McGill University

SOCIAL SERVICE IN THE PSYCHIATRIC DIVISION OF A GENERAL HOSPITAL:

A study of fifty-three patients of the Allan Memorial Institute of Psychiatry, Montreal, from 1950 to 1953.

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by

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PREFACE

The writers are grateful to Dr.D. Ewen Cameron, Psychiatrist-in-Chief, Allan Memorial Institute of Psychiatry, for permission to use all the facilities of the hospital. Special thanks are due to Mrs. Phyllis Poland, Chief Psychiatric Social Worker, Allan Memorial Institute, who facilitated this research project by making the records of her department readily available. For their sincere interest and valuable help the writers wish in particular to thank Dr.John J.O. Moore, Director, McGill School of Social Work and Miss Eva R. Younge of the McGill School of Social Work.

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CHAPTER I

INTRODUCTION

This is a study of the Social Service Department of the Allan Memorial Institute of Psychiatry[1] which is a division of the Royal Victoria Hospital, Montreal. The focus is primarily on two aspects of the function of this department-- treatment of patients and/or relatives, and discharge planning with patients and/or relatives. It is the hope of the researchers that the study should be useful to others in the field. There is a growing trend toward the treatment of emotional illness in psychiatric units of general hospitals. We would hope that people involved in setting up such units would find this material useful.

The study was undertaken at the suggestion of personnel of the Social Service Department that it would be useful to them as a means of consolidating their thinking about the department's functions. Although there is a good deal of literature available on the functions of social service departments in psychiatric hospitals, this literature has not been found by the Social Service Department of A.M.I. to be entirely adequate. The A.M.I. is a psychiatric ward of a general hospital; and it was suggested that as such, it has certain features which differentiate it from a commitment hospital; consequently, material which is useful to a social service department in the latter setting frequently does not apply to the A.M.I.

The study is aimed at an understanding of the above functions, and to see if they are affected by any particular features of the setting, and if so, how.

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1. Hereafter referred to as A.M.I.

Development of Psychiatric Treatment in the General Hospital

It is only within the past twenty years that psychiatric wards of general hospitals have come into being:

> "Generally speaking, psychiatric units in general hospitals are a comparatively recent development as compared to the earlier establishment of psychiatric hospitals and independent psychiatric clinics. The first psychiatric department in a general hospital was organized in 1934. State hospitals, child guidance clinics and psychiatric clinics for adults had been operating for many years prior to this. Many more psychiatric services have been established in general hospitals since 1934, but most of them have come into being within the last 10 years. The units are in general newcomers to the hospitals within which they operate. All such psychiatric facilities, in contrast to psychiatric hospitals and clinics, work within a larger organization which is not primarily geared to the treatment of psychiatric disturbances but toward medical illness." [1]

The changes in the type of institutions provided for the mentally ill result from a new way of thinking about mental illness. Albert Deutsch[2] has traced the development of thinking in this field. In earlier days, according to Deutsch, those who were mentally sick were believed to be possessed, and elaborate rites of exorcism were performed over them to drive out the devils. They were chained in cages and kennels, whipped regularly at the full of the moon and hanged as witches. In early America the only public institutions provided for them were the almshouses and prisons. At this time, they were sometimes "bid off" as paupers on the auction block or exhibited like animals in a menagerie before crowds who paid admission fees. It was only as scientific advances were made in the field of psychiatry that mental illness began to be considered as

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1. Perry, Sylvia, "Implications from the Viewpoint of Psychiatric Social Work in General Hospitals," Journal of Psychiatric Social Work, Vol. 21, No.2, (December, 1951), p.107.

2. Deutsch, Albert, The Mentally Ill in America, (New York, 1949), p.517.

a disease entity with certain causes, rather than just a mysterious affliction, and that the first attempts were made to cure the mentally ill:

> "The clinical attack gained toward the end of the 19th century, when Emil Kraepelin introduced a new system of classification that served as an important stepping-stone to further progress."[1]

When Kraepelin came into the picture, psychiatry was dominated by the loose, oversimplified classification of Pinel, which divided mental diseases into mania, melancholia and demantia. While Kraepelin's classification, like those of his predecessors, was based on symptoms rather than causes, it did take account of the whole course of a disease even when characterized by changes in syndromes.

Freud made tremendous advances in the understanding of man's emotional life and its effect upon behaviour and upon physical conditions. An entirely new approach to the concept of illness began to develop:

> "Thus the concept of illness as a diseased organ gradually gave way to the admission of the obvious fact that the separation of the organ from the person, and the person from the organ, was highly artificial. The patient became a person and was recognized as the unit of practice. The word 'psychosomatic' came into wide use and now threatens to establish an entity of its own. This term recognizes the fact that psyche and soma, mind and body, are one."[2]

With the growing awareness of these two facts-- first, that mental illness like other forms of illness, could be treated and perhaps cured, and secondly, that there can be no sharp distinction between the physical and emotional life of the individual, there has come an increased interest by the medical profession in the mentally ill and provision of

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1. Ibid, p.485.

2. Richardson, Henry, Patients Have Families, (New York, 1945), p.73.

wards for their treatment within the framework of the general hospital.

It was this new way of thinking about mental illness that gave rise to the development of social service departments in psychiatric hospitals. As Lowrey[1] points out, the liaison between social work and psychiatry is a comparatively recent development. Social workers have been employed in commitment hospitals for only a little more than thirty years; training, leading to a diploma in psychiatric social work, has been in existence for somewhat less than thirty years. The liaison came about only as psychiatrists began to see the importance of environmental factors and interpersonal relationships in the development of the illness of their patients .

The Allan Memorial Institute of Psychiatry

The A.M.I. was first opened in 1944. It treats emotionally and mentally disturbed patients whose illness is considered amenable to short-term treatment. Like other units of the hospital, but unlike many psychiatric institutions, the A.M.I. is a voluntary hospital. This means that patients are admitted only with their consent and cannot be detained for treatment against their wishes. The Institute was set up to provide psychiatric treatment, to offer teaching opportunities and to carry on research. As accomodation is limited to sixty-five beds,[2] patients are selected on the basis of treatability, and occasionally consideration is given to the teaching opportunities which a particular

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1. Lowrey, Lawson G., Psychiatry for Social Workers,(New York, 1950), Preface.

2. Facilities for an additional fifty patients will be ready by October, 1953.

case may offer. The research department of the A.M.I. is under the jurisdiction of McGill University, but it works in co-operation with other departments of the hospital.

The Institute has three wards-- one for women, one for men, and a day ward where patients of both sexes are accepted. The third ward was set up as a day ward to permit the treatment of a larger number of patients than would otherwise be possible. Here patients come for treatment during the day and return to their homes at night. It has been found that this plan has advantages beyond the original one in mind. Certain patients can be treated more effectively in this manner than they could be as in-patients. They are the people for whom continued contact with their everyday environment is advantageous during the course of treatment. At times the day ward is effectively used in helping a patient become accustomed to the hospital so that he can accept treatment on an in-patient basis. Conversely, it is occasionally used to help a patient separate from the hospital and gradually move back to his usual environment.

Treatment includes psychotherapy, in conjunction with physical forms of treatment, such as electro-convulsive and insulin therapy, nitrous oxide, pervitin treatment, and hormone injections. More recently, adrenocorticotropin hormone injections have been used experimentally as a result of work in the research department.

The philosophy of the hospital is that of the "total push." By that is meant that every member of the hospital staff from the doctor to the orderly is concerned with the physical and emotional

welfare of the patients. For example, nursing care at A.M.I. is here required less for physical needs than is the case in the other divisions of the hospital; at the same time, the relationship of nurses to the patients is of major importance. Nurses form an important part of the patients' hospital environment; their attitudes to patients and their relationships with them promote the atmosphere of understanding and acceptance which is essential to treatment. In some instances it has been the lack of these factors during the patients' earliest years which has been a contributing element in his illness; and this may be the first experience the patient has known of complete acceptance of himself as an individual.

The psychology department of the A.M.I. studies the patient by means of a battery of standardized tests which are given upon admission. The actual tests given depend somewhat upon the specific problem that needs to be clarified in a particular patient. The psychologist uses these tests to arrive at a psychological evaluation of the personality structure of the patient and of his intellectual assets and liabilities. From the results of these tests the examiner can make an objective appraisal of qualitative and quantitative deviations from the norm. These findings are used, along with the clinical history and various physical and laboratory tests, to understand the dynamics of the patients' behaviour or symptoms. This information is helpful to the doctor when he approaches the patient in psychotherapy. The information is also useful to the social worker for it provides objective material illustrative

of the patient's reaction to his environment.

The Social Service Department of the A.M.I. was established in 1945. At present it is a part of the Social Service Department of the Royal Victoria Hospital and under the Director of Social Service of the Royal Victoria Hospital. At the time the material for this study was collected, the staff consisted of a case work supervisor and three full-time case workers, as well as one full-time group worker. There were also five social work students, supervised by a faculty member of the McGill University School of Social Work.

The Role of the Social Worker in Psychiatric Treatment

There is agreement on certain specific responsibilities which, by and large, apply to all psychiatric social workers.

In general, according to French,[1] the role of the psychiatric social worker includes the following activities: a) evaluating the patient's social situation as it relates to his present situation; b) interpreting the patient's illness to his family and explaining the recommendations of the psychiatrist; c) aiding the patient and his family in working out a more adequate social adjustment; d) interpreting the hospital's program to other social agencies and sharing in the hospital's educational program; and e) assuming responsibilities in co-operative treatment with the psychiatrist.

A more recent attempt to clarify the role of the psychiatric social worker in the psychiatric hospital was undertaken by the Group

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1. French, Lois, Psychiatric Social Work, p.188.

for the Advancement of Psychiatry.[1] Their report points out that psychiatric social work is social case work practiced in a psychiatric setting. The G.A.P. report also lists a variety of responsibilities which are related to the psychiatric social worker's role and function.[2]

Prior to discussing the functions of the psychiatric social worker in the psychiatric hospital, as outlined by the G.A.P. report, some mention should be made of the general function of the case worker in light of the statement that psychiatric social work is social case work practiced in a psychiatric setting.

The social case worker deals with a wide range of social and personal problems such as unemployment, poor housing, need for money, need for medical care, need for help in planning care of children, and need for help with disturbed inter-personal relationships. Whether the individual's problem originates in, or is complicated by, the external situation, the social case worker may be called upon to render various services which meet practical reality needs. Along with offering concrete services, the case worker may assist the individual in the following ways:

a) by helping him to clarify his indecision, or to discharge feelings and also to understand feelings which are obstructing constructive action or inducing destructive action or inducing destructive behaviour,
b) by helping him to understand his situation better,
c) by helping other people significant in his life.[3]

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1. Hereafter referred to as G.A.P.

2. Group for the Advancement of Psychiatry, The Psychiatric Social Worker in the Psychiatric Hospital, (January, 1948), p.2.

3. Ibid. p.2.

In order to be able to render these case work services to people in need of them, the case worker must bring to the situation: a) a knowledge and understanding of psychopathology; b) an understanding of the interplay of family life and its implications for the individaul; c) an understanding of community life and its impact on the individual and his family; and d) a comprehensive acquaintance with community resources and skill in using them in service to an individual and his family.

The caseworker must have, as well:

> " an understanding of the helping relationship and its management. This implies understanding what accepting help commonly means to people and becoming acquainted with the various ways in which clients need to use the relationship. It implies, also, considerable self-understanding in order that the social case worker may regulate his own feelings and objectify his own emotional need so that persons dependent upon him for help may derive strength rather than be weakened through the relationship."[1]

The problems dealt with by the social case worker represent the whole gamut of human ills and the areas of learning requisite for a case worker, as outlined, are basically the same, regardless of the type of setting in which the case worker may function.

Having briefly outlined the main generic aspects of social case work we can now turn to an examination of the function of the psychiatric social worker in the psychiatric hospital as outlined in the G.A.P. report.

The psychiatric social worker functioning in the psychiatric hospital, it is said, has important responsibilities in relation to the

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1. Ibid. p.3.

following:

a) Assistance in the interpretation of the hospital's facilities and program to the patient and his family.

b) Assistance to the family with problems arising from the patient's admission to the hospital, amelioration of the family anxieties in relation to the threat of having a mentally ill relative, interpretation to the family of the hospital's treatment procedures.

c) Formulation of plans, with the assistance of other community agencies, which might make admission less urgent or occasionally prevent unnecessary or ill-advised admissions.

d) Establishing a relationship with the family which will encourage them to maintain a positive, non-rejecting attitude throughout the period of care, and ultimately helping them to receive the returning patient with understanding and acceptance.

e) Participation with other hospital personnel in explanation of routine hospital and medical procedures.

f) Helping the patient to understand that the worker serves as a link between him, his family and the community. Thus the social worker will assist in maintaining and preserving the patient's family and community ties.[1]

From the foregoing summary of the characteristics of the psychiatric social worker's role, it can be seen that the major emphasis is the social environment of which the family is the central and most important unit.

While psychiatric social workers are employed in most psychiatric hospitals, the role and function of the psychiatric social worker varies from one hospital setting to another. This variation in role makes it difficult to provide a definition of the psychiatric social worker's function which would apply to every setting in which he may be employed.

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1. Ibid. p.4.

However, these broad functions themselves or the way they are carried out may be modified by the characteristic of voluntary admission, as well as the purposes of the hospital; treatment, teaching and research, and possibly others. It is the middle ground between these broad functions and the minute variations from hospital to hospital that is the area of interest in this inquiry.

SUMMARY

The focus of this thesis is primarily on two aspects of the Social Service Department of A.M.I., treatment of patients and/or relatives and discharge planning with patients and/or relatives.

Because there is a growing trend toward treatment of emotional illness in psychiatric units of general hospitals, it is hoped that this study will be of use to others in the field. It was undertaken at the suggestion of the head of the Social Service Department at A.M.I. as a means of consolidating thinking about the department's functions. It would seem particularly useful since the literature which applies to such a setting is limited. The study is aimed at understanding the above functions and to see whether they are affected in any way by the particular features of the setting and if so, how.

Pyschiatric units of general hospitals have only come into being in the last thirty years. This is in line with the concepts of psychosomatic medicine by which man's mind and body is treated as a whole. Prior to 1934, emotional illness was treated primarily in psychiatric hospitals or clinics and there had been a long development toward this from the days when the only institutions provided for these patients were almshouses or prisons. The works of Kraepelin and Freud were key factors accounting for increased growth in the understanding and treatment of emotional illness.

This new way of thinking also gave rise to social service departments in psychiatric hospitals as the importance of environmental factors and interpersonal relations in the development of this illness came to be considered.

The A.M.I., a psychiatric unit of the Royal Victoria Hospital was first opened in 1944. It is a voluntary hospital which treats emotionally and mentally disturbed patients whose illness is considered amenable to short-term treatment. In addition the A.M.I. is a teaching and research centre; and while consideration is given primarily to treatment, cases are also accepted for teaching and investigation purposes. Accomodation is limited to sixty-five beds, with an additional fifty being available by October, 1953. There are three wards, one for men, one for women, and a day ward where patients of both sexes are accepted. In the day ward patients return to their homes at night. In this way they are kept in contact with their environments and may also be helped to become in-patients or to return again to the community.

As well as the actual medical treatment administered at A.M.I., it is considered that everyone on the hospital staff has some responsibility for the patient's treatment, with the Nursing and Psychology Departments playing important roles.

The Social Service Department at A.M.I. is part of the Social Service Department of the Royal Victoria Hospital and under the Director of that Department. At the time this material was collected, staff consisted of a case work supervisor, three full-time case workers and one full-time group worker. There were also five students from the McGill School of Social Work.

In a psychiatric setting, the psychiatric social worker has important responsibilities as regards helping relatives with problems around the patient's illness so that they may maintain a positive

contact with the patient during hospitalization and after discharge; interpretation to them of the hospital's facilities, program and treatment procedure; co-operation with community agencies and help to the patient in maintaining environmental and community ties. However, the role and function of the psychiatric social worker varies from one setting to another so that it is difficult to define the function in terms applicable to every setting; that is, the broad functions may be modified by certain characteristics of the setting. This study is concerned with the middle ground between these broad functions and the variations from setting to setting.

CHAPTER II

THE STUDY

Purpose

In this study we began with the hypothesis that there are certain unique features of a psychiatric unit of a general hospital and that these modify the work of its social service department. In the beginning two questions presented themselves to us; namely, what are the characteristics of the psychiatric unit of a general hospital as distinctive from a commitment hospital, and what the implications of these characteristics would be for a social service department within this setting. At that time we were able to identify certain features which seemed either obvious or likely to be found in such a setting. These features were:

1. the voluntary nature of the patients' confinement,
2. treatment limited to a specific short period of time,
3. restricted admissions to those with favourable prognosis for recovery,
4. operation of a day treatment program,
5. teaching and research functions,
6. higher ratio of staff to patients.

We realized, however, that although these were probably characteristics of the setting in which our study was to be made, it would be difficult to establish that they were specifically unique to psychiatric wards of all general hospitals. To establish them as such would require a comparative study of several psychiatric wards of

general hospitals with several commitment hospitals; to understand their full implications would require a study comparing the social service departments of commitment hospitals with the social service departments of psychiatric units of general hospitals. Moreover, in the beginning stages of the research, we realized that to trace out the positive ramifications of such established features in the work of the social service department would be a delicate task, the results of which would be open to much questioning. It was obvious that neither the time, the personnel, nor the required research experience were at our disposal for studies of this type.

We therefore agreed that while such studies were probably necessary, an initial step of value would be to focus our attention on the work of one established social service department in a psychiatric unit of a general hospital, and to attempt to see, through our understanding of its function, what, if any, special characteristics of its setting influence this function. We did not concern ourselves, in the beginning, however, with the unique features of the setting, but rather we concentrated on developing an understanding of the social service department's function. Nevertheless, throughout our work those features already identified as possibly unique were kept in mind and we found ourselves dealing with them as they emerged from the material studied.

We hope then, that this study will serve as an introductory step toward a clarification of the unique features of a psychiatric unit of a general hospital and how they modify the work of the social service department operating in the setting.

The central question asked in this study is: how does the Social Service Department of A.M.I. function? The general function of the department is recognized as having the following principle aspects: administration, intake, treatment of patients and relatives, co-operation with and interpretation to community agencies, discharge planning and follow-up, the Relatives' Group, teaching and research.

It was evident, however, that all of these aspects could not be included within one study, as each of them seemed worthy of one individual's research, and the research team was comprised of three students only. We decided also, that as students, none of the group were qualified to study the administrative function of the department. Therefore, from the point of view of individual interest we chose from the remaining aspects of the general function: treatment, discharge planning and follow-up, and the Relatives' Group as areas for study.

As the study proceeded, discharge planning and follow-up and treatment appeared to be, in fact, so much of the same process that it was decided to combine them. The confirmation of this interrelatedness may well be viewed as the first important result of the study. Owing to certain inherent characteristics of the Relatives' Group, this examination developed as a fairly independent study. Although it was nevertheless originally intended to be included in and related to this report, the student researcher became ill, and its completion was temporarily postponed.

In summary, the functions studied here are those of treatment, and discharge planning and follow-up, treated as a single area of inquiry.

In studying these functions, the following secondary questions presented themselves:

1) what is the nature of the work load as seen through a general description of the patient?
2) what is the origin of the work load?
3) what is the nature of the work done in terms of relationship with psychiatrists, community agencies, and case work with patients and relatives?
4) how and in what way do specific features of the setting seem to have had a bearing on the above?

Scope and Limitations

As stated above, this study is confined to the Social Service Department of the A.M.I. as one psychiatric unit of a general hospital. It is limited to the functions of the treatment of relatives and/or patients, and discharge planning and follow-up with relatives and/or patients. The section to have been devoted to an examination of the Relatives' Group is necessarily omitted.

The main portion of the study has consisted of the examination of fifty-three cases carried by the Social Service Department of the A.M.I. between the years 1950-1953.

Although the study will have evaluative elements, it is not primarily evaluative but rather primarily descriptive and analytic of the above-mentioned functions of the social service department in one particular setting and as seen through the case records of the department. The main purpose is not to evaluate the department; rather this is an effort to find through case material an illumination of the work in a setting of this kind.

We recognize, too, that in addition to being a study of social work practice as it has developed in one particular setting it also is limited to practice at a particular time with particular personnel, which factors to a certain extent might influence the work of the department. We accept this as the situation operating within a particular frame of reference and valid because of it.

In addition, we are aware that the case records, the examination of which constituted the main line of inquiry, were not primarily prepared for research. As in all such cases, the information available leaves much to be desired for research purposes. Nevertheless, the case records have been taken at face value.

Method

Research Approach

The main methods of research were through the use of library material, examination of original data, consultation with the head of the Social Service Department and joint conference with the research advisor for planning and discussion of procedure and findings.

Steps Followed

The specific steps followed were:

1. discussion of the research problem and limiting the objectives of the study;
2. tentative identification of the distinctive characteristics of the setting;

3. selection of cases for the sample which were considered to be illustrative of the work of the Social Service Department;
4. preliminary reading of cases for the development of points to serve as a basis for a more detailed analysis;
5. development of an outline for study of the cases;
6. analysis of the cases;
7. compilation of data;
8. reporting of data.

The schedule for the study of cases was arrived at in conference with the research advisor, and consisted of an outline covering the questions in a broad way.[1] As we read the cases which had been selected, we found that the material tended to fall into specific categories. By approaching the cases in this way, we were enabled to focus on the dynamics involved so that the material came alive for us as it might not have done had a more detailed plan of point by point analysis been applied.

Sample

The main consideration in the selection of the sample was that we were opening up an area of enquiry, and that we were interested, at least as an end product, in the operation of unique features of the setting. At the same time, it was recognized that procedure in this setting might not be uniform, owing to dearth of personnel, individual differences in approach to work and so on, and a truly representative

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1. See Appendix I

sample might not yield the required information. Therefore, the primary requirement for cases was that they should contain pertinent information rather than that they constitute a representative sample. Thus, the procedure followed was to ask members of the department to select for us those cases which they considered most valuable. The main criteria were that the cases reveal the work of the department in respect to treatment, discharge planning and follow-up for patients and/or relatives, and that these cases reflect the operation of the department. As a result, fifty three cases were obtained which could be used. An additional twenty cases were provided, but were discarded after preliminary examination owing to the fact that, for a variety of reasons, they did not lend themselves to the research.

Analysis

Originally, cases were assigned for two separate functions, namely treatment and discharge planning and follow-up. Thirty seven cases were examined by one researcher, thirty six by another. Twenty of these cases were the same for both researchers. Cases were studied independently until it was decided, largely through discussion of the group of twenty assigned mutually, that treatment and discharge planning and follow-up could be dealt with most effectively as a single function rather than as separate ones.

After a preliminary reading of cases which resulted in a preparation of the schedule or framework for the study, each case was read intensively, with material pertinent to the questions on the schedule being abstracted. The cases were discussed mutually as the research

progressed, common features were identified, and tentative observations regarding the implications for this particular setting made. As to the actual analysis of the material, an effort was made to secure a quantitative description in so far as this was possible, and from there on to study the dynamics of the cases in terms of the main questions asked, the nature of the work done in terms of relationship with psychiatrists and community agencies and the work with patients and relatives. Conclusions were drawn from the material section by section and discussed in conference with the advisor.

Presentation

Wherever possible, quantitative material will be presented in tabular form, with the dynamics in individual cases as related to the research findings being presented through reference to specific case material.

Chapter III will present the origin of the work load as to the source and time of referral.

Chapter IV will describe the nature of the work as regards relationships with psychiatrists and community agencies.

Chapter V will be a further presentation of the work, as regards patients and relatives.

Chapter VI will attempt to show the relationship between the functions of the Social Service Department and what appear to have emerged as the unique features of the psychiatric ward of the general hospital.

CHAPTER III

THE ORIGIN OF THE WORK LOAD

This chapter deals with the origin of the work load of the Social Service Department of A.M.I. with reference to the source and the time of the referral, as seen from the research sample.

It should be pointed out that in this chapter we are concerned with the original referral and the original reason for it rather than the actual work which was later done by the department; that is, the work done will be stated in terms of its relation to the origin of the work load.

Source

An analysis of the material revealed that the work load originated from six different sources, namely: admission interviews and referrals from the Admitting Office, the treatment doctor, the Relatives' Group, social agencies and patients.

By admission interviews are meant those contacts which are established by the Social Service Department with the patient's relatives on the day of admission. They are considered to be part of routine hospital procedure and are for the purpose of helping the relatives with any problems or questions they may have about the patient's illness or treatment. However, due to limitations of staff, only one-third of the admissions can be covered.

The Admitting Office is that part of the hospital where the patient is first received, the formalities of admission attended to and the patient seen by either the Resident or the interne on duty.

The treatment doctor is that person in the hospital who has main responsibility for the patient's treatment.

The Relatives' Group functions as part of the Social Service Department. It consists of a series of meetings which run concurrently throughout the year and which relatives of the patients attend voluntarily. These meetings are held once a week usually after visiting hours for the purpose of discussing general problems related to the patient's illness and hospitalization.

Social agencies include social service departments of other hospitals and psychiatric clinics as well as public and private social agencies throughout the city.

Referrals from patients refers to those hospitalized at the A.M.I. who themselves seek out a contact with the Social Service Department.

TABLE NUMBER I on page 25 indicates the source of referral in the sample, according to diagnosis. It was thought that some significant findings might come out of the referral according to diagnosis. For the purposes of this study, however, nothing conclusive was arrived at and the interest is directed rather to the source of referrals as regards the cross totals.

Admission Interviews

Up until June, 1950, referral to the Social Service Department at A.M.I. was usually made by the doctor treating the patient. At that time the Department inaugurated the process of social intake and reception

Table I

SOURCE OF REFERRAL TO SOCIAL SERVICE DEPARTMENT, ACCORDING TO DIAGNOSIS, OF FIFTY THREE HOSPITAL PATIENTS FROM A.M.I. OF ROYAL VICTORIA HOSPITAL, 1950-1953[a]

Source of Referral	Total	Diagnosis									
		Schizophrenic	Anx. hys.	Depressive state	Mixed psychoneur.	Char. neur.	Alcoholic	Conversion hys.	Man-dep.	Brain damage	Senile psychosis
Total	53	15	13	13	4	1	1	1	3	1	1
Social Service Admission	14	4	4	3	1				1		1
Treatment Doctor	27	6	9	7	2	1	1		1		
Admitting Doctor	5	2		2	1						
Social Agency	2							1		1	
Relatives' Group	4	2		1					1		
Other	1	1									

a. The following tables in this thesis refer to the same group of patients in the same place and time. This reference will not be repeated.

Source: Royal Victoria Hospital records, 1950-1953. This source is the same for all the tables and will not be repeated.

whereby it was planned to have all relatives seen by a social worker upon the patient's admission in order that the social situation might be assessed and further contact planned according to need. The shortage of workers, however, has made it impossible for all relatives to be seen at this time. Nevertheless, according to the 1952 annual report of the A.M.I. it is considered that the majority of the social service cases are now opened on the day of the patient's admission when the relatives are interviewed. The report states:

> " this method of working has proved to be the most effective and to offer the best service both to the patient and to other members of the treatment team. It enables us, first, to obtain and share with the doctor a picture of the patient's environmental problems and assets early in the hospitalization and secondly, to attempt to modify the environment while the patient is away from it. This, of course, makes post discharge planning and rehabilitation more effective."[1]

This is in accordance with a view expressed in 1946 when the importance of working with relatives from the time of the patient's admission was recognized.

> " During the period of hospitalization the social worker in his contact with the home will be able to clear up the family and so prepare the home and its interactions for the reception and the returning of the patient. This preparation must be gradual and should be begun with the patient's admission to hospital in order to obviate the necessity for intensive work at the last moment." [2]

In the fifty three cases upon which this study is based, fourteen were found to have originated in admission interviews. Although these findings appear at first hand to be at some variance with the statement of the

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1. See 1952 Annual Report, A.M.I.

2. Orgel, S.Z., Psychiatry Today and Tomorrow, (New York, 1946), p.411.

1952 report as mentioned above, it should be remembered that the sample covers a three-year period from 1950 to 1953 and indicates the way in which the work of the Department was being carried on at that time, rather than the goal of the Social Service Department as far as the origin of its work load is concerned. This latter point is the important one in relation to this study.

Of these fourteen admission interviews, seven contacts were with husbands or wives of patients and seven with parents, siblings or other family members. In eleven of these cases, contact was continued with the relatives after the admission interview, while in three cases the relative refused further contact with the Social Service Department after the initial interview. In these latter instances it was thought that the relatives' own anxiety about the patients' illness was so intense that it prevented them from taking the help that was offered them. The following case illustrates this point.

> Case Number 1 Mr.S. accompanied his wife from out of town when she was admitted to the A.M.I., and he was routinely seen by a social worker the same day the patient was admitted. From the outset of the contact he was openly hostile to the social worker, tending to deny both the need for his wife's hospitalization and his own importance in being drawn into the treatment program. When Mr.S. returned to his own city the worker kept in touch with him by mail, but on his next visit to the hospital he made it clear that he did not wish any further contact with the Social Service Department.

While we cannot be sure of the effect that Mr.S's attitude may have had on the course of the patient's treatment, it is nevertheless interesting to note the unfavourable events of the treatment period ensuing with the eventual need for the patient's commitment and to speculate whether these may not have hinged, in part, on Mr.S' inability to work through

some of his own feelings about mental illness.

In the eleven cases in which the contact with the relative continued the general effect of the admission interview was clearly beneficial. It is the researchers' impression that the relatives were thus assured of the hospital's support and interest right from the beginning of their contact with it. They were also enlisted as active participants in the treatment program and given some orientation to the hospital procedure which for many people is frightening and confusing simply because it is unknown. The following case illustrates how a relative's participation in the hospital program began the day of the patient's admission.

> Case Number 2 When a twenty eight year old single woman with a subsequent diagnosis of extreme anxiety neurosis was admitted to the A.M.I. her mother and sister were seen by a social worker on the same day the patient was admitted. The family came from another province and had a fairly high status in the small community in which they lived. It was obvious that this illness in the family was a blow to its pride and was taken by the mother to be a reflection on herself. From the admission interview a relationship with the social worker developed in which both mother and sister became more accepting of the patient's illness. Their own relationship with the patient improved and at one point, when the latter wished to leave the hospital, they were able to persuade her to stay. During her contact with the Social Service Department, the patient's mother Mrs.O. changed a great deal in her attitude toward her daughter's illness, becoming less frightened and ashamed of it and more able to face the return to her own community. Four months after the patient's discharge the social worker received a letter from Mrs.O. in which it was apparent that the patient was making a good adjustment to her job and community life, with Mrs.O's attitude a contributing and helping factor.

From the foregoing, we are able to see the wisdom of the Department's policy previously stated and the very concrete way in which early contact with the patient's relatives may support the beneficial work of the

treatment doctor, and possibly bring about a crucial change necessary to the patient's recovery. This is in substantiation of the point of view expressed by Leader and Robbins as follows:

> " The fact that a social worker is immediately available to interview the relative grows out of our conviction that the success of the patient's treatment depends in part upon our immediate recognition of what the patient's illness means to the relatives and what the social worker can help them accomplish in their relationships with the patient consistent with therapeutic goals."[1]

They continue:

> " The initial interviews with the relatives mark the beginning of a working relationship between the relative and the hospital, represented by the social worker, which continues throughout the course of the patient's hospitalization. It is focused on working through whatever matters arise for the relative in relation to the patient as he moves through treatment to discharge. This contact is maintained both by correspondence and subsequent personal interviews which may be requested by the hospital or the relative."[2]

In addition, it is the opinion of the researchers from the cases studied that such contact is particularly important in relation to treatment which is undertaken within a relatively short time-span. If the social workers are to contribute effectively to the treatment process, their work must begin as soon as the patient begins treatment. Otherwise the treatment may be well along before this contact is established, and by this time the relatives may have handled their feelings in their own way although not necessarily in the best interests of the patient.

Admitting Office

At the time of, or prior to a patient's admittance to hospital

the admitting interne may recognize circumstances in the patient's environment which call for a referral to social service. It is taken for granted, of course, that in a full social service coverage these problems would be picked by the social worker at admission. In the past three years, however, as has already been stated, this coverage was not complete. Of the fifty three cases in the research sample five were referred by the Admitting Office. In three of these five cases the social problem concerned the need for the care of the patient's children. These appear to have been extremely valuable referrals in that the patient's admittance and treatment were dependent on the solution of this social problem. The following is an illustrative case.

> Case Number 3 Mrs.N., a forty-seven year old widow with a subsequent diagnosis of depressive reaction was referred to social service prior to her admission as there did not seem to be anyone to look after her seven children during her forthcoming hospitalization. Although in need of treatment, the admitting doctor considered that she was not so ill that she could not wait to be admitted until she knew that her children would be cared for. With the social worker making contacts with patient's community, effective plans were made to have a housekeeper look after the children during the patient's absence. At the time it was thought that the patient's ability to respond to treatment depended in part on the fact that she knew her children were being cared for.

The remaining two referrals from the Admitting Office were for a further evaluation of the patient's feelings about hospitalization.

> Case Number 4 A thirty year old woman with a subsequent diagnosis of chronic mixed psychoneurosis was referred prior to admission for "an evaluation of the degree of the patient's hostility as regards hospitalization." The patient was seen by the social worker in one interview in which she expressed some of her fears and reservations about coming into hospital although she considered that she really did need psychiatric care. She seemed to gain relief through talking this over with the social worker and the next move in the case was that the patient came into hospital.

Case Number 5 A thirty three year old single male with a subsequent diagnosis of severe anxiety hysteria was referred through the Admitting Office for investigation and further evaluation prior to admission. When the patient did not keep his appointment with the social worker, his mother was eventually seen and through work with her the patient was finally admitted.

These two referrals suggest the hospital's doubts as to the patients' willingness to accept treatment and are in line with one of the special features of the A.M.I., the fact that only those patients who are willing to be treated are accepted for treatment. They would also seem to point to the fact that the work of the Social Service Department is related to this special feature as well as to underline further the importance of the department in the treatment program because of this feature.

Treatment Doctor

Although it is considered that the majority of social service cases now originate in admission interviews, the largest group in our sample came through the treatment doctor, i.e. twenty seven of the fifty three cases. Of these twenty seven cases, ten were referrals of the relative, seventeen referrals of the patient. It is interesting to note that in the research sample over half of the cases originated in referrals from the treatment doctor. Whether or not the sample is accurate in terms of the actual over-all work load is not the important point here. What does stand out is that the treatment doctor does make use of the Social Service Department and that this being the case, there is a very real need for full communication between doctor and social worker.

In three of the ten cases in which relatives were referred by the treatment doctor the referral requested that the social worker see the relative in order to get a clearer picture of the patient's background. This arose out of the fact that in his contact with the patient the doctor was of the opinion that an understanding of the dynamics of the home situation would help in the patient's treatment. The case cited below is an example of a referral of this type.

> Case Number 6 Miss L., a thirty year old single woman, was hospitalized at A.M.I. from the end of February, 1952 to the end of May 1952 with a diagnosis of chronic mixed psychoneurosis. The treatment doctor referred the case to the Social Service Department two weeks after admission, requesting that the worker see the patient's sister in order to get more background information. There were many problems in the home, including crowded living conditions, the illness and handicaps of the patient's parents, illness in the sister's family and financial difficulties. The worker conveyed this information to the doctor which was undoubtedly helpful in contributing to his understanding of the patient.

In a later chapter it will be pointed out how this referral had negative results for the overall treatment process and that because of it, the patient's relatives did not receive the support they needed, as they might have done had the contact with them been established at admission. Nevertheless, it is suggested that this type of referral is significant in the psychiatric unit of a general hospital because of the emphasis on treatability in such a setting and on the patient's early return to his environment.

In the other seven cases referred by the treatment doctor, he was aware that there were disturbed marital relationships and referred the marital partner to the Social Service Department for supportive help. The case described on the next page illustrates a referral of this type.

Case Number 7 The patient, Mrs.L. was a thirty year old married woman with a diagnosis of anxiety hysteria. Her husband was referred to the Social Service Department by the treatment doctor two days after she was admitted. The referral statement read as follows: "patient is to receive psychotherapy on a long-term plan. She is gaining some insight but it is felt that this is damaging to her husband and unless he can get some support little will be accomplished. Social Service should supply aid in helping him feel and become a more adequate person and partner in his marriage." Mr.L. proved to be an insecure person who had allowed himself to be manipulated by the patient and her parents with whom they lived. Concentration on him early in the hospital experience gave him status as a person as well as the opportunity to work out some of his problems in relation to the patient. The social worker's complete focus on the relative while the patient was being treated by the doctor allowed both Mr. and Mrs.L. to work simultaneously with their problems. In this situation Mr.L. was able to develop a good understanding of his wife's illness and as time went on, to assume more and more responsibility in the home.

This would appear to have been an extremely good referral which took cognizance of the importance of the patient's environment as part of the treatment program and considered the patient's husband as an individual with feelings and problems of his own which needed acceptance in order that he could better understand his wife's problems and his part in the relationship. Again this points up the close collaboration between the doctor and social worker which is necessary in a setting such as the A.M.I.

In the referral of patients by the treatment doctor, eleven of the seventeen cases were referred for help with specific things such as employment, accomodation or general discharge plans. The common characteristic of these eleven referrals is that there is no apparent emphasis on the forming of a relationship with the patient; and in the referrals, as inferred from the case records, there was no interpretation

given to the social worker of the dynamics of the patient's personality. The following case illustrates a referral of this type.

> Case Number 8 Mrs.M., a fifty six year old widow, hospitalized at A.M.I. from August 8, 1952 to September 11, 1952, with a diagnosis of depressive reaction, was referred to the Social Service Department by the treatment doctor one week prior to discharge to discuss the possibility of obtaining housekeeping service for her. The patient had been previously hospitalized at A.M.I. from July 9, 1952 to August 4, 1952. Upon discharge the first time, she had returned home to live alone and her symptoms had almost immediately reappeared, with the result that she was readmitted to the hospital four days later. After her referral to Social Service the patient was seen in one interview by appointment and during several informal interviews on the ward. The patient stated that she considered the discussions with the worker a waste of time. At one point she was able to participate in planning but she was not able to sustain this interest. This indirect expression of hostility toward the worker was typical of her general attitude toward everyone in the hospital. A note in the record reads: "It is unlikely that the worker will be able to help the patient obtain the type of care she has requested. She is obviously ambivalent about having to accept this type of care(housekeeping service)in the home and is resisting the dependence which she feels it illustrates." When the patient was discharged from the hospital the case was closed in Social Service as she did not appear able to make use of the help that was offered.

It is possible that the unfavourable results of this referral may have been due to factors operating as part of the patient's illness, one of these being the degree of hostility underlying the patient's depression which prevented her from entering co-operatively into effective planning for the post-discharge period. However, this would seem to emphasize the difficulties that are involved in a referral made to the Social Service for a specific purpose late in the patient's hospitalization, when the patient's anxieties are again heightened at the prospect of leaving the hospital.

In the remaining six cases referred by the treatment doctor,

emphasis in the referral was placed on the worker establishing a supportive relationship with the patient. In four of these cases the referral requested help with discharge planning as well, and in the remaining two cases the sole reason for referral was for the establishment of a supportive relationship. The following case contrasts with the one cited above and points out the effective contribution which the Social Service Department can make to the treatment program when drawn into it early enough.

> Case Number 9 Mr.D., a twenty four year old man separated from his wife, was hospitalized at A.M.I. from June 28, 1951 to September 25, 1951 with a diagnosis of schizophrenia. He was referred to Social Service by the treatment doctor less than one week after admission for "a supportive relationship to help with post-discharge plans." In his relationship with the worker, Mr.D. gradually became more relaxed and spontaneous and relied on her for support and understanding of the difficulties he faced in treatment. He also referred constantly to his doubts about being able to re-establish himself successfully in the community despite the good progress he had made while in the hospital. He received the worker's support frequently around these fears. Toward the end of his hospitalization the worker arranged for him to go to the National Employment Service regarding a job. In the end, however, the patient returned to his former job and discussed this return with the worker when he came for an interview two weeks after discharge. When he missed his next appointment, the worker telephoned his home and was told that he had returned to his wife.

This instance of close collaboration between the doctor and the social worker serves further to point up the social worker's function not only as an auxiliary to the doctor but as an especially skilled extension of the treatment process in which everyone in the hospital participates, in fact. It also suggests that the treatment doctor might further extend his use of the social worker on a selective basis.

Relatives Self-Referred

In general it can be assumed that the very fact of a relative's asking for help from the social worker indicates a willingness to take help and to enter into the hospital's treatment program for the patient. There will be exceptions, of course, as in other case work situations where the reason for an individual's request for help may not coincide with his real ability to use help or where the help that he seeks cannot be given by a social worker. It would appear correct to assume, however, that referrals which arise out of attendance at the Relatives' Group would stand a good chance of working out, since the relative has already some idea from discussion in the Group of the functions of the Department and how he can be helped with specific and personal problems about the patient's illness.

In the sample, five cases originated in self-referrals from relatives and four of these followed attendance at the Relatives' Group. These referrals originated in late 1952 two to three weeks after the patient's admission. In two of these cases, the relatives asked for help in better understanding the patient's illness; the third offered information to the Social Service as regards the patient's background and the fourth asked for help in discharge planning for the patient. Nevertheless, it was considered that in all four cases the relative was asking for help, directly or indirectly with his or her own problems aroused by the patient's illness. The following is an example of Social Service contact with a relative arising out of the Relative's Group.

Case Number 10 Mrs.R., a fifty nine year old widow, was hospitalized at A.M.I. from January 20, 1953 to March 26, 1953, with a diagnosis of depressive reaction. The patient's daughter and son-in-law referred themselves to the Social Service Department two weeks after the patient's admission, after attending two meetings of the Relatives' Group, requesting help with post-discharge planning. After the death of her husband, the patient's home had been broken up, and before being admitted, her apartment was given up. The main discharge problem centred around the difficult relationship between the patient and her only daughter, Mrs.C., with the latter feeling very guilty that she could not more readily open her home to her mother upon discharge. The social worker's contact was maintained with Mrs.C. and, although discharge planning was kept in mind, the focus was placed on helping Mrs.C. understand something of the underlying causes of the patient's illness, which also had contributed to the unhappy relationship. When discharge time came, the patient went to live with her sister, a plan which seemed acceptable to both. It is believed that during her contact with the Social Service Department, Mrs.C. was able to release much of the emotional energy that had been tied up with her feeling of guilt, and re-invest it in a more positive relationship with the patient, both during the period of hospitalization and following discharge. An important factor was that a satisfactory solution had been arrived at for both the patient and the relative.

In the last case, self-referred by a relative, the patient's wife asked for specific help with discharge planning for the patient.

Social Agencies

Two cases were referred from other social agencies, one from the social service department of another hospital, and one from a psychiatric clinic. While it is apparent that two cases are not sufficient upon which to base any conclusive findings, a brief description of some of the factors involved may be helpful in understanding the work load of the Social Service Department at A.M.I.

In the first place, a patient's contact with another social agency presupposes the existence of a social problem. Questions arise,

then, as to the nature of this problem which has already presented itself to the referring agency; the extent to which the problem was met by that agency as well as the extent to which the problem was amenable to solution. A comprehensive social history, together with an outline of the referring agency's plan for either continued contact or complete referral of the case would be important.

In both of the cases in the research sample in which referral was made by a social agency, long-standing and severe emotional problems were present. In one instance, the referring agency had been acquainted with the patient's problems for a relatively short period of time. In the second instance the case had been known to the referring agency over an eleven-year period, and an attempt had been made to work with the involved emotional problems in the case over that period of time.

> Case Number 11 A thirty three year old woman with a diagnosis of long-standing conversion hysteria was admitted to A.M.I. from another Montreal hospital after undergoing numerous tests there which were directed toward finding a physical basis for her symptoms. She had previously undergone extensive surgery in her own province for the alleviation of these symptoms. When the patient was admitted to A.M.I., she was referred by the Social Service Department of the referring hospital for help in accepting hospitalization in a psychiatric setting. At the same time much relevant background material was forwarded, including social data and a history of the patient's illness and previous treatment. This information proved valuable to both the social worker and the treatment doctor at A.M.I. in that it contributed to a better understanding of the dynamics of the patient's personality and illness. The worker was able to help the patient to some extent with her feelings about hospitalization. In the referring information, however, it was pointed out that the patient had gained a great deal of satisfaction from discussing her previous hospital experiences in which attention had been devoted to her physical symptoms.

It would seem that the patient's reluctance to accept treatment in a

psychiatric setting involved not only her feelings about hospitalization but was deeply tied up with the psychic aspects of her illness. We might expect, than, that the social worker could help the patient with a superficial adjustment to her hospitalization but that a deeper acceptance of it would involve psychiatric treatment. In this case we see the crucial importance of the social history and also that referral from another social agency is not of exclusive interest to the social worker but may have immediate implications for the doctor as well.

The other case referred from a social agency also raises some interesting points in connection with the work of the Social Service Department.

> Case Number 12 A.L., a fifteen year old boy with the possibility of a schizophrenic diagnosis was referred by a child guidance clinic for further investigation. This case had been known to the clinic since 1941. The patient's symptoms included temper tantrums, bursts of rage and destructiveness. Within the family there was a long-standing history of marital difficulty and poor family relationships. The patient was hospitalized A.M.I. for approximately six weeks, then transferred to a neurological hospital for investigation of possible brain damage with the recommendation that he be returned to the referring clinic for follow-up.

In this case there appears to have been a certain ambiguity as to the reason for the clinic's social service department referral of the case to A.M.I. and a lack of clarification as to what responsibilities the social worker in each agency would carry. Although the patient was admitted primarily for investigation, the referring agency apparently considered the case closed once it had been referred to the Social Service Department of the A.M.I. The result was that a constellation of long-standing, unresolved family problems of which the patient's behaviour was

only a part, was transferred to the Social Service Department of the A.M.I. When the patient's mother contacted the former worker at the clinic, she was referred to the worker at the A.M.I. The result was that over a six-weeks period the social worker at the A.M.I. became involved in problems which had been known to the referring agency over an eleven year period. Without going into the various aspects of the situation, the question is raised as to whether the social service department of a short-term treatment centre is geared toward accepting complete responsibility for such a problem. Further, since the patient was admitted for investigation, it seems questionable whether responsibility should be accepted before it has been established that the patient will not be returning to the referring agency. It would appear that the fullest communication between this and other social service departments is particularly important because of the treatment aims and limitations of the setting.

Patients

One case in the sample was referred by a patient himself. A twenty year old single man with a diagnosis of early schizophrenic reaction came to the social service department three weeks after admission requesting help with post-discharge planning. It is not clear from the record whether the patient had been directed to the social service department by the treatment doctor or whether he had come of his own accord, perhaps having learned of the services of the department from some of the other patients. At any rate, we might

assume that referrals of this type are not usual, that they would ordinarily come through the treatment doctor and that, in any event, the social worker would discuss the situation with the treatment doctor before proceeding in the case. In this case, the referral does not appear to be substantially different from those made by the treatment doctor. It might be added, however, that the freedom of the patient to make this contact is significant.

TIME

Table II on the following page indicates the time at which patients were referred to the Social Service Department in relation to their total hospitalization.

The time element would appear to play an obviously important part in the work of the social service department of a short-term treatment centre. The time in which both the patient and his environment can be treated is relatively short. The A.M.I. considers the average period of hospitalization to be six weeks although the average time within the research sample worked out to be somewhat longer, an eight to ten week period.

As stated previously, work with the relative is considered most effective when begun on the day of the patient's admission, when right from the beginning, the relative is made to feel part of the hospital's treatment program. Contact which is made with the relative later in the patient's hospitalization would appear to have less chance of developing positively, for the relative's feeling of guilt, already aroused by the patient's illness, may be further heightened by

Table II

TIME OF REFERRAL IN RELATION TO TOTAL HOSPITALIZATION

Time of Referral	Total	Length of Hospitalization									
		2 weeks less than 4	4, less than 6	6, less than 8	8, less than 10	10, less than 12	12, less than 14	14, less than 16	16, less than 18	18, less than 20	over 20
Total	53		14	13	4	5	4	5		5	3
Pre-admission	7		2	1			1			2	1
Admission	12		4	6						1	1
Less than 1 week	10		1	3	1	2	2	1			
1-2 weeks	6		2	2	1	1					
2-3 weeks	6		2			1	1	1		1	
3-4 weeks	5		2		1			1			1
4-5 weeks	3			1				1		1	
5-6 weeks	---										
6-7 weeks	1				1						
7-8 weeks	---										
8-9 weeks	1					1					
Day of discharge	1							1			
After discharge	1		1								

being left out of the hospital experience. When he is approached by the hospital, he may look on this as a punitive measure directed toward having him behave in a certain way for the sake of the patient. In general, we can say from the material collected that contact established later than two to three weeks after the patient's admission will have less possibility of developing into an effective relationship which can contribute towards the patient's treatment.

In the following case, the relative was enlisted in the hospital experience the day of the patient's admission

> Case Number 13 Mr.J., a thirty four year old single man, was hospitalized at A.M.I. from December 8, 1952 to January 9, 1953 with a diagnosis of a recurrent schizophrenic episode. The patient's brother, who lived some distance from Montreal, was seen by a social worker the day of the patient's admission. He gave the worker useful background information about the patient, expressing at the same time some guilt over his illness and the need for hospitalization. The worker assured him of the hospital's interest and support and at the same time was able to give him some understanding of the patient's needs. The worker's impression from this interview was that this relative was sincerely concerned over the patient's illness and would be a strength in the post-discharge period. After the admission interview Mr.J. did not return to see the worker, but when the patient was discharged, effective plans were made for him to go to his brother's home. In the meantime, however, the worker conveyed the information to the doctor which she had received in the admission interview so that the doctor was given a good idea of the patient's environmental situation.

Although this case was not followed up in Social Service during the course of the patient's hospitalization, largely owing to the relative's distance from Montreal, the value of this single admission interview is clear from the record. It gave the treatment doctor a picture of the patient's environment which appeared to be a positive resource for

the patient after discharge. This would be especially valuable in a short term treatment centre where the focus is on rehabilitation. The admission interview was also helpful to the relative, for the very day on which the patient was hospitalized he was given the idea that the hospital recognized his value in the treatment process and shared with him some of the responsibility for an emotionally-ill family member. This might have particular significance to the relative in view of the patient's diagnosis--recurrent schizophrenic reaction. This case also serves as an example, however, of the fact that relatives do have resources of their own and that not all need the same degree of help with their own feelings around the patient's illness. Nevertheless it can be said that all relatives do need to be assured of the hospital's interest, whether or not they can use the contact in a positive manner.

Referrals for help with the patient's environment which come prior to, or at the time of patient's admission would appear to have an excellent chance of working out since upon their recognition and effective handling may depend the possibility for, and the course of, the patient's treatment. Again, the factor of time has implications for the close working relationship of psychiatrist and social worker.

By contrast, contact established with relatives toward the end of the patient's treatment may have little value. By this time, having received no help with their problems around the patient's illness, they may attempt to handle the situation through denial, particularly if by this time the patient is showing the beneficial effects of treatment. The following case illustrates the results of a contact with

relatives made late in the patient's hospitalization.

> Case Number 14 Miss P., a twenty six year old single woman with a diagnosis of anxiety hysteria, had been in hospital from a period of from four to six weeks when the case was referred by the treatment doctor for an assessment of the home situation. When contacted, the patient's family was extremely defensive, although they did make some attempt to work with the hospital. However, they never seemed really to understand the patient's need for treatment or to be able to participate in it. Owing to the lack of understanding at home the treatment doctor considered it advisable for the patient to have accomodation while continuing on day care.

The question arises as to whether this move would have been necessary had the relatives been drawn into the treatment program from the beginning so that they were helped to feel closer to the patient, rather than separated from her.

Referrals of the patient which come near the end of hospitalization, on the day of discharge or afterwards would seem less probable of receiving effective help, since even around a specific request, time is necessary in order to form a relationship with the patient.

> Case Number 15 Miss X., a thirty four year old single female with a diagnosis of chronic anxiety hysteria, was hospitalized at A.M.I. from September 28 to November 29, 1951. The case was referred to the Social Service Department by the treatment doctor one week prior to discharge to discuss employment. The patient was seen by a social worker twice prior to discharge and three times in the post-discharge period with the discussion centering around employment and the difficulties of getting established. Miss X. was tense and upset at the prospect of having to look for a job. When she seemed unable to face employment she was referred to the Occupational Therapy and Rehabilitation Centre, where she developed a relationship with the social worker. Prior to this, the patient's mother was seen twice by the Social Service Department at A.M.I. She proved to have little sympathy for the patient's illness and seemed unable to understand why she should not be able to start work upon discharge. In September, Miss X's symptoms increased and she was re-admitted from September 5, 1952 to December of that year, being finally committed to St.Jean de Dieu at the end of this time.

The late date of social service contact in this case with both the patient and her mother would appear to have some bearing on its negative aspects. The sudden focus on environmental responsibilities would seem to have been very threatening to this patient, as borne out later by a recurrence of her symptoms. The regrettable results ensuing from a too-late contact with the patient's relatives are apparent.

SUMMARY

This chapter dealt with the origin of the work load with reference to the source and the time of the referral. This is in contrast to Chapter V which will deal with the actual work done.

The work load was found to arise from six different sources, admission interviews and referrals from the Admitting Office, the treatment doctor, the Relatives' Group, social agencies and patients.

From the research sample it was seen that over one quarter of the cases originated in admission interviews, while more than half of the cases were referrals from the treatment doctor. Referrals from the Admitting doctor and the Relatives' Group each comprised about one tenth of the sample, while there were two referrals from other social agencies.

The value of the admission interview was obvious from those cases studied. It is believed it assured the relatives of the hospital's support and interest right from the beginning of the contact and also indicated the Social Service Department's willingness to help them with any problems or questions they might have. Contact established with relatives also proved to have beneficial results for the course of the patient's treatment. In the three cases where the relative refused further contact with the Social Service Department after the admission interview, it was believed that their own feelings about the patient's illness prevented them from taking the help that was offered.

The Admitting Office proved to be a valuable source of referrals, since it was there that environmental problems were picked up prior to,

or on the day of the patient's admission. Early referral of these environmental problems to the Social Service Department enabled the patients to come into hospital and to make a better response to treatment.

Of the cases studied, the treatment doctor referred ten relatives and seventeen patients to the Social Service Department for help. Seven relatives were referred for help with marital problems, and in three cases the doctor requested that the social worker see the relative to get a clearer picture of the environmental situation. Referrals of the relative regarding marital problems appeared to be valuable in contributing to a better home situation for the patient. They indicated the doctor's awareness of the social situation and the fact that the marital partners of patients may often need help themselves. The three cases referred for environmental investigation suggested the doctor's need for a clearer picture of the patient's environment, and suggested that this was a contribution that the social worker might make. Contact with the relatives for this specific purpose, however, appeared to have had deleterious effects, as will be further pointed out in Chapter V.

The referrals of patients by the treatment doctor appeared to have results in direct proportion to the reason for referral. Those referred for a supportive relationship as such and with specific help as a corollary to the relationship had the best results. Those referred for a specific purpose such as help with accomodation or employment had less chance of working out, since even around specific items the worker could only give most effective help when a relationship with the patient had been established. These cases suggested the need

for complete co-operation and co-ordination between doctor and social worker; it further suggested the social worker's function as an extension of the treatment process and pointed to the possibility that the treatment doctor might extend his use of the social worker on a selective basis.

Among the self-referrals of relatives, four followed attendance at a Relatives' Group, and one came of her own accord to the Social Service Department to ask for help with discharge planning. It is believed that attendance at the Relatives' Group prepared these relatives for the work of the department and indicated the help that could be offered. The fact that they referred themselves suggested their willingness to take help. While they approached the Department for different purposes-- to discuss the patient's illness, to give background information, or to discuss discharge planning, it was considered that in fact they were asking for help with their personal problems or those related to the patient's illness.

No conclusive findings were arrived at from the two cases referred by social agencies, but several interesting points emerged: 1) that the social history from the referring agency may have import not only for the Social Service Department, but for the treatment doctor as well; 2) that the reason for referral may encompass not only the social worker's role, but may be deeply tied up with psychiatric treatment; 3) that the special features of a psychiatric unit of a general hospital may influence the extent to which its Social Service Department accepts responsibility in a case; 4) that the referring and

accepting social agencies need to have full communication with each other, which includes treatment aims, together with full understanding of the capacities and limitations of the respective settings.

One case in the sample was that of a patient self-referred. This case presented nothing conclusive about this type of referral, but it was significant in terms of the patient's freedom to approach the Social Service Department.

Because the patient's stay in hospital is relatively short, time would appear to play an important part in relation to referrals. Contacts established the day of a patient's admission were regarded as the most satisfactory, while those initiated by the Social Service Department later in the patient's hospitalization would appear to have less chance of working out. The more time that elapses between the date of the patient's admission and the time the relative is brought into the hospital experience, the more it would seem that his feelings of guilt over the illness is re-inforced; and this appears to cause him to enter the relationship with the social worker in a defensive way. Case work with the patient seems to be most effective when begun early in hospitalization, while contact established late in, or toward the end of the patient's hospitalization may have less favourable results. The patient may look on discharge as a rejection by the hospital, and may associate this feeling of rejection with the person, i.e. the social worker, who enters his hospital experience at this time.

CHAPTER IV

RELATIONSHIP OF SOCIAL SERVICE DEPARTMENT WITH PSYCHIATRISTS AND COMMUNITY RESOURCES

Contacts Between Social Worker and Psychiatrist

Among the activities listed by French[1] as part of the role of the psychiatric social worker are the following:

1) evaluating the patient's social situation as it relates to his present situation,
2) interpreting the patient's illness to his family and explaining the recommendations of the psychiatrist,
3) assuming responsibilities in co-operative treatment with the psychiatrist.

In order to accomplish any of these activities effectively, there must be a close relationship between the social worker and the psychiatrist. There must be a readiness to share their knowledge with one another and a mutual appreciation of what each has to offer the other in the total treatment plan. Lowrey[2] points out that the problems of the psychiatric patient and his family are so great that social work and psychiatry each has its particular province and skill, and they must pool their resources to deal adequately with many situations.

It is necessary to appreciate the novelty of the teamwork concept:

> " The team approach is a relatively new departure in clinical practice. Experiments with respect to its form and the appropriate allocation of responsibility are taking place

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1. French, Lois, Psychiatric Social Work, New York, Commonwealth Fund, 1940
2. Lowrey, Lawson G., Psychiatry for Social Workers, (New York, 1950), p.17.

> constantly, bearing with them renewed proof of the basic validity of the concept. Many of the difficulties which the social worker experiences stem from this confusion and development."[1]

In examining the relationship between the social worker and psychiatrist at A.M.I., we had no set criteria of success or failure. No attempt was made to list the number of cases in which there were successful or unsuccessful working relationships between the worker and doctor. The effort here, as elsewhere, was better to understand this relationship, and to understand how it is affected, if at all, in this setting. To this end, as well as studying the cases available to us, there was some discussion with the director of the Social Service Department regarding the teamwork concept, as well as perusal of the literature on that topic.

The following statement, drawn from remarks of the head of the Social Service Department, sums up briefly the inter-related roles of the psychiatrist and the social worker, as conceived by this department at the A.M.I.

The social worker gives to the psychiatrist as much information as possible concerning the patient's environmental assets and liabilities and community resources available to meet the patient's needs. This will aid the doctor in understanding the patient and in making treatment plans compatible with his reality situation. For example, it might appear that a schizophrenic patient should move away from a rejecting family, but unless an adequate family substitute can be found, it is useless for the doctor to help the patient achieve independence from his family.

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1. Connery, Maurice F., "Problems in Teaching the Team Concept," Journal of Psychiatric Social Work, Vol.21, No.2, (December, 1951), p.94.

The doctor's role in relation to the social worker is to inform her of the dynamics of the patient's personality, his attitudes towards his environment, the treatment plans and aims and the patient's response to treatment.

Together the doctor and social worker modify and alter their plans in accordance with the increasing understanding of the patient and his environment which they are acquiring.

In discussing the relationships between social workers and psychiatrists at A.M.I., we wish to point out certain limitations to such a consideration.

The only source from which we judged the interaction between worker and doctor was through the medium of the Social Service Department's records, which as previously indicated, were not prepared for research purposes. Although this is one of the limitations which made itself felt in every area of the study, it would appear that it is heightened to a certain extent in the area of relationships between social workers and psychiatrists. One of the characteristics of A.M.I. and possibly of psychiatric wards of general hospitals in general, is a higher ratio of staff to patients. This can lead to more informal relationships between staff members, and conferences on a particular case may take place in a more or less casual way. This does not mean that the relationships between worker and doctor will be lacking or deficient, but it may lead to a rather summary type of recording of what transpired between the worker and doctor, or perhaps the lack of any recording on the worker's part of a conference with the doctor.

There is one further limitation which should be mentioned. The

A.M.I. is a teaching hospital; that is, all patients are treated directly by psychiatrists-in-training. As students, their understanding of the services which the social service department has to offer may be somewhat limited. We can easily imagine that a more experienced psychiatrist has a better integrated concept of the function of the social service department, and will use this department more effectively in his treatment planning. Also, some of the cases in our sample were the work of student social workers, and their ability to function as part of the treatment team and their understanding of their role in relation to that of the psychiatrists may have been somewhat limited.

This function appears to be not only an important limitation to the study, but also obviously a major factor influencing the work of the Social Service Department. Not only may the teaching function of the hospital make it somewhat more difficult for the Social Service Department to operate at maximum effectiveness but it makes for added responsibilities on the senior workers of the department.

In Table III the number of contacts between the worker and doctor are classified according to the diagnoses of the patients in the sample. The diagnosis, as seen from the table, did not seem to influence the number of contacts between the worker and doctor to any extent. Although not shown in the table, the person or persons with whom the social service department had contact was examined in this connection. In some cases, the worker's contact was confined to a relative; in other cases, the social worker worked only with a patient; and at times the worker was active with both the patient and one or more relatives. This factor,

Table III

NUMBER OF CONTACTS BETWEEN WORKER AND DOCTOR, ACCORDING TO DIAGNOSIS

Number of Contacts	Total	Diagnosis								
		Schizophrenic	Anx. hys.	Depressive state	Mixed psychoneur.	Character neur.	Conversion hys.	Manic-depressive	Brain damage	Senile psychosis
Total	53	15	13	13	4	1	1	3	1	1
1	15	7	4	2			1	1		
2	11	3	2	5		1				
3	10	2	2	3	1			2		
4	4		3		1					
5	2	1	1							
6	5	1	1	1	2					
7	---									
8	1			1						
No contacts	5	2		1					1	1

likewise did not have much bearing on the extent of contact between the social worker and the psychiatrist.

In the large majority of cases, the amount of contact between the worker and doctor ranged from no recorded contact whatsoever, up to three. In only twelve cases of the fifty three studied were there more than three recorded contacts between the worker and the doctor. Although the number of contacts, if the cases reflect this accurately, would appear to be small, the main point here revealed is that the psychiatrist and social worker do work together--there were contacts in all but five cases-- and must come to terms with each other.

In examining the inter-relationship between the social worker and psychiatrist, the amount of contact recorded is not the only, nor necessarily the most important factor. Of greater import is the quality of the relationship, as described earlier in the chapter. If the social worker and psychiatrist work together, what characterizes the nature of this team work to make it most rewarding for the patient?

As mentioned previously, no attempt was made to classify cases according to whether there was satisfactory or unsatisfactory interaction between the worker and the doctor. On the contrary, we were searching for those instances which most clearly revealed the most productive relationships and vice versa. Some of these are presented below.

In the following case, the social worker's contacts were confined to the patient's mother. Although the worker obtained information regarding the rejecting environment in which the patient was living, the record indicates no contact between the worker and doctor in which she

shared this information with the doctor. It is entirely possible that there was some sharing between the worker and doctor which was not recorded, and that no change in living accomodation for the patient could be made because of lack of facilities in the community. However, this is not the important concern. The case illustrates the point that the information might have been of assistance to the doctor in helping him to understand the patient.

> Case Number 16 J.D., a fifteen year old Roman Catholic boy, was admitted to A.M.I. on May 1, 1952, and discharged June 10, 1952. The patient had a long-standing history of temper tantrums and outbursts of destructiveness. He had been known to a child guidance clinic since 1948, and it was the Social Service Department of that agency which referred the case to the Social Service Department of A.M.I. to facilitate the patient's admission to hospital. Admission was requested by the patient's doctor at the referring clinic for further investigation of his condition. During the course of his hospitalization at A.M.I., it was impossible to establish a definite diagnosis. Some organic damage did exist, but not enough to warrant the type of behaviour which the patient exhibited. Patient's mother, Mrs.D., was seen by the social worker five times during the course of her son's hospitalization. She appeared to be a passive, insecure woman, with extreme feelings of hostility towards her husband whom she described as a punitive, compulsive person. There was a long-standing history of family instability, and on several occasions, the home had broken up completely and the patient and his two younger sisters placed in foster homes. On several occasions Mrs.D. told the worker that if the doctor felt that patient should be placed in an institution she would place the other two children and go to work for herself.

In the above situation, the doctor would have profited by such information as the worker had obtained about the patient's environment, and he, by giving her information about the patient might have helped the worker in her relationship with the mother.

In the following case the social worker's contact was limited to a relative, but there was effective sharing between the worker and the doctor. The information which the worker obtained about the patient's

environmental situation helped the doctor in making treatment plans in line with this situation, and the doctor's understanding of the patient helped him guide the worker in her treatment with the relative.

> Case Number 17 Mrs. X.F., a twenty seven year old married woman with a diagnosis of chronic mixed psychoneurosis, was admitted to the A.M.I. on September 18, 1950 and discharged November 18, 1950. Five days after the patient was admitted to hospital, her doctor referred the case to the Social Service Department. He thought that Mrs.F. would not be able to benefit to any large extent by psychotherapy and thought it would be necessary to modify the environment. As the husband was the most important person in the environment, it was thought that by working with him, giving him support and recognition of his difficulties, he might in turn be able to give more support to his wife. The worker saw Mr.F. a total of eleven times during the course of his wife's hospitalization and in the first three months of the post-discharge period while the patient continued to see her doctor for follow-up psychotherapy. Mr.F. appeared to be a dependent person, with an extreme sense of rejection and deprivation. The worker had four conferences with the doctor during her contact with Mr.F. The doctor pointed out that, because of the patient's extreme dependency on her husband, it seemed to him that Mr.F. would require an accepting, understanding mother-figure from whom he could gain support. As Mr.F. gained some status in the casework relationship, he was in turn able to give more support to his wife. This became evident as they gained mutual satisfactions from sharing recreation which they had hitherto been unable to do.

In some cases, the social worker and the doctor are both working with a patient, and here too, a close sharing relationship is important.

In the case described below, both the worker and the doctor were treating the patient. They discussed the case together, and each developed a clear idea of what his role should be toward the patient in relation to what the other was doing.

> Case Number 18 Miss D.C., a thirty six year old single woman, was admitted to A.M.I. on November 23, 1950 and discharged March 3, 1951, with a diagnosis of anxiety hysteria. Four days after the patient's admission, the doctor referred the case to the Social Service Department for immediate help around finances and long-term help around the problem of socialization. At the time of referral, the doctor gave the worker some understanding of the dynamics of Miss C's personality. He described her as an extremely

dependent person, who was attempting to withdraw into the hospital and away from her environment. The worker saw Miss C. a total of sixteen times during the four months of her hospitalization. During this time the worker discussed the case with the doctor an average of once a month. He helped the worker see what areas she should deal with in her relationship with the patient. Although MissC. wished to discuss her fears and phobias with the social worker, the worker steered her away from these subjects and dealt instead with the problems she would be returning to after her discharge, such as job, living accomodation and recreation.

In the following case, both the worker and the doctor were treating the patient; however, there appears not to have been such an effective sharing relationship between them.

Case Number 19 Miss A.H., a thirty four year old single woman with a diagnosis of depressive state, was hospitalized at A.M.I. from October 2, 1950 to November 7, 1950. The case was referred to the Social Service Department two weeks after admission. In the referral, the patient's doctor suggested that the social worker deal with actual plans for the patient's rehabilitation, with the main emphasis on group associations. The worker saw Miss H. a total of nine times-- four times while she was in hospital and five times within six weeks after her discharge. The patient was a withdrawn, insecure person who quickly formed an extremely dependent relationship with the worker. The worker appeared to be rather controlling in her attitude towards the patient. She suggested a number of times that Miss H. should join a group at the Y.W.C.A. and the latter reluctantly agreed to do so. The referral was made, and Miss H. attended one meeting. She returned for an interview with the worker once after this, feeling depressed because she had not been able to relate weel to the other members in the group. In spite of the worker's assurances that this failure meant very little, Miss H. felt so guilty at having disappointed the worker that she terminated the contact immediately after this. There was one contact with the doctor, in which the worker discussed Miss H's reluctance to join a group. The doctor suggested that the worker should take a more permissive role. However, this suggestion did not come until after the referral to the "Y" had been made, and it was too late at this time to effect any changes in the relationship.

Contact with Community Resources

In the area of the study dealing with contact with community resources the limitation of recording previously noted was a serious

handicap as far as being able to describe the quality of relationships with other agencies in the community. In the records some mention was generally made of a telephone call or a letter to another agency; however the recording most of the time was too brief for the researchers to be able to get a picture of what transpired between a social worker at A.M.I. and a worker in another agency in the community. The only way the researchers could evaluate what happened when a client was referred to another agency was by the client's reaction toward the worker at A.M.I. after the referral.

The policy of the Social Service Department of A.M.I. is described below.[1]

"Our stated policy is as follows:

> If an agency has been giving sustained case work, we believe in general that the agency should sustain their contact throughout the period of hospitalization with the A.M.I. Social Service acting as liaison between the agency and the A.M.I. In practice the agency sends us a social summary which we discuss with, and interpret to the doctor, and in turn we ask the doctor for his findings, treatment and post discharge plans, which we interpret to the agency.
>
> As far as time permits, we try to arrange at least one conference with the doctor, agency and A.M.I. worker. Following discharge, the A.M.I. Social Service sends a summary to the agency.
>
> The main purposes of this are:
> 1) It provides continuity for the patient and reassures him that there is, and will be continued support for him in the community.
> 2) It gives the community worker an opportunity to better understand the meaning of the illness and hospitalization to the patient and his family.
> 3) It provides for the hospital a closer link with, and consequently a better understanding of the environmental and community resources and limitations.

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1. From verbal statement, Director, Social Service Department, A.M.I.

In twenty six cases, there was no contact with any other community resource. In twenty of the remaining twenty seven cases, a contact was established with one community resource. When relationships between the social worker and psychiatrist was discussed, the research indicated that the two do work together. In the same way it can be seen that the A.M.I. does not isolate itself from other agencies in the community, but works as part of a total agency structure.

Table IV lists the number of contacts with other agencies or resources and the reasons for these contacts in the fifty three cases of the sample. "Referral for employment" in most cases meant a referral to an employment agency rather than directly to an employer. When clients were referred for "accomodation" the resource generally used was the Rooms Registry at the Y.M.C.A. or Y.W.C.A. "Referral in" refers to a case where another agency in the community establishes a contact with the Social Service Department of A.M.I. in order to facilitate the admission of one of their clients to the hospital. When a case is "Referred out", it means that a patient or his family is referred to another agency in the community for a service which is outside the function of the Social Service Department of the A.M.I.

In the opinion of the researchers one of the possible unique features of a psychiatric ward of a general hospital emerges here as a probable influence on the use which is made of community agencies. This is the treatability of patients. Generally speaking, except for cases requiring evaluation, only those cases are accepted for treatment in which there is a favourable prognosis. Ability to handle a job or to enjoy group relationships are, in our culture, indicative of an adequate adjust-

Table IV

NUMBER OF CONTACTS WITH AGENCIES OR RESOURCES AND REASONS FOR THE CONTACT

Contact with Agency or Resource	Total	Reason for contact						
		Employ-ment	Accomo-dation	Group associ-ation	Referral in	Referral out	Inter-pretation	Other
No contact with agency or resource	26							
Contact with 1 agency or resource	20	6	4	2		4	3	1
Contact with 2 agencies or resources	5	2	2	1	1	4		
Contact with 3 agencies or resources	2	3		2				1

ment to life. It is true that in many cases, the only way in which the doctor or social worker can know how ready a patient is for this experience, is by referring him to an employment or group agency. However, it would appear that there may be some instances when the expectation of recovery may normally be one of the factors underlying the referral of a client to another agency. The point is that with the possibility of a too-hasty referral, the need for the fullest communication between the social worker and the psychiatrist is emphasized.

The following case is an illustration in point:

> Case Number 20 Miss X, a thirty four year old single female, was hospitalized at A.M.I. from September 28, 1951 to November 29, 1951, with a diagnosis of anxiety hysteria. The doctor referred the patient to the Social Service Department one week before her discharge to discuss employment. The worker saw MissX a total of five times during the month of December, following her discharge. The worker had referred Miss X to the National Employment Service at the time of her discharge from the hospital. The main focus of the contact between the patient and the worker was on the problems which she was having in finding employment. She was unable to find a job which she felt would be suitable and was extremely fearful of approaching prospective employers. At the end of December there was a conference between the worker and the patient's former doctor. The worker described the difficulties Miss X was having and it was decided that perhaps she should be referred to the Occupational Therapy and Rehabilitation Centre as an intermediate step before attempting to compete in the employment market.

The researchers would agree that the strain and tension that the patient was under in attempting to find a job may have been considered by the doctor and social worker as part of the treatment plan. Perhaps it was considered therapeutic for her to be under this type of strain. Also, this might have been the only way for the doctor and social worker to find out whether or not she was ready to undertake employment. However, we would suggest that there is a possibility that the feature of treatability may have influenced the doctor and social worker to a certain

extent in making the referral to the National Employment Service.

The researchers are not attempting to say that the referral of patients to other agencies in the community is an ineffective thing:

> "The fashion has swung from too much escorting and arranging for clients who do not need such support to a severe 'noninterventionist' policy, which may be little suited to the less mature clients and the complexity of interagency practices. In fact, the client is often supposed to bridge in his own person many poorly organized and inefficient community operations. The intake practices of some agencies are formidable. Until these are changed and the community resources are better integrated, indeed, whenever the client needs backing, the worker is prepared to be warm, flexible and supportive in his handling of referrals, evaluating his client's ability to function in a complex agency world and collaberating with workers in other agencies as members of the fraternity of professional service."[1]

There are occasions when referral of a client to another agency in the community can be an extremely constructive experience. Before the social worker at A.M.I. refers a patient to an agency for help in finding employment or for group association, the important thing considered is the readiness of the client to accept a referral of this nature.

The case described below illustrates how such referral to an employment agency was a constructive experience for a patient:

> Case Number 21 J.B., a twenty year old single man, was hospitalized at A.M.I. from August 3, 1950 to September 8, 1950, with a diagnosis of schizophrenic reaction. Two weeks after his admission, the patient referred himself to the Social Service Department, requesting help in making employment plans after his discharge. Several days after his request, the worker discussed the case with the doctor, obtaining some understanding of the dynamics of his illness and what his prognosis was. The worker saw Mr.B. four times while he was in the hospital and four more times in the six weeks after discharge. Although at times the patient provoked rejection by breaking appointments and by

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1. Hamilton, Gordon, Theory and Practice of Social Case Work, (New York, 1951), p.66.

> expressing hostility, the worker persisted in her interest and warmth toward Mr.B. Shortly after his discharge, he was referred to the National Employment Service, and the worker first gave the employment counselor a picture of the kind of person he was and what type of job the hospital felt he should have. During the six week post-discharge period, the worker continued to see Mr.B., always treating him with a good deal of acceptance and showing confidence in his ability to find a suitable job. At the time of his last contact with the worker, Mr.B. was preparing to start a new job and seemed hopeful that he would be able to handle it.

There were two factors contributing to the success of this case. First, the worker discussed the case with the doctor shortly after Mr.B. referred himself to the Social Service Department for help. Through this contact she developed the understanding that contributed to her warm accepting attitude towards Mr.B. in spite of his attempts to provoke her rejection. She also secured the necessary information to give the prospective employer an accurate interpretation of him. A third factor, and, in the opinion of the researchers, the most important, was that Mr.B. was ready for referral to an employment agency. This is indicated by his ability to approach the Social Service Department of his own accord and request their assistance in helping him to find a job. Once his initial readiness was there, the steady support and interest of the social worker was very meaningful to him.

SUMMARY

Although it is accepted that social workers and psychiatrists must work together as part of the treatment team, the teamwork concept is relatively new, and there is still a need for further definition of the related roles of the two groups.

In studying relationships between social workers and psychiatrists at A.M.I., there were several limitations-- first, the social worker's recording of contacts with the doctor may be very brief or totally lacking because of the informal relationships which exist between the two groups; second, student doctors and student social workers use the facilities of A.M.I. as a teaching hospital, and their understanding of their role in relation to the other may be somewhat inadequate.

Whether the social worker deals only with the relative or with the patient, it is equally important that there should be continuous sharing between the professional groups.

The A.M.I. is an integral part of the community and the relationships which the Social Service Department of the Institute has with other agencies in the community may be very effective at times. However, it is necessary that referral of patients to outside agencies should be made with the utmost consideration given to the readiness of the patient to take this step.

CHAPTER V

WORK WITH RELATIVES AND PATIENTS

Introduction

This chapter is a descriptive analysis of the fifty three cases studied at the A.M.I. in an attempt to arrive at conclusions which will help reveal the workings of the Social Service Department.

Because the writers were working from case records, the limitations of which have been previously discussed, it was necessary for them to seek out a point of departure which would serve in the analysis of all the cases. This would be a common factor around which the details of the case and the workings of the department seemed to hinge. It was realized that the choice of this common factor might be an arbitrary one; yet it seemed necessary and valid in view of the general method of the study. This point of departure taken was the social worker's objective in each case.

We are aware that in the case work situation the social worker does not always set an 'objective', which word possibly implies a degree of control not in accord with some of the basic principles of case work. Perhaps the idea is better expressed by the phrase 'focus of help'. At any rate, the researchers became convinced during the course of the study that certain specific features of the setting do, in fact, influence the work of the department, and form as it were the framework of its function; because of this framework and within its limits, the social worker must necessarily think in terms of the objectives or goals that are set in each case.

In some of the case records this objective was clearly stated,

as in admission interviews when the social worker usually made a statement of tentative diagnosis and plan after the first contact. In other cases the objective or plan was outlined at a further point in the contact, and in still other cases the objective was implied if not specifically stated through the recording of the work done. It should be pointed out that the original reason for referral and the worker's objective may not always coincide, but that the objective may alter from the original reason for referral due to circumstances in the case or limitations of the setting. In this respect the material in this chapter will differ from that contained in Chapter III, where the material presented dealt with the original reason for the referral rather than the actual work done.

The different objectives which were abstracted from the case material are listed below. Although there are fifty three cases in the sample, there are more than that number of objectives, since in some cases, the social worker had more than one objective.

Table V

WORKERS' OBJECTIVES IN CASES

OBJECTIVE	NUMBER OF CASES
Discharge planning with patient	16
Work with relative around the illness	21
Work with patient	10
Casework with relatives re interpersonal relationships	8
Environmental change	6
Sociallinvestigation	3

Again, it is pointed out that the listing of some of these objectives and their definition has been arbitrary and constitutes some oversimplification, but was undertaken as a means of clarifying the thinking that went into the analysis of the case material. The meanings of the objectives are made more explicit in the following paragraphs.

Definition of Objectives

Discharge planning refers to those cases in which the worker and the patient and/or relatives come together to work out specific plans for the patient's return to the community-- such things as finding accomodation or employment or joining recreational associations. The emphasis in discharge planning as so defined after an analysis of the material seems to lie more on the accomplishment of these things than on the actual quality of the relationship between the worker and the patient.

Support of the patient refers to those cases in which the focus is on the establishment of a relationship between the worker and patient, as an adjunct to the patient's psychiatric treatment. Although concrete plans around discharge may be part of "support of the patient", the main emphasis is on the actual quality of the relationship, rather than on the formulation of plans concerning discharge.

Environmental change refers to cases in which specific modification is made in the patient's environment, so that treatment will be facilitated. "Environmental change" differs from "discharge planning" in that the changes are being made before or after the patient's

hospitalization. Examples of "environmental change" are: finding a housekeeper to look after a patient's children while she is in hospital, helping a patient find a place to live while she is attending the day ward.

Support of relative around illness refers to those cases in which some member of the patient's family is seen by the social worker during and/or after the patient's hospitalization in order to give reassurance and support in relation to the patient's illness. This may involve working with the relative to help him express some of the guilt he feels in regard to the patient's illness, explanation of the patient's needs and condition and interpretation of the type of treatment he is getting. It is hoped that this objective will result in the most important environmental modification-- that of modifying attitudes and understanding of the people in the environment closest to the patient.

Casework with relatives around interpersonal relationships refers to those cases in which the relative is seen in order to help him with his problems and conflicts. It is true that this is done as a means of helping the patient in that there will be a more adequate person in the family constellation. But it differs from "support of the relative around illness" because in the former group the social worker focuses more on the relative as an individual. By that is meant that the social worker deals with the problems of the relative around the illness, but also with the personal problems of the relative.

Social investigation refers to those cases in which the worker's objective is to explore as fully as possible the patient's social situation in order to help the psychiatrist more adequately understand the patient. This is usually done through seeing members of the patient's family, and requesting summaries from other agencies.

Discharge Planning with Patient

Of the sixteen cases in which the worker's objective was discharge planning with a patient, twelve were referred by the treatment doctor specifically for help in making discharge plans, such as finding employment, accomodation, or recreational activities. The other four cases were referred in different ways. In one case, an agency referred the patient to the Social Service Department of A.M.I. at time of admission, in order to help her accept the need for treatment at this hospital. In one case the relative requested the aid of the Social Service Department in discharge planning for her husband. Another case was self-referred. In the last case the treatment doctor made the referral to the Social Service Department in order to assess the home situation, but out of this arose discharge planning with the patient.

In examining the cases in which the objective was discharge planning there are several points which are felt to be worthy of discussion.

In defining what was meant by discharge planning, we pointed out that the main emphasis appeared to lie on the formulation of specific plans rather than on the forming of a relationship. This was due at times to the fact that the referral came at a late date in the

patient's hospitalization. In a psychiatric ward of a general hospital, where patients are hospitalized for a relatively short time, it is necessary to look ahead to the time when the patient will be leaving the hospital. Otherwise the result may be that referral to the Social Service Department is not made until a short time before the patient's discharge from hospital, and under these circumstances the worker may be forced to accept the referral on an unsatisfactorily superficial level, since there is not time to work the problem through with the doctor or develop a relationship with the patient before he is discharged from the hospital.

> Case Number 22 A.M., a fifty year old widow, was hospitalized at A.M.I. for four weeks with a diagnosis of depressive state. The patient was referred to the Social Service Department by her doctor one week before her discharge. The referral stated that the patient's husband had died recently and it was felt that it would be better for her not to live alone; therefore the worker should discuss housekeeping services with her. The worker's contact with the patient was characterized by extreme hostility on the part of the patient. She reacted negatively to worker's suggestions and indicated that she did not want any help. Following one interview and informal meetings on the ward there was no further contact between the worker and Mrs.M.

In considering this case, it was felt that the difficulty lay in the fact that there was a great deal of hostility underlying the patient's depression. It was impossible for the worker to help the patient with discharge planning until she had built up a relationship with her and helped her work through some of her hostility towards any environmental changes, and the feeling of rejection which for her discharge enhanced. However, because the referral came so late in the patient's hospitalization, the worker was compelled to focus on discharge plans almost

immediately and was not able to spend sufficient time building up a relationship with the patient.

We recognize the extreme difficulty that exists for doctors in a setting like the A.M.I. where the period of hospitalization is relatively short and where patients are treated only during the acute phase of their illness. It is understandable that under such circumstances it is not easy to plan ahead to the time when a patient will be discharged from the hospital. However, the necessity of referring a patient to the Social Service Department for discharge planning late in his hospitalization makes the job of the social worker in this setting doubly demanding, and may defeat the purpose of the referral.

On the other hand, when the worker has sufficient time to form a relationship with a patient before attempting to make discharge plans with him, it would appear to be easier to formulate plans successfully, as indicated in the following case:

> Case Number 23 J.M., a sixty seven year old man in the manic phase of a manic-depressive psychosis, was hospitalized at A.M.I. from December 16, 1951 to January 16, 1952. Several days after his admission to hospital, the patient's wife, from whom he was separated, came to the Social Service Department, asking them to find her husband a place to live when he was discharged from the hospital, since she was unwilling to assume any responsibility for him. The worker continued to see Mrs.M. during the hospitalization period in an attempt to help her work through her feelings toward the patient. However, at the time of the patient's discharge Mrs.M's rejection of her husband still remained. The worker also saw Mr.M. five times during his stay in the hospital and discussed with him plans for discharge. The worker gave the patient the opportunity to express his hostility towards the hospital and his family and he was gradually able to accept the fact that his wife would not take him back and was then able to make plans with the worker to go to a nursing home.

It is our impression that one of the factors that contributed to the success of this case from the point of view of discharge planning with

the patient was that the worker saw him a number of times during his hospitalization and gave him the opportunity to fully express his feelings before attempting to make plans with him.

There may also be instances in which a patient is referred to the Social Service Department at his or her instigation for help in discharge planning when there is not real need for this kind of help. In other words, it would seem that discharge planning can at times be used by patients as extensions of their illness.

> Case Number 24 Mrs. R.D. was referred by the treatment doctor for help with discharge planning two days before leaving the hospital. The doctor felt that the patient could best cope with her many problems, including a marital problem, by taking a job outside the home. This was feasible because the patient's sister-in-law was in the home to care for the children. The doctor wished the worker to help the patient find a job. At the time of referral, Mrs.D. was anxious to talk to the social worker about a job. However, the patient already had very definite plans for a specific job and seemed capable to handling this herself. It was felt that the social worker's contact with the patient around discharge planning was unnecessary and detrimental to the former's relationship with the patient's husband. The patient seemed to want the contact with the worker not really for discharge planning but to exclude her husband from the worker's help.

Support of the Relative Around Illness

In a total of twenty two cases, the worker's objective was to help a relative with the problems created by the patient's illness and hospitalization.

Ten of these twenty two cases were routine Social Service admissions. In four cases the relatives referred themselves to the Social Service Department. In two cases the original request of the relative was for help in discharge planning for the patient, and out of this came support

for themselves with problems aroused by the illness. In the other two cases the relatives requested help for themselves.

Five cases were referred by the treatment doctor. In two of these cases the referral requested support of the relative around the illness. In one case, the treatment doctor requested that a social investigation be done; one case was referred for discharge planning with the patient, and one requested that the relative be seen as an adjunct to the patient's treatment. However, in these last three the social worker set as her objective the support of the relative around the illness.

Two cases were referred by the admitting doctor for social investigation, and out of this came support of the relative around the illness.

Cases Referred by Treatment Doctor:

The five cases referred by the treatment doctor gave rise to some interesting points relating to both the time of referral and the doctor-worker relationship.

When a referral for "support of a relative" is made after the patient has been hospitalized for a time, there is a possibility that the relative, who has not been brought into the hospital experience until this time, may regard it as a punitive measure. During discussions with the director of the Social Service Department, the question of relatives' attitudes to the patient's illness arose. It was mentioned that there is almost universal acceptance of the fact that the relatives of mentally ill patients are burdened with guilt. We can imagine then how threatening a telephone call or a letter would be to a relative after

the patient has been hospitalized for a time. His guilt may make him feel that the only reason the social worker wants to see him is in order to punish him; consequently he may enter the relationship in a very defensive way which will prevent him from using the help which the social worker is offering.

The case described below illustrates this point:

> Case Number 25 Mrs. M.G., a twenty six year old married woman with a diagnosis of anxiety hysteria, was hospitalized at A.M.I. from March 24, 1952 to May 30, 1952. The treatment doctor referred the case to the Social Service Department three weeks after the patient's admission, requesting that the social worker see the patient's husband whom he felt needed help and support around the patient's hospitalization and discharge. The patient's husband had already had several contacts with the doctor in which he had appeared to have little tolerance for the patient's illness. During several contacts with the social worker, Mr.G. proved to be extremely antagonistic toward the patient's hospitalization, the treatment she was receiving and towards her doctor. This attitude did not change and in the end he removed patient from treatment on the Day Ward against advice.

This case illustrates another point. Before having any contact with the social worker, the patient's husband had already had several contacts with the doctor, which, according to the latter, had shown him to have little tolerance for the patient's illness. Although the observation is in no way questioned, there is nevertheless the natural possibility that the doctor becomes identified to a certain extent with the patient, which makes it difficult for the doctor to identify also with relatives. Although in this case it might well have been impossible to work through the relative's resistance to accepting the patient's illness, the researchers feel that if he had been seen by a social worker the day of the patient's admission, there might have been a greater chance of success.

Cases Self-referred by Relatives

There were four cases in which the relatives referred themselves for support around the patient's illness. Although this might at first glance seem to indicate a readiness on the part of the relatives to take help, this is not necessarily the case. The guilt of the relative may be so intense that even though he reaches out for help, he cannot use it when it is offered. Sometimes the support which the relative gets from the social worker may provoke additional guilt on his part. The following case is in illustration of this point.

> Case Number 26 S.N., an eighteen year old single male, was hospitalized at A.M.I. from January 19, 1953, to May 1, 1953 with a diagnosis of paranoid schizophrenia. Following a meeting of the Relatives' Group, the patient's parents spoke to the director of the Social Service Department and asked to see a social worker. The patient, one of the youngest admitted to A.M.I., was extremely ill; his improvement was slow and barely apparent for some time and the prognosis was doubtful. Despite the delusional aspect of his illness, he had a very good intellectual grasp of emotional illness--its nature and origin, and had frightened his parents by these explanations which involved a great deal of hostility directed toward them. When they came to see the social worker they were extremely upset. They continually sought reassurance as to the cause of the patient's illness. They made almost insatiable demands on both the doctor and the social worker as to the cause of his illness, the course of treatment and the prognosis. Their manner gradually became more hostile when these demands could not be met. The social worker saw both parents on three occasions and thereafter there were many phone calls from the patient's mother. She seemed to be able to receive a great deal of comfort and reassurance through being able to have this contact with the hospital, but she did not wish any further office discussions.

It seems apparent that in this situation the pressure of the patient's illness created so much anxiety in the parents that they were really unable to use a supportive relationship to the extent of interviews; nevertheless, they sought and got a kind of more remote help by phone.

The parents felt extremely guilty in this case and this feeling became heightened when the patient directed his hostility towards them, pointing to them as the cause of his illness.

In a case where the relative refers himself to the Social Service Department for help, if there is someone in the environment on whom he can project some of the guilt he feels the support and acceptance he receives from the social worker in this may enable him to deal more positively with the patient in the future.

> Case Number 27 Mrs.D.E., a twenty seven year old married woman with two children, was hospitalized at A.M.I. from Oct.13, 1952 to January 12, 1953, with a diagnosis of schizophrenia. Two weeks after the patient's admission, her husband, who had been attending the Relatives' Group, referred himself to the Social Service Department for more personal service. Mr.E. was seen five times in the remaining two months of his wife's hospitalization and there were also about eight telephone calls during this time. He was a dependent, insecure person, who was quite resentful of his wife's strong attachment to her father, to whom she used to turn in the past for advice rather than to her husband. The social worker gave Mr.E. much support and encouragement, which gradually increased his self-confidence. On the several occasions when his wife went home for the week-end, he came back to the worker with reports about how smoothly things had gone.

In this case the patient's husband was able to allay some of his guilt by saying that the patient's relationship with her father had been an unhealthy one. The social worker made no attempt to help him develop an understanding of what part he might have played in this. Instead she gave him support and encouragement which increased his self-confidence and enabled him to give more to his wife. Although it may be true that Mr.E. might have benefited from more intensive casework, we must realize that in a hospital where patients are hospitalized for a relatively short time it may not be wise to involve them in a relation-

shop so intensive that there willlbe insufficient time to work through their problems effectively before their patient returns home.

In one case where a relative referred herself to the Social Service Department, she came with a specific request that the worker make living arrangements for her husband.

> Case Number 28 J.M., a sixty seven year old man in the manic phase of a manic-depressive psychosis, was hospitalized at A.M.I. from December 16, 1951 to January 16, 1952. Several days after his admission, Mrs.M., who had been separated from the patient for several years, came to the Social Service Department, requesting them to find living accomodation for her husband after his discharge from the hospital, since she was unwilling to go back to him. The social worker saw Mrs.M. three times during the month of her husband's hospitalization. She used her relationship with the worker mainly to release much of her hostility against the patient, who had been suffering with manic episodes over a number of years. However, at the time of his discharge there was little growth in her acceptance or understanding of her husband.

The relative in this case came to the Social Service Department with a specific request that would not involve her to any extent in the planning. The worker realized how hostile the patient's wife was and accepted her rejecting attitude toward the patient; however, in the limited time available, it appeared doubtful that Mrs.M. could use help in modifying this attitude. One value of the contact, however, was that the social worker learned of the real situation between husband and wife and could give this information to the doctor, who could then make use of it accordingly.

Cases Seen at Admission

Generally speaking, the cases which appeared to work out most successfully were those in which the Social Service Department established a contact with the relative at the time of admission.

In a psychiatric ward of a general hospital where the stay in hospital is relatively short, it is imperative that the relative be seen as early in the hospital experience as possible. Related to the short term of hospitalization is another factor; namely, patients are only in hospital during the acute phase of their illness. A good deal of their convalescence takes place after they have left the hospital. It becames doubly important under these circumstances to support the relative, to help him understand and accept the patient's illness.

The following case is illustrative of many in which the Social Service Department established a contact with the relative at time of admission, and maintained a supportive relationship with him throughout the course of the patient's hospitalization:

> Case Number 29 Mrs. G.S., a fifty year old married woman was hospitalized at A.M.I. from December 9, 1952 to January 9, 1953, with a diagnosis of reactive depression. The patient's husband was seen routinely at admission. During the course of the patient's hospitalization, there were two other office interviews with Mr.S., two long distance telephone calls, as well as several letters. Mr.S. was extremely anxious and upset the day of patient's admission. He was concerned about the treatment his wife would get. The social worker explained hospital procedure and something of the different types of treatment. Mr.S. subsequently confided to the worker the patient's long-standing behaviour leading to the present hospitalization. This seemed to give him relief, together with worker pointing out how adequately he had cared for the patient up to now. There was a long-standing marital problem, nevertheless certain obvious strengths in the relationship. The worker attempted to build on these rather than focusing on the problem. Mr.S. reacted to the contact by turning more positively toward the patient. He was able to endure her hostility when he visited and to plan positively for her discharge.

Although there are no particular cases to illustrate this point, the speculation is advanced that there is a subtle difference in the attitude of the social worker toward the relative, depending

on the way in which the contact with the relative is established. When a case is referred by the treatment doctor, requesting that a relative be seen, it may be that the social worker will enter the relationship identified to some slight extent with the patient. When the worker sees the relative at the time of admission, before she knows anything about the patient's history, it may be easier for her to focus more completely on the relative and his problems around the illness.

There is, on the other hand, a certain danger involved when the relative is seen at the time of the patient's admission. At this time "their defences are down," as it were. They may express a great deal of negative feeling against the patient, with the result that they will subsequently feel too guilty to maintain the contact. The following is a case in point:

> Case Number 30 Mr. A.L., a fifty six year old married man with a diagnosis of manic-depressive psychosis, was hospitalized at A.M.I. from November 11, 1952 to December 12, 1952. The Social Service contact originated through a routine admission interview, when the patient's wife was seen. The interview was used to allow Mrs.L. to express what feelings she could and to orient her to hospital procedure. She was extremely upset, and cried a great deal during the interview. She tried continually to find some reason for the onset of her husband's illness. The fact that it had been both sudden and violent and seemingly unprecipitated was very hard for her to bear. At the end of the first contact, the social worker felt Mrs.L. could be helped by a supportive relationship which would allow her to express her feelings about the patient's illness and give her some understanding of hospital procedure. As the family came from out of town, no immediate second appointment could be made, and it was left that Mrs.L. would get in touch with the worker when she next visited the patient. However, she did not do so; and when the worker saw her again she seemed to shrink from further contact. As time went by she made it clear that she did not want any contact with worker. At one point, the social worker helped her find overnight accomodation in Montreal. Mrs.L. expressed her gratitude, but said she thought there would be no further need to see the worker.

It would seem clear that in the admission interview the worker must make some attempt to control the amount of negative feeling that relatives express, so that their guilt is not thereby increased. However, negative feelings may more safely emerge in later contacts once a relationship has been established with the social worker. This would appear to be a matter of timing.

One of the characteristics of the A.M.I., along with other psychiatric wards of general hospitals which has been indicated, is the voluntary nature of treatment; that is, patients are not kept in the hospital unless they wish to be. By involving the relative in the hospital experience at the time of the patient's admission and by giving him support and encouragement, it may be that the relative will in turn be able to encourage the patient to stay when he expresses a desire to leave against the advice of the doctor.

> Case Number 31 Miss R.O., a twenty eight year old single woman, was hospitalized at A.M.I. from June 26, 1952 to August 12, 1952, with a diagnosis of anxiety hysteria. The patient's mother was seen a total of three times during her daughter's hospitalization--once at the time of admission and two more times during the six-week period. At the time of the first contact Mrs.O. was extremely hostile toward the patient and everyone in the hospital. She insisted that if the patient would try to "pull herself together," she could go home and would be alright. The worker was very accepting of Mrs.O's hostility, and in the next interview, Mrs.O. was able to bring out her feeling of guilt and her fear of what the people in her home town would say about her daughter's illness. The worker gave her much support around these feelings and Mrs.O. was able to persuade the patient to continue in treatment even though she wanted to leave against advice.

Support of the Patient

There were ten cases in which the worker took as her objective support of the patient. Nine of the cases were referred by the treatment doctor and one from the Admitting Office. In seven of the ten cases, the referral emphasized the forming of a relationship between the worker and

the patient, expressed as "forming a supportive relationship," "help with the problem of socialization," and "general help." Three of the cases were referred for specific help such as environmental change, employment and accomodation in one instance and social investigation and discharge planning in the other. In all of these cases, however, the worker set as her objective a supportive relationship with the patient, with the other needs being realized as a result of the relationship.

In her capacity of giving support to the patient, it is obvious that the social worker is entering specifically into the patient's treatment program. As such, she will be sharing with the treatment doctor responsibility for the patient's growth toward a healthier emotional adjustment. When this is the case, there would seem to be a need for a clear outline as to just what role each is to play in the treatment program. To this must be added an inclination to share their individaul resources and an ability to allow a flexible use of these resources to be made as the needs of the patient dictate. When these factors obtain, there would appear to be a place for the social worker in the patient's treatment program, not merely as an adjunct to the treatment doctor or as someone simply to help adjust the social situation, but as a working part of a team whose professional skills have in fact been merged with those of the treatment doctor. This working together is not looked on from the point of view of the actual relationship between the members of the team, but from the point of view of the needs of the patient.

With this in mind, the social worker must have a real knowledge of the patient's illness together with a continued awareness of how the treatment process is developing. It can also be said that in making use

of the social worker in a supportive way for the patient, the doctor must know in what capacity this use is to be made as dictated by the dynamics operating in a particular illness. That is, the social worker should enter into the treatment program in a supportive way for a specific purpose and not because the patient is not responding fully to treatment or because the worker, lacking an understanding of the dynamics operating, is willing to be used in an undifferentiated way. The following case illustrates in a positive way the importance of the respective roles of doctor and social worker in the treatment process.

> Case Number 32 Mr.D., a twenty four year old man separated from his wife, was hospitalized at A.M.I. for approximately twelve weeks with a diagnosis of schizophrenia. He was referred by the treatment doctor less than one week after admission for a supportive relationship and help with post-discharge plans. The worker saw Mr.D. several times during the first two months of hospitalization and during the last two weeks acted as a liaison between the patient and the outside community, helping him to make contacts regarding a job. In his relationship with the worker the patient gradually became more relaxed and spontaneous and relied on her for support and understanding of the difficulties he experienced in treatment--which he expressed with a great deal of hostility. The patient also expressed many doubts as to his ability to cope with community life again, which the worker met with encouragement, helping him to realize some of his capacities for getting along. The patient was seen by the worker once after discharge, at which time he was back at his old job and seemed to be doing well. When the patient missed his next appointment the worker phoned his home and was told that he no longer lived there as he had returned to his wife.

The success of this case would appear to be related to the time of the referral and the fact that the worker played a specific role in the treatment process, i.e. the supportive person who was able to accept the patient's hostility toward treatment, thus freeing his energies for a more positive participation in it. Although the contacts between the social worker and the doctor are unfortunately not recorded, except for the referral and a

discussion at the time of discharge, it is unlikely that these favourable results were obtained without a good working relationship between the two.

The above case also points out how discharge planning operates as a part of the supportive relationship and not as an entity in itself. In this case it will be seen that the worker carried on her role of a supportive relationship over a fairly long period of time and that it was made possible, in part, by the length of the patient's hospitalization as dictated by his illness.

In continuing the examination of the cases referred for a supportive relationship, it was seen that the social worker could also serve another purpose, that of acting as a stepping-stone for the patient from the community toward treatment and from treatment back into the community again.

The following is illustrative of this point:

> Case Number 33 Miss T., a nineteen year old single girl, with a diagnosis of anxiety hysteria was hospitalized at A.M.I. for approximately six weeks and referred by the treatment doctor less than one week after admission for general help and discharge plans. Out of this referral the worker took as her objective a supportive relationship with the patient. To the patient the worker assumed the role of a 'big sister' in whom she could confide many of her problems and fears which she did not yet have the courage to take to the doctor but which she was eventually able to do. There were several discussions between the doctor and social worker and there was a clear-cut idea of the social worker's contribution to the treatment program. The patient was able to make effective use of both in the course of her treatment, and at times when she appeared to prefer one helping person to the other there was a definite understanding of how this was related to the course of her treatment. Eventually the worker discussed the patient's activities and interests outside the hospital and job possibilities.

The success of this case would appear to hinge on the complete flexibility and excellent understanding on the part of both the doctor and the social

worker of just what was involved in the supportive role which the latter played in the treatment process.

One final case is worthy of note as another example of what is involved when the social worker takes as her objective a supportive relationship with the patient.

> Case Number 34 Mr.B., a thirty six year old single male, with a diagnosis of character neurosis with alcoholism was hospitalized at A.M.I. for approximately twenty four weeks. Contact with the patient originated four weeks after admission, after a referral from the treatment doctor. The doctor felt that the worker's seeing the patient for short periods every few days might have definite therapeutic value in helping him to relate to someone in the hospital besides the treatment doctor. From this the worker took as her objective the forming of a supportive relationship with the patient as an accepting mother-substitute to help him throughout the course of his treatment and in the post-discharge period. The worker literally became a mother to this patient, and at times her help was focused on encouraging him to eat sufficient food to maintain his physical existence. During the contact the patient began to show improvement both physically and emotionally and was able to build up a firm but dependent relationship. After a change of social workers the patient regressed and was unable to build up the same relationship with the new worker, as might be expected when circumstances forced him into a new relationship allowing for less dependency.

In this case the change of worker, although inevitable, was unfortunate and also points to the dependency which the patient brought to the relationship. Although the final results of this case were unfortunate because of an unavoidable change of workers, the essential contribution of the worker to the treatment process is nevertheless clearly seen.

Casework with Relatives in Interpersonal Relationships

This proved to be a focus of help in eight of the cases studied.

Generally speaking, the nature of emotional illness is that it involves problems in disturbed relationships. These problems exist not

only for the patient, but also for those close to him. They are bound to be related to the immediate situation of the patient's illness, but in addition emotional illness of one of the family's members may create a family crisis, causing to clare up dormant or deep-seated conflicts of which the patient's present illness is a part. These conflicts may branch out into members of the family in different ways, in one resulting in illness which requires hospitalization in a psychiatric setting, in others in problems which may or may not hinder the course of daily living to varying extents.

It would seem that the hospital's intention is to mobilize family strengths on behalf of the patient rather than to treat individaul problems, its assumption being that it is the patient and not the relative who is ill. What does the social worker do, however, when the relative presents personal problems or when his problems in interpersonal relationships appear to play a large part in his consideration of the patient or the patient's illness? Does this prove to be a problem to the social worker herself, who may be limited in the help she is able to give by certain factors within the setting?

From the analysis of the research material it would seem that in this category of the social worker's objective the results are varied. Factors in the individual case which determine the results may include the depth of the problem and what it means in terms of the patient's illness, the relative's ability to make use of help and the worker's skill in dealing with the problem. A central factor which emerges, however, is that time must be in the relative's favour and that those cases

in which favourable results obtained through work in interpersonal relationships extended over the longest period of time. The following is an example of a case in which effective help was given to a relative regarding her own interpersonal relationships, which help contributed to the patient's treatment and was a factor in discharge planning.

> Case Number 35 Miss M., a thirty six year old woman, was hospitalized at A.M.I. from April 3, 1952 to September 8, 1952 with a diagnosis of paranoid schizophrenia. It should be pointed out that this was one of the longest hospitalizations in the sample and exceeds by a number of weeks what is considered to be the average length of stay at A.M.I. This fact, then, may have some bearing on the work of the Social Service Department. Miss M's neice was seen at the time of admission and thereafter regularly once a week throughout the course of the patient's hospitalization. In forming a close relationship with the worker, Mrs.R. discussed her own problems related to her marriage and the social situation which had arisen out of it. As she gained security in her relationship with the worker Mrs.R. was able to consider the strengths in her marriage and to think of her home in positive terms. From this she was able to turn to a consideration of the patient's needs and to enter into constructive plans for her after her discharge in which it was arranged that the patient live with Mrs.R. and her husband. Through the help of the worker Mrs.R's own problems seemed to have resolved sufficiently so that she and her husband could consider the needs of a third person and take her into their home.

The following is another example in which contact, maintained with a relative over a gairly long period of time with the focus of help on interpersonal relationships, resulted in a better environmental situation.

> Case Number 36 Mrs.L. was hospitalized at A.M.I. on the Day Ward from December 28, 1950 to February 9, 1951 with a diagnosis of anxiety hysteria. The referral of the case to the Social Service Department was made on the basis that as the patient would be receiving psychotherapy over an extended period of time (during and after hospitalization), this would be damaging to her husband unless he was given support and helped to become a more adequate person in his marriage. The social worker's contact with Mr.L. was maintained over a period of eight months with a total of twenty seven interviews, which again is longer than most of the contacts in the sample. Mr.L. first considered

> his problems in terms of his financial difficulties. With encouragement, however, he was able to go more deeply into his problems, discussing his home situation and verbalizing his hostility toward the people involved. He was able to relate his own improved relationships to the release of tension through having discussed his difficulties. His work improved and he received a salary increase. He began to think of improving his skills in order to obtain a better job. Gradually as his confidence increased he was able to show more understanding of his wife. As his sense of responsibility developed he was able to think of his child and arrange to have him attend a child guidance clinic.

This would seem to be an example of effective casework with a relative in the area of interpersonal relationships. Factors which led to the success of the case were Mr.L's ability to use help for himself, the early date of the referral, the length of the contact, and the fact that the social worker was able to give her undivided attention to Mr.L. while the patient was receiving long-term psychotherapy from the doctor.

Cases in which there is a long-standing marital problem present difficulties, for it is obvious that if the marriage problem has endured for several years, it will not be resolved in a relatively short period of time. In fact, certain neurotic patterns may have been established which brought satisfaction to both partners. The patient's illness represents a breakdown of these patterns on one side, and it is obvious that this will have certain implications for the other partner. In addition the partner will carry over certain feelings from the marriage difficulties which will be interwoven with his feelings about the patient's illness. It is natural to expect, also, that as the patient receives insight into her own difficulties this may alter her relationship with the partner. Moreover, speaking in broader terms, we can say

that any illness is likely to involve feelings of guilt and anxiety on the part of those close to the patient.

How these feelings can be handled in the casework relationship will depend on their depth and extent and the use which the relative is able to make of the relationship. At times a relative may present personal problems in the casework relationship with which he appears anxious to have help but which may in reality be an expression of his feelings about the patient and his marital situation rather than a positive inclination to take help. The factors operating may be involved and difficult to identify in a short period of time; so that the casework relationship may be in progress for some time, with the worker's objective to help the relative in interpersonal relationships, before it becomes clear that the relative does not really want help for himself but is, instead, indirectly expressing hostility toward his own situation. It would seem that this is a pit-fall of the casework situation but one which might be avoided if specific features of the particular setting are kept in mind. The following case may serve to further develop this point.

> Case Number 37 Mrs.L. was hospitalized at A.M.I. from November 12 to December 11, 1953 with a diagnosis of anxiety neurosis with recurrent depressions. The case was self-referred to the Social Service Department by the patient's husband, who, after attending a Relatives' Group meeting, believed that he had information about the patient which would be valuable in treatment. Mr.L. was seen three times by the social worker, twice during patient's hospitalization and once following discharge and there were contacts by phone. During his contacts with the social worker, Mr.L. discussed his marital situation, expressing a great deal of hostility against the patient. At the same time he brought up his own problems but his approach was always intellectual and although he appeared to be asking the worker for help for himself, in reality he had little insight. The worker considered that Mr.L. wished to gear the relationship toward help for himself both as a punitive measure to himself and also as a means of expressing hostility against the

worker. She thought that any help which would be directed toward Mr.L's own problems would in the long run be negated by him and after assessing the situation she changed her focus from help in interpersonal relationships toward helping Mr.L. with his problems around the patient's illness.

At times it may be a temptation to the worker to become involved in relatives' problems, especially when they are very apparent and influencing the relative's attitude toward the patient. Here the broad principle of case work would hold true that help can only be given where there is a willingness to take it. The following case illustrates the worker's awareness of the relative's problem and how she attempted to deal with it until the relative himself changed the focus.

Case Number 38 Mrs.R.D., a thirty two year old married woman with a diagnosis of anxiety hysteria, was hospitalized at A.M.I. from October 8, 1952 to November 15, 1952. The case was referred the day the patient was admitted when she seemed very upset about her hospitalization. It was decided that worker should see Mr.D. in order to get some picture of the home situation and also his feelings about the patient's illness. The social worker contacted Mr.D. approximately one week after admission. Mr.D. at first resisted the contact, then in the first interviews expressed a great deal of hostility against the patient. Early in the contact it became apparent that Mr.D. had severe problems of his own into which he had little insight and which he tended to rationalize, giving his wife's illness as the core of the problem. This fact had also been pointed out to the social worker by the treatment doctor who had already seen Mr.D. before the social contact and which was considered to have been a factor adding to his defensiveness. The worker's contact with the doctor may also have been a factor leading to her attempt to help Mr.D. with his own problems. However, at the point where Mr.D. seemed to find the concentration on his own problems too threatening, he directed the discussion toward a consideration of the patient's problems, and in so doing began to show much more understanding of her problems. This may have been on a superficial level, but his increased understanding of the patient served to make the post-discharge period easier for her than had been previously expected. Mr.D. was seen during five interviews. He terminated the contact himself at a time after the patient's discharge when he considered she was making a fairly good adjustment.

Environmental Change

Referral of a case to the Social Service Department for environmental change such as care of the children, which is initiated prior to or at the time of the patient's admission to hospital, may be the factor that enables the patient to take the treatment she requires.

> Case Number 39 Mrs.N., a forty seven year old widowed female, was hospitalized at A.M.I. from September 30, 1952 to November 10, 1952 with a diagnosis of depressive reaction. The case was referred to the Social Service Department by the admitting doctor prior to the patient's admission for help in planning for the care of the patient's seven children and in order that patient might come into the hospital for treatment. Because it originated prior to admission it made good Social Service planning possible. The Social Service Department maintained close contact with the patient's minister, in the community from which she came. There was no child welfare agency in that community, however, between the social worker and the minister excellent plans were worked out for the care of the children. It was felt that the patient responded better to treatment because she knew her children were being well cared for.

From the two cases studied in which an attempt was made to meet environmental problems for patients attending Day Ward, it appears that such an attempt may fail, if the patient's inability to change the environment on his own is symptomatic of his illness.

> "......to alter the environment may be undesirable or even risky.....without an understanding of the dynamics, environmental treatment becomes merely symptomatic because it fails to get at the root of the trouble.....Of course the social worker cannot aboid symptomatic treatment, any more than the doctor can avoid the use of sedatives in epilepsy; but in both professions such treatment should be used with a clear realization of its implications and limitations for the problems in hand." [1]

The following case is an illustration:

> Case Number 40 Miss D.N., a twenty five year old single woman, was hospitalized on the Day Ward of A.M.I. from March 20, 1950

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1. Richardson, Henry, Patients Have Families, (New York, 1945), p.134.

to June 6, 1950, with a diagnosis of anxiety hysteria. Four days after the patient's admission to A.M.I., the case was referred to the Social Service Department for social investigation. Before seeing the patient, the worker discussed the case with the doctor and obtained a picture of the patient's living arrangements. She was living with her grandmother in a very small house; during the winter they closed part of it and lived in extremely close quarters. When the patient was working she contributed $20.00 weekly to her grandmother. She complained at the time of admission that she had always been completely dominated by her grandmother. The latter had never allowed her to have friends in. She was never able to buy anything for herself without buying something for her grandmother as well. There was a total of twelve interviews between the worker and Miss N.--eleven while she was in the hospital and one several weeks after her discharge, after which the patient discontinued the contact. Miss N., in her relationship with the worker, would discuss the difficulties she had at home with her grandmother. The worker kept subtly urging her to move into the Y.W.C.A. and finally arranged for the patient to go there and make arrangements for accomodations. Following this, the patient discontinued the contact with the worker.

Social Investigation

The cases in which the worker's objective was social investigation were three in number and originated in referrals from the treatment doctor for that purpose. In these cases, as far as could be, the worker took as her objective the original reason for referral of the case. It is possible that the worker would have wished to set further objectives; but the nature and the time of referral as well as qualities which may have been present in the situation itself would seem to have limited this in two cases. In the third case the objective was changed after a preliminary evaluation of the case. In all three cases the doctor made the referral for help in obtaining further information about the patient's background and environment which would help him in conducting treatment. Three cases do not offer any conclusive findings as regards the work of the department. However, from these three cases, certain factors emerge which may have some

significance when considered as a part of the study as a whole.

The first of these factors is related to the previously discussed point that the time at which contact is established with relatives may influence the way and the extent to which they are able to enter into a relationship with the hospital. This point may be extended to include the fact that the purpose for which they are contacted may also influence the course of the relationship. It has been indicated that a contact established at a certain point after the patient's hospitalization may constitute a threat to the relative. It may also be looked on in the light of an 'investigation'. When 'social investigation' is in fact the purpose of the worker's contact, the relative's suspicions may be confirmed.

The case of Miss P. was previously cited[1] to illustrate the significance of time of referral in the origin of the work load. It is again cited here as an example of a case referred by the treatment doctor for an assessment of the home situation:

> Case Number 41 Miss P., a twenty six year old single woman was hospitalized at A.M.I. for approximately five weeks, with a diagnosis of anxiety hysteria. She was referred four weeks after admission by the treatment doctor for assessment of the home situation. Out of this the worker took as her objective also support of the patient's relatives. However, the patient's family were extremely defensive in their contact with the worker; they gave the impression of not being really interested in the worker's attempt to help them or able to understand or participate in the patient's treatment. The worker reported this home situation to the doctor and it was decided that if patient was to continue with treatment on the Day Ward that living arrangements would have to be made for her away from home, and this the worker helped her to do. In this case, the chances of enlisting the relatives' co-operation appeared negligible and the alternative was to remove her from the home.

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1. Supra, p. 45

There may have been many factors operating in this case, some of them perhaps unrecorded, although known to the social worker, and others which were not within the range of the casework situation. Nevertheless the question remains as to whether the extreme defensiveness of the patient's family may not have served to hide some of the strengths which may have existed in the home and around which the discharge planning might have been shaped.

Another point that is raised here is whether the social worker, taking social investigation as her objective may not quite naturally tend to identify with the patient and treatment program which is already in progress and, in so doing, tend to miss the focus on the relatives and their feelings about the patient.

> Case Number 42 Miss L., a thirty year old single woman was hospitalized at A.M.I. with a diagnosis of chronic mized psychoneurosis. The case was referred by the treatment doctor two weeks after the patient's admission with the request that the social worker interview patient's sister in order to obtain more background information. The sister, Mrs.H., was seen in one office interview and from then on Mrs.H. made numerous phone calls to the worker, continuing for three months after patient's discharge. The background information disclosed that the patient, her mother and father, her sister Mrs.H., together with the latter's husband and two children lived in a small apartment. There were many problems in the home brought about by physical illness and financial stress. To Mrs.H. the patient's illness was one more blow which removed a wage-earner from the home placing her within the comfortable confines of a hospital while the rest of the family were forced to carry on to cope with their very real problems. The social worker gave this information to the doctor and it was decided that, in view of the family relationships and crowded living conditions, accomodation should be found for the patient away from home. It appears that little or no attention was directed to Mrs.H. and her problems. The social worker helped make arrangements for the patient to live at the 'Y'. However, much ill-will continued to exist between the patient and her family, her sister in particular. When the case was closed, the patient had achieved a measure of independence living away from home and working at a job which she liked; but the family relationships appeared to have changed very little.

This would appear to be a case in which the needs of the patient were constantly kept in mind but apparently at the expense of her environment and, eventually no doubt, at the expense of the patient herself, since one of the goals of treatment is to strengthen family relationships where possible rather than to encourage an existing breach, and since a physical separation of a patient from his or her family does not imply a severance of emotional ties.

The third case in this category of social investigation points to the fact that calling in relatives at a certain point in the patient's hospitalization may also be a threat to the patient and may not serve the purpose for which it was originally intended, namely, a contribution to the patient's treatment.

> Case Number 43 Mr.R. a twenty two year old single man was hospitalized at A.M.I. for a period of six weeks with a diagnosis of character neurosis. The case was referred by the treatment doctor one week after admission for social investigation. The worker's first efforts in the case were directed toward this objective and she contacted the patient in order to find out how to get in touch with his family. Mr.R., however, expressed much resentment against his parents, his father in particular. After discussion between the doctor and the social worker it was decided that the patient's family would not be contacted but that the worker would work on a supportive level with the patient himself, helping him to work out some of his ambivalent feelings.

In this case, the worker's objective of social investigation was changed when it was found to constitute too great a threat to the patient.

In summary it can be said that, from the three cases studied, it appears that contact with relatives undertaken for the purpose of social investigation is fraught with problems and with possible negative results for both patient and relative and for the course of the patient's treatment.

SUMMARY

Chapter V is a descriptive analysis of the work with patients and relatives at A.M.I. As a method of analysis, the researchers examined the cases according to the objectives that were set.

It was found that there were sic objectives; namely, discharge planning with the patient, support of the relative around the patient's illness, support of the patient, case work with relatives around interpersonal relationships, environmental change, and social investigation. It was found that the positive results in a case appeared to be related to the objective. Those cases in which the worker's objective was help to the relative around the patient's illness were of benefit to the relative and often of direct consequence to the patient's treatment. Again it was found that most effective help could be given to the relative if it was begun the day of the patient's admission.

Discharge planning undertaken for that purpose specifically often had negative results, which were apt to obtain particularly if the discharge planning was begun late in the hospitalization. An exception would appear to be in those instances where the social worker can maintain a fairly long period of post-discharge contact with the patient. The best conditions for help in discharge planning were those in which the referral was made by the treatment doctor early in the patient's hospitalization. It is believed that some patients may not be able to use help in discharge planning as their request for it may be merely an extension of their illness. Generally speaking, however, there would appear to be a real need for discharge planning as a part of treatment

in a setting such as the A.M.I., where the treatment focus is on the patient's return to his environment.

In those cases where the worker's objective was a supportive relationship, effective results were seen to obtain where there was a close contact maintained by the doctor and the social worker and where the role of each was defined in terms of the treatment process. That is, the worker entered the treatment process in a supportive way as a specific extension of it, and not merely in an undifferentiated way. Out of such a supportive relationship also, the worker was able to give effective help in discharge planning.

In case work with relatives in inter-personal relationships the results were varied and depended on several factors. Cases which were referred by the treatment doctor for help with the marital partner tended to be effective when the focus was kept on the marriage problem as such, rather than an attempt made to go deeply into the partner's own problems. In these cases, as in others in this category, time appeared to be a necessary factor if worthwhile results were to obtain. The question was raised as to whether this factor is always operating prominently in a short-term treatment centre.

The objective of environmental change had effective results when geared to the patient's environmental problems on the solution of which depended the opportunity to come into hospital, or to make best use of treatment. Care of the patient's children was an example of this. It was considered that an attempt to change the patient's environment at discharge might be risky, or even dangerous, since the patient's inability to make the change was probably symptomatic of his illness.

This environmental change would need to be considered also in terms of its effect on the patient's relatives, and whether the immediate benefits arising from the change would not be outweighed by the more permanent breach in family relationships.

Social investigation may serve an immediate worth-while purpose in contributing to the doctor's picture of the patient's environment. The long-range effects, however, may be detrimental to the patient's treatment. Social investigation may constitute a threat to the patient's relatives, so that they become defensive and ties with the hospital are severed rather than strengthened. In this way, their contribution to the treatment program may be negative.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS FOR FURTHER STUDY

This chapter is devoted to a review and correlation of findings of the study. An attempt will be made further to link these findings with the special features of the setting and to show in what way these special features influence the work of the Social Service Department.

The reader is again to bear in mind that the analysis has been primarily descriptive and analytic of the work done, rather than evaluative, although evaluative elements are necessarily present. The object throughout has been not to evaluate the Social Service Department, but to seek through illustrative case records better insight into its function.

Conclusions Regarding the Work of the Department, Drawn From an Analysis of the Cases Studied.

Functions studied

The first significant finding which emerged in the early stages of the study was that treatment, discharge planning and follow-up could scarcely be treated as separate functions of the department, but were, in fact parts of the same process. Discharge planning was seen to be most effective when tied up with the treatment process. Nevertheless it was thought that there might be a tendency to regard one of the functions of Social Service as discharge planning specifically, involving employment, accomodation or return for follow-up treatment. This concept of discharge planning as a specific function of Social Service, as separate from treatment, may be related to the broader concept that social work involves environmental problems and that the patient's treatment is geared toward a return to his environment. The findings of this research point

to the fact, however, that the Social Service Department gives most effective help in discharge planning when it is considered as a part of the treatment process, and not as a separate entity to be handled apart from the patient's treatment. The social worker makes her best contribution to discharge planning when she becomes a part of the treatment process and enters into it in sufficient time to form a meaningful relationship with the patient. By so doing, discharge planning loses some of its threatening aspect for the patient and may be viewed as a subject of less concern by the treatment doctor as discharge approaches.

It was also thought that not all cases referred for discharge planning required this help, but that the apparent need for discharge planning might result from one of the special features of the setting--i.e., a short-term treatment center which involves hospitalization for only the acute phase of illness.

Discharge planning with relatives was also found to be most effective when considered as a part of the whole treatment process in which the relative and the hospital co-operate from the day of the patient's admission. That is, effective discharge planning with the relative begins at admission and continues throughout the hospital experience; for it involves not only specific plans, but a preparation of the environmental situation for the patient before he returns home. Such preparation of the environment permits avoidance of last-minute discharge plans which may constitute a threat to the relatives as well as patients and serve to separate family ties rather than strengthen them. While it may be true that some patients need to return to other environments, generally

speaking the patient's entire emotional life is tied up with his family, and it would seem to be in his best interests to have him return to where his roots are, even though the soil may not always be in good condition. In the crisis of emotional illness, family weaknesses may come to the fore, for the time being hiding some of the strengths. Unless a contact has been maintained with the relative all along, these strengths may never be apparent, and the best plan may appear to be to remove the patient from the source of his difficulties.

The exception to the above would be the single men and women living alone, for whom accomodation and socialization would have to be worked out without the contribution made by relatives.

The need for employment is seen as a very real factor, considering the age group, sex and marital status of the patients whose cases were studied.[1] With the emphasis at A.M.I. on treatability and return to community living, ability to go into employment will certainly be seen as an important goal in the treatment process. There would seem to be a double problem, however, related to community understanding of emotional illness and the fact that at discharge patients may not be ready to undertake employment. The social worker may possibly help a patient most, not by helping him get a specific job, but through support and encouragement and helping him to approach the outside world again where jobs are to be found. Again this kind of support can only be given when the patient and social worker have had time to build up a relationship.

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1. See Appendix A for tables summarizing the information on these points in the cases studied. Since the sample cannot be assumed to represent the Department's work load, caution must be exercised in generalizing from them.

Where the emphasis is on treatability, short-term hospitalization and return to community living, the prevailing opinion may be that the sooner the patient returns to normal community living, the better. This was not entirely borne out by the research findings, which indicated that discharge from hospital and a readiness for employment do not necessarily coincide, and that the social worker may engage in a futile effort to help the patient toward employment when, judging by the reactions to this effort, the patient is not ready for it. However, good rapport between the doctor and social worker and early contact with the patient, would lead to the most effective planning for the patient.

Follow-up

While the researcher originally concerned with discharge planning and follow-up had in every case considered this second aspect, the researcher concerned with treatment carried the analysis of cases only to the point of discharge, and so had no data on follow-up. Therefore, when the data on the fifty three cases was compiled, the information on follow-up was by no means complete. It was decided to carry on with the analysis of the material at hand with the possibility of returning to follow-up later. The limitations of time, however, made this impossible and the study is being concluded without full research and analysis having been made of follow-up.

This is less important since the emphasis is not on quantitative aspects of the data. During the course of the research, certain impressions of follow-up were obtained and they are recorded here as such.

In cases where help has been given to relatives around the

patient's illness, they may tend to break contact with the Department at the time of the patient's discharge, or shortly afterward. This may vary according to the extent that the relative has been able to accept the patient's illness, but it does not necessarily depend on the quality of the social work relationship. In cases where positive movement was made in the relative's participation in the hospital experience, they still tended to break the contact. It would seem to be a need of the relative to break this contact themselves, and their doing so might be seen as their prerogative as well as being therapeutic. Relatives contacted for whatever purpose after the patient's discharge may feel threatened, unless a relationship with the hospital has already been well established. The point is raised as to whether relatives should, or need to be contacted in the post-discharge period (when presumably the environment has already been modified to consider the patient's needs) and whether they may react to such a contact as a form of supervision which tends to undermine their strengths. This observation is countered by the fact that the relative may look on the patient's discharge as a kind of rejection by the hospital, and that in reality the social worker might take the initiative at this point in helping them over the post-discharge period, when difficulties with the patient are bound to arise.

The speculation nevertheless arises as to whether the hospital's most effective follow-up program may not be devoted to the patient himself. It is possible that a social service follow-up program is limited by the short-term nature of the setting and the number of staff available. The fact that the patients are treatable may be one of the factors which results in the relatives breaking contact at, or shortly after, discharge.

The impression is that in the more recent cases studied, case work services are concentrated on the period of hospitalization, with only a fairly short period of follow-up. This is in contrast to earlier cases, where contact was in some cases maintained for a longer time. This shorter contact would also seem to be a realistic goal with the short-term nature of the setting, the turn-over of patients, and the number of staff being kept in mind.

Origin of the work load

Cases in the Social Service Department may originate from the following sources: admission interview, Admitting Office, treatment doctor, Relatives' Group, social agencies and patients.

Fairly definite conclusions were arrived at in considering the source of referral. While comprising less than one quarter of the total number of cases in the sample, contact originating with admission interviews were clearly beneficial, giving relatives support and help with their problems about the patient and contributing to a better hospital and post-discharge adjustment. Not all of the relatives could make use of the admission interview, but this was seen as being tied up with the patient and his illness. The further question might be raised here as to whether, even for them, the admission interview is not beneficial since their right to reject the hospital may in itself be therapeutic. The admission interview was seen to be advantageous to the doctor as well, in that further information about the patient and his environment was obtained.

Referrals made through the Admitting Office were advantageous as

they gave the social worker an immediate contact with the environmental problem and contributed to the patient's treatment. They also indicated that the admitting doctor was immediately concerned with the environment in relation to the patient. A complete coverage of social admittance might do away with the need for referral from the admitting doctor.

Half the referrals of the cases in the sample came from the treatment doctor. In some of the cases, the treatment doctor referred marital problems to the social worker. This bears out the fact that the patient's environment must in most cases be considered when attempting to deal with his illness. The best referrals occured when the doctor recognized the marital partner as having difficulties and also as having the right to individual support around them. It was thought there might be an understandable tendency for the doctor, identified with the patient, to make the referrals on the basis that the social worker deal with the partner primarily in the immediate interests of the patient.

Referrals by the treatment doctor for investigative purposes suggest his need, in a short-term treatment centre, to get an immediate and more adequate picture of the home situation. The results of contact undertaken for this purpose proved detrimental, however, constituting a threat to the relative, increasing his defensiveness, rather than drawing him into the hospital experience. The fact that the social worker may tend to undertake the contact for the purpose specified might be due also to the short-term aspects and some resulting feelings of pressure. These results are seen to be related not only to the reason for referral but to the time

when the contact was first made.

Referrals of the patient for supportive help as a specific part of the treatment process had the most favourable results when the most effective communication existed between the doctor and social worker. Referrals of cases with specific requests tended to have negative results, increased if the referral came late in the patient's hospitalization. The best results obtained when the worker entered into the treatment process in a supportive way with the specific needs being met as a result of this. Again, a setting where only the acute stage of illness is dealt with in a relatively short period of time, may have an influence resulting in the tendency to make referrals late and around specific needs. This feature may also influence the Social Service Department in accepting these referrals, when the immediate needs of the patient must be kept in mind. The point was also raised as to whether referrals to the Social Service Department might not at times develop out of a particular response to treatment. It was questionable as to whether such a referral might work in the patient's favour unless an awareness of the dynamics operating was fully shared by doctor and worker.

Referrals from the Relatives' Group tended to have positive results possibly because the relative, from his attendance in the Group, already had some idea of the work of the Social Service Department. Although the relatives approached the Department for various reasons, it was thought that they all were asking for help around the patient's illness or their own problems. Since these referrals occurred in the late 1952-53 period, they suggest the value of this group as a source of future referrals,

supplementing the incomplete coverage of social admissions.

Treatment objectives

Although the cases were considered from the standpoint of the worker's objective as a method of analysis, it was thought that certain features of the setting do in fact, require that the social worker set certain objectives in every case. This may seem at first glance not to be entirely in keeping with the general conception of case work, overlooking the individual's own personality, his needs and ability to move ahead in the casework relationship. The findings however, point to the fact that the consideration of an objective within a limited casework setting may be in the best interests of the patient.

This implies that certain demands are made on the social worker in this type of setting-- a good diagnostic and evaluative ability, the capacity to work within limitations and often under pressure, and a flexibility which allows for a change of focus should this be necessary. It also implies that at times obvious problems must necessarily go unmet if they do not come within the scope of the setting. It is perhaps true to say that both psychiatric treatment and social case work in a setting such as A.M.I. are concerned generally with the treatable, acute phase of emotional illness and its immediate relationship to the environment.

One of the main objectives was work with relatives around the problems of the patient's illness and need for hospitalization. This was seen to be related, not only to their own needs, but also to the characteristics of the setting. There were more positive results when the contact with the relative for this purpose was initiated the day of the

patient's admission, and this early contact was often of direct consequence to the patient's treatment process.

The objective of discharge planning, with a contact maintained specifically for that purpose, often had negative results, particularly if the discharge planning was begun late in the hospitalization. The best conditions for help in discharge planning were those in which the referral was made by the treatment doctor early enough in the patient's hospitalization so that there was time for the worker to form a relationship with the patient, rather than focus primarily on specific discharge plans. It is believed that some patients may not be able to use help in discharge planning, as their request for it may be merely an extension of their illness.

When the worker's objective is a supportive relationship with the patient, the best results seem to obtain where there was a close contact maintained between the doctor and the social worker, and where the role of each was defined in terms of the treatment process.

In case work with relatives in inter-personal relationships the results were varied and depended on several factors. Cases which were referred by the treatment doctor for help with the marital partner tended to be effective when the focus was kept on the marriage problem as such, rather than an attempt made to go deeply into the partner's own problems. In these cases, as in others, time appeared to be a necessary factor if worthwhile results were to obtain. The question is raised as to whether this factor is not always operating in a short-term treatment centre.

The objective of environmental change had effective results when geared to the patient's environmental problems, on whose solution depended the opportunity to come into hospital or to make best use of treatment. Care of the patient's children was an example of this. It was considered that an attempt to change the patient's environment at discharge might be risky, or even dangerous, since the patient's inability to make the change was symptomatic of his illness.

Social investigation may serve an immediate worthwhile purpose in contributing to the doctor's picture of the patient's environment. The long-range effects, however, may be detrimental to the patient's treatment. Social investigation may constitute a threat to the patient's relatives, so that they become apprehensive and ties with the hospital are severed rather than strengthened. In this way, their contribution to the treatment program may be negative.

Working Relationship Between Psychiatrist and Social Worker

The relationships between social worker and psychiatrist appears to have a definite effect on the work of the Department. In fact, it can be said that the most effective results obtain only when there is complete co-operation between the two. Although this co-operation was not always recorded in the cases studied, when present it was implicit in the work done. The fact that it was often lacking was attributed to several factors. In a setting which is a teaching and research centre as well as a treatment hospital, student internes and student social workers may not be aware of the flexible contribution each can

make to the treatment process. The concepts of the roles of each are likely to be somewhat rigid, with the psychic problems of the illness being allocated to the doctor and the environmental problems the social worker's area. This would seem in any case to hold true in a general way, but the point of view is advanced that since emotional illness cannot be really separated from its environment, special effort is required to the end that the patient, together with his surroundings should be treated as one entity. This would appear to be the underlying dynamic behind the positive results of admission interviews that gear further contact to work with the relative around problems of the patient's illness. It would also seem to be operating in those cases where the worker enters into a supportive relationship with the patient as a part of the treatment process, in order to make for more effective discharge planning. A simultaneous concentration on the illness and the environment should lead to a flexible use of the skills of both doctor and social worker, with the doctor at times dealing with the environmental situation because it is tied up with the illness, and the social worker handling psychic problems because they relate to the environment. It is obvious that this could not be done without the fullest communication between doctor and social worker, with a sensitive awareness of the meaningfulness to the patient of a particular relationship at a particular time.

The fact that full communication does not always exist might also be attributable to the special features of the setting which may often create a sense of pressure resulting in less time for conferences and with emphasis being placed on the more tangible aspects of treatment.

The over-all conclusion is that social case work in the psychiatric ward of a general hospital is bound up with the whole treatment process, and as such, will be most effective when begun at the same time as psychiatric treatment. The entire institution, including the Social Service Department, deals with illness and problems in their acute phase, and must work within a time limit and point outward toward the patient's environment and community life. These positive aspects are bound up with some of the special characteristics as identified in Chapter II; namely, the short-term nature of the hospital and the emphasis on treatability. At the same time the special characteristics of the setting may lead to difficulties in the case work situation, which may in turn, affect the patient adversely. It would follow that an awareness of the implications of these features for both psychiatrist and social worker would lead to further positive gains for the patient.

Recommendations for Further Study

In the course of the study, several other questions arose which would appear to be worthy of further study.

1. Different diagnostic categories present different syndromes. A descriptive study of the relatives of the patients suffering from different diseases might prove interesting and helpful.
2. Ideally the use of the Social Service Department is offered to people of varying socio-economic backgrounds. The time-honoured idea of the social worker as one working with lower economic classes may have some effect on middle and upper-class patients and their relatives in

their ability to work with the social worker. A comparative study of the relationships that lower and middle class patients and relatives form with the social worker might be interesting and informative.

3. In some of the cases studied the social worker's contact in the case was confined to a patient or the relative, while in other cases, the worker had dealings with both the patient and the relative. A study of the differences that arise under these two circumstances would be fruitful.

4. A study dealing with the problems presented by the children of patients at A.M.I. might yield some interesting results.

APPENDIX

Appendix Table I

PATIENTS CLASSIFIED ACCORDING TO AGE

Age Groups in Years	Total Number of Cases
Total	53
Under 20	3
20, less than 25	6
25, less than 30	11
30, less than 35	14
35, less than 40	6
40, less than 45	1
45, less than 50	4
50, less than 55	4
55, less than 60	2
60, less than 65	1
65, less than 70	1

Appendix Table II

PATIENTS CLASSIFIED ACCORDING TO DIAGNOSIS

Medical Diagnosis	Number of Cases
Total	53
Schizophrenic reaction	15
Anxiety hysteria	13
Depressive state	13
Chronic mixed psychoneurosis	4
Character neurosis	1
Alcoholism	1
Conversion hysteria	1
Manic-depressive psychosis	3
Organic brain damage	1
Senile psychosis	1

Appendix Table III

CLASSIFICATION OF PATIENTS ACCORDING TO AGE AND DIAGNOSIS

Age	Total	Medical Diagnosis									
		Schizophrenic	Anx. hys.	Depressive state	Mixed psychoneur.	Char. neur.	Alcoholic	Conversion hys.	Manic-depressive	Brain damage	Senile psychosis
Totals	53	15	13	13	4	1	1	1	3	1	1
Under 20	3	1	1							1	
20, less than 25	6	5				1					
25, less than 30	11	4	6		1						
30, less than 35	14	3	5	3	1		1	1			
35, less than 40	6	2	1	2	1						
40, less than 45	1			1							
45, less than 50	4			2	1				1		
50, less than 55	4			4							
55, less than 60	2			1					1		
60, less than 65	1										1
65, less than 70	1								1		

Appendix Table IV

PATIENTS CLASSIFIED ACCORDING TO LENGTH OF HOSPITALIZATION AND DIAGNOSIS

Length of Hospitalization (in weeks)	Total	Medical Diagnosis									
		Schizophrenic	Anx. hys.	Depressive state	Mixed psychoneur.	Char. neur.	Alcoholic	Conversion hys.	Manic-dep.	Brain damage	Senile psychosis
Totals	53	15	13	13	4	1	1	1	3	1	1
4, less than 6	14	1		8					3	1	
6, less than 8	13	3	7	2	1	1					
8, less than 10	4		2	1							1
10, less than 12	5	2	2				1				
12, less than 14	4	2			2						
14, less than 16	5	2	2	1							
16, less than 18	———										
18, less than 20	5	4		1							
20, less than 22	1	1									
22, less than 24	1							1			
24 and over	1				1						

Outline for Study of Cases

Social Service Function in Treatment and Discharge Planning for Patients and Relatives

Description of patient:

a. Age_____ Diagnosis_____ Admitted_____ Discharged_____

b. Race_____ Religion_____ Residence_____

Number years in Canada_____

1. How did contact originate?

2. How did this seem to affect the case?

3. When did it originate?

Answer:

Effect on the case:

4. Who originated it?

Answer:

Effect on the case:

5. How did the social worker and psychiatrist work together?

Answer: Extent_____ Nature_____

Effect on the case:

6. With whom was the work of the Social Service Department done?

Answer: Extent_____ Nature_____

Effect on the case:

7. What were the objectives in the case?

Answer:

Effect on the case:

8. Were the objectives modified and why?

Answer:

Effect on the case:

9. What was the nature of the work done?

Answer:

Effect on the case:

10. What other community agencies were involved and how?

Answer: Extent_____ Nature_____

Effect on the case:

11. How long was the case followed after discharge?

Number of interviews:

Number other contacts:

12. What was the final disposition of the case?

Answer:

The following is for Assessment and Guidance in Thinking about Relationship to Specific Characteristics of the Setting(the Psychiatric Ward of a General Hospital)

1. Was this a successful case? Yes_____ No _____ _____

Why?

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