This suggests that adaptive functioning is not necessarily depressed in chronic mental patients merely because of psychopathology or maladaptive behaviour. The encouraging aspect of this finding is that the adaptive behaviour could in principle be the focus of an educational effort that is somewhat independent (at least conceptually) from traditional psychiatric cure or therapy.

In a further effort to control for the effect of psychopathology on the performance of the patients tested, the in-patients' data were separately analyzed by diagnostic category. In this manner the out-patients could be compared with in-patients having similar psychiatric diagnosis. Moreover, a separate scale, the Nurses' Observational Scale for In-patient Evaluation (NOSIE) was also administered to each patient at the time of scoring the ABS, so that additional measures of current psychopathology could be had on each patient.[26]

A further set of comparisons was made possible by the availability of published norms for retarded populations in the United States.

Data Analysis

The principal results are summarized in Appendices - Table No. 5 which contains the means, medians, and standard deviations for each population in each domain of the ABS. An aggregate measure of all the maladaptive behaviours surveyed in Part II of the ABS is reported in Appendices - Table No. 5 as well.

1.) Chronic psychiatric in-patients

vs.

Chronic psychiatric out-patients

Since 36 of the 45 out-patients tested were differentiated schizophrenics (ICDA - 8 295.0 - 5)[++], they are best compared with that corresponding population of in-patients.

The out-patients shared a comparable level of psychopathology with the majority in-patients in the schizophrenic categories, as measured by the total maladaptive behaviour score (Part II of the ABS). Statistically the in-patients did significantly worse as evaluated by the tests. However, the distributions of maladaptive behaviour for in-patients and out-patients had a total percentage overlap of 80%. This means that only about 20% of the hospital's population of schizophrenics was more deviant in terms of precise behavioural criteria. However, there were huge differences (all statistically significant) between the two groups with respect to the degree of development of adaptive behaviour.

++ Eighth revision of the International Classification of Diseases, Dominion Bureau of Statistics, Health and Welfare Division, 1969.

For example, in the domain called Independent Functioning, which measures very basic skills of self-care, there was only a 35% overlap of the two distributions; out-patients did far better than in-patients. In the socialization domain the overlap was just 40%, while in Language Development it was less than 40%. In short the two populations were most dissimilar with respect to level of adaptive functioning.

The NOSIE data (See Appendices - Table 6) showed that the out-patients were showing significantly less signs of manifest psychosis, on the average, and relatively more signs of depression than the in-patient schizophrenics. This may reflect in part the presence of eight patients with affective disorders in the out-patient data. In any event, it suggests another set of comparisons, namely between the out-patients and the in-patient population diagnosed as having affective disorders. These data are also contained in Appendices - Table No. 5.

The out-patients sample proved to have no greater psychopathology than the in-patients with affective disorders, as measured by the NOSIE. As measured by Part II of the ABS, however, they even had more maladaptive behaviours than that group of in-patients! One immediately wonders how they survived living outside of the hospital with this evident handicap. The data on their adaptive functioning may provide the answer. The out-patients had significantly better living skills, scoring higher on all domains except two (Self-Direction and Socialization),++ compared to in-patients in the category of affective disorders.

++ Statistically, there was no significant difference between the groups in these two domains.

2.) Chronic psychiatric in-patients

vs.

Mentally retarded in-patients for whom norms have been published

The in-patient schizophrenics (differentiated or undifferentiated categories, as well as the organics) scored significantly worse than the normative populations of retarded in all but two of the domains of adaptive functioning. The schizophrenics scored the same as the normative retarded in the area of language development and better than them in basic concepts of numbers and time. This reflects the relatively greater intellectual capacity of the psychiatric in-patient compared to the mentally retarded in-patient. Evidently, the psychiatric in-patient does not use his potential to best advantage.

Parenthetically, it is of some passing interest to note that the Douglas Hospital in-patients, schizophrenics, organics, and affectives, performed better than the Douglas Hospital Center's own retarded patients. Obviously the Douglas Hospital Center's retarded have massive educational needs compared with retarded from other hospitals, notably in the United States. No evidence was found to conclude that the Douglas Hospital Center retarded did worse than other retarded in-patients in Quebec's psychiatric institutions.

3.) Chronic psychiatric patients

vs.

"Normals"

During the course of this study, it became increasingly evident that adequate testing materials which would tap a higher range of independent adaptive functioning are unavailable. This lacuna is more serious for psychiatric out-patients whose lack of skills occur especially in the higher range. At present there does not exist an appropriate measurement scale which would enable investigators to highlight the adaptive deficits on the range of necessary life management skills for independent living for this particular population. There was a ceiling effect on the ABS for the out-patients, even though the latter evidently were functioning below the level of normals. The adaptive behaviour deficits for this group may be most acute in the vocational and social areas. A scale that was better suited to psychiatric patients would tap higher ranges of performance in these areas.

In summary, the data support the conclusion that there is considerable need for education among chronically disabled psychiatric patients. Moreover, a case can be made that the educational effort required is distinct from traditional treatment and therapy for the mentally ill.

4.) Collogue

A group of professional educators and mental health professionals attended a mini-seminar held on June 17, 1980 at the Victoria Campus of Dawson College. The preliminary findings of the "Data Collection and Analysis" were presented to this group for discussion, comment and feedback prior to the submission of the Final Report.

Among the conclusions and concerns emerging from the mini-seminar, were the following:

- all patients associated with psychiatric hospitals and the psychiatric treatment services of general hospitals either as in-patients or out-patients, as handicapped persons, had the right to education.

- that, in fact, these patients require Adult Basic Education programs, that such programs would differ according to the particular level of functioning they are designed for, and that such programs should have a life management training focus while substantially improving the quality of these patients' lives and preparing them for individual autonomy.

- all patients associated with psychiatric hospitals and the psychiatric treatment services of general hospitals either as in-patients or out-patients should be guaranteed access to the appropriate level of education through psychiatric institutions or community-based mental health agencies and facilities.

- teacher/student ratios for such Adult Basic Education programs should be kept as low as possible so as to allow for individualized programs of instruction, especially given the "special" needs of this population. Such programs should be flexible and achievement oriented while accounting for the often unusual characteristics often manifested by these patients.

- it was felt that existing Adult Education programs were generally unable to respond adequately or effectively to the educational needs of this population, and that even where a fragile link could be made the lack of liaison personnel pretty well doomed the project to failure.

- there was strong agreement that a system of accountability and monitoring for such Adult Basic Education programs would have to be clearly established in order to insure the proper delivery of these programs. It was felt that the Quebec government, psychiatric institutions, community-based mental health agencies, and educational institutions would all have a role to play in this system of accountability, the key to which was seen as various modalities for contracting required services from available resources.

Concluding Statement

The foregoing analysis has clearly established that all patients associated with either psychiatric institutions or the psychiatric treatment services of general hospitals have special educational needs. As handicapped persons, these people have a basic right to education and should therefore be guaranteed access to the different levels of adult education they require. It has also been demonstrated that Adult Basic Education programs capable of responding appropriately to their special educational needs are all but lacking in the province of Quebec. The development and implementation of such programs within psychiatric institutions and under the auspices of community-based mental health agencies should therefore be regarded as a priority. The foregoing analysis strongly emphasizes that these programs of instruction should, particularly for the ever increasing numbers of out-patients, focus upon living and coping skills, life management training, community adjustment, and individual autonomy while substantially improving the quality of life of chronically disabled psychiatric patients.

In conclusion then, it is hoped that the Quebec government will, having recognized the needs identified by this analysis, take on the responsibility of insuring the establishment of Adult Basic Education programs for this handicapped population in the very near future.

Appendices Listing

1.) Hoepfner, R.; Bradley, P.A.; Klein, S.P.; Aebin, M.D.; CSE/Elementary School Evaluation Kit: needs assessment.

2.) Table: 1 Data Summary - Needs Assessment

3.) Table: 2 Part One of the Adaptive Behaviour Scale (adaptive behaviour domains)

4.) Table: 3 Part Two of the Adaptive Behaviour Scale (maladaptive behaviour domains)

5.) Table: 4 Sample Questions from the Adaptive Behaviour Scale

6.) Table: 5 Data Summary - Adaptive Behaviour Scale

7.) Table: 6 Data Summary - Nurses Observation Scale for Inpatient Evaluation (NOSIE)

CSE / Elementary School Evaluation KIT:

Needs Assessment

Ralph Hoepfner
Paul A. Bradley
Stephen P. Klein
and
Marvin C. Alkin

Allyn and Bacon, Inc., Boston

Grade Level:_____

RATING SCHOOL GOALS

Accompanying is a pack of 106 printed cards, each one bearing a goal of elementary education, and 5 blue rating mats. The goals differ in importance. Our school should devote more time, effort, and resources to having the students achieve some of them than it should devote to others. Similarly, progress in achieving the more important goals should be monitored more closely to ensure early detection of problems. Information about the relative importance of the goals is necessary, therefore, in helping us plan both our educational programs and procedures for evaluating them.

If you have a child attending the school, you should make all your ratings on the basis of what you feel your child should learn and know at his grade. Mark the grade for which you are rating your child at the top of this page. If you are not a parent of a child at the school, please make your ratings on the basis of what you feel children should learn and know at the grade specified above.*

Rating Procedure

1. Place the five rating mats in front of you from left to right. Do not make any marks on the cards or rating mats.
2. Look through the whole set of cards briefly to get an idea of the range of importance of the goals. Now find one goal for each of the five categories of importance and sort these cards onto the corresponding rating mats.
3. Sort the remaining cards into these same five piles. Be sure to put at least five cards in each pile. Each card should be put in one and only one pile, and every card should be placed in a pile. If you are not sure into which pile a goal should be placed, put it into the one to which you feel it comes closest. Do not spend too much time deciding; if you have difficulty in rating a card, put it at the back of the pack and sort it last. There are no right or wrong answers in this task. Just rate the goals in terms of how important YOU think they are.
4. When you have sorted all the cards, check that you have put at least five cards in each pile.

You are now ready to tally the goals onto the form that follows on the next pages.

5. Beginning with pile 1, "Unimportant, Irrelevant," mark an X in column 1 of the tally sheet for each goal you have placed in that pile.
6. When you have completed marking in column 1 of the tally sheet all the cards that you had placed in pile 1, proceed to mark an X in column 2, "Marginal Importance," for all the cards you have placed in pile 2. Continue to mark X's in columns 3, 4, and 5 for all the cards in the corresponding piles. The goals are listed in alphabetical order on the tally sheet to help you. When you have finished filling out the tally sheet, it will look something like this:

	1	2	3	4	5
Application of Scientific Methods to Everyday Life (37B)		X			
Appreciation of Arts and Crafts (5A)				X	
Arts and Crafts Comprehension (7A)					X
Attitude and Behavior Modification from Reading (32B)			X		
Attitude Toward Reading (32A)	X				

Returning Materials

1. Before returning your materials, please check that you have done the following:
   a. Entered at the top of this page the grade level for which you sorted the cards.
   b. Put each card into one of the five piles.
   c. Put at least five cards in each pile.
   d. Tallied the piles onto the accompanying tally sheet.
2. Put all the cards back into one stack.
3. Return all the materials (cards, rating mats, and this form) to the principal or his representative.

Figure 2.3 "Rating School Goals" Form

*The raters should be instructed as to how to select the grade level for rating, or the grade level may be filled out in advance by the principal.

TABLE 2.1 Mean ratings and rankings of importance of the 106 goals for all elementary grade levels, based on a collective viewpoints procedure from 2,555 principals, teachers, and parents throughout the United States

Goal	*Ratings*	*Rank*
Application of Scientific Methods to Everyday Life (37B)	3.52	55
Appreciation of Arts and Crafts (5A)	2.91	82
Arts and Crafts Comprehension (7A)	2.02	100
Attitude and Behavior Modification from Reading (32B)	4.04	26
Attitude Toward Reading (32A)	4.41	8
Aural Identification of Music (22A)	2.08	97
Capitalization (13C)	3.75	40
Citizenship (41B)	4.61	2
Classification and Generalization in Science (35C)	2.92	81
Classificatory Reasoning (8A)	3.01	76
Comprehension of Equations and Inequalities (15C)	3.22	69
Comprehension of Number Principles (15D)	3.31	64
Comprehension of Numbers and Sets in Mathematics (15A)	3.93	33
Comprehension of Positional Notation in Mathematics (15B)	3.84	36
Creative Flexibility (9A)	4.06	25
Creative Fluency (9B)	3.60	48
Critical Reading (31C)	3.58	51
Cultural Insight Through a Foreign Language (12A)	2.23	95
Cultural Knowledge (40A)	3.67	44
Dance (Rhythmic Response) (21C)	2.28	93
Dependence-Independence (2A)	4.29	10
Developmental Understanding of Arts and Crafts (7B)	1.90	101
Experimentation in Science (35F)	3.01	76
Expressive Skill in Arts and Crafts (6B)	2.87	83
Familiarity with Standard Children's Literature (32C)	3.13	70
Formulation of Generalized Conclusions in Science (35G)	2.99	79
General Activity-Lethargy (1C)	4.03	29
Geometric Facility (18A)	2.70	88
Geometric Vocabulary (18B)	2.79	87
Grammar and Usage (13D)	4.03	29
Group Activity—Sportsmanship (25A)	4.21	13
Hostility-Friendliness (2B)	4.26	11
Hypothesis Formation in Science (35D)	3.25	65
Independent Application of Mathematical Skills (17B)	3.92	34
Independent Application of Writing Skills (13G)	4.07	23
Inference Making from Reading Selections (31A)	4.07	23
Interest and Independent Participation in Sports and Games (25B)	3.01	76
Interest Areas (4B)	3.76	39
Interest in and Application of a Foreign Language (12B)	1.87	102
Interest in Social Studies (41C)	3.50	56
Involvement in Arts and Crafts (5B)	2.99	79
Knowledge of Governments (38B)	3.71	43
Knowledge of History (38A)	3.56	52
Knowledge of Physical Education Apparatus and Equipment (26B)	3.08	74
Knowledge of Physical Geography (39A)	3.35	61
Knowledge of Scientific Facts and Terminology (36A)	3.23	68
Knowledge of Socioeconomic Geography (39B)	3.25	65
Listening Reaction and Response (27A)	4.45	7

TABLE 2.1 (Cont.)

Goal	Ratings	Rank
Mathematical Problem Solving (17A)	4.12	19
Meaningful Memory (10B)	4.09	22
Measurement Reading and Making (19A)	3.66	45
Muscle Control (Physical Education) (24A)	3.56	52
Music Appreciation (20A)	3.12	72
Music Interest and Enjoyment (20B)	2.84	85
Music Knowledge (22B)	2.14	96
Musical Instrument Playing (21B)	2.04	99
Nature and Purpose of Science (36B)	3.13	70
Need Achievement (4A)	4.52	4
Neuroticism-Adjustment (1B)	4.46	6
Observation and Description in Science (35A)	3.32	63
Operational Definitions in Science (35E)	2.87	83
Operations with Decimals and Percents (16C)	3.53	54
Operations with Fractions (16B)	3.72	41
Operations with Integers (16A)	4.25	12
Oral Comprehension of a Foreign Language (11B)	1.71	104
Oral Reading (29A)	3.60	48
Penmanship (13E)	3.60	48
Phonetic Recognition (28A)	4.21	13
Physical Development and Well-Being (Physical Education) (24B)	3.83	37
Practicing Health and Safety Principles (23A)	4.18	17
Punctuation (13B)	3.80	38
Reading Comprehension of a Foreign Language (11A)	1.57	105
Recognition of Literary Devices (31B)	2.56	90
Recognition of Word Meanings (30A)	4.15	18
Relational-Implicational Reasoning (8B)	3.41	58
Religious Belief (34)	2.80	86
Religious Knowledge (33)	2.32	92
Remembering Information Read (30C)	4.19	15
Representational Skill in Arts and Crafts (6A)	2.39	91
Research Skills in Social Studies (41A)	4.01	31
School Orientation (3A)	4.48	5
Science Interest and Appreciation (37A)	3.72	41
Self-Esteem (3B)	4.67	1
Sex Education (23C)	3.36	60
Shyness-Boldness (1A)	3.86	35
Silent Reading Efficiency (29B)	4.36	9
Singing (21A)	2.08	97
Social Organization Knowledge (40B)	3.64	47
Socialization-Rebelliousness (2C)	4.53	3
Span and Serial Memory (10A)	2.25	94
Spatial Memory (10C)	3.34	62
Spatial Reasoning (8D)	3.44	57
Speaking (27B)	4.19	15
Speaking Fluency in a Foreign Language (11C)	1.78	103
Spelling (13A)	4.10	21
Statistics (19B)	2.64	89
Structural Recognition (28B)	3.65	46
Summarizing Information for Reference (14B)	3.41	58

TABLE 2.1 (Cont.)

Goal	Ratings	Rank
Systematic Reasoning (8C)	3.25	65
Understanding Health and Safety Principles (23B)	4.04	26
Understanding Ideational Complexes (30B)	3.99	32
Understanding of Rules and Strategies of Sports and Games (26A)	3.02	75
Use of Data Sources as Reference Skills (14A)	4.12	19
Use of Numbers and Measures in Science (35B)	3.09	73
Writing Fluency in a Foreign Language (11D)	1.48	106
Written Expression (13F)	4.04	26

SELECTING RATERS

Once the collective viewpoints procedure is clear to you, your concern should turn to the people whom it is important to have make the ratings. Within a school district, if elementary school principals made the ratings, you would have information on the felt priorities of the administrators of the district. Ratings made by the teachers might be expected to reflect more of the attitudes and knowledge gained from their daily classroom interaction. A comparison between goal priorities of principals and teachers might well indicate areas of lack of articulation regarding the school's goals. Uncovering these problem areas, of course, is the first step in the resolution of the problems. Comparisons among groups can be made by repeating the collective viewpoints procedure for each group to be compared. Comparisons would be made by examining differences in rank and/or average rating for each goal.

Let's look at the top ten nationally rated goals (summed over all elementary grade levels) in terms of how the principals and teachers ranked them. These are illustrated in Table 2.2.

TABLE 2.2 Top ten ranked goals with principal and teacher rankings

Goals	Principal Rank	Teacher Rank
1. Self-Esteem (3B)	1	1
2. Citizenship (41B)	2	2
3. Socialization-Rebelliousness (2C)	5	3
4. Need Achievement (4A)	3	5
5. School Orientation (3A)	6	6
6. Neuroticism-Adjustment (1B)	4	4
7. Listening Reaction and Response (27A)	9	7
8. Attitude toward Reading (32A)	8	8
9. Silent Reading Efficiency (29B)	6	10
10. Dependence-Independence (2A)	10	9

CRITICAL READING

Recognizes intentions of author and purpose of the writing. Can decide on the basis of logic and judgment the quality of the writing. Can tell fact from fiction and one type of literature from another (fairy tales, true stories, etc.). Can recognize writing that encourages one point of view over any other or that does not make logical sense. Can tell the difference between fact, opinion, guesses, and statements of feelings.

ATTITUDE AND BEHAVIOR MODIFICATION FROM READING

Selects different types of reading materials according to purposes. Reads newspapers and other sources of information. Seeks out certain types of materials to get specific information, and as an aid to study. Is able to change behavior, feelings, and opinions as a result of knowledge gained through reading.

INFERENCE MAKING FROM READING SELECTIONS

Correctly interprets what is read. Recognizes from the material what kinds of characters are being talked about. Can tell that the characters in a story are sad or happy, trustworthy or untrustworthy, etc. Can tell why characters act as they do.

Table 1: CSE/Elementary School Evaluation Kit: needs assessment

Management/Administrative Personnel			Psychiatric Nursing Staff	
Douglas Hospital			Douglas Hospital	
Rating	Rank	Item	Rating	Rank
2.89	66	Application of Scientific Methods to Everyday Life (37B)	2.33	67
3.11	52	Appreciation of Arts and Crafts (5A)	2.33	67
3	58	Arts and Crafts Comprehension (7A)	2.6	60
3.55	30	Attitude and Behaviour Modification from Reading (32B)	3.1	42
3.78	25	Attitude Toward Reading (32A)	3.	49
3.33	40	Aural Identification of Music (22A)	2.33	79
3.44	35	Capitalization (13C)	3.5	27
4.22	18	Citizenship (41B)	4.5	3
3.22	45	Classification and Generalization in Science (35C)	3	44
3.44	35	Classificatory Reasoning (8A)	2.8	56
1.78	94	Comprehension of Equations and Inequalities (15C)	2.5	61
1.78	94	Comprehension of Number Principles (15D)	3.1	42
1.78	94	Comprehension of Numbers and Sets in Mathematics (15A)	3.3	38
2.44	78	Comprehension of Positional Notation in Mathematics (15B)	3.2	30
3.67	27	Creative Flexibility (9A)	3.8	18
3.11	52	Creative Fluency (9B)	4	10
3	58	Critical Reading (31C)	3.6	26
3	68	Cultural Insight Through a Foreign Language (12A)	3.5	27
3.55	30	Cultural Knowledge (40A)	4.2	8
3.44	35	Dance (Rhythmic Response) (21C)	3.2	39
4.78	4	Dependence-Independence (2A)	4.66	1
2	89	Developmental Understanding of Arts and Crafts (7B)	1.33	103
1.78	94	Experimentation in Science (35F)	1.5	99
4.33	16	Expressive Skill in Arts and Crafts (6B)	3.33	33
2	99	Familiarity with Standard Children's Literature (32C)	1.83	90
1.67	103	Formulation of Generalized Conclusions in Science (35G)	1.5	99
4.78	4	General Activity-Lethargy (1C)	4.5	3
1.67	104	Geometric Facility (18A)	1.66	96
1.55	106	Geometric Vocabulary (18B)	2	84
3.11	52	Grammar and Usage (13D)	4	10
4.11	20	Group Activity-Sportsmanship (25A)	3.8	18
4.67	8	Hostility-Friendliness (2B)	4.66	1
2.78	69	Hypothesis Formation in Science (35D)	2.33	67
2.67	71	Independent Application of Mathematical Skills (17B)	2.33	67
3.11	52	Independent Application of Writing Skills (13G)	3.16	41
3.22	45	Inference Making from Reading Selections (31A) (25B)	3.33	33
4.22	18	Interest and Independent Participation in Sports & Games	3.33	33
3.67	27	Interest Areas (4B)	3.83	14
2.55	74	Interest in & Application of a Foreign Language (12B)	1.33	103
3.22	45	Interest in Social Studies (41C)	2	84
3.22	45	Involvement in Arts and Crafts (5B)	3.33	33
3.55	30	Knowledge of Governments (38B)	2.33	67
3.22	45	Knowledge of History (38A)	2	84
3.55	30	Knowledge of Physical Education Apparatus & Equipment (26B)	2.5	61

Table 1: cont'd.....

Rating	Rank	Item	Rating	Rank
2.55	74	Knowledge of Physical Geography (39A)	2.33	65
2.22	82	Knowledge of Scientific Facts and Terminology (36A)	2.33	67
2.67	71	Knowledge of Socioeconomic Geography (39B)	2.33	67
4.11	20	Listening Reaction and Response (27A)	3.66	20
2.22	82	Mathematical Problem Solving (17A)	2.83	52
4.44	13	Meaningful Memory (10B)	4	10
3	58	Measurement Reading and Making (19A)	3.66	20
4.55	10	Muscle Control (Physical Education) (24A)	4	10
3.55	30	Music Appreciation (20A)	2.83	52
3.78	25	Music Interest and Enjoyment (20B)	3	44
2.69	71	Music Knowledge (22B)	2	84
2.33	81	Musical Instrument Playing (21B)	1.5	99
1.89	94	Nature and Purpose of Science (36B)	2.5	61
4.55	10	Need Achievement (4A)	3.66	20
4.89	2	Neuroticism-Adjustment (1B)	4.5	3
3	58	Observation and Description in Science (35A)	2.16	81
2.11	86	Operational Definitions in Science (35E)	1.66	96
1.78	94	Operations with Decimals and Percents (16C)	1.83	90
2.22	81	Operations with Fractions (16B)	1.83	90
3.11	52	Operations with Integers (16A)	2.66	55
2.55	74	Oral Comprehension of a Foreign Language (11B)	2.66	55
3.44	35	Oral Reading (29A)	3	44
4.11	20	Penmanship (13E)	3.66	20
3.33	40	Phonetic Recognition (28A)	3.33	33
4.67	8	Physical Development & Well-Being (Physical Education) (24B)	4.16	9
4.78	4	Practicing Health and Safety Principles (23A)	3.33	38
2.19	86	Punctuation (13B)	1.3	106
1.55	106	Reading Comprehension of a Foreign Language (11A)	1.5	99
2.11	86	Recognition of Literary Devices (31B)	1.83	96
2.78	69	Recognition of Word Meanings (30A)	3	44
3.33	40	Relational-Implicational Reasoning (8B)	2.5	61
2.22	45	Religious Belief (34)	3	40
2.67	71	Religious Knowledge (33)	2.5	61
3.33	40	Remembering Information Read (30C)	2.83	14
4	23	Representational Skill in Arts and Crafts (6A)	2.83	52
3.22	45	Research Skills in Social Studies (41A)	2.33	67
4.55	10	School Orientation (3A)	3.5	27
2.89	66	Science Interest and Appreciation (37A)	2.2	80
5	1	Self-Esteem (3B)	4.5	3
4.44	13	Sex Education (23C)	3.83	14
4.44	13	Shyness-Boldness (1A)	3.66	20
2.44	77	Silent Reading Efficiency (29B)	2.66	57
2.33	80	Singing (21A)	2	84
4	23	Social Organization Knowledge (40B)	3.5	27
4.78	4	Socialization-Rebelliousness (2C)	3.83	14
3.11	52	Span and Serial Memory (10A)	2.33	67
3	58	Spatial Memory (10C)	3.5	27
3.67	27	Spatial Reasoning (8D)	3	44
4.33	16	Speaking (27B)	3.66	20
2	89	Speaking Fluency in a Foreign Language (11C)	1.83	90

Table 1: cont'd....

Rating/Rank		Item	Rating/Rank	
3.22	45	Spelling (13A)	2.16	81
2.11	86	Statistics (19B)	1.33	67
2	89	Structural Recognition (28B)	1.83	90
2	89	Summarizing Information for Reference (14B)	1.66	96
2	89	Systematic Reasoning (8C)	2.33	67
4.89	2	Understanding Health and Safety Principles (23B)	4.33	7
2.89	66	Understanding Ideational Complexes (30B)	3.5	27
3.44	35	Understanding of Rules and Strategies of Sports & Games(26A)	2.83	52
2.44	78	Use of Data Sources as Reference Skills (14A)	2.16	81
1.78	94	Use of Numbers and Measures in Science (35B)	2.5	61
1.67	108	Writing Fluency in A Foreign Language (11D)	1.33	103
3.33	40	Written Expression (13F)	3	44

Table 2: Part One of the Adaptive Behaviour Scale (adaptive behaviour domains)

Part One of the Adaptive Behaviour Scale is organized along developmental lines, and is designed to evaluate an individual's skills and habits in ten behaviour domains (coherent groups of related activities) considered important to the development of personal independence in daily living. The ten behaviour domains (indicated by Roman numerals) and twenty-one subdomains (indicated by letters) are:

1. INDEPENDENT FUNCTIONING

   A. Eating
   B. Toilet Use
   C. Cleanliness
   D. Appearance
   E. Care of Clothing
   F. Dressing and Undressing
   G. Travel
   H. General Independent Functioning

11. PHYSICAL DEVELOPMENT

   A. Sensory Development
   B. Motor Development

111. ECONOMIC ACTIVITY

   A. Money Handling and Budgeting
   B. Shopping Skills

1V. LANGUAGE DEVELOPMENT

   A. Expression
   B. Comprehension
   C. Social Language Development

V. NUMBERS AND TIME

V1. DOMESTIC ACTIVITY

   A. Cleaning
   B. Kitchen Duties
   C. Other Domestic Activities

V11. VOCATIONAL ACTIVITY

V111. SELF-DIRECTION

   A. Initiative
   B. Perseverance
   C. Leisure Time

1X. RESPONSIBILITY

X. SOCIALIZATION

Table 3: Part Two of the Adaptive Behaviour Scale (maladaptive behaviour domains)

1. VIOLENT AND DESTRUCTIVE BEHAVIOUR
11. ANTISOCIAL BEHAVIOUR
111. REBELLIOUS BEHAVIOUR
1V. UNTRUSTWORTHY BEHAVIOUR
V. WITHDRAWAL
V1. STEREOTYPED BEHAVIOUR AND ODD MANNERISMS
V11. INAPPROPRIATE INTERPERSONAL MANNERS
V111. UNACCEPTABLE VOCAL HABITS
1X. UNACCEPTABLE OR ECCENTRIC HABITS
X. SELF-ABUSIVE BEHAVIOUR
X1. HYPERACTIVE TENDENCIES
X11. SEXUALLY ABERRANT BEHAVIOUR
X111. PSYCHOLOGICAL DISTURBANCES
X1V. USE OF MEDICATIONS

Table 4: Sample Questions from the Adaptive Behaviour Scale

Question 20 (from Independent Functioning Domain)

Telephone (check all statements which apply)

Uses telephone directory	____
Uses pay telephone	____
Makes telephone calls from private telephone	____
Answers telephone appropriately	____
Takes telephone messages	____

Question 43 (from Numbers and Time Domain)

Time concept (check all statements which apply)

Names the days of the week	____
Refers correctly to "morning" and "afternoon"	____
Understands difference between day-week, minute-hour, month-year, etc...	____
None of the above	____

Question 61 (from Socialization Domain)

Consideration for others (check all statements which apply)

Shows interest in the affairs of others	____
Takes care of others belongings	____
Directs or manages the affairs of others when needed	____
Shows consideration for others' feelings	____
None of the above	____

Table 5: Data Summary - Adaptive Behaviour Scale

ABS Domains	Outpatients (Forward House)		In-Patients (Douglas Hospital)										Published Norms for the Retarded ++	
			Differentiated Schizophrenics		Undifferentiated Schizophrenics		Affective Disorders		Organic Syndromes		Retarded			
	$\bar{x}$	s.d.	$\bar{x}$	s.d.	$\bar{x}$	s.d.	$\bar{x}$	s.d	$\bar{x}$	s.d.	$\bar{x}$	s.d	$\bar{x}$	s.d.
Independent Functioning	98.4 (102)	8.4	73.6 (78)	19.1	75.4 (80)	17.1	82.3 (88)	25.9	74.0 (78)	20.4	57.0 (57)	21.6	82.5 (87)	19.0
Physical Development	23.8 (24)	.7	20.0 (20)	3.2	20.6 (21)	2.9	19.4 (21)	4.5	19.2 (19)	3.2	18.6 (19)	3.1	21.7 (22)	3.0
Economic Activity	15.3 (15)	1.8	8.0 (9)	5.2	8.2 (8)	4.9	10.2 (12)	6.9	7.4 (8)	5.5	3.5 (1)	4.5	5.0 (5)	5.0
Language Development	34.2 (35)	3.1	23.7 (25)	9.0	25.4 (25)	8.5	29.3 (29)	8.9	24.6 (25)	9.9	15.2 (14)	9.0	25.0 (25)	9.0
Numbers and Time	12 (12)	0.	9.5 (12)	3.8	9.9 (11)	3.1	10.9 (12)	2.0	9.0 (11)	4.2	3.8 (2)	4.5	6.0 (6)	4.0
Domestic Activity	13.6 (13)	3.0	5.2 (3)	5.2	5.5 (4)	4.7	8.9 (9)	7.7	5.3 (3)	5.6	2.7 (1)	4.4	8.5 (7)	5.0
Vocational Activity	6.8 (7)	2.0	5.0 (6)	4.2	4.7 (5)	4.3	6.9 (9)	4.7	4.8 (6)	4.4	2.9 (0)	4.0	8.5 (9)	4.2
Self-Direction	12.4 (13)	2.9	10.1 (10)	4.5	9.9 (10)	4.1	13.2 (14)	5.5	11.4 (11)	5.3	8.9 (9)	4.5	16.0 (16)	4.3
Responsibility	7.6 (4)	5.4	2.8 (3)	1.9	2.6 (3)	1.8	4.1 (5)	2.4	2.9 (4)	1.9	1.7 (1)	2.0	3.8 (4)	1.8
Socialization	19.7 (20)	4.1	14.4 (14)	4.8	15.3 (15)	4.4	19.2 (20)	5.2	15.1 (14)	5.4	12.9 (13)	4.8	17.0 (17)	4.7
Total maladaptive behaviour (Part 2 of the ABS)	37.6 (34)	20.5	49.4 (41)	36.6	47.5 (40)	28.7	27.3 (20)	16.4	37.2 (35)	27.6	53.0 (41)	39.8	-	
Total number of patients	45		194		49		18		46		62		458	

N.B. Medians given in parentheses.

++ The means and standard deviations shown for the normative retarded population are approximations based on published percentile data. The medians shown are exact.

Table 6: Data Summary - Nurses Observation Scale for In-patient Evaluation (NOSIE)

NOSIE Factors	Outpatients Forward House		Inpatients (Douglas Hospital) Differentiated Schizophrenics		Undifferentiated Schizophrenics		Affective Disorders		Organic Syndrome		Retarded	
	$\bar{x}$	s.d.	$\bar{x}$	s.d.	$\bar{x}$	s.d.	$\bar{x}$	s.d.	$\bar{x}$	s.d.	$\bar{x}$	s.d.
Social Competence	40.8 (41)	2.2	38.1 (38)	4.5	38.3 (38)	3.9	40.4 (42)	3.9	37.3 (39)	5.0	35.8 (36)	5.1
Social Interest	36.8 (37)	4.4	32.0 (32)	4.5	32.3 (31)	4.7	34.4 (33)	4.6	33.6 (34)	4.9	32.4 (32)	5.1
Personal Neatness	31.6 (32)	4.1	29.3 (30)	4.8	29.0 (31)	5.0	30.9 (32)	4.5	30.1 (31)	4.6	28.0 (28)	4.6
Irritability	37.5 (37)	5.8	38.4 (38)	5.4	36.6 (36)	4.5	36.2 (35)	3.9	38.4 (37)	5.1	39.1 (39)	5.2
Manifest Psychosis	22.8 (22)	2.9	24.4 (24)	3.3	24.2 (24)	3.5	21.7 (21)	2.8	22.9 (21)	3.4	24.2 (24)	3.0
Inactivity	18.7 (18)	2.7	19.3 (19)	2.9	19.7 (19)	3.0	19.7 (19)	2.8	19.2 (19)	3.2	19.6 (19)	2.7
Depression	17.6 (17)	2.3	16.6 (16)	2.0	16.4 (16)	1.7	17.4 (17)	2.2	16.0 (16)	1.4	16.3 (16)	1.3
Total Number of Patients	45		194		49		18		46		62	

N.B. Medians given in parentheses.

References

1.) Jones, M., The Therapeutic Community - A New Treatment Method in Psychiatry, New York, Basic Books, 1953

2.) Jones, M., "Intra and Extramural Community Psychiatry", American Journal of Psychiatry, 117, 1961, pp. 784 - 787

3.) Braceland, F.J., "Rehabilitation", American Handbook of Psychiatry, Vol. V. (2nd ed.), Arieti, S., (ed), New York, Basic Books, 1975, p. 686.

4.) Braceland, F.J., "Rehabilitation", pp. 688 - 689

5.) Gunderson, J.G., & Mosher, L.R., "The Cost of Schizophrenia", American Journal of Psychiatry, 1329, 1975, p. 905

6.) Pilon, W., & Marcotte, C., "The Semi-Community Environment and the Reintegration of the Psychiatric Resident: Present Status and Outlook for the Future", Canada's Mental Health Suppl., vol. 24, 1976, pp. 40 - 41.

7.) De Falco, M.L., "The Rehospitalization of Discharged Schizophrenic Patients", Prospectives in Psychiatric Care, vol. XIII (3),1975, pp.130,135.

8.) Dr. F. Fenton (recent home care study - Montreal General Hospital).

9.) Littmann, S.K., "Schizophrenia & Rehabilitation", Canada's Mental Health Suppl., vol. 24, 1976, p. 10.

10.) Braceland, F.J., "Rehabilitation", p. 687.

11.) Canadian Commission for UNESCO, Occasional Paper 34, "Recommendations on the Development of Adult Education", February, 1980, p. 2.

12.) Ibid., p. 4

13.) Ibid., p. 4

14.) Quebec, Les Collèges du Québec: Nouvelle Etape, Projet du Governement à l'endroit des CEGEP, Ministère de L'Education, Québec, 1978, p. 21.

15.) Johnston, L.M., "The Role of Adult Basic Education in an Urban Community Psychiatric Hospital", Ph.D. Thesis, 1977, University of California, Los Angeles, pp. 90 - 100.

16.) Spiegler, M.D., "Classroom Approach Teaches Patients Independence Skills", Hospital and Community Psychiatry, vol. 24, No. 4, April, 1973,p. 216

17.) Mateer, W., "From Patients to Pupils to People", Mental Hygiene, vol. 56, winter, 1972, pp. 58 - 67.

18.) Hewett, F.M., "Establishing a School in a Psychiatric Hospital", Mental Hygiene, vol. 51, 1967, pp. 275 - 283

19.) Lamb, H.R., "An Educational Model for Teaching Living Skills to Long-Term Patients", Hospital and Community Psychiatry, vol. 27 (12), December, 1976, pp. 875 - 876.

20.) Ibid., p. 877

21.) Johnston, L.M., "The Role of Adult Basic Education in an Urban Community Psychiatric Hospital", p. 92.

22.) Ibid., p. 92

23.) Mosher, L.R., "Recent Trends in Psychosocial Treatment of Schizophrenia", The American Journal of Psychoanalysis, vol. 32, 1972, pp. 543 - 551.

24.) Black, B.J., "Rehabilitation of Schizophrenia", Psychiatric Quarterly, vol. 50 (4), 1978, pp. 307 - 319.

25.) Lamb, H.R., & Goertzel, V., "High Expectations of Long-Term Ex-State Hospital Patients", American Journal of Psychiatry, vol. 192, No. r, 1972 pp. 471 - 475.

26.) Honigeld, G., Gillis, R.D., Klett, C.J., "NOSIE - 30: A Treatment-Sensitive Ward Behaviour Scale", Psychological Reports, vol. 19, 1966, pp. 180 - 182.

Bibliography

Anthony, W.A., & Margules, A., "Toward Improving the Efficacy of Psychiatric Rehabilitation: A Skills Training Approach", Rehabilitation Psychology, vol. 21 (3), 1977

Bakker, C.B., & Armstrong, H.E., "The Adult Development Program: An Educational Approach to the Delivery of Mental Health Services", Hospital and Community Psychiatry, vol. 27, No.5, May, 1976.

Black, B.J., "Rehabilitation of Schizophrenia", Psychiatric Quarterly, vol. 50 (4), 1978.

Braceland, F.J., "Rehabilitation", American Handbook of Psychiatry, vol. V (2nd ed.), Arieti, S., (ed), New York, Basic Books, 1975.

Brozost, B.A.,"Psychiatric Community Residences: A Review of Past Experiences", Psychiatric Quarterly, vol. 50 (4), 1978.

Calhoun, J.P., "Modifying the Academic Performance of the Chronic Psychiatric Patient", Journal of Consulting and Clinical Psychology, vol. 42, No. 4.

Canadian Commission for UNESCO, Occasional Paper 34, "Recommendations on the Development of Adult Education", February, 1980.

Cheadle, A.J., & Morgan, R., "The Measurement of Work Performance of Psychiatric Patients: A Reappraisal", British Journal of Psychiatry, vol. 120 (557), April, 1972.

Colten, S.I., & Langlois, J., "Development of a Screening Scale for Programming Psychiatric Rehabilitation", Psychological Reports, vol. 37, 1975.

Cottery, S.I., & Langlois, J., "Development of a Screening Scale for Programming Psychiatric Rehabilitation", Psychological Reports, vol. 37 (1), August, 1975.

De Falco, M.L., "The Rehospitalization of Discharged Schizophrenic Patients", Prospectives in Psychiatric Care, vol. XIII (3), 1975.

Ethridge, D.A., "Pre-Vocational Assessment of Rehabilitation Potential of Psychiatric Patients", American Journal of Occupational Therapy, vol. 22(3), 1968.

Fried, S.R., & Duskes, J., "A Low-Cost Rehabilitation Center for Chronic Patients", Hospital & Community Psychiatry, vol. 23, 1972.

Geisert, M.M., "A Study of Two Heterogeneous Educational-Level Groups in a Participation-Training Program of Adult Education: An Experiment in a Mental Hospital", Ed. D. Thesis, 1965, Indiana University, Bloomington.

Griffiths, R.D.P., Hodgson, R.; Hallam, R.; "Structured Interview for the Assessment of Work-Related Attitudes in Psychiatric Patients: Preliminary Findings", Psychological Medicine, vol. 4, 1974.

Gunerson, J.G., & Mosher, L.R., "The Cost of Schizophrenia", American Journal of Psychiatry, 1329, 1975.

Hewitt, F.M., "Establishing a School in a Psychiatric Hospital", Mental Hygiene, vol. 51, 1967.

Hewitt, F.M., "A Hierarchy of Educational Tasks for Children with Learning Disorders", Exceptional Children, December, 1964.

Holmes, T.H. & Rabe, R.H., "The Social Readjustment Rating Scale", Journal of Psychosomatic Research, vol. 11, 1967.

Honigfeld, G., Gillis, R.D. and Kleth, C.J., Nosie - 30: A Treatment-Sensitive Ward Behaviour Scale, Psychological Reports, 1966, 19, 180 - 182.

Johnston, L.M., "The Role of Adult Basic Education in an Urban Community Psychiatric Hospital", Ph.D. Thesis, 1977, University of California, Los Angeles.

Jones, M., "Intra and Extramural Community Psychiatry", American Journal of Psychiatry, 117, 1961.

Jones, M., The Therapeutic Community - A New Treatment Method in Psychiatry, New York, Basic Books, 1953.

Lamb, H.R., "An Educational Model for Teaching Living Skills to Long-Term Patients", Hospital & Community Psychiatry, vol. 27 (12), December, 1976.

Lamb, H.R., & Goertzel, V., "High Expectations of Long-Term Ex-State Hospital Patients", American Journal of Psychiatry, vol. 192, No. 4, 1972.

Liberman, R.P.; Fearn, C.H.; De Risi, W.; Roberts, J., Carmona, M.; "The Credit-Incentive System: Motivating the participation of patients in a day hospital", British Journal of Social & Clinical Psychology, vol. 16,1977.

Linn, M.W., Caffey, E.M., Klett, C.J., Hogarty, G., "Hospital vs. Community (Foster) Care for Psychiatric Patients", Arch Gen Psychiatry, vol. 34, January, 1977.

Littmann, S.K., "Schizophrenia & Rehabilitation", Canada's Mental Health Suppl., vol. 24, 1976.

Maloney, M., & Steger, H., "Intellectual Characteristics of Patients in an Urban Community Mental Health Facility", Journal of Consulting and Clinical Psychology, vol. 38, No. 2, 1972.

Mateer, W., "From Patients to Pupils to People", Mental Hygiene, vol. 56, winter, 1972.

McDevitt, S.C., Smith, P.M., Schmidt, D.W., & Rosen, M., "The Deinstitutionalized Citizen: Adjustment and Quality of Life", Mental Retardation, vol. 16 (1), February, 1978.

Morissette, P., "Taking a Second Look at Psychiatric Treatment: Therapy is not Enough", Hospital and Community Psychiatry, vol. 26, No. 1, January, 1975.

Mosher, L.R., "Recent Trends in Psychosocial Treatment of Schizophrenia", The American Journal of Psychoanalysis, vol. 32, 1972.

Nair, N.P.V.,"Drug Therapy of Schizophrenias in the Community", The Journal of Orthomolecular Psychiatry, vol. 6 (4), 1977.

Nihira, K.,"Dimensions of adaptive behaviour in institutionalized mentally retarded children and adults: developmental perspective," American Journal of Mental Deficiency, 1976, 81, pp. 215 - 226.

Ozarin, L.D., & Sharfstein, S.S., "The Aftermaths of Deinstitutionalization: Problems and Solutions", Psychiatric Quarterly, vol. 50 (2), 1978.

Pilon, W., & Marcotte, C., "The Semi-Community Environment and the Reintegration of the Psychiatric Patient: Present Status and Outlook for the Future", Canada's Mental Health Suppl., vol. 24, 1976.

Quebec, Les Collèges du Québec: Nouvelle Etape, Projet du Gouvernement à l'endroit des CEGEP, Ministère de L'Education, Québec, 1978, p. 21.

Safier, D., "Using an Educational Model in a Sheltered Workshop Program", Mental Hygiene, vol. 54 (1), 1970.

Schachter, M., Rice, J.A., Cormier, H.G., Christensen, P.M., and James, N.J., "A Process for Individual Program Planning based on the Adaptive Behaviour Scale", Mental Retardation, 1978, 16, pp. 259 - 263.

Shepherd, G., "Social Skills Training: The Generalization Problem - Some Further Data", Behaviour Research Therapy, vol. 16 (4), 1978.

Spiegler, M.D., "Classroom Approach Teaches Patients Independence Skills", Hospital and Community Psychiatry, vol. 24, No. 4, April, 1973.

Spiegler, M.D., & Haig, A., The Community Training Center: An educational-behavioural-social systems model for rehabilitating psychiatric patients, Brunner/Mazel, New York, N.Y., 1977.

Sturm, I.E., & Lipton, H., "Countering Defeatism in a Psychiatric Vocational Placement", Mental Hygiene, vol. 55 (2), 1971.

Sylph, J.A., Ross, A.E., and Kedward, H.B., Social disability in chronic psychiatric patients, American Journal of Psychiatry, 1977, 134: 12, pp. 1391 - 1394.

Wilson, J.D., Is the term "adaptive behaviour" educationally relevant?, Journal of Special Education, 1972, 6 (1), pp. 93 - 95.

Why I Like School

I like coming to School for learning. I like to thank mrs. kift. I like my teacher. I like the room, break-time is fine, fine, fine.

Thanks.

What School Means to Me

I like School. I learn to rea and write. I learn to do Math. I like the students in the School. We talk about School and other things.

Coming to school makes me happy I'm happy to be with the other students. I'm happy to learn to read. I'm very smart to learn to read in school. I feel bad when the School is on strike.

Marion Kift is a nice lady. I feel bad. She is leaving School.

Why I Like School

I like school. I want to get out of here. I love school. I used to hate school when I was a kid. But now I love school. Now I'm trying to help myself. I love to do things myself like Bonnie does. I can read now, understand too. Sometimes I don't understand and some people hurt m by saying things. Now I can do numbers - add, take-away, times and divide. It's very, very good. I kno the letters of the alphabet. I kn the days, and the months. I am ver better than I was. I couldn't

understand before, I couldn't speak But now I'm speaking - I can talk now. Some people say I can talk, and that hurts me hard inside and I cry. It's a nice house, a good place. I am very better.

April 23, 1980.

What School Means to Me

Thank-you for starting this school for us. To me school is important. In society you have to learn to read, to do math, to spell, to write and many other things that are necessary to get a job. Sometimes school is boring. Before I went to this school I was at Chomedey High School and I wasn't interested in doing my homework. So this place means alot to me. The teachers can pay attention to me. There are not too many people in each class and I am given a chance to do well. In the other school people were a bad influence on me because of drugs and alcohol. Here people are helped with their problems. Therefore the school helps me alot. So thank you for bringing the teachers together and making one big family! Thank-you for starting this program for the patients. Its good to get away from the ward.

My Opion Of School.

I was very impressed with school when I first came across it. The atmosphere was very inviting. I had no reason to hate it. As a matter of fact it was wonderful. Many of the students have many problems. The teachers have helped me out immensely. I have a new outlook on life. The school has inspired me very much. I enjoy the reading material I enjoy the ~~teachers~~ I enjoy coffee break because it gives me the chance to talk to other people.

I hope to return next year.

What School Means to me

School is a lot of work and a lot of fun.
I learn to read. Spell. Write and do math.
I made Some good friends.

What School Means To Me

I love school because it makes me feel better. I like biographies and spelling. I like Paul Dolan to teach me algebra. In my opinion a drop out is a bum. I also think that someone who doesn't want to finish school and refuses to finish school is a lazy good for nothing bum.

They are my only friends in school, except for a few people on my ward. I am able to get my opinions across. People listen to me to hear what I want to say.

School makes me feel good. I learn a lot of lessons in school. Next year I would like longer hours in school. Also I would like harder subjects.

WHAT SCHOOL MEANS TO ME

SCHOOL IS IMPORTANT.
I LEARN TO GET ALONG WITH OTHERS.
IT IS PLEASANT TO COME TO SCHOOL
BECAUSE I ENJOY IT. IT MAKES
MY DAY INTERESTING. AND FUN.
I LIKE MY TEACHER. SHE IS A
LOT OF FUN. I HAVE LEARNED TO
READ AND WRITE. IN THE LONG
RUN I HAVE LEARNED A LOT!

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What School Means to Me

School is interesting. I learn to read, to write, to spell & to do Math. The teacher's are taking the time to teach us. We help one another. I knew school would be hard & I had to really think about it. I am working hard & doing very well. It's Work it!

What School Means to Me

I feel happy going to school. I like reading and I like writing. I like to do arithmetic. I like the teachers here very much. They work very hard to teach us lessons. The teachers and the students work together in groups. We help each other. The teachers have lots of patience. When I came here I could read but there were lots of words I didn't know. I feel very happy coming here because I am learning to read and write.

Before I came here I was miserable. When I'm taking the bus to go home I see men and women who work in the office. I would feel very happy if I could work in the office or a bank

I think that school is a Good start for someone that really needs something in life. you learn how to read and write and do math and spelling. a very importand thing is that you meet people who help you you can help them. An education will bring you somethings, like a Good job and very important people Some people think that education is for the pits, that is not true. Education is just not for a job always. It brings you knowledge and maturety. the main thing it brings you is to knowing the would better knowing your fuelinds, and especially knowing your own kids who come in to this would. you can tell your kids what is good for your them and what is bad for them. as they grow up they decide fore them selves the world is changing and you are maturing. I like going to school. It helps me alot. I want to fit in to this would and have a good job, and have close fueinds. I dont know what I want as an education, but when the times comes I will decide. I think this school is a start for someone who doesn't know about things and who will like it to know it better. It is for someone who doesn't know what is going on out side. because he has been in the hospital along time. It helps them to get out really fast. I thank you for starting this school for the patientes. It will help them in life. I wish you the very best in your new job. Enjoy your life as it comes. Thank you mrs hift and good luck.